



HEALTH HOLDING
 HAFA ALBATIN HEALTH
 CLUSTER
 MATERNITY AND
 CHILDREN HOSPITAL

Department:	Facility Management Safety (FMS)		
Document:	Administrative and Policy Procedure		
Title:	Internal Disaster Management Plan		
Applies To:	All MCH Staff		
Preparation Date:	January 08, 2025	Index No:	FMS-APP-012
Approval Date:	January 22, 2025	Version :	2
Effective Date:	February 22, 2025	Replacement No.:	FMS-APP-012(1)
Review Date:	February 22, 2028	No. of Pages:	19

1. PURPOSE:

- 1.1 Maternity and Children Hospital Internal Disaster Plan is to provide direction for preparedness, response and recovery related to any event that may cause major disruption in hospital facilities affecting the environment of care.
 - 1.1.1 To identify the major internal disasters, such as Total power outage, utility disruption Fire. Plumbing outage and or problems. Flooding. Explosion without fire. Non Fire emergencies (such as a toxic gas leak).
- 1.2 To ensure compliance with regulatory agencies, corporate instructions (General Instructions), MCH Safety Office requirements, and the Joint Commission International (JCI) Standards.
- 1.3 To identify the probable impact that each type of disaster will have on all aspects of care and services.
- 1.4 **To identify response to likely disasters, including:**
 - 1.4.1 Determining the type, likelihood, and consequences of hazards, threats, and events;
 - 1.4.2 Determining the structural integrity of existing patient care environments and how they would perform in the event of a disaster;
 - 1.4.3 Determining the hospital's role in such events;
 - 1.4.4 Determining communication strategies for events;
 - 1.4.5 Managing resources during events, including alternative sources;
 - 1.4.6 Managing clinical activities during an event, including alternative care sites;
 - 1.4.7 Identifying and assigning staff roles and responsibilities during an event;
 - 1.4.8 Managing emergencies when personal responsibilities of staff conflict with the hospital's responsibility for providing patient care.

2. SCOPE:

- 2.1 All Maternity and Children Hospital (MCH) staff.

3. DEFINITION:

- 3.1 An Internal Disaster is any event (disaster) that may disrupt operations, jeopardize the safety and well-being of the occupants of the facilities, or significantly cause damage to facilities.
- 3.2 The Internal Disaster plan has been developed to facilitate a smooth, coordinated response to foreseeable emergency situations. It incorporates emergency initial responses and procedures.
- 3.3 MCH – Maternity and Children Hospital.
- 3.4 NFPA – National Fire Protection Association.
- 3.5 **Emergency Codes:** a list of codes (color codes or plain text) that are used to initiate a specific response by the hospital teams. The codes used in Maternity and Children Hospital are:
 - 3.5.1 **Code Red:** fire/internal emergency/disaster.
 - 3.5.2 **Code blue:** cardiopulmonary arrest or imminent arrest (adult or child CPR).
 - 3.5.3 **Code Silver:** Active shooter with weapon, hostage situation.

- 3.5.4 **Code Gray:** Severe weather e.g. high or strong winds, hail, dust/sand storms, excessive precipitation, torrents, lightning, tornadoes and floods.
- 3.5.5 **Code Orange:** used when there is a hazardous chemical spill/release
- 3.5.6 **Code Yellow:** external emergency/disaster
- 3.5.7 **Code Pink:** used in case of infant & child abduction.
- 3.5.8 **Code Black:** used in case of bomb threat.
- 3.5.9 **Code Brown:** used in case of utility failure e.g. power outage, information technology disruption, and utility disruption.
- 3.5.10 **Code White:** combative person, assault/aggressive behaviour, violent situation (with no weapon)
- 3.5.11 **Hospital Evacuation** (no color/no code): any internal emergencies that threatens the patient's safety and needs evacuation.
- 3.5.12 **End of Disaster** (no color/code): when the emergency/disaster ends whether internal or external.
- 3.6 **2222** is the telephone number use to reach the telephone twenty-four hours a day every day of the week in case of a disaster.
- 3.7 **Fire Fighting Equipment** consists of fire hoses and portable fire extinguishers that are distributed throughout patient care facilities, located in built-in cabinets called fire hose cabinets. Additional extinguishers, such as dry chemical powders, carbon dioxide are placed at all inpatient and outpatient nursing stations. Carbon dioxide extinguishers are also placed in areas where there is a substantial amount of electrical or electronic equipment.
- 3.8 **RACE** is the acronym to help staff focus on initial response and evacuation procedures in the event of an actual fire or during a fire drill in MCH (Maternity and Children Hospital) facilities. **RACE** stands for **Rescue, Alarm, Confine and Extinguish/Evacuate.**
- 3.9 **The Fire Alarm System** is an automatic detection system which is connected to the elevators in case of emergency. It is located in all patient care facilities and monitored twenty-four hours a day.
- 3.10 **Fire Doors:** doors rated to contain heat and fire for at least 30 minutes.
- 3.11 **Alarm Sounders** are used to alert occupants about fire condition.
- 3.12 **Fire Drill Plan** is a pre-arranged method for handling fire drills throughout hospital facilities.
- 3.13 **Fire Drills:**
 - 3.13.1 **A Simulated Fire Drill** is a fire drill carried out without actually activating the fire alarm, discharging fire extinguishers, or making phone calls to the call center. The simulated fire drill will be practiced at unit level in all facilities in accordance with the yearly schedule.
 - 3.13.2 **Unit Full Fire Drill:** All necessary arrangements and contacts must be made before the commencement of scheduled drill.
- 3.14 **Evacuation:**
 - 3.14.1 **Horizontal Evacuation** is evacuation from an area of danger to a safe area at the greatest distance to another level for emergency exit.
 - 3.14.2 **Vertical Evacuation** is evacuation to a safe area on another floor [usually a lower level], or to a safe area outside the facility [usually a location in the facility grounds (hospital main entrance) although some patients may require removal to another facility]. Vertical evacuation is only activated when there is a very serious confirmed threat to life and safety.
 - 3.14.3 **Complete evacuation** is the evacuation of people from the entire building to triage point outside the hospital or in the assembly point outside the building.
- 3.15 **Ambulatory Status of patients in Facilities:**
 - 3.15.1 **Ambulatory:** able to walk alone, unattended.
 - 3.15.2 **Semi-ambulatory:** requires some assistance to evacuate. One staff member usually needed to assist.
 - 3.15.3 **Non-ambulatory:** requires significant assistance to evacuate. Two [2] to four [4] staff members needed to assist.
 - 3.15.4 **Special:** requires very special assistance for evacuation. This can apply to patients or visitors, and includes patients undergoing surgery, on life support systems, on dialysis, under deep

anaesthesia, infants and small children, the elderly, the blind and mentally incapacitated. A team of staff members may be needed to assist.

3.16 Code Red:

3.16.1 **Verbal Code Red** is the code used by staff to initiate the **RACE** procedure in the event of a fire. Verbal code red is the professional way to raise the alarm.

3.16.2 **Overhead Paging [Public Address System] Code Red** announces code red over the public address system specifying the location of the fire that is in progress within the area, provides instructions, and advises personnel of areas to be evacuated.

