

Evacuation Decision Guidelines for Private Health and Residential Care Facilities



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ABBREVIATIONS

BCP	Business Continuity Plan
DM	Disaster Manager
DOH	Department of Health (Commonwealth)
EMPLAN	Emergency Management Plan
EOCON	Emergency Operations Controller
ERM	Emergency Risk Management
ESO	Emergency Service Organisation
HSFAC	Health Services Functional Area Coordinator
LEMC	Local Emergency Management Committee
LEMO	Local Emergency Management Officer
LEOCON	Local Emergency Operations Controller
LGA	Local Government Area
LHD	Local Health District
LPG	Liquid Petroleum Gas
MOU	Memorandum of Understanding
NSW RFS	NSW Rural Fire Service
NSW SES	NSW State Emergency Services
PPRR	Prevention, Preparedness, Response and Recovery
REMC	Regional Emergency Management Committee
REMO	Regional Emergency Management Officer
SEMC	State Emergency Management Committee

GLOSSARY

INTERNAL RELOCATION:

The movement of residents/patients to another area within the facility perimeter. This movement is also known as a vertical or horizontal evacuation.

EXTERNAL RELOCATION:

The movement of patients/residents, on the advice from an emergency service organisation, from one facility to another unaffected facility in a systematic, planned and orderly fashion in the lead up to an emergency situation. It can be used to decrease the pressure on critical systems that may be affected during a crisis.

EVACUATION:

The urgent movement of all persons from the facility when conditions may be so hazardous that sheltering-in-place would place patients, residents, staff and visitors in greater danger.

PRE-EMPTIVE RELOCATION:

Movement of some or all residents/patients either internally within a facility or externally to another facility that has been arranged during formulation of the Memorandum of Understanding (MOU) process or via liaison with sister facilities at the discretion of facility management. Relocation should be viewed as a method of reducing the load on a facility.

SHELTER IN PLACE:

A mitigation strategy designed to protect residents, patients, staff and visitors inside a facility in situations when the risk of exposure to the hazard is too dangerous and evacuation is not prudent.

1 BACKGROUND

1.1 Introduction

The decision to Shelter in Place or evacuate prior to or following an emergency can be a difficult choice facing emergency service organisations and facility managers. This document provides a decision making framework to assist in determining the need to evacuate or not to evacuate a Private Health or Residential Care Facility prior to or following an emergency impact.

Residential Aged Care and Private Health Facilities have previously been regarded as vulnerable communities. In reality they are becoming increasingly resilient and self-sustaining due to evolving design and building safety standards applied in recent years. If thought of as a resilient community, then the need to evacuate in all but extreme circumstances is unnecessary.

Recent natural hazard impacts provide evidence that those evacuated from Residential or Aged Care Facilities fare poorly following removal from a place of familiarity. They can suffer an increase in confusion, cognitive impairment, greater risk of injury from falls and mortality rate. In addition, catering for these members of the community in evacuation centres is challenging.

Accordingly, preparation and planning for emergency situations is essential for these facilities. These guidelines provide the opportunity for individual facilities to:

- better manage their preparedness
- build resilient infrastructure, thus reducing the risk during times of emergency
- empower individual facilities to be part of the decision making process
- reduce reliance on emergency services
- assist emergency managers with decision making.

The Evacuation Decision Guidelines for Private Health and Residential Care Facilities project was funded by the NSW State Emergency Management Projects under the National Partnership Agreement on Natural Disaster Resilience.

1.2 Aim

The aim of this guideline is to build resilience of Private Health and Residential Care Facilities in times of an emergency. The guideline aims to ensure that evacuation of Private Health or Residential Care Facilities is undertaken only when there are clear indications to do so.

1.3 Objectives

The objective of the Evacuation Decision Guidelines for Private Health and Residential Care Facilities is to:

- Better manage their preparedness to an emergency impact through changes to facilities infrastructure, planning and business continuity practices.

- Build resilience so that Private Health and Residential Care Facilities are not as reliant on emergency services in times of crisis.
- Provide a systematic and robust framework to determine the need, or not, for evacuation.
- Provide consistency in the approach to evacuation decisions for Private Health and Residential Care Facilities.

1.4 Scope

These guidelines are for use by all Private Health Facilities, Private Hospitals and Residential & Aged Care Facilities registered with the Commonwealth Department of Health (DOH) operating within New South Wales. They are for use in planning prior to an impact or for informed decision making following an emergency event. These guidelines can be used in conjunction with current legislative requirements (Commonwealth and State) and accreditation responsibilities.

1.5 Context

The context of the Evacuation Decision Guidelines for Private Health or Residential Care Facilities is to develop facility resilience to a point where shelter in place is the foundation strategy followed by planning relocation and evacuation is only necessary when specific indications to do so exist. Any decision taken to evacuate should be based on the likelihood and consequence of impact weighed against the increased risk of mortality and morbidity to the medically frail and aged residents and patients within care facilities. The final decision to evacuate will still rest with the agency responsible for combating the emergency or the Emergency Operations Controller (EOCON) at local, regional or state level.

