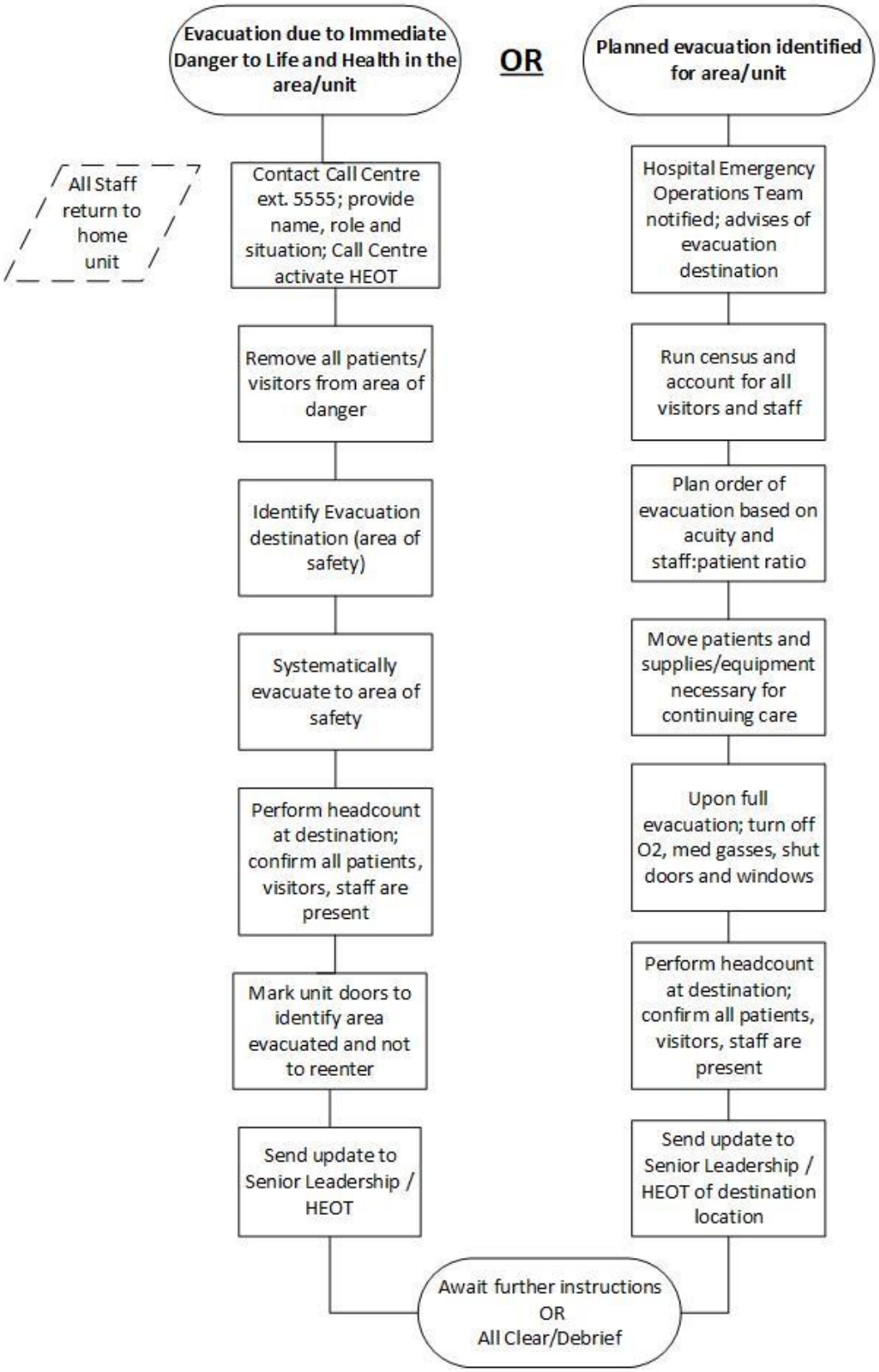
CODE GREEN EVACUATION RESPONSE PLAN ALGORITHM



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Title:	**Code Green – Evacuation Emergency Response Plan**		
Manual:	Corporate		
Section:	Emergency Response Plan		
Approval Body:	ELT Final Approval –COO, CNE, EVP		
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Cross References:			
Code Red, Code Black, Code Brown, Incident Management System			
Key Words:			
Evacuation, Incident Management System			
Developed by: *(Title)*	**Code Green Working Group**	**Owner:** *(Title)*	**Manager, Enterprise Risk**

POLICY:

Mackenzie Health will maintain a process for swift and safe evacuation when an area is, or may become, unsafe for patients/visitors and staff.

