Oregon Healthcare Preparedness Region 1

Trauma Surge Plan
TRAUMA SURGE PLAN: CORE PLANNING GROUP

About Us

Our Mission: To assist hospitals, hospital staff, and first responders in preparing for events which overwhelm the region’s trauma system through education and the provision of resources. The outcome is the safe management and care of the critically injured, and enhancement of a seamless transition of care.

Who we are: A collaborative team of experts representing the region's emergency preparedness, first responder, and trauma center leadership.

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Acknowledgements

This was truly a multi-discipline, multi-agency, multi-jurisdiction, and multi-year effort. Its success is due to our many partners in contributing agencies, as well as funders. We express our deep gratitude to the following for their support:

- Clackamas County Emergency Management
- Legacy Health
- Multnomah County Emergency Management
- Multnomah County Emergency Medical Services
- NW Oregon Health Preparedness Organization
- Oregon Health Authority
- Oregon Health Science & University
- Regional Disaster Preparedness Organization
- U.S Department of Health and Human Services
- Washington County Emergency Management

For further information, or to contact a member of the Core Planning Group please go to our Hospital Emergency Preparedness website at: hospitalemergencypreparedness.org
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Oregon Healthcare Preparedness Region 1
Trauma Surge Plan

Introduction

- Preamble
- Purpose
- Pictorial of Response Events
- Scenario
Introduction

In Oregon, healthcare system preparedness planning is carried out through regional coalitions. In Northwest Oregon the planning coalition is known as the NW Oregon Health Preparedness Organization (HPO). The HPO is a coalition of all hospitals/hospital systems, local health departments and other health providers. HPO leadership has identified updating and solidifying the all hazards Trauma Surge Plan as a priority. This is because the trauma system we use day-to-day was designed to treat small numbers of trauma patients at any one time, and provide a high level of care for each patient. It was not designed to treat large numbers of patients simultaneously.

All disasters present several diverse and unique problems requiring prompt and efficient management. In order to identify the roles and responsibilities for emergency response personnel expected to handle triage and patient care at a disaster scene under the Incident Command System (ICS), a preconceived plan must exist. ICS is a standardized, on-scene, all-hazards incident management approach that is flexible and can be used for incidents of any type.

Preamble

This all hazards Trauma Surge Plan (Plan) is designed to address an incident in which the Level I Trauma Centers in our region have reached capacity (Legacy Emanuel Medical Center [LEMC] and Oregon Health and Science University [OHSU]). It differs from a local mass casualty incident (MCI) plan (see Appendix A for a Sample Mass Casualty Incident Protocol) in that the Level I Trauma Centers have reached their capacity, therefore overwhelming the day-to-day emergency healthcare delivery system and requiring hospitals to accept trauma patients as well as activate their surge or emergency operations plans (EOP). This Plan is intended primarily for those unfamiliar with the current overall concept of operations and will address care, coordination, and the role of various providers. It does not supersede any agency operational plans, medical guidance, or protocols currently in place. This is simply a strategic document outlining current operational plans, while also providing recommendations on how organizations may better prepare for a disaster.

Purpose

This Plan provides guidelines for the medical response to a mass trauma incident throughout the Portland Metro Area. Although the Plan is focused on the Portland Metro Area, it outlines a consistent approach to managing mass trauma incidents, wherever they might occur, with a focus on communication and responding in a way that supports the greatest good for the greatest number of those impacted. This involves the triage, transport, and treatment of emergency victims. This Plan is also intended to identify the basic working relationships that should exist between 911 dispatch, law enforcement, emergency medical services (EMS), fire, hospitals, and other agencies involved in an incident.

Overall, this Plan seeks to establish and promote a continuum of care that provides timely and appropriate delivery of emergency medical treatment for people with acute traumatic injuries in an effort to minimize the loss of life, disabling injuries and human suffering. Furthermore, the goal is to distribute patients in a manner that avoids overwhelming any single facility while optimizing and coordinating resources. An emphasis on the importance of ensuring quick turnaround time of EMS units is also highlighted.
Pictorial of Response Events

1. Incident Occurs
   Clock Starts

2. Fire/EMS Responds
   Minutes

3. Incident Command
   Established
   Within Minutes of
   Fire/EMS Arrival

   Primary triage initiated
   where color coded
   ribbons related to
   severity of injuries
   are applied to each victim
   Within Minutes of
   Fire/EMS Arrival

4. After ribbons are applied
   to each patient,
   secondary triage occurs
   and patients are tagged
   with triage tags
   corresponding to their
   injury severity

5. As patients are tagged,
   they are placed in
   treatment areas
   associated with their
   injury severity

6. A staging area is
   established away from
   the incident location for
   responding personnel
   and supplies

7. Update ED bed
   capacity status on
   HOSCAP daily, upon
   notification of an
   event, and during an
   event in real-time. If
   updates are not
   made, the facility
   will continue to
   receive patients.*

8. Regional Hospital
   assigns hospital
   destination based on
   HOSCAP numbers
   As soon as HOSCAP
   updates are made and
   transportation is
   available

9. 75% of patients
   arrive within 2 hours
   Hospitals initiate surge
   plans as they see
   appropriate.
Scenario
Rather than concentrate on a specific scenario, this all hazards Plan focuses on the medical response to any scenario that creates a mass number of trauma patients which overwhelms the two Level I Trauma Centers. Examples of potential causes include, but are not limited to, a mass shooting, major transportation incident, or earthquake.
Oregon Healthcare Preparedness Region 1
Trauma Surge Plan

Pre-Hospital Response

- Diagram of Pre-Hospital Response
- Awake-Breathing-Circulation (ABC)
- Simple Triage and Rapid Treatment (S.T.A.R.T.)
- Pediatric MCI Triage (JumpSTART)
- Deceased Victim Care Coordination
- Guidelines for Field Triage of Injured Patients
- LaserBand Triage Tag
- Sample Disaster Victim/Patient Tracking Form
- Oregon HOSCAP Sample
- Hospital Treatment Capabilities
Pre-Hospital Response

Upon arrival of Emergency Medical Services (EMS), an Incident Commander (IC) is established and initiates control of on-scene operations. Once the incident scene has been declared safe or a safe alternate area has been established for medical operations, the IC will assign a Medical Branch Director to coordinate all aspects of medical care. The major focus in a mass trauma is triage. EMS will perform primary triage. This is performed on victims in the location where they are found. It is extremely quick (less than 30 seconds per victim). No treatment is done except opening of an airway and/or controlling hemorrhage.
Pre-hospital responders use a variety of triage algorithms; but all result in the same conclusions. Awake-Breathing-Circulation (ABC) and Simple Triage and Rapid Treatment (START) are the most prevalent and allow for rapid assessment and classification of patients in one of four color categories.

Awake-Breathing-Circulation (ABC)

![ABC Triage Diagram](image-url)
Simple Triage and Rapid Treatment (START)

**Red**  Urgent  Patients with a life threatening injury who have a high probability of survival if given immediate care and rapid transport.

**Yellow**  Delayed  Patients with injuries that have life threatening implications but who are not yet showing signs of shock or hypoxia and treatment can be delayed.

**Green**  Minor  Ambulatory (walking wounded) patients with localized injuries that require minimal treatment and do not have systemic implications.

**Black**  Deceased or Expectant  The deceased or patients that are not expected to survive due to the severity of injuries complicated by the conditions and lack of resources.
Once patient classification is decided, a colored ribbon (red, yellow, green, or black) is applied to each victim. This ribbon allows other responders to immediately turn their attention to the victims most in need.

Pediatric victim triage will be done using a slight variation of the adult triage; this is known as JumpSTART. This format helps reduce the emotional burden on triage personnel who may have to make rapid life-or-death decisions about injured children in a chaotic circumstance.

JumpSTART
Deceased Victim Care Coordination

All deceased victim care coordination will fall under the direction of a Medical Examiner (ME). By law (ORS 146), bodies, remains and effects of the deceased, and instruments or weapons related to the death will be left in place until permission is granted by the ME, Deputy ME, or the District Attorney unless there are hazards present or access to other victims requires movement. Life-saving activities should not be hampered or confusion created by the needs of the ME’s Office. The first priority at an emergency scene is always the removal of viable patients.

The first step in treatment, known as secondary triage, is next and follows primary triage. This is a more in-depth assessment of each patient.
Guidelines for Field Triage of Injured Patients

Exhibit 2
Guidelines for Field Triage of Injured Patients

1. Measure vital signs and level of consciousness
   - Glasgow Coma Scale: ≤13, or
   - Systolic Blood Pressure: <90 mmHg, or
   - Respiratory rate: <16 or ≥24 breaths per minute (<20 in infant aged ≤1 year); or
   - Need for ventilatory support

   **YES**
   - Take to trauma center. Steps 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the trauma system.
   **NO**
   - Assess anatomy of injury
     - All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee; or
     - Chest wall instability or deformity (e.g., flat chest); or
     - Two or more proximal long-bone fractures; or
     - Crushed, deviated, mangled, or pulseless extremity; or
     - Amputation proximal to wrist or ankle; or
     - Suspected pelvic fractures; or
     - Open or depressed skull fracture; or
     - Motor sensory deficit

2. Assess mechanism of Injury and evidence of high-energy impact
   - Falls
     - Adults: >20 ft. (one story is equal to 10 ft.); or
     - Children: >10 ft. or 2-3 times the height of the child; or
   - High-Risk Auto Crash
     - Intrusion, including roof: >12 in. occupant side; >18 in. any side; or
     - Ejection (partial or complete) from automobile; or
     - Death in same passenger compartment; or
     - Vehicle telemetry data consistent with high risk of injury; or
     - Auto vs. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact; or
     - Motorcycle or ATV crash >20 mph

   **YES**
   - Take to trauma center. Steps 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the trauma system.
   **NO**
   - Assess special patient or system considerations
     - Older adults
       - Risk of injury/death increases after age 55 years; or
       - SBP <110 might represent shock after age 65 years; or
       - Low impact mechanisms (e.g. ground level falls) might result in severe injury; or
     - Children
       - Should be triaged preferentially to pediatric-capable trauma centers; or
     - Anticoagulants and bleeding disorders
       - Patients with head injury are at high risk for rapid deterioration; or
     - Burns
       - Without other trauma mechanism: triage to burn facility; or
       - With trauma mechanism: triage to trauma center; or
     - Pregnancy >20 Weeks; or
     - EMS provider judgment

   **YES**
   - Transport to a trauma center or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries. Consider consultation with medical control.
   **NO**
   - Transport according to protocol
Exhibit 2  
Guidelines for Field Triage of Injured Patients

**Measure vital signs and level of consciousness**

<table>
<thead>
<tr>
<th>Glasgow Coma Scale</th>
<th>≤13; or</th>
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</thead>
<tbody>
<tr>
<td>Systolic Blood Pressure</td>
<td>&lt;90 mmHg; or</td>
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<tr>
<td>Respiratory rate</td>
<td>&lt;10 or &gt;29 breaths per minute; or</td>
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<td></td>
<td>≤20 in infant aged &lt;1 year; or</td>
</tr>
<tr>
<td></td>
<td>Need for ventilatory support</td>
</tr>
</tbody>
</table>

**Take to trauma center.** Steps 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the trauma system.

**Assess anatomy of injury**

- All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee; or
- Chest wall instability or deformity (e.g., flail chest); or
- Two or more proximal long-bone fractures; or
- Crushed, degloved, mangled, or pulseless extremity; or
- Amputation proximal to wrist or ankle; or
- Suspected pelvic fractures; or
- Open or depressed skull fracture; or
- Motor sensory deficit

**Take to trauma center.** Steps 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the trauma system.

**Assess mechanism of injury and evidence of high-energy impact**

**Falls**
- Adults: > 20 ft. (one story is equal to 10 ft.); or
- Children: > 10 ft. or 2-3 times the height of the child; or

**High-Risk Auto Crash**
- Intrusion, including roof: > 12 in. occupant site; > 18 in. any site; or
- Ejection (partial or complete) from automobile; or
- Death in same passenger compartment; or
- Vehicle telemetry data consistent with high risk of injury; or

**Auto vs. pedestrian/bicyclist thrown, run over, or with significant (> 20 mph) impact; or**

**Motorcycle or ATV crash > 20 mph**

**Take to closest appropriate trauma center**, which depending on the ATAB plan, need not be the highest level trauma center.

