Ambulatory Surgery Center

Emergency Operations Plan

Effective Date:

Review/Revision Date(s):

1. **Introduction**: This Emergency Operations Plan (EOP) has been developed to manage a wide variety of emergency situations. These can include, but are not limited to, natural or man-made disasters. Coordination and collaboration with other local healthcare and response organizations is key in not only the mitigation and preparedness activities, but in the Ambulatory Surgery Centers (ASC) ability to respond and recover from a disaster. This EOP has been developed by the list title of person and/or safety/emergency preparedness committee and/or describe process and the medical staff.

The EOP is one component of the ASC’s Emergency Preparedness Program which also includes emergency preparedness policies and procedures and a communication plan. The Emergency Preparedness Program describes the emergency preparedness testing and training program. The EOP is a dynamic document and is reviewed at least annually and revised as needed based on a desire to maintain a safe and supportive environment for our staff and patients, on findings during drills and exercises, on lessons learned from actual events, and/or in order to meet accreditation standards and applicable rules and regulations. It references policies and procedures as well as appendices (contact lists, maps, tools, agreements, etc.).

The overall objectives for emergency preparedness and response are to

* Care for current constituents – patients/staff/family members/visitors
* Care for additional victims/survivors – disaster patients/community partners
* Protect organization – decrease risk and liability/business continuity planning

The EOP identifies the capabilities of the ASC and establishes response procedures based on our facility-based and community-based risk assessment using an all-hazard approach as described in the Emergency Preparedness Program. (See appendix 2 for Hazard Vulnerability Analysis.)

1. **ASC Information**:

Organization: Name

Address: Street address, City, Indiana, Zip Code

County: Name

District: ## (See appendix 6 for map showing Indiana Public Health Emergency Preparedness and Response districts.)

Telephone: ###-###-####

Fax: ###-###-####

Primary Services Provided: List the specialties served by your ASC, e.g., pain management, ophthalmology, general, orthopedics, ENT….. This list should include all business functions essential to your operatons that should be continued during an emergency

Emergency Contacts:

Director/Administrator Name Phone (land and/or cell) Email

Medical Director Name Phone (land and/or cell) Email

Alternate Emergency Contact Name Phone (land and/or cell) Email

Other Name Phone (land and/or cell) Email

Organizational Chart: See appendix 8 for current facility/company organizational chart.

1. **Authority**: The director/administrator has the authority to activate the EOP and to delegate activities/tasks to the center’s staff. Acting as the incident commander, the director/administrator has the authority to terminate the EOP’s response and recovery phases based on the progression of the event and the recovery needs.
2. **Healthcare Coalition**: In an effort to provide a safe environment and respond to an internal or external emergency/disaster, the ASC cooperates and collaborates with local, tribal, regional, State, and Federal emergency preparedness officials. (See Emergency Preparedness Program.)
3. **Facility Ownership**: Do you own your building? If not, then this section needs to cover how you have discussed emergency preparedness concerns with the landlord to ensure continuation of care if the structure of the building and its utilities are impacted. It is recommended that you sit on their safety committee (if they have one). More importantly, that they send a representative to sit on your safety committee. At a minimum you should meet with the landlord and develop a strategic plan for management of your area especially related to life-sustaining systems, life safety code regulation, management of utilities and failures of such, building integrity, building security, etc. This meeting must be documented.
4. **Hazard Mitigation**: The ASC has taken actions and/or completed activities to eliminate or reduce the probability of the event, or reduce the event’s severity or consequences, either prior to or following an emergency/disaster. Mitigation activities are derived from the Hazard Vulnerability Analysis/Risk Assessment, regulatory compliance, and lessons learned from other agencies and/or actual events/exercises in the ASC community.
   1. Communications
      1. Redundant methods of communication with staff, patients, partner facilities, and local emergency responders include, but are not limited to, the following.

