SA Health Healthcare Facility Shelter & Relocation Strategy

Version 2.2 - January 2019

Government of South Australia
SA Health

Document developed by: SA Health Emergency Management Unit

Next review due: 01 January 2023

Date	Version	Who approved (New/Revised Version)	Reason for Change
12/01/18	V1.0	State Controller Health – CMO/CPHO	New document
20/02/18	1.1		Edits post Executive Evacuation exercise
01/03/18	1.2		Clean version for restricted consultation
13/03/18	1.3		Post EM Coordinators feedback
20/03/18	2.0	Health Emergency Management Committee (HEMC) review	Final Draft
30/07/18	2.1	Final draft	Incorporating Feedback from SAAS and CHSALHN
04/09/18	2.1		Name change from guideline to strategy
04/10/18	2.1	Health Emergency Management Committee (HEMC)	Final version approved, incorporating feedback from HEMC members.
10/01/2019	2.2	Strategy and Governance Committee (SAGC)	Final version noted by SAGC, incorporating their feedback regarding engineering assessments post impact

Contents

Table of Figures

Overview

1. Purpose

The SA Health – Healthcare Facility Shelter & Relocation Strategy (‘*this document’*) outlines key principles to guide decision makers faced with planning for the evacuation or relocation of a healthcare facility and are designed to inform the planning undertaken within the Local Health Networks (LHNs), Health Services and SA Ambulance Service (SAAS) in relation to incident management and business continuity planning to guide network and site level operations.

This document should be read in conjunction with the AS 4083 Planning for Emergencies – Health Care Facilities which provides operational detail in relation to the planning for and management of a Code Orange incident.

LHNs, Health Services and SAAS are expected to review and embed this strategy within their existing network and site plans ensuring that the strategies contained within are contextualised and for their respective site(s). To assist with this, ANNEX F – NETWORK/SITE PLANNING FRAMEWORK has been provided.

1.1 Key terms

The following terms are fundamental and interchangeable when reading this document;

- Shelter in Place / Shelter / Sheltering
- Planned relocation / relocate
- Emergency evacuation / evacuation
- Commander / Command / Leadership
- Healthcare facility / hospital
- Affected site / impacted site / damaged site
- Receiving site / receiving facility

1.2 Senior clinical leadership

This document uses the term ‘senior clinical leadership’ in numerous areas and context.

It is intended that this accountability be primarily assigned to the Executive Director – Medical Services (EDMS) or Chief Medical Officer (CMO) for each Network/Service. It is acknowledged that this may be a shared (and/or delegated responsibility), particularly at Country Health SA LHN sites where the EMDS may liaise with local clinical leaders to inform decision making.

There are three distinct responsibilities assigned to the ‘senior clinical leader’ in the context of this document, these are;

- Clinical input to decision making as to whether to shelter or relocate
- Clinical advice as to the relocation order and destination of patients
- Leading a Transfer Coordination Centre, where required and/or established.

1.3 Assumptions

1.3.1 Assumption 1

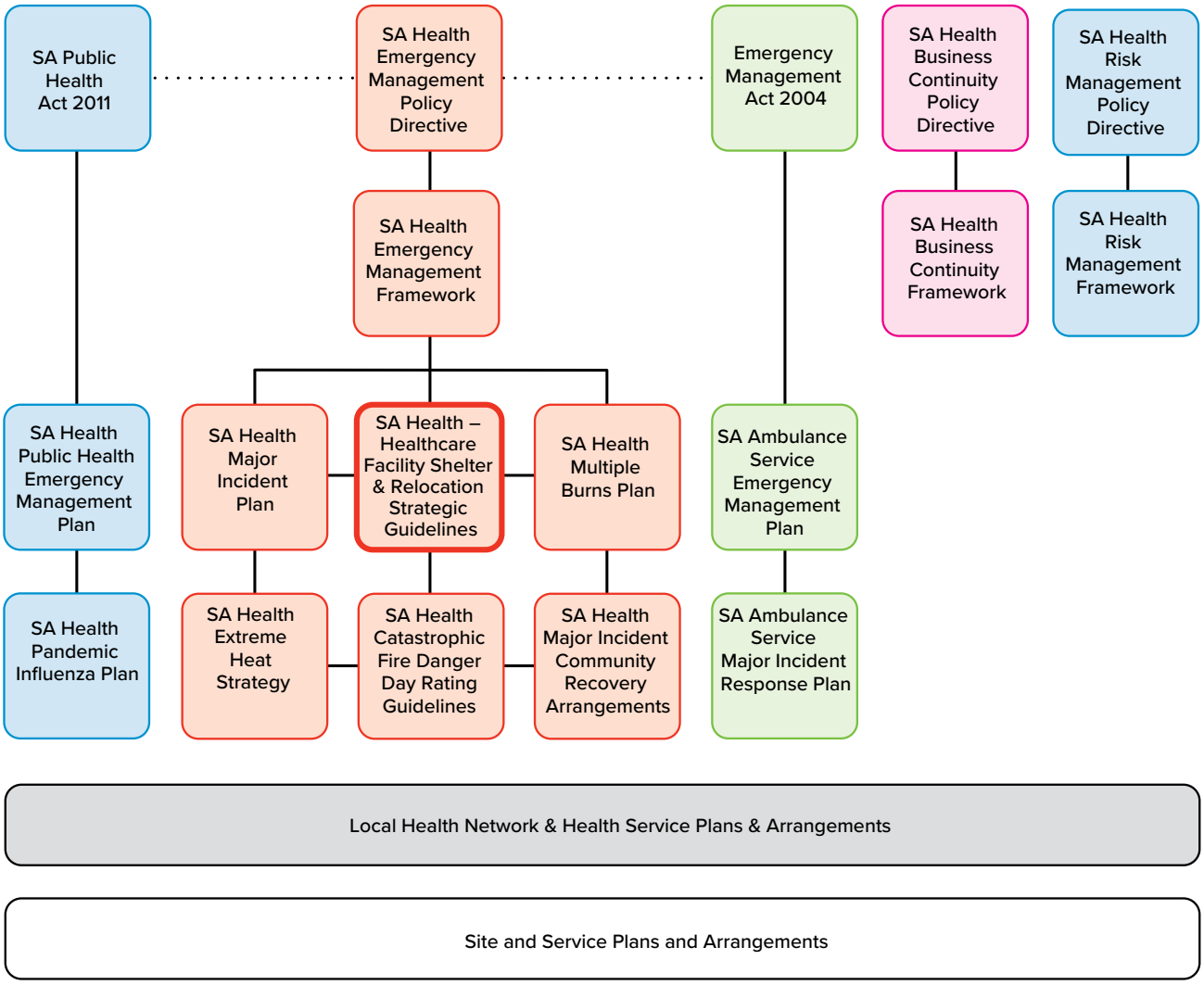
The public health system remains largely functional and is not impacted across multiple sites through a single catastrophic incident such as an earthquake or multiple, joined up deliberate acts.

1.3.2 Assumption 2

In the instance that a widespread incident has significantly impacted upon multiple larger SA Health sites, then it is likely that state and/or national arrangements will be invoked to support and manage the ongoing assessment of facilities and any subsequent patient/service relocation required.

1.4 Planning hierarchy and map

Figure 1 – Plan Map



2. Core Principles

Two core principles are paramount in planning for, and considering options for sheltering in place and/or relocating:

1) Sheltering in a facility is almost always the PREFERRED option

Healthcare facilities will almost always represent the safest and preferable location for patients. Where the facility, utilities or services are compromised (see Annex A) every effort should be made to support on site services/utilities to optimise patient and staff safety except where the necessity is clear e.g. a major internal fire or catastrophic infrastructure failure.

2) Senior clinical input in all decision making is CRITICAL

Senior clinical advice[1] must always be included in the planning for and decision to shelter in place or move. In extremis, restrictions or limitations of normal standards of care are inevitable. In the likelihood of demand for services exceeding or overwhelming supply, as is the case with healthcare in general, the underlying principle is to achieve the best health outcomes for patients based on the ability to achieve health benefits. Some patients may experience greater harm by being moved than by not being moved and this will require dynamic clinical and managerial oversight and review.

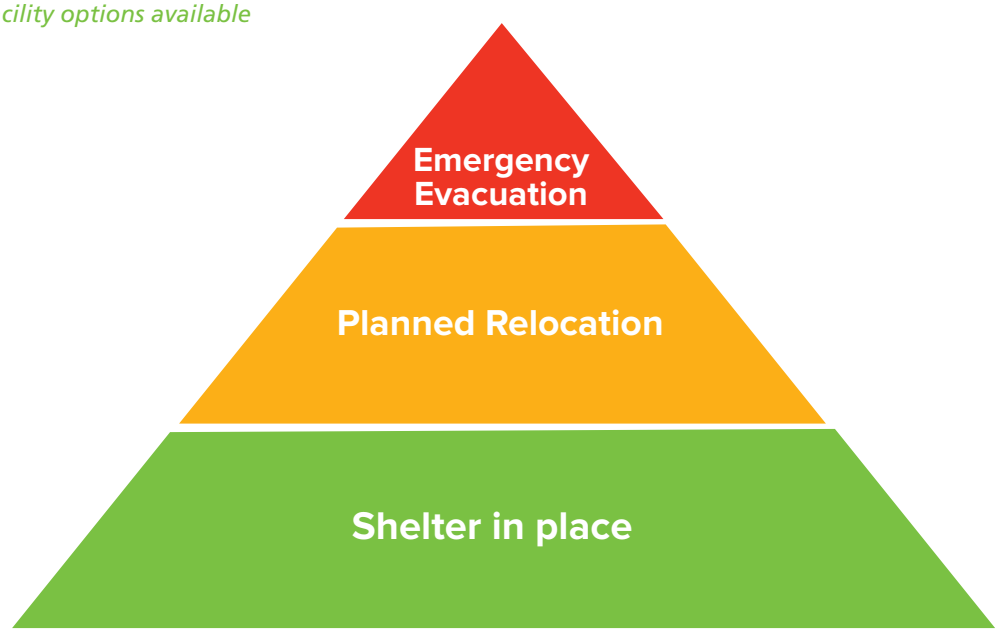
1 Senior clinical advice should be considered as senior clinical/medical input & leadership commensurate to the scope/size and complexity of the service/facility. (This may be a local General Practitioner for a small CHSA site through to an EDMS for a larger, metropolitan site). LHN and Site plans are to outline and identify the likely 'senior clinical advice' sources in context to their sites and services.