1.6 Supporting Documents

The following supporting document should be read in conjunction with these guidelines:

- NSW State Emergency Management Plan (EMPLAN)
<http://emergency.nsw.gov.au/content.php/476.html>
- NSW Health Service Functional Area Supporting Plan (NSW HEALTHPLAN)
http://www0.health.nsw.gov.au/policies/PD/2014/PD2014_012.html
- National Emergency Risk Assessment Guidelines
<https://www.ag.gov.au/EmergencyManagement/Tools-and-resources/Publications/Documents/Handbook-series/NERAG-Handbook10.pdf>
- National Emergency Risk Assessment Guidelines: practice guide
<https://www.ag.gov.au/EmergencyManagement/Tools-and-resources/Publications/Documents/Handbook-series/NERAG-Handbook11.pdf>

- Planning for Emergencies – Health Care Facilities (Standard AS4083-2010)
- Business Continuity – Managing disruption related risk (standard ASNZS5050-2010)
- A practitioners guide to business continuity management (Standards handbook HB292-2006)
- Executive Guide to Business Continuity management (Standards handbook HB293-2006)

2 SHARED RESPONSIBILITY

Emergencies vary in nature, scale, time to impact, duration and consequences. They may be a small localised event or affect a wide geographical area. In order to strengthen or build resilience the concept of shared responsibility should be adopted and practiced. Shared responsibility is where government (at all levels), combat agencies, facility managers and individuals are equal partners in building resilience to an emergency impact. This fits with the current initiative of enabling and empowering communities to build resilience from the ground-up.

In the event of an emergency impact of any magnitude or type affecting a facility, the decision making and resolution will be the responsibility of the facility management in consultation with the relevant combat agency.

In order to build resilience and to actively involve facilities in the evacuation decision making process it is essential to cultivate and maintain solid networking and resource sharing arrangements. Relationships should be in place with surrounding Private Health or Residential Care Facilities, from the same group or other providers. These associations are required to be fostered and formalised prior to an emergency.

2.1 Networking and Resource Sharing

During emergency events emergency services will be engaged in managing the unpredictable consequences of the emergency. Facilities need to be self-sufficient by way of preparation. Facilities need to have options, arranged in advance, to source resources from commercial third parties, or share additional physical resources with other facilities. Suitable local, alternative accommodation is required to be negotiated as part of the resource sharing arrangements and as part of the emergency planning process.

2.1.1 Networking

In order to facilitate the sharing of resources and information, managers of Private Health or Residential Care Facilities should network, both formally and informally. It is suggested that managers meet at regular intervals (quarterly or prior to seasonal emergency periods) to discuss emergency planning and preparedness of their facilities.

Facilities should also undertake regular contact with representatives from the emergency services and functional areas, in particular the Local Health District (LHD) Disaster Manager and the Local Emergency Management Officer (LEMO), for provision of advice in the emergency management sphere.

The Local Emergency Management Officer (LEMO) is also able to bring any particular issue raised by facilities to the Local Emergency Management Committee (LEMC) or Local Emergency Operations Controller (LEOCON). Issues that are not able to be resolved at this local level are able to be escalated to the Regional Emergency Management Committee (REMC), for consideration.

2.1.2 Memorandums of Understanding (MOUs)

Private Health or Residential Care Facility managers, in consultation with their executive should have in place arrangements and where necessary Memorandums of Understanding (MOUs) with surrounding facilities from the same group or other providers. Agreements should be sought with suppliers and commercial hire companies for the provision of consumables and emergency equipment to support a facility during an emergency. These arrangements should be documented and detail specific arrangements to be implemented prior to or immediately following an emergency event. These agreements should be reviewed annually by a designated manager.

2.1.3 Resources

In the event of an emergency threatening or impacting a facility, resources should be initially sought and obtained from within the facilities organisational structure, other local facilities or from commercial sources before seeking assistance from emergency service organisations. This can be pre-impact or post-impact and it is only once these resources or supply avenues have been exhausted that escalation should occur. Escalation should occur early and initially to the Commonwealth Department of Health (DOH) using the NSW emergency contact number, followed by the Local Health Services Functional Area Coordinator (HSFAC) to ensure that a timely response is initiated.

3 RISK AWARENESS

3.1 Emergency Risk Management (ERM) Process overview

Emergency Risk Management (ERM) is the systematic identification, analysis, evaluation and treatment of risks associated with ongoing events. ERM is based on Australian/New Zealand Standard AS/NZ ISO 31000:2009 – Risk Management – Principles & Guidelines. It is a legislated requirement that all Local Government Areas (LGAs) conduct a risk assessment of identified hazards (natural and technological) within their boundaries.

'The Emergency Risk Management process can improve outcomes by:

- *Establishing a decision-making process*
- *Focusing on the opportunities to reduce or manage the risk-rather than on the response to emergencies that may result from the risk*
- *Engaging a wide range of individuals and communities*
- *Promoting partnerships and enhancement of relationship*
- *Fostering resource sharing and mutual aid arrangements*
- *Providing auditable and credible means of reducing risk*
- *Using a language that is common to decision-making in both the public and private sectors.'*

Emergency Risk Management - Applications Guide (2004) P1

The ERM process involves understanding hazards, consultation with stakeholders and production of treatment options to minimise the impact or, if possible, eliminate the resulting risk. Identified risks for the local area/s are contained in Local Emergency Management Plans. These are public documents and are obtainable from the Local or Shire Council.

3.2 Local Risk Awareness

Private Health or Residential Care Facilities should make themselves aware of the risks that they may be exposed to through consultation with their Local Emergency Management Officer (LEMO) and Local Emergency Management Plan. As well as understanding the risks identified in their local emergency plans, facilities should give thought to issues that may affect them specifically, such as: isolation due to weather; localised inundation or landslip; and utility (power, water, sewerage, and telecommunications) failure for extended periods.

