PLANNING GUIDELINE

FOR HOSPITAL EMERGENCY RESPONSE PLAN (HERP)

(For Primary-Level Hospitals)

Updated as of July 2022

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01 HERP OVERVIEW

1. Introduction

Both Hospital Emergency Response Plan (HERP) and Hospital Disaster Safety Assessment (HDSA) are interrelated. HDSA dictates HERP; HERP is based on HDSA findings and recommendations. HERP focuses on how the hospital will respond to an actual threat from early warning, activation, mobilization, command, and control through Incident Command System (ICS), coordination, communication, logistics, including recovery and business continuity. HERP is complementary to and update of the DGHS's Hospital Emergency Preparedness and Response Plan developed in October 2011 with the technical assistance of the WHO Country Office for Bangladesh.

Likewise, HDSA, the HERP tool, requires contextualization for Bangladesh as the national tool as per the recommendations of the National Policy Dialogue (NPD) facilitated by the Asian Disaster Preparedness Center (ADPC) in November 2019 in collaboration with the DGHS on Hospital Emergency Preparedness and Safety under the USAID's Strengthening Earthquake Resilience in Bangladesh Project (June 2013 – November 2019). The NPD also recommended for the enactment of a national HERP with the inclusion of a national HERP tool, and adaptation of the findings of HDSAs to develop a relevant and effective HERP.

Under the USAID's Program for Strengthening Emergency Preparedness and Resilience in Bangladesh (SERB), ADPC in collaboration with NCDC/DGHS and NIPSOM, conducted a pilot test of draft HERP tool developed in the Bangladesh context and custom per NPD recommendation. This version of the HERP tool incorporates the lessons learned and participants' feedback on the pilot test for developing the HERP at a primary level hospital.

2. HERP Purpose

HERP purpose is to promote a system to: save lives, protect health and ensure the safety of the hospital environment; alleviate damage and hardship, and reduce future vulnerability within the hospital facilities and patient care areas. Further, the document indicates the commitment to annual planning, training, and exercise activities to ensure the level of preparedness necessary to respond to emergencies or incidents within the hospital.

3. HERP Endorsement and Authorization

Likewise, the HDSA tool ADPC prepared the HERP tool through the involvement and endorsement of DGHS, and it is not an externally driven activity rather a value-addition to the DGHS effort in mass casualty management.

The authority concerned of the hospital should authorize the HERP by approving the plan for implementation and indicating that the plan is an update of and complementary to the DGHS's Hospital Emergency Preparedness and Response Plan dated October 2011.

4. HERP Structure

HERP structure presents the components, each with a list of priority actions. Hospitals experiencing an excessive demand for health services due to a critical event are strongly encouraged to implement each action effectively as soon as required. HERP comprises chapters on emergency response operation procedures, resources, contingency plans and procedures, and critical policy guidance documents. The HERP is divided into four main chapters and organized as follows:

- **CHAPTER I – Introduction.** This chapter of the plan presents a brief introduction followed by its purpose and scope, background on hazard exposure and vulnerabilities.

- **CHAPTER 2 – Hospital Emergency Management.** This chapter describes the disaster management system comprising of structures and functions of the disaster health management committee and incident management team. Specifically, the chapter contains the phases of response in mass casualty incidents and levels of alert mechanism.

- **CHAPTER 3 – Emergency Response Procedures.** This is the core chapter of HERP detailing the step-by-step response operation procedures. It covers the standing operating procedures to carry out the emergency response operation from the preparation phase in pre-disaster time to the phase of recovery in the post-disaster time.

- **CHAPTER 4 – Contingency Plans and Procedures.** This chapter contains the list of contingency plans required for both routine and emergencies for managing the internal emergencies to ensure safety and continuation of operation of the hospital.

02 HERP TOOL

1. HERP Tool Development Strategies and Processes

- Contextualize and customize the HERP tools based on lessons learned and feedback from the participating hospitals in the HDSA.
- Contextualization process involves working with national program partners from DGHS, and NIPSOM, reviewing the existing tool of WHO, and developing a national assessment tool that the DGHS can use in conducting similar hospital assessments.
- Customization follows the participatory and ownership approaches through the engagement of DGHS and its local hospital authority.
- Incorporate the WHO frameworks issued on infectious/viral diseases, (such as COVID-19 pandemic, Dengue, Zika, Aedes mosquito-transmitted viral disease).
- Follow the National Strategic Plan (2018-2025) that focuses on surveillance and response measures to reduce infection and incidence and enhance services to patients to alleviate the suffering due to chronic and pandemic diseases.
- Update the existing guidelines, and use the 2011 WHO-DGHS Hospital Emergency Preparedness and Response Plan (which is more comprehensive on preparedness than response).
- Take the bottom-up approach to ensure an effective contextualization – Gather comments/feedback of the tools' end-user hospitals, share them with the decision-makers, and obtain the ideas and endorsement of the concerned DGHS authority.
- Form a core group of NCDC/DGHS, WHO, ADPC for the whole process of establishing the national HDSA and HERP tools.
- Considering the findings of the HDSA, especially Module 1 (Hazards Affecting the Safety of Hospitals) and Module 4 (Emergency and Disaster Management Capacity of Hospitals), the tool guides the development and implementation of contingency plans for the HERP.

- For managing internal events such as fire, floods, chemical spills, and utility failures, business continuity, the hospitals should establish contingency plans such as:
  - Suggested plans are Fire Safety Contingency Plan
  - Flood Management Contingency Plan
  - Hazardous Materials Management Plan
  - Power Failure Contingency Plan
  - Logistics and Supply
  - Risk Communications
  - Alerting System
  - Dead Bodies Management
  - Business Continuity Plan

2. Applicability of HERP Tool

HERP is a unique tool to each hospital as it depends upon its bed strength, staff, and other resources. The tool applies to all three levels – Upazila, District, and National - classified as primary, secondary, and tertiary based on their capacities - bed strengths and service facilities. Since the primary level hospitals' role in MCI is mainly to provide intermediate stabilization and forward referral of severe patients to the nearest networked hospital, the emergency plan of primary level hospitals largely depends upon the concept of hospital networking (Refer to 2.14 – Network Essential Link (Primary Hospital) of the HERP Template). Since the HDSA and HERP of SERB1 Project has generated considerable interest in the private sector hospitals it is worth exploring private sector investments in this humanitarian effort as part of their Corporate Social Responsibilities (CSR).

3. HERP Tool Components

The development of HERP follows the Guideline issued by the DGHS. Besides the guidelines, the tool comprises a Template, Checklist, and Glossary.

- Guidelines describe the guiding principles and processes for the development of the plan.
- Template presents the structuring and organizing of the plan.
- Checklist ensures the readiness of the hospital and its administrators and emergency managers in responding effectively to the most likely disaster scenarios.
- Glossary assists stakeholders' understanding the meaning of unique terminologies used in the Guidelines, Templates, and Checklist.

03 HERP PLANNING GUIDELINE

HERPs are living documents containing reference tools for hospital incident management systems for responding to mass casualty incidents (MCI) in multi-hazards. In summary, the HERPs shall cover primarily emergency response aspects of the management of MCI.

- In developing the HERPs, at first the hospitals shall draw on many sources for information, including:
  - GoB Disaster Management Act 2012, Standing Orders on Disasters 2019; and National Strategic Plan 2018-2025.
  - Findings and recommendations of the Hospital Disaster Safety Assessment (HDSA).

- HERPs shall be finalized through validation exercises and meetings with the hospital management, HOPE graduates, and HDSA participants.

- HERPs shall be prepared focusing on multi-hazard casualty management, specifically natural, human-induced, technological, and societal incidents, but it shall be adaptable to respond to incidents ranging from severe but purely local to large-scale catastrophic disasters.

- Elements of the emergency plan shall be implemented as needed on a flexible, scalable basis to improve response.

- The authority concern of the hospital shall authorize the HERP by approving the plan for implementation and indicating that the plan is intended to supersede all previous versions.

- HERP requires routine update and revalidation since it is a living document (Refer to the Guidelines for Hospital Contingency Plan, Directorate General of Health Services, Ministry of Health & Family Welfare, Government of the Peoples' Republic of Bangladesh, September 2010.

- Therefore, the hospital should make continuous revisions in the HERP, taking leads from the regular disaster drills in the hospital.

HERP Planning Steps and Guidance: HERP is structured according to sections and sub-sections of functions, indicating the checklist of recommended actions for priority functions. The recommended actions will support the hospital's readiness and its administrators and emergency managers in responding effectively to the most likely disaster scenarios. The checklist is intended to complement the multi-sectoral hospital emergency response plans and, when possible, augment standard operating procedures during non-crisis situations. The tool supplements the HERP Revision and Revalidation Procedures provided in **Annex A.**

In developing a HERP, all related personnel of every hospital department must participate and go through a thorough discussion before setting the HERP for the hospital. Refer to the Guidelines for Hospital Contingency Plan, 2010. The kinds of disasters in a particular area and their probable impacts, the vulnerability of the hospital building, the number of hospital beds, and the availability of other resources like water, electricity, and gas supply during a disaster must be considered while developing the plan. The plan should be finalized after consulting with the related institutions like the fire service, civil defense, gas supply authority, water supply authority, blood donation center, police, scouts, girls' guides, etc. The four important steps to consider while developing a HERP:

Step 1. Likely Disaster and its Probable Consequences

Before working on a HERP, the foremost condition is to identify the likely hazards in the hospital catchment area and their probable consequences. The identification of hazards should be made in a very scientific way. The past statistics of disasters in the catchment area should be collected along with the figures for losses and casualties, which will be done by Hospital Disaster Safety Assessment (HDSA).

Step 2. Adequacy of the Hospital Resources

The hospital needs to analyze appropriately to cope with the aftermath of a disaster, what kind of resources the hospital would need, and what quantity. Here both human and material resources need to be considered. If the existing resources become dysfunctional or damaged, deciding on an alternative management system should be a primary concern while developing a HERP.

Step 3. To Decide and Activate an Alternative System During a Disaster

The hospital building might get fully or partially damaged in a severe calamity. The water, electricity, and gas supply may be disrupted; even the communication system might collapse. The HERP should have a guideline for contingency plans for such situations so that all sorts of connections and communication systems can be reestablished at the earliest possible time.

Step 4. Establish HERP Structure

Upon completing Steps 1 to 3, the hospital shall establish the plan's structure following the Template provided in Section D.

04 HERP TEMPLATE

See the Attached Template of HERP of a Primary Level Hospital

Name of Hospital

Hospital Emergency Response Plan

LOCATION OF HOSPTAL (UPAZILA/DISTRICT/CITY), BANGLADESH

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ACRONYMS

MESSAGE (TO BE DRAFTED BY THE HOSPITAL)

<By Directorate General of Health Services (DGHS)>

FOREWORD (TO BE DRAFTED BY THE HOSPITAL)

<By the Head of the Hospital>

"A preface or foreword deals with the origin, purpose, limitations, and scope of the plan and may include acknowledgments of gratitude for the support received"

ACKNOWLEDGEMENT (TO BE DRAFTED BY THE HOSPITAL)

PLAN AUTHORIZATION (SAMPLE)

This Hospital Emergency Response Plan (HERP) has been developed specifically for use by the (NAME OF HOSPITAL). By affixing the signature indicated below, this HERP is hereby approved for implementation and intended to supersede all previous versions.

This HERP has been established to promote a system to: save lives; protect the health and ensure the safety of the hospital environment; alleviate damage and hardship; and reduce future vulnerability within the hospital facilities and patient care areas. Further, this document indicates the commitment to annual planning, training, and exercise activities in order to ensure the level of preparedness necessary to respond to emergencies or incidents within the hospital.

_____ _____

Name
Designation
Hospital

Date

Chapter 01

INTRODUCTION

Hospital Emergency Response Plan (HERP) describes critical health care services in responding to mass casualty incidents (MCI). The plan contains a set of written procedures that guide emergency actions, facilitate recovery efforts and reduce the impact of the events occurring inside and outside the hospital requiring additional staff, resources, communication, and preparation. The guiding policies and procedures include: GoB Disaster Management Act 2012 and Standing Orders on Disasters 2019.

1.1. Purpose, Scope and Objectives of HERP

1.1.1. Purpose

To provide a blueprint for the mobilization of the resources of the hospital to respond to a local emergency that can result in a mass casualty scenario.

HERP is activated when the number of ill or injured exceeds the capacity of the Emergency Department or the normal operations of multiple departments to provide the acceptable level of care required.

1.1.2. Scope

HERP is a reference tool for the Incident Management Systems (IMS) of a hospital. The contents of the plan include:

- Information on both general and specific responsibilities for the Incident Management Team (IMT) and hospital departments, sections and units;
- Formats and reference material for assessing and reporting on populations at risk;
- Descriptions of external and internal disaster preparedness and management;
- General information related to disaster activities; and
- Information on working with the disaster committees, authorities and other stakeholders and divisions and departments in the city and around.

1.1.3. Objectives

a) To provide policy for response to both internal and external emergency situations which may affect hospital staff, patients, visitors and the community.

b) Identify responsibilities of individuals and departments in the event of an emergency situation.

c) Identify Standard Operating Procedures for emergency activities and responses.

1.2. Planning Situations and Assumptions

Several types of hazards pose a threat to the hospital:

a) Internal disaster: fire, explosions, and hazardous materials spills or releases.

b) Major external emergency: incidents involving a large number of casualties.

c) Threats affecting the hospital and the surrounding community (large or nearby fire, flooding, explosions, etc.).

1.3. Organization of HERP

The HERP is prepared to address management of mass casualty incidents, specifically earthquakes, it is adaptable to align for responding to incidents ranging from serious but purely local, to large-scale catastrophic natural disasters and other non-disaster mass casualty events. The elements of this HERP can be implemented as needed on a flexible, scalable basis to improve response. The document is divided into five main chapters and organized as follows:

- **CHAPTER I – Introduction.** This chapter of the plan presents a brief introduction followed by its purpose and scope, background on hazard vulnerability hazard, and level of earthquake intensity, and organization and maintenance of the plan.

- **CHAPTER 2 – Hospital Emergency Management.** This chapter describes the disaster management system comprising of structures and functions of the disaster health management committee and incident management team. Specifically, the chapter contains the phases of response in mass casualty incidents and levels of alert mechanisms.