3. Decision Making

3.1 Options Available

There are three strategies available for consideration to support patients and occupants when responding to a hazard/impact incident at a site;

Figure 2 – Facility options available



3.1.1 Shelter in Place

Definition	*Shelter in place is defined as "a precaution aimed to keep you safe while remaining indoors. (This is not the same thing as going to a shelter in case of a storm.)"* – Source: American Red Cross.

It may be assessed and most probably likely that patients and staff would be safer staying and sheltering in place rather than leaving a healthcare facility. This may be because the risks of undertaking relocation outweigh that of sheltering in place.

> *An imminent burn over of a healthcare facility may cause damage and interrupt utilities but this is outweighed by the risk of moving patients and staff and being caught and exposed in the bushfire in transit. There may also not be enough time to effect relocation before an imminent impact.*

Shelter in place should always be considered a valid strategy when the risk associated with moving is seen as greater than that of sheltering in place.

Key considerations include timeliness of hazard impact/loss of habitation and resources to plan, prepare for and undertake a safe movement of facility occupants.

NOTE - Internal relocation and/or repurposing of clinical and non-clinical areas should be considered. This may include progressive internal movement, with only those people directly at risk being moved. The transport of certain cohorts of patients to alternate facilities for procedures or treatment may also be considered where infrastructure/equipment has been damaged or compromised may be preferred, rather than relocating an entire facility.

3.1.2 Planned Relocation

Definition	*Planned relocation is defined as a controlled and planned movement of healthcare facility occupants, including patients, visitors and staff from an affected site to a safe and suitable receiving location.*

Planned relocation may occur following the receipt of sufficient and reliable information of an impending (or actual) incident and where time/resources and circumstances permit.

Planned relocation also allows greater opportunity for planned decanting and discharge to occur from an affected site.

Following Shelter in Place, a planned relocation is a next preferred strategy when dealing with the impact of incidents on, at or near Healthcare facilities.

3.1.3 Emergency Evacuation

Definition	*Emergency evacuation is defined as a process that results from a sudden hazard impact that forces immediate action, allowing little or no warning and limited preparation time.*

Emergency evacuation is often undertaken with minimal or no lead time and involves moving building occupants away from life threatening danger. Simply put, it's an urgent movement of occupants to a car park, park or other nearby location (also known as an assembly point) to preserve life as a result of a catastrophic hazard impact to a site.

Emergency evacuation is usually an escalated action as part of a local site 'code response', and for this strategy is considered once Stage 3 has occurred, (AS4083:2010, Pp24).

Emergency evacuation will most likely see an urgent response from emergency service organisations to both address the hazard as well as provide immediate support to healthcare facility occupants in the form of basic care provisions, shelter, hydration, lighting and transport. Under these circumstances, there is likely to be a Control Agency and an Incident Controller, with whom the Site Commander (or nominated delegate – possibly Chief Warden) should liaise with.

3.2 Risk Assessment & Hazard Vulnerability Assessment

A risk assessment/hazard vulnerability assessment needs to be undertaken during 'peacetime' and built into regular risk, emergency management and business continuity planning to inform planning in relation to sheltering or relocation.

SA Health uses the SA Health Risk Management Framework which is a holistic, enterprise-wide risk assessment methodology that should be used for identifying and reporting risk to SA Health. Various Control Agencies in SA offer hazard specific vulnerability assessment tools that may also be utilised at a site level.

The information identified through these processes is captured in several ways, including;

- Business disruption risk assessments
- Resource Outage Contingency Plans (ROCPlans)
- Site emergency management plans and arrangements
- Hazard specific mitigation and action plans

The information obtained must inform planning processes and site specific sheltering or planned relocation arrangements.

ROCPlans should be informed by sources of disruption and outline appropriate hazard impact mitigation measures, especially where they may support a sheltering in place option rather than relocating.

Dynamic, pre-impact risk assessments should be undertaken to provide key information to make an informed decision, and do need to include expected time of impact and/or loss of critical utilities, services and infrastructure and the time required to move.

Sites must also ensure that they have relevant hard copies of crucial documents/plans available to inform pre-impact hazard mitigation and post-impact assessment, such as;

- Water / plumbing
- Electrical
- Building / site
- Sewer
- Gas / medical gas
- Telecommunications

3.3 Decision to 'Stay or Go'

3.3.1 Pre impact/incident

A decision whether to shelter in place or move a healthcare facility will be based on the two core principles outlined in Section 3 and sound, informed and dynamic risk assessment.

Commanders will need to balance the time to impact and incident duration with anticipated dependency and resource requirements when authorising a shelter in place or relocation strategy.

The availability and integrity, as well as re-supply of consumables and support services such as medical consumables, cleaning supplies, linen, catering, pathology, pharmacy and patient medications should be considered in the decision making process whether to stay or go.

A decision to relocate **MUST** only be made when there is a risk of loss of life or injury not preventable by other means (including sheltering in place) **AND** when there is sufficient time and resources to safely undertake the move.

Deciding whether to shelter in place or relocate requires consideration of a number of factors, (non-exhaustive list):

- Risk assessment and hazard vulnerability assessment information
- Credibility and currency of intelligence to underpin decision making
- The nature of the hazard/incident, including its expected impact time, magnitude, area of impact, and duration
- Anticipated effects/impacts on both the hospital and essential services/utilities
- Access to and availability of, and capacity of receiving facilities
- Adequate resources and staffing to support options
- Number of patients and mix of patient acuity
- Patient transportation requirements
- Available transportation resources (vehicles, as well as the necessary staff, equipment, and supplies that must be in the vehicles)
- Entry and egress points at the hospital (pedestrian and vehicle)
- Road and traffic conditions
- Availability and Location of receiving care sites

NOTE - If the decision is made too early and the hazard recedes, relocation may have exposed patients and staff to unnecessary risk. If the decision is made too late, the Commander may have no other option but to evacuate under high-risk conditions or shelter in place without adequate preparedness and resources.

Some considerations that will influence the decision making have been documented in ANNEX B - RELOCATION DECISION MAKING CONSIDERATIONS.

3.3.2 Post impact/incident

Post incident infrastructure assessments should be undertaken as soon as safety practicable to determine whether the capability of the site to continue to provide services.

Key assessment considerations include;

- building integrity
- infrastructure
- critical utilities and services (see Annex A) and
- environmental factors

The template found in ANNEX D – SERVICE / SITE IMPACT ASSESSMENT CHECKLIST is taken from the current SA Health Business Continuity Framework and can inform local, site level assessment of damage.

Whilst a building may not look like it is fit for habitation, it is essential that subject matter experts, including independent engineering and building assessment experts if necessary, are engaged to assess the habitat and likelihood of continuing to shelter in place/resume occupancy, post impact, and provide a damage assessment report.

New Zealand (Wellington) earthquake experiences in recent years has seen internal fixture damage to healthcare facilities however none of the larger facilities relocated as it was safer to remain than go. Key subject matter expertise was sought to assess building structure and integrity and this used to decide as opposed to obvious internal, (often cosmetic) fittings that were collapsed and displaced.

Commanders need to know how long their facility can shelter in place if infrastructure is damaged or compromised or utilities affected (which is informed by the site ROCPlan).

How long can the site maintain a safe temperature during the summer months or how long could essential power be maintained with only the current on-site fuel supply for generators?

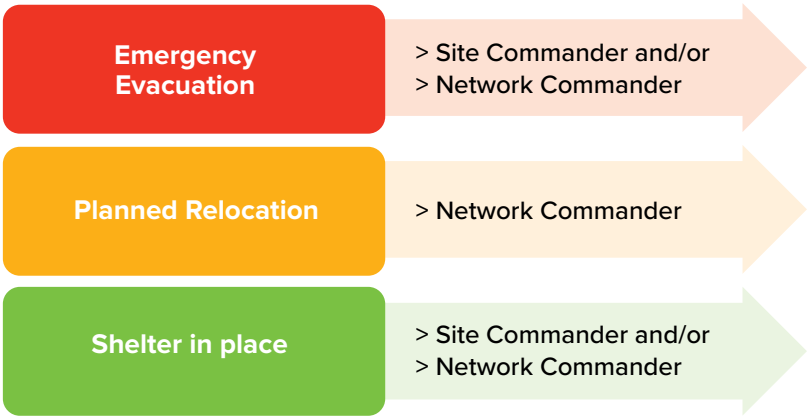
Would this look different if you could internally load-shed power or divert/zone air-conditioning or implement additional hazard impact mitigation strategies?

3.4 Decision-making authority

This Strategy is consistent with SA Health's strategic emergency management doctrine and employs a principle of subsidiarity for both decision making authority and command, to enable leaders and executive at the appropriate level.

It should be noted that wherever possible this process is a collaborative one between the levels of command, with LHN and State Commanders supporting decision making at the local level and site and LHN commanders consulting and sharing information up the chain of command wherever possible. However where normal channels of communication (landline/ mobile) are compromised and this collaborative process is not possible, authority for decision making is outlined as below