* Landline and cell phone capabilities
* LiveProcess (a web-based event communication system used by the district Healthcare Coalition)
* WebEOC (a web-based event communication system used by local emergency management officials, district Healthcare Coalition, Indiana State Department of Health, and Indiana Department of Homeland Security )
* Audible paging system
* Internal 2-way radios
* 800 Mega Hertz (MHz) radio
* Satellite phone
  + 1. The ASC has a procedure for calling staff back to the organization, when needed, and a process whereby staff report if they become aware of an emergency and landlines/cell phones cannot be used to contact staff. The center may also post messages to staff on public radio and/or local television stations. (See appendix 5 for employee contact list.)
    2. The ASC has a procedure to communicate with patients to cancel procedures/appointments when necessary.
  1. Management of an incident
     1. The ASC director (or person with highest authority level) will assume the role of Incident Commander (IC). The ASC is aware that local emergency management officials use the Incident Command System (ICS) and healthcare organizations may use the Hospital Incident Command System (HICS). (See appendix 10 for HICS organization chart and Job Action Sheets.) Due to the size and depth of our staff, the ASC will use a modified HICS approach to managing an incident. The Incident Commander will always be appointed to manage an incident. The IC may activate the Operations Section Chief and Logistics Section Chief. Additional positions will be appointed as necessary to manage the incident.
     2. During an incident, the IC will communicate with local partner healthcare organizations and emergency management officials. (See appendix 6 for contact information.)
  2. Resource Management
     1. The ASC has established a Clinical Review Committee or its equivalent to determine how decisions will be made at the ASC given limited human and material resources.
     2. The ASC administration has identified the ethical issues that may affect operations, staff, and patients during an incident.
  3. Infection Control and Hazardous Materials and Waste
     1. The ASC has a staff person whose responsibility is Infection Control Prevention.
     2. The ASC has procedures for the isolation of patients who are discovered to have an infectious disease along with the procedures for the safe transfer of this patient to an appropriate facility. (Reference facility isolation policy and transfer agreement)
     3. The ASC has procedures in place for the proper collection and holding of biological wastes should established systems for such disposal be disrupted. (Reference biohazard and waste management policy/program)
  4. Staffing
     1. The ASC has call-back system to ensure that proper staffing levels can be maintained in an incident. If staff do not or cannot show up for work because of the incident, the ASC may cancel procedures, close for the duration of the incident, and/or use supplemental staffing (contract agencies, affiliated healthcare system staff, and/or qualified volunteers).

1. **Preparedness**: Preparedness includes developing the plans to address how the ASC will meet the needs of staff, patients, and others present in the ASC in various emergency/disaster situations.
   1. Policies and Procedures
      1. Based on the completion of the Hazard Vulnerability Analysis (HVA), regulatory compliance, the EOP, the Communication Plan, and best practices, the following policies have been implemented to manage the incident most likely to occur at this ASC (policies are in alpha order).

* Bomb Threat
* Chemical Spill
* Earthquake
* Emergency Tracking System
* Evacuation
* External Disaster (Mass Casualty Incident)
* Fire Plan (includes RACE, plan for loss of fire alarm system, testing and maintain fire protection system/equipment
* Influenza/Pandemic
* Internal Flooding/Water Damage
* Medical Documentation
* Role of ASC under waiver
* Security Breach
* Severe Weather
* Shelter-in-Place
* Utilities System Failure
* Volunteer Management
* Other policies based HVA identified risks or that directly are related to the Emergency Preparedness Program
  + 1. Policies and procedures are reviewed and updated at least annually.
  1. Plain Language Communications
     1. As there are no national/state standards for emergency/disaster code alerts, the ASC will use plain language in announcing the nature of the incident. If your ASC has not adopted plain language, change this section to reflect your current alert system .
  2. Evacuation (See Evacuation Policy and Procedure.)
     1. An evacuation can be implemented in phases. Relocation of patients, visitors, and staff away from the area of the emergency can be accomplished by moving to areas in adjacent zones. A full evacuation would be implemented if the impact of an emergency renders the ASC inoperable or unsafe for occupancy and is initiated at the direction of the Incident Commander.
     2. The ASC maintains alternative care site agreements with adjacent medical facilities and identified back-up alternate site. (See Appendix 15 for agreement.) If you would always close, you can state that here.
     3. The Incident Commander will assign staff to ensure required equipment, medications, staffing, communications, and transportation are mobilized to support relocation and management of patients during an evacuation.
  3. Resource and Asset Management
     1. Inventory management has been developed and is reviewed annually. Resource inventories include personal protective equipment (PPE), water, fuel, staffing, and medical/surgical/pharmaceutical equipment/supplies. (See appendix 11 for resource inventory list.)
  4. Utilities Management
     1. The ASC has a back-up generator that initiates during a power outage. This generator is maintained by list title/agency. The generator is a describe the name/brand of the generator. The generator can run for ## hours, based on the current fuel allocation.
     2. Alternative means of providing for water, non-potable water, fuel, medical gas/vacuum systems, and essential utility systems is in place. (See policy for Utility System Failure.)

