2003 Clinical Center Emergency Management Plan

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH

2003 Emergency Management Plan

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Chapter One

Emergency Management Plan Overview

Section 1. Purpose

The Warren Grant Magnuson Clinical Center's (CC) Emergency Management Plan (CC-EMP) describes the CC's approach to responding to emergencies within the facility and in its community that would suddenly and significantly impact the organization's services.

In the event of a threat or act of terrorism, the Clinical Center is a valuable resource to the citizens of the United States and the public health care communities. However, the Clinical Center is not a participant in the Montgomery County Emergency Medical Services Multiple Casualty Incident Plan (i.e., we do not provide emergency medical service). This aspect of the program is not intended to change although the CC may dispatch staff to assist in the federal response or admit patients under a research protocol.

Section 2. Objectives

This Plan seeks to ensure that disasters or hazardous circumstances are managed in a manner that minimizes injury to persons and damage to property. It also provides written procedures for a safe building evacuation process, needed medical care, and appropriate containment and management of hazards.

The CC-EMP addresses the four phases of emergency management: mitigation, preparedness, response, and recovery. This plan is based on a Hazard Vulnerability Assessment that includes the identification of likely hazards and the direct and indirect effect that these hazards may have on the organization.

Section 3. Resource and Responsibility Allocation

The Clinical Center Director, or designee, is responsible for managing the Clinical Center during an emergency situation.

It is the responsibility of all CC Department Heads to ensure that their employees are informed about the procedures and policies specified in this manual. Each department will develop and implement a department-specific Emergency Management Plan that follows the CC-EMP.

Chapter Two

Mitigation

Section 1: Hazard Vulnerability Assessment (HVA)

The Clinical Center will conduct an organization-wide Hazard Vulnerability Assessment as indicated, but at least once every three years. Information collected during this exercise will drive improvements to the CC-EMP. A copy of the organizational Hazard Vulnerability Assessment tool can be obtained by contacting the Hospital Safety Officer, Office of the Deputy Director for Clinical Care at 301-496-5281.

Chapter Three

Preparedness

Section 1. Incident-Specific Emergency Management Plans

Based on information collected from the HVA, incident-specific Management Plans have been developed. These Management Plans provide guidance to personnel who respond to these events. The Clinical Center has developed incident-specific Management Plans for the following potential emergencies:

- Biological Threat
- Bomb Threat
- Casualties Resulting From a Clinical Center Disaster
- Chemical Threat
- Civil Disturbance/Demonstration
- Community Disasters with Casualties – Role of the Clinical Center
- Explosion Emergency
- Fire Emergency
- High Winds (Tornado/Hurricane)
- Medical Assistance to the Community
- Metropolitan Commuting Failure (Inclement Weather, Major Accident, Police Road Block)
- Power Loss/Utility Failure
- Radiological Threat
- Requests for Shelter
- Structural Damage
- Telecommunication Failure

The incident-specific Management Plans are located in Chapter 5 of this Plan.

Section 2. Orientation/Training

A. New Employee Orientation

All employees (Institute, Clinical Center, agency, and contract staff) who work in the Clinical Center are required to receive Emergency Management Training during their initial orientation period. The Emergency Management Training program will include, but is not limited to, the following topics:

- The purpose and scope of the Clinical Center Emergency Management Plan
- Location and availability of department-specific Emergency Management Plans

- Appropriate response to immediate threats
- Frequency and type of emergency drills
- Initiation of an emergency

B. Department Specific Emergency Management Training

Each department and service should review this manual on a routine basis with their staff and during new employee orientation. All employees are expected to be familiar with the policies and procedures described and capable of demonstrating the ability to alert and respond to emergency responders.

Each Department Head is responsible for assuring that all new employees are oriented to, and familiar with, the department-specific Emergency Management Plans. The Department Head will assure that each new employee is educated about specific roles and responsibilities during emergencies including, but not limited to:

- Location of emergency equipment; areas of refuge; and exits
- Recognition of specific types of emergencies
- Information and skills required to perform assigned duties during emergencies
- The Communication processes and systems to be used during emergencies
- Evacuation procedures

This training will be documented by the Department Head or Section Chief in the employee's personnel evaluation.