**Assess special patient or system considerations**

**Older adults**
- Risk of injury/death increases after age 55 years; or
- SBP <110 might represent shock after age 65 years; or
- Low impact mechanisms (e.g. ground level falls) might result in severe injury; or

**Children**
- Should be triaged preferentially to pediatric-capable trauma centers; or

**Anticoagulants and bleeding disorders**
- Patients with head injury are at high risk for rapid deterioration; or

**Burns**
- Without other trauma mechanism: triage to burn facility; or
- With trauma mechanism: triage to trauma center; or

**Pregnancy > 20 Weeks; or**

**EMS provider judgment**

**Transport to a trauma center or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries. Consider consultation with medical control.**

**Transport according to protocol**

Eff: 01/01/2013
At the conclusion of the assessment, a colored triage tag with a unique number is applied to each patient, again corresponding to the severity of injuries. This tag also initiates patient tracking.

**LaserBand Triage Tag**
## Sample Disaster Victim/Patient Tracking Form

### SAMPLE DISASTER VICTIM/PATIENT TRACKING FORM

<table>
<thead>
<tr>
<th>INCIDENT NAME</th>
<th>DATE/TIME PREPARED</th>
<th>3. OPERATIONAL PERIOD DATE/TIME</th>
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#### 4. TRIAGE AREAS (Immediate, Delayed, Expectant, Minor, Morgue)

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<tr>
<th>MR#</th>
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<th>Name</th>
<th>Sex</th>
<th>DOB/Age</th>
<th>Area Triage to</th>
<th>Location/Time of Diagnostic Procedures (x-ray, angio, CT, etc.)</th>
<th>Time sent to Surgery</th>
<th>Disposition (home, admit, morgue, transfer)</th>
<th>Time of Disposition</th>
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#### 5. SUBMITTED BY

#### 6. AREA ASSIGNED TO

#### 7. DATE/TIME SUBMITTED

#### 8. FACILITY NAME
Simultaneously with triage, treatment zones are set up to correspond with each triage category. These zones are identified by colored tarps. This location should be easily accessible for both patients arriving on backboards and those that will be removed by ambulance.

As assisting personnel and supplies arrive, the IC will establish a staging area strategically located away from the incident. This is an area where supplies and personnel wait for assignment.

Once ambulances arrive for patient transport, Regional Hospital (the patient distribution coordinator and communications link between EMS and hospitals during a major incident in the Portland Metro Area) will designate each patient destination. **Regional Hospital will direct trauma patients to the two Level I Trauma Centers in Portland and, subsequently, PeaceHealth Southwest Medical Center in Vancouver, WA (Level II) first. Once these hospitals are at capacity, Regional Hospital will distribute the trauma patients by triage color to the remaining hospitals based on their availability.** As soon as Regional Hospital is notified of the incident (typically during primary triage), Regional Hospital will immediately notify all hospitals so that preparation can begin.

Overall, the medical branch is responsible for patient management. This includes triage, on-scene treatment, communications, and transport. Hospitals must update the hospital capacity website (HOSCAP) in real-time to ensure Regional Hospital can effectively determine the destination of patients. Based on HOSCAP availability numbers, Regional Hospital will make every effort possible to avoid overloading any individual receiving facility.

As ambulances are transporting patients to the facility, they will contact the receiving facility via radio to provide a patient report.
Oregon HOSCAP - How To Make Status Updates

To provide current hospital status, your hospital is requested to make updates to the following areas once every 24 hours. If your hospital status changes drastically, more frequent updates are requested.

**Hospital Status Areas to Update**

1. **Click on any one of the elements in the red area to change its status.**

2. **Example of ED Diversion Update:**

   - **ED Diversion:** Status of Emergency Department to receive patients via emergency medical services
   - **Closed:** Requesting reroute of EMS traffic to other facilities
     - Not Applicable: This hospital does not have an emergency department
     - Open: Department is open

   - **Example of an Adult ICU Update:**
     - **Adult ICU:** This value should be within 72 hours. These can slowly increase.
     - **Comment:**
       - 2: 17 Jun 10:59
       - 1: 17 Jun 10:59
       - 0: 17 Jun 10:59

**Important Items for Updating:**

- **Click on the Key Icon 🎨 next to the hospital's name to update multiple status items.** If you do not see this icon, you do not have the ability to update.
- Click on the hospital name to show capacity details and **Current Hospital Capacity/HAvBED**, Click on a specific **Status** item to update.

**Always click Save to finalize your update(s).**

For an informational video, go to [www.HAN.Oregon.gov](http://www.HAN.Oregon.gov) ➔ Videos in the left Column ➔ HOSCAP - EMResource overview
## Hospital Treatment Capabilities

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Oregon Healthcare Preparedness Region 1

Trauma Surge Plan

Hospitals

- Map of Oregon Trauma System Hospitals
- Oregon Trauma Hospital's Contact Information (by Healthcare Preparedness Region)
- Sample Hospital Surge Plan Checklist
- Altered Standards of care
- Crisis Care Guidelines
- Hospital Security Priorities in a major Incident Checklist
- General Evidence Handling
- Behavioral Health
Hospitals

There are two Level I trauma centers in the Portland Metro Area and the State of Oregon; Legacy Emanuel Medical Center and Oregon Health and Science University. There is also a Level II trauma center, PeaceHealth Southwest Medical Center in Vancouver, Washington. With a major traumatic incident, ideally, these three facilities will accept, to their capacity, all trauma patients. All area hospitals will enact their own rapid discharge protocols in an effort to increase both emergency department (ED) and inpatient treatment ability. Hospitals have plans in place to increase capacity and capabilities by 15-20%. All patients that can continue their care safely at home or alternate care facilities will be discharged to create room for the influx of patients. Elective surgeries and procedures may be cancelled. Other ways to increase hospital capacity will also be considered, such as converting single rooms to double or triple rooms and the use of lobbies or conference rooms as treatment areas. Triage and treatment tents along with decontamination (if necessary) will be set up outside the hospital to further facilitate patient triage and treatment.

Hospitals will likely need to initiate their own Emergency Operations Plan (EOP) which should include Hospital Incident Command System (HICS). HICS is a command system designed to assist in the operation of a medical facility in a time of crisis. Typically a Hospital Command Center (HCC) will be activated under the direction of an IC. The IC will initiate other necessary command staff (operations, planning, logistics, and finance) that facilitates the hospital response.
### Oregon Trauma Hospital’s Contact Information (by Healthcare Preparedness Region)

<table>
<thead>
<tr>
<th>Region 1</th>
<th>Region 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Columbia Memorial Hospital</strong> 2111 Exchange St. Astoria, OR 97103 Telephone: (503) 338-4017 Level: 4</td>
<td><strong>Legacy Emanuel Medical Center</strong> 2801 N Gantenbein Avenue Portland, OR 97227 Telephone: (503) 413-2100 Level: 1</td>
</tr>
<tr>
<td><strong>Oregon Health &amp; Science University</strong> 3181 SW Sam Jackson Park Rd Portland, OR 97239 Telephone: (503) 494-9000 Level: 1</td>
<td><strong>Tillamook County General Hospital</strong> 1000 Third St. Tillamook, OR 97141 Telephone: (503) 842-4444 Level: 4</td>
</tr>
<tr>
<td><strong>Good Samaritan Regional Medical Center</strong> 3600 NW Samaritan Drive Corvallis, OR 97330 Telephone: (541) 757-5111 Level: 2</td>
<td><strong>Salem Hospital</strong> 890 Oak St. SE Salem, OR 97309 Telephone: (503) 561-5200 Level: 2</td>
</tr>
<tr>
<td><strong>Samaritan Albany General Hospital</strong> 1046 W. 6th St. Albany, OR 97321 Telephone: (541) 812-4194 Level: 3</td>
<td><strong>Samaritan Lebanon Community Hospital</strong> 525 N. Santiam Hwy Lebanon, OR 97355 Telephone: (541) 258-2101 Level: 4</td>
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<tr>
<td><strong>Samaritan North Lincoln Hospital</strong> 3043 NE 28th Street Lincoln City, OR 97367 Telephone: (541) 994-3661 Level: 4</td>
<td><strong>Samaritan Pacific Communities Hospital</strong> 930 SW Abbey Newport, OR 97365 Telephone: (541) 265-8800 Level: 4</td>
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<tr>
<td><strong>Santiam Memorial Hospital</strong> 1401 N. 10th Ave Stayton, OR 97383 Telephone: (503) 769-2175 Level: 4</td>
<td><strong>Silverton Hospital</strong> 342 Fairview St. Silverton, OR 97381 Telephone: (503) 873-1500 Level: 4</td>
</tr>
<tr>
<td><strong>West Valley Hospital</strong> 525 SE Washington St Dallas, OR 97338 Telephone: (503) 623-8301 Level: 4</td>
<td><strong>Willamette Valley Medical Center</strong> 2700 SE Stratus Avenue McMinnville, OR 97128 Telephone: (503) 472-6131 Level: 3</td>
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<td>1775 Thompson Rd.</td>
<td>(541) 269-8124</td>
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<tr>
<td>Coos Bay, OR 97420</td>
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<tr>
<td>Lower Umpqua Hospital</td>
<td>600 Ranch Rd.</td>
<td>(541) 271-2171</td>
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<tr>
<td>Reedsport, OR 97467</td>
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<tr>
<td>Mercy Medical Center</td>
<td>2700 NW Stewart Pkwy.</td>
<td>(541) 673-0611</td>
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<tr>
<td>Roseburg, OR 97471</td>
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<tr>
<td>Sacred Heart Medical Center</td>
<td>3333 River Bend Drive</td>
<td>(541) 222-7300</td>
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<tr>
<td>Springfield, OR 97477</td>
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<tr>
<td>Coquille Valley Hospital</td>
<td>940 E 5th Street</td>
<td>(541) 396-3101</td>
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<tr>
<td>Coquille, OR 97423</td>
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<tr>
<td>McKenzie-Willamette Medical Center</td>
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<td>(541) 726-4400</td>
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<td>Springfield, OR 97477</td>
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<tr>
<td>Peace Harbor Hospital</td>
<td>400 9th Street</td>
<td>(541) 997-8412</td>
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<tr>
<td>Florence, OR 97439</td>
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<tr>
<td>Three Rivers Community Hospital</td>
<td>500 SW Ramsey Avenue</td>
<td>(541) 472-7000</td>
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<tr>
<td>Curry General Hospital</td>
<td>94220 Fourth St.</td>
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<tr>
<td>Gold Beach, OR 97444</td>
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<tr>
<td>Sky Lakes Medical Center</td>
<td>2865 Daggett</td>
<td>(541) 882-6311</td>
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<tr>
<td>Klamath Falls, OR 97601</td>
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<tr>
<td>Providence Medford Medical Center</td>
<td>1111 Crater Lake Ave</td>
<td>(541) 732-5000</td>
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<tr>
<td>Medford, OR 97504</td>
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<tr>
<td>Sutter Coast Hospital</td>
<td>800 E. Washington Blvd.</td>
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<tr>
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<td><strong>Mid-Columbia Medical Center</strong></td>
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<tr>
<td>1700 E. 19th St.</td>
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<td>The Dalles, OR 97058</td>
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<td>Telephone: (541) 296-1111</td>
<td>Telephone: (541) 386-3911</td>
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<td>Telephone: (541) 575-1311</td>
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<td>564 E. Pioneer Drive</td>
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<td>Pendleton, OR 97801</td>
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<td>Telephone: (541) 881-7100</td>
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Sample Hospital Surge Plan Checklist

