

National Health Emergency Plan

Guiding Principles for Emergency
Management Planning in the
Health and Disability Sector

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MANATŪ HAUORA

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Foreword

Emergency management planning is about being prepared for events or incidents that stretch our ability to cope beyond our normal day-to-day capacity.

While an emergency is usually devastating in its own right, we can prepare as much as possible to reduce its impact and speed the recovery process. In some cases being prepared can help prevent an emergency situation from turning into another kind of crisis. It is this topic – what you can do to prepare for the ‘unexpected’ – that is the focus of this document.

Over the years, New Zealand providers have had extensive experience in dealing with major incidents or events: the 1918 influenza pandemic, the Napier earthquake in 1931, the sinking of the *Wahine* ferry near Wellington harbour in 1968, Cyclone Bola in 1988, through to more recent crises such as the 2003 SARS outbreak, which demonstrated how international crises can also affect New Zealand.

These kinds of events have shaped the way we prepare for emergencies, and have also shown the important role that providers play in responding to major incidents. Although emergency preparedness can never be a perfect science, we can take what we have learned from our experiences to continue to improve our ability not just to cope but also to exceed expectations.

These guiding principles are not standards. This document has been prepared on the premise that providers need to consider as wide a range of options as possible in the emergency preparedness process. Many of the ideas contained in this document will be relevant only to some providers, but it is designed to be as comprehensive as possible. Use it as a guide, think about how it might be relevant to your situation, and, most important of all, take action now.

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Part One: Introduction

Emergency planning and health care go hand-in-hand. In fact a significant part of our health sector is responsible for dealing with health-related emergencies on a day-to-day basis. Dealing with health issues and problems for these providers is 'business as usual'.

As a result, health service providers¹ will always be at the centre of any major emergency response process, providing medical attention and social services after a natural event such as a flood or earthquake, a major transport accident, a serious flu epidemic or even – as recent events have shown internationally – a terrorist attack. Invariably it is how well a provider prepares for an emergency that determines an effective response and shortened recovery process for those affected.

This document aims to help providers build on their existing emergency management plans by introducing four guiding principles that reflect the latest thinking in emergency management planning for the health sector. These guiding principles have been developed by referencing existing standards in New Zealand and overseas. Each guiding principle is followed by a series of suggested action points that providers can use as part of their emergency management planning processes.

The Ministry of Health, through this document, aims to get providers thinking about what kind of emergency situations they may face and how to tailor their planning. Planning may not take into account unforeseen events, though planning will better prepare an organisation to meet an unforeseen event. In almost any emergency situation communities will look to their local health services for help and guidance, so it is vital that they are ready for what the future may bring.

Who is this document for?

This document is aimed at all providers of health services, including:

- public and private hospitals
- public health services
- ambulance services
- primary care services, such as Public Health Organisations
- residential-based services and facilities (including continuing care hospitals)
- mental health services
- disability services
- other contract-based services, such as home care and community-based services.

Not all the information in this document will be relevant for all providers. Some providers will play a limited role appropriate to their size, capacity or responsibilities, whereas a larger provider with access to more resources may take an expanded or leading role.

¹ Note: 'Health service providers' will be known as 'providers' from this point onwards.

Providers will play a role in any response effort that involves their local community. This document aims to encourage all providers to think about what their role is, and to put the foundations in place to ensure they are as ready as possible.

The emergency management context

The Ministry of Civil Defence & Emergency Management (MCDEM), Department of Internal Affairs, is responsible for the administration of the Civil Defence Emergency Management Act 2002.

The National Civil Defence Emergency Management Strategy (2004)² promotes the concept of comprehensive emergency management, which incorporates a consideration of the '4 Rs' (reduction, readiness, response and recovery) in the planning process. The 4 Rs are most effective when activities overlap without barriers between the Rs, thus preventing gaps developing. For example, when considering readiness and response, planners should take into account any residual risk (after mitigation has taken place) and the implications for recovery.

The Ministry of Civil Defence & Emergency Management works with other agencies such as the Ministry of Health to facilitate and guide emergency planning activities. Providers will link to the National Health Emergency Plan (NHEP), which will provide the national strategy and guidance for the health sector. District Health Boards (DHBs) are required to have in place major incident and emergency plans, which are community-based integrated health plans that link to CDEM Group³ planning and the regional health groups.

Sound business practice dictates that providers have an active service continuity plan, which is embedded in daily business practices to minimise service disruption. Providers are encouraged to refer to their local DHB and CDEM plan for information on intersectoral and interagency planning. A community that plans together, exercises and trains together, responds together and recovers together will be a 'resilient' and strong community.

What is an 'emergency'?

The defining characteristic of an emergency event or situation is that usual resources are overwhelmed or have the potential to be overwhelmed. For example, a car crash with casualties is likely to be labelled an incident (business as usual) for many hospitals but a major emergency for an accident and emergency medical centre. Likewise, an outbreak of influenza is a normal winter occurrence, but a pandemic (an influenza outbreak on a larger scale) is a major emergency.

The kind of emergency events or situations this document covers fall into two categories:

- a specific event with a clear beginning (even if this is not immediately apparent at the time), an end and a recovery process

² Ministry of Civil Defence & Emergency Management, 2003.

³ Ministry of Civil Defence & Emergency Management, 2002.

- a situation that develops over time and where the implications are gradual rather than immediate.

Examples of the first kind of event are disasters caused by a natural hazard (an earthquake, flooding, tsunami or bush fire), a specific terrorist attack such as happened on 11 September 2001 in New York, or a transport-related accident such as a plane crash.

Examples of the second kind of event are an outbreak of influenza or a disease like the SARS 'epidemic' in overseas countries, or even a bio-terrorist event such as the anthrax crisis that took place in 2001. In these cases, the implications of the situation may only become known over time.

To cope with an emergency situation, a hospital or other provider must have – or be able to create – 'surge capacity'. This refers to the provider's capabilities to expand and reprioritise services to cope with a major emergency.

Some emergencies raise issues that balance the welfare of the community against the welfare of individuals. For example, the need to triage at a mass casualty event, or to isolate infectious disease cases and contacts, may mean adopting a strategy that would bring greater benefit for the majority of the population but may impinge on individual freedom. Planning must address such issues. Emergency preparedness allows usual resources to be utilised more effectively and extra resources to be employed.

How to use this document

This document uses four guiding principles to create an overview of emergency management planning. It works from the premise that the wellbeing of health consumers must always be the ultimate goal. This four-principle approach has been developed specifically for the health sector, although it still includes many elements of the 4 Rs planning approach.

Part Two: The Four Guiding Principles

This document is structured around four guiding principles modelled on the NZS 8134:2001 Health and Disability Sector Standards prepared by Standards New Zealand with the Ministry of Health. These principles aim to provide an overview of the different aspects of emergency planning for providers.