C. Competency and Continuing Education

Continuing education will be offered to existing Clinical Center, Institute and contract staff to assure that employees are familiar with emergency procedures. Ongoing competence will be documented in the employee's personnel evaluation.

D. Emergency Preparedness/Management Practices

Fire evacuation drills are conducted by the Division of NIH Fire Marshal on a regular basis in all patient care areas and departments. Drills familiarize hospital personnel with components of the fire protection systems and procedures for managing emergencies under varied conditions.

Emergency Management (disaster) drills are conducted by the Clinical Center semiannually. These exercises assess the hospital's ability to maintain essential activities during dire circumstances. In lieu of a scheduled practice, the Clinical Center's response to an actual emergency may be used to evaluate the organization's preparedness and response procedures. Both types of exercises (real and simulated) aid in maintaining an effective and rapid emergency response capability among Clinical Center staff.

Section 3. Emergency Alarm/Notification System(s)

A. Fire Alarm Pull Stations

Fire alarm pull stations are located throughout the Clinical Center. These manually-operated pull stations should be used by any building occupant to report fires, the odor of smoke, and other major hazardous incidents. The pull stations should NOT be used to report bomb threats.

B. Audiovisual Fire Alarm System

The fire alarm system provides early notification system for all occupants of the Clinical Center. It divides the building into zones based on the risk of fire. Zones are separated by fire rated barriers. The fire alarm system is activated by fire alarm pull stations, smoke detectors, and water flow switches in the sprinkler system. When activated, the fire alarm system automatically flashes white strobe lights and broadcasts an electronic signal and instructions over the fire evacuation speakers to occupants in the zone of the emergency only. Simultaneously, it transmits the exact location of the emergency to the NIH Fire Department along with other designated personnel in the NIH Emergency Communications Center.

C. Central Paging System

The central paging system is not part of the fire alarm system. However, it is used along with the fire alarm system to alert the staff of an emergency situation or other important information.

- Fire emergencies are announced on the central paging system as "Page 100" followed by the room number or zone where the emergency occurs.
- Medical emergencies are announced on the central paging system as "Code Blue" followed by the room number or zone where the emergency occurs.
- In the event of activation of the Clinical Center Emergency Management Plan, "Code Yellow" will be announced over the central paging system as well as via the fire alarm announcement system.

Section 4. Mutual Aid Agreements

The NIH has agreements with other agencies (e.g., Montgomery County and National Naval Medical Command) for the provision of fire, rescue, or emergency medical assistance upon request. It also has a Memorandum of Understanding with the Montgomery County Department of Police and contracts with the U.S. Park Police and the Federal Protection Service for law enforcement assistance on the NIH reservation when necessary.

Chapter Four

General Response

Section 1. General Procedures for Reporting an Emergency Situation
Section 2. Code Yellow
Section 3. NIH Emergency Phone Numbers
Section 4. Organizational Communication Regarding an Emergency
Section 5. Emergency Management Plan Activation
Section 6. Establishment of the Emergency Management Command Center
Section 7. Communications with External Entities
Section 8. Security
Section 9. Assuring Adequate Staffing During an Emergency
Section 10. Management of Personnel During a Metropolitan Commuting Failure (Inclement Weather, Major Accident, Police Road Block)
Section 11. Management of Patient Care and Services During Emergencies
A. Patient Discharges and Admissions
B. Internal Patient Transfers
C. External Patient Transfers
D. Suspension of Elective Procedures
E. Establishment of Alternative Work/Function Sites

Section 12. Establishment of a Triage Site
Section 13. Decontamination
Section 14. Building Evacuation Plan
A. Responsibility and Patient Disposition
B. General Evacuation Instructions
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D. General Evacuation Procedures
i. From the Patient Care Unit Where the Emergency Occurs
ii. From the Patient Care Unit Other Than Where the Emergency Occurs
iii. From Service Departments, Laboratories, or Office Spaces

Section 1. General Procedures Reporting an Emergency Situation

Dial 911

if there is an immediate threat or hazardous situation involving fire, odor of smoke, arcing of equipment; explosive, chemical, biological, radiological, or other threats that may require NIH Fire Department intervention.

In addition to dialing 911, **activate the nearest fire alarm manual pull station**. This will alert all occupants within the emergency zone as well as the NIH Fire Department personnel of the event. Pull stations can be used by any building occupant to report fires or other major hazardous incidents except bomb threats.

