

## EVACUATION AND SHELTER POLICY

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Relevant Staff Group/s:	All senior managers, hospital matrons, mental health ward managers and members of Trust inpatient staff.

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# **IMMEDIATE ACTION**

**IF YOU ARE REQUIRED TO TAKE IMMEDIATE ACTION  
ON THIS POLICY AND YOU HAVE NOT READ IT BEFORE**

**DO NOT READ IT NOW**

**FIND YOUR LOCAL EVACUATION AND SHELTER PLAN**

**AND FOLLOW INSTRUCTIONS**

## DOCUMENT CONTROL

Reference AS/Mar16/ESP	<b>Version</b> V2	<b>Status</b> Final	<b>Authors</b> Head of Corporate Business/ EPRR Officer
<b>Amendments</b>	Revised document following publication of national NHS Evacuation and Shelter guidance.		
<b>Document Objectives:</b> This document sets out the Trust's plans to effect safe and effective evacuation of its inpatient facilities to ensure patients and staff are given appropriate shelter after being evacuated.			
<b>Intended Recipients:</b> All senior managers, hospital matrons, mental health ward managers and members of Trust inpatient staff.			
<b>Committee/Group Consulted:</b> Regulation Governance Group			
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## **1. INTRODUCTION**

- 1.1 The NHS Emergency Planning, Response and Recovery National Framework (2015) identifies evacuation and shelter as a key priority for NHS Trusts. Major incidents, including fires at the Royal Marsden, Chase Farm and Northwick Park Hospital sites, have reaffirmed the need to evacuate hospitals and other healthcare premises.
- 1.2 This policy provides a framework for the Trust to plan, prepare and respond for evacuating and sheltering patients, staff and others from, or within, its inpatient settings, including whole site evacuation.
- 1.3 While this policy concentrates on the shelter and evacuation of inpatient sites, the principles are sufficiently flexible to be adapted for use in other Trust buildings or facilities.
- 1.4 Evacuation planning is part of broader emergency planning and preparedness and takes account of the Trust:
- Incident Response Plan;
  - Fire response plans;
  - Business Continuity Management plans;
  - Lockdown Policy and local plans.

## **2. AIMS AND SCOPE**

- 2.1 This policy will help the Trust to:
- support a partial or total evacuation involving patients and staff;
  - ensure all Trust inpatient facilities have plans in place to effect an evacuation if required;
  - maintain the services being evacuated whenever possible;
  - identify and support vulnerable people being evacuated.
- 2.2 Local plans will be produced for each Trust inpatient site with the support of the Trust Emergency Planning Officer. The plans will be held locally, centrally and within the Incident Control Room.
- 2.3 This policy seeks to:
- enable a robust and effective response to an incident requiring the partial / full evacuation of an inpatient facility;
  - allow staff to act effectively in support of an evacuation;
  - provide appropriate information to the Trust's senior managers;
  - provide a risk-based process to enable the decision to evacuate and shelter.
- 2.4 The Trust is required to have business continuity arrangements in place to reduce the risk of evacuation in predictable circumstances.

2.5 The Trust owes a duty of care to both its patients and staff and understands it is not the responsibility of the emergency services to decide to evacuate one of its facilities; this responsibility rests with the Trust.

2.6 The Trust has responsibilities under the:

- Health and Safety at Work Act 1974, (section 2(1) and (section 2(2));
- The Management of Health and Safety at Work Regulations 1999 (regulation 3), (regulation 4 and Schedule 1), (regulation 8(1)), (regulation 8(1)(a) and (b)) and regulation 4(4);
- Safety Signs and Signals Regulations 1996;
- Regulatory Reform (Fire Safety) Order 2005 (article 14(1) and (article 14 (2));
- Department of Health Fire code guidance (HTM 05-01) Regulated Activities Regulations Section 9 sub section (2), Section 7 sub section (1 and 2) and Section 10 sub section (2

### 3. DUTIES AND RESPONSIBILITIES

3.1 During the evacuation and shelter incident the **most senior person on duty**, normally the Matron, Ward Manager or Senior Nurse in charge will be responsible for taking the decision to activate the local evacuation and shelter plan. The individual roles and responsibilities for Trust staff and supporting partner agencies are detailed below.

3.2 The **Chief Operating Officer** has overall responsibility for ensuring the Trust has an Evacuation and Shelter Policy and local plans in place and will lead the tactical response to any evacuation incident.

3.3 The **Director of Governance and Corporate Development** as Emergency Planning Accountable Officer will ensure local plans are regularly tested to assure the Trust response is as effective as possible and is accountable for ensuring all evacuation incidents are reviewed to ensure lessons are learned.

3.4 The **Head of Corporate Business**, as Emergency Planning Officer, has responsibility for the Trust's evacuation plans and processes, supporting the testing and exercising local evacuation and shelter plans at appropriate intervals and communicating Trust plans to all key parties.

3.5 The **Director of Finance and Business Development** is responsible for ensuring the recording of additional expenditure arising during an evacuation and shelter incident and for seeking compensation arrangements for the Trust, including insurance, are sought at the earliest opportunity.

3.6 The **Heads of Division/Senior Managers** will ensure local plans are developed, agreed, managed and monitored. They will act as the Trust liaison at the multi-agency Tactical (Silver) Command, if activated.

3.7 **Local managers (and/or their deputies)** will:

- develop, disseminate and implement the local evacuation and shelter based on risk assessments specific to their area;
- will verify and validate their local plans by regularly testing through tabletop or live exercises;
- fulfil the function of **Evacuation Co-ordinator** for their area of responsibility;
- appoint a deputy in their absence;
- identify themselves to the Emergency Services Response Team and act as the Trust liaison at scene;
- ensure good housekeeping of evacuation routes is maintained at all times;
- support debriefing sessions after an evacuation and shelter incident.

3.8 The **Evacuation Response Team** will:

- respond and attend the central point identified in the local plan;
- await further instruction from the Evacuation Co-ordinator;
- assist with evacuation and shelter should it be required.