3.17 Internal Emergency Triage Team:

3.17.1 A special dedicated team at Maternity and Children Hospital (MCH) in order to expedite treatment to those injured from major fires and compose of the following members:

3.17.1.1 Emergency physician

3.17.1.2 Emergency Medical Technician (EMT)

3.17.1.3 Nurses

3.17.1.4 Security Supervisor

3.17.1.5 Patient Relations representative

3.17.1.6 Respiratory Care Technician (needed if major)

3.17.1.7 Emergency Medical Services (EMS) (needed if major)

3.17.1.8 Admission Officer

3.18 **Fire Alarm Control Panel [FACP]** is an automatic monitoring and control system, that all the fire alarm systems are connected to it; it is located in the control room.

3.19 **End of Disaster** is a status whereby the emergency situation is declared over.

3.20 **The Call Center** is the command center for all disasters and is located at the first floor (**extension # 2222**) where designated members of management direct and control disaster response activities.

4. OBJECTIVE:

4.1 The objective of Internal Disaster plan is to effectively prepare for and manage a disaster and to quickly restore facility to the same operational capabilities pre-disaster levels.

4.2 Maintain the safety of patient, staff and hospital property by continuous training and education for all hospital staff.

5. GOAL:

5.1 To establish procedures to be followed in the event of an internal emergency within the hospital facilities.

5.2 To protect patients, visitors and staff and contractors and to minimize property damage.

5.2.1 To provide guidance to personnel through detailed instructions, to increase confidence and efficiency and to reduce panic, through staff involvement in internal emergency drills and fire drills.

5.3 To reduce the risk of fire through education and safe work habits.

5.4 To practice an orderly evacuation procedure in the event that evacuation becomes necessary.

5.5 To carry out the scheduled drill, instructed by MOH.

6. POLICY:

6.1 **This policy describes the hospital staff preparation to meet any internal disaster that may occur at MCH including but not limited to the following:**

6.1.1 Explosions

6.1.2 Major fires

6.1.3 Leak of fumes or chemicals

6.1.4 Oil spills

6.1.5 Accidents

- 6.1.6 Utility system failures
- 6.1.7 Natural disaster (floods, wild storms, lighting)
- 6.1.8 Plumbing outage and/or problems
- 6.1.9 Flooding
- 6.1.10 Non fire emergencies (such as a toxic gas leak)
- 6.2 The action taken by personnel will depend gently on the nature of the incident; obviously the same action would not be required for a flood or a gas leak.
- 6.3 MCH meet the response needs for incidents that require, or may require, significant support from several departments to assist with emergency needs, within the hospital, or on its grounds.
- 6.4 The Internal Disaster plan and the whole program is tested annually.
- 6.5 Actions identified from testing and debriefing shall be developed and implemented.
- 6.6 Between MCH and several hospitals: mutual agreement between MCH and other hospital to be ensured for patient transfer/backup resources. Mutual agreement hospitals will be contacted and this will be initiated for transfer of patients. In case the affiliated hospitals were unable to provide a mutual aid, MCH shelters located at assembly point emergency entrance parking area will be prepared for the evacuation of MCH's own patients.
- 6.7 Between MCH and red cross/civil defence: The contacts with paramedical during disasters should take place once the disaster occurred and following the initiation of the disaster plan. Concerns should be centered as to the types of casualties that are to be accepted and to direct other casualties to the hospitals providing mutual agreements with MCH.
- 6.8 **Fire Protection Equipment and Related Items:**
 - 6.8.1 Fire protection equipment and emergency systems (including sprinkler systems, fire hose cabinets, hydrants, fire/smoke detection and alarm systems, automatic magnetic release door systems and emergency power and lighting systems) shall be maintained in fully operational condition at all times. Inspections shall be carried out regularly by the safety and maintenance departments.
 - 6.8.2 All the telephones available in the hospital has been listed in a list to determine their location and kept in call center as a database.
 - 6.8.3 Fire extinguishers shall be kept in their designated places and inspected regularly, as per NFPA inspection, testing and maintenance of Fire Protection Equipment.
 - 6.8.4 Evacuation plans shall be displayed in corridors in all facilities. The development of these plans must be made in cooperation with the Safety Unit.
- 6.9 **Codes Used on the Overhead Paging System:**
 - 6.9.1 Code blue (Cardiopulmonary arrest or imminent arrest(adult/paediatric):
 - 6.9.1.1 To facilitate the arrival of code blue team and specialized personnel to the location in case of cardiopulmonary arrest. Code blue is to be initiated immediately whenever a patient is found in cardiac or respiratory arrest.
 - 6.9.2 Code red (Fire):
 - 6.9.2.1 To provide the needed procedures to be followed in the event of a real or suspected fire to protect patients, visitors, staff and property. Code red should be immediately initiated whenever any one of the following indications of a real or suspected fire is observed:
 - 6.9.2.1.1 Seeing smoke or a fire;
 - 6.9.2.1.2 Smelling smoke or other burning material;
 - 6.9.2.1.3 Feeling unusual heat on a wall, door or other surface;
 - 6.9.2.1.4 Other indications as identified by the facility.
 - 6.9.2.2 Code red alarm may also be initiated automatically by automatic fire detection equipment in the facility. Such equipment includes heat and smoke sensors in the building areas and in ventilation equipment and water pressure sensors in fire sprinkler lines.
 - 6.9.3 Code orange (Hazardous spill):
 - 6.9.3.1 To provide the needed procedures to be followed in the event of a hazardous spill to protect patients, visitors, staff and property.

- 6.9.3.2 Code orange should be immediately initiated whenever there is a spill of a hazardous material or nature, with a volume greater than 5 liters or covering a surface of more than 16 square meters.
- 6.9.4 Code pink (Infant/Child abduction):
 - 6.9.4.1 To protect infants from removal by unauthorized persons, and to identify the typical physical description and actions demonstrated by someone attempting to kidnap an infant from a healthcare facility.
- 6.9.5 Code white (combative person, assaultive/abusive behaviour, violent situation with weapon):
 - 6.9.5.1 To provide a safe and secure healthcare environment for patients, visitors and staff. It is also to assist the staff in managing and/or de-escalating the situation by a show of force, to gain the cooperation of the abusive or assaultive person, or to subdue and restrain the individual if necessary.
- 6.9.6 Code silver (Active shooter with weapon, hostage situation):
 - 6.9.6.1 To provide well organized procedures how to resuscitate paediatric patient in a cardiac arrest.
- 6.9.7 Code brown (Utility failure):
 - 6.9.7.1 To provide an organized guidelines how to deal or handle the situation during the utility failure.
- 6.9.8 Code black (Bomb threat):
 - 6.9.8.1 To provide a well-organized procedures in order to obtain a safe, secured and well-mannered response in dealing with bomb threat and any suspicious packages.
- 6.9.9 Code gray (Severe weather):
 - 6.9.9.1 To provide warning during severe weathers to avoid injuries or even casualties.
- 6.9.10 Hospital Evacuation:
 - 6.9.10.1 In the event of any internal disaster that may cause threat to patients safety.
- 6.9.11 End of Disaster (Disaster Clear):
 - 6.9.11.1 After clearing an emergency situation, the call center with the decision from the Chief Executive Officer or his designee will announce "End of Disaster".
- 6.9.12 Assembly points:
 - 6.9.12.1 Holding Areas are situated in front of the emergency exits in each floor, this is where staff nurses, patients, or any staff involved in an evacuation procedure will gather prior to take the vertical evacuation.
 - 6.9.12.2 Assembly points outside the hospital during total evacuation;
 - 6.9.12.2.1 MCH Assembly Point 1- Parking area at the rear side of the hospital.
 - 6.9.12.2.2 MCH Assembly Point 2- Parking area near the emergency entrance
 - 6.9.12.2.3 MCH Assembly Point 3- OPD parking area.
- 6.9.13 The individual responsible for announcing the emergency state and contacting local authority:
 - 6.9.13.1 CEO of the hospital or duty manager is responsible for deciding whether the emergency situation will be announced at the overhead paging system and contacting local authority.
- 6.9.14 The call center will receive a call or alert from the staff where the incident happen stating the severity of the situation.