Advice on specific hazards and mitigation measures can be obtained from the Emergency Service Organisation (ESO) with the responsibility for control of a specific hazard e.g. NSW Rural Fire Service (RFS) for bushfire or NSW State Emergency Services (SES) for flood and storm. These organisations maintain up to date information regarding hazards, risks, warnings and management plans. Emergency Service Organisations and Bureau of Meteorology websites should be consulted regularly as a means of staying informed of current risks and warnings.

4 EMERGENCY PLANNING

4.1 Emergency Plans

Emergency Plans are required for individual Private Health or Residential Care Facilities. Residential Aged Care Facilities under the Aged Care Act 1997 and Care Principles 2014 have a responsibility to have in place emergency risk management plans and be prepared for emergencies. The Australian Aged Care Quality Agency's Accreditation Standard 4, expected outcome 4.6: *Fire, security and other emergencies* requires that approved Aged Care providers are to have emergency plans and protocols in place to protect the health, safety and wellbeing of residents, staff and visitors.

Private Health Facilities Regulation 2010 part 8 requires Private Hospitals to have a documented emergency response policy outlining the procedures to be followed in the event of natural disaster or other emergency affecting the facility.

Facility emergency plans should be written using an all hazards methodology and contain details to address the established comprehensive approach framework of Prevention, Preparedness, Response, and Recovery (PPRR). Emergency plans should contain contingency arrangements and decision triggers for implementation of Shelter in Place, relocation (internal/external) and evacuation arrangements.

4.1.1 All Hazards Approach

The all hazards approach to emergency management planning considers that any hazard (even unrecognised) could impact an area or facility at any time. This approach ensures that Emergency Plans are designed with flexibility to provide guidance and governance in all emergency situations.

4.1.2 Prevention

Applied emergency management prevention entails actions undertaken to eliminate or reduce the impact of hazards themselves and/or to reduce the susceptibility and increase the resilience of the community to the impact of hazards. Facilities must undertake regular risk mitigation tasks, such as maintaining required fire protection zones, maintenance of essential plant and equipment and monitoring of seasonal warnings and environmental conditions.

4.1.3 Preparedness

Preparedness activities establish arrangements and plans and provide education and information to prepare the facility to deal effectively with emergencies that may eventuate. These include undertaking regular emergency exercises and staff education sessions, maintaining and testing emergency generators, ensuring communication lists and plans are up to date and networking with sister and/or other local facilities. Psychological preparedness of residents/patients, staff and relatives is an important aspect of preparedness.

4.1.4 Response

The response details the roles, responsibilities and actions to be undertaken when an emergency occurs. Roles and responsibilities in the emergency plan should be assigned to a position, in the facility, not an individual.

4.1.5 Recovery

The recovery section of emergency plans details the actions necessary to assist a facility affected by an emergency in the restoration/reconstruction of the physical infrastructure and restoration of emotional, social, economic and physical well-being of residents, staff and visitors.

Facility Emergency Plans must be readily accessible to and understood by all managers and staff. Plans should be exercised and reviewed annually or following implementation, to ensure that information, procedures and processes remain relevant.

5 BUSINESS CONTINUITY PLAN (BCP)

Closely linked with the Facility Emergency Plan is the facility Business Continuity Plan (BCP). Business continuity is defined as “maintaining the uninterrupted availability of all key business resources required to support essential business activities”. (The Australian National Audit Office, Business Continuity Management - Keeping the wheels in motion 2000, p11).

A BCP is a practical plan of how the facility will prepare for, respond to and maintain its core functions and recover or partially restore patient care and related services when operations are impacted. The BCP should adopt the comprehensive risk management approach framework of Prevention, Preparedness, Response and Recovery (PPRR) to address identified risks.

Business continuity management is an integral part of the risk management framework within an organisation and has an integral link with facility emergency plans. BCP's should be reviewed regularly and updated to reflect current arrangements and contract details. These should be readily accessible and understood by staff to ensure that

business as usual is maintained or resumed to as soon as practicable in the event of an emergency.

6 FACILITY PREPAREDNESS

Preparedness is defined as “Measures to ensure that, should an emergency occur, communities, resources and services are capable of coping with the effects” (Emergency Management Australia Manuals Series, Part III, Volume 3 - Guidelines, Guide 1). By being prepared a higher level of resilience is attained and reliance on emergency services is decreased. Preparedness is more than undertaking scheduled or planned maintenance of infrastructure and equipment. It means having in place, or the ability to obtain, the necessary equipment to support essential services, and consumables for the provision of ongoing care during an emergency.

6.1 Situational Awareness

Private Health or Residential Care Facilities must remain aware of hazards and the potential impacts that these pose to the facility. This situational awareness needs to be considered routine to ensure that any advanced preparations are able to be undertaken. In particular facilities should remain vigilant and not be reliant on the emergency services to provide individual warning or advice to facilities on impending impacts.

6.2 Emergency Power

Interruption to power supply can occur at any time and can have serious consequences for facilities. Best practice is to have an emergency power supply, in the form of a generator, capable of sustaining power to critical systems within the facility. At a minimum, electrical switchboards are required to facilitate the connection of a generator/s. A bulk supply of fuel to maintain the operation of the generator needs to be considered in the plan.