### 1. Command and Management

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<td>Plan identifies triggers and decision-making processes for activating the Emergency Operations Plan (EOP) and surge plan in response to a surge event.</td>
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<tr>
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<td>• Initial assessment of the event type, scope and magnitude, estimated influx of patients, real or potential impact on the hospital, and special response needs (e.g., infectious disease, hazardous materials).</td>
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<td>• Activation of the Hospital Incident Command System (HICS) and determination of appropriate positions to be activated. Utilize incident specific HICS Incident Response Guide (IRG) where appropriate.</td>
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<td>• Activation of the Hospital Command Center (HCC).</td>
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<td>• Notification to appropriate local governmental point of contact (e.g., local health department, local emergency medical services agency, Medical and Health Operational Area Coordinator) of the surge status and activation of the EOP and surge plan. The EOP identifies the local government points of contacts and 24/7 contact numbers, alternate contacts and appropriate notification priorities and processes.</td>
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<td>• Internal notification/communications and staff call-back protocols (e.g., call trees, contact information, etc.).</td>
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<td>• Processes, procedures and paperwork for contacting local or regional licensing authority (e.g., California Department of Public Health Licensing and Certification) for potential or actual request for temporary permission to exceed staffing ratios or utilize non-traditional patient care delivery areas (e.g. tents). Include the licensing authority’s contact information in the plan, templates and checklists.</td>
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<tr>
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<td>• Memoranda of Understanding (MOU) with local government, area hospitals, long term care facilities and other health providers to accept or receive patients and share resources as appropriate and possible.</td>
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</table>
|        |          | • Establish ongoing communications with local governmental point of contact to report:  
  o Patient census and bed capacity using standardized reporting terminology (e.g., HOSCAP).  
  o Hospital status, critical issues and resource requests. |
|        |          | • Activation of resource management system including inventory, tracking, prioritizing, procuring and allocating of resources. |

### 2. Creating Surge Capacity

#### Immediate Response

**Triage**: Plan to activate and operate additional/alternate triage area(s) during a surge event.

- Activation triggers for establishing alternate/additional triage areas are defined.
- Set-up checklists and operations plan.
- Identifies primary and alternate triage areas (e.g., consider external triage areas, event type, and facility damage).
  - Responsibility and processes for set-up and operation of triage area(s) are defined.
  - Communications plan for communications between triage areas, Emergency Department, other key departments and the HCC (e.g., landlines, handi-talkies, radios).
  - Staffing of the alternate triage sites.
  - Provision of supplies and equipment for the triage area considering scope and type of event, based on the facility HVA.
- Infectious and/or exposed patient triage area(s) and protocols (e.g., standard precautions, staff Personal Protective Equipment, ventilation, infection control protocols for staff and patients).

- Flow of patients to and from the triage area(s).

- Signage for directing patients to triage area(s).

- Communication with the HCC to identify available community resources (e.g., checklist with level of care capability and contact information).

- Triage protocols for internal and external patient disposition (e.g., minor care, delayed care, holding, hospital or local government alternate care sites, etc.).

**Decontamination:** Plan to activate and perform decontamination, as necessary.

- Plan for set-up (checklist) and operation of holding and decontamination area(s) (list individuals responsible).

- Plan for segregation and prioritization of contaminated individuals for decontamination.

- Methods for directing patients to decontamination area(s) (e.g., signage, stations, cones, etc.).

  - Primary and alternative decontamination areas (consider external areas, event/agent, and facility damage potential).

  - Communications protocols within the decontamination area(s) and between other units.

  - Staffing plan.

  - Equipment and supplies.

**Holding Areas:** Plan for activation and operation of holding areas for patients awaiting triage, decontamination, treatment, admission, discharge or transport to lower levels of care.

- Responsibility for set-up and operation of holding area(s) (identify by area).

- Map and signage, using appropriate languages, for directing staff/family and patients to holding area(s).

- Set-up checklists and operations plan.

  - Primary and alternate holding area(s) while considering type of event, capacity, level of care, infectious disease, facility status.

  - Communications between treatment areas, with HCC.

  - Staffing plan considering scope and type of patient (level of care, infectious disease, etc.).

  - Equipment and supplies.

**Treatment Areas:** Plan for activation and operation of additional treatment areas to include identification of sites, signage, capacity, responsibility, communications, staffing, equipment and supplies, patient tracking/medical records, etc., to allow the Emergency Department to focus on higher acuity patients.

- Minor care area(s).

- Delayed care area(s).

- Additional immediate care area(s), if available or necessary.

- Infectious disease care area that is specific to type of contagion.

**Security – Facility Access:** Plan(s) for securing and limiting facility access during a surge event.
- Security assessment with plans to address vulnerabilities.

- Plan for activating traffic control measures for access to facility (pre-planned traffic control measures, tools, etc.).
  - Road map outlining ingress, egress and traffic controls during surge event that is coordinated with law enforcement.
  - Specific staffing assignments and instructions for traffic control that includes who, what, and how during a surge event.

- Plan for initiating facility lock-down and/or limited access and entry.
  - Identification/diagram of all access points in facility.
  - Identification of limited access points for entry and procedures for monitoring/managing staff.
  - Criteria and protocols for entry and exit to/from facility(ies) -- including staff, volunteers, patients, family and other individuals (e.g., who, identification requirements).
  - Staffing plan for monitoring closed entrances (which will only be locked for external entry).
  - Communication between security, manned access points and HCC.
  - Special considerations following a terrorist attack/active shooter event (e.g. creating a secure perimeter, restricting access to adjacent parking areas, increasing surveillance, limiting visitation, etc.).

- Training for staff who may be utilized in security roles including protocols, handling abusive behavior, etc.

- Plan and mutual aid agreements for assistance with hospital security (e.g. hospital labor pool, local law enforcement, outside agencies, etc.).

**Direct Patient Care Areas**

Specific protocols for creating surge capacity to care for a significant surge of disaster patients.

- Plan for immediate cancellation/delay of scheduled/non-emergent admissions, procedures and diagnostic testing.
  - Inpatient admissions including scheduled surgeries/procedures).
  - Clinic visits.
  - Outpatient surgeries and procedures (e.g., GI, Catheterization, Radiologic).
  - Diagnostic/Ancillary services (e.g., Imaging, Neurology).

- Protocols for rapid and periodic review of patients for admission, discharge or transfer by teams of physicians, nurses and discharge planners for:
  - Emergency Department (ED).
  - Inpatients by unit or service.
  - Outpatient surgery and procedure areas (e.g., Colonoscopy)
  - Clinics
• For potential terrorist or criminal event, chain-of-evidence for law enforcement is addressed.

• Communication and coordination with HCC regarding activated and available community resources to triage, discharge or transfer to. The plan should include checklist with location, level of care and contact information.

**Capacity Plan Contents:** Specific protocols for expanding ambulatory and inpatient capacity beyond licensed capacity.

• Identify how ED, inpatient units, clinics, clinical areas and other hospital areas (e.g., cafeteria, auditorium, conference rooms, surge tents, open spaces, etc.), will be utilized to expand surge capacity. Address all key elements for use including forms and protocols for each area.
  
  o Capacity and use, considering cohorting of patients (e.g., inpatient, minor care, holding).
  o Activation including definition of responsibility and activation process.
  o Management and operation of the area (describe responsibilities and procedures).
  o Equipment and supplies (including re-supply).
  o Staffing (identify requirements and staffing plan).
  o Management of special needs patients (e.g., mobility impaired, hearing impaired, etc.).
  o Method of triage to/ discharge from area, including transport method(s).
  o Work with local fire officials and OSHPD in preplanning and deployment of surge tents.

Inpatient Capacity: Specific plans for increasing bed capacity to care for surge of inpatients, including expanding beyond licensed capacity on inpatient units and use of alternative care areas (e.g., dialysis, outpatient surgery, recovery, etc.) while maintaining continuity of operations and care for current patients who cannot be discharged or transferred.¹

• Trauma (assume all hospitals will receive trauma cases when trauma center capabilities are exceeded)

• Critical care (expand bed capacity in existing units, use of other areas/units).¹

• Burn (assume all hospitals will receive burn patients when burn center capabilities are exceeded).

• Isolation plan that identifies specific hospital unit(s) or areas for negative pressure or isolation through independent ventilation if event involves contagious/infectious disease.

• Medical/Surgical acute care

• Pediatric (assume all hospitals will receive pediatric cases when pediatric center capabilities are exceeded).

• Neonatal Intensive Care Unit (includes disaster victims and/or continuity of operations).

• Maternity (assume continuity of operations).

**Ambulatory Care Capacity:** Specific plans for expanding capacity to care for surge of emergency/ambulatory patients, including use of ambulatory care centers, and opening Alternative Treatment Areas (e.g., surge tents, clinics, other hospital areas and facilities).²

**Ancillary and Support Services**

**Ancillary Services:** Specific plans have been established for increasing capacity and capability for ancillary/diagnostic services during a surge event.

• Laboratory services, including communication and reporting to and from county public health.

• Imaging services (including MRI, CT, Ultrasound, etc.).

• Other ancillary and diagnostic services.

**Mass Fatality Management:** Plans have been established for management and disposition of deceased patients.
• Plans are consistent and coordinated with Operational Area Mass Fatality Management Plan such as the Medical Examiner/Coroner Plans.

• Includes mortality estimates by type of event to anticipate and secure supply needs (e.g., body bags, shroud packs, visquine, twine, etc.).

• Plan for expanding decedent storage capacity, including alternative hospital areas, that identifies current and prospective capacity.

• Agreements with external agencies for additional decedent storage capacity, consistent with local plans that include contacts and capacity.

**Medical Waste:** Plans have been established for storage and/or disposition of increased medical waste during a surge event.

• Expansion of storage facilities and/or disposition capabilities.

• Agreements with vendor(s) to increase medical waste pick-up.

### 3. Personnel

**Staffing:** Specific plans for staffing during a significant surge event using hospital staff, contracted pools, and mutual aid resources, taking into consideration type and scope of event.

• Identification of staffing needs by staff type, service area, and status of regulatory waivers regarding staffing ratios, licensure and scope of practice.

• Contingency staffing plan identifies minimum staffing needs and prioritizes critical and non-essential services.

• Maintain up to date staff contact information and ensure availability to HCC and individuals responsible/systems used for making staff contacts.

• Staff disaster response assignments/roles (e.g., labor pool, specific units/areas, etc.) considering type of event.

• Staff notification and call-back protocols, including responsibilities. Multiple methods identified and automated if possible.

• Agreements with staffing agencies (assume multiple organizations have agreement with the same agencies).

• Protocols for requesting and receiving staff resources (e.g., volunteers, special needs/teams, etc.) through HCC to local government point of contact.

• Cross-training and reassignment of staff to support critical/essential services.