- **CHAPTER 3 – Emergency Response Procedures.** This is the core chapter of HERP detailing the step-by-step response operation procedures.

- **CHAPTER 4 – Contingency Plans and Procedures.** This chapter contains the list of contingency plans that are required for hazard and situation specific for managing the emergencies to ensure safety and continuation of operation of the hospital.

Chapter 3, Emergency Response Procedures, is the core of this HERP with main focus on phases and procedures of emergency response in the context of management of mass casualties by sudden onset disasters. This Chapter covers the standing operating procedures to carry out the emergency response operation from the phase of preparation in pre-disaster time to the phase of recovery in the post-disaster time.

ANNEXURES – The document contains five annexures:

Annex A – HERP Validation Procedures;

Annex B - DGHS Circular Dated September 2013 Regarding Formation of Disaster Health Management Committee;

Annex C – Hospital Human Resource Capacity;

Annex D – Glossary of key HERP terms and terminologies; and

Annex E – Hospital (Upazila Health Complex) Staffing.

HERP is structured according to sections and sub-sections of functions, indicating the checklist of recommended actions for priority functions. The recommended actions will support the hospital's readiness and its administrators and emergency managers in responding effectively to the most likely disaster scenarios. The checklist is intended to complement the multi-sectoral hospital emergency response plans and, when possible, augment standard operating procedures during non-crisis situations. The tool supplements the HERP Revision and Revalidation Procedures provided in **Annex A** to this plan.

1.4. Plan Maintenance

The Disaster Health Management Committee (DHMC) of a hospital, described in **Chapter 2**, is responsible for review and approval of the HERP. Given that incidents change in size, scope and complexity, the HERP requires periodic updates to adapt these changes especially after a major plan activation. The checklist of recommended actions for this priority function are as below.

CHECKLIST - HERP REVISION AND REVALIDATION

HERPs are developed based on unique circumstances of plans and procedures about preparedness, response, and recovery to meet mass casualty management requirements. It is important to remember that the plan is never ultimately final. In other words, once written, the plan needs to be tested on the ground, and accordingly, the shortfalls and/or gaps need to be reduced by altering and updating the same and finally ready for implementation in actual plan activation during a response. As a cyclical process, validation, revision/update, and revalidation are continuous in the life of a plan. Therefore, the hospital should make regular revisions in the HERP, taking leads from the regular disaster drills in the hospital and conducting After Action Reviews (AAR) to learn from actual response operations. Refer to **Annex A**, which describes the process, options, and guidance for validation of the HERP so that the plan can represent the reality on the ground better.

Indicators/Recommended Actions (RA)	Action Due	In Progress	Completed
Indicator: Hospital policy established for a corresponding budget and assigned focal point for HERP review and updating			
Indicator: A fully functional HERP is subject to routine updates and revalidation.			
RA: Hospital has established validation exercise (simulations, discussions) guidelines.	○	○	○
RA: Hospital has developed validation exercise (simulations, discussions) scheduled to test the HERP at least once in a year.	○	○	○
RA: Hospital has trained staff for conducting the revalidation test/exercise	○	○	○
RA: Hospital has arrangements for external assistance to conduct revalidation exercise.	○	○	○

The DHMC will constitute a plan review process after 12 months of the plan not used or activated whether in part or a whole. Certain changes in information, arrangements, and procedures in the IMT and DHMC, logistics, resources and contingency plans and procedures shall be current. Any major revision of the HERP will require the IMS Operation Review Sub-Committee to be formed of five members of the DHMC as suggested below.

IMS Operation Review Sub-Committee

(This is suggestion only; The hospital needs to identify and approve the Sub-Committee)

Role	Position
Chairperson:	Resident Medical Officer
Secretary:	Nursing Supervisor
Members:	Section Head, Emergency
	Department/Section Head, Surgery
	Department/Section Head, Administration
	Department/Section Head, Logistics and Administration

Table 1: HERP History (Template)

DATE	ACTION	COMMENTS
	Plan Approved	Draft Plan Approved by

Chapter 02

HOSPITAL EMERGENCY MANAGEMENT

This chapter pertains to the preparedness and readiness of (Name of Hospital) and describes the emergency management system of Mass Casualty Incidents to include the structures and functions of the Hospital Disaster Health Management Committee (DHMC), Hospital Incident Command System (HICS), and Incident Management Team (IMT) with specific focus on mass casualty management.

2.1. General Organization and Responsibility

1) The Upazila Health and Family Planning Officer (UHFPO) receives regular reports of the activities of the Emergency Management Program from the DHMC Chairperson and the Hospital Emergency Planning Committee. The UHFPO reviews the reports and, as appropriate, communicates with the Hospital Emergency Planning Section Chief and other concerns about identified issues and regulatory compliance. The UHFPO also supports facilitating the ongoing activities of the Emergency Management Program.
2) The Hospital Resident Medical Officer (RMO), who serves as the Chairperson of the Hospital Emergency Planning Committee (HEPC), works under the general direction of the UHFPO. Other members of the HEPC include: Junior Consultants, SACMOs and Nursing Supervisor. The HEPC Chairperson is responsible for managing all aspects of the Emergency Management Program. The Chairperson advises the Committee regarding emergency management issues that may necessitate changes in policies and procedures, orientation or education, or equipment purchase. The HEPC Chairperson recommends HPC purchasing supplies and equipment necessary to improve the emergency response capability.
3) The RMO, Junior Consultants, and Nursing Supervisor are responsible for orienting new personnel to the department's procedures and, as appropriate, to the job and task-specific responsibilities for emergency management. Where necessary, the HEPC Chairperson and members assist these personnel.
4) Any hospital employee or staff without specific duties during a Disaster shall report to their immediate supervisor, who shall assign them as needed. In turn, supervisors will be directed by the Incident Commander (IC) or his/her designee.

5) Individual personnel is responsible for learning and following job and tasks specific procedures for emergency response and participation in emergency activities as appropriate to their jobs.

   a. Familiarize themselves with evacuation procedures and routes for their areas.

   b. Become familiar with basic emergency response procedures for fire, HazMat, and other emergencies

   c. Understand their responsibilities stated in (Insert the Name of the Upazila) Emergency Response Plan (HERP).

   d. Participate in organizational training and exercises intended to practice emergency response activities and improve readiness.

   e. Prepare family and home for consequences of incidents.

Note: Insert a diagram that illustrates the linkages/relationship of UZDMC, DHMC, UHPC and other sub committees.

2.2. Disaster Health Management Committee (DHMC)

(Insert the Name of the Hospital) Disaster Health Management Committee comprises 24-member multidisciplinary members responsible for implementing the health service activities before, during, and after disasters and the HERP for responding to MCI. The DHMC is established by order of the Directorate General of Health Service (DGHS) of the Ministry of Health and Family Welfare dated September 2013 **(Annex B)**. Table-2 provides the membership of the DHMC.

Table 2: Hospital Disaster Health Management Committee

Serial No.	Name of Post and Position	Position in DHMC	Contact Telephone Number/E-Mail Address
1	UHFPO	Chairperson	
2	Medical Officer	Member	
3	Junior Consultant -I	Member	
4	Junior Consultant - II	Member	
5	Store Keeper	Member	
6	Senior Staff Nurse – I	Member	
7	Senior Staff Nurse - II	Member	
8	Medical Technologist (Lab)	Member	
9	Medical Technologist (EPI)	Member	
10	Sub Assistant Community Medical Officer - I	Member	
11	Sub Assistant Community Medical Officer - II	Member	
12	Sub Assistant Community Medical Officer - III	Member	
13	TB Leprosy Control Assistant	Member	
14	Civil Surgeon, (Name of District)	Member	
15	Representative of Chittagong Hill Districts	Member	
16	Representative of Name of Upazila Parishad	Member	
17	Representative of Police Administration, (Name of Upazila)	Member	
18	Representative of Fire Service, (Insert Name of Upazila)	Member	
19	Representative of Gas Supply and Distribution, (Name of Upazila)	Member	
20	Representative of Electric Supply Department, (Name of Upazila)	Member	

Table 2: Hospital Disaster Health Management Committee

Serial No.	Name of Post and Position	Position in DHMC	Contact Telephone Number/E-Mail Address
21	Representative of Water Supply Department, (Name of Upazila)	Member	
22	Representative of Public Health Engineering Department, (Name of Upazila)	Member	
23	Project Implementation Officer, (Name of Upazila)	Member	
24	Resident Medical Officer, Name of Hospital	Member Secretary	

The 24-member DHMC of Insert the Name of Hospital is represented by 14 administration and academician from the hospital and 10 officials from CHD, District/Upazila administration. The committee is headed by the UHFPO of Insert the Name of Hospital. DHMC will:

1) Meet annually to establish an annual set of objectives, priorities, and work plans to achieve the objectives and priorities. The minutes from each meeting should be published and widely disseminated to appraise all hospital staff of committee activities and any changes to the HERP.
2) Appoint sub-committees as necessary to accomplish specific projects identified by the HEPC to plan training and exercises. Members of subcommittees may include members of the DHMC or other individuals from the hospital or external agencies or subject matter experts relative to the specific project.
3) Coordinate all disaster planning activities within the hospital and the Upazila Disaster Management Committee (UZDMC) concerning mass casualty management in and around (Insert the Name of the Upazila.
4) Conduct an annual Hazard Vulnerability Assessment (HVA) in coordination with external agencies and partners
5) Develop processes, policies, and procedures related to reducing disaster risks of hospital and preparedness to respond and recover from emergencies and disasters that disrupt the regular operation of the hospital
6) Develop capacity building and conduct training program identifying education and training needs for the staff on all-hazards response as well as hazard-specific roles and responsibilities during the HERP activation
7) Ensure that appropriate resources are allocated for risk reduction and preparedness activities as part of the annual work program and budgeting.
8) Implement health service activities approved by the Health Directorate for emergency assistance of victims of disasters during and after the incidents
9) Secure necessary resources to ensure prompt, coordinated, and effective response by the hospital to all disasters affecting the environment of care.

10) Plan annual exercises, including one in conjunction with local agencies (UPAZILA/ Municipality), conducted according to standard, code, or regulation.

11) Conduct After Action Review intended to examine actual response while identifying opportunities for improvement to update HERP.

12) Develop mutual aid agreements and network with external agencies, including other hospitals.

CHECKLIST – DISASTER HEALTH MANAGEMENT COMMITTEE (DHMC)

Indicators/Recommended Actions (RA)	Action Due	In Progress	Completed
Indicator: DHMC is up-to-date and fully functional. **RA:** DHMC meets annually to establish an annual set of objectives, priorities, and work plans to achieve the objectives and priorities and work plan to achieve the committee objectives. Refer to §2.2 above for DHMC responsibilities.	○	○	○
Indicator: DHMC members are oriented in MCI emergency response. **RA:** Hospital shall ensure that all DHMC members have adequately orientation on their roles and responsibilities.	○	○	○

2.3. Hospital Incident Management System (HIMS)

HIMS is a robust framework for all hospital emergency responses and provides a vital link to outside agencies. The Hospital Incident Management Team (HIMT), a multidisciplinary body of the HIMS, provides the overall operational leadership and oversight for all aspects of crisis management, coordinates the overall response, and approves all action, response, and mitigation plans. It is an authority on all activities and decisions during emergency response operations.

The Hospital Incident Command System (HICS) is an all hazard management system of command and control, which includes a combination of facilities, equipment, personnel, procedures, and means of communication, operating within a hospital's organizational structure designed to aid in the management of resources for emergency incidents. HICS allows for the efficient transfer of command by recognizing that personnel initially assuming a command position may be relieved by someone with more experience as additional personnel arrive and share the incident command workload, or at shift change. Refer to HERP 2.4.2: Efficient Transfer of Command.

CHECKLIST – HICS

Indicators/Recommended Actions (RA)	Action Due	In Progress	Completed
Indicator: A well-functioning HICS is essential for effective hospital emergency management operations. **RA:** Activate the Hospital Incident Management Team (IMT) for directing hospital-based emergency management operations.	○	○	○