Figure 3 - Responsible authority for decision making

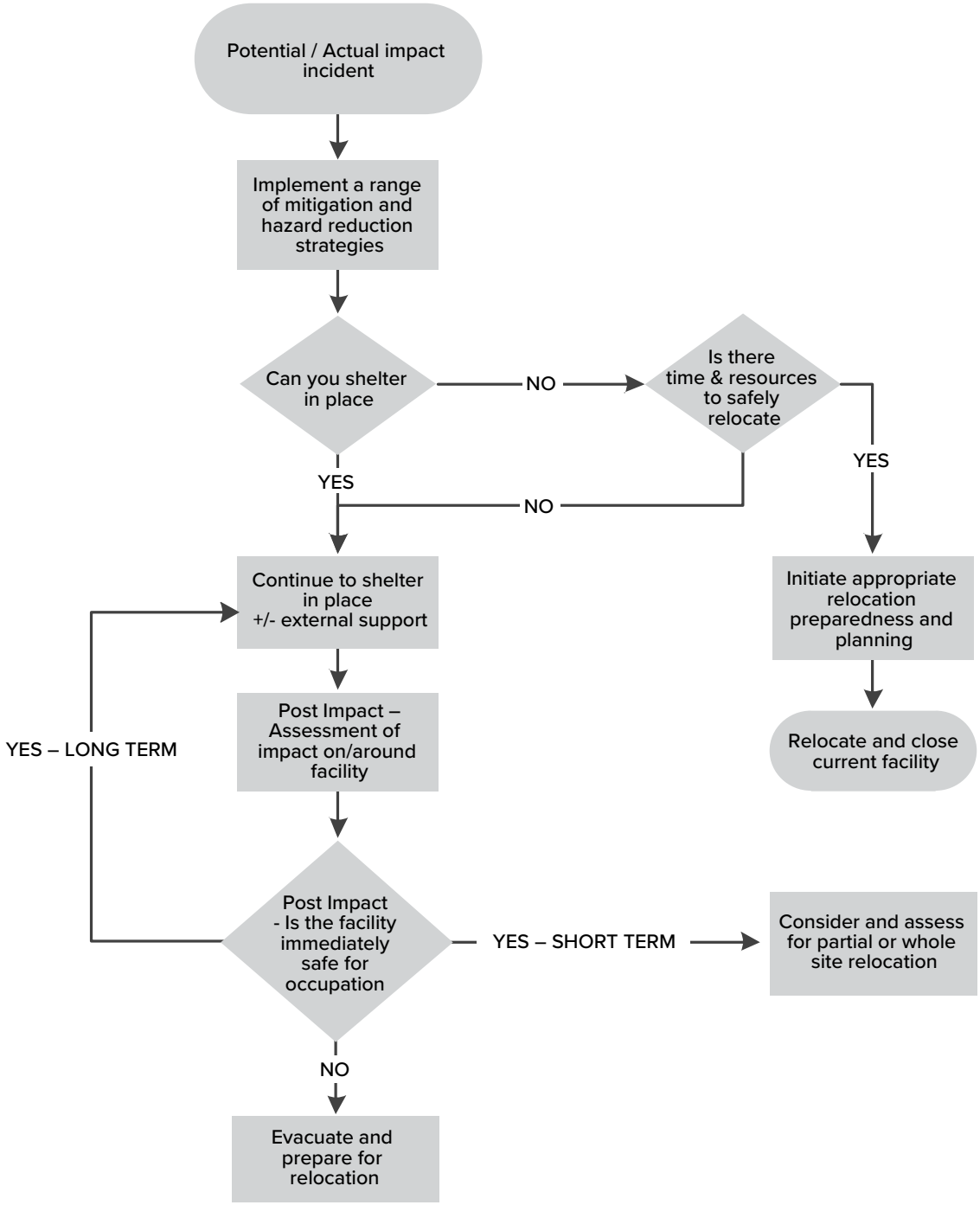


NOTE – Whilst Site Commanders have authority (as per above) to initiate a 'Shelter in place' or an 'Emergency Evacuation', the necessary logistical arrangements (namely transport and receiving facilities) to undertake a planned relocation will be beyond the resources of a single site and so authority sits with the Network Commander.

It is critical that where relevant, the affected network/site Commander and their Incident Management Team (IMT) seek to access relevant subject matter experts (SME) to inform and advise them regarding the following;

- Time to impact
- Hazard reduction / impact mitigation strategies
- Anticipated / actual severity of impact
- Duration of impact and/or disruption

Figure 4 - Decision making process



NOTE – The above diagram 'assumes' that an incident command structure has been implemented.

3.4.1 Conflict Resolution

Where a conflict may arise between authorising Commanders (network/site) in relation to a decision to shelter in place or relocation, the following shall occur;

- The most Network Commander shall undertake a conference (face to face and/or tele/videoconference) with the following;
  - Senior, relevant subject matter expert and/or Control Agency representative.
  - Senior, most appropriate (senior) Ambulance Commander shall also be engaged.
- Where relevant, the State Commander.

They shall convene a discussion to determine an appropriate and ***agreed*** course of action.

3.5 Role of SA Health – Department for Health and Wellbeing executive management

The SA Health Emergency Management Framework identifies that "Command" is a core function of incident management and shall be undertaken by appropriately trained staff with clearly outlined roles and responsibilities.

The role of the State Commander is separate to, and delineated from normal organisational and line management arrangements.

The DHA Deputy Chief Executives and the SA Health Chief Executive **do not** have an incident command nor incident management role – this is for the State Commander. They do have a role in crisis management and ministerial liaison role in complement with the State Commander.

3.6 State Emergency Management responsibilities (Control Agency)

The local response to a hazard and its impact at or near a site, including the subsequent movement or internal relocation of staff and patients under hospital emergency procedures (ie Code response) will be managed locally.

Where SA Health and the State Commander believe that its ability to support a shelter in place or relocation is beyond the agency's resource capabilities, it should seek to undertake one of the two options;

- Identified Control Agency – Where an identified and named hazard (as per the State Emergency Management Plan - SEMP) is potentially or actually impacting on SA Health then they shall seek support from the Control Agency.
- No identified Control Agency – Where the hazard and/or its impacts arise from an incident that isn't currently identified within the SEMP and potentially or actually impacts on an SA Health healthcare facility, they shall seek support/direction from the Coordinating Agency (SA Police).
  - This shall occur via a request from the Health State Commander to the State Coordinator, outlining the problem and assistance sought.
  - It is 'assumed' that the State Coordinator will then appoint SA Health as the 'designated' Control Agency.
- The Health State Controller shall then exercise their responsibilities and powers to manage and resolve the incident as required.

> *If a large SA Health healthcare facility were to experience a catastrophic failure of a Heating, Ventilation and/or Air-conditioning (HVAC) system, this may require consideration for relocation from site. This scenario isn't listed as a hazard within the SEMP and doesn't have a nominated Control Agency; however SA Health may need extraordinary support (State EM arrangements) to manage.*

Where State Emergency Management arrangements have been activated under the Emergency Management Act, due to a hazard or incident that requires consideration for sheltering or relocation, (for example a bushfire threatening a facility), the Health State Commander will be ultimately responsible for command and coordination of the health response as per SA Health emergency management arrangements, along with the identified State Controller - rural fire, in overall control of the incident.

3.7 National Emergency Management arrangements

National plans and arrangements exist to ensure a coordinated response to and management of incidents of national significance. Any request to activate national arrangements would be made by the State Commander in consultation with the State Coordinator. The Australian Government Department of Health maintains National plans and arrangements for responding to health related emergencies which includes:

- National Health Emergency Response Arrangements for coordination of the health sector in response to emergencies of national consequence
- AUSTRAUMAPLAN - domestic response plan for Mass Casualty Incidents of National Consequence
- AUSBURN annex – national response and recovery arrangements for an incident resulting in mass casualties with severe burns

In the likelihood of a SA Health facility providing specialty services such as burns or spinal requires relocation and can no longer provide these services it may be necessary to request activation of National arrangements to assist in the coordination of available interstate capacity and aeromedical evacuation.

The Chief Public Health Officer (CPHO) as the SA member of the Australian Health Protection Principal Committee (AHPPC) will support the Health State Commander in requesting such activation.

Key Section Points

- *Sheltering in place is likely always the preferred option with regards to stay or go, unless there is imminent threat to life*
- *Sheltering in place must be supported by active hazard mitigation strategies*
- *Planned relocation requires reliable intelligence, sufficient lead time to plan and adequate resources to move.*
- *Emergency evacuation is about immediate protection of life.*
- *Risk assessment and hazard vulnerability assessments are critical to understanding risk and inform planning*
- *Resource Outage Contingency Plans (ROCPlans) are critical for capturing hazard mitigation arrangements and maximum acceptable outage timeframes*
- *Have you identified and implemented hazard mitigation strategies to enhance a 'shelter-in-place' approach.*
- *How long could you manage sheltering in place before your supplies and services levels would compromise patient and staff safety?*

4. Information Management

4.1 SA Health Emergency Management System (SAHEMS)

The SA Health Emergency Management Policy Directive outlines the mandated requirements for the use of SAHEMS.

At the point that any Commander needs to consider sheltering or relocation as a strategy before, during or post an incident, and then they shall ensure that the incident is created/initiated (if not already recorded) within SAHEMS and other relevant internal partners are informed via the SAHEMS notifications mechanism.

All Networks shall also ensure that they have their current plans and supporting documentation uploaded into their Network document repository within SAHEMS for access pre, during and post incident.

4.2 Media and Public Information

The SA Health emergency management communications framework establishes broad roles and responsibilities and considers communications strategies for incidents and would be coordinated by the Director SA Health Media and Communications, in support of the Health State Commander during hospital sheltering and/or relocation.

The framework focuses on the following areas:

- Target Audience
  - SA Health staff
  - South Australian public and media
- Communications objectives during an incident
  - To provide South Australians with fast and accurate information during every stage of the incident.
  - To advise the public on where to go for medical help and advice.
  - To reduce fear, panic and miscommunication through clear, consistent information.
  - To instil public confidence in SA Health by demonstrating the agency is effectively managing the current hazard.
  - To ensure clinicians receive accurate and timely information.
  - To promote containment of the spread of any illness through continued personal infection control practices.
  - To reduce pressure on health services by empowering the public to make informed decisions about whether they need treatment.
  - To restore the community's confidence after the incident.

Key messages will be developed for each specific hazard at the time of the incident and in general will cover the following:

- The status of the incident
- What to expect during the course of a hazard
- What SA Health is doing
- What SA Health wants the public to do
- Where to go for more information and/or assistance

Communications should come from a single source that is regarded as authoritative and that represents the response. A consistent message is important and will reduce the risk of miscommunication and/or conflicting messages.

While planning for communications during an incident, responders are to consider that disruptions to infrastructure may compromise this vital requirement. Effective and robust business continuity procedures to ensure systems are in place to communicate both internally and externally regardless of the incident that is being faced should be in place.

4.3 Telecommunications

It is expected that normal business communication mediums be used such as;

- desk phone,
- email and
- mobile telephone,

however where loss of conventional communications is experienced during an incident, business continuity plans and/or loss of conventional communication plan should be implemented.

Key Section Points

- *SAHEMS should be an early consideration for incident notification and common, centralised intelligence gathering and sharing*
- *Timely, accurate, clear and consistent messaging is paramount - for both internal and external partners*
- *Be aware of telecommunications redundancies, especially during business disruption incidents*

5. Relocation Planning

5.1 Identification and selection of receiving facilities

It is the responsibility of the ***affected*** Network through its Incident Management Team to manage relocation planning.