7. PROCEDURES:

7.1 General actions should be taken:

- 7.1.1 Raise the Alarm: The staff who discovers should ensure that all personnel in the area are aware of the situation.
- 7.2 The head of department or the most senior person present should ensure that the Hospital Administrator or designee is advised of the situation.
- 7.3 The Hospital Administrator or designee shall, at his discretion, investigate disaster procedure.
- 7.4 **Safety of the patients:**

- 7.4.1 Where the area is a patient care area (particularly an inpatient area) the safety of the patients must be prime concern. When necessary the evacuation of patients (and visitors) must be investigated as soon as practical.
- 7.5 Evacuation to Stage 1 may be investigated by the most Senior Nurse present without instructions should the situation warrant such action.
- 7.6 **Security:**
 - 7.6.1 When practical and safe to do so, valuable documents should be removed from the area and/or protected from damage.
- 7.7 **Doors:**
 - 7.7.1 Doors must be closed, - but not locked - although they may be required to be opened later to disperse fumes/smoke or to dry out materials.
- 7.8 **Gases and electricity:**
 - 7.8.1 Gas supplies and/or electricity supplies may be required to be isolated; subject to the nature of the incident where this is required it shall be the responsibility of unit staff to carry out this function.
- 7.9 **Command Center Members**
- 7.10 **Hospital Command Center:**
 - 7.10.1 The Hospital Command Center is in-hospital based body comprising of key personnel. It is tasked with ensuring that all hospital staff and facilities are mobilized to meet with the particular demands of the Internal Disaster in hand.
- 7.11 On initiation of an **Internal Disaster Stage II** evacuation within the hospital, the members of the Hospital Command Center will, when possible, report to the Command Center and establish communications with coordinators within the hospital as outlined in individual departmental plans;
 - 7.11.1 The Hospital Command Center will comprise of all key personnel
 - 7.11.2 **Alternate Control Center:** The emergency involve the command center the control group will report to the meeting room.
- 7.12 **Duties Command Center:**
 - 7.12.1 The members of the hospital command center are tasked with the following individual responsibilities.
 - 7.12.2 On being notified of a situation which might be considered an internal disaster, key personnel (or designee) will:
 - 7.12.2.1 Determine the need to declare an internal disaster
 - 7.1.2.2.2 Activate the internal emergency operations plan if necessary by advising the telephone operator to make the announcement over the public address system.
 - 7.1.2.2.3 Report directly to the disaster command center
 - 7.12.2.4 Determine alternative disaster command center members to replace that not on site.
- 7.13 **Hospital Administrator:**
 - 7.1.3.1 Report directly to the disaster command center.
 - 7.1.3.2 In the absence of the CEO/medical director (or designate), he will assume the duties as outlined above.
 - 7.1.3.3 Mobilize departments as required, liaise with department heads.
 - 7.1.3.4 Ensure that all essential administration is carried out.
 - 7.1.3.5 Compile a list of all casualties received from safe refuge area; those transferred out to the medical facilities.
 - 7.1.3.6 On termination of the incident, supervise the return of normal medical services.
- 7.14 **Medical director:**
 - 7.14.1 Report directly to the disaster control center;
 - 7.14.2 Assume control of all medical department;
 - 7.14.3 Receive and evaluate reports from all medical department heads and mobilizes medical staff as required;
 - 7.14.4 Set up a close liaison with the triage officer and the director of nursing;
 - 7.14.5 Implement medical staff procedure as required.

- 7.14.6 Liaise with other medical facilities to determine patient acceptance levels and the availability of back-up medical teams;
- 7.14.8 Coordinate re-establishment of normal medical services during the recovery phase.
- 7.15 **Director of Nursing** (On being notified of an Internal Disaster she will:)
 - 7.15.1 Report directly to the disaster control center and assume control of all nursing services;
 - 7.15.2 Receive and evaluate reports from all nursing units and directs personnel accordingly;
 - 7.15.3 Liaises with the medical director and the housekeeping supervisor in charge of personnel pool for the allocation of interdepartmental staff;
 - 7.15.4 Ensure adequate nursing back-up for triage and casualty support facility;
 - 7.15.5 Implement essential departmental procedures.
- 7.16 **Internal Disaster:**
 - 7.16.1 To meet the response needs for incidents that require, or may require significant support from several departments to assist with emergency needs, within the hospital, or on its grounds.
 - 7.16.2 Examples of what might constitute an internal disaster are:
 - 7.16.2.1 Explosions
 - 7.16.2.2 Major fires
 - 7.16.2.3 Leaks of fumes or chemicals
 - 7.16.2.4 Oil spills
 - 7.16.2.5 Accidents
 - 7.16.2.6 Utility system failures
 - 7.16.2.7 Natural disaster (floods, wild storms, lighting)
 - 7.16.2.8 Plumbing outage and/or problems
 - 7.16.2.9 flooding
 - 7.16.2.10 Non-fire emergencies (such as a toxic gas leak)
- 7.17 **Emergency codes are words used to represent other words in order to:**
 - 7.17.1 Keep announcements brief.
 - 7.17.2 Alert personnel to an emergency situation without alarming patients and visitors.
 - 7.17.3 The overhead paging system enables announcements to be heard throughout the hospital.
- 7.18 **The overhead paging system shall be used only under the following circumstances:**
 - 7.18.1 To summon assistance in an emergency situation.
 - 7.18.2 To locate an individual only after all other attempts.
 - 7.18.3 All announcements made on the overhead paging system shall be in English.
 - 7.18.4 The use of other languages is prohibited.
 - 7.18.5 Misuse of the system shall result in disciplinary action.
 - 7.18.6 Access to the system in MCH is through the operator by the following:

CODE
1. Dial 2222
2. There is a Code _____
3. On _____ unit
4. Room _____, bed no. _____
5. My name is _____

- 7.19 **Evacuation indications:**
 - 7.19.1 To remove patients and personnel from actual or eminent danger as fire:
 - 7.19.1.1 The fire is out of control.
 - 7.19.1.2 The resultant effect of the fire (e.g. dense smoke, fumes, excessive water or excessive water damage, electrical failure) has rendered the area unsuitable or dangerous for patient care continuation.
 - 7.19.1.3 Bomb threat or discovery of suspicious items as a sign of a threat. The security department orders an evacuation.
 - 7.19.1.4 Utility failure rendering hospital premises unsafe for patient management.
 - 7.19.1.5 Leakage and spread of hazardous chemicals/ gas that is dangerous for people in the facility, etc.

7.20 **Evacuation rules:**

- 7.20.1 The initiation of the "emergency code" e.g. code red call will be the responsibility of the person who first detects the problem e.g. ward staff smells or sees smoke/presence of fire, chemical spill or fumes or other circumstance receives the bomb treat call etc. that endanger the patient and the staff within the area.
- 7.20.2 The order to evacuate the unit will be given when there are indications.
- 7.20.3 This assessment for evacuation need will be made and discussed by the department heads and the CEO of the hospital or his designee.
- 7.20.4 The order to evacuate will be decided by the CEO of the hospital or his designee, announced by the call center personnel via overhead paging system and implemented by the department heads or their designee. The call center will also call external agencies e.g. civil defence, police, MOH etc. regarding the incident and implement the instruction receive from them.
- 7.20.5 If the call center announces an evacuation, it will be necessary to do so quickly and safely. It is important that the first responders and the response team knows the method which will suit your patient's disabilities and needs.