2.4. Hospital Incident Command System (HICS)

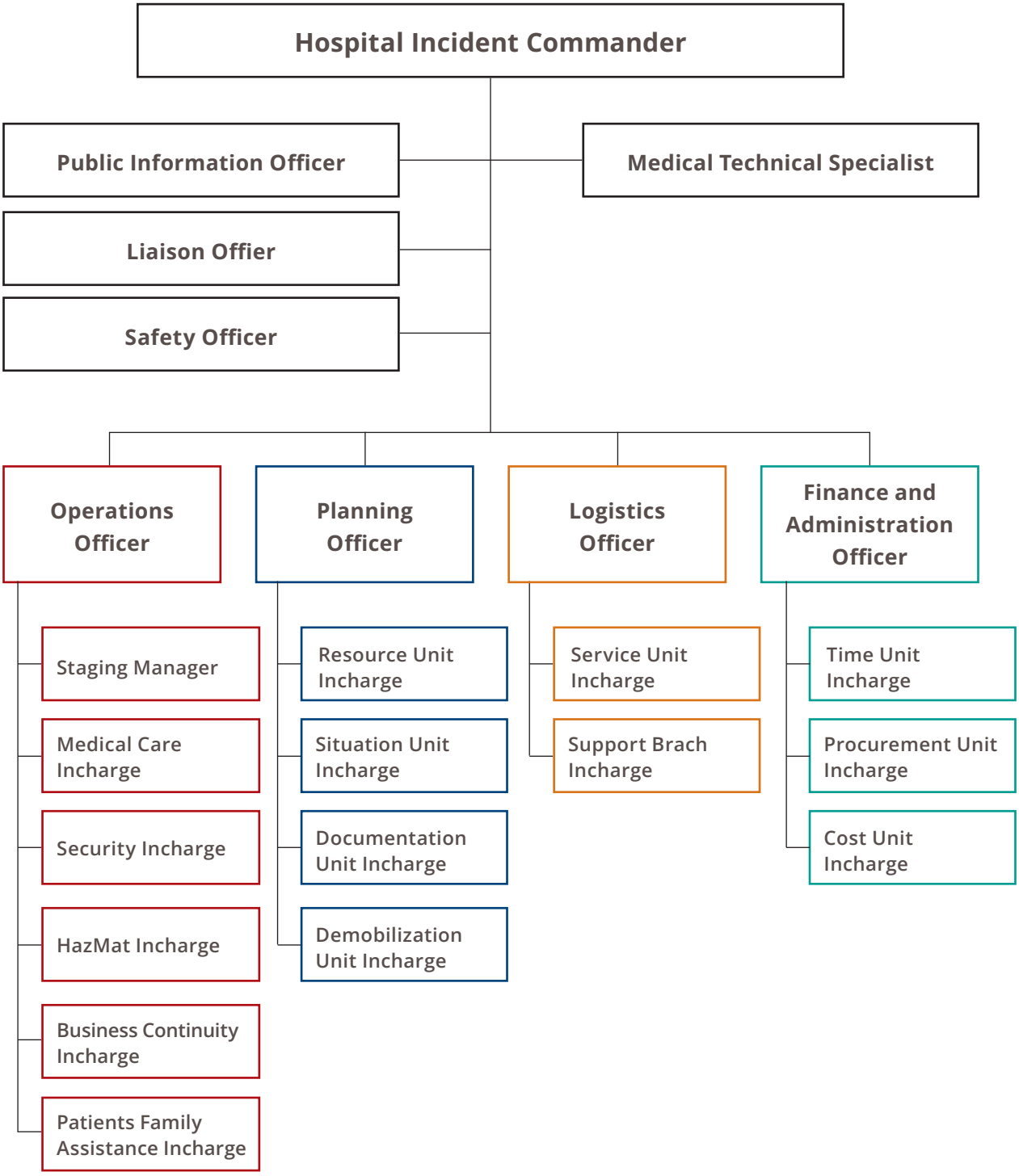
HICS is an incident management system based on the incident command system (ICS) principles, which assist hospitals and healthcare organizations in improving their emergency management planning, response, and recovery capabilities for unplanned and planned events. It is a designated system of command and control, which includes a combination of facilities, equipment, personnel, procedures, and means of communication, operating within a hospital's organizational structure designed to aid in managing resources for emergency incidents. HICS allows for the efficient transfer of command by recognizing that personnel initially assuming a command position may be relieved by someone with more experience as additional personnel arrive and share the incident command workload or at shift change.

CHECKLIST – HICS

Indicators/Recommended Actions (RA)	Action Due	In Progress	Completed
Indicator: A well-functioning HICS is essential for effective hospital emergency management operations. **RA:** Activate the Hospital Incident Management Team (IMT) for directing hospital-based emergency management operations.	○	○	○

2.4.1. Hospital Incident Management Team (HIMT) Members

Chart 1 provides the Hospital Incident Management Team structure. The persons to be designated for each position are indicated in **Table 3.** The chart is illustrative, and the positions are subject to availability at the UHC. The designated individuals are to be agreed upon and finalized by the hospital.



CHECKLIST (INDICATORS) – IMT

Indicators/Recommended Actions (RA)	Action Due	In Progress	Completed
Indicator: Hospital's incident management team is fully functional. **RA:** Incident Commander ensures each appointed Command/General Staff member is properly briefed on response issues and objectives. For further details refer to the Incident Action Plan (IAP).	○	○	○
Indicator: IMT members are trained in MCI emergency response plan. **RA:** Hospital shall ensure that all IMT members have adequately trained on the structure and function of the IMT including Hospital ICS.	○	○	○

2.4.2 Efficient Transfer of Command

Hospital Incident Command System (HICS) allows for the efficient transfer of command by recognizing that personnel initially assuming a command position may be relieved by someone with more experience as additional personnel arrive and share the incident command workload or shift change.

1) The transfer of command begins with a transition meeting in which the outgoing commander briefs the replacement on the current situation, response actions, available resources, and the role of external agencies in support of the hospital.
2) Health, medical, and safety concerns are addressed, and, if relevant, political sensitivities and business continuity capabilities may also be discussed.
3) After the transfer of command is completed, proper documentation is prepared and, where appropriate, broadly communicated to staff.
4) Hospital Incident Commander (IC) ensures each appointed Command/General Staff member is adequately briefed on response issues and objectives. This IC responsibility should be documented in the Incident Action Plan (IAP).

Table 3: Suggested Hospital Position of the IMT Member

(Hospital shall identify the hospital staff for the IMT positions)

IMT Position	Hospital Position	Remarks
Incident Commander	UHFPO	Primary
	Medical Officer	Alternate
	RMO	Weekends, Holidays and Off hours
Public Information Officer		Primary
		Alternate
Safety Officer		Primary
		Alternate
Liaison Officer		Primary
		Alternate
Medical Technical Specialist		Primary
		Alternate
Operations Officer		Primary
		Deputy Chief / Alternate
		Weekends, Holidays and Off hours
Planning Officer		Primary
		Deputy Chief / Alternate
		Weekends, Holidays and Off hours
Logistics Officer		Primary
		Deputy Chief / Alternate
		Weekends, Holidays and Off hours
Finance and Admin Officer		Primary
		Deputy Chief / Alternate

2.5. Functional Roles of Incident Management Team (IMT)

2.5.1. Command

2.5.1.1. Hospital Incident Commander (IC)

1) Designated IC is responsible for conducting the initial assessment of the situation and decides on the level of activation of the HERP.
2) IC is always activated (24 hours a day, even during weekends, holidays, and off-hours) when there is any declaration of hospital emergency.
3) IC is responsible for the management of the incident within the hospital.
4) IC directs all activities within the Hospital Emergency Operations Center (EOC), sets the operational periods, and devises strategies and priorities to address those objectives communicated in the Incident Action Plan (IAP), prepared by the Planning Section Head for each operational period.
5) The IC may delegate some of his/her functions to the following Command Staff when the incident is escalated. If not delegated, IC will have to assume all command roles.
6) The IC assumes the role of Public Information Officer (PIO), Safety and Liaison if there are no designated persons during response.

2.5.1.2. Public Information Officer (PIO)

1) Responsible for coordinating information sharing inside and outside the hospital.
2) Point of contact for information to internal personnel and external stakeholders, including the media or other organizations/agencies.

2.5.1.3. Liaison Officer

1) Primary contact for external agencies assigned to support the hospital during incident response.
2) May be assigned to the EOC.

2.5.1.4. Safety Officer

1) Monitors hospital response operations to identify and correct unsafe practices.
2) Implements measures for assuring the safety of all assigned personnel

2.5.1.5. Medical Technical Specialist

1) Persons with specialized expertise in infectious disease, legal affairs, risk management, and medical ethics may be asked to provide the IMT staff with needed insight and recommendations.
2) S/he may be assigned anywhere in the HICS structure as needed.

2.5.1.6. General Staff

Depending on the event, the IC may activate other General Staff positions (e.g., Operations, Planning, Logistics, and Finance/Administration Sections In-charge/Heads). Qualified personnel assigned to lead these functions shall receive a briefing, their names are recorded on the IMT chart **(see Chart 1 at Section 2.4.1. Hospital Incident Management Team)**, and their appointment is announced as outlined in the HERP.

2.5.1.7. Operations Officer

1) Develops and implements strategies and tactics to carry out the objectives established by the IC.
2) Organizes, assigns and supervises Staging, Medical Care, Infrastructure, Security, Hazardous Materials, and Business Continuity Branch resources.
3) Operations Section comprises a Staging In-Charge, Medical Care In-charge, Infrastructure In-charge, Security In-Charge, HazMat In-Charge, Business Continuity In-Charge, and Patients Family Assistance In-charge. The responsibilities of these positions are as below.

   Staging Manager: Organizes and manages the deployment of supplementary resources, including personnel, vehicles, equipment, supplies, and medications.

   Medical Care In-Charge: Organizes and manages the delivery of emergency, inpatient, outpatient, casualty care, and clinical support services.

Infrastructure In-Charge: Organizes and manages the services required to sustain and repair the hospital's infrastructure operations, including: power/lighting, water/sewer, HVAC, buildings and grounds, medical gases, medical devices, structural integrity, environmental services, and food services.

Security In-Charge:

- Coordinates all personnel and facility security activities such as access control, crowd and traffic control, and law enforcement interface.
- Ensures the security of facilities and personnel by monitoring individuals entering and exiting the building.
- Maintains scene safety and ensures crowd control. Organizes and enforces vehicular traffic security for the facility.
- Coordinates the search and rescue of missing staff, patients, and family members.

HazMat In-Charge:

- Organizes and directs hazardous material incident response activities: detection and monitoring; spill response; victim, technical, and emergency decontamination; and facility and equipment decontamination.
- Coordinates detection and monitoring of activities related to hazardous material incident response.
- Coordinates on-site activities related to implementation of hospital's internal hazardous material spill response plan.
- Coordinates the on-site patient decontamination activities related to hazardous material incident response.
- Coordinates on-site facility and equipment decontamination activities related to hazardous material incident response.

Business Continuity In-Charge: Ensures business functions are maintained, restored, or augmented to meet designated Recovery Time Objectives (RTO) and limited interruptions to continuity of essential business operations.

Patients Family Assistance In-Charge: a. Manages, directs and briefs patient's family members, relatives and visitors. b. Coordinates with the Security Branch Director concerning the access control, crowd and traffic control, and law enforcement interface.

2.5.1.8. Planning Officer

1) Oversees all incident-related data gathering and analysis regarding incident operations and assigned resources, develops alternatives for tactical operations, conduct planning meetings, and prepares the Incident Action Plan (IAP) for each operational period.

2) Planning section comprises a Resource Unit, Situation Unit, Decontamination Unit and Demobilization Unit. Responsibilities of these units are as below.

Resource Unit Incharge:

a) Maintains information on the status, location, and availability of personnel, teams, facilities, supplies, and major equipment to ensure availability of use during the incident.

b) Maintains a master list of all resources assigned to incident operations.

Situation Unit Incharge:

a) Collects, processes, and organizes ongoing situation information; prepare situation summaries; and develops projections and forecasts of future events related to the incident.

b) Prepares maps and gather and disseminates information and intelligence for use in the Incident Action Plan (IAP).

Decontamination Unit Incharge: Maintains information on the status, location, and availability of personnel, teams, facilities, supplies, and major equipment required for decontamination.

Demobilization Unit In-charge: Maintains information on the status, location, and availability of personnel, teams, facilities, supplies, and major equipment required for demobilization. *(Refer to Sections 2.8 and 2.9 for further details.)*

2.5.1.9. Logistics Officer

1) Organizes and directs those operations associated with maintenance of the physical environment and with the provision of human resources, materials, and services to support the incident activities.
2) Participates in Incident Action Planning (IAP).
3) Logistics section comprises a Service Unit, and a Support Unit. Their responsibilities are as below.

Service Unit In-Charge:

a) Organizes and manages the services required to maintain the hospital's communication system, food and water supply for staff, and information technology and systems.
b) Organizes and coordinates internal and external communications connectivity.
c) Provides computer hardware, software and infrastructure support to staff.
d) Organizes food and water stores and prepares for rationing during periods of anticipated or actual shortage.

Support Branch In-Charge:

a) Organizes and manages the services required to maintain the hospital's supplies, facilities, transportation, and labor pool.
b) Ensures the provision of logistical, psychological, and medical support of hospital staff and their dependents.
c) Ensures the availability of medical care for injured or ill staff.
d) Ensures the availability of behavioral and psychological support services to meet staff needs during and following an incident.
e) Coordinates mass prophylaxis, vaccination, and immunization of staff, if required.
f) Coordinates medical surveillance program for employees.
g) Ensures the availability of medical, logistic and mental health and day care for the families of staff members.

h) Coordinate mass prophylaxis / vaccination / immunization of family members if required.

i) Acquires, inventory, maintains, and provides medical and non-medical care equipment, supplies, and pharmaceuticals.

j) Organize, manage and support building systems, equipment and supplies. Ensure proper cleaning and disinfection of hospital environment.

k) Organizes and coordinates the transportation of all ambulatory and non-ambulatory patients.

l) Arranges for the transportation of human and material resources within or outside the facility.

2.5.1.10. Finance and Administration Officer

1) Monitors the utilization of financial assets and the accounting for financial expenditures.

2) Supervises the documentation of expenditures and cost reimbursement activities.

3) The Finance and Administration Section comprises a Time Unit, a Procurement Unit, and a Cost Unit. Responsibilities of these positions are as below.

Time Unit In-Charge: Responsible for the documentation of personnel time records. Monitor and report on regular and overtime hours worked/volunteered.

Procurement Unit In-Charge: Responsible for administering accounts receivable and payable to contract and non-contract vendors.

Cost Unit In-Charge: Responsible for providing cost analysis data for the declared emergency incident and maintenance of accurate records of incident cost.

2.6. Key Actions in Different Emergency Phases

The HERP of (Insert the Name of Hospital) will be implemented in four phases of activation: Alert; Stand by; Mobilization; and Stand down. The levels will be determined by the (Insert the Name of Hospital) IMT depending on the information received on the eminence of danger. Depicted in **Table 4** are the levels of notifications and types of actions to be taken by the IMT based on prognosis of the situation.

Table 4: Phases of Activation & Actions by IMT

Prognosis of Situation	Phases of Activation	Actions by IMT
Potential Disaster Impact	Alert	No change in IMT but be prepared to expand; Upon receipt of warning or information that an emergency may occur or affect the hospital and relevant area of responsibility, the hospital must be alerted to ensure its readiness to act if called upon. Some of the activities that should be considered in this phase are: • Warnings for key personnel. • Monitoring of Warning Information. • Testing of communications arrangements. • Establishing flow of information between Upazila administration and Control/Support Agencies.
Possible Disaster Impact	Standby	As the threat, or the effect of the emergency, becomes imminent, members of the hospital are placed on standby, thus being ready to move immediately they are required. Some of the activities that should be considered in this phase are: • Staffing of respective emergency centres. • Preparing equipment and personnel for immediate action. • Identifying assembly areas.
Actual Disaster Impact	Mobilization	This is the operational phase of the emergency when the hospitals, combating and support agencies are committed to contain or control the emergency. Some of the activities that should be considered in this phase are: • Mobilisation of personnel/equipment as requested. • Production of records on a regular basis for higher authorities. • Deployment of additional resources as required. • Registration of volunteer workers.
Post Disaster Recovery	Stand Down	Once "Alert", "Standby" and/or "Mobilization" have been implemented and objectives met, the IC must declare a "Stand Down". When the Disaster Health Management Committee (DHMC) of the hospital is satisfied that the response to the emergency has been completed, then committee will advise all participating departments and agencies of 'Stand Down'.

