SCHL health emergency policy and plan

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- Recovery

In order to achieve our vision and values and meet legislative requirements[1] SCHL will maintain a current Health Emergency Plan (HEP). Southern Cross Healthcare Limited (SCHL) emergency management planning has been developed to ensure SCHL has a standardised 'accepted industry good practice framework' which accommodates our emergency systems, processes and capability to respond to any emergency event.

Under the National Civil Defence Emergency Management Plan District Health Boards are required to develop and maintain HEPs for significant incidents; these HEPs apply the structures and processes (e.g: the 4R's of emergency management) identified in the Ministry of Health National HEP by district and region; the SCHL HEP framework will align with the 4R's format of the NHEP and DHB HEPs.

Policy

The General Manager, COO and CEO, for Hospitals and National Support Office respectively, ensures each facility HEP is localised to ensure it is fit for purpose and that all employees are capable of activating the HEP as appropriate to the circumstances; HEPs will feed into a coordinated National HEP.

The emergency management policy is to protect and ensure:

- first the safety and welfare of any people in the facility i.e. patients, employees, practitioners, contractors and any visitors to the hospital; and
- the safety and security of the SCHL's property and SCHL's good reputation.

We are committed to acting responsibly by being part of the wider community however SCHL cannot provide external emergency management contributions except as:

- authorised by the CEO on the recommendation of the regional COO and / or
- legislatively mandated to provide services, supplies or physical facilities by Government agencies with requisitioning powers to do so, for example, Civil Defence.

Application

The General Manager, COO and the CEO are responsible to ensure HEPs are current and their teams capable of responding appropriately. SCHL HEPs are approved and signed off by the SCHL CEO (National) or Chief Operating Officers (Hospitals). This process must be repeated:

- After any significant HEP revision informed by exercise or experience or,
- service/facility, technology, or risks change; or
- Every third year at minimum.

The Quality Improvement Advisor and ELT will provide strategic support, oversight and champion the HEP.

The policy is applied as follows:

- HEPs
- Incident Management Team (IMT)
- Emergency Preparedness and Response Procedures (EPARP) including Emergency flip chart

As part of our commitment to comprehensive emergency management we will continue to develop, implement and revise the HEPs including emergency post-event.

Using this framework

The SCHL HEP Framework includes major business continuity planning and establishes the link with specific NZ national and local Health Emergency Plans using common terminology applicable to the NZ public health sector by district and region. (refer HEP Glossary). It provides direction and guidance to hospitals/National Support Office completing their own HEPs.

This Framework provides information on the emergency management approach used throughout SCHL, based on the four 'R's of emergency management: reduction, readiness, response and recovery. References are included for relevant legislation and key documents that may be useful for facilities as they develop their own HEPs (refer HEP References).

This document should be read with:

- Single Point of Contact (SPOC) Guidelines
- Hospital and National Support Office Health Emergency Plans and associated documents.

The audience for this document is all employees of SCHL throughout New Zealand, plus those agencies who interact with SCHL such as service providers, DHBs, ambulance, fire and police services, Civil Defence and Emergency Management Groups and other government agencies.

For the purposes of this document, the term 'hospitals' will be used to describe network hospitals and National Support Office.

Southern Cross Healthcare Limited (SCHL) Network

Southern Cross Healthcare operates New Zealand's largest network of private surgical hospitals. In addition to our nine wholly-owned hospitals, we have ownership interests in eight innovative joint venture facilities operated in partnership with other leading healthcare providers and medical specialists. Our network provides access to quality healthcare for more than 65,000 people each year.