7.21 **Vertical flow:**

- 7.21.1 Vertical or downward movement to a safe area is used in multi-storey buildings. If stairways or fire protected refuge can be found on one floor below the fire although two floors are recommended, if time permits, ambulatory patients should form a chain and follow a lead nurse or the security staff.
- 7.22.2 Elevators should not be used during actual fire, unless declared safe by the responsible fire or hospital authority at the scene and only in special situations.
- 7.23.3 The list of fire zones for each floor and the areas included in each zone are part of the departmental safety files.

7.22 **Horizontal flow:**

- 7.22.1 Patient is removed laterally by wheeled stretcher, non-wheeled stretcher, wheelchair, blanket, sliding mats or other conveyance to the nearest and safest protected area on the same floor.
- 7.22.2 Patient in immediate danger should be moved first including those who may be separated from safety, if the fire enters the corridor. Next to move (contrary to some opinion) should be the ambulatory patients. Panic is less to likely to be caused by helpless people. Those who are ambulatory should be instructed to line outside their rooms, form a chain by holding hands and follow a lead nurse or security staff into a safe area.

7.23 **Total evacuation:**

- 7.23.1 Patients are moved outside the facility to the triage zones in the front and back of the hospital.
- 7.23.2 To prepare for evacuation of any kind, especially total, personnel should be trained to perform certain duties as well as act in teams to have an effective response to eth emergency.
- 7.23.3 There should be a well-planned program (internal disaster plan), in which each person has a designated role or play defined by the action cards.

7.24 **Evacuation equipment available in Maternity and Children Hospital:**

- 7.24.1 Wheeled stretchers and wheelchairs: A wheeled stretcher is loaded by using the three-man carry, a wheelchair with the swing carry. When these are unloaded they are immediately taken back to the emergency area for use with other patients.
- 7.24.2 Sliding mats are also available on each floor. These can be used by single or two rescuers to evacuate bed ridden patients down a stair well.
- 7.24.3 Cribs for babies are available in nursery.
- 7.24.4 Blankets: Of all the possible equipment that can be used for evacuation, the blanket is more important than any other. It can be used to smother a fire or drag a patient from a room. It can be made into a stretcher, with or w/out poles for carrying patients in halls or downstairs.
- 7.24.5 It may be possible to remove six or eight patients on blankets at the same time, it might take two nurses to steer a bed out of a room.
- 7.24.6 When the blanket is doubled lengthwise for use as a stretcher, three or four nurses can carry patients. One or more nurses can place the patient on the blanket.

- 7.24.7 For vertical evacuation there is a choice of four removals, the two-man swing carry, the three men and four-man blanket carry and the pole and blanket stretcher carry can all be used.
- 7.25 **Evacuation maps:**
- 7.25.1 Evacuation maps are posted in all zones in all floors. Smaller sized ones are available in the patient rooms. The content of the evacuation maps includes the below:
- 7.25.1.1 Location "You are here".
 - 7.25.1.2 Fire extinguishers
 - 7.25.1.3 Fire hose reel/cabinet
 - 7.25.1.4 Fire blankets
 - 7.25.1.5 Escape routes
 - 7.25.1.6 Assembly points
 - 7.25.1.7 Fire exits
 - 7.25.1.8 Call points break glass/pull station
 - 7.25.1.9 Medical gas isolation valves
- 7.26 **Relocation of patient:**
- 7.26.1 With the exception of patients in critical care areas, and the emergency room, stable patients will be relocated to the site assembly point.
- 7.26.2 Any patient in critical condition will be relocated to nearest critical care area.
- 7.26.3 Patients in critical care areas will be relocated to other nearest critical care areas or to recovery room.
- 7.26.4 Patients in OR's should be maintained where they are, if possible and safe. Otherwise, patients should be moved to critical care areas or the nearest recovery room.
- 7.26.5 All patients must be accounted for by the Head/Charge Nurse of the area.
- 7.26.6 At the relocation site, an ID band with the information "relocated from" with the name of originating ward or nursing care units, will be placed on the wrist of each patient. Admissions will maintain a record of these patients, indicating each name, age, doctor and location. Admitting personnel will document all transfer information on the appropriate logs. This information will be forwarded to the medical staff.
- 7.26.7 Condition of patient should be documented by medical personnel as soon as possible.
- 7.27 **Patient Evacuation (Adults):**
- 7.27.1 Priority Order of Evacuation (Patients will be evacuated in the following order):
- 7.27.1.1 Ambulatory patients will be first let to safety;
 - 7.27.1.2 Wheelchair patients will be taken next to safety;
 - 7.27.1.3 Non-ambulatory patients will be moved next using one of the emergency patient handling methods;
 - 7.27.1.4 Critical care unit patients and other critical patients will be evacuated last but will generally, at the discretion of the most senior medical staff present, nursing supervisor on duty or the head nurse or nurse in-charge on duty for that area, receive priority in transportation from the assembly area or triage area as soon as ambulance transportation is available; nursing staff on duty to record details of patients evacuated
 - 7.27.1.5 Note: The preferred emergency exit for the nursing units is always the nearest and safest exit door.
- 7.28 **Patient Evacuation (Paediatrics):**
- 7.28.1 Wrap each child in blanket and make certain the identification band is in place
 - 7.28.2 Any beddings or towels outside the door signals "Empty Room"
 - 7.28.3 Head Nurse / Nurse In-Charge takes patient census.
 - 7.28.4 Medical triage Officer or designee shall ascertain those patients who will require evacuation to another hospital.
- 7.29 **Patient Evacuation (Nursery):**
- 7.29.1 Where practical, give babies to mothers – evacuate mothers
 - 7.29.2 Nursing personnel will evacuate all babies requiring special care
 - 7.29.3 Ensure each infant has its identification band, and is wrapped in a blanket