The principles cover:

- activating and co-ordinating a response
- managing service delivery
- setting up a safe and appropriate environment
- organisational management and structure.

Structure

The principles are structured into three main sections: indicators, examples of real incidents and suggested activities.

Indicators

One or more indicator follows each of the four principles. These indicators are designed to act as a checklist of achievements that help indicate the principles are being put into practice.

Examples of real incidents

Examples are included to provide context and to help providers decide how relevant each of the suggested activities is for them.

Suggested activities

The suggested activities give more detail about what a provider can do to achieve the indicators and principles. Whether they are relevant depends on the type of organisation, the type of emergency, and who your 'clients' are. By working through the indicators and suggested activities, considering which ones are relevant and then putting them into practice, you will have the making of a comprehensive emergency management plan.

Overview of guiding principles

Principle 1: Activating and co-ordinating a response

Providers are able to respond quickly and effectively to the health care needs of patients/clients following a major incident while ensuring the continuation of the community's health services.

Principle 2: Managing service delivery

Providers are able to provide services that, as much as possible, meet the needs of patients/clients and their community during and after an emergency event, even when resources are limited.

Principle 3: Setting up a safe and appropriate environment

Providers should aim to provide services that are managed in a safe, efficient and effective manner, given the circumstances of the incident.

Principle 4: Organisational management and structure

The provider is able to establish efficient and effective governance that ensures major incident and emergency management services are planned, co-ordinated and appropriate to the needs of the population.

Principle 1: Activating and co-ordinating a response

Providers are able to respond quickly and effectively to the health care needs of patients/clients following a major incident while ensuring the continuation of the community's health services.

Indicator for Principle 1

- 1.1 A provider is able to immediately initiate a response and, where appropriate, establish an 'emergency operations centre' to co-ordinate and mobilise resources.

Examples of real incidents

The following examples identify the number of casualties; the initial inability to activate, coordinate and deactivate an effective response. These examples also highlight the difficulties emergency services face at the incident site; the effects on those injured and to those responding and lessons learned.

Football crowd crushed in Hillsborough, United Kingdom, 1989:⁴

- 95 dead, 159 injured
- difficult to reach and treat the injured at the scene
- unprecedented crush injuries – difficult at first to ascertain the nature of the injuries
- extensive social and psychological trauma
- prompted alterations to stadia and health service support for sports events.

Fog causes multiple car crashes on the A12, Essex, United Kingdom, 1997:

- 157 injured – no deaths
- 26 separate road accidents in two hours
- extreme difficulty in establishing command and control at the scene
- hospitals on standby but major incident procedure not enacted.

Suggested activities for Principle 1

Plan

Define and document major incident and activation criteria in your emergency management plan (see Ministry of Health's activation response phases – Appendix 4).

When you do this, think about what major incidents or events your service may be faced with (based on your location, the make-up of your community and other variable factors). The likelihood of certain events will be higher in some areas than others. For instance, is your region more at risk of earthquakes, infectious disease, floods, volcanic eruptions, tsunami or bush fire, or are you close to a main highway and therefore would

⁴ Department of Health, 1998.

be required to help in the event of a major vehicle crash or hazardous materials incident? Are you close to a large stadium and therefore likely to be required to deal with crowds of people? A prioritised table of hazards (both natural and technological) can be found in the CDEM Group plans on the Ministry of Civil Defence & Emergency Management website.⁵

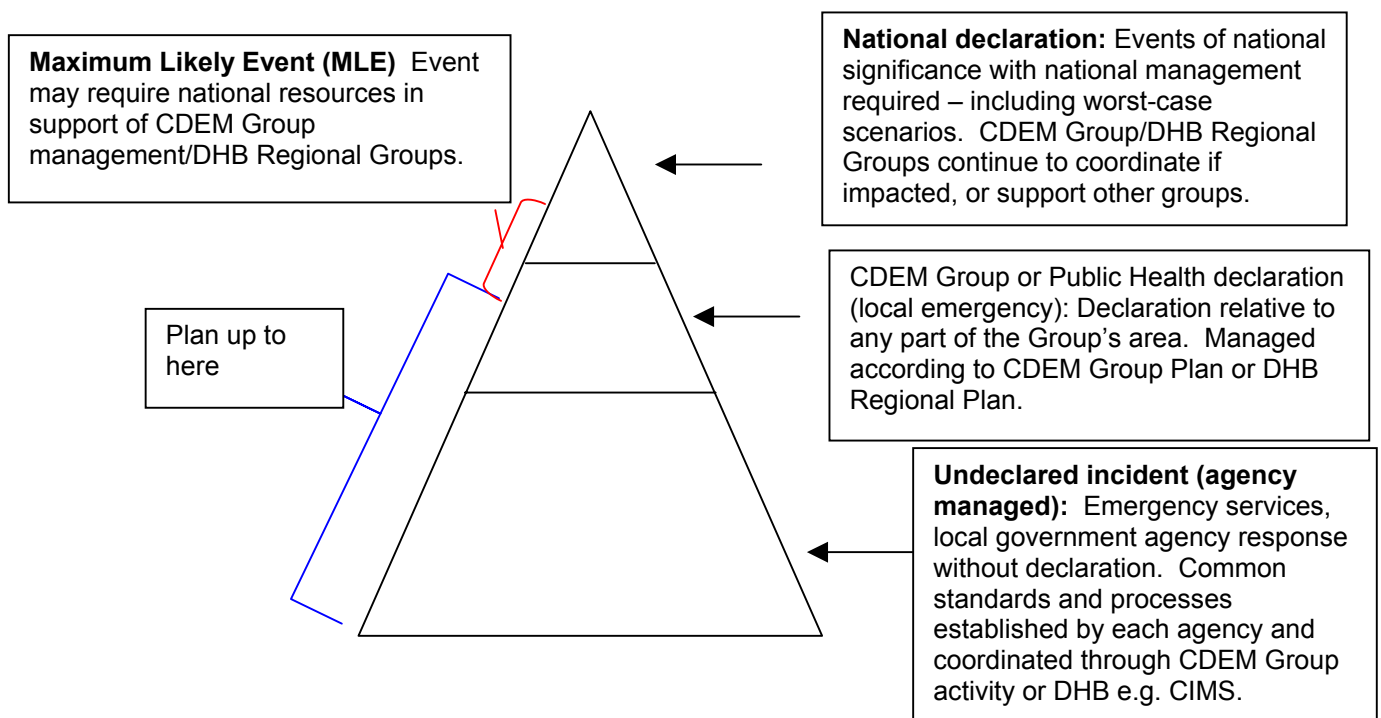
Also think about other factors, such as who makes up your community. Do you have a large older population, are there students with disabilities mainstreamed in your local schools and do many of your community members speak languages other than English?