The primary factors influencing and underpinning the selection of receiving sites include;

- Scale and geographical spread of impact from an incident, including transport route
- Size and footprint of the relocating facility,
- Number of patients & occupants needing to be relocated,
- Mobility status and
- Care acuity/complexity

> *A relocation of a smaller country hospital and transfer of patients to other surrounding country facilities may be relatively easily accommodated owing to the small quantity of patients however may be subject to transport limitations.*
>
> *However a relocation of a large metropolitan hospital presents a significant challenge to the health system from a capacity perspective but might be better supported from a transport capability.*

The identification of receiving facilities should allow for provision of appropriate/safe delivery of care and services but recognise that expectations of service delivery at a receiving site may have to be revised.

Sites within the South Australian context may include;

- Metropolitan, peri-urban and rural SA Health healthcare facilities
- Other SA Health community facilities, including GP Plus
- Private Hospital facilities
- Residential Aged Care Facilities
- Residential facilities
- Hotel and accommodation facilities
- Interim measures may include the consideration of a staging/temporary care area;
  - These may include Local Government/community/commercial facilities

The use of a staging / temporary care areas could be utilised for;

- transport staging facility before onward transfer to an appropriate receiving facility,
- lower acuity and/or extended care facility
- offsite discharge lounge

5.2 Creation of capacity & reduction on system load

The initial priority at a relocating site is to significantly reduce overall occupancy numbers (through decanting and discharge), supplemented by a similar approach at likely receiving sites (subject to the size/complexity of the relocation) in order to reduce the transportation and logistics requirements and ensure beds in receiving facilities are allocated to the most appropriate cases.

A series of broader **system wide strategies** to reduce impact and occupancy on the healthcare system includes;

- Cessation of elective surgery.
- Cancellation/reduction of outpatient services.
- Diversion of cases from relocating facility to next most suitable site
- Establish a diversion of intra- and interstate patient transfers in to SA.
- Enacting established hospital avoidance strategies through SAAS and Primary Health Care.
- Public messaging and General Practitioner (GP) communication strategy to minimise walk-ins to all hospitals.
- Surge State-wide Clinical Support Service capability to support timely patient movement and discharge through imaging, pathology and pharmacy requirements.
- Focussed effort to repatriate patients to their home areas with suitable support, where clinically appropriate.
- Utilisation of private sector capacity.
- Consideration of interstate repatriations of interstate patients and/or clinical specialty types.

5.3 Emergency Department

Where the relocating facility presently provides an Emergency Department facility, it is preferred that this service be supported onsite for as long as reasonably practicable.

This may require a See, Treat and Transfer (STT) model of care to be adopted.

The STT shall focus on providing a service that can support self-presentation and walk-ins of both time critical nature and low acuity, assess and intervene before deciding on a referral pathway of discharge or on-transfer to another suitable facility.

Where it is not possible to deliver a STT service at the relocating hospital, then two considerations should be considered;

- Establish (at an alternate site) a low acuity, primary health service with the view to treat and discharge, and/or
- If safe, place a SAAS Ambulance at the 'closed' Emergency Department to support any presentations after the facility has been relocated.

5.4 Resources & Logistics considerations

5.4.1 Staff

Depending on the type of incident, there may be staff absences and shortages as employees may themselves become victims of the incident, or may have family responsibilities that interfere with their ability to staff the healthcare facility (e.g. evacuating dependent children). Time of day and day of week can also affect on-site workforce capacity at healthcare facilities.

All SA Health sites have structured Emergency Control Organisations in place at all sites and the associated Emergency Wardens may present as a disciplined, trained workforce to assist with local operations during a relocation incident.

Pre-incident planning should consider the workforce policies in place (or required) and the workforce issues that could occur in different types of incidents. Consideration should also be given to how to manage workforce during the closure of a facility post-relocation as well as re-deploying staff to other SA Health facilities.

It is the responsibility of the ***receiving*** Network(s) to develop incoming workforce management plans.

Arrangements should consider the following as a minimum (non-exhaustive list);

- Local orientation/induction
- Shift timings
- Local escalation and reporting
- Work area access / security
- Staff transport

It's expected that staff will be required to assist with the movement of patients, intra-site and in-transit to receiving sites as well as the ongoing care at receiving sites.

Alternative workforces such as hospital and community volunteers, visitors, and family members may also be available to assist in relocating selected patients. The use of volunteers and non-SA Health staff should be done sparingly and with caution.

Ongoing communication and messaging with staff both during and post facility relocation is crucial.

5.4.2 Procurement and Supply Chain

Any healthcare facility relocation for extended periods will have significant social, economic, resource and logistical implications for the relocating facility, receiving facilities, transportation providers, service providers, procurement and supply chain, community and Governments.

It is the responsibility of the ***receiving*** Network(s) to develop surge equipment and consumables management plans.

The SA Health Emergency Situation Procurement Policy recognises that a public authority may be required to undertake the procurement of goods and services in responding to an incident.

The relocating facility should consider the movement of essential equipment and consumables to receiving sites where possible to support service delivery. This is an undertaking that shall occur between network/site IMTs.

Where the incident and operational requirements are beyond the capacity and/or capability of LHNs/Services, they shall escalate to the State Commander will ensure appropriate support through Procurement and Supply Chain Management (PSCM) and when necessary, activation of State or National arrangements as required.

In the event of a declared Level 1 or Level 2 Major Incident, all procurement directly relating to the incident must be approved by the Chief Procurement Officer (CPO). The CPO will exercise approvals utilising the specific delegation authorising approval of procurement processes for declared Level 1 or Level 2 Major Incidents up to $15 million (inc GST).

ANNEX C – COMMANDERS RELOCATION CHECKLIST is intended to act as a prompt for Commanders to consider the logistics/resources required for the various stages and tasks of relocation.

5.4.3 Patient identification

There are several points of reference within SA Health to guide the patient identification and medical records, all which align with National Safety and Quality Healthcare standards – Standard 5 (Comprehensive Care).

Networks and sites shall ensure that they develop arrangements to support patient safety in accordance with the SA Health – Patient identification guideline which also incorporates the SA Health - Patient identification band standard – section 4 outlines the requirements for 'transfer of care'

All handover, transfers and discharge documentation should include the three national patient identifiers as listed in 5.3.2.1 of the SA Health – Patient identification policy.

5.4.4 **Where** the transfer is between SA Ambulance Service and a health service, then the SAAS crew shall comply with SAAS Information Notice – Recording of Event Numbers of Patient Clinical Records (INFO-18-047, effective 27/03/18). Medical records

Each Network has its own requirements for transfer of medical records

The following principles should be adhered to when working in either EPAS or ATS for the transfer of patients' medical records:

- Effective clinical handover and continuity of medical record/patient care is paramount
- Primary source of medical record from EPAS live site + temporary folder (consents, ACD's)
- OACIS remains available
- Paper medical records can be requested
- In most circumstances usual processes can/should be followed and adapted as required
- If in doubt, talk to the treating clinician.

5.4.5 Transfer documentation

The following documentation should be included in the transfer of patients' medical records between the EPAS and non-EPAS systems:

5.4.5.1 Paper to EPAS

- Paper-based medical records
- Main file
- Photocopies
- Scanned images
- Electronic and/or printed adjuncts (OACIS, ECG, Echo, etc.)

5.4.5.2 EPAS to Paper

- Interhospital Transfer Summary
- Minimum standard
- Only as useful as data entered
- Mandatory:
  - Identifiers
  - Allergies
  - Precautions
  - Resus status
- Required:
  - Updated Problem List
  - Medication orders and status
  - Last vital signs, any RDR modifications
- Medical Officer documentation (except for brief MI visit)
  One or more of the following to be included in transfer:
  - Outpatient note o ED standard visit or condition specific document
  - Progress note
  - Ward round note
  - ISBAR handover note
- Clinical situation should determine appropriate document(s)

5.4.5.3 Temporary files

- Includes stickers/labels, original signed by patient (e.g. consent, ACD)
- Accompany patient when required

5.4.5.4 Scanned documents

- From EPAS site visible on read-only and/or can be printed from scan for paper-based site, e.g. Jones & Partners radiology report, ECG, echo
- From paper based site can be scanned in where relevant to continue medical record

An additional reference for consideration when relocating patients directly to an in-patient unit at a receiving facility can be found here - SA Health - Direct admission to a hospital inpatient unit

5.5 Special consideration groups

The following cohorts will require additional, specialised considerations that are not presently outlined within this document,

- Mental Health patients, particularly those under an in-patient treatment order
- Paediatric patients, neonates and unaccompanied minors

5.6 Securing a Healthcare Facility

The security of a hospital is of principal concern while it is being relocated to ensure movements and transfers are coordinated and allow safe flow of patients and staff through the facility.

The affected network/site Commander and their IMT should consider the use of a lockdown process for controlling the movement and access/egress of people in and around their facility.

SA Health cannot physically prevent building occupants from leaving their sites (even if the hazard or threat is outside the building which is locked down) but by operating a lockdown the hospital can help to prevent further safety issues from occurring.

Lockdown is achieved through a combination of physical security measures and the appropriate deployment of security personnel. The speed at which the assessment of need and the decision to activate a lockdown is taken is critical and will determine the success of the lockdown in preventing the situation from worsening.

The ***affected*** network/site Commander and IMT shall be responsible for ensuring the securing and closure of a relocated facility. This may (in some cases) see a team of personnel remain on site (known as a 'Stay Team'). Consideration shall be given to the securing of the facilities, equipment, and valuables.

Key Section Points

- *The requirement to generate system capacity will be commensurate to the size of the facility being relocated*
- *Public messaging is critical to supporting both a relocation and reducing system load*
- *Receiving Networks and sites need to develop and manage workforce management plan to accommodate the re-deployment of SA Health staff.*
- *Affected Networks and sites are to utilise (where possible) existing patient identification and medical record processes to ensure patient safety during a move*
- *The affected Network/Site is responsible for the securing of a relocating facility, both during a relocation and post move.*

6. Transfer Coordination

6.1 Responsibility

The coordination of relocating patients and staff shall be the responsibility of the *affected* network/site IMT..

Where the affected network/site IMT cannot adequately coordinate the relocation of patients with its scope of operations, they shall seek to establish a separate Transfer Coordination Centre (TCC), as outlined further in this section.