Dial 111

for life-threatening medical emergencies in the Clinical Center complex only ("Code Blue" situations).

Section 2. Code Yellow

Code Yellow is the code that will be announced over the central paging system to alert staff that the Clinical Center Emergency Management Plan has been activated. Upon activation of the Emergency Management Plan all staff should contact their Department Head or supervisor to receive further instructions regarding the emergency. Upon activation of the Emergency Management Plan, the Clinical Center Office of the Director will establish the Emergency Management Communication Center for the hospital and direct operations of the emergency from that location (see Chapter Four; Section 6).

Section 3. NIH Emergency Phone Numbers

Fire and Police Departments	**911**
Medical "Code Blue" Team	**111**
Engineering/Maintenance	**108**
STAT Overhead Page (Clinical Center only)	**112**
Telecommunications failure	**611**

Section 4. Organizational Communication Regarding an Emergency

When an emergency occurs, first notify the NIH Fire Department by calling 911 to assist in immediate management of the event.

Contact the offices below if additional support is required to manage the event:

During business hours

Clinical Center Director's Office	301-496-4114

After business hours

Nursing Administrative Coordinator	*(via the page operator)*	301-496-1211
Admissions		301-496-3315

Emergency response organizations assisting with an external disaster may request medical care or shelter from the Clinical Center. In these circumstances, the Clinical Center Director, or designee, will coordinate any relief assistance requiring the use of hospital resources. Should an official from a local government or other organization outside of the NIH request assistance, please refer the caller or the request as follows:

During business hours

CC Director's Office	301-496-4114

After business hours

Nursing Administrative Coordinator	*(via the page operator)*	*301*-496-1211
Admissions		301-496-3315

The Director's Office will verify the request and decide what action to take.

Section 5. Emergency Management Plan Activation

The Clinical Center Director, or designee, in consultation with the NIH Officer in Charge (police or fire) will activate the Clinical Center –Emergency Management Plan (CC-EMP). In the absence of the Director, Clinical Center, the senior Clinical Center administrative staff in-house (e.g., Clinical Center Senior Administrative Officer, Nursing Administrative Coordinator who are available through the page operator at 301-496-1211) will assume the role of the Emergency Leader.

The Emergency Leader will contact the page operator and instruct him/her to contact the following Clinical Center staff:

- Clinical Center Director (if not the Emergency Leader)
- Deputy Director for Clinical Care
- Chief Nurse
- Chief Operating Officer

- Senior Administrators
- CC Safety Officer
- CC Facilities Manager

The Emergency Leader will contact the page operator and instruct him/her to announce a "Code Yellow" to alert Clinical Center staff that the Emergency Management Plan has been activated. Upon plan activation and the announcement of a Code Yellow, all staff should report to their departments/patient care units to receive instructions from their supervisors.

Upon activation of the CC-EMP, the Emergency Management Communication Center will be established in the Clinical Center. The location of this Communication Center will be communicated to all Department Heads and Clinical Directors. The location will vary depending on the availability of refuge within the building.

Upon activation of the CC-EMP, all departments and patient care units should activate their local Emergency Preparedness Plans.

The Emergency Leader (Clinical Center Director, or designee) will, in collaboration with the NIH Officer in Charge, direct all emergency activities and evacuation, if necessary.

Communication regarding Clinical Center operations, the status of the emergency, and other critical information will be coordinated and communicated to staff by the Emergency Leader via the Emergency Management Plan communication structure (see Attachment IV).

Section 6. Establishment of the Emergency Management Communication Center

When the CC-EMP is activated, the Clinical Center Emergency Management Communication Center (EMaCC) (hospital command) will immediately be established. This command center system directs the activities of key Clinical Center and Institute staff. Primary and alternate sites for the EMaCC are listed below:

- Medical Board Room (2C-116)
- Bioethics Department (1C-116)
- Duke Conference Room (B1-L410)
- Visitor Information Center (10/B1-C218)

The location of this Communication Center will be communicated to all Department Heads and Clinical Directors by the Emergency Leader or the Office of the Director, Clinical Center.