Document community resources that your organisation could use in an emergency. For example, during Cyclone Bola on the East Coast in 1988, local marae were used as shelters for those who had nowhere else to stay. Because the marae had kitchens and sleeping places, they made ideal shelters.

Have an up-to-date list of contact details for all identified community support groups, including iwi, hapū and interest groups.

Identify systems and processes for contacting and accessing community resources and community support or interest groups. DHBs are already required to do this in their Major Incident and Emergency Plan.

The levels, or basis of planning may be viewed as a pyramid⁶:



⁵ Ministry of Civil Defence & Emergency Management, Wellington, New Zealand: www.mcdem.govt.nz

⁶ Ministry of Civil Defence & Emergency Management, 2002.

Emergency operations centre

Identify a location to physically establish an emergency operations centre (EOC) and arrange for an alternative location in case the first option is unable to be used. Include the process for establishing the EOC in your emergency plan.

List the essential equipment and supplies required for the EOC in your emergency plan. Include evidence in your plan that all your resources are readily available, and ensure that those who need them know where to find them.

Include evidence of back-up electricity and communication systems for the EOC in your plan. For example, do you need a generator, and if so, how would you go about arranging one, getting it delivered and connecting it into your system?

Call-back system

Develop and maintain a call-back system and document this as an appended contact list and prioritised communication tree in your plan.

Have an alternative call-back communication system (such as radio broadcasts) worked out and documented in your plan in the event of a telecommunications failure. An alternative strategy may be for all staff to automatically report for duty in the event of a civil defence emergency declaration, as telephone lines could be inoperable.

Check that the call-back system accounts for the different types of staff required to deal with different types of incidents (e.g., mass casualty, biological, chemical).

Organisational details

Create 'action cards' that set out the duties and actions required of key staff in an emergency. An action card should briefly and simply describe the tasks that person is required to undertake during the emergency – it is like a job description. Each staff member will need to be familiar with what their emergency role requires them to do *before* they are required to do it.

Create and document an organisation structure for emergency management. This is not likely to reflect the usual management structure and will need to be based on the New Zealand Co-ordinated Incident Management System (CIMS) (see Appendix 3). The emergency management structure contained in each DHB's Major Incident and Emergency Management Plan is also based on CIMS.

Identify an overall co-ordinator for the emergency response, and an 'incident management team'. Use your DHB's Major Incident and Emergency Management Plan as a guide.

Principle 2: Managing service delivery

Providers are able to provide services that, as much as possible, meet the needs of patients/clients and the community during and after an emergency event, even when resources are limited.

Indicators for Principle 2

A provider:

- 2.1 can establish a system to ensure that the necessary services, equipment and supplies are available to support the required response and meet the needs of patients/clients
- 2.2 ensures it has identifying information about affected patients/clients that is accurate, current, confidential and easily accessible
- 2.3 establishes a process to ensure casualties are continually prioritised and treated according to their level of need and their ability to benefit from treatment
- 2.4 communicates appropriate information to patients/clients, other organisations and staff at the right time and in the right way
- 2.5 is able to manage the rehabilitation and restoration of the health care services and health status of the population as appropriate for their contracted services
- 2.6 can provide suitable decontamination facilities, equipment and procedures to protect health care workers and presenting patients/clients following a major hazardous substances spill
- 2.7 can secure (lock down) their key facilities and maintain a single point of entry
- 2.8 establishes procedures for minimising the spread of infectious diseases into the community and to staff
- 2.9 has alternative communication channels to use in emergencies when normal telecommunication facilities are overloaded.

Examples of real incidents

These examples highlight the need for an effective co-ordinated effort amongst responders.

Train crash in Clapham, England, United Kingdom, 1988:

- 35 dead, 123 casualties
- failure to make use of all the locally available hospitals
- too many health care workers arrived at the scene
- health service communications systems were inadequate
- variations in protective and identifying clothing worn by National Health Service emergency services staff caused confusion
- criticism at the public enquiry led to a national standardisation initiative.

Train derails in Makikihi, New Zealand, 2001:

- a train collided with a stock truck near Timaru
- 20 seriously injured, eight with minor injuries
- St John Ambulance Christchurch alerted duty managers at five hospitals likely to receive casualties
- Waimate District Council civil defence team set up at community hall in Makikihi to care for uninjured passengers
- Timaru Hospital activated mass casualty plan
- hospitals were given regular updates by the EOC
- an example of good communication and co-ordination between different agencies and providers.

Suggested activities for Principle 2

Provision of services, equipment and supplies

Responsibilities include arranging or providing for:

- a process for managing mass casualties, regardless of the cause (including having isolation spaces, and being ready to evacuate and relocate patients/clients if needed)
- the development of logistics (especially transport) arrangements to cater for patient/client transfer and discharge
- the development of logistics (transport and equipment delivery) arrangements if triage points are set up as part of a casualty clearing station at the scene
- a system of triage that meets New Zealand standards
- health care services at welfare and evacuation centres – utilisation of existing facilities should be considered as this provides a familiar practice environment
- continued operation of ambulance services
- a system to handle enquiries from staff, the community, families of those directly affected and other emergency response teams – it is also important to be able to

provide advice, information and support to responding health services to enable them to meet their demands during the major incident

- having processes for authenticating, registering and assigning volunteers who offer assistance during an incident
- the needs of staff called in to assist with an emergency, particularly those from out of town, for example, accommodation, catering, canteen hours, food stock, child-care, contact with family, spiritual and support needs.
- critical sources of information, equipment and supplies for biological, chemical and radiological incidents
- the use of GIS formatted technology to map health care facilities, contact details, utilities, fire safety systems, resources and other agency locations, for example, ambulance services, alternative 'health care' facilities, education institutions and fire and police services.

Internal

Identify key internal relationships and dependencies. For instance, understand what your organisation depends on for its usual business operations, then work out which ones you will need in an emergency situation and plan to have them available. This could include people or services (e.g. a power generator in the event of power cuts), or even simply knowing how to contact key personnel if the emergency takes place outside normal business hours.

Identify the role of designated officers (e.g. medical officers of health) so that they can carry out their statutory duties in the course of an emergency without hindrance.

External

Maintaining good and effective relationships with other organisations before an emergency situation is vitally important as they could be of assistance to your organisation during an emergency.

Identify key external relationships and dependencies. This could be providers of non-related health services (such as food, telecommunications or security) or other providers you might need to work with in an emergency situation.

Values and beliefs

Include processes and systems for contacting and accessing iwi and hapū representatives and whānau during a major incident. Identify these in your emergency management plan.

Include systems and processes for responding to the cultural values and beliefs of all patients/clients in your emergency management plan.