• Establish Just-In-Time (JIT) training for key areas to allow staff to be assigned where most needed (e.g., Pediatrics, Burn, Respiratory, Security, Critical Care areas).

• Address shift change, rotation, rest areas and feeding of staff.
  - Protocols for shift changes and rotation of staff (consider type of event)
  - Specific areas designated for staff respite and sleeping that (identify areas, responsibilities).

**Volunteers:** Plan includes utilization of non-facility volunteers including policies and procedures for accepting, credentialing, orienting, training and using volunteers during a surge event.

• Volunteer check-in protocols including staffing of check-in location (e.g., single entry).

• Registration, credentialing and privileging protocols, including use of local Medical Reserve Corps (MRC) and Disaster Healthcare Volunteers (DHV).

• Systems to collect, track, and maintain volunteer information (e.g., HICS form 253 Volunteer Staff Registration).

• Issuance of identification badge and other means of identification (e.g., colored/printed armband).
- Protocols for assignments and roles by type of volunteer (consider buddy systems as appropriate).
- Just-in-Time (JIT) training as appropriate to volunteer role(s).

**Staff/Family Needs:** Specific plans for addressing staff needs, family and domestic concerns during a surge event.

- Internal or external arrangements for dependent care to include, if necessary, boarding, food and special needs to remove barriers that may prevent staff from coming to work (e.g., encourage staff to have family disaster plan and to pre-arrange, if possible).
- Internal or external arrangements for pet care and (encourage staff to pre-arrange).
- Protocols and specific assignment of appropriately trained professionals to monitor and assess staff for both stress-related and physical health concerns.

### 4. Supplies, Pharmaceuticals and Equipment

Plan addresses supplies, pharmaceuticals and equipment (SPE) for patients and staff for a significant surge event.
- Essential SPE have been identified and summarized (consider type of event and patient age).

  - Equipment and furnishings (e.g., beds, cots, ventilators, IV pumps, etc.).
  - Supplies.
  - Personal Protective Equipment (e.g., masks, respirators, gowns, gloves, hand hygiene products).
  - Pharmaceuticals (including prophylaxis for inpatients, staff and family members).
  - Food and water for patients, staff, families and volunteers.

- Plans to meet SPE needs/requirements have been established including who, how, and where.
  - Standard hospital resources/supplies.
  - Hospital caches, including pallets, trailers and methods for transportation/delivery.
  - Agreements with vendors for surge SPE (list of contacts and deliverables) and list of alternative vendors (assume multiple organizations have agreements with the same vendors).
  - Agreements with local pharmacies and stores including list of contacts and deliverables.
  - Community/government caches that includes list of cached items.
  - Other resources
    - Security needs during transport, delivery and storage of SPE.

- Needs and plans have been shared with local government point of contact and planning partners.

- Describe responsibilities and protocols for providing, requesting, accepting, distributing and tracking mutual aid resources including who, where, and how.

- Strategies/protocols included for how priorities would be established if there is a need to allocate limited patient equipment, pharmaceuticals and other resources.

- Identified reporting process on status of SPE resources available and/or needed, and urgency of needs to local government point of contact.
### 5. Important Considerations

<table>
<thead>
<tr>
<th><strong>Healthcare Coalitions:</strong></th>
<th>Hospital participates in local Healthcare Coalitions for surge planning and community risk assessment/needs activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication:</strong></td>
<td>Plan describes primary and back up internal and external communication systems, assigned frequencies and uses, maintenance and equipment locations (e.g., internet, telephone, cell, internal radios, satellite, HAM radio, ReddiNet, EM System, Command Aware, Live Process, WebEOC, Vocera, CAHAN, etc.).</td>
</tr>
<tr>
<td><strong>Behavioral Health Needs:</strong></td>
<td>Plan addresses how behavioral health needs of staff, patients and family members will be met. Have printed and electronic resources available. Identify any community resources that may be available.</td>
</tr>
</tbody>
</table>
| **Media Communication:** | Plan includes protocols for communication with the media in coordination with county and other healthcare providers.  
  - Protocols for communication with media and identifying media spokesperson(s).  
  - Coordination with county Emergency Operations Center/Joint Information Center (JIC) to establish common messaging and information dissemination.  
  - Pre-prepared templates for issuing press statements that consider key event types, common statements and facts. |
| **Documentation – Patient Tracking:** | Plan includes minimum patient documentation requirements for use during a surge event and protocols for patient tracking (e.g., HICS form 254 – Disaster Victim Patient Tracking Form) and reporting to appropriate agencies (e.g., county, American Red Cross). Identify systems in place that address community wide patient tracking. Consider activation of a hospital based Family Information Center (FIC) to assist in reunification. |
| **Information Sharing:** | Plan addresses release of patient information to appropriate entities and individuals for patient/family reunification. |
| **Continuity of Operations:** | Hospital has Continuity of Operations Plan which identifies and plans for maintaining critical/essential functions and services during a disaster or significant surge event. Manual backup processes and forms are identified. |
| **Prioritization of Resources:** | Hospital has protocols for prioritization of resources during a surge event when demand exceeds available resources. |
| **Care Requirements for Services not Normally Provided:** | Plan addresses protocols and resources for providing services not normally provided by hospital (e.g., infants and children, maternity, burn, trauma).  
  - Care area(s) identified.  
  - Equipment resources or adaptations identified (inventory lists).  
  - Supplies identified with appropriate supply on hand (inventory lists).  
  - Protocols (e.g., adapting adult beds to pediatric beds, handling burn cases).  
  - Clinical expertise and Just-In-Time resources  
  - Protocols for transfer of patient to a facility with appropriate capabilities, when they become available. |
| **Prophylaxis/Vaccination Plan:** | Hospital has plan and, as available, pharmaceutical and other resources to prophylax or vaccinate staff, staff family members, volunteers and patients. |
### Crisis Standards of Care

Hospitals are encouraged to develop policies and procedures specific to their organization that address allocating scarce resources during mass casualty events. Hospital incorporates state and local level planning efforts into plan.

### Recovery

Utilize HICS Incident Response Guides for recovery activities. Plan refers to EOP recovery activities.

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**Altered Standards of Care**

Increasing staffing during a major incident occurs through each department initiating a phone tree or other notification systems. At the same time the staffing department may contact on-call staff and those that potentially could assist.

There are also alterations in the standard of care. In a mass trauma, a different approach, termed *minimal acceptable care*, is advised. This approach is intended to keep patients alive by providing lifesaving procedures at the initial phase and providing more comprehensive care at a later date when adequate resources and personnel are available. Minimal acceptable care applies primarily to critical patients but is extended to less severe ones as well. For example, imaging tests are not performed at the initial phase and treatment is directed by clinical judgment only until the situation clears and imaging can be performed.

**Crisis Care Guidelines**

The Oregon Health Authority has outlined specific Crisis Care Guidelines when healthcare resources may be overwhelmed. These can be found at the Oregon Medical Association website:


Also, staff may need to expand their span of control to efficiently handle the volume of patients. This can also entail the use of ancillary staff members. Studies have shown that the optimal span of control range is from 3-7 persons, depending on the elements presented.

During a disaster there are two types of documentation that are required. The first is the historical record of the incident command system and the disaster response. This captures the activity, decision making, action plans, requests and follow-through during the disaster response. This will provide a way to assess the quality of the response and any weaknesses that will require improvement. This summary of the events is required when filing for state and federal reimbursement, insurance claims, and funding requests to replace or upgrade items following the disaster.

The second type of documentation is patient care documentation. This should be concise and facilitate a smooth continuity of care as the patient moves through the care process. Hospitals must develop procedures and tools to capture data for a morbidity and mortality review following the disaster. Computer charting can be challenging, especially if power is interrupted or the volume of patients is overwhelming. Paper charting may be easier. Minimal documentation tools such as modified every day charting forms that still capture essential information are recommended. A facility's “downtime” form may be a helpful resource to use in this instance.
Hospital security plays a pivotal role in optimizing the workings of the medical response and minimizing interference.

**Hospital Security Priorities in a Major Incident Checklist**

- Central command and the support sections
- Entrances/exits
- Emergency services
- EMS traffic route/patient drop-off
- Intersections to secure EMS traffic routes
- Triage/medical decontamination
- Morgue/temporary morgue
- Outside perimeter
- Traffic around facility
- Visitor/staff parking
- Entrance/exits
- Air ducts/ventilations systems
- Water systems/oxygen storage
- Communications
- Radio delivery
- Ham radio oversight
- Dispatch
- Clinic and support patient care buildings
- Media
- Casualty patient family center
- Casualty patient discharge holding area
- Community volunteer screening
- Community donations screening

Hospitals should consider controlling access to their facilities to prevent an onslaught of walking wounded, worried well onlookers, and the media. Access should be restricted to all but those who require immediate life-saving care and whom have undergone any necessary decontamination.

Any object (or part of an object) indicating that a crime has occurred or establishing a link between victim and perpetrator is physical evidence. Physical evidence includes such items as clothing, footwear, hairs, fibers, stains, bullets, sharp objects, physical injuries, and laboratory specimens. Staff should consult their departmental policy and procedures manuals as routine collection procedures vary across hospitals. It is important that items of evidence be collected, handled, and stored in a way that will ensure their integrity.
General Evidence Handling

Guidelines
- Protect yourself and others
- Protect the evidence
- Consider all types of forensic evidence
- Chain of custody starts at the crime scene – keep it short
- Document location with notes, sketches, and/or photographs
- Mark evidence and/or packaging with your case identifier, initials, date, and description of evidence or as required by your agency
- Package all evidence separately
- Allow wet biological stains to air-dry
- Obtain standards if needed for a comparison of evidence
- Use packaging that is appropriate for the specific type of evidence such as paper bags, envelopes, plastic bags, cardboard boxes, tamper-proof sealing, etc.

Evidence Collection

Packaging
The type you choose depends on the type of evidence, the condition of the evidence, and the examination(s) you want the laboratory to perform. Use the information in the table below to select the proper way to package specific evidence. All packaging types need to be clean and unused (e.g. no recycled grocery bags).

<table>
<thead>
<tr>
<th>Packaging Type</th>
<th>Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper bags or envelopes</td>
<td>Any biological material, (marijuana, psilocybin mushrooms, blood or semen stained items, condoms, etc.) <em>If unable to air-dry prior to packaging, submit to the laboratory as soon as possible and notify them that it is a wet sample.</em></td>
</tr>
<tr>
<td>Plastic bags or Ziplocs</td>
<td>A non-biological material such as powder drug samples</td>
</tr>
<tr>
<td>Metal cans</td>
<td>Arson evidence</td>
</tr>
<tr>
<td>Plastic buckets</td>
<td>Samples from clandestine laboratories that are individually packaged in glass vials and set in an absorbent material (e.g. vermiculite, kitty litter, etc.) in the plastic bucket.</td>
</tr>
<tr>
<td>Glass vials</td>
<td>Liquid drug samples, syringe contents, samples from clandestine laboratory, etc.</td>
</tr>
<tr>
<td>Paper folds and Post-It notes, then placed into a clean envelope</td>
<td>Small pieces of trace evidence, hairs, fibers, minute glass particles, paint chips, residue amounts of powder drugs, etc. Place inside a larger paper envelope. Use a Post-It note by placing the trace evidence on the adhesive and folding the Post-It in half to cover the adhesive.</td>
</tr>
</tbody>
</table>
Sealing

A proper seal ensures that evidence has not been accessed, altered, compromised, or lost during storage. A good seal is tamper-proof and is detectable if tampered with. The person packaging the evidence should initial and date across the seal.