An assessment of the required capacity to power all critical systems must be conducted by an electrical engineer or person with expert knowledge of power requirements. If sourcing a generator from a third party during an emergency, installation is required to be undertaken by a person/s trained to install such equipment.

6.3 Water Supply

Disruption of the supply of water can have a critical effect on the ongoing viability for the continued provision of care during emergencies. To cater for emergency situations facilities should have a supply of water for drinking (potable water) and a separate supply for general use (cleaning, ablutions etc.) from the reticulated system. Facilities should refer to local or shire council for the regulations on the use of rainwater storage as a source of drinking water.

The average water consumption per person is 15 litres per day, distributed as follows:

- Drink and food – 2.5 - 3 L (dependent on climate and individual physiology)
- Basic hygiene practices – 2 - 6 L (dependent on social and cultural norms)
- Basic cooking needs – 3 - 6 L (dependent on food type and norms)

World Health Organisation, Field Manual for Capacity assessment of Health Facilities in Responding to Emergencies, P87

6.3.1 Potable Water

Potable water is water that is suitable for human consumption. It can be sourced from: proprietary emergency water purification system; rain water collection system; delivered by tanker and stored in tanks or storage bladders; or in bottled form for distribution. Collected rain water systems for drinking should be reviewed by appropriately qualified persons to advise appropriate purification requirements.

6.3.2 General Water

A supply of water for general use, such as general cleaning, should be maintained separately from potable water. It can be collected from rain water but does not need the same level of purification as potable water. Any containers used for storage of this water are required to be marked '**non potable water**' so that confusion between safe drinking and non-drinking water does not occur.

6.4 Gas

If the facility has mains gas supply to the kitchen, an alternate supply of gas is necessary for meal preparation and possibly boiling drinking water. Emergency supply can either be bottled gas or an external storage tank. Alternate cooking equipment using either Liquid Petroleum Gas (LPG) or bottled natural gas needs to be considered and sourced for use in emergency situations.

6.5 Foodstuffs

Adequate supply of non-perishable foodstuffs, to last for a minimum of 7 days, suitable for the resident population (soft/pureed/thickened fluids/parenteral) must be available. Ideally perishable items need to be consumed and/or prepared first to prevent excessive spoilage. Meals should be kept as simple as possible to prepare and cook/reheat to take advantage of limited cooking options.

6.6 Communications

Facilities utilise cordless phones, commander systems or the National Broadband Network (NBN) that are susceptible to failure when power outages occur. Emergency power supply to operate these systems and alternative devices such as landline telephones and to a lesser extent mobile phones should be used if possible. It should be

noted that mobile phone coverage can be decreased, and inconsistent, during emergency events as result of damage to communication towers and associated infrastructure along with network congestion.

6.7 Medical/Care Records

Electronic Medical/care records should be backed up on a regular basis with offsite/remote server storage as a secondary back up method. Records should be accessible by management remotely. This methodology needs to be used for all records or important documents required for management of the facility. Electronic offsite storage with remote access is necessary to prevent loss or damage of records and ease of retrieval from any location. Paper based medical/care records should be easily accessible and transferred into a plastic storage tubs for ease of movement and safekeeping in the event of relocation or evacuation. All records need to be as accurate as possible for the provision of continued and ongoing care at other Private Health or Residential Care Facilities.

6.8 Medications

Medication supply for all residents/patients should be held to last a period of no less than 7 days. Additional supplies should be pre-arranged with a local pharmacy in the event of an advanced warning event. Arrangement for local supply and an alternative supplier for urgent resupply should be documented in the facilities Business Continuity Plan (BCP).

6.9 Staff/Residents/Patients/Relatives

Plans should address logistical needs to cover staff that are either unable to attend work or who are must remain in place, due to the emergency. Minimum staffing levels and the reallocation of roles to support continued care should be included. As necessary patients/residents and relatives should be made aware of the facilities emergency plan and the implications and strategies that may be undertaken if implementation of the plan occurs.

6.10 Training

All staff (including agency staff) should be adequately trained and be conversant with the facility's emergency plan. Management should encourage staff whose position will undertake a role during an emergency to complete an introductory emergency management courses such as:

- Emergency Management Overview (online) and
- Introduction to Emergency Management.

This will provide staff with knowledge on current practice and the opportunity to network with local emergency services. Information on these courses can be obtained at the Emergency NSW website <https://www.emergency.nsw.gov.au/emsector/training-capability/>.

6.11 Emergency Exercises

To ensure that a facility's emergency plan remains current and staff are able to implement designated roles, an emergency exercise to practice and test arrangements should be held annually.

Where possible, residents and their relatives if able could be included in training sessions/drills/exercises on the emergency plan. Having residents and families involved in this manner increases psychological resilience, strengthens coping mechanisms and provision of assistance if needed.

6.12 Emergency Kits

A supply of emergency consumables and equipment to support continued care of residents or patients should be assembled. These should be kept in an easily accessible location and kept in transportable storage containers for deployment within a facility or for use during an evacuation. Smaller grab bags with patient/resident information and identification need to be located in close proximity to patients/residents in case an unscheduled relocation or evacuation takes place. An example list of items contained in an emergency kit from a facility is included at Appendix 4.