3.9 The **Estates Department** will:

- send appropriate technical representation to the evacuation to assist the **Evacuation Co-ordinator** and the emergency services;
- support the isolation of utility services, including medical gas supplies, should it be required.

3.10 **Staff working at Trust inpatient facilities** will make themselves familiar with their duties and actions required in their local evacuation plan.

#### 4. EXPLANATION OF TERMS USED

4.1 **Evacuation** is the removal, from a place of actual or potential danger to a place of relative safety, of people and (where appropriate) other living creatures.

4.2 **Horizontal Evacuation** means moving away from the area of danger to a safer place on the same floor as the individual(s) is on. If fire is the cause of evacuation, movement should be to the next fire compartment section on that floor (i.e. through at least one set of fire doors). If necessary those who have evacuated horizontally may need to consider a vertical evacuation.

4.3 **Vertical Evacuation** means using a stairwell, or lift (if safe and appropriate (i.e. only a designated fire lift should be used during a fire)) to move to either the floor above or below, as appropriate, to move away from the area of danger to a safer place.

4.4 **Shelter** is defined as “a place giving temporary protection”<sup>2</sup>. It may be necessary to move patients into temporary shelters until such time as they

are able to return to the affected healthcare facility, or until they are able to be transported to another healthcare facility.

4.5 **Shelter in place/ Invacuation:** In certain situations the safest place to take refuge or cover is to remain in the current location. This is often referred to “shelter-in-situ” or “invacuation”.

4.6 **Vulnerable/vulnerability** can generally be defined as affecting those that are less able to help themselves or who are unable to be ‘self-reliant’, however, it is diverse and can also be the result of one or more external factors coming together simultaneously that creates vulnerability in some people who were previously not vulnerable.

## 5. RISK ASSESSMENT

5.1 There are many types of incident which may affect the Trust and its ability to maintain patient and staff safety. There are various risks which may result in a need to shelter patients and staff in places of greater safety or to activate partial or full site evacuation. These can include:

- power and other utility failure;
- adverse weather;
- utilities failure;
- flooding;
- fire;
- irritant fumes or hazardous materials release;
- hostage incident;
- external event such as a terrorist incident.

5.2 The different nature and severity of these risks will determine the level of evacuation and support required.

5.3 The primary purpose of any evacuation is to ensure the safety and security of patients and staff; this will be at the forefront of every decision. The the decision to shelter or evacuate must be made based on the overall risk to patients, staff involved in their care and other members of the public who may be affected by the incident.

5.4 It is essential a risk assessment starts the local planning process. Site specific evacuation and shelter plans should be informed by risks most likely to impact the site and the wider local area using relevant resources including the Local health Resilience Partnership (LHRP) and Trust EPRR Risk Registers. Within each site, the risk assessment process should include the risks associated with the location(s) of certain types of patients in relation to the ease of evacuation. This risk assessment will not only direct mitigating measures but also lead the planning process.



## 6. PLANNING ASSUMPTIONS

- 6.1 Local site-specific plans must identify possible places to shelter and triage patients. Plans should identify on-site and off-site shelter locations to hold patients in the initial stages of an evacuation. Planning should identify how patient care would be delivered in the short, medium and long term, depending on the cause of the evacuation.
- 6.2 Local plans should consider and plan for partial and complete evacuations; this should include suitable triage and sheltering areas outside the building. Planning should also identify the staff required in these areas in order to ensure the continued care of patients.
- 6.3 Where appropriate patient care and safety together with sufficient staff, medication and other resources cannot be maintained, it may be preferable for some patients and personnel to remain *in situ* rather than evacuate.
- 6.4 *In extremis* it is acknowledged in certain circumstances restrictions or limitations of normal standards of care will be inevitable. It should also be noted some patients may experience greater harm by being moved than by not being moved.
- 6.5 The Trust will take into account the diverse needs of all people on site including patients, staff, visitors and contractors when developing evacuation and shelter plans and will undertake assessment and planning in the pre-incident phase including engagement with partner organisations.
- 6.6 Planning will include:
- the development of local evacuation plans which are integral to the organisation's business continuity arrangements;
  - local exercising as part of the overall EPRR training programme including suitable exercises to support the requirements of the site and the likely risks faced. It is acknowledged it is difficult to conduct a live exercise of these plans and other arrangements, such as tabletop exercises, will be used;
  - local plans will be based on a reasonable worst case scenario, taking account the requirements of different times of the day and days of the week and the numbers of staff on duty.

## 7. ACTIVATION TRIGGERS

- 7.1 The decision to evacuate may be triggered by an internal incident e.g. a fire, or an external incident e.g. flooding.
- 7.2 Local staff may activate immediate shelter or partial evacuation plans to ensure the safety of patients e.g. in the event of a fire in their locality.
- 7.3 The decision to conduct whole site evacuation is the responsibility of the Chief Operating Officer (or their nominated deputy) or the On Call Director.
- 7.4 The Trust will take into account factors such as the risks patients and staff are exposed to, the nature and diverse needs of the patients being cared for

on the site, the level of staffing available, the trigger for the evacuation and the time of day an evacuation may be needed and the command control structure which will be required.

## **8. SHELTER**

- 8.1 Local plans will identify possible places to shelter, including holding areas appropriate to local needs. Trust links to other healthcare partners (including independent providers) and the LHRP will be an important part of this.
- 8.2 In the initial stages of evacuation a number of 'shelter in place' locations should be considered to include options both on-site, as well as healthcare settings off-site and non-healthcare settings off site. On-site shelter points should take into account local fire planning. Off-site shelter points should reflect an area of safety, away from the premises, where people can wait until they are either redirected to another place, hospital or taken home. Common off-site shelter points may include:
- churches;
  - town halls;
  - community centres;
  - Local Authority rest centres (if in the locality)
- 8.3 The choice of shelter locations will be pre-determined with assistance from the Head of Corporate Business and where appropriate the Local Authority and other healthcare partners.