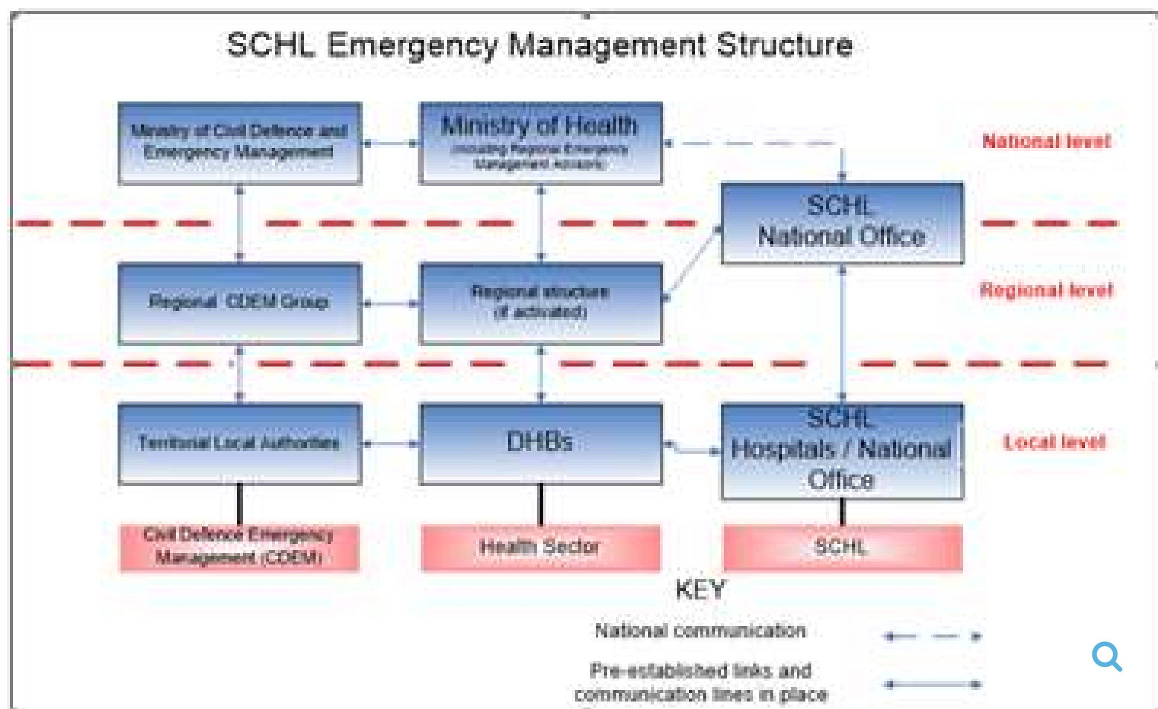
A national resource team including a Executive Leadership Team (ELT) are predominantly located in a central Auckland office and provide support across all business streams including finance, information systems, procurement, facilities, clinical and human resources. Chief Operating Officer provides leadership to hospitals in their areas and is located in Auckland.

Our business operates on a not-for-profit basis, and is owned by the Southern Cross Health Trust. Although we operate independently, with a separate Board of Directors, we make up part of the Southern Cross Healthcare Group of businesses that include Primary Care, Travel Insurance and Health Insurance.

For further details refer to the Southern Cross Healthcare Limited Corporate Profile 2011 and the Southern Cross Healthcare website.

Our emergency planning objectives

The HEP Framework is based upon the Ministry of Health National Health Emergency Plan[2] which provides overarching direction to the health sector and all of government. See figure 2 below.



National Civil Defence Emergency Management (CDEM) planning in New Zealand is a requirement of the CDEM Act 2002 (refer SCHL HEP References). Use of the term *emergency* is based upon Civil Defence Emergency Management Act (CDEM Act 2002) definition (refer National CDEM definitions and abbreviations).

Key objectives of the HEP framework are directed by the SCHL Emergency Management Policy to ensure SCHL facilities have an emergency management structure that:

- supports, to the greatest extent possible, the protection of its patients, visitors, employees, medical and health specialists
- aligns with the wider health sector and enables a consistent and effective response to emergencies at the local, regional and national level; keeping as far as practicable within business norms
- enables SCHL to respond as required/appropriate during an emergency, this may involve closing facilities or keeping them open (albeit in a different capacity).

HEPs are activated when usual resources are overwhelmed or have the potential to become overwhelmed in a local, regional, or national emergency. To trigger the activation of a HEP, the event must require more than the business-as-usual management of emergencies (refer: Attachment A: SCHL Emergency Response Tiers). A detailed definition of 'overwhelmed' has not been given to allow for hospital / service flexibility in the assessment of a pending, developing or current emergency on an hour-by-hour or day-by-day basis.

Emergency management documents

The relationship between the HEP framework documents and their management levels

HEP framework

The Southern Cross Healthcare Limited's HEP framework has been developed to ensure SCHL has policy systems, processes and capability to respond to any emergency event and is a national framework based on the 4R's of emergency management as they apply to our organisation:

- **Reduction** – Identifying and analysing long-term risks to human life and property from natural or man-made hazards; taking steps to eliminate these risks where practicable and where not, reducing the likelihood and the magnitude of their impact
- **Readiness** – Developing operational systems and capabilities before an emergency happens
- **Response** – Actions taken immediately before, during or directly after an emergency, to save lives and property, 'prevent the spread of disease as well as help the service to recover

- **Recovery** – Activities beginning after initial impact has been stabilised in the response phase and extending until the facilities capacity for self-help has been restored.