Advocacy and support

Include processes and systems in your emergency management plan for contacting and accessing translators and patient advocates.

Set up Memorandum of Understanding (MOU) agreements with translator and advocacy groups.

Include systems and processes in your emergency management plan for meeting the spiritual needs and beliefs of those affected. By planning for these things now, you have more chance of speeding the recovery rates of those you provide services to. Have in place systems and processes for accessing and implementing independent advocacy services, interpreter services, counselling, consumer support groups and cultural support persons/groups for patients/clients.

Consider the needs of people with sensory disabilities, for example, people who have guide dogs, including the scenario of such a person, through the emergency, becoming separated from their dog.

Have an up-to-date list of contact details (including after hours) for assistance with people who have sensory disabilities.

Personal privacy/dignity

Include an up-to-date list of contact details for spiritual advisers and ministers of religion.

If possible, create a separate space for dying patients/clients and their families/whānau and loved ones.

Information management system

As much as possible, existing information management systems should be used to collect, store and analyse information during and after an event.

Use of existing system and NHI numbers

Ensure the existing National Health Index (NHI) system is operational for patient tracking. If patients/clients do not have NHI numbers, ensure a 'temporary' system is established to allocate a unique identifying number for when they are first treated and until an NHI number is allocated.

Establishing a unique identifier

If your organisation is not required to collect data according to the New Zealand Health Information Service's (NZHIS's) standards, then set up a system that allows you to collect adequate patient detail to safely manage this information.

Put in place a system to 'back capture' information collected manually or electronically on a system not linked to the National Health Index system.

Ensure that any hand-completed forms collect enough information to meet NHI requirements: you will require name, date of birth, gender, ethnicity, address and New Zealand resident status.

Determine how you will enter information relating to the emergency response into your usual patient information management system in an accurate and timely manner.

Put in place systems and processes that minimise the risk of consultation interruption or of being overheard by a third party, and the release and public exposure of patient information.

Keeping track of people

If people are coming to your facility after an incident for treatment or services, it is likely that family members will call to enquire after them. Ensure you have a system in place that enables you to record people coming into your facility to 'track' them around and also record enquiries made so that matches can be made later.

Information on staff numbers, expected requirements for staff and availability of staff in what could be a rapidly changing environment is essential. An existing staff management system that is flexible and robust before an event will facilitate staff management after a major incident.

Develop a system for recording and managing volunteers.

Identify procedures for isolating and quarantining cases and contacts and for contact tracing.

Keeping track of facilities, equipment and supplies

Have a bed status information system that will facilitate bed management when demand is heavy for bed space.

Develop an inventory of critical equipment so that when demand is high or there is failure of equipment, it is known where equipment is and its use can be prioritised. Link this with contact information for suppliers and repairers of equipment.

Ensure that the providers of essential supplies are documented and that there is an inventory of where in your organisation the supplies are used and by whom. This facilitates access of supplies from areas of low need to high demand.

Monitoring and recording

Put in place a system to collect, collate and analyse information about disease incidence from providers to monitor and predict the event. This system will also identify patterns of disease distribution.

Establish a rigorous system for recording the financial costs of the incident.

Prioritisation of care delivery

Put in place a system to provide pre-hospital primary care in the community. This helps avoid overloading services in an emergency department.

Have a system to ensure that appropriate care is available according to need and resources.

Have a system that ensures existing patients/clients who are discharged into the community will have adequate follow-up care.

Surge capacity

Identify contingencies to deal with a surge in demand for staffing and facilities (eg, arrangements for early discharge and home care; cross training for redeployment; regional arrangements to bring in additional specialist staff or equipment).

Check that your plan covers all parts of the health sector that may come under strain or be required to be reprioritised: ambulance, public health, primary health, secondary and tertiary services, mental health services, support services.

Communication strategies

Create a communications plan. DHBs are required to have a communications plan as part of their Major Incident and Emergency Management Plan, and it is a good tool to include in other providers' emergency plans. The communications plan needs to identify key people, audiences, communication systems and the diagrammatic flow of information.

Prepare templates for standard information that will be updated regularly.

Pre-prepare or utilise existing information⁷ on where patients/clients can go for more information, and use this in information leaflets or press releases and other fliers. For example, create a list of counsellors in the area who might be available to help following an emergency, and have their details ready to distribute. During the February 2004 flood event, an 0800 number was established to direct those affected to a 'one-stop shop', which assisted people with enquiries and directed them to the appropriate agency for response.

Waste and hazardous substances management

Ensure decontamination facilities are available and adjacent to the emergency department. In an emergency situation it is not always possible to have ideal facilities, but thought needs to be given to how these facilities might be provided.

Consider waste and hazardous material disposal in conjunction with regional councils.

Make protective equipment and clothing available to those involved in the response effort, and make sure they know how to use it.

⁷ Refer to your local DHB, Public Health Services, Ministry of Health and/or Ministry of Civil Defence & Emergency Management for information pamphlets. Other national bodies provide information specifically designed for their patients/clients, for example, Royal New Zealand Foundation of the Blind.

Make provision for the management of those people who arrive without prior screening or whose personal and clinical details have not been captured.

Ensure you have procedures for security and the lock-down of health facilities to help prevent contamination.

Restoration of health care services

Pre-event: develop a recovery plan, which should include how to monitor the health status of your community during and after the incident.

Post-event: communicate effectively with relevant audiences after a major incident.

Review the physical and mental health needs of the affected community.

Reconcile expenses incurred by your own organisation and others you managed during the response.

Principle 3: Setting up a safe and appropriate environment

Providers should aim to provide services that are managed in a safe, efficient and effective manner, given the circumstances of the incident.

Indicators for Principle 3

- 3.1 The provider is able to provide emergency management services (when facility based) in an environment that promotes safety.

Example of a real incident

This incident exhibited coordinated planning, sensitivity and cooperation amongst the responders and the media towards the well being of the survivors and the families of victims.

Shooting, Dunblane, Scotland, United Kingdom, 1996:

- 16 children and 1 adult killed, 12 children and 3 adults injured
- a shooting incident with nationwide reverberations
- a major impact on community health care services
- there was continued collaboration between agencies to meet the community's needs and the management of media.

Suggested activities for Principle 3

Identification

Require health care staff to wear name badges at all times. Ensure visitors to the site have organisational identification.

Create a system for identifying volunteers.

Ensure the system/process for the care of personal belongings of patients/clients, including discreet identification with their name or other unique identification, is identified in the emergency management plan.

Create systems for non-visual communication with blind, vision-impaired and deaf-blind people and train staff to communicate confidently with people who cannot see. Systems might be a network of people to act as buddies or wardens in times of emergency who know 'sighted guide' techniques and how to communicate effectively with blind people.