- 7.29.4 Assign two employees to check each nursery to confirm removal of every infant.
- 7.30 **Emergency Patient Handling Methods:**
 - 7.30.1 The choice of method to be used in the emergency evacuation of patient is determined by a number of factors, including:
 - 7.30.1.1 The intensity of the emergency;
 - 7.30.1.2 The medical condition of the patient;
 - 7.30.1.3 The physical consideration of the patient and handler
 - 7.30.1.4 The number of staff available to carry out evacuation.
- 7.31 **Disaster Recovery Period:**
 - 7.31.1 The Internal Disaster Plan will be considered to be in the recovery period when this has been determined by the Disaster command Center Team. When all the internal disaster casualties are either admitted or discharged the Internal Disaster Plan will be deactivated and personnel will either return to their normal duties or report off duty via the personnel pool;
 - 7.31.2 A critiques meeting shall be called and the comments shall be reviewed by the Environmental & Safety Committee for further improvement and correction as necessary.
- 7.32 **Patient Evacuation (Carrying) Techniques:**
 - 7.32.1 In the event of a disaster such as fire, the first duty is to remove the patients who may be in immediate danger. This may require by removing one person or many. If some patients are helpless, personnel must be trained in workable methods of removing them. Care and treatment of the ill and injured, the new born, and the aged must also include preparedness to cope with unexpected situations. Responsibility for the helpless never ceases.
 - 7.32.2 Factors to consider in emergency handling of patients:
 - 7.32.2.1 The nature of emergency.
 - 7.32.2.2 The weight and condition of the patient.
 - 7.32.2.3 The strength and adaptability of the rescuer.
 - 7.32.2.4 Each person must find one that he or he can handle best.
 - 7.32.2.5 Height of the bed.
 - 7.32.3 On all carries, patients must be "hugged" firmly. The carrier should use his own body and that of the patient to sustain the patient's weight, over the whole of the carrier's body, rather than concentrating on the hands and arms alone. When one carries a heavy bag or package, it is not transported with arms extended full length, it is hugged to side where the process is partly lifted and partly pressed with a degree of frictional assistance from the object against body resistance.
 - 7.32.4 Carry for one nurse (1st) Hip Carry:
 - 7.32.4.1 The nurse approaches from the patient's right side and pulls the patient's left arm over her left shoulder by grasping the patient's left wrist with her left hand-palm down. She pulls down on the arm, raising and turning the patient's body so she can slide her right hand into armpit. The procedure is reversed if the nurse approaches from the patients left.
 - 7.32.4.2 The nurse then releases the patient's wrist, makes a half turn to her left so that her hips are squarely against the patient's abdomen. With her knees slightly bent and her feet apart, she reaches back with her left arm and grasps both of the knees.
 - 7.32.4.3 The nurse draws the patient up on her hips before she leaves the bedside. If the nurse carries the patient on her buttocks, the patient may start to slide. A great deal of lifting power results from the nurse pushing against the floor with her feet as she stands erectly as possible and straightens her knees. She walks with her chest and her shoulders back.
 - 7.32.4.4 To unload the patient in the corridor, the nurse places the patient's buttocks against the wall and drops on her knees close to the wall. Leaning against the patient as the person slides down the wall, the nurse uses the wall to sustain the patient's weight and maintain her own balance. The patient is locked between her body and the wall.

- 7.32.5 The Slide or Cradle Drop:
- 7.32.5.1 First, the nurse doubles a blanket lengthwise and places it on the floor, parallel to and next to the bed. She then stands next to the bed. Her knee (thigh) that is nearer to the head of the bed is placed against the bed, opposite the patient's shoulders. Both feet are flat on the floor, about six inches apart, with the foot farther from the head being about six inches apart, with the foot farther from the head being about six inches from the bed. The nurse slips her hand that is nearer the head of the bed under the patient's neck and continues until the nurse grasps the patient's far shoulder and the patient's head rests on her arm.
 - 7.32.5.2 She slips her other arm under the patient's knees and grasps the far leg. The nurse does not lift the patient but gently pulls with both hands pushing against the bed with her knee (thigh). The order in which to move the patient from the bed is: first the ankles, then the knees, thighs, buttocks and chest and finally the shoulder and head.
 - 7.32.5.3 The moment the patient starts to leave the bed, the nurse drops to her knees farther from the head of the bed.
 - 7.32.5.4 As the patient clears the bed, the nurse's arm that is under the patient's knees controls the lower portion of the patient, the cradle formed by the knee further from the head of the bed.
 - 7.32.5.5 As the patient clears the bed, the nurse's arm that is under the patient's knees controls the lower portion of the patient. The cradle formed by the knee and arms protects the patient's back.
 - 7.32.5.6 The nurse lets the patient slide gently to the blanket. She then pulls the blanket and the patient from the room, head first.
- 7.32.6 The Pack-Strap Carry:
- 7.32.6.1 The nurse brings the patient to a sitting position by elevating the back rest (if time permits) or by pulling the patient to a sitting position. She grasps each wrist.
 - 7.32.6.2 The nurse takes a step backwards with the leg nearer the head of the bed. She raises the wrist that is farther from her and turns herself. She slips under the raised arm and places her back against the patient's chest.
 - 7.32.6.3 The nurse then pulls the patients arms over her shoulders and crosses them on her own chest.
 - 7.32.6.4 The nurse pulls downward on the arms and leans slightly forward, bending her shoulders only.
 - 7.32.6.5 The nurse turns both her body and her feet sharply around toward the head of the bed. It is not necessary to drag or lift the patient; the forward momentum of this turn should roll the patient on to the nurses back easily.
 - 7.32.6.6 To unload the patient, the nurse leans the patient's shoulder against a wall and also leans against the patient. She drops to her knees closer to the wall and lowers both herself and the patient. She can ease the patient to the floor by allowing the patient to roll off her shoulder and hip. The patient will be secure between the wall and the nurse's body.
- 7.32.7 Ankle Roll:
- 7.32.7.1 If a nurse finds a patient lying on the floor, she places a blanket, open to full length, parallel to the body. She then places the arm closest to the blanket down the side of the body. For purpose of removal, it makes no difference the patient is face down or face up.
 - 7.32.7.2 The nurse takes the ankle that is farther from the blanket and places it on the top of the nearest ankle. She keeps her back rigid and uses her arms to press down on the top ankle and pull up on the bottom ankle in order to turn the patient over on to the blanket. She pulls the blanket and the patient, head first from the room.
- 7.32.8 Hip roll:

- 7.32.8.1 A variation of the ankle roll is the use of the shoulder and hip bone as pulling points. The method is probably easier in most instances and should always be used if the patient is very heavy or has injuries, which precludes the use of ankle roll.
- 7.32.8.2 The nurse places the patient's arm by the side next to the blanket and then drops to one knee on the blanket just above the patient's hips. Her other foot is flat on the blanket. She leans forward and grasps the patient by the shoulder and hipbone and rolls the patient over towards her with a steady pull, moving back out of the way as she does.
- 7.32.8.3 On all blanket drags, the blanket must extend six or eight inches beyond the head to avoid injury. If the patient's feet are closer to the door, the nurse must spin the blanket and pull the patient out, head foremost.
- 7.32.9 Carry for two nurses (2nd) Swing Carry:
 - 7.32.9.1 If the nurse approaches from the patient are left, the first nurse standing with her feet together slips her right arm under the patient's neck and grasps the right shoulder, in the right hand she slides her left palm behind the left biceps and grips the patient's upper left arm.
 - 7.32.9.2 She brings the patient to sitting position by taking one step with the left foot toward the foot of the bed. This employs the swing of her whole body. She gains additional leverage if she pushes her right shoulder once the patient is in motion. When the patient is sitting, the second nurse grasps the ankle and swings the feet off the bed (if the nurse approaches from the right, all the mechanics are reversed).
 - 7.32.9.3 Both nurses stand close to the patient's side, facing the same direction. Each takes one of the patient's wrist and pulls the arm around the neck and down across the chest. Each nurse then reaches across the patient's back and places her free hand on top of the other nurse's shoulder.
 - 7.32.9.4 Both nurses then release the patient's wrist. Each reach under the patient's knees and grasps the wrist of the other nurse. If the nurse at the right side reaches under with her right palm down, and the nurse at the left side reaches under with her left palm up, their hands will quickly lock together.
 - 7.32.9.5 The patient is removed from the bed by both nurses pushing up with their shoulders. Weight makes no material difference because the patient is hanging like a pendulum off the nurse's shoulders. This is the easiest removal of all and is the two-man carry used on the stairs and fire escapes. Any two nurses can carry any patient anywhere.
 - 7.32.9.6 To unload in the corridor, each nurse drops on the knee closer to the patient. While leaning against the patient, the nurses place the patient's buttocks on the floor and lower the patient to her back.
- 7.32.10 Extremity Carry
 - 7.32.10.1 The first nurse brings the patient to a sitting position in the same manner described in the swing carry. When the patient is sitting, she places her arms through the armpits and grips her own wrist above the patient's chest. The second nurse approaches from the same side and halts at the patient's left hand under the patients left heel. She pulls the ankle clear of the bed as she slides between the patient's legs as far as the patient's right knee.
 - 7.32.10.2 As the second nurse makes a half turn left, she grasps the patient's right knee under the right arm. Completing the turn, she transfers her left hand to the patient's left knee, which she then encircles with her left arm. She now has a leg under each arm.
 - 7.32.10.3 Both nurses then take one step away from the bed, carry the patient from the room, Like so many other carries, this involves a "hugging" action, with the patient's back carried tight against the nurses.