**THE LABORATORY CANNOT ACCEPT EVIDENCE THAT IS NOT SEALED.**

<table>
<thead>
<tr>
<th>Do Use</th>
<th>Don’t Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence tape (tamper-proof)</td>
<td>Staples</td>
</tr>
<tr>
<td>Heat seals</td>
<td>Masking tape or Scotch tape</td>
</tr>
<tr>
<td></td>
<td>Paper clips, binder clips, etc.</td>
</tr>
</tbody>
</table>

Gloves should be worn during handling of all physical evidence and should be changed throughout evidence collection. All packages used to collect evidence are to be sealed and labeled with the date, time, patient's name, description and source of the material (including anatomic location), name of the healthcare provider, and names and initials of everyone who handled the material thus ensuring the proper chain of custody.

Ambulance throughput is a critical step to ensuring patient treatment in a timely fashion as well as ambulance turnaround time, thus clearing the scene quicker. Traffic ingress and egress routes should be developed prior to an incident. All area hospitals are expected to be ready to accept a substantial number of patients, including trauma. Medical personnel should not be dispatched to a scene location as their greatest value is in their ability to deliver care in a resource-rich hospital environment. More than 50 percent of all disaster casualties that present to a hospital will arrive within the first hour, and 75 percent within two hours. In previous disasters, 80 percent of casualties bypass EMS transport and arrive to the nearest facility on their own.

A large-scale disaster or major medical emergency may cause widespread stress reactions such as anxiety, anger, fear and frustration that may in turn create a temporary surge in demand for behavioral health services in a community. A major incident may also cause community members to go to local medical centers and seek relief from symptoms that are predominantly psychological in nature. Behavioral health interventions can reduce community anxiety levels, provide comfort to traumatized individuals, support emergency workers and help restore a community to its pre-disaster level of functioning.
Behavioral Health

Hospitals and health systems in the region have behavioral medicine departments and chaplaincy services that can assist in providing counseling to an increased number of people who seek assistance in their facilities. Hospitals can also partner with their Community Mental Health Programs (CMHPs) to develop protocols for an unusually large number of community members seeking assistance. Two methods to address a hospital behavioral health surge may include:

- Family Assistance Center (FAC): A defined location near the hospital for families and friends seeking information about missing or recently-admitted loved ones. FACs include specific providers such as chaplains and social service professionals who facilitate reconnecting patients with their families. Family members will call and arrive at all hours; services must be immediately available for crisis intervention and stress management (see Appendix B for the Family Assistance Center Quick Guide).

- Psychological Support Center: A defined location adjacent to the hospital for those requiring further assessment in a safe, calming environment but who do not appear to need immediate medical intervention.

Staff from behavioral medicine and/or chaplaincy departments may also support or join local disaster response teams during a large-scale incident to help provide appropriate triaging of medical and behavioral health patients in community settings.

Psychological First Aid for Emergency Workers (PFA) is a brief supportive intervention designed to assist affected individuals in the immediate aftermath of disaster. The National Child Traumatic Stress Network offers a free 6-hour course online at http://www.nctsn.org
Oregon Healthcare Preparedness Region 1
Trauma Surge Plan

Communications
Communications

Regional Hospital is an Emergency Communications Center (ECC) designated to facilitate and coordinate emergency communications and patient destinations for EMS and area hospitals during an incident. Assume that Regional Hospital will communicate what they know when they know it via HOSCAP. The HOSCAP website is also used to track ED and hospital inpatient capacity. Through this website, Regional Hospital can see hospital saturation levels and subsequent bed availability for patient transport. **It is critical that hospitals maintain real-time updates on hospital capacity and the ability to receive new patients. If capacity updates are not made, a facility will continue to receive patients.** With specific HOSCAP number updates, it is more likely Regional Hospital will not overwhelm a facility with patients. Overall, a more fluid process will assist in ambulance turnaround time, subsequently clearing the scene quicker and enhancing patient care.

Regional Hospital will preferentially triage pediatric patients to Doernbecher and Randall Children’s Hospitals. Non-pediatric hospitals may be required to provide care if these facilities are overwhelmed. Hospital emergency plans should address the needs of pediatric patients and it is imperative that all hospital EDs have the appropriate resources (medications, equipment, policies, and education) and staff to provide effective emergency care for children. This Plan does not specifically address the care and resources necessary to treat pediatric patients. Guidelines for care of children in the emergency department can be found at: [http://www.acep.org/content.aspx?id=29134](http://www.acep.org/content.aspx?id=29134)

Non-trauma hospitals whose staff needs advice on trauma treatment will be able to consult with trauma staff members at either OHSU or Emanuel by calling Regional Hospital at 503-494-7333 and being connected with the Trauma Advice Line. This line will not provide any patient movement or transfer assistance, but will give staff members a live resource to assist with any patient treatment questions that may arise in the unfamiliarity of treating trauma patients.

Hospitals should have access to very high frequency (VHF) and amateur (HAM) radios to assist in incidents that challenge everyday communications. Training in radio function as well as competency in communication and radio etiquette for a variety of staff members is vital. Regional Hospital has dedicated 800 MHz mass casualty radio channels with VHF and HAM radio backup and will be a reliable communication link throughout an incident.

Jurisdictional mobile command centers will be activated and respond to any complex incident. These command centers are fully outfitted apparatus with mobile capabilities that allow emergency responders to have a command hub on the scene of any major incident.

Disaster Medical Assistance Teams (DMAT) fall under the Department of Health and Human Services and can be activated by the Federal Government to assist in medical care during a major incident. These teams sustain themselves for up to 72 hours and depending on the situation can triage, provide care, prepare patients for evacuation, or augment staff at medical facilities.
Incident Command System (ICS)

- Health/Medical Multi–Agency Coordination Group
Incident Command System (ICS)

Key Characteristics and Principles

- The organizational structure is determined by functional requirements and not by titles or individuals.
- The ICS structure is modular and built around five major management activities (Incident Command, Operations, Planning, Logistics, Finance/Administration) common to all major incidents.
- The span of control is kept to a manageable size, changing with the fluctuating needs of the incident.
- The structure of ICS is the same regardless of the nature of the incident.
- Incident Commanders and key leaders are identified before incidents occur.

This Plan fully supports and utilizes the concept of the National Incident Management System (NIMS). NIMS provides an organized set of scalable and standardized operational structures, which is critical for allowing various organizations and agencies to work together in a predictable, coordinated manner.

Health/Medical Multi-Agency Coordination Group

Health/medical policy decisions are made by local public health officials at the jurisdictional level. In the event of a large-scale regional health emergency, the Health/Medical Multi-Agency Coordination (MAC) Group will be activated as necessary during health emergencies involving more than one county. When activated, the MAC Group will provide a structure for regional public health and healthcare leaders to provide the following:

- Incident periodization related to a strained healthcare delivery system.
- Ethically-based strategies to allocate/re-allocate critical scarce resources.
- Altered standards of care and alternative care systems policy recommendations.
- Community mitigation approaches to limit transmission of disease in the community.
- Consistent and accurate public information messages concerning the health emergency within the region.
Oregon Healthcare Preparedness Region 1

Trauma Surge Plan

Drills and Exercises
Drills and Exercises

All response plans should be regularly rehearsed with hospital drills and community exercises to identify weaknesses and strengthen each organization and community plan. Avoidance of the “paper plan syndrome,” believing that a written plan is sufficient to assure adequate disaster preparation, is critical. The process of planning and including those individuals that actually will respond to the incident is an essential element of preparation. Hospitals should conduct a hazard vulnerability analysis to create a more logical focus of threats. Planning around ICS and HICS should involve preselecting individuals for the key positions and functions. These individuals must be thoroughly familiar with the job description and requirements for that function. Additional personnel should also be trained in these roles as backups that can substitute effectively.

All hospitals in the Portland Metro Area are accredited by the Joint Commission on Accreditation of Healthcare (Joint Commission), an independent, not-for-profit organization recognized throughout the United States in symbolizing the quality that reflects an organization’s commitment to meeting certain performance standards. Joint Commission requires that all hospital facilities conduct drills to test their hospital disaster plan at a minimum twice per year. Also, all hospitals must exercise integration with the community plans once per year. Drills should be challenging and stress a hospital's resources and staff in an effort to simulate a true disaster. Critical aspects to test in every drill are implementation of HICS, securing the hospital, EMS traffic routes, communication systems, patient flow, and media cooperation. Drills should always have defined measurable outcomes and once completed, formal critiques should review the actual performance. All staff should be involved in the critique process. This should take place immediately following the exercise to ensure what occurred is captured. An after-action summary should lead to procedure changes within the facilities disaster plan and further drills should incorporate these changes.
Oregon Healthcare Preparedness Region 1
Trauma Surge Plan

Training and Volunteer Recommendations

- FEMA Independent Study Curriculum
- State Emergency Registry of Volunteers in Oregon (SERV-OR)
Training and Volunteer Recommendations

Staff training at the trauma centers should continue with Advanced Trauma Life Support (ATLS) and Advanced Trauma Care for Nurses (ATCN) for physicians and nurses. These programs correlate their curriculum and create a standard of training while at the same time developing a common language among those involved. At both trauma and non-trauma hospitals, we encourage use of the course, Disaster Management and Emergency Preparedness (DMEP). DMEP is a one-day course that is both didactic and interactive. It addresses core competencies as outlined by the American College of Surgeons (ACS) Committee on Trauma (COT) and Disaster and Mass Casualty Management Committee. Major topics addressed include planning, triage, incident command, injury patterns and pathophysiology, and consideration for special populations. The target audience includes acute care providers who will most likely be the first receivers of casualties following major disasters and other health care providers, administrators, public health personnel, and emergency managers. The objectives include:

- Understand the surgical problems, injury patterns, and issues that may result from disasters.
- Discuss the role that surgeons and other acute care providers can plan in planning for and responding to mass casualty incidents and disasters, especially at a hospital level.
- Become familiar with the terms and concepts of incident command.
- Understand the principles and challenges of disaster triage.
- Become familiar with treatment principles related to blast injury, chemical attacks and radiological dispersal devices.
- Know the civilian and military assets available for support.

For rudimentary nursing care of the trauma patient, Trauma Nursing Core Course (TNCC) is recommended. The purpose of TNCC is to present core-level knowledge, refine skills, and build a firm foundation in trauma nursing. The Emergency Nurses Association (ENA) developed and implemented TNCC for national and international dissemination as a means of identifying a standardized body of trauma nursing knowledge. TNCC is a 16 hour course designed to provide the learner with cognitive knowledge and psychomotor skills. TNCC may be officially attended by registered nurses (RN's). Other health care providers working in the emergency care setting, may attend the course and receive contact hours, but not the four year verification status. In order to maximize success in TNCC, it is recommended that the participant have at least six months of clinical nursing experience in an emergency care setting. It is assumed that the course participant possesses generic nursing knowledge, has an understanding of emergency care terminology, and has familiarity with standard emergency equipment.
FEMA Independent Curriculum Recommendations

The Emergency Management Institute (EMI) operated by the Federal Emergency Management Agency (FEMA) offers a variety of free online courses. We recommend that each individual associated with this Plan take advantage of this opportunity to enhance their understanding of both the medical and emergency management response. Below are links to the website and a list of recommended courses specific to this Plan. These courses vary in length and depth, but provide a valuable overview and understanding of the emergency management process.