## **9. EVACUATION LEVELS AND PHASES**

### **Evacuation Levels**

- 9.1 There are three levels when evacuation may be necessary or should be considered:

**Table 1: The levels when evacuation may be necessary and its implications**

Level	Implication
<b>Level 1</b>	No immediate threat to life or safety, but there is an incident on an adjoining floor or in an adjacent building (advance warning provided)
<b>Level 2</b>	A situation with no immediate threat, but one where the incident is likely to spread, or be prolonged so as to affect patient care in that area, from an adjoining area (advance warning provided)
<b>Level 3</b>	The situation where there is an immediate threat to life or safety (no advance warning provided)

- 9.2 The decision to shelter or evacuate should only be taken if, following a dynamic risk assessment, the risk to life of remaining *in situ* is assessed to be greater than the risk of evacuation. It may be safer to remain *in situ* or invacuate rather than evacuate.

**Phases of Evacuation**

- 9.3 The need for evacuation will depend on the incident. The type of incident will also influence the time available for evacuation and whether partial or full evacuation is required. Should evacuation be necessary, advance warning may allow staff and patients to prepare an efficient and effective evacuation.
- 9.4 Phased evacuation should be considered where different parts of premises are to be evacuated. Evacuation is undertaken in a controlled sequence with those parts of the premises expected to be at greatest risk being evacuated first.
- 9.5 The following stages apply:

**Table 2: The Stages/Phases of an evacuation and the implications**

Phase	Implication
<b>Phase 1</b>	Evacuation of a single ward/department
<b>Phase 2</b>	Evacuation of one floor
<b>Phase 3</b>	Evacuation of an entire block/building
<b>Phase 4</b>	Evacuation of an entire site

- 9.6 Should evacuation become necessary in one ward/department there will be a variety of patient dependencies to consider. The evacuation should be based on the concept of progressive horizontal evacuation, with only those people directly at risk from the effects of the incident being moved. This involves moving people at immediate risk to a primary holding area or place of

temporary safety (Phase 1). If the incident is not contained to one ward, a whole floor may need to be evacuated with patients moved to a lower or upper floor (Phase 2), as appropriate.

- 9.7 The occupants may remain in the primary holding area until the incident is dealt with or await further evacuation to another area. This procedure should give sufficient time for non-ambulant and partially ambulant patients to be vertically evacuated down or up stairways as appropriate to a place of safety. It may become necessary to evacuate an entire block or zone (Phase 3). In addition, it may be that more than one block or zone is affected leading to the evacuation of the entire site (Phase 4).
- 9.8 Tracking staff during an evacuation is a challenge, however the Trust has a duty of care to know which staff are working within the building at any one time. The nurse/person in charge must be aware of which staff are on duty.
- 9.9 Following evacuation, it is highly likely there will be a need to assess and reassess (re-triage) patients to assist with their appropriate allocation to other shelter places, for example another hospital, a nursing home or their own/relative's home.

## **10. PATIENT MANAGEMENT**

### **Triage**

- 10.1 Triage assists with making decisions on whom to evacuate and in what order and needs to be a dynamic process. Triage also helps determine the resources required to evacuate patients, their mobility, the type of shelter and equipment required, the length of time to relocate and the transport required for evacuation.
- 10.2 The National Ambulance Service major incident triage card system will be used to assist evacuation. This triage algorithm uses mobility and dependency to determine the evacuation triage priority, categorising patients into the groups Very Dependent, Dependent, and Independent (see Table 3 overleaf).
- 10.3 In order to aid planned and emergency evacuation Trust staff will record the patient's evacuation triage priority, the equipment required for the patient, staff resources needed and the drugs required.

### **Clinical Decision Making**

- 10.4 When considering whether to move a patient, a number of factors should be considered:
- difficulty of movement (i.e. mobility of patient, what equipment is needed to be taken to ensure patient care);
  - the time that would be taken in moving a patient vs moving other patients on the ward/in the clinic;
  - the risk to the patient of being moved;
  - the risk to the patient of remaining *in situ*.

Evacuation Priority	Category	Triage card Colour	Definition
Evacuation Priority 1	Very dependent	Red	<ul style="list-style-type: none"> <li>a. patient is on assisted ventilation</li> <li>b. patient is of such a weight as to require the assistance of 3 or more staff to effect evacuation</li> <li>c. patient cannot be disconnected from 1 or more pieces of apparatus for more than 60 seconds</li> <li>d. patient is connected to life support machinery</li> <li>e. patient is unconscious and in life threatened state</li> <li>f. patient requires more than 7 minutes to be disconnected from 1 piece of equipment</li> <li>g. patient is undergoing surgery</li> <li>h. patient has undergone major surgery under general anaesthetic</li> <li>i. patient requires 2 staff to effect evacuation</li> <li>j. patient can only be moved on his/ her bed</li> <li>k. patient is in critical condition/attached to more than 1 piece of apparatus</li> <li>l. patient is unconscious</li> <li>m. patient is detained under the Mental Health Act</li> <li>n. patient is blind or deaf or has other extraordinary communication needs</li> </ul>
Evacuation Priority 2	Dependent	Yellow	<ul style="list-style-type: none"> <li>a. patient can only move on his/her bed</li> <li>b. patient is connected to 1 piece of apparatus ( e.g. drainage bag)</li> <li>c. patient must be moved in a wheelchair by another person</li> <li>d. patient requires more than minimal assistance or is unwilling to be dressed in adequate clothing requiring therefore 1 or more persons to assist</li> <li>e. patient has dementia to the extent that they cannot be left without supervision</li> <li>f. patient can walk unaided for less than 5 metres</li> <li>g. patient has severe sight impairment or severe hearing impairment</li> </ul>
Evacuation Priority 3	Independent	Green	<ul style="list-style-type: none"> <li>a. patient can mobilize by him/herself in a wheelchair</li> <li>b. patient can walk unaided at less than normal pace</li> <li>c. patient has significant sight or hearing impediment</li> <li>d. patient can walk at same speed and for same distance as a member of staff</li> <li>e. patient can get out of bed and dress in adequate clothing with none or minimal assistance</li> </ul>

10.5 A tear off transport tag to track a patient's departure from a particular area will be used for immediate tracking purposes.