Any relocation from an affected site will require three key elements, these being;

- Prioritisation of outbound patient movements
- Transport and in-transit care
- Appropriate receiving site

The Executive Director, Medical Services (EDMS), (or equivalent delegate) for the affected Network shall be engaged by the affected network/site IMT when deciding to stay or go and during any planned relocations.

For smaller, less complex sites, transfer coordination considerations outlined below, may be undertaken within the affected network/site IMT, however for larger, more complex sites, the transfer coordination responsibilities are likely to be separated out in to a dedicated TCC resource, as discussed further in this section.

6.2 Key considerations

The key considerations by any affected network/site IMT when coordinating relocation include;

- identifying receiving sites
- establishing the capacity (general and specialty) at receiving sites
- prioritising the movement order of patients
- coordinating the outbound transfer of all patients from a relocating facility to receiving sites
- ensuring that appropriate clinical support is provided during transport.

Transfer types include;

- **Up transfer** - public (including CHSALHN) or private site (intra or interstate)
  Defined as 'movement of a patient to a higher level of care'
- **Cross transfer** - public (including CHSALHN) or private site (intra or interstate)
  Defined as 'movement of a patient to an equivalent level of care'
- **Down transfer** - public (including CHSALHN) or private site.
  Defined as 'movement of a patient to a lower level of care'
- **Discharge** (where transport considerations are required)
  Defined as 'discharge of a patient from care to their home/normal environment'

6.3 Prioritising patients for movement

The affected Network EDMS (or most senior medical officer at the affected site), is responsible for the prioritisation of patient movements during a relocation. This cannot occur in isolation and will require consultation with SAAS regarding availability of human and physical resources to support the patient transportation.

Where possible, patients who can fully or partly mobilise and/or self-relocate shall be encouraged to do so. This may be via car or bus and may be coordinated by the relocating facility or even supported by family and friends/carers.

To assist prioritisation of patient movements, the affected network/site IMT/TCC shall seek to identify the following;

- Number of patients requiring relocation
- Specialties/craft groups of patients
- Mobility and lifting requirements
- Pre-transport, in-transit and post-transport care requirements
- Relocation transport requirements

The senior clinician/TCC Commander must decide whether first (subject to the context of the potential/actual incident);

- to relocate the most resource intensive patients (usually clinically unstable patients, e.g., those requiring powered life-support equipment) or
- to relocate the ambulant, nil/minimally resource intensive patients.

The senior clinician/TCC Commander shall use the following to inform their decision making process;

- Type of hazard and expected impact
- Ability to implement hazard mitigation strategies to reduce impact severity
- Availability of transport and resources
- Safe and suitability access / egress of transport routes
- Time to impact
- Anticipated duration of impact/disruption
- Availability of appropriate in-transit clinicians
- Distance to suitable receiving sites

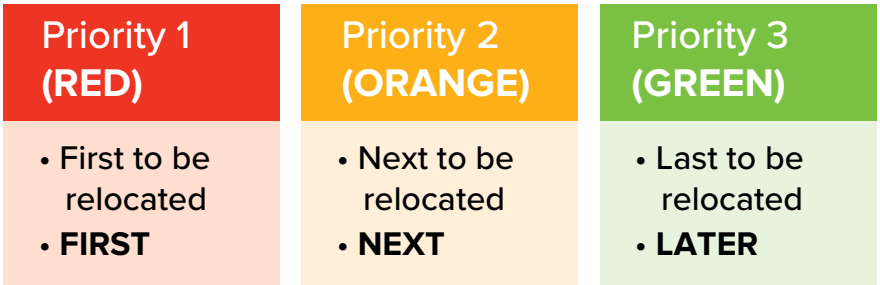
The risks of moving resource intensive, clinically unstable patients are high – senior clinicians and the affected IMT and/or TCC Commander must dynamically weigh the risks of moving these patients against the risks of sheltering-in-place, relative to the circumstances (hazard/impact source and timeliness).

Relocating resource intensive patients well before an incident may allow opportunity for transport resources to return to the healthcare facility to care for those sheltering in place or to relocate additional patients.

6.3.1 Relocation priority

One recommended methodology for categorising the movement order of patients can be found below.

Figure 5 – Patient relocation category



The above categories do NOT directly correlate to the clinical acuity of a particular patient cohort, as the order of relocation will be different in each incident and should be assigned in a dynamic manner.

> *The deliberate strategy of relocating the most resource-intensive patients first in a pre-warned relocation emerged following Hurricane Katrina. Previous experience of waiting too long, and then being stranded in hospitals without water or power, was a powerful lesson for Commanders and staff. Those who went through this ordeal advise that it is preferable to pre-emptively relocate resource-intensive patients, so as to avoid having to move them in even more dangerous conditions.*

In cases where all patients are in immediate danger and evacuation must be conducted as quickly as possible, the evidence suggests that the most mobile patients should be evacuated first.

6.4 Transfer Coordination Centre

Where transfer coordination cannot be safely managed within the capacity of the affected network/site IMT, then a separate IMT shall be convened known as a Transfer Coordination Centre.

A Transfer Coordination Centre is a scalable and structured physical resource that shall centrally coordinate the outbound patient transfers in the event of (larger) healthcare facility relocation. It is likely that the larger, more complex a facility is the greater the expectation and requirement for a stand-alone TCC becomes.

Where a separate TCC is established, it shall be led (in the first instance) by the Executive Director, Medical Services for the affected Network - (This supports the Core principle of 'senior clinical input'). They shall be known as the TCC Commander.

The TCC Commander shall be considered equivalent to a Network Commander and liaise closely with the relocating Network Commander and affected Site Commander (if appointed), however they shall report and be accountable to the State Commander.

The TCC will be staffed by key liaison staff from identified receiving sites (often Patient Flow/Bed Manager personnel) that will assist with capacity and bed allocation at receiving sites.

The TCC will also have SAAS/MedSTAR personnel present (management and clinical lead) to ensure that ongoing consideration (and booking capability) is made for transport resources and in-transit care and MedSTAR to further plan and support the higher acuity patient movements.

The TCC shall be established (where possible) at the affected, relocating facility – subject to habitat/accommodation permitting. For larger healthcare facilities that require relocating, the TCC shall replicate similar accommodation, hardware and infrastructure requirements as a network/site Incident Command Centre (ICC).

Where the affected Network is **NOT** Country Health SA, then early engagement with the Country Health SA, Local Health Network (CHSALHN) Network Commander shall occur to establish the support of CHSA in both peri-urban and regional/rural locations.

Where the expedited/prioritised provision of state-wide clinical support services (SCSS - which may include imaging, pathology and pharmacy) are required to ***prior*** to moving patients, these requests shall be managed by the affected network/site Commander and their IMT and is not the responsibility of the TCC.

NOTE - The single largest advantage of placing the TCC at the relocating site is to have access to relevant Patient Administration Systems (PAS) and other records and proximity to the clinicians that are caring for the patients (to guide decision-making and prioritisation of patient movements).

Key Section Points

- *Patient prioritisation is largely based on the anticipated lead time and severity of impact to a site, as well as expected duration of impact to a site*
- *Patient relocation prioritisation is always led by the EDMS (or nominated senior clinician) for the affected LHN/Site*
- *TCC is a physical resource to centrally coordinate the safe relocation of patients, usually for larger, complex sites*

7. Transport Management

7.1 Transport responsibilities

All patient relocation movements shall be the responsibility of the affected network/site IMT or TCC (where established).

The responsibility for coordinating transport resources are shared between the affected Network and SAAS as per below;

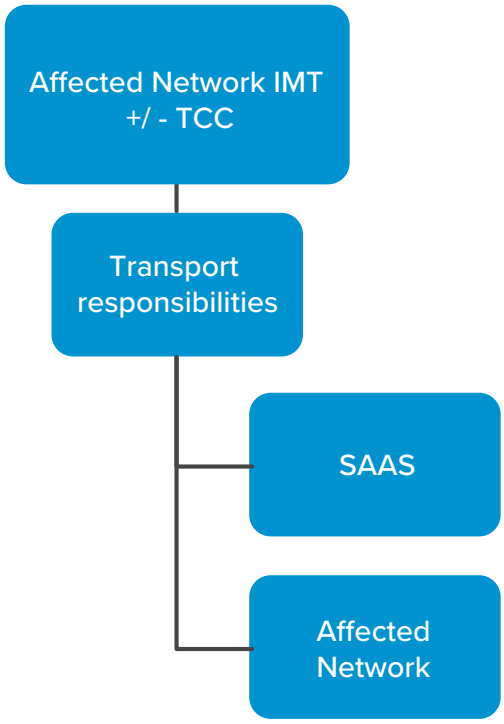
7.1.1 SAAS transport responsibilities

- SAAS are responsible for coordinating the transport and in-transit care for the following cohorts;
  - up-transfer of patients
  - cross-transfer of patients
  - down-transfer of all bed/stretcher bound patients and those requiring clinical support during transit.
  - discharge of all bed/stretcher bound patients and those requiring clinical support during transit.

7.1.2 Affected Network responsibilities

- Affected network are responsible for coordinating the transport and in-transit care for the following cohorts;
  - down-transfer where stretcher transport or in-transit clinical support isn't required.
  - discharges where stretcher transport or in-transit clinical support isn't required.
  - any building occupants who may require additional support in leaving the site, especially where mobility may be an issue.

Figure 6 – Transport responsibilities



All patient movements need to ensure the safety and well-being of the patient and staff as paramount. However, it is reasonable, under circumstances such as healthcare facility relocation that less conventional arrangements may be implemented.

> *Under 'normal' circumstances a majority of inter-facility movements are undertaken with 1 patient and 1 ambulance; however it may be reasonable during a healthcare facility relocation for 10 – 20 fully ambulant patients to be placed onto a bus with appropriate clinical support (ie paramedic / nurse / doctor).*

7.2 Transport planning

Several key considerations are required for planning the transport phase, including;

- Number of patients
- Mobility of patients
- Receiving site location
- Safe and suitable access /egress routes
- Complexity / acuity of patients
- In-transit support/resource requirements
- Type of movement – relocation or post-evacuation

Subject to the size, scale and complexity of the relocation and associated transport requirements, it may be prudent for a SAAS Liaison Officer to be located within the affected network/site IMT or TCC to assist with transport arrangements.

Where state emergency management arrangements are enacted (either due to the hazard/impact type or to support the patient relocation), the affected network/site Commander and their IMT, along with SAAS need to escalate and ensure that Transport Functional Support Group resources are requested and coordinated in a collaborative and consistent manner.