The following key personnel shall report to the EMaCC and will receive their assigned roles and responsibilities relative to the emergency:

- Administration/Executive Staff
- Admissions
- Critical Care Medicine Department

- Department of Anesthesia and Surgical Services
- Department of Clinical Research Informatics
- Department of Laboratory Medicine
- Department of Network Applications
- Department of Transfusion Medicine
- Diagnostic Radiology
- Facilities
- Housekeeping
- Hospital Epidemiology Service
- Laboratory Pathology NCI/CC
- Materials Management Department
- Medical Executive Committee
- Medical Records Department
- NIH Fire Department
- NIH Police Department
- Nursing Service Chiefs
- Nutrition Department
- Office of Clinical Center Communications
- Pharmacy Department
- Psychiatry
- Safety
- Social Work Department

The organizational communication structure is included in Attachment IV.

Primary and secondary modes of communication will be identified by the Emergency Leader upon implementation of the EMaCC. Preferred methods of communication will be by telephone, email, walkie-talkies, written communication via runners, etc.

The EMaCC will be equipped with the following supplies and equipment:

- Battery-operated radios
- Bottled water
- Copy of the most recent Emergency Management Plan
- Detailed building plans
- Emergency communication list
- Emergency organizational chart
- Extension cords
- Fax machine
- Flashlights and batteries

- Food
- Identification vests
- Laptops (4)
- Network hookup and other wireless communications
- Patient care unit location list
- Telephones (regular/cell)
- Television/VCR
- Walkie-talkies
- Writing boards/flipcharts/pens

Section 7. Communications with External Entities

Clinical Center Communications, in collaboration with the NIH Office of Communications, and at the direction of the Emergency Leader, coordinates the release of all information to press, radio and television reporters, and the public. Public information and press rooms will be established as the focal point for dissemination of this information. All calls from the media should be referred to Clinical Center Communications at 301-496-2563. Any reporters who show up at the scene should be escorted to the established public information/press room. Family members who arrive at the scene will be directed to a family gathering area to receive information.

Section 8. Security

The NIH Police have sole jurisdiction for law enforcement on campus. During an emergency, the NIH Police may restrict access or egress, conduct security searches, modify vehicular traffic control, etc., as warranted.

Section 9. Assuring Adequate Staffing During an Emergency

In the event emergency management plan activation, all Clinical Center scheduled personnel, regardless of position are expected to report to their duty station. Every employee is considered essential and will not be sent home but will be assigned to the Labor Pool as directed by the Emergency Leader and/or the person's Department Head. All staff with a customized CC identification badge (NIH badge with dark blue stripe) will be allowed entry into Building 10, except when the NIH Officer in Charge deems an area of the facility is unsafe. In such circumstances, the NIH Officer in Charge will determine a "safe" route for physicians, nurses, and other direct caregivers; and senior administrative personnel. Upon activation of the EMaCC, each Department Head and Clinical Director will forward to the EMaCC a list of available staff. All patient care staff will be appropriately credentialed and privileged before they begin patient care duties.

Section 10. Management of Personnel During a Metropolitan Commuting Failure (Inclement Weather, Major Accident, Police Road Block)

In the event of blizzard, ice storm, major road block, etc., in which radio announcements advise that government employees are excused from work, CC staff deemed essential employees are expected to report to work.

In the event of a snow emergency, employees who require assistance coming to work or going home should call the Admissions Desk in the Outpatient Department on 301-496-3315, to request a ride. Those who wish to offer rides to their coworkers should call Admissions to volunteer their services. In addition, the Senior Administrator On-Call may request help from the volunteer transport system provided by Montgomery County's Office of Emergency Preparedness.

Should it be necessary, the Admissions staff, with the approval of the Senior Administrator on-call, can assign patient bedrooms to employees for overnight housing during inclement weather. To expedite the process, supervisors are asked to submit a list of their employees requiring housing to the Admissions staff rather than have the individuals call the desk directly.

Section 11. Management of Patient Care and Services During Emergencies

A. Patient Discharges and Admissions

Upon activation of the EMaCC, the Medical Care/Clinical Services Section Chief and the Patient Care Section Chief, in collaboration with the medical staff, will discharge patients as appropriate. Patients will be instructed to leave the Clinical Center, if appropriate, or will be directed to the Patient and Family Gathering Area (location to be determined at time of event and communicated to staff by the Emergency Management Communication Center) to await further instructions. In the event of an emergency, all planned admissions will be suspended. Patients waiting to be admitted will be directed to the Patient and Family Gathering Area for instruction and information

B Internal Patient Transfers

All internal patient transfers will be coordinated by the Medical Care/Clinical Services Section Chief, the Patient Care Section Chief and the Medical Staff.