## **Moving vulnerable patients**

- 10.6 What makes a person vulnerable, or become vulnerable in an emergency will vary from person to person and from one type of incident to another. Some people may become vulnerable because of their inability to cope with changing circumstances or the need for support with communications when explaining the evacuation process.
- 10.7 The main groups of vulnerable patients are likely to be:
- those with infectious disease;
  - those with cognitive impairment
  - operating theatres and their associated recovery areas;
  - mental health, including PICU, secure wards and dementia care;
  - children/young people's wards;
  - outpatient units;
  - renal dialysis units, outpatient units and associated areas;
  - cardiac outpatient units and associated areas;
  - stroke units;
  - bariatric wards and units.

## **Transport**

- 10.8 The Trust will consider how transport to support of evacuation and shelter, and any subsequent re-shelter, will be arranged. This may need to form part of existing mutual aid.
- 10.9 Particular attention and consideration will be given to the transport of patients:
- on site between buildings;
  - to places of shelter on site e.g. to a holding area;
  - from one site to another site;
  - to places of shelter off site
- 10.10 Possible sources of transport including:
- SWAST;
  - patient transport services;
  - commercial organisations;
  - buses e.g. accessed via local authority;
  - voluntary agencies.

## **11. EQUIPMENT TO SUPPORT THE MOVEMENT OF PATIENTS**

- 11.1 Where progressive horizontal evacuation is adopted, non-ambulant patients should, where possible, be evacuated by bed or by wheelchair with any equipment required for their welfare.
- 11.2 When/if the need for vertical evacuation is identified, alternative equipment may be necessary if evacuation lifts are not provided. Examples of such equipment include evacuation sheets, ski pads, evacuation chairs, stretchers etc.
- 11.3 The Trust will ensure all very dependent inpatient beds (see Triage section) have ski sheets under the mattresses, or equivalent drag mattresses, or rapid casualty evacuation sheets should be available to aid the swift evacuation of patients.
- 11.4 On wards with dependent patients where ski sheets (or equivalent) are not used under each mattress, there will be an adequate supply of drag mattresses or rapid casualty evacuation sheets available for emergency use.
- 11.5 The Trust will ensure all evacuation equipment is tested on a regular basis.

## **12. SITE MANAGEMENT**

- 12.1 The security of a building is of principle concern while it is being evacuated. The local lockdown process will control the movement and access – both entry and exit – of people around the building or area.
- 12.2 By operating lockdown, further safety issues can be prevented from occurring. Lockdown is achieved through physical security measures and the appropriate deployment of staff.
- 12.3 Lockdown activation can lead to an evacuation. For example, if a lockdown continues to the point at which the Trust premises can no longer adequately function, a partial or full evacuation of a site or building may be necessary. Therefore, the Trust local lockdown activation plan and local evacuation plan are mutually supportive.
- 12.4 Lockdown and site security will be arranged in the event of a Trust site being fully evacuated for an extended period.
- 12.5 Full reference should be made to the Trust Lockdown policy and local plans.

## **13. RECOVERY**

- 13.1 Recovery planning should start as soon as possible, ideally during the evacuation itself, although this will be dictated by circumstances at the time. Early consideration of recovery and patient repatriation options will ensure a smooth transition through each phase of the incident.
- 13.2 The Recovery Team should be led by an Executive Director, ideally independent of the Incident Response Team.

13.3 There are four main areas to consider, Humanitarian, Economic, Environmental and Infrastructure

Humanitarian	<p>Patient return</p> <p>Ongoing patient care</p> <p>Updates to patients, families and carers</p> <p>Displacement of staff to other Trust sites (travel costs, welfare, management)</p> <p>Psychological support</p>
Economic	<p>Insurance</p> <p>Incident costs</p> <p>Landlord/tenancy agreements</p> <p>SLAs</p> <p>Supplies/equipment for Trust patients in other agencies</p> <p>Budget arrangements</p>
Environmental	<p>Site clean up</p> <p>Waste</p>
Infrastructure	<p>Repair/rebuilding</p> <p>Provision of temporary facilities</p> <p>Site security</p>

(Emergency Response and Recover, Cabinet Office, 2013)

## 14. EQUALITY IMPACT ASSESSMENT

14.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

## 15. TRAINING AND EXERCISING

15.1 Training will take place within the context of an EPRR training needs analysis undertaken by the Trust and agreed by the Trust Executive Management Team. An EPRR training strategy is in place to ensure staff are confident in their roles during an evacuation and shelter incident.

- understand the role they are to fulfil in the event of an incident;
- have the necessary competences to fulfil that role;



- have received training to fulfil these competencies.
- 15.2 Training and exercising enables the Trust to respond appropriately to a shelter and/or evacuation scenario and will be a formal part of local staff training and be part of an overall programme including suitable exercises to support the requirements of the Trust and the likely risks faced.
- 15.3 Where evacuation equipment is provided, staff will be adequately and regularly trained in its use and there should be sufficient numbers of adequately trained staff on duty at all times.

## 16. MONITORING COMPLIANCE AND EFFECTIVENESS

- 16.1 This policy will be regularly updated to take account of organisational changes and new guidance.
- 16.2 Each Director/Head of Division should ensure all organisational changes within their area of responsibility are notified promptly to the Head of Corporate Business:
- at least annually;
  - following organisational change;
  - when an evacuation and shelter incident occurs;
  - after any test or exercise of the plan [validation].
- 16.3 The Head of Corporate Business will provide quarterly EPRR reports to the Regulation Governance Group and an annual EPRR Assurance Report to the Trust Board.

## 17. COUNTER FRAUD

- 17.1 The Trust is committed to the Counter Fraud and Security Management Service (CFSMS) Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

## 18. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

- 18.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the fundamental standards which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 12:	Safe care and treatment
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing

- 18.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 18: Notification of other incidents

- 18.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

## **19. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS**

NHS England

Emergency Preparedness, Resilience and Response (EPRR) NHS England 2015: Planning for the Shelter and Evacuation of people in healthcare settings

Department of Health – NHS Emergency Planning Guidance (Planning for the evacuation and sheltering of people in health sector settings)

Department of Health NHS Emergency planning Guidance

Review of five London hospital fires and their management

## **20. APPENDICES**

- 20.1 For the avoidance of any doubt the appendices in this plan constitute part of the body of this plan and shall be treated as such.