DEFINITION(S):

Horizontal Evacuation (ACROSS)
The removal of all individuals on a floor to a place of safety beyond smoke barrier doors on the same level. Horizontal evacuation is the first principle of evacuation before vertical evacuation is considered.

Vertical to Ground Evacuation (DOWN)

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Evacuation in a vertical downward direction.

Total Building/Wing Evacuation
A complete evacuation of all persons in the building/wing.

Place of Safety
Nearest and safest protected area, beyond a set of smoke barrier doors.

Evacuation Assembly Area
Identified safe area outside the hospital walls. Identified by large white signs, with red lettering "EVACUATION ASSEMBLY AREA" (site specific locations).

Offsite locations
Offsite locations shall follow the evacuation procedures and directions of the building management.

HEOT
Hospital Emergency Operations Team

PROCEDURE:

Check closets, washrooms, and under beds, etc., where a frightened or disoriented person might hide.

CRITERIA FOR INVOKING:

A. Situations that pose a direct threat to all individuals, and requires **IMMEDIATE EVACUATION** (e.g., fire/smoke infiltration, flood, hazardous material spill, explosion,

B. Situations that may pose a threat to all individuals but allows for **PLANNED EVACUATION**. (e.g., loss of building heat, chemical air pollution, etc.)

C. AUTHORITY TO INVOKE:

CEO/Manager/ Shift Manager/ Manager/Administrator-on-Call/HEOT/Area Manager/Program Director and/or staff at scene for situations that require immediate evacuation
Director, Professional Practice, Education
Facilities Director
Customer Business Manager (JCI), Cortelucci Vaughan
Fire Safety Specialist
Manager, Risk
Specialist, Emergency Preparedness & Risk

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York Regional Police

Richmond Hill Fire Department
Vaughan Fire & Rescue

A. IMMEDIATE EVACUATION ACTIONS

ALL STAFF

1. Call the Call Centre at Ext. **5555** and alert them to the situation as described in the related Emergency Response Plan and request Call Centre to announce that all staff are to return to the unit.
2. Remove all patients/visitors from the immediate area.
3. Using appropriate Evacuation Principles ***(See Appendices I – IV),*** systematically move patients away from danger.
4. Ensure that all staff members/patients and visitors are accounted for.
5. Report any missing individuals to the Incident Manager or delegate
6. Redirect all questions regarding patient/safety whereabouts from family members/significant others ***to*** incident manager or delegate.
7. Take further direction from Incident Manager/Most Responsible Person (MRP) or delegate (MRN, PCC, Manager, etc.)

8. Do not re-enter the affected area until the "All Clear" is given.
9. HEOT will take into consideration and the coordination of any outside agencies that are required to assist with the evacuation

UNIT/AREA MANAGER/MOST RESPONSIBLE NURSE (MRN) or DELEGATE

Evacuation of patients, visitors and staff shall be the top priority.

Personal judgement must be exercised in determining the order or safely undertaking the following steps:

1. Ensure that all staff are aware of the impending evacuation and assign duties as required. If additional staff are required to assist with the evacuation, contact the Call Centre at Ext. 5555.
2. Choose an appropriate evacuation destination and route and inform all staff.
3. If an operation or treatment is underway and it is felt that it cannot be discontinued without significant detriment to the patient, it may be continued at the discretion of the medical staff in charge. Ensure one individual is dedicated to monitoring treatment/operation areas and providing frequent

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updates on status and conditions.

4. Remain in an area of safety to coordinate evacuation if unless ordered to leave by the Incident Manager.
5. At the evacuation destination, receive report from staff regarding status and conditions.
6. Ensure that all staff are accounted for.

Provide report on status and conditions to the HEOT.