2.7. Alert Phase of Plan Activation

- IC notifies DHMC, hospital staff and admitted indoor and outdoor patients, visitors about potential hazard impact.
- Follow the level of alert notification **(Refer to Section 2.6 of this Chapter)** – Levels of Alert Mechanism.
- In case of cyclone, floods and sudden-onset hazards alert based on the forecast by the meteorological departments.
- In case of earthquake alert (alarm, cell phones, siren, loud speaker, microphone, megaphone) after the 1st shake.
- Designated IC of (Insert the Name of the Hospital) partially activates the HERP by proceeding to the designated EOC located at <insert location in the hospital>.
- Designated members of the IMT General Staff report to the EOC at <insert location> to receive assignment and briefing from the IC. IMT reviews its plan, procedures and resources to get ready for response.

2.8. Standby Phase of Plan Activation

- The designated Planning Officer assigns a person from his team to record and maintain event logs (chronology of events). This will be documented in <insert whether manually using log book or electronically using computer>. The events log will be used as one of the reference in conducting the After Action Review (AAR).
- Planning Officer or his/her designee gathers and updates information and report to IC. As a minimum, the following information are needed and updated regularly:
  - » Number of available beds and how many can be added as surge capacity
  - » Available human resources (doctors and nurses)
  - » Number and type of vehicles available for deployment
  - » Damage assessment of hospital facilities and areas which are not operational
  - » Record incident-related problems and actions taken in the incident log system
- Medical Officer (IPD/OPD) prepares casualty receiving area for triage and treatment freeing up beds to accommodate incoming patients. If needed, uses available spaces to expand capacity including conduct of briefing and assigning task to the staff of the department.
- All head of units/sections of the hospital review with their staff of "Action Cards / Job Action Sheets", and verify that action cards describe the assigned duties of each hospital staff member in case of an internal or external disaster.

2.9. Mobilization Phase of Plan Activation

- Expansion of IMT depending on the extent of the emergency response operations.
- Hospital (IMT) requests assistance from external agencies (e.g. Health Authority, Fire Department, Police, Bangladesh Red Crescent, etc. at the Upazila and district) for additional resources to support hospital response.
- Emergency Unit conducts patient triage referring to **Section 3.3 of Chapter 3:** Triage Plan and Procedure to determine treatment priority of patients.
- Planning Unit under the HEPC conducts patient tracking documenting information regularly on the following:
  - » Number of patients received in the Emergency Department with its corresponding triage status (Red, Yellow, Green, Black).
  - » Patients in surgery department (Number of patients on que for surgery, ongoing surgical operation and estimated time of completion, Number of patients in recovery).
  - » Number of patients admitted in wards.
  - » Number of patients transferred to other hospitals and where.
- Full activation of the IMS including the EOC.
- In case of sudden–onset hazards (cyclone, floods, landslides, earthquake), all heads/ chiefs of departments make a quick damage assessment of their work area and report to IC through <insert means of communication> on its damage status and operability if staff and patients are safe to continue working to provide services.
- Protect patients, relatives and hospital staff to create an environment of safety and security during emergencies.
- Implement surge capacity strategies to cope with increasing demand of emergency healthcare from the emergency. Refer to Section 2.21 - Hospital Surge Capacity/ Capability for more details.
- Coordinate with external agencies to support hospital response including other hospitals for secondary transport and evacuation.
- The Support Branch under the Logistics Section is responsible in providing support to hospital staff and dependents especially during if it requires a long-term response. (e.g., food, water, facilities for accommodation, transport going to hospital, etc.)
- IC together with the PIO make appropriate briefing to visiting VIP's and officials. This include providing appropriate and regular information to the public, hospital staff and media as needed about the hospital response.
- Planning Unit under HEPC responsible for documenting all activities performed by the hospital during the response planning. The Unit continues recording of event logs (chronology of events) and incident-related problems.

2.10. Demobilization Phase of Plan Activation:

- IC issues stand down order to scale down response activities and return of non-essential staff to their original work station.
- All department/unit in-charge/heads conduct inventory of all the equipment and supplies used during the response phase for re stocking supplies and maintenance of equipment.
- All department/unit in-charge/heads are responsible to conduct debriefing sessions with all staff involved in the response to gather what went well and needs improvement for future response in preparation for the hospital wide after action review.
- IC/PIO conducts a critical incident stress debriefing for high risk staff to address psychosocial needs of personnel after the response
- IC/Planning Unit Head develops a recovery and rehabilitation action plan especially of the damaged and affected hospital facilities.

Refer to Chart 1: Hospital Incident Management Team (IMT) Structure and Section 2.5: IMT Functional Roles.

2.11. Emergency Staff List

Insert the Name of Hospital will compile and maintain an internal contact list including key external support agencies that will include the information for department heads, focal persons and assistants: name, position title, home phone or cell phone, and preferred method of contact during off hours. Table 5: provides a **template** of list of human resource recall telephone list. Each section, department and unit heads will review, maintain and update their staff recall telephone list periodically.

Each section, department and unit will maintain a complete departmental roster (Staff Call List) with the following information: name, job title, home or cell phone, and preferred method of contact during off hours. The Staff Call List contains sensitive contact information and will be treated confidentially. The list of staff phone numbers will be kept offsite as well as onsite by key employees and at key locations.

Table 5: Insert the Name of Hospital Staff Recall Telephone Focal Persons)

Department / Section / Unit	Focal Person	Contact Information	Role
Emergency			
Surgery			
Operating Theatre			
Medicine			
OBGYN			
Paediatric			
Nursing			
Administration			
Finance			

CHECKLIST – EMERGENCY STAFF LIST & ROSTER

Indicators/Recommended Actions (RA)	Action Due	In Progress	Completed
Indicator: Hospital's emergency staff list and departmental roster are up-to-date. **RA:** Hospital should compile and maintain an internal contact list and departmental roster including the preferred method of contact during off hours.	○	○	○

2.12. Coordination of Emergency Management Activities

The GoB Standing Orders on Disaster 2019 (SOD) calls for establishing the Upazila Disaster Management Committee (UzDMC), given that local coordination is a crucial component of disaster management. The UzDMCs are to carry out all activities (prevention, mitigation, preparedness, response, and relief) of disaster management. One of the responsibilities of the UzDMC is to prepare and implement the Upazila Disaster Risk Management Plan to reduce the loss of lives and assets substantially. According to the SOD 2019, the other committees and groups pertinent to disaster management and response at the Upazila/ Municipal level include the Municipal Disaster Management Committee, Upazila Disaster Response Coordination Group, and Municipal Disaster Response Coordination Group. The UHFPO and his/her designees are members of these committees and groups. In addition to these disaster management committees, there is another vital entity of the DGHS at the district level (Civil Surgeon), responsible for creating awareness on earthquake management among all field staff (Upazila Health Administrators) as one of their disaster risk reduction activities. The same office is also responsible for preparing and updating the earthquake contingency plan. Furthermore, a wide network of national and international NGOs, private organizations, hospitals involved in disaster preparedness and response activities. Insert the Name of Hospital IMS will take advantage of these committees and resources during normal and emergency times. These will help sound implementation of mass casualty management. Table 6 provides a **template** of list of essential contacts that the hospital will maintain and update periodically every three to six months.

Table 6: List of Essential Contacts (Template)

Name of Organizations[1]	Contact Person & Alternate	Contact Numbers[2]	Role
1.Civil Surgeon, Insert the Name of District			
2. Fire Service Stations, Insert the Name of Upazila			
3. Police Control Room			
4. Army			
5. UzDMC			
6. FSCD			
7. T&T			
8. BDRCS			
9. Electric Supplies			
10 Upazila Health Complex, Insert the Name of Upazila			
11. Upazila Authority (UNO, Upazila Engineer, PIO)			
12. Private Clinic at Insert the Name of Upazila			

CHECKLIST – COORDINATION OF EMERGENCY MANAGEMENT ACTIVITIES

Indicators/Recommended Actions (RA)	Action Due	In Progress	Completed
Indicator: Coordination among network of national and international NGOs, private organizations, for informed decision-making in emergency response management. **RA:** Hospital shall maintain regular and effective collaboration and cooperation among the network members, and public awareness and trust necessary to ensure informed decision-making in emergency response management.	○	○	○

[1] Name of Organizations are illustrative. The hospital will include relevant partners/organizations and their concerned representatives.

[2] Update of contact numbers of external agencies every three to six months.

2.13. Network Essential Link (Primary Hospitals)

HERPs for smaller hospitals such as community health centers may only focus on providing either mobile emergency care on the incident site or intermediate stabilization and forward referral of severe patients to the nearest networked hospital. In most mass casualty incidents, most of the victims are not seriously injured and come in the walking wounded category. Such small centers can provide immense help during disasters/MCI by providing definitive care to such victims who are not seriously injured. The HERPs of such small hospitals would largely depend upon the concept of hospital networking.

Network essential means a dynamic link between various health care facilities of a given geographical area for augmentation or optimization of available resources. It means that the district authorities must have information about the available health resources in their area. Different state medical directorates and district medical authorities have to sit together with various health care providers in their areas and work out how to network these facilities.

CHECKLIST – NETWORK (PRIMARY HOSPITALS)

Indicators/Recommended Actions (RA)	Action Due	In Progress	Completed
Indicator: Hospital/Health care networking is an essential step in medical preparedness planning for mass casualty incidents. **RA:** Primary healthcare facilities shall consider the network for information, materials, human power, and training.	○	○	○

2.14. External Notification

Insert the <Name of Upazila> will compile and maintain an external contact list of phone numbers of emergency response agencies, key vendors, stakeholders, and resources

- Basic Facility Support lists routine and emergency contact numbers for basic support services for facility operations (e.g., utilities, repair services, etc.).
- Table 6 - Essential Contacts provides information for use in response to incidents (e.g., government response agencies, nearby hospitals and hospitals, media, etc.).
- <Insert position> is responsible in maintaining the external contact list and ensures its updated every 3 months

2.15. Information Management

2.15.1. Incident Documentation

<Insert position> is the designated Incident Command Recorder will report on the whole response operation beginning from the alert phase to the recovery phase to the Planning Section Chief of the IMT.

- Written report of major incidents describing the cause and course of events, and findings of a complete investigation.
- Maintain event logs (chronology of events)
- Record incident-related problem
- Record any other documentation necessary as directed by the IMT.

2.15.2. Patient Registration and Tracking

The disaster cabinet (proposed) contains necessary numbers of MCI charts that have active medical record numbers and can be used with only minimal demographic information. Registration and ED Clerks supplemented with Hospital Finance and Admitting staff will assist in the tracking and registration of disaster patients. The patients must complete the registration process before discharge. Registration of patients should not prevent the rapid triage and assignment of patients to care areas.

During the emergency phase, information on patient received (Name, Sex and Triage category at the emergency department should be communicated to the Planning Section of the IMT. If patients are cleared in the emergency department and transferred to Operating Room or hospital ward, this needs to be communicated to Planning Section for patient tracking. In case patient is transported to another hospital as secondary patient transfer, same information should be reported on what hospital the patient was transported.

2.15.3. Discharge Office

The discharge office will obtain additional patient information for discharge and report to Planning Section of IMT if a patient gets discharged. A designated representative from the treatment area will escort patients ready for discharge to the discharge office.

2.16. Communicating Media

The main responsibility in talking to the media and conduct press briefing / interview will be with the IC unless this responsibility is delegated to the Public Information Officer (PIO). The PIO will prepare all news releases, organize press conferences and interviews. The media will be directed to the <Insert the Name of Upazila> to mention the building location at the hospital. Regular press release will be issued by the IMT every 12 hours.

The absence of transparent and credible information leads to media speculations and increases the stress and pressure of the incident, especially on the hospital and its staff. Every news and information source will seek access to the latest and most up-to-date information. The hospital should designate one person from the hospital for regular media/ press briefing.

CHECKLIST – COMMUNICATION

Indicators/Recommended Actions (RA)	Action Due	In Progress	Completed
Indicator: Transparent and credible information mechanisms ensure informed decision-making, effective collaboration and cooperation, and public awareness and trust. **RA:** Hospital shall appoint a public information spokesperson to coordinate hospital communication with the public, the media, and health authorities.	○	○	○
RA: Ensure the availability of reliable and sustainable primary and backup communication systems.	○	○	○
RA: Hospital shall establish streamlined information exchange mechanisms between hospital administration, department/unit heads, and facility staff.	○	○	○

2.17. Communications Facility

<Insert the Name of Hospital> telecommunications systems include land phone, mobile phone, audio sound box, hand mikes. The system shall be initiated under the direction of the EOC.

2.18. Logistics and Supply

The Planning Section is responsible in the following:

- Develop and maintain an updated inventory of all equipment, supplies and pharmaceuticals and establishment of a shortage-alert mechanism.
- Estimate consumption of essential supplies and pharmaceuticals and request accordingly.

The Logistics Section is responsible in the following:

- Develop mechanisms for storage and stockpiling of additional supplies including pharmaceuticals and ensure an uninterrupted cold chain.
- Establish mechanisms for quick assessment of the functional status of different equipment and prompt maintenance and repair of those equipment required for essential services.
- Establish coordination for a contingency transport strategy for patient transfer.

The Finance and Admin Section is responsible in the following:

- Assess the quality of the contingency items prior to purchase.
- Establish contingency agreements with vendors to ensure the procurement and prompt delivery of equipment and supplies in a disaster situation.
- Establish a simple disaster budget protocol for quick mobilization of funds for disaster response.
- Ensure availability of petty cash/dedicated contingency fund which could be used for disaster response.
- Introduce special accounting policies and procedures for efficient financial management during emergencies.