- 7.32.10.4 To unload the patient in the corridor, the second nurse stoops with her right foot slightly behind and about six inches from her left and lowers the patient's leg to the floor. The first nurse lets the patient slide down her body until the buttocks reach the floor.
- 7.32.10.5 Then she lowers the patient to his back. This is a very fast removal. (Any two nurses can carry any patient. The carry is useful when the path of exit is narrow because of furniture or fire).
- 7.32.11 Double Cradle Drop:
 - 7.32.11.1 The nurse places a blanket, folded lengthwise on the floor next to the bed. They stand next to the bed, one opposite the knees and the other near the head.
 - 7.32.11.2 The nurse nearer the head of the bed slips one hand under the patient's neck and grasps the far shoulder; she grasps the biceps of the patient's near arm with the other hand. The other nurse grips the blanket above the shoulders and opposite the elbows.
- 7.32.12 Carries for four nurses (3rd) Four-Man Blanket Carry:
 - 7.32.12.1 Use the three-man carry to lower the patient to the floor next to a blanket doubled lengthwise. If four nurses are available for carrying, one squats at each of the patient's shoulders and at each of the patient's knees.
 - 7.32.12.2 Those at the shoulders grip the blanket above the shoulders and opposite the elbows. Those at the knees grip the blanket six inches below the patient's knees. They roll the blanket toward the patient, with the palms of their hands down, until the knuckles are tight against the patient's body.
 - 7.32.12.3 All the nurses lift together; they keep their backs straight and lift with their legs. Arms are extended.
 - 7.32.12.4 The bearers must carry with their hands hip high, and not at arm's length. Down a hallway, stairway or fire escapes, the patient is moved feet first.
 - 7.32.12.5 NOTE: Others are variations of these depending upon personnel available and the weight and condition of the patient.
- 7.33 **Intra Departmental Emergency:**
 - 7.33.1 Every department has a specific internal disaster plan.
 - 7.33.2 These plans should be kept within the department.
 - 7.33.3 Evacuation maps and procedure are posted in every department in case of evacuation.
 - 7.33.4 Departmental level emergency will be announced initially by the staff that experiences the disasters situation by accounting trice within the department.
 - 7.33.5 A call to the call center at 2222 will be done and emergency situation will be explained to the person receiving the call, stating the type of code alert, location and the severity of the situation.
 - 7.33.6 The situation will then be reported to the CEO of the hospital or the duty manager to decide whether it will be announced at the overhead paging system.
 - 7.33.7 All the staff at the incident area will execute and follow the safety guidelines and procedures, and will prepare for evacuation. .
- 7.34 **NICU and Nursery Disaster Protocol:**
 - 7.34.1 A major problem in any hospital is the evacuation of infants during disasters. NICU nurses must be prepared to safely evacuate medically-fragile, premature infants in a well-organized systematic manner, to ensure the best outcome for our high risk patients.
 - 7.34.2 Evacuation Initiation:
 - 7.34.2.1 At the first indication of a disaster, electrical power or medical failure the first person who detects the emergency situation will notify the Call Center at extension #2222 initiating the Hospital's Emergency Codes. The Nursing Director in cooperation with the Medical Director and the Hospital's CEO will assess and decide whether the situation is subject for evacuation. If conditions present an immediate danger, staff nurses under the supervision of the charge nurse or its designee may relocate patients and visitors to another area of the building without prior approval.
 - 7.34.3 Type of disaster that will determine if an internal or external evacuation will be initiated.

- 7.34.3.1 **Horizontal Evacuation:** Consider this first. A site adjacent to the fire or emergency, but beyond the firewall; move patients away from the area of the emergency; keep infants on unit if possible, close fire doors and contain.
- 7.34.3.2 **Vertical Evacuation:** Do not use elevators if fire or explosion, may need to evacuate down ramps or stairs.
- 7.34.4 Transporting Of Infant:
 - 7.34.4.1 Evacuation order
 - 7.33.4.1.1 Least acute move first. Evaluate based on situation.
 - 7.33.4.1.2 If infant too critical to move, must remain in NICU.
 - 7.34.4.2 Horizontal move: Move in cribs (co-bed as a last resort, but infant must be properly identified first). Can also apply to vertical move if elevators can be used.
 - 7.34.4.3 Vertical move: Prior to vertical evacuation, the staff will receive notifications from the General Maintenance if the elevator is safe for use.
 - 7.34.4.4 If unable to use the elevator the use of staircase will be done, two nurses will assist in moving cribs downward with proper care.
- 7.35 **Intensive Care Unit Disaster Protocols:**
 - 7.35.1 In the event of disaster (e.g. fire) inside the ICU these procedures will be followed:
 - 7.35.1.1 ICU patients can be evacuated as per the physical & medical condition that the ambulatory patients (if there is) will be evacuated first
 - 7.35.1.2 The ambo bag & portable cylinders can be used
 - 7.35.1.3 Attending nurses or physician who first detects the incident will immediately call the call center @ 2222.
 - 7.35.1.4 Initiate the proper hospital codes during emergency situation such as fire.
 - 7.35.1.5 The first responder will be the first who detects or anyone of the staff who undergone a proper training.
 - 7.35.1.6 Fire fighting equipments are available inside the ICU which can be used during incipient stage.
 - 7.35.1.7 With proper trainings he/she will execute the RACE procedure immediately.
 - 7.35.1.8 If the situation needs evacuation an immediate evacuation procedures will be executed.
 - 7.35.1.9 Patients who need an adequate care and attention should be move to the nearest hospital (such as King Khalid General Hospital) with proper aid and life support equipments, assisted by a physician and nurses.
 - 7.35.1.10 Patient who does need life support equipments but still needs an adequate care will be moved to inpatient ward for further attention with the presence of attending ICU nurses and physician.
 - 7.35.1.11 The Safety and Security, General Maintenance and Biomedical Department will immediately respond to the area to assist ICU staff in evacuations.
- 7.36 **Operating Room Disaster Protocols:**
 - 7.36.1 In the event of emergency situation (e.g. fire) inside the Operating Room these procedures will be followed:
 - 7.36.1.1 During an emergency situation such as fire inside the operating room the surgical team is responsible of the situation.
 - 7.36.1.2 Anaesthesiologist:
 - 7.36.1.2.1 Bring surgical table to wheels
 - 7.36.1.2.2 Turn off medical gasses and disconnect circuits
 - 7.36.1.2.3 Ventilate using ambo bag and air and continue IV sedation
 - 7.36.1.2.4 Maintain respiration during transport.
 - 7.36.1.3 Primary Surgeon:
 - 7.36.1.3.1 Give final order for OR evacuation and patient removal
 - 7.36.1.3.2 Control operative zone, assist with drape removal and control/cover operative wound. Pack wound with moist towels and cover with sterile drape