**FEMA EMI Independent Study Program**

http://training.fema.gov/is/

**FEMA Independent Study Program Course List**

http://training.fema.gov/IS/crslist.aspx?all=true

**Course Recommendations**

IS-100.HCB: Introduction to the Incident Command System (ICS 100) for Healthcare/Hospitals

http://training.fema.gov/EMIWeb/IS/courseOverview.aspx?code=IS-100.HCb

IS-200.HCA: Applying ICS to Healthcare Organizations


IS-700.A: National Incident Management System (NIMS) an Introduction

http://training.fema.gov/EMIWeb/IS/courseOverview.aspx?code=IS-700.a

IS-806: Emergency Support Function (ESF) #6 – Mass Care, Emergency Assistance, Housing, and Human Services


IS-808: Emergency Support Function (ESF) #8 – Public Health and Medical Services


**State Emergency Registry of Volunteers in Oregon (SERV-OR)**

It is encouraged that all medically trained personnel register with SERV-OR, a statewide registry system to help pre-credentialed health care professionals volunteer their services during emergencies with significant health impacts. The registry is sponsored by the Oregon Public Health Division in partnership with the Medical Reserve Corps. It utilizes a secure database to register, credential, and alert volunteer health providers. The mission of the Medical Reserve Corps (MRC) is to improve the health and safety of communities across the country by organizing and utilizing public health, medical, and other volunteers. Registration can be done online through [https://serv-or.org](https://serv-or.org/).
Appendix A
Sample Mass Casualty Incident Protocol (Courtesy of Multnomah County)

50.100
Mass Casualty Incident (MCI)

Mass Casualty Incident (MCI)

The National Incident Management System (NIMS) will be used to manage all incidents.

1. Incident Command (IC) is the responsibility of the agency having jurisdiction (AHJ).

2. Each assisting agency shall retain full authority to operate within the scope of its agency operational and administrative protocols and procedures.

3. Agencies that are assisting in the support of a single jurisdiction will function under the direction of that jurisdiction’s designated Incident Command.

4. Incident Command of a multi-discipline event should be predicated on the “Primary Hazard” of the event.

5. In a Unified Command, the “Lead Agency” may change as priorities change.

The Mass Casualty Incident Protocol is a tool that may be used in part or whole as determined by the on-scene Incident Commander. There is no set number of patients that will automatically initiate this protocol. If the Incident commander determines that additional resources or incident structure is needed to better manage due to the complexity of the incident, he/she shall announce to dispatch that an MCI is being declared. This may be done upon arrival or at any time during the incident.

- If the incident involves multiple asymptomatic patients (HazMat exposure) set up secure evaluation area. See Multiple Toxic Exposure protocol.
- During a declared MCI, the Trauma System is not in effect.
- “Licensed ambulances” are not needed for transport.
- If transport resources are limited, more than one critical patient may be placed in an ambulance.
Task Card - Medical

Reports to Incident Commander (or Operations in large incidents)

Objectives:
1. Coordinate all On-Scene EMS activity.
2. Coordinate Medical activities with Incident Commander (IC), and other ICS branches as needed.
3. Provide accountability for supervised personnel.

Actions:

- Establish Medical with Command.
- Obtain a separate working radio channel for use by Medical.
- Establish the following roles/functions and hand out vests, triage tags and task cards.
  - Triage
  - Treatment
  - Transport
  - Destination (reports to Transportation)
  - Staging Area (confirm area, and proper talk group)
  - An assistant to help you with radio and face-to-face communications
  - Landing Zone (LZ)
- Order additional resources and ambulances through Incident Command.
- Establish accountability system for personnel working within Medical.
- Refer to Medical checklists (see following page).
- Monitor performance of subordinates. Provide support and changes as needed.
**50.100**  
Mass Casualty Incident (MCI)

### SCENE CHECKLIST

<table>
<thead>
<tr>
<th>Functional Assignments:</th>
<th>Tac:</th>
<th>Order Resources:</th>
<th>Tac:</th>
<th>HazMat</th>
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<tr>
<td>Triage</td>
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<td>Ambulances (specify #)</td>
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<td>Mass Decon</td>
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<td>Treatment</td>
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<td>Police (Secure Area)</td>
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<td>Safety</td>
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<td>Transportation</td>
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<td>Buses</td>
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<td>Rescue</td>
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<td>Specialty Teams</td>
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### OTHER ASSIGNMENTS

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<th>Triage</th>
<th>Treatment</th>
<th>Transportation</th>
<th>Destination</th>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>Staging Area</td>
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</tbody>
</table>

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Task Card - Treatment

Reports to Medical Branch (Use assigned radio channel).
Coordinates with Triage and Transportation.

Objectives:
1. To rapidly treat and transport all patients.
2. Identify and establish large treatment area(s) to stabilize and care for patients until transported.
3. Coordinate all activities within the treatment area.
4. Coordinate movement of patients from treatment area(s) with Transportation.
5. Provide accountability for personnel working in Treatment.

Actions:
- Establish treatment area(s) large enough to receive estimated number of patients. Set up area with room to expand if necessary. Provide for environmental protection of victims and allow easy ambulance access and egress. If multiple treatment areas are needed, identify each geographically. (e.g. - North/South, street name, division name, etc.). See Diagram.
- Order additional resources through Medical.
- Clearly identify treatment area entry point. Assign a person at the entrance to conduct primary or secondary triage, attach triage tags and direct patients to correct treatment area.
- Consider appointing "Red," "Yellow," and "Green" Treatment Team Leaders and assign support personnel.
- Establish a medical supply drop area for incoming ambulances and fire units.
- Provide BLS care in the treatment area until resources allow a higher level.
- Ensure all patients in treatment area have been tagged with a triage tag.
- Identify the order in which patients are to be transported. Coordinate patient movement to the loading zone with Transportation.
- Provide accountability for personnel working within treatment area.
Treatment Area Guidelines

- Set up treatment area WELL AWAY from hazards. Consider ambulance access/egress, wind direction and slope.
- Make it BIG. Set up in an area that will allow you to expand.
- Clearly identify entry point and exit point for patient transportation.
- Utilize colored tarps and flags to identify each treatment area.
- Separate the green area from yellow/red area. Consider separating with CBRNE unit or other natural barrier.
- Assign treatment team leaders to each area and identify them with the appropriate colored vests.
### SCENE CHECKLIST

<table>
<thead>
<tr>
<th>OPS Channels</th>
<th>Medical:</th>
<th>Treatment:</th>
<th>Transport:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assign Treatment Team Leaders</td>
<td>Current Patients in Treatment Area</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **RED Team Leader:** RED
- **YELLOW Team Leader:** YELLOW
- **GREEN Team Leader:** GREEN
- **Supply:** BLACK

### OTHER ASSIGNMENTS

<table>
<thead>
<tr>
<th>Command</th>
<th>Operations</th>
<th>Triage</th>
<th>Staging</th>
<th>Destination</th>
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<td>OPS:</td>
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</tbody>
</table>

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Mass Casualty Incident (MCI)

Task Card - Triage

- Manage the triage function at the incident. (Should not perform task level triage.)
- Coordinate personnel/crews performing primary and secondary triage.
- Maintain accountability of all triage personnel/crews.
- Ensure rapid primary triage is performed – no more than 30 seconds per patient.
- Ensure secondary triage point is established when necessary or that secondary triage is accomplished in place.
- Coordinate movement of triaged patients to treatment/collection/transport area. (Order personnel and equipment as appropriate to accomplish this.)
- Ensure appropriate patient triage log is initiated and maintained. (Multiple logs may need to be managed and information integrated depending on the scope of the incident.)
- Relay triage information up the chain-of-command and update status as needed.
- Assist treatment and transport supervisors/creams to locate their patients (after triage is completed).
  - In a hazardous incident, patients may not be able to be triaged until they are removed from the hazard zone.
  - Consider having crews utilize triage tags during secondary triage so that primary triage may be performed at appropriate speed.

Triage & identify patients by category utilizing “ABC” method:

- **Red**: Immediate life threat. (Must have rapid transport to survive.)
- **Yellow**: Delayed (Injuries can wait 1-3 hours before transport.)
- **Green**: Ambulatory (Injuries can wait 3+ hours before transport)
- **Black**: Dead (No transport) Move only if needed to reach other live patients.
Task Card - Transportation

Reports to Medical Branch (Use assigned radio channel)

Objectives:
1. Coordinate movement of patients from treatment area with Treatment.
2. Coordinate all activities within the loading zone.
3. Coordinate flow of transport vehicles with staging.
4. Provide accountability for personnel working in Transportation.

Actions:
- Establish patient loading zone.
- Establish one-way vehicle access/egress with Staging.
- Request additional resources as needed from Medical.
- Assign Medical Communications.
- Supervise patient movement to loading zone with Treatment.
- Monitor medical radio channel to estimate number of incoming patients.
### Loading Zone Location:


### Access/Egress Location:


### Resources Requested:

<table>
<thead>
<tr>
<th>Time</th>
<th>Resource</th>
<th>Unit/Agency</th>
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</table>

### Medical Communications:

Name: ________________________________

Unit/Agency: __________________________

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Task Card - Destination

Reports to Transportation

Objectives:
1. Coordinate hospital destination for patients leaving the loading zone.
2. Maintain the patient transport log using web based or protocol approved alternative.

Actions:
- Establish communications with “Regional Hospital.” [Via MCI channel, phone number or approved alternative (800 radio MCI channel or phone (503) 494-7333.)]
- Confirm MCI has been declared with Regional Hospital and Dispatch.
- Provide total number of estimated patients.
- Establish communication with loading zone to receive information on patients ready for transport (e.g., face-to-face, runner, radio etc.).
- When a unit is ready to transport, contact Regional Hospital. Provide & record the following information.
  1. Triage Tag #’s/ UPI if available
  2. Triage color/category
  3. Age/gender
  4. Unit number of transporting vehicle
- Confirm hospital destination with Regional and record.
- Inform the transporting unit of its destination.
Task Card - Regional Hospital Coordinator

Objectives:
1. Coordinate movement of patients from the scene to the hospital.
2. Optimize patient outcomes by matching available hospital resources (both quality and quantity) with need for resources (patients).

Actions:
- Assign destination hospitals / facilities for patients identified by hospital destination coordinator.
- Assist Scene Hospital Destination Coordinator in tracking patients.
- Provide a regional hospital response to the scene.
- Complete Patient Transportation Log as follows:

<table>
<thead>
<tr>
<th>Triage Tag</th>
<th>Triage Level</th>
<th>Destination</th>
<th>Unit</th>
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<tbody>
<tr>
<td></td>
<td>Yellow:</td>
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<td></td>
<td>Scene</td>
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<td>Transportation Supervisor (i.e., Hospital Destination Coordinator)</td>
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<td>Teal:</td>
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<td></td>
<td>Regional Hospital</td>
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### Patient Transport Log

<table>
<thead>
<tr>
<th>Triage Tag # (last 4 digits)</th>
<th>Triage Level R/Y/G</th>
<th>Age</th>
<th>Sex</th>
<th>Injury Type/Location</th>
<th>Destination</th>
<th>Unit #</th>
<th>Transport Time</th>
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<tbody>
<tr>
<td>RYG</td>
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<td>M</td>
<td>F</td>
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Appendix B
Hospital Family Assistance Center Quick Guide (FACS)

Hospital Family Assistance Center (FAC) Quick Guide

Developed by J. Olivier & Associates, LLC
for NW Oregon Health Preparedness Organization
June 2013
Disaster literature tells us that, in the immediate aftermath of a large-scale community incident, people will concentrate their efforts on locating their family and friends; and they will most definitely include hospitals in their search. Hospitals must plan for providing services to large volumes of visitors who may not require medical attention. If there are large numbers of missing people, there will be even larger numbers of family members and friends arriving to look for loved ones and obtain information about them.