C. Patient Transfers to External Facilities

The Clinical Center facility, in excess of 3 million square feet, can provide refuge to preclude the need to transfer patients to outside facilities. In the unlikely event of an evacuation, and under the direction of the Emergency Leader, all ambulatory patients will be discharged first, followed by non-ambulatory and critical patients last. All critical patients will be transferred to local healthcare facilities. Ambulatory and stable non-ambulatory patients may be transferred to an alternate patient care site on the NIH campus (to be determined by the Emergency Leader and the NIH Fire Department). The patient care unit transferring the patient is responsible for assuring the patient's medical record, personal belongings, medical

equipment, treatment requirements, etc., are transferred with the patient. Transfer of patients will be coordinated through the EMaCC and the NIH Fire Department. Points of entry and exit for patients and staff will be identified by the NIH Police Department and communicated to Clinical Center staff by the Emergency Management Communication Center.

D. Suspension of Elective Procedures

Elective procedures may be cancelled, if appropriate.

E. Establishment of Alternative Work/Function Sites

Each Department Head is responsible for developing a plan for assuring optimal departmental operations during an emergency. Potential alternative worksites should be identified and plans developed for efficiently moving departmental operations, if required.

Section 12. Establishment of a Triage Site

In the event of an internal situation that results in casualties, at the direction of the Emergency Leader, the Clinical Center Critical Care Medicine Department, in collaboration with the Occupational Medicine Service and the NIH Fire Department may establish a triage site to assist in the management of casualties. This site will provide a staging area for the treatment of minor injuries/traumas and the triage point for admissions to the Clinical Center or for transport to an external facility as appropriate.

Section 13. Decontamination

In the event of a real or potential hazardous materials exposure, the NIH Fire Department will establish a decontamination site. The location of this site will be communicated by the Emergency Leader to staff. Staff potentially exposed to a hazardous material will report to the decontamination site and follow the instructions of NIH Fire Department personnel.

Section 14. Building Evacuation Plan

Note: Evacuations in the event of high winds (potential hurricane or tornado) are different from the building evacuation procedures listed below.

A. Responsibility and Patient Disposition

The authority to order an evacuation is the joint responsibility of the NIH Fire Department and the Clinical Center Director, or designee. Patients will be evacuated to an area of safety by whatever means are available. Although the complex is sufficiently large to provide alternative care sites negating patient discharges, procedures are in place with the NIH Ambulance service and Montgomery County Ambulance Service to transfer patients to other healthcare institutions, as necessary.

B. General Evacuation Instructions

The Clinical Center primary response to an emergency situation in patient care areas is to "Defend in Place" if possible. In the event that a portion, or all, of the Clinical Center patient care space must be evacuated, the following procedures should be followed:

- During emergencies evacuations, the Chief of Facilities Management,(or designee, under the direction of the Fire Officer in Charge, will direct the evacuation of building.
- Supervisors must assure that their staffs are knowledgeable about evacuation procedures. Supervisors need to know the location of workers with disabilities who may need special assistance during an emergency.
- The NIH Fire Department will lead the rescue and emergency management activities.
- The NIH Police will manage crowd control and facility security. They may also evacuate individuals from hazardous areas as deemed necessary by the Fire Officer in Charge.
- The CC maintenance staff will manage critical utility services and other facility matters under the direction of the Fire Officer in Charge. They may evacuate patients or confine the hazard as directed by the Fire Officer in Charge.
- When the fire alarm is activated in a zone, staff should follow the instructions broadcast over the fire alarm speakers in their work area.
- When the fire alarm is activated in a patient care unit, ***it is the responsibility of the Nurse Manager/Charge Nurse and Medical Officer to initiate an evacuation of their area should harm to patients and staff be imminent.***
- The Nursing Department will ensure that emergency evacuation procedures of patient care areas are carried out. Each area is to refer to its specific plan for evacuation.
- Evacuees from patient care areas ***should not*** leave the building but "Defend in Place" and seek safe refuge unless dire circumstances exist or emergency personnel direct them to evacuate. ***(Note: Refuge is available by evacuating a portion of the CC while still remaining within the building. This procedure permits staff to take a census of the patients, visitors, and staff during each stage of the evacuation. Site-specific emergency plans address the routes and areas of refuge for each area of the CC).***
- If the Fire Officer in Charge determines that additional areas of the building need to be evacuated as a precautionary measure, instructions for the movement of staff, patients, and visitors will be announced over the speakers that are part of the fire alarm system.
- During an evacuation, staff should remain calm and follow the directions given by the NIH Fire Department.