2.19. Human Resources

<Insert the Name of Hospital> on-campus human resources include: Hospital staff including administration, nurses, technicians and support staff; and medical college teachers, students, technicians and support staff. Also there may be a number of community and non-affiliated health care professionals who on-call will volunteer their services. Depending on the resources available, the Hospital may decide to close the non-essential services to repurpose staff in the critical areas involved in operations. Please refer to **Annex C:** <Insert the Name of Hospital> Human Resources Capacity.

2.20. Volunteers

During a Mass-Casualty Incident or other disaster, there may be a need to utilize volunteers. All volunteer activities will be coordinated by the designated Liaison Officer. There may be a number of community and non-affiliated health care professionals who will volunteer their services. However, once the ICS is activated these individuals will not be allowed to enter the hospital premises unless they register first to the EOC and get assigned to specific task. If the hospital decides to use volunteers, they need to engage them before the disaster, including training and orienting them on their role during response.

2.21. Hospital Surge Capacity/Capability

Surge capacity is the ability of a health service to expand beyond standard capacity to meet increased demand for clinical care. In the case of newly arriving patients, the primary level hospitals might require to increase the bed capacity for definitive treatment. The suggestions include discharging elective cases and stable recovering patients, stopping admitting non-emergency patients, and converting waiting/non-patient care areas into makeshift wards. Hospitals shall undertake the following actions to support surge capacity management:

- Available spaces at building corridor and some open areas within the hospital compound will be utilized to expanded care or patient observation space.
- During plan activation, Surgery Department, OPD, and other non-essential departments and sections will cancel all elective surgeries scheduled on that day and prioritize only emergency procedures.
- A rapid staff recall procedure will be conducted to call off duty staff back to the hospital for emergency duties.
- Mutual aid agreements through the Civil Surgeon of Rangamati for transfers and accommodation with network of public and private hospitals and clinics.

CHECKLIST - SURGE CAPACITY

Indicators/Recommended Actions (RA)	Action Due	In Progress	Completed
RA: Hospital has spaces identified at the building corridor and some open areas within the hospital compound to expand care or patient observation space.	○	○	○
RA: Hospital has an established rapid staff recall procedure to call off duty staff back to the hospital for emergency duties.	○	○	○
RA: Primary level hospitals have mutual aid agreements through the Civil Surgeon for transfers and accommodation with the network of public and private hospitals and clinics.	○	○	○

2.22. Safety and Security

During HERP is activation the Hospital Security personnel will secure all entrances to the Hospital Campus. All ambulatory people seeking emergency care will be directed to the building entrance. No family or visitors will be admitted to the main Hospital. All family visitors will be directed to the shed at outdoor. Hospital will allow 2 visitors per patients at maximum. OPD will be closed and all patients will be asked to leave. The Safety and Security Management activities shall be coordinated by the <Insert the Name of Hospital> DHMC in association with all concerned stakeholders, internal and external. In order to ensure adequate security and safety, every hospital/healthcare facility shall:

- Appoint a hospital security team responsible for all hospital safety and security activities.
- Prioritize security needs of the hospital and identify areas where increased vulnerability is anticipated.
- Establish early control of facility access points, triage, and other areas of patient flow.
- Establish reliable modes of identifying authorized hospital personnel, patients, patients' attendants and visitors.
- Establish mechanisms to escort medical personnel related to disaster relief to the patient care areas when needed.
- Define security measures required for safe and efficient hospital evacuation.
- Define the rules for engagement in crowd control.
- Solicit inputs from the hospital security team to identify potential safety and security.
- Request for additional support requiring assistance from local police department.

2.23. Other Hospital Services and Facilities

The following services and facilities are essential during MCI emergency response.

- **Blood Bank:** The Blood Bank is alerted to the Disaster Activation and will coordinate the distribution of blood and contact outside blood banks if necessary. Blood bank should initiate blood donation activities to ensure that enough blood products are available for patients during mass casualty incidents. If no blood bank available at the UHC, coordinate with District Hospitals or other Referral Hospitals or BDRCS.
- **Pharmacy:** Dispatches required personnel and medications to the ED. Also prepares for use of possible antidotes in HAZMAT and Biohazard incidents. Provide immediate inventory of stocks to the Planning Section in the IMT and updates regularly.
- **Messenger Services:** Bring all available stretchers and wheel chairs to ED and report to the EOC.
- **Lab services:** Is prepared to receive a large influx of samples and prepare for downtime procedures if Healthcare Documentation system (HDS) is down and report to the EOC.
- **Admitting:** Conducts a rapid evaluation for available ICU and Medical/Surgical beds and report to the EOC.

Chapter 03

EMERGENCY RESPONSE PROCEDURES

This Chapter of the HERP of describes the procedures of emergency response from the Phase I – Preparation in pre-disaster time to Phase IV – Recovery in the post-disaster time.

3.1. Mass Casualty Incident Scenarios

The HERP provides guidance to the <Insert the Name of Hospital> IMT for conducting response operation in the aftermath of Mass Casualty Incidents (MCI). The procedures described in this chapter are applicable to the management of both internal and external MCI in all three possible scenarios, which are:

- Scenario A - Hospital Affected
- Scenario B - Community Affected
- Scenario C - Both Hospital and Community Affected

Internal emergency is defined as any incident that originates inside the hospital or on campus that disrupt the normal operations of the hospital and/or endangering patients or staff, creating a need for evacuation or relocation. External emergencies are incidents that occur outside the hospital (natural or human-caused) requiring the activation of the HERP.

3.2. Steps of Emergency Response Operation

Table 7 below presents the step-by-step procedures and corresponding tasks/actions by the IMT. Also provided just bottom of the table are additional information and relevant references.

Table 7:
Step-by-step procedures and corresponding tasks/actions by the IMT

Phases of Response	Phases of HERP Activation	Steps of Procedures	Tasks/Actionsw	Person, Group or Team Responsible
Phase 1 – Pre Disaster (Preparation /Readiness)	Alert Phase	**Step 1 Obtaining and Relaying Information**	Any employee of <Insert the Name of Hospital> who learns of an occurrence that might constitute a disaster should attempt to obtain the following information: • What is the type of incident? • Where is the location of the incident? • How many casualties are estimated? • What type of injuries? • How many victims may the hospital expect, and when?	• Any employee of <Insert the Name of Hospital> • IMT members • DHMC members
		Step 2 Log of Events	• Start and maintain log of events*	• DHMC • IMT * The Hospital Command Center Recorder (EOCR) will assume this responsibility soon after the IMS is activated until end of operation.
Phase 2 – Alert and Warning (Assessment/Notification)	Standby Phase	**Step 3 Notify Hospital**	• Notify DHMC, hospital staff and admitted indoor and outdoor patients, visitors about potential of disaster. • Follow the level of alert notification **(Refer to Chapter 2 Section 2.6 – Levels of Alert Mechanism)** • In case of earthquake alert (alarm, cell phones, siren, loud speaker, microphone, megaphone) after the 1st shake.	• ED • EOC
		Step 4 Review Readiness	• IMT reviews its plan, procedures and resources to get ready for response.	

Table 7:
Step-by-step procedures and corresponding tasks/actions by the IMT

Phases of Response	Phases of HERP Activation	Steps of Procedures	Tasks/Actionsw	Person, Group or Team Responsible
Phase 3 – Disaster Onset (Activation/Response)	Mobilization	**Step 5 Activation of IMS**	• Mobilization of Incident Management Team. • Mobilize personal external to hospital to provide assistance, managerial or administrative support. • Activation of supplementary emergency response procedures (as and when needed). • Each department will activate their section plan under administrative control of the Incident Commander.	• IMT
		Step 6 Initial Assessment of Treatment Capacity/ Capability	• Review of the surge capacity to determine number and type of casualties the hospital will be able to accommodate, handle and treat. **(Refer to Chapter 2/Section 2.21 – Hospital Surge Capacity/ Capability)**	
		Step 7 Management of Casualties	• Set-up and implementation of Triage Plan. **(Refer to Section 3.3 of this chapter)** • Receive and unload ambulances and other transports carrying casualties.	

Table 7:
Step-by-step procedures and corresponding tasks/actions by the IMT

Phases of Response	Phases of HERP Activation	Steps of Procedures	Tasks/Actionsw	Person, Group or Team Responsible
Phase 3 – Disaster Onset (Activation/Response)	Mobilization	**Step 8 Evacuation/ Transfer of Patients**	• Management of Transfer / Patient Holding Area. • Arrangement of ambulance and vehicles for evacuating and transferring patients to other hospitals for specific treatment as needed. • The Transfer Coordinator will have the authority, responsibility, and accountability of implementing admitting, transfer, discharge and evacuation. • The Transfer Coordinator shall be responsible for the orderly transfer of patients and other personnel, proper identification procedures, transfer and maintenance.	• Designate Transfer Coordinator at EOC by IC or his designee. • Additional personnel to assist in implementing these procedures will be assigned from the respective departments; i.e. Admitting, Hospital Records, etc.
		Step 9 Management of Different Functions	• Management of essential services and facilities. • Management of external traffic flow. • Management of Human Resources. • Management of logistics and supplies. • Management of dead bodies (temporary morgue) Management of Dead & Missing. • Management of Burns. • Management of security. • Management of hospital lifelines (e.g. water, power, communication).	

Table 7:
Step-by-step procedures and corresponding tasks/actions by the IMT

Phases of Response	Phases of HERP Activation	Steps of Procedures	Tasks/Actionsw	Person, Group or Team Responsible
Phase 4 – Post Disaster	Stand Down	**Step 10 Recovery**	• As soon as possible after each incident, all participating departments should send knowledgeable representatives to review the measures that were taken by each department or agency. (IC will make this communication). The purpose of this review is to evaluate the response and overall response coordination effort. • Other hospital post-emergency actions shall include but are not limited to: » Written report of major incidents describing the cause and course of events, and findings of a complete investigation. » Reporting of all emergencies to the DHMC for review, discussion, critique and further follow-up as necessary. • Continue to assist employees and community with Behavioral Health needs. (Refer to Chapter 3/Section 3.5-Psychosocial Support Plan) • Assist employees with benefits needs.	• IMS • All participating departments and units • Refer to **Chapter 2 Section 2.10 – Stand Down (Demobilization and Recovery) Phase for IMT responsibilities in post-disaster phase.**
Additional Information and References	✓	✓ There are various means to notify a community disaster or mass casualty incident. Besides the obvious notification via casualties and emergency personnel arriving from the scene, another way is by the PIO/(Insert Name of Upazila) or District Control Room at <Insert the Name of the District> to call the hospital Administration or ED. The same action shall be taken however, regardless of the means of notification.		

3.3. Triage Plan and Procedure

Need for Triage: Triage is the process of sorting injured people into groups based on the severity of their conditions. During mass casualty situations the number of patients and the severity of their injuries exceed the capability of the facility and staff, and patients sustaining major injuries who have the greatest chance of survival with the least expenditure of time, equipment, supplies, and personnel are managed first.

Primary Triage and Patient Flow: In case of an MCI outside the <Insert the Name of Hospital> **(Scenario B - Community Affected; See Section 3.1)** all Patients arriving will be rapidly triaged by the Triage Officer at the <Insert the Name of Hospital> Triage Area in the Emergency Department of the hospital. The Triage Officer and Triage Nurse will assign patients at triage to one of the following categories and will dispatch patients evaluated of their vital signs, chief complaint and other key indicators to be categorized as:

- **Category I - RED (Obvious life-threatening emergency):** The physician at the IMT or DMO shall examine the patient with zero delay. Case examples include cardiac arrest, continuous seizures, acute severe chest pain, hematemesis, sudden loss of consciousness, major trauma with hypotension, etc.
- **Category II - YELLOW (Potential for life-threatening emergency):** The possibility of an occult or pending emergency condition but can wait. Although some of these patients initially may appear to have not-so-serious chief complaints, some of these patients have high-risk conditions. The patient shall be fully evaluated and treated by a physician within 10 minutes of arrival, since there could be potential instability to the vital signs. Case examples include dyspnea, high fever, acute abdominal pain, acute confusion, severe pain, serious extremity injuries, large lacerations, etc.
- **Category III - GREEN (Non-life-threatening emergency):** These patients' presentation need emergency care but provide no reason to consider the possibility of threat to life or limb. These patients shall be seen by an Emergency Management physician on a first come first served basis in the Consultation Room. Case examples include chronic, minor, or self-limiting disorders, medication refill, skin disorders, mild adult upper respiratory tract symptoms, mild sore throat, blood pressure check, etc.
- **Category IV – BLACK** (Deceased or dying patients and those who have no chance of survival): These patients will be taken to the morgue.

Opening of Disaster Triage Area: To undertake effective triage the hospital shall:

- Designate <insert position> as the triage officer to oversee all triage operations.
- Ensure that areas for receiving patients, as well as waiting areas, are effectively covered, secure from potential environmental hazards and provided with adequate work space, has adequate lighting and access to back up power.
- Ensure that the triage area is in close proximity to essential personnel, medical supplies and key care services and that entrances and exit routes to and from the triage area are clearly identified.
- Identify an alternative site for patient reception and triage of mass-casualty victims and an alternative waiting area for wounded patients who are able to walk.

- Use triage tags or ribbons as method of identification of triaged patients.
- Head Nurse on duty at emergency department ensure adequate supply of triage tags.

Triage Priority and Tags: Each patient will be identified by the triage team headed by the triage officer supported by triage nurse and support staff with a triage tag, which gives the name of the individual, nature of injuries, category of injuries, medical problems and any known allergies. When the tags have been completed as described above, the tags will be retained for the clinical record until disaster response has ended, and then transmit copies to hospital record for documenting of information. After the information contained on the tag is entered in the records log book, the tag may be destroyed.

Each casualty will be given a color-coded disaster tag, described below, by the triage staff, which will indicate the severity of injury and area to which the victims will be transported for treatment. The disaster tags are stored at the triage location at the emergency department disaster box.

1. **Green:** Minor injuries that can wait for appropriate treatment
2. **Yellow:** Relatively stable patients needing prompt medical attention
3. **Red:** Critical patients in need of immediate life-saving care
4. **Black:** Deceased patients and those who have no chance of survival.