7. Prioritize patients for further evacuation according to medical condition and urgency of need. Injuries sustained during the evacuation should be treated immediately.

8. Stand by for further instructions from the Incident Command Centre and/or external emergency response teams (e.g., fire, police, etc.)

- **Mackenzie Richmond Hill**
  Primary: D-Wing, Level 1, #1301
  Secondary: B Wing, Level 4, #4908.
- **Cortelucci Vaughan**
  Primary: 1.963.C (Inside Learning Centre)
  Secondary: 1.836 (Outside Medical Imaging)

INSTRUCTIONS WILL BE GIVEN BY HEOT OR EXTERNAL EMERGENCY RESPONDERS, IF THE EMERGENCY REQUIRES EVACUATION OUTSIDE THE BUILDING

1. The unit/area Manager/delegate should assemble their group outside in an orderly fashion at one of the designated Evacuation Assembly Areas. **Do not block exits or locate people near fire hydrants**.

2. Perform a head count once assembled of all staff/patients/visitors. Notify HEOT of any missing individuals.

3. Assign available staff member to liaise with a HEOT representative and provide any pertinent information. All other staff will remain with their groups until otherwise directed.

4. Assess patients. Identify critical patients for first available transfer. Assign staff to care for patients / groups of patients based on acuity. Wait for instructions to move patients to emergency transport or external triage / transfer point.

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A. PLANNED EVACUATION

UNIT/AREA MANAGER or DELEGATE

If at any point in the process the situation changes, or safety becomes an issue, move immediately to *Section A - IMMEDIATE EVACUATION*

1. The Hospital Incident Command Centre OR Delegate will advise you of your evacuation destination.
2. Plan the order of patient/resident evacuation, taking into consideration the following:
    - Acuity
    - Staff Complement (ratio of staff-to-patient at departure and destination)
3. Move patients and visitors. Staff will move patients, medications sufficient for the next 4-6 hours, I.V poles, charts, oxygen etc. as directed under pillow / in bag on back of wheelchair /, etc.
4. Record the patient's destination and send this updated copy to the Incident Command Centre.
5. Turn off oxygen and other medical gases, shut the windows. Use portable oxygen if patient cannot tolerate a short time without.
6. Assign staff to transport the following:
    - Records (if not sent with patient)
    - Medication Carts (if moving within the building)
    - Essential equipment / supplies not immediately available at the evacuation destination.
7. Assign two (2) staff to systematically search the unit making sure everyone has been evacuated.
8. Provide updated information to the Call Centre.
    a. Document callers full name, title, and evacuation area.
    b. Upon receiving information of **Code Green,** alert the following personnel.
        - Shift Manager / Manager/ Admin on-Call
        - Fire Safety Specialist
        - Manager, Risk
        - Specialist, Emergency Preparedness
        - Manager of Security
        - Facilities Director
        - Customer Business Manager (JCI), Cortelucci Vaughan

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- Fire / Police / EMS (as directed by the Incident Manager)

c. Call Centre to announce **CODE GREEN** on the overhead system two times as follows:
   i. "**Attention Please, Attention Please, there is a Code Green on (location). All staff should return to their home area immediately to receive further instructions. All visitors should remain where they are until further notice.**
d. Unless in immediate danger, Communications staff will remain in the Call Centre until directed to leave. If instructed to evacuate, the Incident Command Centre will assume responsibility for further internal communications between Mackenzie Richmond Hill and Cortelucci Vaughan.
e. Stand by for further instructions
f. Call Centre to announce "**CODE GREEN ALL CLEAR on (location)"** X 2 when instructed to do so.

A. IMMEDIATE EVACUATION ACTIONS

SECURITY

1. Deploy Security Officers to assess the situation and provide assistance as required.
2. Security to direct Parking staff to put all parking gates in the "up" position.
3. Contact Security and request immediate deployment of four (4) additional security officers, as resources permit.
4. Post Officers at the main entrances to keep entrances clear and control traffic flow. If Security Officer staffing does not permit coverage at all areas, HEOT will deploy staff from other areas as appropriate.
5. Manager of Security will attend Incident Command Centre and assume role.