Health sector emergencies can range from the slow build-up of an infectious disease outbreak to the sudden devastation of an earthquake. Often the consequences are extreme and the likelihood is certain, but the actual timing is impossible to predict and it may change in scope and impact. Most emergencies will not be catastrophic – the structure and documents which comprise this HEP framework have been designed to provide guidance for responding to the majority of emergencies from which recovery is manageable.

The effectiveness of the HEP framework is reliant on a continuing process of training, communicating, evaluation and review of HEP procedures and performance at all levels within SCHL (refer Attachment D: Evaluation and Review of HEP performance).

Hospital and National Support Office HEPs

Each SCHL facility (hospitals/National Support Office) develop local HEPs consistent with the SCHL framework to provide their site with a robust structure for the management, coordination, and control of emergency events and that explains how services will be prioritised, organised and delivered throughout the phases of an emergency event. Key elements of each hospitals plan are organised under the '4 R's', Reduction, Readiness, Response and Recovery.

Preparedness strategies are outlined for key areas (business units, services), with particular focus on business continuity. HEPs include current site capacity and utility/service plans, contact lists and related processes. Risks are routinely analysed and monitored with plans being adapted as necessary.

Incident Management Team (IMT) activation kits

In line with the NZ health sector and emergency services SCHL uses the Coordinated Incident Management System (CIMS) to manage an emergency response within the hospital and or region/network. The CIMS structure assigns specific roles to members of an Incident Management Team (IMT) that are understood internally within SCHL and externally between outside agencies. Hospitals/national develop internal competency and resources (record templates, processes, equipment) to support the activation of the IMT when the response is required.

Emergency Preparedness and Response Procedures (EPARP)

Emergency Preparedness and Response Procedures (EPARP) provide guidance for all staff to assist them in preparing for, and in the immediate response to emergency situations such as for example fire, hazardous material spill or natural or manmade hazards, influenza pandemic. EPARP information is also available in summarised form in Emergency Flipcharts readily accessible in every facility.

Reduction

The principles of reduction are to identify and analyse risks that are significant because of the likelihood or consequences to human life and property from natural or man-

made hazards. Having identified and analysed the risk, steps are then taken to eliminate these risks where practicable and where not, to reduce the likelihood and the magnitude of the impact.

Hospitals identify and regularly review proactive measures to reduce the health impacts of emergencies or other events based on their local Civil Defence Emergency Management Hazard plans. These provide a guide to threats that could impact service provision and their own Hospital Hazard and Risk Registers and Strategic Risk Registers.

Where risks are identified the implications for the facility are considered. These may include the following:

- Stretched medical services, strain on public health resources
- Staff issues
- Medical supplies not readily available (demand exceeds supply)
- Widespread social and psychological disruption and isolation.

The General Manager/CEO ensures the site is assessed at least annually by the Facilities Manager to ensure that the site, buildings, infrastructure and trees etc are safe. Note for National Support Office this relates to just the infrastructure managed by SCHL. Maintenance is undertaken as appropriate. Where possible back-up systems (eg: emergency power, alternative water) are in place (refer Facilities audit programme and localised; Facilities emergency systems and alarm tones and Site location plan).

Refer also:

Hazard and Risk List Procedure

Risk Assessment and Guide to Action Guideline

Readiness

This section considers actions to ensure a state of readiness for health emergencies is maintained.

Ensuring business continuity[1] requires effective management of organisational risk, including the possibility of disruptive events. The HEP provides an integrated effective business continuity framework to articulate the principles, resources and responsibilities for managing such disruptive events. Particular attention is given to those activities, resources, processes and dependencies that are most critical.

[1] AS/NZS ISO 3100:2009, Risk Management-Principles and guidelines. AS/NZS 5050:2010, Business Continuity – Managing disruption – related risk.

Facilities / resource to manage an emergency

National Support Office and each hospital have an Emergency Operation Centre (EOC) available for immediate activation if required. The National Support Office and hospital Incident Management Teams (IMT) have access to equipment and resources to manage an incident.

Emergency Operations Centre (EOC)

The EOC is established and maintained at a distance from the emergency event to ensure that the EOC is not compromised by 'operations'. The EOC is staffed by the members of the IMT and other support personnel as required. This facility is suitably equipped, has been actively tested and is continually improved upon after each exercise and incident. Should the primary EOC location be compromised an alternate EOC facility should be identified in advance.

IMT members and support personnel will require immediate access to:

- communications (landline/cellular telephones, facsimile, radio-telephone networks, TV and Radio, email/intranet)
- information systems (electronic and hard copy)
- refreshments and ablutions.

DHB's will have emergency plans and procedures and in an emergency the DHB Emergency Planners or EOC can be contacted to request assistance.