- 7.36.1.3.3 Direct and assist with movement of surgical table and patient to the area of refuge.
- 7.36.1.4 Scrub Nurse:
 - 7.36.1.4.1 Gather all necessary surgical instruments to stabilize or close patient in a basin or towel and place on patient
 - 7.36.1.4.2 Assist in movement of surgical table and patient to the area of refuge.
 - 7.36.1.4.3 Disconnect patient leads, lines and gets IV's off poles
 - 7.36.1.4.4 Take drugs to maintain anaesthesia
 - 7.36.1.4.5 Disconnect anaesthesia machine and move machine if necessary
 - 7.36.1.4.6 Assist with ventilation and clear exit path to the area of refuge.
- 7.36.1.5 After OR Evacuation:
 - 7.36.1.5.1 Move patient to closest appropriate room
 - 7.36.1.5.2 Re-prepare site (irrigate)
 - 7.36.1.5.3 Re-drape and complete procedure
 - 7.36.1.5.4 Oxygen may be shut down to room of fire origin by staff
 - 7.36.1.5.5 OR staff, including the ancillary personnel will notify the call center @ **2222** as quickly as possible initiating the proper hospital emergency codes and the location.
- 7.36.1.6 Surgical patients may be moved to on the following safe areas based on assessment needs:
 - 7.36.1.6.1 ICU
 - 7.36.1.6.2 ER/OPD
 - 7.36.1.6.3 Transferred to the hospital /care facility.
- 7.37 Laboratory Disaster Protocol:**
 - 7.37.1 In the event of emergency situation (e.g. chemical spills and fire) inside the laboratory these procedures will be followed:
 - 7.37.2 Chemical substances are kept inside the chemical safety cabinets to minimize the risk of chemical spills.
 - 7.37.3 In the event of chemical spills, chemical spill kits are available inside the laboratory.
 - 7.37.4 In a small amount of chemical spills an authorized personnel with proper trainings on handling chemicals is responsible in using the spill kit.
 - 7.37.5 When the chemical spills are at large an order for evacuation is a must to avoid any harm or even fatalities.
 - 7.37.6 Biohazard Spill Kit is available in case of any spills of blood and any sample specimens.
 - 7.37.7 In case of fire happen inside the laboratory any staffs who first notice a smoke or a fire should immediately notify the call center @ 2222 and follow the RACE procedures.
 - 7.37.8 Fire fighting equipment are available any time in case of fire.
 - 7.37.9 Fire Blankets are used for incipient fires.
 - 7.37.10 Fire extinguishers are also available when notices that the fire cannot be tackle with the use of fire blankets.
 - 7.37.11 FM200 is installed in case fire is beyond control.
 - 7.37.12 A quick evacuation is required. Evacuation map and procedures are posted inside the laboratory in case of emergency situation.
- 7.38 Pharmacy Preparedness during Internal Disaster:**
 - 7.38.1 In the event of disaster inside the pharmacy (such fire) these procedures will be followed
 - 7.38.1.1 Upon discovery of an Internal Disaster (fire and other emergency) any pharmacy staff will immediately activate the recommended procedure to deal with the situation by following the code "RACE" after assessing the situation.
 - 7.38.1.2 Immediately notify the call center @ 2222 with proper hospital codes and the location.
 - 7.38.1.3 When the situation is beyond control start quickly the evacuation procedure with the aid of the responding team.
 - 7.38.1.4 Close safe the narcotics and evacuate all important documents.

- 7.38.1.5 In any disaster outside the pharmacy which resulted to casualties:
 - 7.38.1.6 Director of Pharmacy and supervisee of pharmacy units will remain in their respective units.
 - 7.38.1.7 The unit will prepare for medication management of disaster area.
 - 7.38.1.8 Pharmacy staff will go to the Disaster Treatment Areas as quickly as possible.
 - 7.38.1.9 Coordinates with disaster area leader regarding demands of medication and IV fluids.
 - 7.38.1.10 Drugs should be available any time in case of any disaster.
- 7.39 **Kitchen Preparedness Control:**
- 7.39.1 A kitchen fire is one of the leading causes of fire-related injuries and death. Preparation and safety habits are the key factors to prevent kitchen fires.
 - 7.39.2 Safety tips and procedures are included in our Kitchen Fire Preparedness Plan.
 - 7.39.3 In the event of fire inside the kitchen any staffs who first notices the incident is responsible to execute the first response.
 - 7.39.4 Immediately notify the call center @ 2222.
 - 7.39.5 When the fire spreads anyone inside is advised to execute an immediate evacuation.
 - 7.39.6 Evacuation procedures and maps are available inside the kitchen.
- 7.40 **Use of Action Cards:**
- 7.40.1 To have an organized response to the emergency codes called it is mandatory that the teams work in a synchronized fashion irrespective of their individual designations. This is achieved by following the instructions on the designated action cards. These action cards are available in the safety files of the department as well as in the Command Center office. Refer to action cards for internal disaster.
 - 7.40.2 An Action Card is a brief set of instructions detailing critical tasks that need to be carried out by a designated staff member. This document is usually presented as a laminated plastic card. This will enable the designated staff member to carry the action card while performing the specific tasks, thereby serving as a handy reference.
 - 7.40.3 The details in the action cards for each department include the below:
 - 7.40.4 Responsibility: The Manager is responsible for the design tasks
 - 7.40.5 Actions: required tasks to be completed
 - 7.40.6 Alternate: The designated alternate manager
 - 7.40.7 Reporting to: who the manager reports to in the disaster phase

8. RESPONSIBILITIES:

- 8.1 **Top management shall:**
 - 8.1.1 Approve the Internal Disaster Plan and ensure that all departments comply with its requirements.
 - 8.1.2 Ensure adequate resources are provided to effectively train, rehearse and, if necessary, implement the Internal Disaster Plan.
 - 8.1.3 Familiarize themselves with their roles in the command center.
- 8.2 **Department/Unit head shall:**
 - 8.2.1 Ensure department/unit staffs conduct regular internal disaster training and drills for their employees.
 - 8.2.2 Provide RACE instruction to all unit staff, including evacuation procedures and rescue techniques.
 - 8.2.3 Ensure all new hires receive orientation on the Internal Disaster Plan, and are made familiar with their roles and responsibilities within their specific department/unit in any given emergency.
 - 8.2.4 Ensure that all personnel attend regular on-service training and drills.
 - 8.2.5 Retain documentation of all employee in-service training and drills performed.
 - 8.2.6 Ensure that all drills are effectively critiqued and that any deficiencies observed are corrected, with appropriate documentation.