MANAGER and/or ADMINISTRATOR-ON-CALL ONCE ON-SITE

1. Set up the Incident Command Centre and deploy senior administrative staff to fill the appropriate Incident Management System (IMS) roles. **[See Incident Management System (IMS)]** If the Incident Command Centre is restricted due to the nature of the emergency, the Incident Command Centre could be set up at an alternate location selected at the time of the event.
2. The liaison officer will communicate with external agencies related to the Code e.g., fire department, police etc. and will provide leadership throughout the code. If an external evacuation of patients is deemed necessary. Relocation of patients will be coordinated by HEOT.

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B. PLANNED EVACUATION

1. The Incident Manager or delegated member of the HEOT will determine the destinations and sequence of unit moves and will inform each unit of the estimated time available to complete their evacuation.
2. The Incident Manager or delegated member of the HEOT will process the incoming census lists and will direct the delegate to create an interim inpatient index that reflects the new locations of patients.

HOSPITAL INCIDENT COMMAND CENTRE RELOCATION

1. Relocation of the Incident Command Centre to an off-site location is at the discretion of the Incident Manager.
2. If the Incident Command Centre is relocated, someone may be assigned as a "runner" between the off-site Incident Command Centre and the authorities located at the Hospital.

STEP DOWN: As directed by the Fire Department / York Region Police or other external emergency response providers and in consultation with Incident Manager when all patients, visitors and staff are safely accounted for and relocated if necessary.

FOLLOW UP: A code debriefing will be organized by the Manager, Risk and/or Specialist, Emergency Preparedness as soon as possible after the event, involving relevant stakeholders and participants. Staff counselling and other follow-up (where necessary) will be offered within 24 hours via Occupational Health and Safety, and Employee Assistance Program (EAP).

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APPENDICES:

APPENDIX I – GENERAL EVACUATION PRINCIPLES

Following are general evacuation principles that may be utilized in any type of evacuation, eg. room, horizontal, vertical or total.

1. In general the following sequence of evacuation will apply in an IDLH Room of origin
    - Room **opposite** room of origin
    - Rooms on **either side** of room of origin
    - People who are experiencing anxiety and whose **behaviour is disruptive** to the evacuation process
    - **Ambulatory** patients **who can follow instructions non-ambulatory** patients
    - Check closets, washrooms, and under beds, etc., where a frightened or disoriented person might hide
2. Shut down all machines, turn off oxygen and ensure patients are on portable supplies.
3. Reassure patients and visitors, and calmly and quickly evacuate them from the floor/areas.
4. Close all doors if the situation involves fire, smoke, or other noxious substances.
5. Ensure all Patients/visitors/staff are accounted for.
6. Do not use elevators unless directed or escorted
7. For those patients who cannot be moved other than by bed, stretcher or wheelchair, special elevator activation is possible
8. Utilize proper lifting techniques if required.

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APPENDIX II –HORIZONTAL EVACUATION PRINCIPLES

A Horizontal Evacuation takes place when there is an IDLH inside a room or unit that threatens to spread to adjoining areas, or another emergency situation dictates the need for a horizontal evacuation. This appendix uses fire/smoke as a classic example, however the principles are equally applicable to situations where other factors pose a serious risk to all individuals, eg. flooding, bomb threat, hazardous material spill, etc.

1. All patients should be moved laterally to the nearest and safest protected area, beyond smoke barrier doors. If possible avoid crossing the area of origin.

2. If possible, evacuate everyone into the same area of refuge to facilitate tracking of patients.

3. Patients in immediate danger should be moved first.

4. Those who are ambulatory should be instructed to line up outside their rooms and follow a lead staff person into the area of refuge.

5. The rooms should be checked and marked for and all windows and doors closed.

6. Complete a headcount for the patients/staff/visitors once in the area of refuge.

If it is apparent that the emergency is escalating, or at the direction of the Incident Manager or external agencies, continue to evacuate horizontally, putting at least one “fire zone” between the patients and the zone of emergency. If this is not possible, it may be necessary to go to the next level of evacuation – a Vertical Evacuation ***[See Appendix III – Vertical Evacuation Principles.***

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APPENDIX III – VERTICAL EVACUATION PRINCIPLES

A Vertical Evacuation is the evacuation of an entire floor area in a downward direction. The goal is to move toward the ground floor in anticipation that exit from the building may be required. In this type of evacuation, those in the basement would move to the main floor, and those on the main floor would likely move outside. This appendix uses fire/smoke as a classic example, however the principles are equally applicable to situations where other factors pose a serious risk to all individuals, eg. Flooding, bomb threat, hazardous material spill, etc.