Appendix A Local Evacuation and Shelter Plan Template

## LOCAL EVACUATION AND SHELTER PLAN TEMPLATE

The following pages contain an Evacuation and Shelter Plan template for completion by each Trust inpatient facility. It is important to ensure all departments located within the building/site are consulted with and included in the final version.

### **Evacuation – getting people out**

### **Shelter – Receiving those who have been evacuated**

Once completed, the Evacuation and Shelter Plan will contain locally sensitive information and its circulation should be restricted on a “need to know” basis. Copies should be version controlled and dated.

The Evacuation and Shelter Plan should detail who is responsible for updating/amending it, notifying changes in contact details etc. and how often this should take place. Editions of the Plan must be dated to avoid confusion.

Text that is in *italics* is guidance and should be replaced with information relevant to the ward/department.

The Contact Directory is a resource which, once completed, should contain contact details relevant to your potential needs. Details of In Hours, Out of Hours and Mobile Telephone numbers should be included.

A simple layout map of the facility should be included as an appendix or details of where site maps can be obtained.

The person completing this Plan must ensure the area has been identified for evacuation as temporary, short, medium or long term use.

It is also necessary for the receiving area to identify any current ways of working that may have to be followed by those evacuated staff working in that area.

Provision of additional resources such as cleaning, food, office accommodation, car parking and relative visiting arrangements once evacuation has been completed should be considered.

It may be desirable for the identified receiving area to produce its own plan for managing additional staff and patients in its facility in the short term, and any medium to long term arrangements.

Once completed, the Evacuation and Shelter Plan must be:

- approved by the Emergency Planning Lead;
- tested annually (table top);
- reviewed after it has been used during a real evacuation.

## EVACUATION AND SHELTER PLAN FOR

*INSERT WARD/DEPARTMENT/SITE*

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# **EVACUATION AND SHELTER PLAN**

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## 1 INTRODUCTION

The purpose of evacuation is to achieve a timely and safe evacuation of all people from an area of risk to a place of lesser risk, without exposing either them to unacceptable risks.

This plan details the agreed management arrangements and processes to be undertaken to ensure the evacuation and shelter of patients, staff and visitors from **NAME OF WARD/DEPARTMENT** to a suitable place of safety in the shortest period of time, whether resulting from an internal incident, local incident or a false alarm.

The plan also describes the arrangements to ensure continuation of services and the treatment and continuing care of patients in the short, medium and long term after an evacuation has been completed.

## 2. OBJECTIVES

The objectives of this plan are to:

- establish clear command, control and communications procedures for the incident;
- outline the stages of evacuation;
- define the responsibilities for the conduct and control of the evacuation;
- detail the process for conducting a safe and efficient evacuation of patients, staff and visitors to places of safety;
- detail transport for evacuees to the pre-identified receiving area;
- outline the security of the evacuation area;
- detail the registration and tracking of all evacuated patients, including ensuring the provision of basic clinical patient risk assessments which detail the issues and identifies suitable alternative accommodation;
- ensure clear plans for the onward allocation of all patients are available and are followed;
- ensure liaison with other services within the trust and, if necessary, external to the Trust;
- describe the establishment and maintenance arrangements for the provision of:
  - temporary accommodation;
  - media information;
  - psychological support to those affected;
  - detail the return of evacuees;
  - detail the process to ensure the safety, comfort and dignity of patients throughout the evacuation.

### 3 SITE INFORMATION

*An outline description of the site will be of particular use to external agencies who may not be familiar with the:*

- *site layout;*
- *services provided on site;*
- *usual numbers of patients/clients/staff/visitors;*

*It is important to remember throughout this plan that external agencies may not necessarily be familiar with health service terminology and acronyms which should be used sparingly and/or explained.*

### 4. TRIGGERS TO EVACUATION

Evacuation may need to take place due to a number of incidents:

- danger from spreading fire and/or smoke;
- a siege or hostage situation;
- serious flooding or the threat of flooding;
- damage caused by severe weather, such as storms;
- threat of environmental contamination which could have detrimental effects on health, for example following an accident or fire involving chemicals;
- threat of explosion, either from explosives such as a suspicious item/package, from gas pipelines or installations, or from chemicals involved in an accident or fire;
- loss of essential services such as power or safe water supplies.

### 5. THE DECISION TO EVACUATE

There may be times when staff, patients and visitors face immediate danger e.g. **A FIRE INCIDENT**. In such circumstances the senior member of staff on duty will take the decision to start the evacuation procedure

A decision to evacuate for incidents **OTHER THAN A FIRE** will be governed by assessing risk, both immediate and in the longer term and, time permitting, be taken in conjunction with the Executive Management Team.

Advice from specialists such as the Police, Fire Service, and Local Authority should also be taken into consideration. It will be **the last resort** and will occur following a full risk assessment whereby the risk to life of remaining in situ is assessed to be greater than the risk of evacuation.

In exceptional cases the Police may insist on evacuation, although they will always do so in cooperation with Trust staff.

Where time permits, the Head of Division or On Call Manager will decide the priority of evacuation in consultation with the Executive Director in conjunction with other multi-agency partners as appropriate.

The decision to evacuate all or part of any Trust inpatient facility may endanger patient and staff welfare and will not be taken lightly. Therefore,

the decision to evacuate will be based on operational experience and the advice of specialists. In some situations it may be advised only a certain part of a Trust facility should be evacuated.

Factors which influence the decision on whether or not to evacuate include whether the building would provide adequate protection for the period the hazard is expected to last. For example, in most chemical emergency situations the preferred method of ensuring patient and staff safety would be to advise everyone to go/stay inside, close doors and windows and listen to the radio and/or television, as carrying out an evacuation may result in unnecessary exposure to the danger.

The **TITLE OF APPROPRIATE TRUST PERSON** will decide the priority of evacuation, in consultation with the emergency services. The ultimate decision on moving patients rests with the Chief Operating Officer /Nominated Deputy.