Any disaster victim exposed to radioactive and/or other contaminated materials, poisons or chemicals will be transported to the decontamination area outside the emergency department (to be identified) prior to being transported to the general treatment area. From Ambulatory or Ambulance Triage the patient will be taken (after decontamination) to:

Major Casualty (Red and Yellow tags) will be taken to the Adult ED or Pediatrics ED children <13

Minor Casualties (Green tags) will be sent to:

- (Minor Trauma) - ED/Minor OT Room
- (Minor Medical) – OPD Medicine
- (Minor Pediatrics) – OPD Pediatric
- (Behavioral Health) – Medical Officer (Note: Hospital has no designated post for this activity)

After treatment is complete, minor casualties will be taken to the building lobby to obtain further inpatient information, discharge, and assistance with contacting family. Psychiatric cases will be referred to the Psychiatric Department.

Casualty Transport: The Head Nurse of the Emergency Department will provide an organized flow of patients from one treatment area to another. Efficient use of nearby hallways will assist in moving the injured to the designated treatment areas including to surgery.

CHECKLIST (INDICATORS) TRIAGE PLAN AND PROCEDURE

Triage is the process of categorizing and prioritizing patients to provide the best care to as many patients as possible with the available resources. During mass casualty situations, the number of patients and the severity of their injuries exceed the capability of the facility and staff, and patients sustaining major injuries have the greatest chance of survival with the least expenditure of time, equipment, supplies, and personnel are managed first. Maintaining patient triage operations based on a well-functioning mass-casualty triage protocol is essential for the appropriate organization of patient care. The indicators to measure the effectiveness of triage are:

Indicators/Recommended Actions (RA)	Action Due	In Progress	Completed
RA: Hospital has a designated triage officer to oversee all triage operations.	○	○	○
RA: Hospital has clearly marked triage area with different categories including possible expansion areas if needed.	○	○	○
RA: Hospital has arrangements for receiving patients and the waiting areas are effectively covered, secure from potential environmental hazards, and provided with adequate workspace, including adequate lighting and access to backup power.	○	○	○
RA: Hospital has clearly identified entrances and exit routes to and from the triage area.	○	○	○
RA: Hospital has the alternative sites identified for patient reception, triage of mass-casualty victims, and alternative waiting area for wounded patients who can walk.	○	○	○
RA: Hospital has arrangements to ensure an adequate supply of triage tags or ribbons as a method of identification of triaged patients.	○	○	○

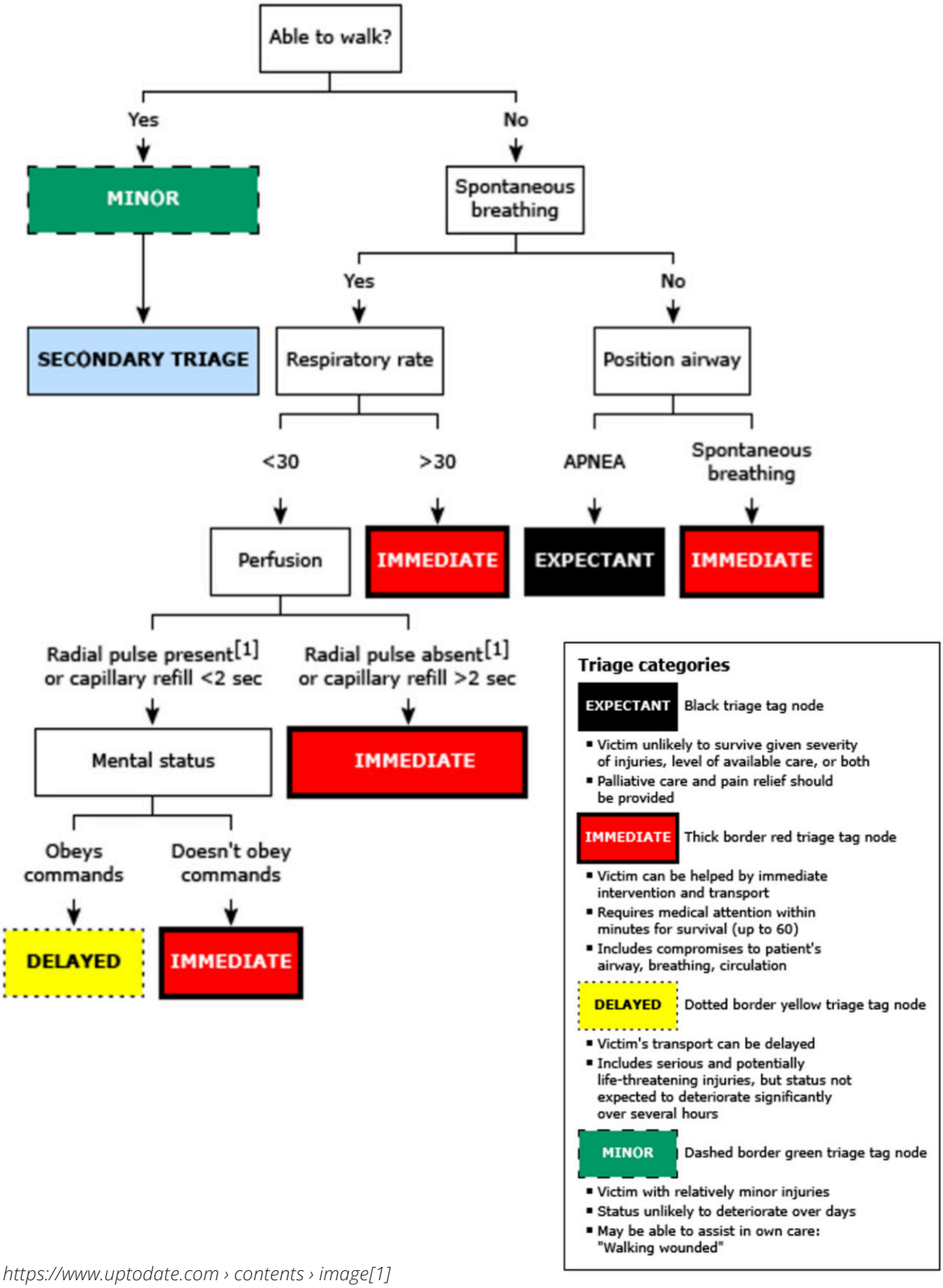
An illustration of whole triage operation procedure is presented in Table-8 below followed by the flow chart of triage plan in internal and external mass casualty management by the <Insert the Name of Hospital> IMS.

Table 8: Illustration of Triage Operation in MCM
(TO BE REVISED CONSIDERING PRIMARY LEVEL HOSPITAL CONTEXT)

PRIORITY	TAG COLOR	INJURY CATEGORIES	TRANSPORT TO	AREA LEADER
1 Immediate	**Red**	Major injuries, which are life-threatening and require immediate medical treatment	Critical Care Treatment Area at the ICU	Immediate Treatment Unit Leader (Anesthesiologist, Anesthesiology Department)
2 Delayed	**Yellow**	Serious injuries which are not life-threatening, but require immediate medical attention	Delayed Treatment Area at the General Surgery Ward	Delayed Treatment Unit Leader (Unit Head of Surgery)
3 Minor	**Green**	Minor injuries requiring some or minimal medical attention	Minor Treatment Area in the Surgery OPD	Minor Treatment Unit Leader (Resident Surgeon and Medical Officer of Surgery)
0 Dead	**Black**	Individuals who are "Dead On Arrival" (DOA)	Morgue on the Ground Floor of <location>	Morgue Unit Leader (Head of Forensic Medicine)

Chart 2:
<Insert the Name of Hospital> Mass Casualty Triage Flowchart

START (Simple Triage and Rapid Treatment) Protocol: START includes rapidly assessing (in less than 1 minute) every patient, determining which of 4 clinical categories the patient belongs, and visibly identifying the category for rescuers who will treat the patient.



https://www.uptodate.com › contents › image[1]

3.4. Management of Dead Bodies

<Insert the Name of Hospital> has a mortuary. The hospital shall establish procedures for preparing sites for temporary placement of dead bodies and for forensic medicine to handle mass fatality situations. Specific actions are as follows:

- Decedents and their personal effects must be secured and safeguarded at all times until the arrival of the coroner's or mortuary's authorized representative, or law enforcement (if evidentiary).
- Placed in a human remains pouch or wrap in plastic and a sheet.
- If personal effects have been removed from the body, ensure the items have been catalogued (such as on the Decedent Information and Tracking Card) and are secure.
- Be sure the decedent is tagged with identification information.
- Existing hospital morgue refrigeration capacity will be exceeded during a disaster, especially if there are many unidentified bodies or remains recovered. In order to increase its capacity the following will be considered as options:
  - » Rooms, tents or large refrigerated transport containers used by commercial shipping companies that have the temperature controlled may also serve as surge morgues.
  - » Containers may be used to store up to 30 bodies by laying remains flat on the floor with walkway between.
  - » The floor can be used for storing remains, however it may be safer and easier to identify and move remains on beds, cots or racking systems.

3.5. Psychosocial Support and Critical Incident Stress Management

Policy: To provide psychosocial support interventions to the community members and hospital personnel who lost loved ones or have witnessed death on a large-scale during disasters. The hospital needs to provide resources and trained staff to deliver this intervention.

3.5.1. Staff Welfare:
Management of Burnout and Secondary Traumatic Stress

Sources of stress for emergency responders may include witnessing human suffering, risk of personal harm, intense workloads, life-and-death decisions, and separation from family. Stress prevention and management is critical for responders to stay well and to continue to help in the situation. There are important steps responders should take before, during, and after an event. To take care of others, responders must be feeling well and thinking clearly. People with preexisting mental health conditions should continue with their treatment plans during an emergency and monitor for any new symptoms.

3.5.2. During Response

Limit your time working alone by trying to work in teams. Responders experience stress during a crisis. When stress builds up it can cause:

Burnout – feelings of extreme exhaustion and being overwhelmed.

Secondary traumatic stress – stress reactions and symptoms resulting from exposure to another individual's traumatic experiences, rather than from exposure directly to a traumatic event.

Recognize the signs of both of these conditions in yourself and other responders to be sure those who need a break or need help can address these needs.

Signs of Burnout		Signs of Secondary Traumatic Stress
• Sadness, depression, or apathy • Easily frustrated • Blaming of others, irritability • Lacking feelings, indifferent • Isolation or disconnection from others • Poor self-care (hygiene) • Tired, exhausted or overwhelmed	Feeling like… • A failure • Nothing you can do will help • You are not doing your job well	• Excessively worry or fear about something bad happening • Easily startled, or "on guard" all of the time • Physical signs of stress (e.g. racing heart) • Nightmares or recurrent thoughts about the traumatic situation • The feeling that others' trauma is yours

Getting support from team members

Use buddy system, identify a partner to support each other, and monitor each other's stress, workload, and safety.

- Get to know each other. Talk about background, interests, hobbies, and family. Identify each other's strengths and weaknesses.
- Keep an eye on each other. Try to work in the same location if you can.
- Set up times to check-in with each other. Listen carefully and share experiences and feelings. Acknowledge tough situations and recognize accomplishments, even small ones.
- Offer to help with basic needs such as sharing supplies and transportation.
- Monitor each other's workloads. Encourage each other to take breaks. Share opportunities for stress relief (rest, routine sleep, exercise, and deep breathing).
- Communicate your buddy's basic needs and limits to leadership – make your buddy feel "safe" to speak up.

Self-Care Techniques

- Limit working hours to no longer than 12-hour shifts.
- Work in teams and limit amount of time working alone.
- Write in a journal.
- Talk to family, friends, supervisors, and teammates about your feelings and experiences.
- Practice breathing and relaxation techniques.
- Maintain a healthy diet and get adequate sleep and exercise.
- Know that it is okay to draw boundaries and say "no."
- Avoid or limit caffeine and use of alcohol.

Chapter 04

CONTINGENCY PLANS AND PROCEDURES

4.1. Hospital Fire Safety Plan

Policy: All fires must be reported including those in which there is little or no loss to the hospital facilities.

Purpose: To determine the cause of fires and the conditions surrounding them so that remedial and preventive measures can be taken.

Procedures: All persons in the Hospital system shall be familiar with the fire response procedure and the fire plan. A fire condition exists when a presence of fire or visible smoke in areas is neither common nor expected. The basic actions that must be taken in case of fire are:

- Rescue or remove persons in immediate danger away from fire or smoke.
- Activate nearest interior fire alarm box and call security guards/police.
- Notify the nearest fire service stations.
- Confine the fire and smoke by closing doors and windows.
- Extinguish the fire using a portable fire extinguisher.
- Evacuate if the safety of occupants is threatened by fire and smoke.

4.1.1. General Procedures

All hospital staff are required to know their department's fire response plan or procedures and follow the fire response plan and any instructions that are announced over the fire alarm and PA systems for ALL fire alarms. Employees are also required to know the locations of all manual pull stations in their work area.

4.1.2. Alarm Activation

When there are visible flames, visible smoke, smell of smoke, unusual heat, or other indications of fire – even if uncertain if the conditions are caused by a fire – hospital staff shall activate the manual fire alarm pull stations and inform the hospital operator for wider announcement in the hospital PA system.

4.1.3. Fire Alarm and PA System Notifications

Upon fire alarm initiation, the hospital operator will notify the fire department.

Upon fire alarm initiation, visible and audible alarms will be signaled throughout the building where the alarm was activated. In areas with fire alarm annunciation capabilities, in addition to visible and audible alarms occupants will hear the following:

May I have your attention please! (2 – Times)

A Code Red condition has been detected in the building, initiate Code Red procedure at once. (3 – Times)

In addition to the fire alarm notifications, the hospital Operator will announce "Code Red and the location" (3 – Times) over the PA system.

4.1.4. Employee and Staff Response

Hospital personnel, including physicians, who are at or **near the fire's point of origin,** shall follow the procedures outlined by the R.A.C.E acronym:

- **Rescue** all patients, visitors, employees, staff and volunteers from immediate danger.
- **Alarm** by pulling the closest fire pull-station and reporting the location of the fire to the hospital operator.
- **Confine** the area by closing all doors.
- **Extinguish** the fire if the fire is small (use P.A.S.S).
- **Evacuate** patients from the area if instructed to do so by fire officials or hospital leadership.