1. **Response**: Response are the activities taken by the ASC and its staff immediately before (for an impending threat), during, and after an emergency/disaster to address the immediate and short-term effects of the incident.
   1. Incident Notification
      1. Notification of an external incident may come from other healthcare facilities, Emergency Medical Services (EMS), public health department, emergency management agency, fire services, law enforcement, district and state partners, and/or local knowledge (visible confirmation, warning via media, etc.).
      2. Notification of an internal incident will be brought to the attention of the discovering person’s supervisor and/or directly to the ASC director/administrator.
      3. As soon as able, if the situation warrants outside assistance, the ASC will notify local authorities. This may include law enforcement, fire services, EMS, public health, emergency management agency.
      4. If the ASC is part of a network healthcare system, that system will be notified (change this sentence to include the name of the system to which you belong, if you are not part of a network system, you can delete this sentence).
      5. If the situation continues to escalate beyond the capabilities of the local agencies, the ASC will notify its partners in the district healthcare coalition.
      6. Documentation will be maintained of the ASC’s efforts to communicate with community and healthcare partners. (See Communication Plan for further information.) (See Appendix 6 for agency contact information.)
   2. Initiating the EOP
      1. The decision to activate the EOP is made by the director/administrator or person with highest level of authority at incident awareness. This person will assume the role of the Incident Commander (IC).
      2. If the EOP is activated, the IC will instruct that a code alert be announced internally alerting all staff to the type of incident using plain/clear text. (ASC can include their code names here if they chose to do so.) (ASC can include name of overhead paging system or other method for alerting staff).
   3. Incident Management
      1. The IC should be aware of other resources that may assist the ASC in managing the incident and how to contact those resources. If local resources are taxed or depleted, the ASC may contact its partners through the district healthcare coalition.
      2. Efforts will be made to continue to maintain normal operating procedures regarding clinical activities and to ensure the safety of all patients, staff, and persons in the ASC during the incident.
      3. If there is potential or known damage to the facility, the IC will request a damage assessment to be completed by facilities management/plant operations.
      4. During an external disaster, the ASC will respond dependent on the type of disaster, its ability to be operational, the resources available to the ASC, the needs of the community healthcare system, and public health concerns. Having worked with the local jurisdiction emergency management officials and/or the district Healthcare Coalition, these options may include, but are not limited to, closing the center, functioning as an adjunct overflow surgery center to the nearest hospital, treating outpatients within the scope of its services, setting up and functioning as a triage center, supplementing its community healthcare partners with supplies and/or equipment that may be needed at other locations, acting as a rest/rehabilitation center for first responders and receivers, used as a charging station for home care patients needing electricity, family assistance center, …….
      5. Normal hours of operation may need to be extended during a community-based disaster and this determination will be made by the IC.
   4. Staff Responsibilities
      1. Staff will be identified by wearing a nametag/name badge at all times while on duty. This identification may be necessary to move about the community as an essential healthcare provider and therefore should be carried with the person at all times.
      2. The location of on-duty staff will be tracked during an emergency. If the on-duty staff are relocated during the emergency, the ASC will document the specific name and location of the receiving facility or other location. (See policy on Emergency Tracking System.)
      3. As necessary to maintain or enhance operations during an emergency/disaster, the staff call-back protocol may be initiated to contact off-duty staff. (See appendix 5 for employee contact list). If the disaster occurs outside of normal business hours, the IC will contact staff for their availability depending on the services needed by the ASC to assist in community-wide response efforts.
      4. If staff are called-back and expected to stay for extended period of time, they should bring certain items with them, if available. (See appendix 12 for call-back ready kit.)
      5. Staff are instructed that if a mass causality event has occurred that affects the ASC and they have not been contacted by the ASC, they should make an attempt to contact the ASC. If that is not possible and it is safe to do so, they should make an attempt to report to the ASC.
      6. Staff may continue to work in their assigned area, or be directed to assist in other areas and asked to perform various jobs, depending on the needs at the ASC. Staff responsibilities may change as the needs change. Just-in-time training may be necessary for staff during an incident response. Staff, not needed for direct patient care, are to assemble in the insert location for assignment.
      7. Specific roles/responsibilities of staff include, but may not be limited to the following.
         1. Incident Commander (IC)