Security

Your security plan should include:

- a process for calling up (recruiting) extra security personnel

- identify which areas will need increased security
- the agreed role of the police for security and traffic control.

Include systems and processes in your emergency management plan for managing visitors.

Media

Include a media management component in your emergency management plan. Some suggestions include:

- identifying a spokesperson for media enquiries
- putting a system in place for communicating with the media (e.g., through press conferences and having a dedicated fax line – if communication lines are still in place – for media releases)
- providing consistent information by developing media management plans with an interagency focus – this is important when an incident involves different agencies
- ensuring that every time a written communication is given to the media, the time and date are noted on the release.

Personal safety

Provide advice and direction to volunteers to ensure they are aware of which patients/clients require the most supervision.

Consider in advance the minimum number of carers that are necessary to support and/or supervise those patients/clients with special needs. Ensure you have enough people to provide that care.

Establish systems and processes that allow providers to obtain informed consent when and where possible.

Ensure processes are in place to protect the health of staff, patients/clients and visitors (e.g., infection control, staff support).

Fire safety

Have a current 'warrant of fitness', for your building which shows that:

- the building design and construction minimise the risk of spread of fire and smoke
- there are detection and alarm systems in place
- suppression systems are installed where required
- fire-fighting equipment is located appropriately and meets relevant standards.

Ensure you have an evacuation scheme in place that has been approved by the New Zealand Fire Service in accordance with the Fire Service Act 1975.

Provide annual fire safety training to your staff. This should include how to use the fire alarm, how to notify a fire, and how to use and operate fire-fighting equipment.

Ensure staff are aware of the method and route of evacuation from the area where they work.

Train designated staff to be able to physically evacuate patients/clients from wards or other locations.

Document and make clearly visible throughout your organisation a plan that outlines what to do in the event of patients/clients having to be moved. Consider those patients/clients who are blind, vision impaired or deaf-blind.

For all fire and other drills, document what went well and what did not so that you can learn from the experience.

Designate a fire safety officer within your organisation who can provide presentations on fire safety issues to relevant committees and management.

Principle 4: Organisational management and structure

The provider is able to establish efficient and effective governance that ensures major incident and emergency management services are planned, co-ordinated and appropriate to the needs of the population.

Indicators for Principle 4

- 4.1 Providers have CIMS response structures (see Appendix 3) in place and management support that enables them to coordinate with each other and other agencies to respond to an emergency and meet the needs of patients/clients while ensuring the continuation of the community's health services.
- 4.2 Through regular reviews, audits and practical testing the provider knows that its emergency management plans are valid.
- 4.3 The provider's staff are all adequately and appropriately trained for major incidents.
- 4.4 The provider has established, documented and maintained quality and risk management systems that reflect continuous quality improvement principles, both within the health and disability sector and, in the case of hazards and risks, in the external environment.
- 4.5 The provider provides the funding and resources to ensure that it can meet its emergency management planning responsibilities.

Examples of real incidents

The following examples show the need for early assessment of the incident so that both response and recovery phases can be initiated immediately. They also highlight the consequences of an initial incident that could escalate to something else.

Hospital generator failed, University College Hospital, London, United Kingdom, 1996:

- all 202 inpatients/clients were urgently evacuated, including the labour ward and Special Care Baby Unit
- the 'internal' contingency plan was activated
- immediate organisational changes were made
- impact on relatives and on neighbouring hospitals and community services.

Road traffic accident including chemical spill, Leominster, Herefordshire, United Kingdom, 1997:

- an entire village was evacuated
- 20,000 litres of formaldehyde spilled and dispersed instantaneously
- initial health effects to residents and responders
- contamination of the area created longer-term impact on water and food.

Suggested activities for Principle 4

Governance

Ensure your governing body has signed off your emergency plans.

Ensure your emergency management planning group meets regularly.

Ensure that a member of your senior management team holds a portfolio for emergency management.

Include responsibility for emergency management in employment contracts for those staff expected to respond in an emergency.

Include emergency management as a written requirement in contracts with other providers.

Ensure your emergency management team includes representatives from ambulance, public health, primary, secondary, tertiary and support services.

External relationships

Involve other service providers that have a particular focus or speciality in your emergency planning process. Think about which consumers might be affected in a particular kind of emergency and work with relevant providers – they could be a Māori service provider, a mental provider, agencies who can advise on and provide awareness training and strategies for communicating with people who have one or more sensory disabilities or a service for older people. Find out from these providers how you might be able to respond to the particular needs of their patients/clients.

Nominate someone within your organisation to liaise and meet with external stakeholders on a regular basis.

Be part of multi-agency planning groups such as civil defence emergency management and Hazardous Substances Technical Liaison Committees (HSTLC) groups and participate in cluster/special interest groups.

Identify key stakeholders and a single point of contact for each one.

Have MOU agreements with other agencies and organisations, where appropriate. Such agreements should make specific reference to where the responsibility of funding lies, for example, who will pay and for what?

Undertake joint health sector planning. An example might be a regional infectious diseases response plan that includes other agencies.

Ensure your region's CDEM Group plan lists your DHB Major Incident and Emergency Plan as a supporting plan.

Consult with local iwi and hapū and obtain input from them into your emergency management plan.

Consult with community support/interest groups and obtain input into your emergency management plan.

Maintain links with iwi, hapū and whānau and other community interest groups on an ongoing basis. This helps to strengthen relationships, which in turn will make communications and systems more effective following an emergency.

Internal understanding

Put in place an internal emergency management-planning group with representatives from all relevant departments and services.

Include key roles and responsibilities in your emergency management planning documents and MOU agreements (see Appendix 5).

Create a list that includes the number and location of each copy of your emergency management plan.

Date and document all amendments to your emergency management plan.

Ensure your service continuity planning is based on evidence of the process of risk and hazard identification, methods of risk reduction, scenarios of possible failures, modes of failure and impact on the organisation.

Keep minutes from all emergency management planning group or risk management committee meetings.

Promote as much as possible any major incident and emergency management activities that take place within your organisation.

Testing/exercising

At least once a year, test plans by:

- putting them into practice within your own organisation
- practising the plans with other agencies
- carrying out communication exercises.

Document and test service continuity plans regularly.

Review plan exercises comprehensively and produce debrief reports.

Providers who are involved in CDEM Group planning should also be actively involved in CDEM Group and other agency exercises.

Reviews/audits

Schedule planned reviews of your service's emergency management plan or plans and amend them accordingly.

Have another provider or other suitably qualified person assess or audit your emergency management plan.

Document all audit committee meetings and reports.

Provide a summary report on major incident and emergency management activities to your governing body at least every six months.

Review incident and exercising debriefing reports and provide an action plan for senior management. Review within six months to ensure tasks have been completed and the plan reviewed.