7 EVACUATION DECISION ALGORITHM

Evacuating the elderly or ill is not without risk. The Evacuation Decision Algorithm allows Private Health and Residential Care Facilities to assess and plan the actions to be undertaken in order to make an informed decision to shelter in place or the evacuate.

Evacuation of frail/aged or medically dependent people is resource intensive, time consuming and requires close collaboration between multiple agencies.

Initial responsibility for the decision to evacuate or not rests with the onsite managers of Private Health and Residential Care Facilities as they are in the best position to assess the prevailing circumstances and decided on the sustainability or viability of their premises. It is important that facility management consults with the agency designated to manage the incident and follows any direction or advice given.

7.1 Decision Algorithm

The algorithm (Appendix 1) is a decision making tool that presents a guided process for facilities to assess the readiness for (in the case of an imminent event), or resultant damage (following impact) from an emergency event. The tool is based around two assessments. These are an Advanced Warning/Imminent Impact Assessment and a Post Impact Assessment.

7.1.1 Advanced Warning/Imminent Impact Assessment

The Advanced Warning/Imminent Impact Assessment is to be undertaken when a facility has become aware of a pending threat. The consequences of the impending impact may not directly damage the facility; however it may have an indirect impact such as isolation for a considerable amount of time. The assessment must include the facility preparedness items outlined in section 6. Items must be on hand or obtainable well before impact and should be pre deployed in a serviceable condition in anticipation.

The sample Advanced Warning/Imminent Impact Assessment checklist provided (Appendix 2) may be amended to include threat specific items at the discretion of the facility management. The sample represents the minimum areas to be considered.

The Advanced Warning/Imminent Impact Assessment can also act as a prompt when reviewing Emergency and Business Continuity Plans (BCPs). It is also useful when reviewing readiness for seasonal emergency periods such as bushfire/storm/flood danger periods.

7.1.2 Post Impact Assessment

The Post Impact Assessment is a rapid assessment undertaken following a sudden or unexpected hazard impact affecting the facility. A sample checklist is provided at Appendix 3. This process will provide: an accurate evaluation of the functionality of critical systems; the viability of the infrastructure to provide continued safe and secure shelter; and the sustainability of ongoing care.

Both the Advanced Warning/Imminent Assessment and Post Impact Assessment examples (Appendix 2 and 3) will provide facility managers with the necessary tools to formulate decisions on the state of preparedness of their facility and an informed decision on a strategy to be implemented, such as Shelter in Place, Pre-Emptive Relocation or Evacuation.

Once assessment has been conducted, necessary facility preparedness arrangements implemented and a final strategy decision reached it is imperative that the process is documented and communicated to the Local Emergency Management Committee (LEMC) via the Local Emergency Management Officer (LEMO) and to the Local Health District Health Services Functional Area Coordinator (LHD HSFAC).

8 EVACUATION DECISIONS

Completion of the Advanced Warning/Imminent Impact or Post Impact Assessment will facilitate appropriate decision making to Shelter in Place, Pre-Emptive Relocation (internal or external), or Evacuation.

8.1 Shelter in Place

Shelter in Place is a mitigation strategy to protect residents, patients, staff and visitors inside the facility.

In general Shelter in Place is the most appropriate strategy to be adopted in emergency situations. The decision to Shelter in Place by a Private Health or Residential Care Facility should be considered when:

- ESO can support/protect the facility.
- Facility capabilities are adequate to care for residents/patients and staff for the estimated event duration.
- Evacuation would pose a greater risk to patients, staff and visitors.

A decision to Shelter in Place should always be accompanied by alternative plans for Pre-Emptive Relocation or Evacuation.

8.2 Pre-Emptive Relocation

Pre-Emptive Relocation is the movement of residents and or patients either internally within a facility or externally to another pre-arranged facility.

8.2.1 Internal Relocation

Internal relocation is the movement of residents and/or patients within the perimeter of the facility. This movement is also known as vertical or horizontal evacuation.

Horizontal evacuation involves moving persons in immediate danger away from the threat, but keeping the patients on the same floor of the facility or an adjoining building. This typically involves moving to an area of refuge in an adjacent smoke/fire zone or in some cases, at the opposite side of the building.

Vertical Evacuation refers to movement to another floor in a building typically at least two floors away from the incident floor.

8.2.2 External Relocation

External relocation is the movement of patients/residents from a facility to another facility in a planned fashion in the lead up to an impending emergency. It can be used to decrease the pressure on critical systems or agencies that may be affected during an emergency.

External relocation should be viewed as a method of reducing the load on a facility and considered when:

- Duration and scope of threat to a facility is clear but may evolve.
- Facility's capabilities are not adequate or would be improved by partial evacuation to care for residents/patients and staff with available support for duration of the event.
- It is determined that it is necessary to conserve resources.

Relocations can be to relatives to provide care at residential premises outside of the impact area, other facilities that have spare capacity, an appropriate facility for those that are palliative/terminal with the likelihood of succumbing during isolation or a health facility for those requiring medical intervention.

Prior to any movement of patient/s or resident/s to a NSW Health facility, contact must be made with the Local Health District Health Functional Area Coordinator (LHD HSFAC) to ascertain if a NSW Health facility is able to accept the patient/s.

Any Pre-Emptive external relocation undertaken prior to impact needs advanced transport planning and is to be undertaken and managed using facility Memorandums of Understanding (MOUs) and internal resources or organized through third party commercial providers. It is only once these resource avenues have been exhausted should assistance be sought from Emergency Service Organizations (ESOs).