* Initiate and terminate the EOP activation.
* Assume overall responsibility for incident operations.
* Work with Incident Management Team and staff to develop incident objectives and tasks.
* Activate additional HICS roles as needed to manage the incident.
* Utilize/distribute items in Disaster Supply Toolkit. (See appendix 13 for Disaster Supply Toolkit.)
* Delegate tasks to appropriate people/areas.
* Conduct or direct a facility damage assessment.
* Authorize resource acquisition and/or allocation of resources to partner agencies.
* Determine viability of the ASC and its functional operational status for expanded services, alternative services, and/or closure.
* Assign a scribe(s) to document actions taken during incident management and recovery.
* Manage incident recovery, both clinical and non-clinical.
* Conducts debriefing and ensures completion of After Action Report and Improvement Plan.
  + - 1. Operations Officer (Ops) if assigned. If not assigned, IC assumes these responsibilities.
* Track patients (including medical condition) on site at time of incident or sheltered-in-place during the incident and report findings to IC.
* Ensure clinical documentation of patient care and implementation of paper charting if necessary to include disaster chart for disaster victims treated at the ASC. (See appendix 14 for paper charting (if your facility has electronic medical records and disaster chart.)
* Determine staffing needs for incident management and make assignments as indicated.
* Discharge appropriate patients following normal procedures and/or cancel future appointments.
* Ensure safe transport of patients not able to be discharged or that need alternate care site.
* Ensure safe environment for patients and staff.
* Follow policies and procedures for specific hazards.
* Report to the IC.
  + - 1. Logistics Officer (Log), if assigned. If not assigned, IC assumes these responsibilities.
* Inventory current resources and track usage.
* Restock resources as needed.
* Ensure staff are provided with necessary items, given appropriate rest/rehabilitation space/time, and offered mental health services. Implement Staff Prophylaxis Plan, if indicated.
* Ensure provisions are available and provided for staff and patients that cannot leave the facility.
* Acquire and/or procure repairs to communication and/or technology systems.
* Acquire appropriate transport of patients or injured staff/visitors.
* Communicate with healthcare partners regarding needs and/or services that the ASC can provide during a disaster affecting the community.
* Report to the IC.
  + - 1. Clinical and Administrative Staff:
* Provide direct care to patients or injured. Report status to Ops or IC.
* Report any concerns regarding safety, patient care, resources (supplies/staff/space).
* Provide additional responsibilities as assigned during the incident.
  + 1. The ASC recognizes that its staff are critical for a positive outcome during an incident response and will make every effort to support them during and following the incident.
    2. Volunteers may be incorporated into the response efforts. (See Volunteer Management Policy).
  1. Patient Care and Support Activities
     1. If normal clinical operations cannot be maintained or are compromised during the incident, every effort will be made to ensure the best medical outcomes are achieved and for the safety of all individuals.
     2. If necessary, active clinical procedures and/or surgeries will be taken to a point of safe stoppage. If necessary, the patient may be transferred to an acute care hospital for completion of a surgical intervention.
     3. Non-emergency procedures/surgeries may be canceled/rescheduled. If the patient is present at the ASC prior to the start of their procedure/surgery, they will be released/discharged to leave the ASC dependent on external conditions. If the procedure/surgery is scheduled for later, every attempt will be made to contact the individual so they do not arrive at the ASC unnecessarily. Do you have the ability to get the patient schedule if you cannot get into the ASC to cancel future patients? If so describe that here.
     4. If ASC is needed to increase community disaster surge capabilities, strategies may include increasing space by converting non-patient care areas into patient treatment areas (break rooms, meeting rooms, etc.). Parking lots or other outdoor space may be used for registration, family waiting, triage, vaccinating, etc. Describe any other strategies you may already have in place.
     5. Patients may need to be held longer than 24 hours depending on the patient’s condition and or the community situation. If this is necessary, the ASC will contact the Indiana State Department of Health for a waiver. The ISDH Licensure division would need to be contacted for this waiver.
  2. Resource Management
     1. The ASC maintains essential supplies, pharmaceuticals, medical supplies, equipment, linens, water, and food for the type of services that it provides on a day to day basis. A resource inventory list is maintained.
     2. Additional resources will initially be obtained by following normal procedures. If these processes are ineffective, alternate vendors may be contacted. Additional resources may be available through the local Emergency Management Agency /Public Health Department. (see appendix 6 for HCC and Local contact information.)
     3. In case of a mass casualty incident, the ASC may be requested to curb normal operations, and send resources (including staff) to an alternate healthcare delivery location. If requested to do so, the transport of these resources will be the responsibility of the requesting agency unless otherwise determined at the time of the request.
     4. If necessary, due to depleted resources, the ASC may close temporarily.
     5. Although not normally required to provide substantive support to its staff and patients, the ASC does maintain a minimal supply of potable liquid (bottled water/soft drinks) and pre-packaged food in the event of a need to shelter-in-place for an extended period of time.
  3. Safety and Security
     1. Safety and security for staff and patients is of upmost concern for the ASC. During an incident, the IC/Safety Officer and appointed staff will maintain control of ingress and egress points. If safe, only one point of ingress/egress will be used during the incident and others will be locked.
     2. Staff are required to wear nametags while on duty.
     3. If the ASC has restricted access or locked down, proper identification will be required by responders and authorities for access.
     4. If a security breach or the incident requires, local law enforcement will be contacted. Additional support for security also may be obtained in coordination with the county Emergency Management Agency (EMA).
     5. Overflow waste and biological waste is managed. (See Waste Management Program).
     6. If infectious disease and/or hazardous materials is a concern during the incident, the ASC will follow standard protocols. (See Isolation/Decontamination/Hazardous Material policy...)
  4. Utilities
     1. The ASC has sufficient utility management for day-to-day operations. The maintenance of these utilities falls under the responsibility of list title or company responsible for this.
     2. In the event of an emergency or disruption of a specific utility (electricity, water, medical gases/air/vacuum, heating/ventilation/fuel) the Utility Failure protocols should be activated. (See policy on Utility System Failure.)