Department for Planning, Transport and Infrastructure (DPTI), Local Government and SA Police can be utilised (subject to available resources) to support;

- Traffic management strategies including
  - Lane/road closures
  - Road diversions
  - Traffic light management

SA Police may also be required to assist with the relocation of detained/in-patient treatment order (ITO) patients – both through personnel and/or fleet.

7.3 In-transit clinical care

The affected network/site IMT or TCC are required to identify any patient acuity and in-transit care levels required – this will assist SAAS in determining appropriate fleet and clinical crewing requirements for patients they are responsible for, (as outlined in section 7.1.1).

For patient relocation movements (as outlined in section 7.1.2) the affected network/site IMT or TCC is responsible for ensuring that appropriate clinician support and in-transit care is considered as well as basic life support equipment/capability is supplied and available during transit, where reasonably practicable.

There may be a mixed clinical workforce supporting the in-transit movements, including paramedics, nurses and doctors.

Relocating facility clinical staff may accompany patients during transport, both to provide ongoing care and/or as a means to deliver the staff in a staggered way to the receiving facility.

7.4 Use of Staging/Temporary Care facilities

Where an urgent relocation needs to occur post an emergency evacuation it may be necessary to utilise temporary staging/ temporary care facilities to enable rapid movement of all patients as well as redistribution options for lower acuity patients.

It is the responsibility of the ***affected*** Network for identifying and sourcing a 'staging/relocation facility' (when the need is identified).

It is the responsibility of the ***affected*** Network for staffing/resourcing and managing any staging/temporary care facility. Clinical and support staff from the ***affected*** facility may be deployed to support ongoing care and services for patients until they are redistributed, and/or discharged directly from site.

Where a staging/temporary care facility is established, then close liaison between staging leadership/coordination staff and the affected IMT or TCC shall occur to ensure timely on-transfers of patients occur.

A staging/temporary care facility will provide a safe area for stabilisation and normalisation, as well as the provision of basic care whilst awaiting transport to the most appropriate facility.

Any such staging/temporary care facility must be capable of being equipped to provide appropriate levels of care until such time that patients can be re-triaged and redistributed.

There shall be consideration given as to any patient/clinical cohorts that are deemed NOT suitable for relocation to a staging facility which may include;

- Detained/Inpatient Treatment Order
- Bariatric/special manual handling requirement patients
- Infectious disease patients including Multidrug-Resistant Organism (MRO)
- Patients requiring ongoing clinical interventions, oxygen, monitoring, medication infusion

This principle (utilisation of a staging/temporary care facility) could be scaled up or down for use in regional centres, as regional locations large enough for a hospital are also likely to have community facilities that could be appropriate.

In selecting such an option some key considerations would include but not be limited to:

- Climate controlled facility of significant size
- Functioning utilities to support the anticipated population (water, power, sanitation etc)
- Good accessibility for vehicles including buses, ambulances, cars etc.
- Significant onsite parking for staff private vehicles
- Secure facility (i.e. external perimeter fencing and lit well after hours)
- On site catering facilities or ability to coordinate patient food delivery/distribution
- Existing public transport routes which make site easily accessible
- Assistance from emergency service agencies and/or community groups such as CFS/SES to assist with establishment of staging facility and hospital equipment (i.e. beds. etc.)

Key Section Points

- *Transport coordination is the responsibility of the affected Network*
- *IMTs and TCC need to ensure that they don't 'compete' for the same, limited pool of transport resources - need to ensure centralised approach*
- *Staging/temporary care facilities are a lesser preferred option but assist with initial transport resource limitations*

8. Re-occupation & Recovery

8.1 Re-occupation of Healthcare Facilities

The objective is to return patients and staff at the earliest opportunity after the principal hazard(s) and/or impact has been negated, when it is reasonably safe to do so.

It is critical that where a relocation was undertaken in relation to an identified hazard (as per the SEMP), that the Incident Controller or State Controller for the Control Agency is consulted for subject matter and hazard specific intelligence to assist with re-occupation decision making.

An "ALL CLEAR" for re-opening and to commence re-occupation shall occur to all health partners (internal and external) as soon as practicable.

Figure 7 – Authority to re-occupy and return to facility

The process used to move patients as part of a re-occupation of a previously relocated facility shall largely replicate those undertaken during the relocation.

The receiving and affected network/site IMT and/or TCC shall be reassembled to support and coordinate patient movements at the previously affected site.

In the same way that the EMDS and senior clinical advice contributed to the outbound relocation of patients, they shall prioritise and seek to identify and coordinate the in-bound movements of all returning patients.

Following an 'ALL CLEAR' for re-occupation, the duration of time that patients are returned to the affected site is crucial and needs to be carefully planned.

There is a need to strike a balance between going too fast and too slow. Too fast, and there risks being panic and the transport system becomes overwhelmed. Too slow, and there will be a significant impact on workforce as they will be trying to support the site being re-occupied AND the other sites.

8.2 Recovery

Recovery planning should start as soon as possible, ideally during the relocation itself, although it will be dictated by the circumstances at the time. Early consideration of recovery and patient repatriation options including the strategic opportunity to plan for a new normality will ensure a smooth transition through each phase of the incident.

Recovery should consider but not be limited to the following:

Humanitarian	> Patient repatriation/return > Ongoing patient care > Ongoing liaison with and updates to patients, families, and visitors > Displacement of staff to other healthcare sites, both within and outside the LHN, welfare, travel costs, providing managerial support and visibility > Psychological support
Economic	> Incident costs > Budget arrangements > Insurance > Landlord / tenant agreements & responsibilities > Provision of supplies / equipment where inpatients are in other LHNs
Environmental	> Site clean-up requirements (damage, pollution or contamination – specialist companies required) > Waste
Infrastructure	> Repair / rebuilding > Consideration of leased modular buildings / trailers to provide temporary accommodation for specific areas/services such as treatment rooms, Operating Theatres, Imaging facilities etc > Site security

8.3 Psychological Support

A person's response to a traumatic event such as an evacuation will be unique and influenced by their prior experience and personal circumstances. This may be complicated by other elements in their life including prior trauma, current circumstances and physical/mental health history.

Early connection and compassionate support from colleagues, family, friends, community and participation in community based activities are known to be strong indicators of long term recovery.

Employee Assistance Programs (EAP) are designed to assist all employees address work related or personal issues that may affect their personal wellbeing, work performance, their health or their safety. EAP programs should be an important early consideration for Commanders to ensure appropriate supports are offered to all staff involved in an evacuation.

Social work and appropriate counselling services for patients and their families should also be considered including the availability of psychological first aid (PFA) services available through Red Cross SA as outlined in the SA Health Major Incident Community Recovery Arrangements.

9. Bibliography

1) NHS England Emergency Preparedness, Resilience and Response , Planning for the Shelter and Evacuation of people in healthcare settings, Dec 2014, Leeds UK, NHS England EPRR

2) California Hospital Association, Hospital Evacuation Plan (Checklist), Oct 2010, Sacramento CA, USA, CHA

3) Agency for Healthcare Research and Quality, Hospital Evacuation Decision Guide, May 2010, Rockville, MD, AHRQ

4) Cairns and Hinterland Hospital and Health Service, Cairns Base Hospital Evacuation Plan, Jan 2013, Cairns QLD, CHHHS

5) CHSALHN, Bushfire Safety and Fire Danger Rating Days, Jan 2018

6) Department for the Premier and Cabinet, State Emergency Management Plan-Part 3-Annex A-Evacuation. Sept 2016, Adelaide, DPC

7) EQuIP National Guidelines – Standard 15 – Corporate Systems and Safety, 2012, Australian Council of Healthcare Standards (ACHS)

8) AS4083-2010 - Planning for emergencies—Health care facilities, Australian Standards

9) SA Health Patient Identification Guidelines, 2014

10) Information Notice – Recording of Event Numbers on Patient Clinical Records, (INFO-18-047), SA Ambulance Service, V1.0, 27/03/2018

10. Annex A - Critical Utilities and Services Considerations

Mains Water

Considerable anecdotal evidence, as well as published reports, indicates that loss of water will lead to hospital evacuation if not promptly restored. Loss of the municipal water supply also jeopardises hospital sprinkler systems and in some hospitals, heating and cooling systems. A hospital ROC/BCP should record the presence/absence of backup water supply lines (in the likelihood that the main line fails) and any on-site water reserves, such as a storage tanks.

Natural Gas

For hospitals that use natural gas for heat and/or hot water, damage to gas mains and extended loss of supply (especially in the winter) could lead to an evacuation. A hospital ROC/BCP should therefore consider reliance on natural gas, whether there is more than one gas line feeding the hospital, and whether gas from just one intact gas line could meet the most critical needs of the hospital.

Electricity

Electricity plays a large role in evacuation decisions. Prolonged loss of electricity can lead to heating, ventilation and air conditioning (HVAC) loss, which can necessitate evacuation. In addition to controlling ambient temperature, electricity is essential for many medical technologies (e.g., monitors, scanners, dialysis machines, ventilators, incubators) as well as other critical functions. Patients dependent on electricity driven life support equipment would require evacuation soon after power failure if battery supplies are exhausted.

Most hospitals have backup generators but the number of hours that a hospital can function without mains electricity, or adequate fuel for backup generators, may be critical factors in an evacuation decision, and on site fuel storage capacity should be considered as well as whether there is a direct feed from the fuel tank to the generators, and whether it would be possible to refill the fuel storage tank during an incident. A hospital ROC/BCP should include the number and size of backup generators and an estimate of the length of time these generators can sustain electrically powered life-support equipment and HVAC. A self-assessment should also consider the fuel storage capacity on site and any potential refuelling issues.

Medical Gasses

Many hospital use reticulated systems to deliver medical gases to all parts of the hospital. These systems and storage facilities can be damaged and compromised during emergencies. Storage supplies, facilities and reticulation systems must be included in any ROC/BCP to ensure redundancy of onsite supplies and/or timely supply of contingency supplies.

Boilers/Chillers

Some hospitals use boilers to generate hot water; others use them for heating purposes, as well. Most hospitals also have chillers for air conditioning (with or without cooling towers). Redundancy in these types of critical infrastructure is rare, and their loss could necessitate an evacuation, depending on weather conditions. A hospital ROC/BCP should therefore recognise vulnerabilities due to the loss of boilers or chillers, irrespective of the loss of electricity and/or water.