At the conclusion of an emergency event it is the responsibility of the facility that has relocated residents/patients to undertake repatriation. As with the initial movements all transport arrangements, planning, management and resourcing must be organized and managed by the facility.

8.3 Evacuation

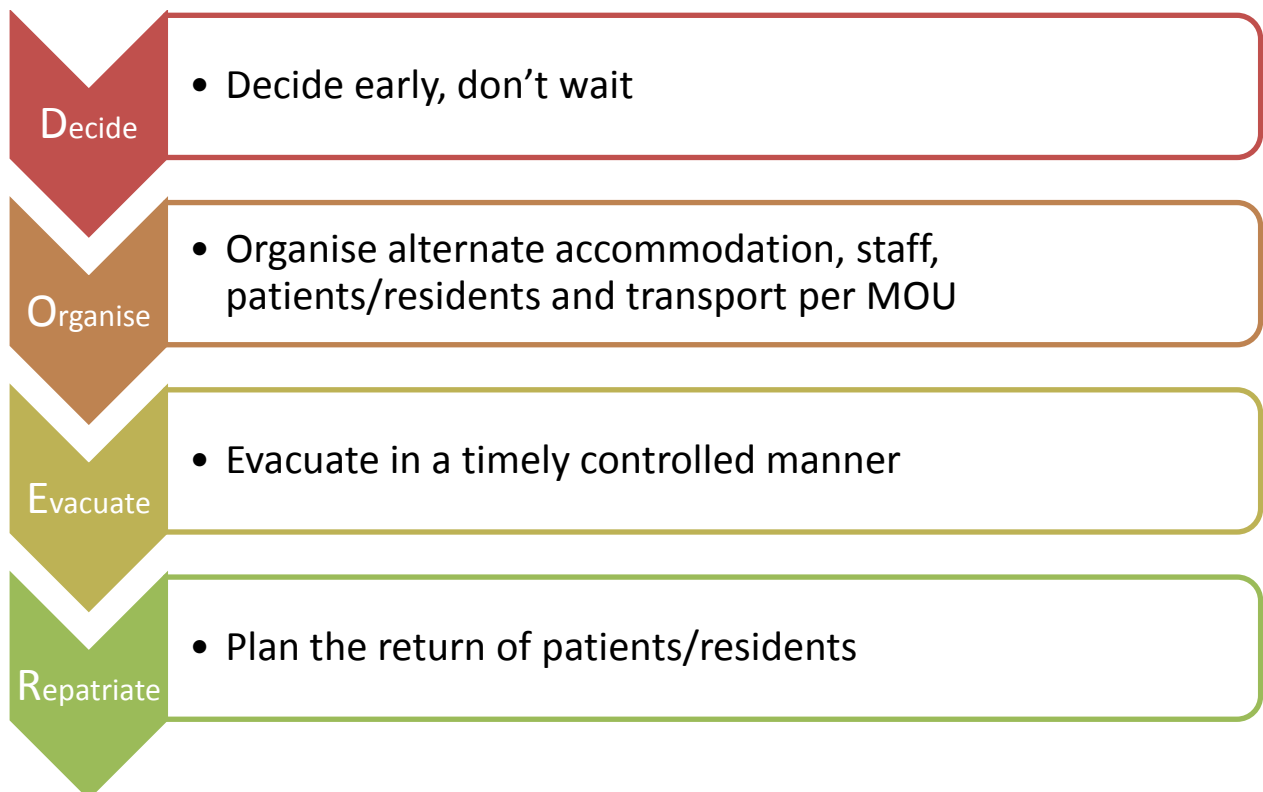
An evacuation is implemented when this option is safer than sheltering-in-place. It should be considered if:

- The proximity, scope and/or expected duration of the emergency poses an immediate threat to resident/patient and staff safety.
- ESO's are unable to support/protect the facility
- Adequate and timely facility and/or mutual aid resources are available and accessible to support full or partial evacuation.

Evacuations are a resource intensive, time consuming undertaking, particularly when Private Health and Residential Care Facilities are involved. It requires extensive planning to move all residents/patients out of a facility and transport them to other facilities where ongoing care will be provided.

Any decision taken to evacuate should be based on the likelihood and consequence of impact weighed against the increased risk of moving the aged and ill. By undertaking and maintaining preparedness actions, evacuation should rarely occur and be considered a strategy of last resort and not an immediate first step.

If an evacuation is deemed necessary following advice from a combat agency or having completed the self-assessment the 'DOER' mnemonic will help facilities plan.