*The plan must specify which individuals are responsible for making these decisions over a 24 hour period and how they can be contacted.*

Notification of the decision to evacuate will be given to the Trust Communications Team.

*Add contact details.*

All decisions must be logged. Appropriate Trust command, control and co-ordination arrangements will be established as soon as practicable.

## 6. ALERTING

*It is necessary in this section to detail how staff, patients and visitors will be alerted to the need to evacuate. This could be through the activation of the Fire Alarm, through internal telephone calls, radios, mobile telephones or through word of mouth. Whichever method is chosen, avoiding panic must be taken into consideration.*

*If it is unclear as to whether an evacuation is required, a 'Stand by' message should be issued to allow staff to prepare for an evacuation in advance.*

## 7. STAGES/PHASES OF AN EVACUATION

Evacuation of patient areas can jeopardise the health and welfare of patients and it is important to avoid unnecessary evacuation. If evacuation is necessary, advance warning will allow staff and patients to prepare and facilitate an efficient and effective evacuation.

*In larger Trust premises, the site may have multiple buildings and it will be possible to prepare a staged Evacuation and Shelter Plan to better cater for incidents of varying scales and/or allow the response to be escalated as appropriate.*

The stages/phases of an Evacuation are:

- Stage/Phase 1: Warning/Standby
- Stage/Phase 2: Evacuation of a single ward/department
- Stage/Phase 3: Evacuation of the entire building



- Stage/Phase 4: Evacuation of the entire site

If Stage/Phase 1 is activated but it proves unnecessary to evacuate, it is essential all agencies are “stood down”.

Stage/Phase 2 may be activated in response to a smaller incident that does not require the evacuation of the entire site, or as a precursor to Stage/Phase 3 and/or 4. The evacuation points detailed in the Local Fire Procedure are to be used unless circumstances dictate alternative locations have to be used.

### **The Process of Evacuation**

The process of evacuation can be broken down into two distinct phases:

- Progressive Horizontal Evacuation (Initial phase)
- Total Evacuation (Final Phase)

### **Progressive Horizontal Evacuation**

The principle of progressive horizontal evacuation is that, in the case of danger in one area, the patients/staff are evacuated to an adjoining safe area, on the same level. This new area is a **relatively** safe area or holding area unless advised otherwise.

The patients/staff from the evacuated area may then remain in the safe area until the danger is dealt with. If, however, the danger spreads further and thus increases, the patients and staff may then be moved into yet another adjoining safe area.

### **Total Evacuation**

Depending on the incident, it may be necessary for the whole floor or building to be totally evacuated to designated assembly/muster points outside the building.

The evacuation priority will always be:

- **Persons most in danger** – Those people in the area of or closest to the danger or the effects of the danger, will be evacuated first

Under no circumstances will patients, staff or visitors who have already been evacuated be allowed to re-enter until the danger is over.

Evacuation at this stage will require the declaration of a Major Incident if not already declared.

## **8. EVACUATION ASSEMBLY/MUSTER AREA**

*Ward/Departmental Fire notices will detail the evacuation assembly/muster area. It would be useful to identify in this section an alternative evacuation assembly/muster area. Confusion in the assembly/muster area can lead to delays in rescuing anyone trapped in the building, or unnecessary and dangerous search-and-rescue operations where a roll call has not been taken.*

*It is unacceptable for patients to be assembled in the open air for any lengthy period.*

*The plan should suggest suitable locations on and off site. See Appendix XX*

## 9. FIRST AID

*Consideration should also be given to identifying a suitable location for the provision of immediate first aid and minor injuries treatment for those affected by the incident.*

## 10. SPECIFIC NEEDS

*The evacuation of any Trust inpatient area will affect four broad groups of people, each with different needs. Specific provision will need to be made within the plan to meet the needs of each group:*

- *people injured as a result of any incident occurring on site (patients, staff, visitors, contractors, bystanders);*
- *patients with existing needs/illness (as opposed to those injured as a result of the incident);*
- *uninjured visitors;*
- *staff including those with a presence on site but not directly employed by the Trust e.g. Social Services, contractors and volunteers*

*Remember some people within a Trust building are unlikely to be familiar with the premises including entrance/exit routes.*

*It may be impossible to move some patients and consideration should be given to the care/support which can be provide for them at each stage.*

## 11. DISABLED PEOPLE

*Consideration must be given to the needs of people with impaired mobility. **It is recommended any member of staff or patient with a disability which could hinder a prompt and safe evacuation must have a Personal Emergency Evacuation Plan (PEEP).***

## 12. BARIATRIC PATIENTS

*The requirement for the evacuation of a bariatric patient may pose particular challenges. Issues which will require consideration include:*

- *as far as possible, locating designated bariatric accommodation on the ground floor close to appropriate exits;*
- *ensuring appropriate evacuation routes have been identified and tested e.g. no obstacles, adequate space in corridors and access and egress points to accommodate the size of the patient, transportation equipment and staff, floor surfaces minimise drag, are level. Such an exercise may advise as to where bariatric patients are routinely accommodated on admission to the facility, particularly if it is unable to be on the ground floor;*
- *ensuring there is a mechanism in place to keep emergency evacuation pathways free of obstacles;*
- *transporting the patient in the bed, if necessary, to move them out of immediate danger. Staff will be responding to the demands placed on*

*them in evacuation, consequently less staff will be available to assist with transfers to, for example, a bariatric wheelchair if available*

- *providing specialist lifting and handling equipment or beds;*
- *knowing the safe workload of evacuation equipment and have appropriate protocols in place where there may be patients who exceed this limit;*
- *providing relevant staff with on-going training in the safe emergency evacuation of bariatric patients.*

### **13. MAINTENANCE OF EVACUATION EQUIPMENT**

*Equipment which is provided for evacuation needs routine maintenance or servicing. This may range from battery replacement to the more technical servicing requirements of equipment such as evacuation chairs.*

*It is essential a record of maintenance or servicing is kept detailing how, when and by whom this was carried out and who is responsible for ensuring that this is repeated at an appropriate interval.*

*Identify whose role it is to take responsibility for this.*

### **14. COMMAND AND CONTROL**

A TACTICAL Command and Control Team will manage the Trust's response. It will receive information from and give advice to those Trust staff located at the scene of the incident and managing the evacuation (OPERATIONAL Team). It will also supply information to the Trust Executive STRATEGIC Command and Control Team should this be convened. Representatives of this team will participate in tactical interagency decision making.