Competent people to manage an emergency

As part of the national and hospitals HEPs, measures are in place to ensure that trained staff are available to initiate the response immediately it becomes necessary:

- The SCHL CEO (National Support Office) and the General Managers are the single point of contact for their site unless otherwise notified. Read the single point of contact guidelines.
- The hospital has specific operational Emergency Response And Preparedness Procedures (EPARP) to manage emergency events and these are available in hard copy and on the Intranet
- Emergency procedures training, education and development is undertaken at each Hospital (refer Education, Training and Development Guidelines):
- Designated persons such as managers, certified handlers, charge nurses, night staff, maintenance staff have a higher responsibility for initially managing an emergency and are to be trained accordingly. Read about the safe use of hazardous substances.
- The CEO/General Manager is responsible for appointing adequate Fire/emergency wardens and ensuring staff training in emergency management (refer:Fire Wardens)
- All staff who are required to assist/participate in the Incident Management Team are trained in the Coordinated Incident Management (CIMS) to assist them to be effective in their response to manage incidents
- The EOC set up procedure including location and IMT role responsibilities and task cards are documented in the plan
- Employees complete an orientation familiarisation of the Emergency Folder, Emergency Flipcharts and equipment by the completion of the second full day of employment, or as otherwise agreed. This is recorded in the orientation and training, development and educational records at each site
- All staff will receive on going regular training in emergency management that is appropriate to their level of supervision in the facility including annual updates in emergency procedures are completed

All training is to be recorded for audit purposes,

The Coordinated Incident Management System (CIMS)

The Coordinated Incident Management System (CIMS) has been adopted for use in partnership with Civil Defence for use by the Health and Disability Sector at district, regional and national levels and provides a common format that facilitates close liaison between all responding agencies.

The CIMS structure uses:

- a common terminology including predesigned titles for major emergency functions, facilities and resources
- Standard information and communication templates eg: Situation Reports (Sitreps) and written Incident Action Plans (IAP) that document objectives, support activities, responsibilities and timeframes
- a means of organising and deploying resources during an event.

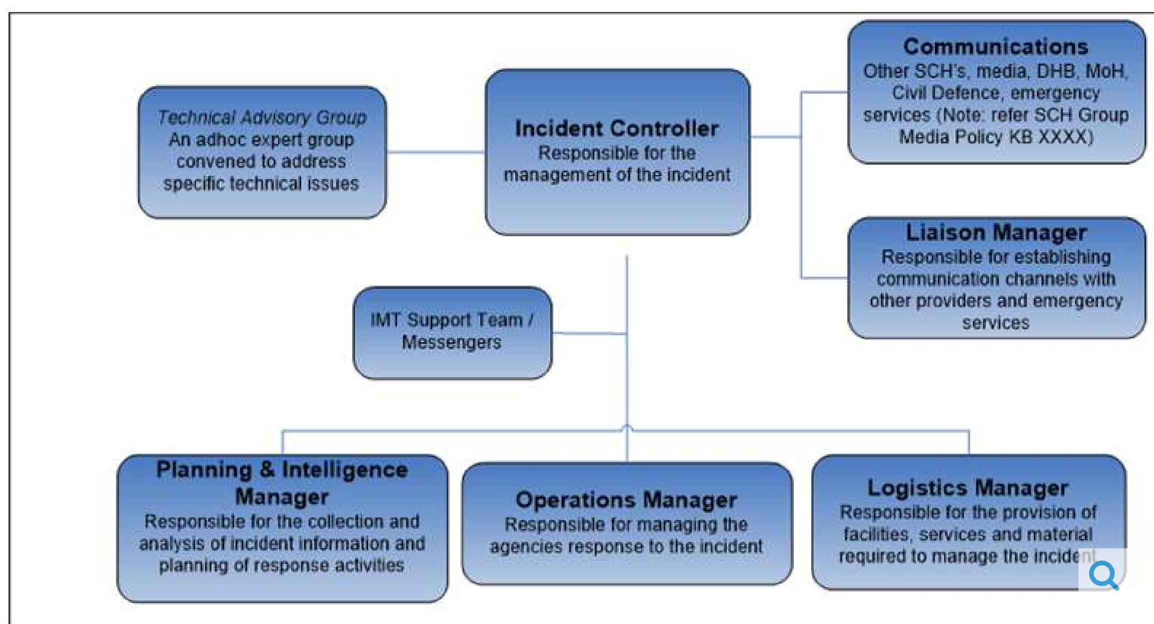
Typically the CIMS is built around five major positions forming an Incident Management Team (IMT) and additional roles can be included for example Communications (see Figure 4 below).