After the 9/11 terrorist attack, the New York State Department of Health developed a guide for operating a family assistance center and started their document with this:

During the 9/11 attacks in New York City and Washington D.C., many family members and friends went from one hospital to another looking for their loved ones. Each time families arrived at a different hospital and found that their loved ones were not there, their confusion, fears, and anxiety levels increased.

Hospitals should anticipate that eight to ten family members-per potential victim-may be requesting information and assistance.

Children injured or involved in a disaster will have additional emotional distress. A Center for Bioterrorism task force estimates that “for every child arriving at an emergency department, the hospital can routinely expect an average of 4-5 family members or caregivers to accompany them. During a disaster, emergency department staff will be faced with the medical management of multiple victims and will not have the time, space, and training that this population of concerned family members requires.”

A hospital Family Assistance Center (FAC) addresses two objectives in its operation:

1. Provide a secure, private area for sharing information regarding survivors or deceased to families and visitors searching for missing loved ones

2. Provide a location for emotional calming and healing during a disaster or mass casualty event
Objectives of this Hospital FAC Guide

The term “family assistance center” is used in disaster literature to describe local government’s community wide response to a mass casualty event, a Red Cross victim identification location following an air crash, or a quiet gathering place for family services during high demand in a hospital emergency department. The materials included in this guide are intended for a temporary hospital location that simultaneously assists family members and visitors searching for loved ones while enabling medical staff to concentrate on treatment of multiple casualties during a large-scale community incident.

This guide assumes if the incident is quite widespread and affects multiple communities, then the community services required may eventually overwhelm any one hospital’s efforts. A community wide family assistance center may be set up to address a wider range of need with ability to sustain service demand as long as is necessary. However, immediate services will likely take place in hospitals. The sooner community-based services are set up, the better. Note the following startup times and length of service for FACs from recent U.S. mass fatalities:

- The Oklahoma bombing (169 deaths): FAC opened within 3 hours and stayed open for 16 days, until the last body was recovered.
- The 9/11/2001 Pentagon attack (182 deaths): FAC call center was open by 3pm September 11th and the FAC opened with 50 volunteers by 7am the next morning. It operated 24/7 from September 12 through October 12, 2001.
- The 9/11/2001 World Trade Center attack (approximately 2800 deaths): FAC was opened at its first location on September 12, moved to a second location that afternoon, and moved to its third location on September 15. When lines of concerned family members stretched eight blocks in four directions, a new fourth site was prepared at Pier 94. FAC was open for approximately 460 days at Pier 94, closing December 2002.
- Hurricane Katrina hit Louisiana on August 29, 2005 (approximately 1460 deaths-910 deaths processed through DMORT morgues- and 13,197 missing persons reports): FAC opened September 7, 2005 and stayed open for 342 days closing August 14, 2006.
Key Assumptions for Hospital FAC\textsuperscript{3,4}

- Families and visitors will begin to arrive immediately
- Hospital FACs must be able to set up immediately and operate until either the need is diminished or a wider reaching community assistance center is set up
- Support will be critical for workforce from the very start of an incident

Hospital FAC Services

Services address key assumptions while supporting two objectives:

Objective #1: Provide a secure, private area for sharing information regarding survivors or deceased to families and visitors searching for missing loved ones

FAC staff act as liaison to other parts of the hospital, facilitate communication among departments, help locate patients and reunite families within the hospital, and provide reliable information to assist in identifying victims

Objective #2: Provide a location for emotional calming and healing during a disaster or mass casualty event

The FAC provides psychological first aid and emotional comfort, protects family members from media or curiosity seekers, offers crisis counseling, triage and mental health referrals, and helps the bereaved find private space

FAC can also shelter unattended children until families are located, provide dependent daycare for hospital workers and care for children of distraught family members or those continuing the search for missing loved ones.

Information Flow in Hospital FAC

The role of providing information during disaster is a critical service. Families desperate to find answers to their questions about loved ones require clear, accurate information delivered in a timely fashion. “Providing essential information about a missing person is the first step in enabling the coping process”\textsuperscript{4} and helpful
information may include official circumstances of the event (how, why, where), circumstances surrounding evacuation of casualties, other hospitals where victims are being taken, psychological reactions to trauma and coping resources for related stress symptoms.  

**Figure 1: Optimal Information Flow Within the Family Assistance Center (FAC)**

**FAC Information Summary**
- Information on patient status and identification may come from ED, ICU, other hospitals, Incident Command Center
- Information may flow to FAC via FAX, telephone, electronically or by runners
• The FAC will act as a liaison between families and other hospital units
• The FAC is in constant communication with Incident Command Center
• Any media seeking information about patients, families or the nature/status of events are directed to the hospital’s public information officer

**Hospital FAC Structure**

FAC services must be efficiently connected to the hospital wide response effort and easily accessible to the public. A FAC should be located away from the emergency department, secure, and large enough to accommodate a number of families comfortably. The structure of a FAC within a hospital should be set up to be in close proximity to communication sources and allow for additional staff requests as needs arise. The optimal FAC set up might be as follows: 1, 2, ^3, ^4

• **Reception Wait Area**- In anticipation of a large crowd, the reception area provides both crowd control and a family-oriented system by which those searching for missing loved ones can register and receive assistance. Staff can greet families and friends as they arrive and sign in, take their information, show them around the waiting area where food and beverages are available. If warranted, they may be offered the assistance of social workers or other mental health professionals. Ideally, each visitor receives a badge or name tag at sign-in that identifies them as a FAC visitor. Hospital security staff should be assigned to the FAC reception area.

• **Information Desk**- Information should be constantly updated to and from the hospital FAC and the emergency department, intensive care unit, and incident command. FAC updates are retrieved by computer, phone, FAX, and assigned staff “runners”. A Patient Information Officer may be assigned to the Information Desk to see that patient information is both handled within hospital protocol while appropriately available to families. Consider providing a message board near the Information Desk for family communications and an area equipped with phones/computers with email availability for visitor use.
- **Safe Child Area** - Set aside a portion of the hospital FAC for children who may be accompanied or alone. Unaccompanied children may have been uninjured but brought into the hospital emergency department and subsequently discharged, or have been separated from their caregivers and are awaiting reunification. Accompanied children may arrive with family members who are injured or seeking missing loved ones and require family assistance. Dependent care for children of hospital workers may also be provided. If possible, the Safe Child Area should be staffed with child life specialists who can address the special needs of children. It should also set up its own check-in and registration system to safely shelter all children in its care. Security staff assigned to FAC reception can share duties with this area as well.

- **Photo/Identification Room** - One room is set aside for family members lacking confirmed information on a missing relative when it is highly probably that the person is among the casualties. At this stage, the need for support is at its greatest and requires sensitive and careful intervention. Only the closest relatives should be brought to this room. The Photo Room may also serve as the center for family reunification through photo identification.

- **Consultation Areas** - Private, quiet side rooms are used for those members of the public who express extreme stress reactions (i.e. shock, pain). When assigned staff identifies a visitor reacting in an extremely agitated manner and feels they would benefit from personal, supportive attention in a quiet atmosphere, then they are encouraged to withdraw to one of these side rooms.

- **Medical First Aid Station** - The purpose of a medical aid station is to provide immediate emergency medical evaluation and stabilizing care. Assigned
medical staff can serve as liaison with other medical providers. This area may also provide convenient access to assigned mental health staff providing crisis intervention, psychological triage and referral when needed. It should be located near the Photo/ID Room and consultation areas.
Figure 2: Suggested Layout for Hospital FAC:

**Tip:** FAC is apart from Emergency Department, secure, and large; also readily accessible to communication and requests for additional hospital personnel as need arises.
Hospital FAC Supplies & Equipment Essentials

The hospital FAC will be providing critical family services, so plan for easy supply access and develop systems to replenish supplies throughout the time it is operating. Be sure all FAC forms and documents are readily available. For a complete list, see Appendix A: FAC Forms & Documents. Plan also to ensure all phones, computers, and internet access are up and running smoothly.

Hospital FAC Staffing

Assemble a pool of hospital responders who will work in the hospital FAC. Plan for contingencies in assigning staff and scheduling/backfilling from each department that is going to be involved in FAC operations. Determine if volunteers will be used in the FAC. If so, then pre-screen and assign them to the appropriate department(s).

FAC staff may include: 1, 2, 4

- FAC Coordinator- who is ideally a hospital human resources, social work or behavioral health department manager
- Patient Information Officer- Assigned to the Information Desk, helpful in reuniting families and knowledgeable regarding hospital protocols for sharing patient information; comfortable acting as liaison with other hospital units; ideally is also proficient in technical and IT equipment
- Administrative Support/Tech Staff- Support staff may be assigned to the FAC from throughout the hospital, and ideally are also familiar with hospital facilities and information systems. Some support staff may be assigned as “runners” and literally run to and from hospital departments to provide timely information when the need arises.
- Assigned Professional Behavioral Health (BH) Staff- Hospital employees may include mental health professionals, chaplains, child life specialists and human resources personnel
- Assigned BH Volunteers- FAC volunteers are pre-screened and support the work of assigned professional staff. Volunteers may include community
members such as graduate students assigned to social services fieldwork, clergy from nearby religious institutions, staff from a community-based human service organization and crime victim specialists. Ideally, they may already be hospital volunteers and are familiar with various hospital systems.

- **Medical Provider** - A medical professional who is either assigned to the FAC Medical First Aid Station or has clear access to it while the FAC remains open.
- **As-Needed Staffing** - Additional FAC services may be provided by assigning hospital staff from security and food service departments. Translator/interpreter services may be provided either through pre-identified hospital staff or local community groups who could quickly become a supportive part of the FAC.

**NOTE:** Hospitals may require written documentation of all staff assignments; a job action sheet (JAS) can be developed for each of the listed FAC positions or one general JAS can be developed for anyone assigned to the FAC. (See Appendix A: Sample Job Action Sheet)

**Staff Training**

Staff members who are likely to be assigned to the hospital FAC are encouraged to become familiar with materials included in this *Hospital FAC Guide* prior to deployment. Just-in-Time training can also be provided, along with a JAS, when staff are assigned to the FAC. Training should include a brief review of protocols and checklists on FAC operations as well as procedures for screening and supporting families. Psychological First Aid (PFA) training is highly recommended for all FAC workers.

Supervisors who are likely to be involved with staffing the hospital FAC are encouraged to participate in training to familiarize themselves with the important processes that would be involved. (See Appendix B: Hospital FAC Tabletop Exercise)
Disaster Response

When needed, the hospital FAC must be able to open and operate as soon as possible. The following steps can be implemented during activation, operation, and demobilization disaster phases. 1, 2, 4, ^2, ^3 Suggested staff assignments and useful forms are included.