1. A Vertical Evacuation is the evacuation of an entire floor area to a lower floor,
2. If possible, evacuation by stairwell should proceed from the side of the building that is not affected by the emergency.
3. Do not use elevators unless directed/escorted If an elevator is made available, use it for non-ambulatory patients only;.
4. Ambulatory patients should proceed down stairwells first, followed by transport of non-ambulatory patients, applying the "keep-to-the-right" rule and using appropriate lift-and-carry techniques.
5. With the exception of the below ground floors evacuation should always take place to a lower floor. The intent is to move toward an exit point on the ground level floor
6. Responding/support staff should be positioned at all stairwell and exit points to (a) coordinate movement, (b) restrict access and (c) facilitate patient tracking.
7. If possible, evacuate everyone into the same area of safety
8. Patients in immediate danger should be moved first
9. Those who are ambulatory should be instructed to line up outside their rooms, and follow a lead staff person down the stairs to the safe area
10. The rooms should be checked and marked for any remaining patients, visitors, and staff and all windows and doors closed.
11. Complete a headcount for the patients/staff/visitors once in the area of refuge

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APPENDIX IV – EVACUATION GUIDELINES FOR MOVING PATIENTS

Non-Ambulatory (eg. "Mummy" Drag)

Used for patients unable to be mobilized.

1. Push bed against the wall, heavy furniture etc. so it will not move.
2. If possible, put the bed down to the lowest position.
3. Place a blanket on the floor making sure to have sufficient blanket in which to cradle the patient's head.
4. Move the patient to the edge of the bed.
5. Kneel with one knee on the floor, and the other knee up and opposite the patient's head.
6. Put your arm under the patient's head/neck to support and protect it.
7. Lean against the bed. With your other hand reach under the patient's knees and pull their legs off the bed.
8. Let the patient slide between your body and the bed to a sitting position on the blanket.
9. Lay the patient down on the blanket. Move to the head end of the blanket, cradling their head in the blanket and drag to the planned area of relocation e.g., beyond the smoke barrier doors. If safe to do so, stop to close the door to the room enroute.

Ambulatory Patients

Where possible, have patients form a human chain walking or crawling with rescuer leading.

Walking Assist

Used for ambulatory patients requiring little assistance, i.e., elderly, agitated or confused individuals who can move but are slow to move.

Side Assist One Person

This is used for ambulatory patients requiring a little assistance, i.e., strokes, fractures hips, abdominal surgery, some elderly.

Swing Carry (chair lift)

Used for patients unable to ambulate without assistance, i.e., abdominal surgery, respiratory conditions, amputees, some leg casts.

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APPENDIX V – EVACUATION GUIDELINES FOR REACTIVATION CARE CENTRE

In the event the Reactivation Care Centre needs to evacuate all patients or a portion of patients the following procedure should be followed. There are two types of evacuation that may occur, an emergency evacuation or a controlled evacuation. These evacuations generally may be due to a fire but could be due to another situation such as flooding, loss of infrastructure. Staff and patients are to proceed to the nearest and safest assembly point exterior to the building (please see Humber River Code Green for exact information). Staff and patients will be marked off using patient lists and duty rosters. Once outside follow the transportation procedure below to evacuate patients off the premises.