Upon activation of a Code Red, hospital personnel, including physicians who are **away from the fire's point of origin** shall do the following:

- Be ready to accept patients from near the fire's point of origin if required (especially for areas adjacent to the fire's point of origin). Also, be aware that the fire event in the facility may have an effect on their ability to effectively care for patients.
- Listen for additional instruction.
- Keep patients and visitors in rooms if possible until directed to do otherwise.
- Keep all doors closed except when passing through them in order to avoid the spread of smoke and fire.
- Be ready to evacuate if directed.
- DO NOT use Elevators.

- In addition to the above, upon activation of an alarm, physicians are specifically requested to:
    - » If in a patient area, go to the nurses' station to be available for response to a medical emergency.
    - » Assist other staff (when needed) in moving patients and visitors to safety, and evacuate with the other staff.

4.1.5. Oxygen Shut-Off

The nurses, respiratory technician in charge, or manager/supervisor in charge of area has the responsibility and authority to shut-off of medical oxygen gas valve in any life threatening situation. Provisions will be made to provide patients with portable Oxygen gas.

4.1.6. Emergency Response Team (ERT)

Upon notification of the alarm, Security Officers will respond to the location of the fire or alarm. In the event of an actual fire, responding officers shall assist as needed and also call backup security officers to ensure free unobstructed access for emergency response vehicles and personnel. The Security Officers will meet fire department and direct them to the fire location, maintain communication at the fire location, and may direct those not involved in the emergency response to evacuate the area. Security Officers will also prevent non-emergency responders from entering the building.

Upon receipt of the fire alarm, the hospital operator will dispatch via mobile radio all ERT responders to the fire location. The Control Room operator will notify Security to ensure that they received the fire alarm notification. All Hospital ERT responders should bring an extinguisher with them when responding to a Code Red. The hospital will coordinate with FSCD fire stations at the (UPAZILA) city and neighboring Upazilas.

4.1.7. Evacuation

The hospital shall designate a safe evacuation area or collection point to place the evacuated patients. In buildings, patient, visitor, employee, and staff evacuation shall be initiated when there is immediate danger due to fire, smoke, chemical release, structural failure, or similar condition.

Evacuation of patients by bed or mattress from a room or floor may not be practical due to the large number of non-ambulatory patients. If required, direct evacuation of patients shall be conducted per the following guidelines:

- **Partial Evacuation** - Partial evacuation or relocation to other areas of the building may be used depending on the particular emergency and the level of danger that it poses. When partial evacuation is indicated, horizontal followed by vertical evacuation will be used.

- **Vertical Evacuation** - If necessary and as directed, patients may be moved to another floor - typically the floor below. If it becomes necessary to evacuate patients to a lower floor, stairwells should be used.
- **Complete Patient Evacuation** - Should the emergency condition persist or be of a severity such that the building is endangered, a complete evacuation of the building shall be initiated. Directions given by the Incident Commander of the fire department shall be carried out immediately.
- **Patient Removal** - Patients are to be removed horizontally by stretcher, wheelchair, blankets, or other method of transportation to an adjacent fire/smoke compartment. Patients in immediate danger shall be removed FIRST - including those who might be subject to danger should the fire spread into their area. Ambulatory patients should be accompanied or directed to an appropriate fire/smoke compartment, depending on the situation. Non-Ambulatory patients should be moved using wheelchairs or stretchers when available to an appropriate fire/smoke compartment. Patients being evacuated should be wrapped in blankets before placing them in wheelchairs.

4.1.8. Code Red All Clear

The Hospital Incident Commander or the FSCD officer in charge at the scene will verify that the situation has been resolved. Any of these individuals can declare the incident "All Clear". The hospital operator will be notified and will announce "Code Red All Clear" (3 – Times) over the PA system. Security will advise of the "All Clear" to any in areas not covered by the PA system. Employees and staff shall continue Code Red procedures until a "Code Red All Clear" signal has been announced.

4.2. Flood Management Contingency Plan

Policy: To ensure uninterrupted coverage of services when impacted by a sudden large influx of patients.

4.2.1. Procedure/Responsibilities:

- Monitor flood forecasting issued by the Bangladesh Meteorological Department (BMD). The Hospital Situation Unit Leader (To be identified by the hospital) is responsible in monitoring flood forecasting.
- If the situation warrants then activate EOC. Follow the response operation procedures (Chapter 3).
- Notify the hospital and community. Coordinate with UZDMC.

- **Duty Schedule Modifications:** When notified of a flood by the District/Upazila (Control Room), all hospitals shall be prepared to function on a 12 hour tour basis, if required. This shall include key administrative staff, Physicians, Nurses, and Chiefs or Head of Clinical Service. This eliminates the need to call in staff after normal working hours.
- **Duty Modifications:** To meet the emergency, the Incident Commander in consultation with the General Staff will reassign personnel to duties outside their normal functions in order to address the needs of the facility and its patients. In the most severe circumstances, the hospital can expect a large influx of patients and/or those requiring shelter. In such cases clerical staff may be called upon to perform minor Nursing duties, food handling, etc.
- **Staffing:** All Department Heads or supervisors must survey their areas to determine whether sufficient personnel are available to service a sudden large influx of patients. This shall include both the types and numbers of additional personnel required. Department Heads are authorized to adjust schedules where necessary to maximize staff coverage. The use of overtime shall be permitted with the approval of the appropriate Administrator. It is essential that accurate time and leave records be kept during this period. The Department Head or senior supervisor shall report this information to IMT.
- **Supply Levels:** All departments impacted by an increase in patients/others shall closely monitor supply levels on an ongoing basis. The Operations and Maintenance Department Chief shall be responsible for overseeing this function and providing materials as required. The EOC is to be kept abreast of supply levels and potential problem areas.
- **Clinical and Ancillary Services:** Chiefs and Clinical Heads shall be responsible for maintaining services during the period of disaster and for keeping the Command Center abreast of all potential problems.
- **Facilities Management:** Immediately upon receipt of the alert, personnel shall be deployed to:
    - » Check roof tops for loose items/debris that could become flying missiles in high winds.
    - » Clear roof gutters to assure proper drainage of rain water.
    - » Check functioning of the emergency generators and the level of diesel fuel available for each.
    - » Tape loose windows as needed.
    - » Power Failure - in the event the flood results in a power failure activate the back-up system.
    - » Food Service - The Dietary Department shall evaluate its preparedness to serve larger numbers of meals for patients and staff plus an influx of those seeking shelter or requiring emergency care.

- Hospital Police/Security staff shall be prepared to assist other departments where necessary, especially in the areas of communications and transportation. The readiness of all vehicles shall be reported to the EOC.
- Mental Services - Upon declaration of the alert, the Disaster Medical Officer (DMO), in conjunction with the Admitting Office and Nursing Service, shall determine the need for space to house an influx of a large number of patients, those seeking shelter and staff. This shall include the need for beds/cots and floor mattresses. This information shall be conveyed to the EOC.

- **Patient Discharge and Admissions:** Upon establishment of a storm alert by Administration, action should be taken to discharge as many patients as possible to make room for the influx of new patients or those displaced from other facilities. If so determined, elective admissions shall be canceled and patients notified and rescheduled. Likewise, those patients already admitted and awaiting elective procedures shall be discharged.
- **Outpatient Services:** Outpatient Services shall be suspended for the duration of the emergency. Outpatient areas may be utilized to house patients transferred from other facilities or community members as needed. OPD staff shall be reassigned by the EOC to assist other departments (i.e. medical staff to E.R.) or monitor shelter areas.
- **Emergency Services:** Shall be prepared for the influx of large numbers of patients. Staff shall be drawn from other areas of the hospital to supplement existing personnel.
- **Operating Rooms:** Elective admissions/surgery will be canceled if necessary. All other O.R. scheduling will be handled on a day-by-day basis depending on the influx of patients and availability of staff.

4.3. Hazardous Materials Management Plan

Policy: All department heads are responsible for the designation of staff responsibilities in the event of a chemical spill in their respective areas, and in addition, this policy will ensure that adequately trained personnel are available to respond to any release/spill of potentially hazardous chemicals anywhere in the hospital on a 24-hour basis.

Purpose: To establish and implement the proper procedure for the removal of chemical spills at the hospital. This policy serves to minimize/eliminate the exposures of employees, patients, visitors to the spills of potentially hazardous products. All chemical spills referred to in this policy includes but are not limited to, mercury, formaldehyde, ethylene oxide, acids, chromates, organic solvents, antineoplastic-contaminated body fluids, and all unidentified spills.

4.3.1. Department Responsibilities

- Each department is responsible for identifying and labelling all hazardous material within its department work area.
- All departments should inventory their hazardous materials, and review them for appropriateness as part of the overall department's inventory programme.
- A Material Safety Data Sheet (MSDS) must be obtained for every chemical identified as hazardous which is used in the department/ section. MSDS's must be kept in users departments/sections for employee use.
- It is the responsibility of each department to provide training for individual staff who handle hazardous materials, training records must be maintained.
- Emergency preparedness and spill clean-up procedures must be developed.
- Purchase of all chemicals including cleaning solutions, laundry chemicals and chemicals routinely used for facility and grounds maintenance shall be accompanied by a MSDS.
- All accidents/spills must be reported to Environmental Services, Safety Section **(to be identified by the hospital)** and any other departments or persons as the situation requires (i.e., Radiation Safety Officer in case radiation is involved, Lab Safety Officer, Research Centre Chemical Safety Officer, Clinical Engineering or others).
- All hazardous materials received in a department shall be handled by appropriate personnel and shall be stored in an appropriate cabinet with proper ventilation, designated for chemical use only.

4.4. Power Failure Contingency Plan

Policy: Hospital will provide emergency power cover at least 70% of total power needs of the hospital during emergencies.

4.4.1. Implementation Procedure:

This plan shall be implemented immediately upon notification of an actual or anticipated power failure or load shedding.

a) **Alternate/Additional Sources of Power:** Hospital shall, in addition to its stand-by generators, arrange for sources of power from solar panel, gas supplies, IPS and UPS for uninterrupted services in the event of failure of main power supplies from PDB. The hospital shall have written instructions in place that:

- All Supervisory personnel must contact the EOC as soon as possible in the event of a power emergency. All hospital personnel shall be prepared to function on a 12-hour tour basis, if required.
- All other personnel shall follow instructions and keep patients and visitors calm.
- Use telephone only for emergency calls whenever possible.
- Use stairs instead of elevators if you have no physical and health problem.
- Follow power saving principles. Turn off non-essential equipment such as copying machines, air conditioners, fans, electric toasters, coffee pots, etc.
- Minimize use of non-essential patient care equipment. Staff are to use stairs.
- If a severe power reduction is necessary, elevator use in all patient buildings will be limited to a maximum of one elevator. Elevator in non-patient buildings will be shutdown.
- Ensure that all telephones (not the lights thereon) throughout remain intact, fire alarm system throughout - remains intact.
- Cancel all elective procedures.
- Lanterns, extension cords, portable pumps, flush lights, torch, etc. are to be kept in a locker in the EOC, Emergency Department, all hospital wards. These are to be used only for emergency cases in ward, etc.

4.5. Business Continuity Plan

Policy: To ensure the continuity of essential services of the hospital and management of hospital isolation from external resources.

Procedures: Responding to emergencies, specifically in the wake of mass casualty events, requires additional staff, resources, communication, and preparation. The normal operations of the hospitals can rapidly become overtaxed to the extent that additional measures and resources must be committed in order to avoid the disruption of operations. In this regard, as part of its preparedness, the hospital shall have a plan to ensure business continuity during emergencies, that is, that the hospital can continue to provide its regular services to the community while simultaneously handling an emergency situation. The Business Continuity Plan (BCP) will be activated in emergencies to facilitate in continuing essential/critical services of the hospitals. The main elements of a hospital BCP shall be as follows:

- Plans and procedures for all readiness levels.
- Essential business functions.
- Succession of key leadership positions and delegations of authority for their associated duties; safekeeping of vital records and resources.

- Identification of continuity facilities.
- A plan for interoperable and redundant communications.
- Human resource planning.
- Validation of the plan through testing, training and exercising activities.
- Specify a plan for devolution of essential business functions.
- Provide a plan for reconstitution after the disaster.
- List and identify all hospital services and rank them in order of priority.
- Develop a utility management plan and protocols for the hospital, with clear actionable mechanisms to ensure proper maintenance, 24x7 availability of the routine/normal and emergency domestic and treated water systems, power systems, medical gas and vacuum systems, natural gas systems, heating, ventilation and air conditioning systems, elevators/lifts, fire/life safety systems.
- Identify the resources needed to ensure the continuity of essential hospital services, in particular those for critically ill and other vulnerable groups (e.g. pediatric, elderly and disabled patients).
- Ensure the existence of a systematic and deployable evacuation plan that seeks to safeguard the continuity of critical care.
- Coordinate with local health authorities, neighboring hospitals and private medical practitioners to ensure continuous provision of essential medical services to the community.
- Ensure the availability of appropriate back-up arrangements for essential life lines including water, power, food supplies, medical gases etc.
- Ensure the availability of adequate hospital supplies.
- Ensure contingency mechanisms for hospital waste management.

A key aspect of continuity of essential support services is the structural design and safety of the essential support service systems.