- 8.2.7 Coordinator of safety and risk management committee shall:
- 8.2.8 Ensure that the safety officer provides fire drill schedules to all directors and department heads.
- 8.2.9 Ensure that fire drill instructions are incorporated within the annual fire safety-training program.
- 8.2.10 Consider questions, suggestions and recommendations concerning fire prevention, potential hazards, etc. from any supervisor conducting critique meetings as a result of a fire drill.
- 8.3 **Hospital safety officer shall:**
 - 8.3.1 Serve as a leader of the Emergency Response Group (ERG).
 - 8.3.2 Liaise between departments/units, Civil Defence, Maintenance and the Security Department, on all issues pertaining to internal disaster.
 - 8.3.3 Monitor fire drills hospital-wide.
 - 8.3.4 Review and maintain records of fire drill critique reports and make recommendations for corrective action as appropriate to the supervisor of the area in which the drill was conducted
 - 8.3.5 Review and maintain records of fire drill critique reports and make recommendations for corrective action as appropriate to the supervisor of the area in which the drill was conducted
 - 8.3.6 Oversee fire drills in nursing areas, as required in the fire drill schedule, and submit a critique form for drills to the Hospital Safety Officer.
 - 8.3.7 Assist with evacuation of patients, visitors and personnel, if necessary.
 - 8.3.8 Prevent patients, visitors and personnel from re-entering evacuated areas of the unit.
 - 8.3.9 Assist in directing fire crews to the site of the fire.
- 8.4 **Nurse manager/in-charge nurse shall:**
 - 8.4.1 Ensure the unit-specific Internal Disaster Plan is implemented.
 - 8.4.2 NOTE: If there is a disaster in one of the critical units implement RACE procedure
 - 8.4.3 Coordinate nursing division response for incidence and assist hospital CEO regarding all nursing requirements during incident response.
- 8.5 **Safety coordinator shall:**
 - 8.5.1 Be appointed from each department/unit within the facility to help ensure a physical environment free of hazard and reduce the risk of human injury.
 - 8.5.2 Ensure the department/unit is a safe place for people to be and to work by monitoring work areas and employees work habits.
 - 8.5.3 Orientate all new departmental employees in safety practices specific to the department and their job requirement.
 - 8.5.4 Retain documentation of staff attendance to all educational sessions.
 - 8.5.5 Take necessary action to correct any deficiencies and unsafe conditions.
 - 8.5.6 Ensure department safety policy and procedures are available, current and approved.
 - 8.5.7 Promote safety awareness within the department by ensuring all employees are aware of their duties in the event of fire emergency and internal emergency preparedness plan.
 - 8.5.8 Request assistance on safety related issues as necessary from Safety Officer.
- 8.6 **Security department must:**
 - 8.6.1 Take immediate role controlling traffic, opening and closing doors as applicable, and securing affected area(s) to perform their duty in an effective way.
 - 8.6.2 Check elevator and stairways.
 - 8.6.3 Secured restricted areas such as ED, ICU, operating rooms, and NICU.
 - 8.6.4 Control vehicles entering the MCH facilities.
- 8.7 **All personnel shall:**
 - 8.7.1 Familiarize them with this Internal Disaster Plan focusing on their work area's specific plan and their responsibilities in the event of an actual emergency.
 - 8.7.2 Participate fully in all drills scheduled in their specific area.
 - 8.7.3 Practice RACE procedures, including evacuation and rescue techniques.
 - 8.7.4 The crew is responsible for dealing with power supply if there is fire or explosion:
 - 8.7.4.1 Hospital Electrician
 - 8.7.4.2 Charge nurse
 - 8.7.4.3 Safety coordinator in each department
 - 8.7.5 The crew is responsible for dealing with medical gases valves during fire or explosion:

- 8.7.5.1 Charge nurse
- 8.7.5.2 Safety coordinator in each department

9. ORIENTATION AND EDUCATION PROGRAM:

9.1 Training of staff:

- 9.1.1 All employees shall receive training in internal disaster and will be thoroughly briefed and rehearsed on procedures to be followed when incidents occur in their work areas such as fire and smoke.
- 9.1.2 The training shall be conducted during new hire orientation, and through in-service education, annual refresher training, and drills.
- 9.1.3 All employees should receive an orientation regarding the hospital emergency codes.
- 9.1.4 All employees should be familiar on how to initiate the emergency codes, emergency numbers and how to utilize the overhead the overhead paging systems.
- 9.1.5 All personnel shall be familiar with their unit fire drill and be aware of the locations of the fire alarms, extinguishers, oxygen shutdown valves, fire exits and evacuation routes for their work area. During evacuation, every room in the unit shall be checked to ensure that all occupants have vacated and the room shall be tagged with a room checked signed on the door to the corridor.
- 9.1.6 Fire extinguisher for actual fire training shall be conducted when a new employee is hired or when current employee is reassigned and at least annually thereafter. If work process changed, if new hazards are introduced into the workplace, or if different portable fire extinguishers are introduced into the work area, training or retraining shall be appropriate. If the emergency fire action plan or the fire prevention plan is changed, all employees shall be notified and trained to operate their different role in the plan. Instructors teaching portable fire extinguishers shall be trained for a different set of knowledge and skills and at a higher level than the content and level of knowledge and skills needed by employees operating portable fire extinguishers. Instructors' training and education shall be more frequent.

9.2 Fire drill frequency:

- 9.2.1 A simulated fire drill shall be held once per year in administrative areas and twice per year in patients' areas.
- 9.2.2 **Critiques of drill:**
 - 9.2.2.1 All drills at a unit and department level shall be thoroughly documented and critiqued. Deficiencies identified shall be addressed promptly.
 - 9.2.2.2 A fire drill evaluation form shall be completed and returned to the Coordinator of the patient safety and risk management committee to facilitate the compilation of statistics of the number of drills performed.
- 9.2.3 All independent entities whom present within the patient care facilities shall be surveyed & oriented to be sure from complying with all aspects of facility management program including:
 - 9.2.3.1 Safety and security
 - 9.2.3.2 Hazardous materials and disposal
 - 9.2.3.3 Response to disasters and emergencies
 - 9.2.3.4 Fire safety response

10. PERFORMANCE IMPROVEMENT MEASURES:

10.1 Monitoring Data:

- 10.1.1 The annual evaluation of the internal disaster plan will include a review of the scope according to the current CBAHI standards to evaluate the degree in which the plan meets accreditation standards and the current risk assessment of the hospital.
- 10.1.2 The performance and effectiveness of the internal disaster plan shall be reviewed by the Safety Committee, the Quality Assessment and Administration.

10.2 Performance Indicators:

10.2.1 The indicators intended to measure are:

10.2.1.1 Staff percentage (%) who could identify disaster (code red).

10.2.1.2 Staff percentage (%) who could identify how using fire extinguisher (PASS).

10.3 Reviewing Indicators:

10.3.1 These indicators and how we measure it will be reviewed every six months.

11. INTERNAL DISASTER PLAN REVIEW:

11.1 The Internal Disaster Plan is updated annually as policies and procedure are changed as a result of code changes, construction additions and new methods implemented.

11.2 Annually, the Hospital Safety Committee will evaluate the Internal Disaster Plan. Any revision, updating or changes shall be forwarded to the Quality Management Director for final review. Upon review, these policies & procedures and plans will be submitted to CEO of Maternity and Children Hospital for final approval.

11.3 The evaluation will be on the following:

11.1.1 Determine any issues and implement a solution;

11.1.2 Staff knowledge: If staff is knowledgeable of their duties and responsibilities during emergency code activation.

12. CONCLUSION:




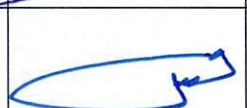
12.1 It is of utmost importance that the hospital leadership in collaboration with the department heads develops a response plan to different type of disaster including fire & safety. It is the responsibility of the leadership to ensure that all employees are trained in how to respond to the codes and that they proficient in the use of different are fire fighting & evacuation equipment.

12.2 Repeated training, drills and education is the key to a successful implementation of these disasters plan and the safety team and departmental safety links play a huge role in getting this done.

13. REFERENCES:

13.1 MOH and Civil rules and regulations

14. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Mr. Mishari Fahad Al Mutairi	Facility Management Safety Manager		January 08, 2025
Reviewed by:	Mr. Thamer Nasser Al Anizi	Support Services & Maintenance Director		January 12, 2025
Reviewed by:	Mr. Abdulelah Ayed Al Mutairi	QM&PS Director		January 15, 2025
Approved by:	Mr. Fahad Hezam AlShammari	Hospital Director		January 22, 2025