Procedure:

1. To initiate any code at Humber River call Security at extension x5000 (internal) and 416 242 1000 x5000 (external)
    a. *Note: Use Humber River specific phones*
2. Follow the internal Humber River emergency response plan per the situation
3. The decision or determination to evacuate and process of evacuation will be made by Humber River Hospital/Mackenzie Health (MH) Unit Manager/MOC/AOC or by Community Partners (i.e., Toronto Fire). MH MOC AOC would make decisions in collaboration with Humber River and other community partners, as well as onsite leadership at MH sites.
    a. As per the Humber River Code Green policy the decision to evacuate will be made between the Site Administrator and in consultation with the Wilson Site Administrator (see page 2 of Humber River Code Green)
    b. The order in which to evacuate will be determined by the Code Green Command Centre. A representative from the RCC will coordinate with the partner hospital leads.
    c. If an evacuation is to occur ensure the proper escalations procedures have occurred (i.e., informing manager during business hours or shift manager during non-business hours).
4. The decision for type of evacuation will need to be made, & consideration given to the following:
    a. Is this impacting the whole facility or only certain areas?
    b. The situation – does the evacuation need to happen urgently or is it controlled?
5. To evacuate the building itself follow the Humber River Hospital Code Green – Evacuation plan (page 6).

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6. Call Mackenzie Health Senior Leadership (business hours) or activate the Manager on-call/ Administrator on-Call escalation (non-business hours) to activate Mackenzie Health Hospital Emergency Operations Team (HEOT) and Incident Management System (IMS) as soon as possible so that preparations can begin to receive patients, if not already done.
7. Ensure there is communication between the on-site person in charge and Incident Command at Mackenzie Health.

Transportation of Patients from RCC:

1. Arrange transportation of patients from the RCC to MH Hospital site *(*decision to be made on sending patients to one MH site or both MH sites dependent on the situation at RCC and MH*)
   a. MH to call transport partners to transport all patients
      i. Note: information regarding approved non-urgent patient transport (NEPT) vendors is available at the nurses' station.
   b. In the event of an **emergency evacuation** or when more support is required, call the real-time operations center (York Region EMS) at 905-895-2562 and ask for "the on-call commander and/or deputy chief." The following will need to be said:

      i. Declare an emergency, *"We (Mackenzie Health) have declared an emergency at the RCC at 2111 Finch Ave W. We have XX patients at this facility. We are in a code green-evacuation situation at the RCC and have initiated a code orange-mass casualty incident at Cortellucci Vaughan Hospital/Mackenzie Health Richmond Hill to accommodate an influx of patients"*
      ii. Indicate to the operation centre we have engaged our private transportation options for help in evacuation as well as the status.
2. Instruct all those transporting Mackenzie Health patients to transport to Cortellucci Vaughan Hospital to the Learning Centre and/or Mackenzie Richmond Hill Berwick Auditorium as determined by the RCC Leadership/Delegate or Emergency Services.

Arrival of RCC Patients to CVH/MRHH:

1. *MH staff at CVH/MRHH will direct transport/EMS partners to the correct location within the hospital.*
2. Determine specific locations where patients can be placed based on current status of MH (i.e., Berwick Auditorium, Learning Centre, empty units, classrooms, etc.)
3. Once locations determined inform logistics for any equipment needs (i.e., beds, commodes, sharps containers, medication disposal bins, syringes, alcohol swabs etc.)

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4. EVS staff to help prepare rooms which would need to be converted to temporary patient care spaces
   a. Emptying rooms of non-patient care equipment
   b. Bringing beds/stretchers into rooms
   c. Bringing in patient care equipment (i.e., WOW, commodes)
5. Once location determined inform pharmacy for patient medication supply
   a. Pharmacy will supply all non-urgent and non-narcotic controlled substances as required (new patient medication orders) and a 24-hour patient medication supply

      **Pharmacy to work with leadership to consider and review secure storage areas for patient supplied medications, considerations will based on location of patients*

   b. Urgent medications including all narcotic and controlled substances will be retrieved by the nurse from the closest ADU

      **If patient are expected to remain in this area for greater than 24 hours, pharmacy will consider providing an ADU in collaboration with leadership*

6. Notify food services there will be an influx of patients (provide number of patients) and approximate location.
7. If not already done, contact the families to inform of the situation. Consider the set-up of the Family Information & Support Centre. See Code Orange for details.
8. Work with Patient Flow and transport partners for placement of patients in appropriate care settings. Determine which patients can go home, transferred to Long Term Care, or who will still need hospital care at MH. (CVH/MRHH)
9. Once patients have been cleared out of the non-clinical spaces, terminally clean those spaces.