9 APPENDICES

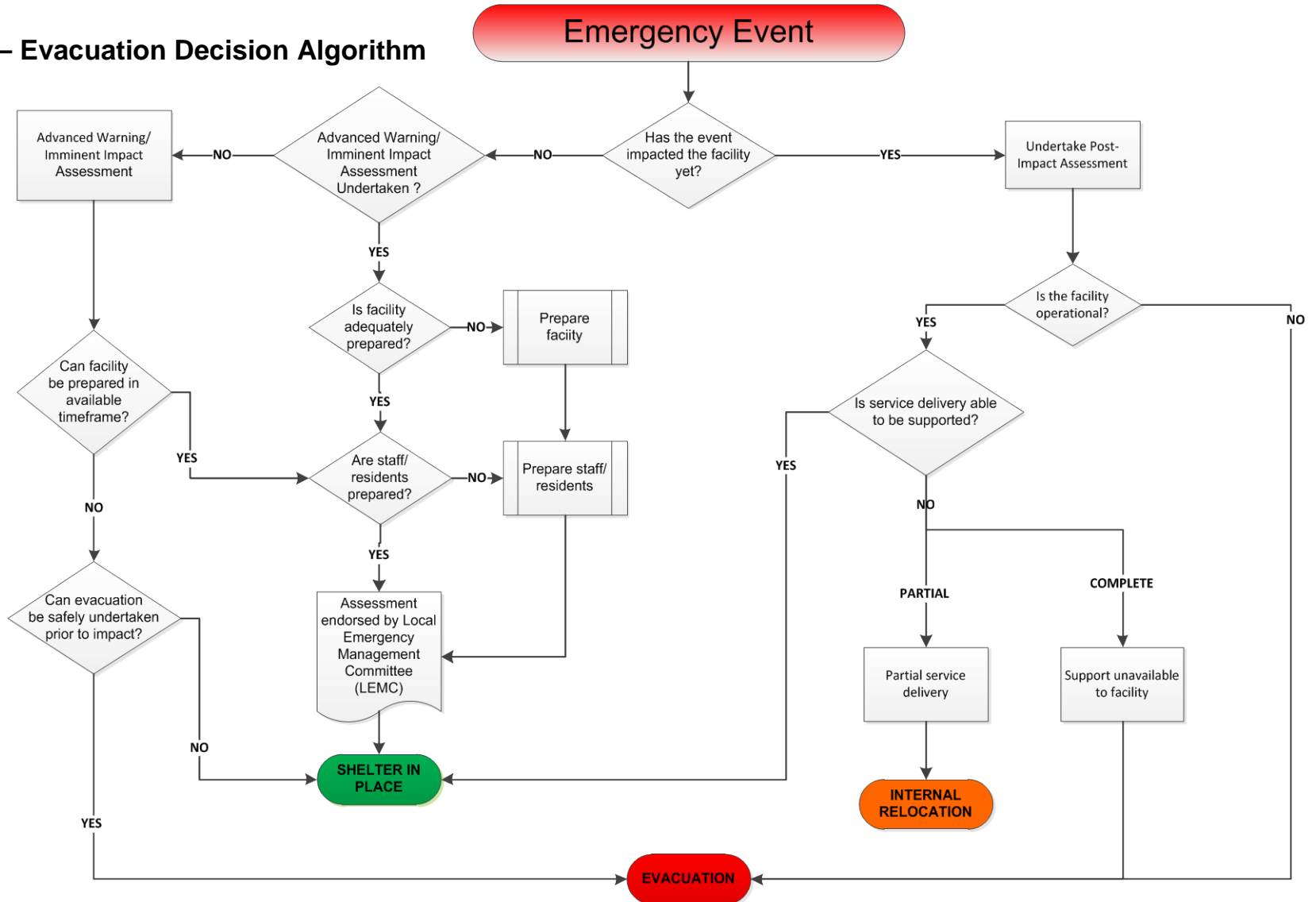
Appendix 1 - Decision Making Algorithm

Appendix 2 - Advanced Warning/Imminent Impact Assessment (example)

Appendix 3 - Post Impact Assessment (example)

Appendix 4 - Emergency Equipment - Example

9.1 Appendix 1 – Evacuation Decision Algorithm



9.2 Appendix 2 - Advanced Warning/Imminent Impact Assessment
(example)

	ACTION	TASK	COMMENTS
COMMAND	In Charge Identification	Appoint suitably qualified/trained senior staff member to be In Charge.	Name: Designation:
		Select suitable staff member/s to undertake Advanced Warning/Imminent Impact Assessment.	Name: Designation:
	Dynamic Situational Assessment	Check outside regularly and monitor BOM, RFS, Radio Station, RSS Feed (RSS) (web based information), and email for latest updates.	
		Monitor conditions and stay alert to environmental conditions.	
	Plans & Strategies	Determine the safest location within the building to shelter.	
		Activate Sheltering In Place preparations	
		Prepare alternate plans i.e. relocation and evacuation.	
		Relocate high care patients/residents to another facility	
	Warning/ Evacuation Order	Verify – Which authority (e.g. combat agency, incident controller etc.) has issued the warning/shelter in place/evacuation advice.	Authority: Rank: Contact No:
	COMMUNICATIONS	Internal	Inform all staff and agency staff of developing situation.
Inform residents/patients of situation			
Facility Executive		Inform facility executive/s of developing situation	
External stakeholders		Inform external stakeholders of developing situation: 1. DOH (Commonwealth) 2. LHD Disaster Manager/HSFAC 3. Combat Agency	
		Liaise with sister facilities to ascertain if they are able to assist with any required resources/resident accommodation.	
Next of Kin	Contact family members to give option of collecting residents/patients.		