A CIMS response may be required for short or extended period of time and for 24 hours a day, seven days a week. The range of CIMS IMT roles that are activated will be dictated by the size and nature of the emergency event (for smaller events multiple roles can be taken on by an individual). IMT members are flexible and it is the expectation that there are sufficient staff members able to work across the different roles as required.

Task cards describing the role and responsibility for each IMT team member are developed and included for example in the IMT Activation Kits and Emergency Operations Centre (EOC) kits.

[1] Appendix 1, The New Zealand Coordinated Incident Management System

[2] National Civil Defence Emergency Management Strategy (2007) pp 43-44.



Typical Role and Structure of Health & Disability Sector CIMS Incident Management Team adopted for use by the health and disability sector at district, regional and national levels

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Communication and information management

In an emergency response a formal communication structure is required so that critical information is captured and acted on quickly and effectively. Refer to 5.2.1 for a list of group documents. This structure includes the mechanisms to develop and disseminate critical information, both within SCHL, the wider health sector and to other organisations involved in the response. It complements the informal communication mechanisms that are used in a response (e.g. phone conversations, briefings). Critical information that results from informal communications must be formally logged using the agreed structure, to stop multiple lines of communication forming and to minimise the risk that information is not captured and acted on.

The key areas that require a formal structure include:

- logging information and tracking tasks
- requesting information or action and tracking responses
- developing and disseminating reports on the current situation
- summarising and communicating key intelligence on the incident as it affects the hospital site and services
- liaison, support and information sharing with the SCHL National team as applicable and local external agencies eg: Civil Defence, DHB, Police, St Johns Ambulance.

SCHL emergency event communications structure

The CEO Southern Cross Healthcare has responsibly for establishment, maintenance and compliance with the Southern Cross Healthcare Group Policies. The CEO delegates the accountability for local establishment, maintenance and compliance with the Plan to the COO; where there is no COO the General Manager is responsible for this. Refer to:

- Southern Cross Crisis Communication Communication Plan
- Group Media and Government Relationship Policy
- Group Media and Public Communications Policy
- Group Media and Public Communications Guidelines
- Emergency preparedness and response for pandemic flu

SCHL internal communication

Global Email Staff Alert:
The Incident Controller, in consultation with the SCHL CEO and SC Group Communications Manager, is to authorise the release of a global email to all staff. The email may make reference to the following:

- a brief description of the incident
- an outline of the current response, for example EOC activated

- EOC location, contact details and reporting channels
- appropriate advice or action required, for example, staff should avoid overloading the telephone system
- reference to further information being made available on the Intranet
- notification to staff is to exclude information that is likely to cause unnecessary alarm or confusion.

Intranet:

An announcement regarding the incident may be entered on the Intranet Home Page along with periodic updates by the SC Group Communications Manager in consultation with the SCHL CEO and the Incident Controller.

SCHL External Communication

Public enquiries:

In order to avoid overloading the telephone system, the Incident Controller may authorise the diversion of incoming calls for the duration of the incident response. Use of an automated pre-recorded message should be considered to reassure the caller that normal communications will be resumed as soon as practicable.

News media:

The SC Group Communications Manager (in consultation with the SCHL CEO, the Incident Controller and members of the IMT) will be required to generate press releases to update members of the public and hospital staff who are unable to receive information by more discrete methods. (refer: Group Media and Public Communications Policy and Guidelines).

Local relationships

Emergency management planning is a function that requires collaboration across many agencies internal and external to health. Local relationships are vital to providing a coordinated response to any emergency event. Hospital plans include General Managers/CEO making contact with the DHB Emergency Manager in their region and ensuring emergency services including the local CDEM office has the hospital/National Support Office and site on its list of local hospitals. Hospitals/National Support Office maintains routine and emergency contact routes/methods for all agencies as relevant.

Systems for alert and notification

This procedure ensures that information is relayed to the appropriate team members. Escalation/de-escalation is not always a linear process; the nature of the incident will dictate the rapidity of onset and impact level.

Single Point of Contact (SPOC)

The SPOC system is a communication method that is used to provide an effective system for notification of a regional or national actual or emerging threat or event including where a facility is unable to cope with a local incident alone.

The SPOC system is an integral component of readiness that remains in place at all times. It supplements but does not replace normal day-to-day non-emergency

communication channels and processes. The SPOC system needs to be monitored 24 hour, seven days a week to be effective. It is only intended to be used for initiating an emergency response.

Point of Note: The MoH and MCDEM use agency specific codes for communicating the actual or potential magnitude of events Notification of an emergency may come to SCHL from the MoH, MCDEM or DHB SPOC.(ref: Single Point of Contact Guidelines).