Training

Provide all staff with an introduction to emergency management and CIMS during their orientation/induction programme.

Train all staff who have a specific role in a major incident response.

Train members of your organisation's incident management team in CIMS.

Ensure that emergency management staff training includes an understanding of how you might deal with the particular values and beliefs of a particular group of people – think about the customs of different cultures. For example, consider how your response effort will deal with a situation where the family of a Muslim person who has died would like to bury that person within 24 hours of their death.

Ensure staff that have a specific role in a major incident response understand the role of other agencies and the statutory role of designated officers.

Quality and risk management systems

Include a list of standards used in your emergency management plan for reference.

Check that your emergency management plan complies with standards and accepted best practices.

Create a risk management programme that:

- includes reference to how the identification and analysis of identified risks comply with AS/NZS4360: 2004 (Risk Management) and HDSS 2.2
- prioritises risks
- analyses risk treatment options and determines the best solution
- includes a hazard and risk matrix that has been developed in consultation with the health and disability sector and local community
- monitors, evaluates and reviews risks at a frequency determined by the severity of the risk and the probability of change in the status of that risk.

Also include in your emergency management plan an assessment of local hazards and risks, and an action plan for reducing or eliminating those hazards.

Create an action plan that addresses gaps in standards and/or requirements.

Set up systems and processes that allow providers to obtain consent where required.

Funding and resources

Document business planning and budgetary arrangements for funding for an emergency management planner/officer or for staff time within the organisation to be responsible for:

- preparing and producing plans and action cards
- training staff in major incident management
- participating in exercises
- communication equipment, as appropriate
- appropriate specialist facilities as identified from hazard assessment and risk analysis
- appropriate specialist personal protective clothing and equipment
- documenting the process for the reconciliation of costs associated with any incident.

Glossary

Action plan	A document used to guide the implementation of improvements. It contains task assignments, schedules, resource allocations and evaluation criteria.
Business continuity plan	Business continuity planning is about ensuring critical business functions can continue after an unexpected event, albeit in a downgraded mode. It is about planning the activities you should undertake to ensure the resumption of your business in the event of an emergency.
Communication tree	<p>A communication tree is a structure identified for the conveyance of information to other parties.</p> <p>A communication tree allows effective dissemination of information leading up to and during an emergency through a previously agreed structure that will span identified individuals/services/agencies, both internal and external to an organisation. It originates from a single point of contact and has a set of agreed protocols for activation and responsibilities amongst all parties.</p> <p>It is the responsibility of each recipient to make sure that the process continues until all intended recipients have been contacted.</p>
Capacity	The content or measure of resources (including supplies, equipment and personnel).
Civil Defence Emergency Management (CDEM) groups	Consortia of local authorities working in partnership with emergency services, major utilities and others to ensure that emergency management principles are applied at the local level.
Co-ordinated Incident Management System (CIMS)	A national standard approach to incident management, which is understood and committed to by all services. DHBs will have a guide to this in their Major Incident and Emergency Plan that other providers can refer to.
Current accepted good practice	<p>The accepted range of safe and reasonable practice that results in efficient and effective use of available resources to achieve quality outcomes for the patient. Current accepted good practice should reflect standards for service delivery, and may include:</p> <ul style="list-style-type: none">• codes of practice• research, evidence and experience-based practice• professional standards• best practice guidelines• recognised/approved guidelines• benchmarking.

Debrief	A comprehensive, objective examination of the response to an incident or an exercise, to evaluate what was done well and where improvements can be made. The development of a new action plan is an outcome of a debrief report, or a revision or updates to an existing plan.
Emergency	<p>An emergency:</p> <ul style="list-style-type: none"> • is the result of any happening, whether natural or otherwise, including, without limitation, any explosion, earthquake, eruption, tsunami, land movement, flood, storm, tornado, cyclone, serious fire, leakage or spillage of any dangerous gas or substance, technological failure, infestation, plague, epidemic, failure of or disruption to an emergency service or a lifeline utility, or actual or imminent attack or warlike act, and • causes or may cause loss of life or injury or illness or distress or in any way endangers the safety of the public or property in New Zealand or any part of New Zealand.
Emergency operations centre (EOC)	An emergency operations centre is implemented in response to a major incident (or incidents) which requires higher than normal co-ordination and support of the overall emergency effort. An EOC will usually have established communication, administration and service facilities. It could be a company office or an established emergency operations room.
Evacuation	The removal of people or a service from an area.
Facility	The physical location, site or building within, or from which, the service is provided (eg, an emergency department of a hospital). It is not the same as the EOC, which is responsible for controlling and managing the overall operation.
Governance	Taking responsibility for the overall direction of the organisation, including the development of policy, which determines the purpose and goals of the service.
Hapū	The sub-tribe component of a tribe to which a patient or family/whānau may indicate their connection or affiliation.
Hazard	Something that could cause, or contribute substantially to, an emergency or event.
Health care	Those services provided to individuals or communities by agents of the health services or professions, for the purpose of promoting, maintaining, monitoring or restoring health. Health care is broader than medical care, which implies therapeutic action by or under the supervision of a physician. The term is sometimes extended to include self-care. ⁸ It can also include mental health care.

⁸ Last's *Dictionary of Epidemiology*.

Incident	An event that causes or may cause an interruption to or a reduction in the quality of the service(s) provided and requires a response from one or more agencies.
Incident/emergency management	Comprehensive and co-ordinated planning and response processes and systems that identify and manage the risk of incidents that may terminate or significantly disrupt core business. This includes mitigation activities and contingency planning for response and recovery.
Incident management team (IMT)	The group of incident management personnel carrying out the functions of incident controller, operations manager, planning/intelligence manager and logistics manager.
Iwi	A tribe with a common ancestor, canoe and region(s).
Kaumātua/kuia	A senior man or woman respected for their age, life experience and cultural wisdom.
Major incident	Any event that: <ul style="list-style-type: none"> • presents a serious threat to the health status of the community; or • results in the presentation to a health care provider of more casualties or patients/clients in number, type or degree than they are staffed or equipped to treat at that time, or • cannot be dealt with by emergency services or otherwise requires a significant and co-ordinated response under the CDEM Act 2002, or • leads to or represents the loss of services which prevent health care facilities from continuing to care for patients/clients.
Major Incident and Emergency Plan	Community-based integrated health plans that have been developed as a result of consultation and collaboration during the planning stages with other emergency services, providers and local agencies. Joint planning will identify local risks and hazards and common strategies to minimise the impact and identify the required response.
Management	Implementing the policy determined by the governing body and co-ordinating the day-to-day service activities, which achieve the purpose and goals of the organisation.
Mass casualties	An influx of patients/clients requiring assessment, treatment and care that is beyond the normal capacity of the organisation to manage.
National Health Index (NHI)	The National Health Index is a central database that allocates a unique identifying number to New Zealanders who have used medical services.