C. Evacuation Levels

Level One: Immediate Life Safety
If someone is trapped in a room, staff must decide whether to "fight or flee." Staff may try to rescue others only if they can do so without harming themselves.

Level Two: Horizontal evacuation to a refuge area on the same floor
Areas of refuge are used as temporary holding or staging areas for patients, staff, and visitors. Nursing staff need to confirm their patient census in the refuge area and after each subsequent stage of an evacuation.

Persons in areas of refuge should be prepared to relocate to a more remote area of refuge if dire conditions persist. *Horizontal movement to an even more remote refuge on the same floor is preferred because of the difficulties of moving individuals in the stairwells.*

Level Three: Vertical evacuations
Should the actions above fail to provide a protected environment, refuge may be sought on another level of the building. Vertical evacuations using the stairs or Fire Department-manned elevators only to a lower floor of the building is the third level of evacuation.

Note: In some patient care units, vertical evacuation may be the only means of secondary egress. If ordered by the Fire Officer in Charge, evacuees should use the stairwells to move to a level that the Officer has designated as a holding area. If alternate routes are necessary, instructions for evacuation will be announced over the fire alarm system.

Elevators shall be used for vertical evacuation only under the direction of the Fire Officer in Charge. Freight Elevators 8, 9, 15, 16, located on the B and D wings respectively and staff elevators 26 through 28 on the bridge should be used for non-ambulatory patients, as these elevators are large enough to accommodate beds.

Level Four: Total Building Evacuation
This action carries a significant risk to both patients and staff, and would be done only under extreme circumstances at the direction of the Fire Officer in Charge.

D. General Evacuation Procedures

i. From the Patient Care Unit Where the Emergency Occurs
Ambulatory patients, staff and visitors should be directed to the areas of refuge by the Fire Officer in Charge. The Nurse Manager/Charge Nurse from each area is responsible for assuring that all persons are present (i.e., census taking), or for delegating this task to another staff member.

Wheelchair patients will be assisted by staff as directed by the Nurse Manager/Charge Nurse or Medical Officer. Freight elevators may be used when authorized by the Fire Department. If the need for wheelchairs is acute, patients who reach refuge need to yield their chairs so that other patients may be moved.

Staff members are also responsible for moving patients on stretchers. The freight elevators may be used to transport these patients when authorized by the Fire Department.

The Nurse Manager or Charge Nurse for the area being evacuated must ensure that:

- patients are accounted for and that protective measures are taken;
- medications are prepared and transported;
- life support equipment and necessary supplies are moved to the relocation point for evacuated patients; and
- medical records and charts of evacuated patients are removed and protected, when possible.

ii. From the Patient Care Unit Other Than Where the Emergency Occurs
When there is an emergency in an area adjacent to a patient care unit, the fire alarm system will activate alarms in the emergency zone as well as the amber light located across from the nurses' station. Staff in the patient care unit should remove equipment and obstructions from the corridor, close all doors on the unit, and outline possible routes of evacuation.

The patient care units should be alert for possible further orders or for the announcement that the "100 period has ended." The fire alarm lights will stop flashing when the fire fighters clear the emergency call and reset the system.

iii. From Service Departments, Laboratories, or Office Spaces
Occupants should follow the instruction broadcast over the fire alarm system or instructions given by the Fire Officer in Charge. Occupants who are knowledgeable of the facility shall assist visitors in moving to exits and evacuation routes. Individuals should leave the zone in alarm via the closest stairs.