Health Emergency Management Information System – EMIS

During any regional/national emergency event the MoH and DHBs have access to a web based Emergency Management Information System (EMIS). Information contained on this system may assist the SCHL response. The system provides DHBs with a task tracking system, standard templates for requests for information or action, and a mechanism to track process on these results. This information is visible to all organisations involved in the response that have access to EMIS. Access to the national DHB system is not yet available to SCHL; typically at this point the information is printed and shared with our hospitals. This is contingent on the General Manager developing and maintaining relationships with regional agencies including the local DHB.

Health sector alert codes

The MoH has developed alert codes, the purpose of which is to provide a system of communication for an emergency that is easily recognised within the sector. These alert codes are issued via the SPOC system (refer Figure 5 below).

Ministry of Health Alert Codes for the SPOC system

Phase	Example situation	Alert code
Information	Confirmation of a potential emergency situation that may impact in and/or on New Zealand. For example, a new infectious disease with pandemic potential, early warning of volcanic activity or other threat.	White
Standby	Warning of imminent Code Red alert. For example, a possible emergency in New Zealand such as an imported case of a new and highly infectious disease in New Zealand without local transmission or initial reports of a major mass casualty event within one area of New Zealand which	Yellow

	may require assistance from unaffected DHBs.	
Activation	A major emergency exists in New Zealand requiring immediate activation of HEPs. For example, a large-scale epidemic or pandemic or major mass casualty event requiring assistance from outside the affected region.	Red
Stand-down	Deactivation of the emergency response. For example, end of outbreak, epidemic or emergency. Recovery activities will continue.(refer 4.7)	Green

Warnings received as part of the Civil Defence SPOC system use different codes depending on the issuing agency, refer to the National Civil Defence Emergency Management Plan, 2015 (PDF, opens in new window).

Management of volunteers

In any emergency event volunteers internal and external to SCHL may offer their services. In the first instance spontaneous volunteer services at SCHL hospitals/National Support Office is discouraged if the hospital/National Support Office has the capability to manage its own services. Where this is not the case utilising spontaneous volunteer services would be at the discretion of the General Manger/Incident Manager and within a controlled framework.

There are two types of volunteer,

- A volunteer is an affiliated member of a recognised group, has some CDEM training and is accountable and responsible through their organisation
- A spontaneous volunteer is not a member of an organised recognised group; they are untrained in CDEM relevant skills, not responsible or accountable to any given organisation and therefore an unknown quantity.

In emergency health practitioners, for example credentialled doctors who admit and treat patients at the hospital or off duty staff or contractors may voluntarily offer their services. The same duty of care applies to the health and safety management of volunteers, employees, visitors and contractors under health and safety legislation

- this duty provides that the person for whom the volunteer is doing the work activity must take all practicable steps to ensure the health and safety of the volunteer.
- all identified hazards need to be communicated and managed

- the volunteer should not be asked to complete any task they are not competent to perform

Key considerations in relation to all volunteers (including credentialed specialist doctors and employees) are:

- clear purpose
- sound management structure
- recruitment and selection
- properly equipped
- training

Refer to the 'Director's Guideline for Civil Defence Emergency Management Groups: Volunteer Coordination in CDEM' (PDF, 3.1mb, opens in new window), November 2013.

Continuous quality improvement: testing and exercising

As part of the HEP development process:

- All SCHL facilities have a current HEP in place
- Contact, coordination and collaboration between SCHL and its service providers is maintained to a high level of preparedness for emergency events
- HEPs are regularly checked and tested
- Post emergency event/exercise reviews of the effectiveness of HEP responses are undertaken (refer Attachment D: Evaluation and Review of HEP Performance)
- Opportunities for improvements to systems and process including sharing best practice and implementing learning are identified and actioned

To achieve continuous improvement emergency planning, all plans are linked as appropriate to the current Business Plan purpose, vision and core strategies, Quality Plan, Hazard and Risk List and Strategic Risk Register (refer also SQR Folder). Examples include:

- Health Emergency Plans (HEPS)
- CIMS Incident Management Team and Activation Kits
- Emergency preparedness and response procedures
- Emergency Flipcharts
- Evacuation Plans
- Site Plans (Clinical and Facilities)
- Emergency training, e.g. CIMS, fire safety, resuscitation

Monitoring auditing, review and reporting includes emergency planning and emergency management with linkages to:

- Senior management and board reporting
- Internal and external audit programmes
- Consumer, employee and medical specialist / stakeholder feedback as appropriate
- Hospitals' SQR and National Support Office QARM Committees

Response

This section explains how a response is activated and managed. It involves mobilising and deploying resources immediately prior to, or during an emergency, in collaboration with other services and agencies, to ensure as far as practicable the:

- continuation of essential services
- relief and treatment of people injured or in distress as a result of the emergency
- avoidance or reduction of on-going public or personal health risks to all those affected by the event.