### **15. BRONZE EVACUATION AND SHELTER TEAM (OPERATIONAL)**

*Key roles need to be undertaken during any evacuation scenario, in any area. The plan, therefore, needs to detail who will be members of the Evacuation and Shelter Team and who will be responsible for the following:*

*(Please note, use titles rather than names and do not forget that administration staff can also play a vital role in this situation)*

- *Informing staff of the need to evacuate*
- *Informing staff in unaffected areas of the situation should the evacuation be localised*
- *Liaising with the TACTICAL Command and Control Team*
- *Preparing the patients for evacuation*
- *Assisting should a patient refuse to leave*
- *Alerting the identified receiving ward/department if necessary*
- *Ensuring any safety/security procedures are followed prior to evacuating areas such as reminding staff of the need to prepare for*

*evacuation by backing up/closing down computer systems, storing patient/staff records securely at STAGE 1 of evacuation.*

*If time, who will be responsible for:*

- *Collecting the ward list*
- *Collecting the Visitor's Book from reception to assist with the roll call*
- *Collecting Healthcare Records/Staff contact details*
- *Who will take the drug trolley if appropriate*
- *Who will take anything else*
- *Who will check the ward is fully evacuated - consider using fire wardens even if evacuation is not due to a fire*
- *Once in the Evacuation Assembly area/muster point, who will carry out a roll call for patients/staff/visitors*

## **16. TRUST STAFF NOT INVOLVED IN PATIENT EVACUATION**

Staff who are not directly involved with the evacuation of patients should assemble at a predesignated assembly area/muster point(s) and await further instructions. The staff should not leave the site and should be prepared to be redeployed to assist further with the evacuation.

## **17. COMMUNICATIONS**

*Effective early communication within and between ward/department and the Emergency Services is vital to an effective response. However, an evacuation can hinder communications so this plan must make provision for maintaining communications internally and externally.*

### ***Internal***

*The plan should detail how information/instructions will be disseminated, e.g. internal telephone, mobile phones. Remember mobile phone cells can become overloaded or the service switched off by the police.*

*Plans should include details of how staff coming on duty will be advised that there has been an evacuation of premises e.g. face to face at the entrance.*

### ***External***

*Early provision will be made to alert relevant agencies and prevent further transfers/admissions. Again this plan should detail how information/instructions will be disseminated.*

### ***The Public***

*Provision must be made for informing relatives of the evacuation. Provision must be made for members of the public calling the Trust to find out about their relatives etc. when phone lines are damaged or the site is evacuated.*

*Arrangements will be made as soon as possible to communicate the postponement of outpatient appointments, planned admissions and professional visits.*

*If necessary the media can assist with disseminating information. However, the Trust Communications Team must be contacted in the first instance to facilitate this.*

## **18. RECEPTION CENTRE/HOLDING AREA**

*It may be appropriate to accommodate some patients in a Local Authority Rest/Reception Centre with appropriate numbers of Trust staff whilst arrangements are made for their onward transfer to identified temporary accommodation.*

*Local Authorities will have a plan listing suggested emergency reception centres and facilities, some of which may be appropriate for use by Trust patients. Any potential reception centre must be visited by appropriate Trust staff to ascertain its suitability. Consideration will additionally need to be given to the provision of healthcare needs.*

## **19. IDENTIFYING ALTERNATIVE ACCOMMODATION**

*In the event there is a decant ward or beds available, the plan should identify in advance suggested on-site and off-site locations which would be appropriate for people from each ward/department taking into account their likely needs.*

*It may be appropriate to identify temporary accommodation in emergency rest centres established by the Local Authority with appropriate medical support.*

## **20. RECEIVING WARD/DEPARTMENT**

*Make brief notes in this section plans which have been made with the receiving ward/department to facilitate the transfer of service.*

*Other information which may be required by evacuating staff for continuing to provide services in temporary accommodation could also be included.*

*If the temporary evacuation to a new ward/department is likely to be for at least four hours, details of where meals will be provided from and who should be contacted to ensure delivery would be useful.*

*Details of who will provide additional keys for the temporary accommodation and how staff gain access could also be provided.*

*Other suggestions for this section might be advice on staff car parking.*

*Another suggestion would be to produce a checklist for these and other things such as:*

- computers;
- phone numbers;
- food and drink;
- cleaning and Infection Prevention and Control;
- visitors' information.

## 21. PATIENT/STAFF TRACKING

It is important to ensure there are arrangements to remove/recover patient records from the evacuated area. Existing Trust documentation such as Healthcare Records must be maintained with evacuated patients where possible.

The Trust environment is different from almost any other in that some evacuees simply cannot be 'sent home'; the Trust has various responsibilities for staff, patients and others and it is important to record where patients and staff have been sent.

*The plan should therefore include provision for a 'tracking' function in support of the management team to keep track of where evacuated patients/clients and staff are located at all times. (See appendices to the Trust Evacuation and Shelter Policy).*

It is important to maintain close links with the Police Casualty Bureau, if established, in order to avoid duplication and/or confusion. Other agencies will need to keep this team updated and may provide representative(s) to assist with tracking.

Clinical teams are likely to want to retain responsibility so it may be possible to move patients as part of a self-contained unit.

Uninjured friends or relatives visiting at the time of the evacuation are also likely to wish to stay with patients if possible.

Any arrangements made for staff will be compatible with Trust Health and Safety responsibilities.

The Police may also need to access details of everyone present on site for use in a criminal investigation.

## 22. CO-ORDINATION OF TRANSPORT

Even internal evacuation may require some transport resources, dependent on patient needs, weather conditions etc. However, it is likely there will be a time lag before adequate transport resources are available. It is unlikely the ambulance services will be able to assist with the evacuation of patients.