Advanced Warning/Imminent Impact Assessment

FACILITY ASSESSMENT	ACTION	TASK	COMMENTS	
	Emergency Power		Check alternative power source (For generators- maintain regular testing and adequate fuel supply) Installed by licenced electrician	
			Arrange for generator to be supplied from third party supplier per BCP	
			Ensure battery powered torches are accessible. Replace with new batteries and have additional battery supply available	
	Water Supply		Ensure there is adequate water supply for 7 DAYS. (8-15 ltrs per person/day)	
	Gas supply		Ensure alternative bottled gas or bulk supply is available.	
	Foodstuffs		Ensure there is non-perishable supply for 7 days including soft/puree/thickened fluids	
	Communication Equipment		Check communication systems: <ul style="list-style-type: none"> • Are they accessible and available with battery supply? • Rotary dial phone as emergency back up • radio systems • paging systems • public address systems • battery operated walkie/ talkie • mobile phones • consider using runners 	
	Medical/Care Records		Ensure records are up to date and available on a battery powered laptop and also in hard copy.	
			Hard copy of medical records placed in easily transportable container.	

Advanced Warning/Imminent Impact Assessment

	ACTION	TASK	COMMENTS
FACILITY ASSESSMENT (cont.)	Medications	Ensure there is adequate medical supplies for 7 days (consider cold storage requirements)	
	Staff	Check staff availability	
		Arrange for additional staff as required i.e. agency, sister facilities	
		Compile list of staff on site	
	Residents/ Patients	Check linen supplies	
		Ensure adequate supply of continence aids are available for 7 days	
		Residents/patients have a 2 ID forms ready for attachment.	
		Compile list with number of: <ol style="list-style-type: none"> 1. Ambulant 2. Requiring Wheelchair 3. Stretcher Special needs e.g. Dementia, Violent/aggressive or resistive and medical needs, O2 dependant	
	Emergency kit/s	Ensure emergency kits are fully stocked and accessible.	
	SAFETY	Bush Fire	Check all external firefighting equipment, ensure pumps have adequate fuel supply and that hoses are in good working order
Ensure vegetation is not in direct contact with building			
Check internal fire protection systems, equipment and smoke alarms			

Advanced Warning/Imminent Impact Assessment

	ACTION	TASK	COMMENTS
SAFETY (cont.)	Imminent Threat	Close all facility outer doors and have a staff member stationed at the main entrance.	
		All visitors are to be informed of the shelter in place order due to the situation and advised to remain in the facility	
		Should they choose to leave, advise them of the risk, document their intent to leave and if possible record a witness	
		Communicate with all staff, agency staff and visitors	
		Instigate Shelter in Place	
		Move residents to designated refuge area within the facility	
		Follow specific instruction from the combat ESO to assist facility withstand impact	
		Turning off gas supplies	
		Re-circulate if possible or turn off air conditioning	
		Stay in regular touch with: DOH (Commonwealth); ESO's; Combat agency for updates. Provide any known situational or impact information and receive a situational awareness reports.	

9.3 Appendix 3 - Post Impact Assessment (example)

	Component	Type of Damage	Amount of Damage/Loss of Functionality			
			Nil	Part	Mod	Comp
STRUCTURE	Foundation	movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		subsidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Walls	cracking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		tilting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		buckling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		collapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Roof	separation with wall/s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		broken tiles/panels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		collapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Windows	cracking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		breakage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		separation with wall/s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Access/Egress	Main entrance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Alternate entrances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Emergency exits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stairways		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
elevator/s		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FUNCTIONALITY	Critical systems	emergency power	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		water supply	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		gas supply	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		air conditioning/HVAC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		oxygen supply	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		fire suppression/alarm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Communications	hard-line telephone/s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		emergency phone/s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		switchboard/PABX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		mobile phone/s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ongoing patient/ Resident care	medication supply	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		linen/bedding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		alternate internal safe area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		food supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		kitchen/food preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
staffing		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
emergency kits		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
patient/resident records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

9.4 Appendix 4 - Emergency Equipment - Example

The equipment list below has been kindly supplied by the Snowy River Hostel in Berridale NSW. The hostel has 14 beds and the inventory is designed to attempt to survive a major catastrophic event and shelter in place until help arrives. Past experience has taught them that it may be some time before help arrives. It may also be dark, cold and extreme weather so they have tried to keep the measures simple, so that 2 people could manage or 1 person if necessary.

1. Emergency Backpacks – total 3 (one for each wing) and contain:

- Torch & spare batteries
- Small polar fleece blanket & Space blanket
- Small Bottles of water & plastic cups
- Folder containing Medication Charts, Staff Contact List, Next of Kin List, Diagnosis List, Lanyard with picture of Residents & Transfer Letters
- Blank Stickers & Marker
- Adult Wipes

They are stored in the staff area under a desk along with a first aid kit and are checked monthly and are in preparedness to “grab & go”.

2. Space cases - total 4 (110cm x 54cm x 57cm) and contain:

- Large Bottles of water & plastic cups
- Large Field First Aid Kit
- Small Burner & Spare Butane Cartridges
- Saucepan
- Tins of baked Beans & Spaghetti
- Tea Bags & Long life milk & Sugar with plastic cutlery & plates
- Polar Fleece Blankets
- Contenance Aids, Toilet Paper & Adult Wipes
- Gloves, Masks, Aprons, Body and Rubbish Bags (which can double as ground sheets).
- ID Bands & Markers (particularly for injured or deceased staff & residents)

**To be added in future – small table and chairs and 2 five person quick erect tents (OzTent) with joiner along with a small storage shed built in the grounds on a concrete slab, the Space cases will be tied down with dynabolts in the concrete, so if the main building is partially collapsed, the cases are not buried under rubble, and can be accessed by releasing the tie downs from the slab.*

To ensure contents are kept in date, it is checked quarterly and new items purchased as required.