Planning for recovery

Consideration of recovery spans all four phases of emergency management planning. Recovery activities commence while response activities are still in progress. The priority actions for each are different; however, decisions made during the response phase will have a direct influence on recovery action planning.

Emergency events

Examples of emergency events which will require activating a HEP may include, but are not limited to the following:

- epidemic or pandemic
- an event involving mass casualties
- terrorist threat (includes bomb threat requiring evacuation)
- loss of essential services (includes communications failure or blackouts)
- critical staff shortage (includes strikes)
- reduced operational capability of a DHB
- natural hazard event, e.g. volcanic eruption

Any actual or potential emergency event that may overwhelm normal resources is to be escalated by staff using the processes described in the HEPs. The critical services and equipment issues described in the HEPs will ascertain the extent to which an event is deemed an emergency; this is also dependent upon the nature of the event and the resources available at the time.

On receipt of the alert/notification the General Manager/CEO / Incident Controller will call an initial meeting of key people to assess the emergency and decide on the level of response required (each facility will have a list of these people in their HEP). These levels are likely to be either:

- Immediate, short duration events
- Extended emergencies

Based on the initial assessment, an escalation of the plan may be deemed necessary. If this is the case an Emergency Operations Centre (EOC) will be set up to coordinate, direct and support the hospital response.

Activating the Incident Management Team (IMT)

A SCHL facility must activate their HEP when they believe they are overwhelmed or have the potential to be overwhelmed (refer Attachment A: Emergency Activation and Alert Table).

Southern Cross Healthcare Emergency Response Tiers

Tier	Impact of event (actual / potential)	National EOC	Activity	Local EOC/s	MoH National and Regional Activation
1	Unlikely to impact on other business units or hospitals	On notice		Locally managed	
2	Other business unit functions and/ or hospitals impacted. Unlikely to significantly impact on remainder of the business functions	Modified EOC activated to support local response	May Activate Southern Cross EMIS Event for site	Locally managed	
3	Significant impact on business functions	Full EOC activated to lead response	Activate Southern Cross EMIS Event	Nationally coordinated	MoH Code Yellow National and Regional EOC on Standby EMIS Event may be activated
4	Significant impact on community	Full EOC activated to lead SCHL response and partner with National/Regional health service response	Activate Southern Cross EMIS Event	Nationally managed	MoH Code Red National and Regional EOC activated EMIS Event activated

When a facility activates their IMT they will communicate that they have taken this action to the SCHL CEO, collocated services and their local DHB. At this point National Support Office will determine the level of activity required and will activate its IMT accordingly.

When National Support Office activates its IMT this action is to be communicated to the Southern Cross Healthcare Group CEO, SC Group Communications Manager and the SCHL Board notifying them of a potential or actual large-scale emergency.

Generic Management of Emergencies

All emergencies are managed using the CIMS structure. With the use of these clear procedures the hospital can be either self-sufficient or interconnected with the SCHL network, the local DHB and emergency services as appropriate.

The EOC will be set up. The CIMS structure (IMT or modified IMT) does not affect the normal day to day vertical operation of the hospital and other health agencies unless instructed otherwise by the Incident Controller.

The IMT will initiate communication will all other agencies as required. The team will complete Situation Reports (Attachment B: SITREPS) and Incident Action Plans (IAP), refer Attachment C: CIMS Incident Action Plan, for communication to SCHL National Support Office and other agencies as appropriate.

- key clinical and non-clinical people are called for a briefing either face to face or tele/video conference at regular times
- key people are required to provide updates to the EOC of any issues, impacts and developments

SITREP Form

19KB docx

CIMS incident action plan

28KB docx

Standing down an IMT

The date and time of the official stand down or deactivation of an emergency response will be determined by the SCHL CEO. Deactivation of an emergency response is dependent on a wide range of variables that must be satisfied before the announcement occurs. Some basic principles that should be followed are that the:

- emergency response role has concluded
- immediate physical health and safety needs of the affected people have been met
- essential services and facilities are re-established and operational
- immediate health concerns of patients and staff have been satisfied.

Recovery

Recovery[1] includes those activities that begin after the initial impact has been stabilised and extends until normal business has been restored. It considers all opportunities to reduce the risks from future emergencies. It may involve a local, regional, national health-related response or it may involve a whole-of-government response involving economic, social and legislative issues.