4.6. Checklist of Contingency Plans

Hospitals may not always require full activation of the HERP (refer to the above recommendation) for internal events such as fire, floods, chemical spills, and utility failures provided they have contingency plans and procedures established for these internal events to ensure a safe hospital. The <Insert the Name of the Hospital> HDSA recommended that the hospital develop and implement contingency plans and procedures required for certain critical events and essential services. Suggested plans are:

- Fire Safety Plan
- Flood Management Contingency Plan
- Hazardous Materials Management Plan
- Power Failure Contingency Plan
- Business Continuity Plan

CHECKLISTS OF RECOMMENDED ACTIONS FOR THE PLANS

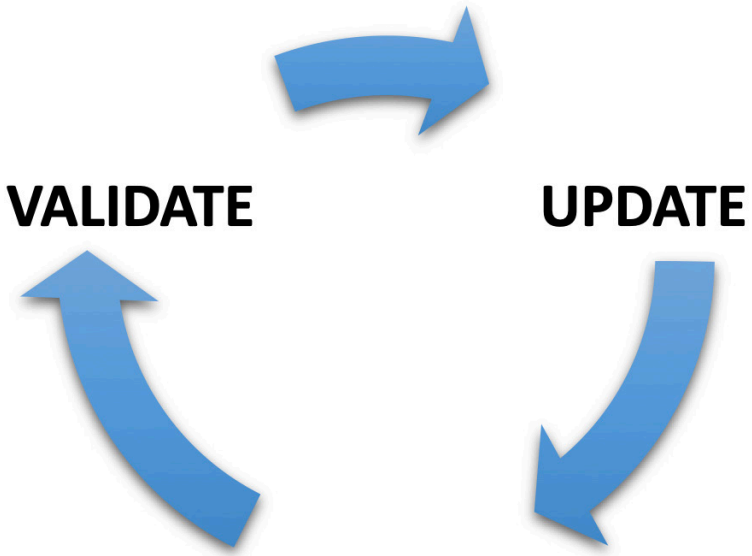
Indicators/Recommended Actions (RA)	Action Due	In Progress	Completed
RA: Keep track of plans for all readiness levels.	○	○	○
RA: Update of plans of succession of key leadership positions and delegation of authority for their associated duties.	○	○	○
RA: Development of a utility management plan and protocols for the hospital, with clear actionable mechanisms to ensure proper maintenance, 24x7 availability of the routine/normal and emergency domestic and treated water systems, power systems, medical gas and vacuum systems, natural gas systems, heating, ventilation and air conditioning systems, elevators/lifts, fire/life safety systems.	○	○	○
RA: Identification of the resources needed to ensure the continuity of essential hospital contingency plans.	○	○	○
RA: Coordination with local health authorities, neighboring hospitals and private medical practitioners to ensure continuous provision of essential medical services to the community.	○	○	○
RA: Ensure the availability of appropriate back-up arrangements for essential life lines such as water, power, food supplies, and medical gases.	○	○	○

ANNEX A:

HERP VALIDATION PROCEDURES

Validation Processes and Options

The <Insert the Name of the Hospital> HERP is developed based on unique circumstances of plans and procedures about preparedness, response and recovery to meet mass casualty management requirements. It is important to remember that the plan is never completely final. In other words, the plan once written, needs to be tested on ground and accordingly the shortfalls and/or gaps need to be reduced by altering and updating the same and finally ready for implementation. Again this process is never ending as can be seen from the following diagram that validation, revision/update and implementation go in a circle throughout the life of a plan once it has been developed.



Through this process of trial and error, the plan will be able to represent the reality on the ground better. Another reason for testing plans on a regular basis is to keep the plans alive in the minds of the hospital staff who will ultimately put it into action, during the time of an actual exigency. There are various ways and options to validate/test the HERP. Some of the emergency response simulation exercises to see the readiness of the system developed are described below.

Types of Validation Options

Activities	Timeline	Responsible Agencies
Tabletop Exercises	Ongoing	Lead: Individual Hospitals <Insert the Name of the Hospital>
Command Post Functional Exercise	Ongoing	Lead: Individual Hospitals <Insert the Name of the Hospital>
Evacuation Drills	Ongoing	Lead: Individual Hospitals <Insert the Name of the Hospital>
Full Scale Exercise	Real Time	Lead: Individual Hospitals <Insert the Name of the Hospital>

Table Top Exercise is a classroom based activity attended by internal and external participants. Internal participants include: IMT members, representatives of DHMC, administration, finance, nursing, logistics, supplies, etc. External participants are the representatives of UZDMC, such as the UNO, PIO, Upazila Engineer, police, army, Fire Service, NGOs, etc. The outcome expected from this exercise is a sound HERP ready for implementation by addressing the shortfalls and/or in the plan developed.

Command Post Exercise is conducted specifically to test the incident command system with the participation of key personnel incident management team (IMT). In case of testing a new HERP the venue may be any rooms in the hospital while revalidation exercise of an existing HERP is most suitably held at the EOC. As this exercise is controlled and conducted by the IMT and held at EOC with the existing manpower and equipment available at the EOC.

Evacuation Drill is most appropriate exercise to test evacuation plans developed by hospitals in case of partial evacuation of a ward or a section of the hospital or total evacuation of the hospital. A sudden onset disaster, such as building fire, building collapse, is a better choice for the evacuation drill in a mass gathering area (schools, hospitals, shopping complex, etc.). Invite external agencies including other hopsitals listed in the city and around for coordination and support hospital response during emeregncies.

Full-Scale Excercise is as close to the real thing as possible. It is a lengthy exercise that takes place on location using, as much as possible, the equipment and personnel that would be called upon in an actual event. A full-scale exercise is intended to test and evaluate the operational capability of the emergency management system interactively. It is a multiagency, multijurisdictional, multidiscipline operations-based exercise involving functional (e.g., Joint Field Office, emergency operations center) and "boots on the ground" response (e.g., firefighters decontaminating mock victims).

Validation Exercise Guideline

It is not hard and fast that the institutions conduct simulations with external assistance and resources. It is important that the plan is tested regularly through simulations and drills, which are evaluated and modified as appropriate. An institution is capable of doing simulations itself if it has trained staff (designated floor warden, drill coordinator, etc.) and established guidelines. The institution should however bring outside observers and evaluators for their constructive comments and suggestions for improvement for effective and efficient simulations. Following guidelines are provided for designing and conducting practical validation exercises by <Insert the Name of the Hospital> with internal resources or external assistance.

- Select scenario(s) of simulation(s) of a sudden onset disaster (natural or human-caused) that the hospital or (Insert the Name of the town) and around may face (earthquake, fire, building collapse, civil strife, bomb burst, etc.).
- Hospital Incident Management Team shall lead the simulations. Activate Emergency [Incident Operation Center (EOC)].
- Develop evacuation plan and draw evacuation and exit route maps.
- Consult response procedures (Chapter 3) referred to in the emergency response plan.
- Don't disrupt hospital operations, disturb patients and create panic. As there will be real patients during the exercise that needs to be cared for by on duty staff on that day, so involve off duty staff to play the exercise to prevent disruption.
- Inform and coordinate with police, fire department, neighboring community, and patients/ relatives in advance of the exercise.
- Information center: maintain updated information of casualties and death.
- Invite media personnel.
- Arrange essential services as per needs of the victims (provision of essential drugs, dressing/ plaster, surgery and management of dead bodies).
- Set up casualty reception zones based on triage categories (red, yellow, green, black)
- Manage internal and external traffic flow of emergency vehicles
- Manage security issues at the emergency department and EOC.

<Insert the Name of the Hospital> will decide how frequent they need to conduct an exercise. A suggestion is that there should be a designated person who should coordinate the exercise planning. The hospital can develop an exercise program in which small exercises can be planned with the different departments or test portions of the plan and do a full scale exercise at the end of the year to out altogether the small exercises.

ANNEX B:

DGHS CIRCULAR REGARDING DHMC

২৪ সদস্য বিশিষ্ট মেডিকেল কলেজ ও হাসপাতাল দুর্যোগ স্বাস্থ্য ব্যবস্থাপনা কমিটি ঃ

কমিটি ঃ (জেষ্ঠ্যতার ভিত্তিতে নয়)

ক্রমিক নং	কর্মকর্তাদের নাম ও পদবী	অবস্থান
১.	পরিচালক	সভাপতি
২.	অধ্যক্ষ, মেডিকেল কলেজ	সদস্য
৩.	বিভাগীয় প্রধান (সার্জারী)	সদস্য
৪.	বিভাগীয় প্রধান (অর্থো সার্জারী)	সদস্য
৫.	সহকারী পরিচালক (প্রশাসন)	সদস্য
৬.	সহকারী পরিচালক (অর্থ ও ভান্ডার)	সদস্য
৭.	আবাসিক সার্জন (ক্যাজুয়ালটি)	সদস্য
৮.	এস.এল.পি.পি/ষ্টোর অফিসার	সদস্য
৯.	নার্সিং সুপারিনটেনডেন্ট	সদস্য
১০.	ওটি ইনচার্জ	সদস্য
১১.	ব্লাড ট্রান্সফিউশন বিভাগ, প্রতিনিধি	সদস্য
১২.	উপ-পরিচালক, সমাজ সেবা	সদস্য
১৩.	পরিবহন কর্মকর্তা	সদস্য
১৪.	পরিসংখ্যানবিদ	সদস্য
১৫.	ওয়ার্ড মাষ্টার (ইনচার্জ)	সদস্য
১৬.	নিরাপত্তা প্রধান	সদস্য
১৭.	বিভাগীয় কমিশনার ঃ মনোনীত প্রতিনিধি	সদস্য
১৮.	পুলিশ প্রশাসন ঃ মনোনীত প্রতিনিধি	সদস্য
১৯.	ফায়ার সার্ভিস ঃ মনোনীত প্রতিনিধি	সদস্য
২০.	গ্যাস ও জ্বালানী বিভাগ ঃ মনোনীত প্রতিনিধি	সদস্য
২১.	বিদ্যুৎ বিভাগ ঃ মনোনীত প্রতিনিধি	সদস্য
২২.	পানি সরবরাহ বিভাগ ঃ মনোনীত প্রতিনিধি	সদস্য
২৩.	জনস্বাস্থ্য প্রকৌশল বিভাগ ঃ মনোনীত প্রতিনিধি	সদস্য
২৪.	উপ-পরিচালক	সদস্য-সচিব

০২/০৭/১৩

(অধ্যাপক ডাঃ খন্দকার মোঃ সিফায়েত উল্লাহ)
মহাপরিচালক
ও
লাইন ডাইরেক্টর
নন কমিউনিকেবল ডিজিজ কন্ট্রোল প্রোগ্রাম
স্বাস্থ্য অধিদপ্তর, মহাখালী, ঢাকা।

ANNEX C:

(NAME OF HOSPITAL)
Human Resources Capacity

1. HOSPITAL STAFF: Human Resources
(To be completed and then updated annually)

Table 1:
(NAME OF HOSPITAL) Staff by Categories (As of Date/Month/Year)

#	Category of Personnel	Sanctioned Posts	Proposed Additional Posts	Existing Status	Vacant Post
1	Class I Officers				
2	Class II Officers /Nursing Staff				
3	Class III Employees				
4	Class IV Employees				
	TOTAL				

2. PHYSICIANS: xx - As of Date/Month/Year
(To be updated annually by the hospital)

3. HOPE/HICS Graduates: HOPE & HICS –xx; HOPE - xx

Hospital	Male Doctor	Female Doctor	Male Nurse	Female Nurse	Others	Total
HOSPITAL NAME	xx	xx	-xx	-xx	-	xx

4. **(Name of Hospital) Capacity at a Glance** (As of Date/Month/Year) Hospital shall keep it up-to-date on a regular basis)

Table 2: (NAME OF HOSPITAL)) CAPACITY AT A GLANCE

Dept./Specialized Services	Number of Beds	Maximum Capacity	Remarks
Total			

ANNEX D:

GLOSSARY

Hospital Incident Command System (HICS)
HICS is a designated system of command and control, which includes a combination of facilities, equipment, personnel, procedures, and means of communication, operating within a hospital's organizational structure designed to aid in the management of resources for emergency incidents.

Hospital Incident Management Team (IMT)
IMT is multidisciplinary body of the Hospital IMS, which provides the overall operational leadership and over¬sight for all aspects of crisis management, coordinates the overall response, approves all action, response and mitiga¬tion plans, and serves as an authority on all activities and decisions during emergency response operations.

Incident Commander (IC)
Designated IC is responsible in conducting initial assessment of situation and decides on the level of activation of the HERP. Always activated when there's any declaration of hospital emergency 24 hours a day even during weekends, holidays and off hours. IC is responsible for the management of the incident within the hospital. Directs all of the activities within the Hospital Command Center (EOC), sets the operational periods, and devises strategies and priorities to address those objectives that are communicated in the Incident Action Plan (IAP). The IC may delegate some of his/her functions to the following Command Staff when there's escalation of the incident. If not delegation, IC will have to assume all command roles.

Triage
Triage is the process of categorizing and prioritizing patients to provide the best care to as many patients as possible with the available resources. During mass casualty situations, the number of patients and the severity of their injuries exceed the capability of the facility and staff, and patients sustaining major injuries have the greatest chance of survival with the least expenditure of time, equipment, supplies, and personnel are managed first. Maintaining patient triage operations based on a well-functioning mass-casualty triage protocol is essential for the appropriate organization of patient care.

Surge Capacity
Surge capacity is the ability of a health service to expand beyond standard capacity to meet increased demand for clinical care.

ANNEX E:

PLACEMENT OF PERSONNEL IN THE 31-BED HOSPITALS

(UPAZILA HEALTH COMPLEX)

(Ref. MIS, DGHS, HEALTH BULLETIN 2019)

UH&FPO

Administration-43	Hospital-6	Personnel-7	Indoor-28	Outdoor-7
Cleaning Services-1	*Office-6*	Statistician-1	*Medicine-1*	*OPD-5*
Cleaner-1	Medical	Head Assistant-cum-	Junior Consultant -1	RMO-1
Security Services-2	Technologist-1	Accountant-1	*Surgery-1*	Medical Officer-2
Security Guard-2	Junior Mechanics -1	Office Assistant-	Junior Consultant -1	Medical Assistant
Enforcement and	Office Assistant	cum-Typist-1	*Gyne and Obs-1*	(SACMO)-2
Public Health-2	-cum-	Store-keeper-1	Junior Consultant -1	*Dentistry-2*
Medical	Typist -2	Cashier-1	*Pathology-2*	Dental Surgeon-1
Technologist	Gardener -1	Office Sahayak-1	Medical	Medical
(Sanitary	Driver-1		Technologists-2	Technologist- 1
Inspector)-1	Ward Boy-3		*Nursing Services-12*	
Office Sahayak-1	Aya-2		Nursing Superviser-2	
Domiciliary Services	*Kitchen and*		Senior Staff	
-32	*Cooking-2*		Nurse-10	
Health Inspector-2	Cook-1		*Store & Discipline-2*	
Assistant Health	Moshalchi-1		Pharmacist-2	
Inspector-5			Anesthesia -1	
Health Assistant-24			Junior Consultant -1	
TB/Leprosy Control			*Radiology-1*	
Assistant			Medical	
(Communicable			Technologist-1	
disease)-1			*Ward Services-5*	

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