Powered Life Support Equipment

Some powered life support equipment (e.g., ventilators) may have backup battery packs in the case of an electricity failure. The life of these batteries varies and patients dependent on such equipment may therefore need to be evacuated more quickly than others. A ROC/BCP should include an inventory of the powered life-support equipment in use on an average day, how many of these have backup battery packs, and how many hours these batteries will last (the latter being a critical factor in deciding how quickly such patients must be evacuated).

Health Information Technology

Loss of key health information technology (IT) and telecommunications systems will, at a minimum significantly reduce a hospital's ability to deliver health care services efficiently and could result in substantial delays as well as increased risk of errors. In other instances, service delivery may cease altogether because automated systems cannot be quickly replaced by manual systems. If patients must be evacuated, paper records are relatively easy to send with them, but some hospitals have already moved away from paper records. EPAS business continuity arrangements include creating and printing a paper discharge summary/downtime summary to accompany each evacuated patient but the time required to create these must be considered.

Telecommunications

In extreme circumstances landline and mobile communications can be compromised or lost. The SA Health loss of conventional communications arrangements considers such a loss and includes strategies for use of the government radio network (GRN) and/or satellite communications for coordination of emergency response and recovery. Increasing reliance on digital networks can also result in loss of data for IT applications and loss of telecommunications and data must be considered in ROC/BCPs.

Security

During a disaster, additional security staff are often needed to:

- Keep unauthorized people out of the hospital,
- Guard transport vehicles as they move to and from the hospital evacuating patients, or
- Maintain order inside the hospital.

While the hospital is empty, security staff may be needed to safeguard the property and the costly medical equipment and supplies left behind. Some hospitals rely on a contracted service for primary or backup security while others employ their own security staff and augment this force when needed. Night and weekend shifts may have fewer security staff, making an evacuation at those times potentially less secure.

11. Annex B - Relocation Decision Making Considerations

Considerations and Triggers for Decision Making	Consider Shelter in Place	Consider Planned Relocation	Consider Emergency Evacuation
A hospital, especially a large tertiary high acuity facility, will almost always represent the safest and preferable location for patients during an incident. Reliable and credible intelligence to inform decisions to shelter in place or relocate are essential. If you do not have reliable credible intelligence to inform your decision you should remain in place until you can make an informed decision			
TIME **Time is a crucial element in deciding on a course of action.** **It should be considered whether the facility will be impacted by a hazard within a certain timeframe and also how long it will take to perform patient/ staff movement**	> Impact imminent > Likely to impact facility before safe to relocate > Likely to pass by the facility and not directly impact (bushfire, storm, flood waters) > Minutes - hours	> Impact likely to occur in a timeframe where all/some patients can be evacuated safely, > Time allows high acuity patients to be transported > Hours - days	> Hazard is occurring internally to the site and present risk to life/safety (e.g. fire) > Internal hazard is going to present risk to patient safety/care (loss of facility, water, air conditioning etc) > Minutes - hours
RESOURCES **Available resources to successfully and safely move patients within or away from a facility** **> Vehicles and SAAS Availability** **> Staff/Volunteers** **> Supplies/Medications/other** **> Wheelchairs/stretcher beds/ beds**	> Limited transport options available > Staff availability on site > Capacity at receiving facilities > Limited portable resources such as communication devices, medical equipment > Limited movement assistance aids or resources for non-ambulant > Well stocked and prepared shelter areas	> Staff and transport readily available within crucial safety timeframes > Portable resources where needed available > Resources available at receiving facility/ facilities	> Staff and transport available at short notice > Portable resources sourced where needed > Staging area resources may be required

Considerations and Triggers for Decision Making	Consider Shelter in Place	Consider Planned Relocation	Consider Emergency Evacuation
OCCUPANCY/CAPACITY Capacity will be a key factor in deciding if the patient numbers outweigh the resources and patient movements time available > How long per patient will it take > Are there sufficient staff and volunteers to assist movement	> The site has a higher occupancy than available transport and staffing can effectively move > The site has a low occupancy can sufficient resources available	> The site has a higher occupancy than available transport options (partial relocation may be an option) > The site has an occupancy that can be accommodated by transport options in the available time > The site has a low occupancy	> Occupancy becomes less of a consideration as the immediate threat necessitates immediate movement, but adds complexity to urgency, resources and timing
ACUITY What types of patients are within the site? > Will specialised equipment/ staff be needed to transport > How long will high acuity patients take to get ready for transport > How long will higher acuity patients take to transport? > Can a lot of low acuity patents be transported easily or walk un-aided	> High risk or high dependency patients that are likely to present complications in movement > Low acuity patients if time does not allow safe pre-warned evacuation/discharge	> A mix of high and low acuity patients where resources and staffing are sufficient to manage movement > Receiving facility/ facilities can cater for acuity of patient mix > Consider planned relocation of patients that may deteriorate or may present complications in shelter in place if safe to do so and time, transport and a receiving location are available) > Discharge (where safe to do so) of low acuity patients	> When the imperative is to move, patient dependency will dictate the time, resources, planning required to move complex highly complex patients. > Ambulant patients will be moved early and quickly whilst complex cases are planned and conducted independently but concurrently or as soon as possible

Considerations and Triggers for Decision Making	Consider Shelter in Place	Consider Planned Relocation	Consider Emergency Evacuation
FACILITY	> The facility has been prepared to withstand the hazards type i.e. bushfire preparation and maintenance, compartmentalised areas, sprinkler systems etc > The facility is already under threat or is likely to be under threat within the timeframe to safely consider planned relocation > Parts of the facility can be made safe	> The facility is unlikely to withstand the hazard (may still be a safer location than in transport) > The facility will get cut off by the hazard (flood waters, fire, roads compromised etc) > Have an identified and sufficient facility to relocate to, not impacted by the hazard where continuity of care can be provided	> Facility has been critically compromised > Ability to care for patients within the facility has been compromised (air quality, power loss, heat, structural safety)
INTELLIGENCE/ INFORMATION Decisions should be made on reliable and accurate intelligence and information sources to prevent a site because of critical decisions such as: > Leaving an area of safety > Traveling into danger > Deciding to leave when time does not allow	> The hazard will be present before planned relocation allows > Intelligence is unverified and unreliable > Impacts are widespread and assistance from own/other agency is unlikely for some time to assist in planned relocation (dependant on own site resources which are insufficient) > The hazard will not be as severe or presents only a threat to part of the site (e.g. low flood waters affecting only one area of the site, loss of power or services in one building)	> Reliable/Credible and Verified that the hazard will not impact within the time it takes to safely relocate some/all patients and staff/ volunteers > Identified safer place/ facility/facilities is communicated and decided upon > Information is able to be communicated back and forth between command structure to ensure all are aware plan	> Reliable/Credible and Verified that the facility is no longer safe for patients and staff

Considerations and Triggers for Decision Making	Consider Shelter in Place	Consider Planned Relocation	Consider Emergency Evacuation
PLANNING AND EDUCATION If well-developed plans on either option have been circulated, educated and exercised then they have a greater chance of being successfully implemented during an Incident	> Identified shelter in place locations > Well stocked and proficient areas > Communication available within shelter areas > Staff trained on role and in setting up, stocking and managing shelter areas > Safety precautions taken (extinguishers, air-conditioning known if can remain on or off, generators fuelled, external sprinkler systems activated if necessary etc)	> Relocation plans practiced and circulated > Transport and receiving site preparation, planning and exercising conducted > Sufficient awareness of logistics of relocation (see Commanders evacuation checklist Annex C)	> Evacuation plans practiced and circulated
HAZARD Some hazards will effect certain sites and not others, depending on the site preparation, location and type of hazard	> Likely to pass or mildly effect site (external, low level flooding, leaking roofs, extreme weather)	> Likely to affect facility or patient and staff safety on site	> Has affected or compromised facility and patient/ staff safety
SAFETY – external environment	> Transport conditions are compromised (flooded roads, smoke, heavy rainfall etc)	> Transport conditions favourable	> Safety compromised on site > External arrangements are safer options
RECEIVING FACILITY	> Not available within timeframe	> Prepared and ready (will be ready) to receive	> May or may not be identified (a staging area may need to be considered while receiving facility/facilities are considered)

12. Annex C – Commanders Relocation Checklist

Action	Complete
NOTIFICATION – (see Section 3 – Decision Making) **Network Commander** **Once the decision has been made to shelter OR relocate** > SA Health emergency management command & control structure and roles & responsibilities will be employed > Notify the Site Commander of decision > Consider notifying the Health State Commander of decision	
STATE COMMANDER AND NETWORK COMMANDERS - ESTABLISH COMMAND/IMT > State Control Centre Health and IMT if required > Relocating network/site command centre and IMT to commence support/planning for shelter or relocation > Inclusion of senior clinical input in decision making processes and advice to Commanders > Receiving network/site command centre and IMTs as required > Transfer Coordination Centre Commander and team if required	
ACTIVATION OF STATE/OR NATIONAL ARRANGEMENTS (IF REQUIRED) – > Where the incident is outside the capability or capacity of the LHN/Service, State or National arrangements may be requested > Health State Commander will coordinate requests for activation of State or National arrangements.	
RELOCATING AND RECEIVING FACILITIES (in consultation with all commanders) > Identification of receiving facilities > Private Hospital facilities > Aged Care Facilities > Local Government/community/commercial facilities > Appropriate accommodation facilities such as hotels > Ramp down and maximisation of SA Health facility capacity > Cessation of categories 2 and 3 elective multi-day surgery > Cancellation of outpatient services > Minimisation of intra- and interstate patient transfers > If a metro hospital requires relocation, where appropriate, patients at other metro sites will need to be relocated to alternate Health sites, including Country Health SA LHN designated near-urban sites (creation of bed capacity) > Implementation of the See / Treat / Transfer model – where applicable > Implementation of a Transfer Coordination Centre > A public and General Practitioner (GP) communication strategy to minimise walk-ins to the affected hospital > The ramp up of Statewide Clinical Support Services to ensure services are available to optimise timely patient flow, access to diagnoses and care and safe transfer of patients across the State where necessary > Focussed effort to repatriate patients (including Country Health SALHN patients) to their home with suitable support where clinically appropriate > Utilisation of private hospitals > Transfer Coordination Centre (TCC) > Affected Network Commander to activate if required > Appointment of TCC Commander > Multi-LHN/SAAS facility	