- In the event that a major incident occurs that is likely to be *protracted or have significant impact*, the IMT is brought together to assist with planning and management of aspects of the hospital recovery and response.
- The IMT may include a financial advisor and other technical advisors
- Dependent upon the nature and duration of the event a Recovery Manager may be required to co-ordinate the transition into, and management of, recovery phase activities; they should be appointed during the response phase.

[1] Focus on Recovery: A Holistic Framework for Recovery in New Zealand, 2005 (IS5/05, MCDEM)

Issues that might require attention

To align with the requirements of the Civil Defence Emergency Act (2002)the definition of *recovery activities* the actions that SCHL should undertake after an emergency include, without limitation

- assessment of the health needs of the affected community (patients and staff)
- coordinating resources available
- reassessing measures to reduce hazards and risks[1].

It is usually Ministry of Civil Defence and Emergency Management (MCDEM) who becomes the lead agency for coordinating any necessary government support for recovery. MCDEM coordinates the recovery activity of relevant CDEM groups, lifeline utilities (for example, electricity, telecommunications and water), government departments and international aid following the transition from response to recovery

Personnel and organisational issues:

- Staff debriefing, replacement issues.
- Payroll
- Staff welfare
- Staff recovery time
- Assistance with family related issues
- Planning and co-ordination monitoring and evaluation for the services that cannot return to their original location.

Operational issues:

- Communication, expenditure management
- Contract review and assistance where business as usual cannot continue.
- Damage & needs assessment
- Resource management
- Repair damaged infrastructure e.g. communications, water and power supplies

- Re-establishment of reliable systems for re-building to occur.

[1] More in-depth information on recovery can be found in: Recovery Management-Director's Guidelines for CDEM Groups (2005) and the Guide to the National Civil Defence & Emergency Management Plan (2006, s25).

Psychosocial recovery

Psychosocial recovery[1] is not limited to the recovery phase of an emergency event. Psychosocial recovery in the field of emergency management begins at the level of prevention through risk reduction.

The process of psychosocial recovery from emergencies involves easing the physical and psychological difficulties for individuals, families/whānau and communities, as well as building and bolstering social and psychological wellbeing.

[1] Psychosocial Recovery Planning Guidelines, National Health Emergency Plan, 2007

Restoration of services

A number of factors will affect the speed of recovery, for example:

- Critical infrastructure may not be able to be restored for a considerable period of time
- International supply chains may take time to get back to normal following an international event such as a pandemic
- It may take a considerable time to return to pre-event level of service delivery.

SCHL may need to maintain an emergency response capability for the initial months of the recovery phase.

Evaluation of emergency response and exercises

Evaluation of the emergency occurs in the recovery phase. SCHL shall conduct debriefings and an internal review of its plans following exercising and activating of a HEP. Read Evaluation and review of HEP performance.

Aligning plans and resources

As part of the Plan development process, SCHL will ensure that:

- All SCHL facilities have a current HEP in place which is reviewed (Evaluation and review of HEP performance)
- Contact, coordination and collaboration between SCHL and its service providers are maintained to a high level of preparedness for emergency events.

In addition, all DHBs have plans and resources in place that ensure that their emergency responses are integrated, coordinated and exercised according to the MoH Operational Policy Framework for DHBs; these resources can assist SCHL in the development of its HEPs.

References

- Glossary of terms, abbreviations, notifications systems and tiers

- References and associated documents
- Single Point of Contact Guidelines
  A: Flowchart example
  B: SPOC network contact list
- Certification Training, Education and Development to meet minimum standards
- Southern Cross Healthcare Group Policies:
- Group Crisis Communication Plan
- Group Government Relationship Policy
- Group Media and Public Communications Policy
- Group Media and Public Communications Guidelines
- Site Location Plan Guidelines FOR LOCALISATION
- Hospital site plan examples
- Plant shut off procedure example
- Facility & Emergency Alarm Tones FOR LOCALISATION
- Emergency Flipchart Guidelines
- Hospital Flipchart Example
- Bomb Data Checklist
- Security Threat and Intruder / Hold up Checklist
- Emergency Warden Responsibilities FOR LOCALISATION
- Pandemic Influenza EPARP
- Suspicious mail/packages/objects guidelines for managers and staff
- Safe Use of Hazardous Substances and refer Health & Safety Folder.
- Approved Handlers - Environmental Risk Management Authority Certificates:
  Certificates for Approved Handlers, refer Health & Safety Folder.
- Hazardous material emergency management, refer Health & Safety Folder.

CONTENT CONTROL

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