Needs assessment	A systematic process to collect and examine information about health issues and then utilise the data to prioritise goals, develop a plan, and allocate funds and resources efficiently and effectively to meet the health needs of the community.
Organisation	Includes associations, agencies, groups, independent practitioners and individuals accountable for the delivery of services to the patient.
Recovery	The co-ordinated efforts and processes to effect the immediate, medium- and long-term holistic regeneration of a community following a disaster.
Review	A formal process of updating, amending or re-planning based on evaluation outcomes.
Risk	The likelihood of an adverse event or outcome; the likelihood and consequences of a hazard (CDEM Act 2002).
Risk management	The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects. It is a process involving the systematic application of management policies, procedures and practices to the tasks of establishing the context, and identifying, analysing, evaluating, treating, monitoring and communicating risk. ⁹
Service	The provision of teaching, research, assessment, treatment, care, support, promotion of independence and other inputs provided to the patient by the organisation.
Service continuity plan	A document or set of arrangements planned and practised before a disruptive event that guides management through the restoration of normal services or activities at an individual location. A service continuity plan is a risk treatment option that relates to a single site or activity.
Service delivery	The act of service provision by the organisation or service provider to the patient, especially in the context of a response to a major incident.

⁹ AS/NZS 4360: 2004 Risk Management Standard.

Service provider	<p>An individual or service provider who is responsible for performing the service either independently or on behalf of an organisation. This covers the provision of direct and indirect care or support service to the patient and includes all staff and management that are:</p> <ul style="list-style-type: none"> • employed • self-employed • visiting • honorary • session • contracted • volunteer service providers • anyone who is responsible or accountable to the organisation when providing a service to the patient. • For the purpose of these guiding principles it excludes the informal/unpaid carer and family/whānau network.
Suitably qualified/skilled	<p>Professionals who provide services (including clinical care or judgement) to patients/clients and who have qualifications and registration required by statute to practice; or individuals with experience in the provision of care or support to patients/clients and who are deemed competent to perform this function by a recognised representative body. Where the above does not apply, the organisation will be accountable for ensuring the service provider is competent to provide the service required of them.</p>
Surge capacity	<p>A health care system's ability to rapidly expand beyond normal services to meet the increased demand for qualified personnel, medical care and public health in the event of large-scale health emergencies or disasters.</p>
Triage	<p>The sorting or classification of casualties according to the nature or degree of illness or injury.¹⁰</p>
Whānau	<p><i>In relation to another adult:</i></p> <p>family includes a patient's/client's extended family/whānau, their partners, friends and advocates, guardian or other representatives nominated by the patient/client.</p> <p><i>In relation to a child or young person:</i></p> <p>a group including an extended family/whānau in which there is at least one adult member with whom the child or young person has a biological or legal relationship; or to whom the child or young person has a significant psychological attachment; or the child or young person's whānau or any other culturally recognised family/whānau (Children, Young Persons and their Families Act 1989).</p>

¹⁰ Accreditation standards for Health and Disability Services.

Appendix 1: References

Documents

- Department of Health. 1991a. *Accommodation in Hospitals*. Wellington: Standards Association of New Zealand for the Department of Health.
- Department of Health. 1991b. *Emergency Evacuation Planning and Staff Training in New Zealand Hospitals and Community Care Buildings*. Wellington: Standards Association of New Zealand for the Department of Health.
- Department of Health. 1998. *Planning for Major Incidents: The NHS guidance*. United Kingdom.
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- Ministry of Health. 2004. *National Health Emergency Plan: Infectious diseases*. Wellington: Ministry of Health.
- New Zealand Fire Service Commission. 1998. *The New Zealand Co-ordinated Incident Management System (CIMS)*. Wellington: New Zealand Fire Service Commission.
- Standards New Zealand. 2003. *Business Continuity Workbook*. Joint handbook/workbook, HB 221:2003.
- Standards Australia International. 1997. *Planning for Emergencies: Health care facilities*. Australian Standard, AS 4083.
- Standards Australia International. AS/NZS 4360:2004. *Risk Management*. Standards Australia.

Website links

Health

Ministry of Health, Wellington, New Zealand:

- www.moh.govt.nz
- www.moh.govt.nz/nhep

New Zealand government agencies

Ministry of Civil Defence and Emergency Management, Wellington, New Zealand:

- www.mcdem.govt.nz

International

United States Centers for Disease Control and Prevention:

- www.cdc.gov/

World Health Organization

- www.who.int/

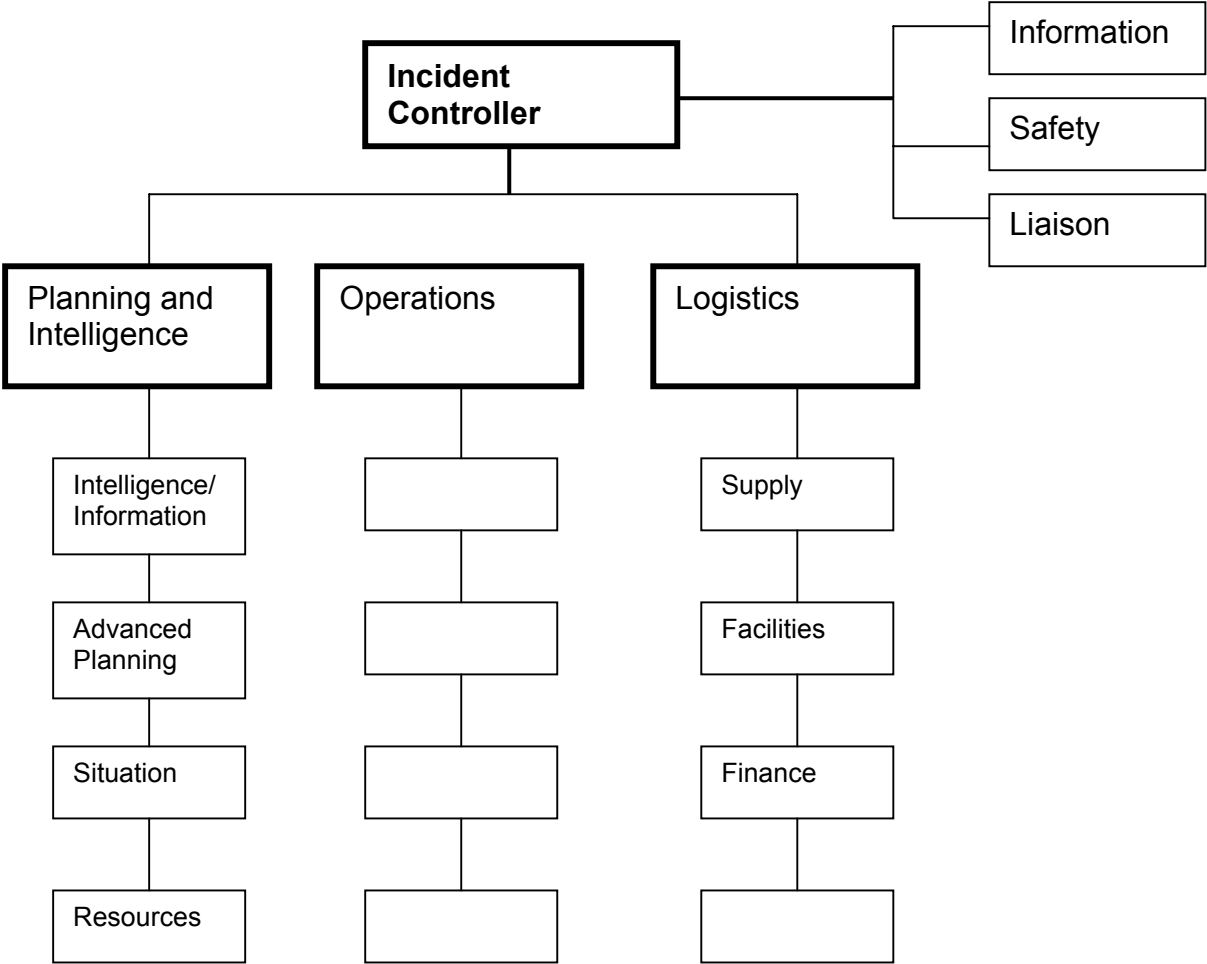
Appendix 2: Relevant legislation and regulations