Action	Complete
TRANSPORT > Shared responsibility > SAAS - All up-transfer and cross transfer patient movements > SAAS – Down transfer and discharge of all bed/stretcher bound patients > SAAS – Any transfer who requires clinical support / intervention > Affected LHN (and/or TCC) – Down transfer and discharges where stretcher transport isn't required > Affected LHN (and/or TCC) – In-transit clinical care isn't required > Affected LHN (and/or TCC) – Building occupants requiring support to leave, including mobility support > Determine Requirement > Consider > Enacting 'non-life threat – non-attendance' principles to redirect SAAS resources (incl. MedSTAR) for movement of patients > Cancel / divert all patient movements away from relocating facility > Activation of MedSTAR, RFDS etc. to consider moving patients to country facilities > Activate external suppliers to establish necessary high use items (i.e. gases, linen, medical consumable etc.) > DPTI (SAAS and LHN/TCC) liaison to assist with: > buses for patient transport; > possible road / lane closures; > assistance with traffic flow via Traffic Management Centre > National Arrangements (through Health State Commander) > Emergency Services (through SAAS Commander) > Staging Area > If required consider an appropriate staging area to manage transport of patients and continuity of care > Establish logistical requirements relative to scale and anticipated duration of operations (see receiving facility requirements) > Appropriate and adequate safe space > Appropriate staffing > Security > Catering > Linen > Waste management > Cleaning > Develop Schedule > Assembly Points at relocating and receiving facilities > Select safe assembly point > Communicate assembly point > Establish requirements of assembly points > Security and mustering of patients and staff > Access and egress > Traffic control	

Action	Complete
PATIENT RELOCATION > Patient identification > Patient Records > EPAS BCP Downtime report > Paper based with patient > Medication/needs > with patient > Patient Aids > with patient > Patient belongings > with patient	
CLINICAL PREPARATION/CONTINUITY OF CARE > Determine Requirement of level of care > Staff/resource support for each patient > Determine requirements of receiving facility > Clinical suitability of staff required > Specialised equipment required e.g. ventilators > Handover protocol > Priority for transportation > Triage	
PATIENT TRACKING > Master schedule development > Tracking IDs. > Wrist tags > Triage Tags (priority and/or tracking)	

Action	Complete

BRIEFING CONSIDERATIONS – Initial and periodic during relocation and reoccupation operations
> Health
  > Minister for Health
  > Chief Executive
> External Agencies and Stakeholders
  > Situation
  > Timeframe
  > Requirements
> IMT (at all levels of Command)
  > Situation
  > Roles and responsibilities
  > Tasks to be undertaken
  > Timeframe
  > Safety
> Staff/volunteers
  > Situation
  > Roles and responsibilities
  > Tasks to be undertaken
  > Timeframe
  > Safety
> Patients
  > Situation
  > Timeframe
  > Safety
> Relatives
  > Communicate the relocation timeframe, relevant alternate facility relocation details with relatives
  > If details not known at this point inform at a later time
  > If safe to do so consider relatives collect patients ready and able for discharge
> Contractors
  > If not needed for the relocation or within the receiving facility ask to leave (if safe to do so), or brief on situation
  > If security is needed brief roles and responsibilities
  > Consider requirements from spotless and other providers	

CURRENT SITE STAND DOWN > Communication forwarding > Site security > Turning off utilities > Signage > Stay Team > Medical Emergency capability / basic life support for on-site personnel	

Action	Complete

MEDIA AND COMMUNICATION
> Target Audience
  > SA Health staff
  > South Australian public and media
 	
Objectives
> Fast and accurate information during every stage of the event.
> Advise the public on where to go for medical help and advice.
> Reduce fear, panic and miscommunication
> Instil public confidence in SA Health
> Ensure clinicians receive accurate and timely information.
> Promote containment of the spread of illness
> Empowering public to make informed decisions about whether they need treatment.
> Restore community's confidence after the event.
 	
Key messages
> Status of the shelter or relocation
> What to expect during the course of evacuation.
> What SA Health is doing?
> What SA Health wants the public to do?
> Where to go for more information and/or assistance.	

13. Annex D – Service / Site Impact Assessment Checklist

(Use to assist with reporting the extent of the impact during a Business Disruption Incident)

Assessment Information	
Date / Time	
Person conducting assessment (Name and role)	
Description of / source of impact and disruption	
Casualties / injuries	
Physical Damage	
Evacuation/s	
Impact on service delivery	
Continuing or emerging threats	
Levels of response and capacity	
Impact assessment submitted to – (Name / date & Time)	

14. Annex E – Transport Considerations

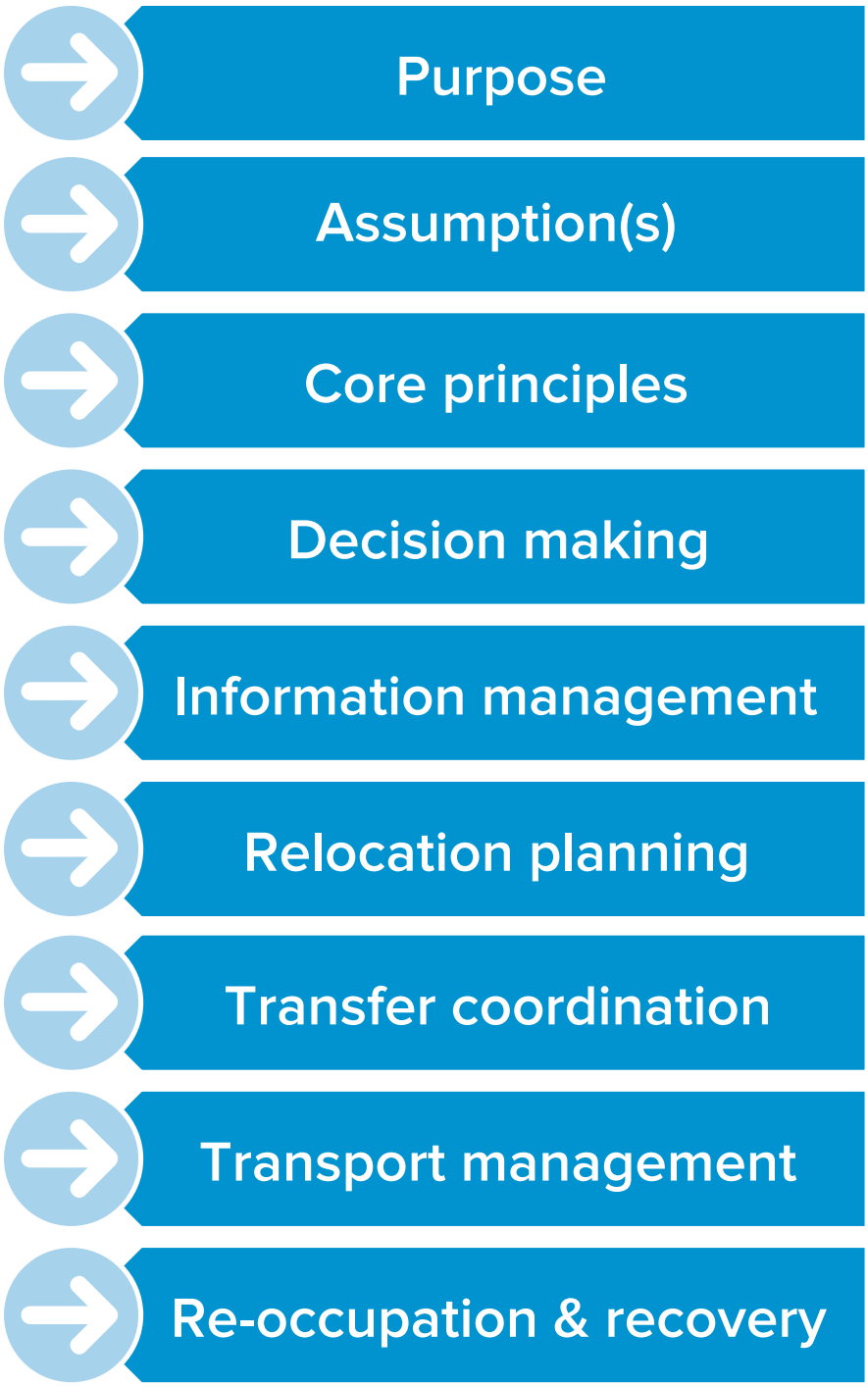
Additional transport planning and operational considerations would include:

- SAAS to flex up its human and physical resource capacity to support patient transfers.
- Activate internal and external suppliers to establish necessary high use items (i.e. gases, linen, medical consumable etc.)
- DPTI and/or Transport Functional Support Group liaison to assist with:
  - Buses and taxis, including Access Cabs for patient transport;
- Need to ensure that close relationship between affected network/site IMT or TCC and SAAS for accessing, booking and tracking transport resources.
- SAPOL liaison re possible support for moving inpatient treatment orders (ITO) patients etc.
- Patient manifest for identification of specific patient cohorts (including but not limited to):
  - High acuity / care patients
  - 'Specialled' patients
  - High risk patients (i.e. prisoners, ITO patients, etc.)
  - Infectious patients
  - Palliative care patients
- Vehicle access to sites
- Patient access and egress SAAS fleet, taxis, buses and private fleet
- Leadership roles of
  - Affected site – outbound patient tracking
  - Transport – patient and resource matching
  - Receiving site – inbound patient tracking
- Consider door to door or bed to bed transfers
- Handing over of patient, medical records and any relevant in-transit information

Patient movements may be undertaken via various methods and arrangements:

- SAAS fleet - including AMBUS, Twin Carry, Bariatric and regular ambulances, light fleet (if mobile and clinically stable)
- Rotary and fixed winged aircraft
- Engagement of private ambulance transport providers - i.e. St. John, First Care Medical etc.
- Engagement of transport resources via DPTI (climate controlled, can be staffed with RNs / SAAS Paramedics for on route care if required); buses transporting approx. 30 patients per trip could continue to turn around and do multiple trips

15. Annex F – Network/Site Planning Framework



For more information

Public Health and Clinical Systems
Emergency Management Unit
Department for Health and Wellbeing
11 Hindmarsh Square
Adelaide 5000
Telephone: (08) 8226 7115
www.sahealth.sa.gov.au

For Office Use Only – I1 – A1

Interpreter

Government of South Australia

SA Health