*Requests from transport must be co-ordinated by the TACTICAL Command and Control Team so that use of specialised vehicles can be targeted appropriately. The plan should provide information about the suggested order of evacuation to maximise patient welfare and the efficient use of resources.*

Availability of transport resources is likely to necessitate initial evacuation to holding area(s) on site or close by.

*To maximise the speed and efficiency of evacuation, consideration of using a 'shuttle' method to enable a small number of vehicles to move a larger number of patients a relatively short distance initially to an appropriate facility from which onward transport can be provided.*

*Specialist transport resources are likely to be obtained from a variety of sources (ambulance service, local authority etc.).*

*It may be appropriate to use non-specialist vehicles such as minibuses, coaches, taxis and so on to speed transfer of less dependent patients and 'free up' ambulances. The plan should contain details of relevant local contacts. Local Authorities may be able to draw on existing relationships with bus and coach companies.*

*Prior consideration should also be given to the priority of transfer where possible.*

## **23. SITE ASSET AND SECURITY**

During any evacuation, it is important the security of the affected area and its assets are maintained. The primary aims once evacuation is complete are to prevent unauthorised re-entry into the building and to protect the Trust's assets as far as is reasonably practicable.

## **24. THE MEDIA**

Intense media interest in the full/partial evacuation of any Trust owned or occupied premise is to be expected.

Under **NO** circumstances must any member of Trust staff enter into discussions with the media or press either during or following any evacuation situation.

All information/press releases will be prepared and disseminated by the Trust Communications Team in co-ordination with other responding agencies, if appropriate. This will minimise confusion and misunderstanding.

The media can be useful in disseminating information to patients, relatives staff etc. but this must be arranged through the Trust Communications Team.

## **25. LONGER TERM RESPONSE/RECOVERY PLANNING**

Recovery planning should start as soon as possible during the evacuation. Recovery and restoration of the provision of services are likely to be dictated by the circumstances at the time of the event.

*The longer term response is likely to be dictated by the circumstances at the time of the event.*

*However, the plan should highlight some likely areas for consideration in the medium-long term including:*

- *relief for evacuated staff and information for the next shift;*
- *longer-term placements if it is not possible to reoccupy the site immediately or for some time;*
- *support for friends and relatives of those moved to other (more distant) sites;*
- *support for staff working temporarily at other sites;*
- *psychological support for staff if appropriate;*
- *clear up of the site and return to 'normality;'*

- *planning the return to the 'home' area.*

## **26. POST EVACUATION ACTIVITY**

### **Debriefing**

The evacuation of part or all of a Trust building is a stressful event for staff, patients and visitors. At the earliest opportunity following 'stand down' a short 'Hot Debrief' will be held. This will allow staff to voice pressing issues and express any concerns they have.

A 'Cold' Debrief may be convened by the Emergency Services, Local Authority at a later date.

Post incident support will be made available to staff after an evacuation. Clinical support to patients will be provided as appropriate.

## **27. TRAINING AND EXERCISING**

Training will be made available to enable staff to fulfil their roles and responsibilities to facilitate evacuation.

Staff training records will be kept up to date.

Initially, a 'table top' or discussion exercise will be held to validate the plan.

Subsequently, the plan will be exercised on an annual basis.

A post exercise report will be sent to the Head of Corporate Business.

## **28. EVACUATION AND SHELTER PLAN REVIEW**

Evacuation may take place as a precautionary measure in which only a brief period is required to return to normal working. However, after any activation of the Evacuation and Shelter Policy, the appropriate management team must:

- identify the circumstances surrounding the need for evacuation;
- review the experiences of patients and staff;
- identify any difficulties encountered;
- review and revise the relevant Evacuation and Shelter Plan in light of experience and lessons learned;
- consider education and training issues that may have arisen;
- produce a formal report for the Trust Quality & Risk Committee;
- inform the Trust Head Corporate Business of any lessons learned that may lead to the revision of the Evacuation and Shelter Policy



## 29. MAPS

*Trust sites have often expanded over time and can be confusing for those not familiar with the layout. Ideally this procedure should include clear and up to date maps (available by request from the Estates and Facilities Team) to show the location of relevant features such as:*

- *general site layout;*
- *vehicle entrances and exits;*
- *name and number of floors in each building, use and capacity of each floor;*
- *car parks and their users, for example, staff, public;*
- *emergency information including location of evacuation assembly areas, fire hydrants;*
- *suggested off-site reception centres*

**APPENDIX 1 SHELTER AND EVACUATION PLAN - PATIENT TRACKING FORM**

**WARD/DEPARTMENT:**

Patient ID Number	Patient Name	Original Bay & Bed Number	Dependency Independent Wheelchair Bedbound	Special Notes	Infection Control	Time & Location	Time & Location	Time & Location	Time & Location	Time & Location	Time & Location
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											

**APPENDIX 2      SHELTER AND EVACUATION PLAN - PATIENT EXIT LIST**

**WARD/DEPARTMENT:**

<b>Patient Incident Number</b>	<b>Patient Name</b>	<b>Location Sent</b>
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

**APPENDIX 3      SHELTER AND EVACUATION PLAN – STAFF EXIT LIST**

**WARD/DEPARTMENT:**

	<b>Staff Name</b>	<b>Location Sent</b>
<b>1</b>		
<b>2</b>		
<b>3</b>		
<b>4</b>		
<b>5</b>		
<b>6</b>		
<b>7</b>		
<b>8</b>		
<b>9</b>		
<b>10</b>		

**APPENDIX 4 SHELTER AND EVACUATION PLAN - PATIENT INCIDENT NUMBER ALLOCATION FORM**

**WARD/DEPARTMENT:**

Patient ID Number	Patient Incident Number	Patient Name	Inpatient Ward
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

**APPENDIX 5      SHELTER AND EVACUATION PLAN – MISSING PERSONS LIST**

**WARD/DEPARTMENT:**

	<b>Name of Person</b>	<b>Staff or Patient</b>	<b>Last Seen &amp; Time</b>
<b>1</b>			
<b>2</b>			
<b>3</b>			
<b>4</b>			
<b>5</b>			
<b>6</b>			