(For a complete list of forms, see Appendix A: FAC Forms & Documents)

---

### Activate the FAC

**Staff:** FAC Coordinator, Patient Information Officer, Admin Support Staff

**Forms:** FAC Layout, Operations Summary, Sample JAS, Signage List

1. Locate viable physical space(s)
2. Notify & begin to schedule staff for shifts (include security/food service)
3. Provide FAC with supplies and set up communication/IT equipment
4. Begin to provide services

**NOTE:** Every shift, supervisors responsible for FAC shift coverage within their department will assess the following:

- Need for additional assigned staff/volunteers
- Replenish supplies, check equipment, print more forms/documents and visitor handouts
- Psychological First Aid training
- Liaison briefing with Patient Information Officer

---

### Provide Basic Needs

- **Safe Child Area**
  - **Staff:** Hospital mental health, child life specialists
  - **Forms:** Child Care Registry Sheet, Child Identification Survey

- **Food/Beverages**
  - **Staff:** Food service workers; community vendors w/ pre-arranged donations

- **Medical First Aid**
Staff: Medical Provider, Assigned Professional BH Staff/Volunteers

Documents/Handouts: See Appendix A: Mental Health Provider Go-Kits

Emotional support/relaxation; Psychological First Aid

Staff: Assigned Professional BH Staff/Volunteers

Documents/Handouts: See Appendix A: Mental Health Provider Go-Kits

Family Interaction

Staff: Assigned Professional BH Staff/Volunteers, Admin Support Staff

Forms: Reception Center Sign-in, Check-in Protocols, Family Member Registration

Documents/Handouts: See Appendix A: Mental Health Provider Go-Kits

- Sign in and interview families; follow FAC check-in procedures
- Keep families updated with most current and accurate information available
- Accompany family members to and from the Photo/Identification Room
- Assign mental health staff to some families as needed to provide crisis intervention and triage for possible clinical referral/medications
- Assign staff throughout the FAC to answer general visitor questions

Worker Support

Open up a Provider Respite Center or designate a staff only break room

Staff: Mental Health department supervisors and clinical specialists

Documents: See Appendix A: Provider Respite Center Information

Provide dependent daycare for children of staff

Staff: Hospital mental health, child life specialists

Forms: Child Care Registry Sheet, Child Identification Survey
Demobilize and transfer services to community-wide center

When service demand is diminished, or when a community wide family assistance center opens, it will be determined that the hospital FAC may close. If a community center is opened, then the hospital FAC Coordinator and Patient Information Officer will follow hospital protocols for records sharing as they oversee transfer of all documents and services out of their hospital system. As appropriate, all hospital FAC visitors will be provided assistance in any way possible if they move from the hospital FAC to the community wide location to receive continued services.
References

Hospital Family Assistance Center (FAC) Guide


3. Shultz, James M. etal; Surge, Sort, Support: Disaster Behavioral Health for Health Care Professionals. DEEP Center, Miller School of Medicine; University of Miami. www.umdeecenter.org

4. Creating and Operating a Family Assistance Center; Seattle/King County Public Health http://www.apctoolkits.com/family-assistance-center

5. Family Assistance Center, Coos County EOP Support Annex 4 http://www.co.coos.or.us/Portals/0/Emergency%20Management/SA-4-FamilyAssistanceCenter.pdf


FAC Guide & Tabletop Exercise


^3. King County Healthcare Coalition: Regional Medical Evacuation & Patient Tracking Mutual Aid Plan (MAP) Hospital Evacuation Tabletop Exercise, 2009 www.kingcountyhealthcarecoalition.org/...exercises/regional-exercises


Respite Center & Resources on Coping

- Childhood Traumatic Stress, http://www.nctsn.org
- Coping with Disasters & Traumatic Events, www.samhsa.gov/trauma
Appendix C
Definitions

A-B-C Triage – Awake, Breathing, Circulation. This is a modified triage algorithm that Multnomah County EMS uses during primary triage (See Appendix F).

Advanced Trauma Care for Nurses (ATCN) – An advanced course designed for the registered nurse interested in learning more about managing the patient with multiple traumas.

Advanced Trauma Life Support (ATLS) – A course designed for doctors to assist in developing an organized approach for evaluation and management of seriously injured patients.

Area Trauma Advisory Board (ATAB) – A regional board composed of pre-hospital and hospital trauma care providers and interested citizens who oversee the regional trauma system. Oregon is divided into seven regions. The Portland Metro Area is within ATAB 1.

Deceased – A person who has died.

Decontamination – The removal or neutralization of a contaminating substance, such as poisonous gas or a radioactive material.

Deputy Medical Examiner – Investigates deaths as prescribed by Oregon statutes in which there are questionable or unexplained circumstances in an effort to determine the manner, cause of death and whether it resulted from overt or natural causes.

Disaster Management and Emergency Preparedness (DMEP) Course – A one day course accredited by the American College of Surgeons Committee on Trauma that includes planning, triage, incident command, injury patterns and pathophysiology, and consideration for special populations during a disaster.

Disaster Medical Assistance Team (DMAT) – A group of professional and paraprofessional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide medical care during a disaster or other incident.

District Attorney (DA) – An elected official of a county or designated district with the responsibility of prosecuting crimes.

Egress – A place or means of going out, exit.

Emergency Communications Center (ECC) – Communications center located at OHSU that facilitates and coordinates emergency communications and patient destinations for EMS and area hospitals during an incident.

Emergency Management Institute (EMI) – Supports the Department of Homeland Security and FEMA’s goals through conducting courses for local and regional public agency emergency managers and interested members of the public, where the courses are intended to improve the level of national emergency responsiveness to all forms of man-made and natural disasters.

Emergency Medical Services (EMS) – A network of services coordinated to provide aid and medical assistance from primary response to definitive care. It involves personnel trained in the rescue, stabilization, transportation, and advanced treatment of traumatic or medical emergencies.
Emergency Operations Plan (EOP) – A plan for responding to appropriate hazards that describes who will do what, when, with what resources, and by what authority; before, during, and immediately after an emergency.

Expectant – Severely injured patients that are going to die from their injuries or are unlikely to survive given the limited resources available.

Federal Emergency Management Agency (FEMA) – An agency within the Department of Homeland Security whose mission is to support our citizens and first responders to ensure that as a nation we work together to build, sustain, and improve our capability to prepare for, protect against, respond to, recover from, and mitigate all hazards.

Finance Officer – Responsible for all financial, administrative, and cost analysis aspects of the incident and for supervising members of the Finance/Administration Section.

Hazard – Something causing unavoidable danger, peril, risk, or difficulty.

Health and Medical Multi-Agency Coordination (MAC) Group – Provides a structure for public health and healthcare leaders to come together to discuss policy decision-making and prioritization.

Healthcare Preparedness Organization (HPO) – A regional planning collaboration of regional hospitals and health systems, local and state public health, county emergency management, emergency medical services, medical societies, safety net clinics, and behavioral health. The HPO works to ensure that Northwest Oregon is prepared and responds effectively and efficiently to large-scale health emergencies that have impacts across institutional and jurisdictional lines.

Hospital Capacity Website (HOSCAP) – A website that connects public health, hospitals, clinics, laboratories, public safety, and EMS. It is used by Regional Hospital to track emergency department and hospital inpatient capacity.

Hospital Incident Command System (HICS) – An incident command system designed for hospitals and intended for use in both emergency and non-emergency situations.

Hypoxia – Insufficient levels of oxygen in blood or tissue.

Incident Command System (ICS) – A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies; both public and private, to organize field-level incident management operations.

Incident Commander (IC) – The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site.

Ingress – A place or means of access; an entrance.

JumpSTART Triage – An objective tool developed specifically for the triage of children in a disaster setting. It parallels the structure of the START Triage system and the objectives include: optimizing the primary triage of injured children, enhancing the effectiveness of resource allocation for all victims, and
reducing the emotional burden on triage personnel who may have to make rapid life-or-death decisions about injured children in chaotic circumstances (See Appendix H).

**Labor Pool** – individuals who are available and qualified to function in a specific employment situation.

**Level I Trauma Center** – Provides the highest level of definitive, comprehensive care for the severely injured adult and pediatric patient with complex, multi-system trauma. A Level I facility is the regional resource trauma center in the system and has the capability of providing total patient care for every aspect of injury from prevention through rehabilitation.

**Level II Trauma Center** – Provides definitive care for severely injured adult and pediatric patients with complex trauma. Level II trauma centers serve as regional resource centers for definitive care, quality assurance, community education, outreach, and injury prevention.

**Level III Trauma Center** – Provides initial evaluation and stabilization, including surgical intervention, of the severely injured adult or pediatric patient. A Level III trauma center provides comprehensive inpatient services to those patients who can be maintained in a stable or improving condition without specialized care. Critically injured patients who require specialty care are transferred to a higher level trauma system hospital in accordance with criteria established in the Area Trauma Plan.

**Level IV Trauma Center** – Provides resuscitation and stabilization of the severely injured adult or pediatric patient prior to transferring the patient to a higher level trauma system hospital. Resuscitation and stabilization may involve surgical intervention.

**Logistics Officer** – Responsible for providing facilities, services and materials for the incident.

**Mass Casualty Incident** – An incident in which emergency medical services are overwhelmed by the number and severity of casualties.

**Mass Trauma Incident** – An incident that produces a volume of trauma patients that overwheels the normal day-to-day trauma system resulting in all area hospitals being willing to accept trauma patients.

**Medical Branch** – Responsible for managing patients generated by the incident including the triage, treatment and transportation.

**Medical Examiner (ME)** – A physician officially authorized by a governmental unit to ascertain causes of deaths, especially those not occurring under natural circumstances.

**Minimal Acceptable Care** – Providing lifesaving procedures at the initial phase of care and providing more comprehensive care at a later date when adequate resources and personnel are available.

**National Incident Management System (NIMS)** – A system used to coordinate emergency preparedness and incident management among various federal, state and local agencies. It identifies concepts and principles that answer how to manage emergencies from preparedness to recovery regardless of their cause, size, location or complexity.

**Operations Officer** – Responsible for managing on-scene tactical operations to meet the incident objectives as established by the IC.

**Patient** – A person who receives medical attention, care, or treatment.

**Patient Tracking** – Assigning each patient a unique tracking number that allows location tracking throughout an incident.

**Phone Tree** – A system for contacting a large number of people quickly in which each person called then telephones a number of other designated people.
Planning Officer – Collects, evaluates and disseminates incident situational information to the IC and incident management personnel.

Portland Metro Area – Metropolitan area of Oregon and Washington centered on the principal city of Portland.

Primary Triage – An initial patient assessment executed in less than 30 seconds to determine the urgency of a patient’s condition. This is the step where a triage ribbon is applied to each patient.

Public Information Officer (PIO) – Serves as the conduit for information to internal and external stakeholders, including the media or other organizations seeking information directly from the incident.

Rapid Discharge – To rapidly allocate treatment spaces for a surge in patients through the strategy of emptying beds (discharge) of relatively healthier patients.

Regional Hospital – An ECC designated to facilitate and coordinate emergency communications and patient destinations for EMS and area hospitals during an incident.

Ribbon – A colored (red, yellow, green, black), long, narrow strip of fabric used in primary triage to identify the urgency of a patient’s condition.

Safety Officer – An individual whose function is to develop and recommend measures for assuring personnel safety, and to monitor and/or anticipate hazardous and unsafe situations.

Secondary Triage – An in-depth reassessment of the patient’s condition which includes application of a triage tag and subsequent placement within a treatment zone based on acuity.

Shock – A medical emergency in which the organs and tissues of the body are not receiving an adequate flow of blood.

Span of Control – The number of subordinates a supervisor has.

Staging Area – An area serving as a point of assembly or preparation on the way to a destination.

Standard of Care – A written statement describing the rules, actions, or conditions that direct patient care. Standards of care guide practice and can be used to evaluate performance.

START Triage – Simple Triage and Rapid Treatment. A triage method used to quickly classify victims during a major incident based on the severity of their injuries (See Appendix G).

Surge Plan – A plan to evaluate and care for a markedly increased volume of patients that challenges or exceeds normal operating capacity.

Trauma – An injury to the body that occurs when a physical force contacts the body.

Triage – The sorting of victims to determine priority of need and proper place of treatment.

Victim – A person harmed, injured or killed as a result of a crime, accident, other incident or action. In reference to this plan, the term victim refers to an individual that has not received medical attention.

Walking Wounded – A triage term for an injured person who is ambulatory and has minor injuries.
Appendix D

References