When interpreting these guiding principles it will be helpful to refer to the following legislation, regulations and quality guidelines.

- Biosecurity Act 1993
- Civil Defence Emergency Management Act 2002
- Children, Young Persons and their Families Act 1989
- Hazardous Substances and New Organisms Act 1996
- Health Act 1956
- Health and Disability Services (Safety) Act 2001
- Health and Safety in Employment Act 1992
- Health and Safety in Employment Amendment Act 2002
- New Zealand Public Health and Disability Act 2000
- Tuberculosis Act 1948
- Management of Substances Hazardous to Health (MOSHH) in the Place of Work 1997
- National Civil Defence Plan (2002) Part 6 (Health)
- New Zealand Health Strategy 2000
- NZS 8134:2001 Health and Disability Sector Standards
- NZS 8151:2001 Quality Standards for Accident and Medical Clinics
- Quality Health New Zealand Safe Environment and Practice Standards
- AS/NZS4360: 2004 Risk Management Standard

Appendix 3: Co-ordinated Incident Management System (CIMS) response structure

This is an example of a CIMS response structure, which can be used for internal or external responses to incidents.



This CIMS framework can be expanded across¹¹, down and up dependent on the incident and may include external integration with the sector (locally, regional and/or national) or with other agencies (Fire, Police, Ambulance, Territorial Authorities) at local, regional and national levels.

¹¹ See Ministry of Health, 2004.

The CIMS organisation is built¹² around four major components. These components apply during a routine emergency or when preparing or managing a response to a major emergency.

CONTROL – The management of the incident

PLANNING / INTELLIGENCE – The collection and analysis of incident information and planning of response activities

OPERATIONS – The direction of an agency's resources in combating the incident

LOGISTICS – The provision of facilities, services and materials required to combat the incident

¹² See New Zealand Fire Service Commission, 1998.

Appendix 4: Ministry of Health activation response phases

The initial phase of plan activation begins when the Ministry of Health learns, or is advised of, a potential national health-related emergency. The Ministry on the basis of overseas and domestic information, intelligence and technical advice, will instigate subsequent phases of activation and/or stand-down.

The Ministry will advise DHBs of plan activation, using the standard code structure (alert levels) outlined in the table below. The actions of the Ministry of Health and affected DHB during these phases are also outlined.

Alert level	Communications
Code White [Information phase]	The Ministry of Health communicates with the following, advising them of the situation: <ul style="list-style-type: none"> • chief executive officers of all 21 DHBs (DHBs) • 21 DHB single points of contact • public health managers.
Code Yellow [Standby phase]	The CIMS structure is activated in the Ministry. The national co-ordinator initiates communication to the 21 DHB single points of contact, who advise and prepare activation of the regional CIMS structure.
Code Red [Activation phase]	The national co-ordinator directs activation of the regional CIMS structure. Communication is now with the four advised regional co-ordinators, who communicate with their DHB incident controllers.
Code Green [Stand-down phase]	The national co-ordinator notifies the regional co-ordinators of the stand-down phase in respect of the regional CIMS structure.

It is possible that activation may proceed from Code White to Code Red within hours. National communications from the Ministry of Health will be numbered under the appropriate alert code; for example, White – Information Situation Report No. 1; White – Information Situation Report No. 2; Yellow – Standby Situation Report No. 1 and so on.

In some circumstances, a single regional co-ordination team may be activated without the national plan moving to the red phase. This may occur:

- during the Code Yellow phase of national plan activation
- when a health-related emergency is localised and likely to remain so
- when the Ministry of Health considers national plan activation is not currently required.

When the above criteria are met, activation of the affected region's regional co-ordination team will be subject to discussion between the affected regional DHBs and the Ministry of Health.

Appendix 5: Memorandum of understanding template

Draft

EMERGENCY
MANAGEMENT

MUTUAL AID PROTOCOL

between:

<<organisation name>>

and

<<organisation name>>

Date

PARTIES

- 1. <<First Party>>
- 2. <<Second Party>>

Draft

AGREEMENT

- 1. In the event of an emergency, the Parties agree to support each other, where possible, with the provision of facilities and equipment (support).
- 2. The Parties will pay each other for this support at reasonable rates. Due to the urgency of emergency situations, it may be necessary to negotiate payment after support has been provided.
- 3. Agreement to use each other’s services/facilities will be between Managers of the facilities named or respective Incident Controllers during an emergency.
- 4. Support may be provided without charge.
- 5. The Parties will treat each other’s facilities and equipment with the care and respect and to a standard reasonably expected in the circumstances.
- 6. The Parties will comply with all relevant law and professional standards when using the other’s facilities and equipment.
- 7. In the event of a declared Civil Defence emergency the Parties will abide by the decisions of the Civil Defence Controller pursuant to the Civil Defence Emergency Management Act 2002.
- 8. The Parties will assist each other by the exchange of information about emergency management.

Signed on behalf of
the First Party

Signed on behalf of
the Second Party

Signature

Signature

Full name

Full name

Position

Position

Date

Date