1. **Continuity of Operations**
   1. Efforts will be made to continue normal operations as long as possible if safe to do so.
   2. If the day to day services provided are interrupted, the IC/Administrator will determine the order in which to restore essential services. Can re-list essential business functions here, indicating priority ranking for which to continue or order in which to bring back in line. Additionally, the IC/Administrator will determine who are essential personnel. If not already on-duty, they may be called back into work. Non-essential staff may be released from duty or asked to stay and assume another role in the emergency response. Does the ASC have need/process for “work –at-home? If so, describe here.
   3. If the building is to be non-occupied for an extended period of time, the administration will determine if an alternate site can be used temporarily to provide continuation of some services. This may include activation of a Memorandum of Understanding (MOU) and/or Mutual Aid Agreement (MAA) with another healthcare provider or the use of a temporary location. Regulatory requirements will be followed if this is necessary. (list/describe who have MOU/MAA with and/or ID temp location and reference these as an appendix.)
   4. Succession planning process identifies individuals to potential fill key business leadership positions. A qualitied person has been authorized (in writing) to act in the absence of the administrator or person legally responsible for the operations of the ASC. (See appendix 9 for succession plan.)
2. **Recovery**: Recovery is those activities taken by the ASC to return the facility to normal business operations or new normal operations. Short-term actions assess damage and return critical and necessary functions to minimum operating standards; long-term actions focus on returning all ASC operations back to normal operating standards or developing new procedures. Recovery is an ongoing process and begins as soon as a response to an incident occurs.
   1. Deactivation of the emergency response will be made by the Incident Commander or agency executive when the center can return to normal or near normal services, procedures, and staffing.
   2. Based on damage assessments and evaluation of operational needs, incident recovery plans will be developed and implemented to restore the systems critical to providing care, treatment, and services during and after an emergency. Each individual department and/or unit shall be responsible for initiating this activity. The command center will remain operational during this period, but may gradually de-escalate as warranted. Meetings shall be scheduled as deemed appropriate by the incident commander. Criteria that shall be considered as part of the recovery process include:

* Facility repair/restoration
* Utility system restoration
* Equipment replacement
* Supply inventory restoration
* Patient care support
* Staff support
* Financial issues
* Traumatized staff members
  1. Incident Command Team

1. Keep ASC officials and Healthcare Coalition partners informed of the status of activities of the recovery process, including the resources necessary to continue facility recovery.
2. Maintain documentation in the recovery process to include, but not limited to, salvage, records and files, communication (include computer equipment), medical supplies, and other equipment.
3. Plan for personnel, supplies, and modified operation in incident that require an extended period of recovery (e.g., weeks-months).
4. Offer modified normal clinical operations in the event of an incident considering alternate locations and methods for continuity of operations.
   1. Critical Incident Stress Debriefing
      1. Mental health resources will be made available to staff and patients during and following the incident through the healthcare coalition partner initiatives. (See appendix 6 for HCC and local contact list.)
   2. Physical Environment
      1. Damage to the facility will be assessed by the Director/Administrator, Safety Officer, Facility Maintenance, Risk Manager in conjunction with architects and building inspectors as indicated. Arrange appropriate inspections to determine safety for occupancy.
      2. Damages and emergency repairs will be documented by pictures/video.
      3. Utility systems (internal and external) will be evaluated for safe and proper function and for impact on facility/environment.
      4. Restoration of normal communication will be a priority.
      5. Debris removal and clean-up will be accomplished by safest process available. If necessary, a restoration company will be contacted do this.
      6. Decontaminate equipment and facility, if necessary.
      7. Building re-occupancy will be based on authorization from authorities (law enforcement/fire services/building inspectors).
   3. Resources
      1. An inventory of supplies and equipment will be completed.
      2. If any supplies or equipment are damaged, pictures/video will be used to document this damage.
      3. Additional supplies or equipment will be requisitioned to restock / replace damaged/used supplies and equipment.
      4. Return equipment and supplies from holding site or replace as needed.
      5. Machines requiring calibration or medical device testing will be completed following normal protocols prior to use following the incident, if indicated.
   4. Clinical Activities
      1. Patients will be contacted to reschedule canceled appointments.
   5. Administrative
      1. Ensure documentation is complete and accurate for all incident response, communication efforts, and tracking.
      2. Keep detailed records and ensure that documentation is protected.

* Maintain accurate records of all related expenditures.
* Prepare claims for potential state and/or federal reimbursement.
* Analyze the impact of the emergency/disaster on the budget, including direct operating costs, costs from increased use, all damage or destroyed equipment, replacement of capital equipment, and construction-related expenses.
  + 1. Follow up with staff injury reports, as appropriate.
    2. Develop mechanism for re-staffing.
    3. Notify the community regarding resumption of services.
    4. Contact insurance company and make appropriate claims.
  1. Incident Evaluation
     1. Conduct an incident debriefing/hotwash will all staff. Attempt to obtain input from the community support agencies as well as patients affected by the incident and the ASC response.
     2. Complete an After Action Report (AAR) that includes strengths and opportunities for improvement along with an Improvement Plan (IP).
     3. Review and modify EOP, Communication Plan, and associated Policies and Procedures based on lessons learned and best practices. (See Emergency Preparedness Program.)
     4. Test IPs in future exercises. (See Emergency Preparedness Program.)

**Acronyms** (Definitions can be found in the Emergency Preparedness Program)

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| AAR | After Action Report |
| ASC | Ambulatory Surgery Center |
| EMS | Emergency Medical Services |
| EOP | Emergency Operations Plan |
| HICS | Hospital Incident Command System |
| HVA | Hazard Vulnerability Analysis |
| IC | Incident Command/Commander |
| ICS | Incident Command System |
| IP | Improvement Plan |
| ISDH | Indiana State Department of Health |
| Log | Logistics Section Chief |
| MAA | Mutual Aid Agreement |
| MHz | Megahertz |
| MOU | Memorandum of Understanding |
| PPE | Personal Protection Equipment |
| Ops | Operations Section Chief |