Staff should assist persons and visitors with disabilities to the stairway landing. Staff should remain with disabled persons until the disaster threat or emergency subsides. Individuals should call the NIH Fire Department on 911 for immediate assistance to evacuate mobility-restricted occupants.

Persons who use TTY telephone lines can call the NIH Police or Fire Department on 301-496-0063.

For information about evacuation procedures for specific departments, consult the Departmental Emergency Management Plan.

Chapter Five

Incident-Specific Responses

This section presents specific instructions on the management of the disasters listed below.

Internal Emergencies

Section 1. **Biological Threat**
Section 2. **Bomb Threat**
Section 3. **Casualties Resulting From a Clinical Center Disaster**
Section 4. **Chemical Threat**
Section 5. **Civil Disturbance/Demonstration**
Section 6. **Explosion Emergency**
Section 7. **Fire Emergency**
Section 8. **High Winds (Tornado/Hurricane)**
Section 9. **Power Loss/Utility Failure**
Section 10. **Radiological Threat**
Section 11. **Structural Damage**
Section 12. **Telecommunication Loss**

External Disasters

Section 13. **Community Disasters with Casualties–Role of the Clinical Center**
Section 14. **Metropolitan Commuting Failure (Inclement Weather or Road Block)**
Section 15. **Requests for Shelter**

Internal Emergencies

Section 1. Biological Threat

The distinction between biological and chemical agents requires specialized expertise. First responders equipped with detection instruments can determine the identity of the agent(s). The response to identification of an act of bioterrorism must be swift and contained.

A. Key points in the response are:

- Minimizing exposure of staff, patients and visitors;
- Containing whatever agents have been disseminated in the smallest area possible;
- Rapid identification of the agent(s) involved;
- Rapid decontamination, where appropriate;
- Institution of appropriate infection control procedures;
- Immediate, appropriate post-exposure management.

B. Immediate Response

- Dial 911 immediately to report the event and the exact location of the incident;
- Do not approach the scene;
- NIH Fire Department will provide care to victims;
- If deemed safe and appropriate, move all victims to a controlled and safe location;
- Do not allow anyone suspected of being contaminated to leave the immediate controlled area until cleared by the NIH Fire Department;
- Reassure victims that help is on the way;
- Do not attempt to clean up any suspect material;
- Follow directions of the NIH Fire Department concerning evacuation;
- Make a list of all individuals who may have been in the room and in the area when the exposure occurred and give this list to the first responders.

C. Containing Disseminated Agents

- Seal the room off if possible to prevent biological agents from leaving the room;
- Close access doors to your unit;
- Move into an adjacent room and seal the room behind you, if possible, or, move to a location in the room that is as far from the exposure source as possible;
- Secure perimeter and isolate area and deny entry to non-essential personnel;
- If possible wash hands and face with soap and water;
- Follow the instructions of the first responders concerning leaving the building. In some instances the first responders may prefer to have you stay in the building to avoid spreading contamination.

D. Identification of Agents

Identification of the agent(s) is performed by first responders and collaborating government agencies.

	Anthrax	Pneumonic Plague	Tularemia	Q Fever	Ebola	Smallpox	Venezuelan Equine Encephalitis	Botulinum Toxin	Ricin
Method of dissemination	Contact, ingestions, aerosol	Aerosol	Aerosol	Aerosol	Direct, aerosol	Aerosol	Aerosol	Aerosol, food/water	Aerosol, food/water
Transmission person to person	Rare	High	No	Rare	Moderate	High	Low	No	No
Incubation period	1-5 days	1-3 days	1-10 days	14-26 days	4-16 days	10-12 days	1-6 days	Hours to days	Hours to days
Post exposure vaccination	No	No	No	No	No	Investigational	No	No	No
Antibiotic prophylaxis	Yes	Yes	Yes	Yes	No	Investigational	No	No	No
Antibiotic Treatment	Yes	Yes	Yes	Yes	No	Investigational	No	Antitoxin	No

E. Decontamination

First responders will provide instructions about where to go and what to do for decontamination.

- Decontamination procedures vary for different types of exposure;
- Exposed individuals should follow first responders' instructions concerning decontamination procedures.

F. Infection Control Procedures

All patients should be managed using basic "Standard Precautions" infection control procedures; certain organisms or toxins require additional control precautions.

Disease	Precaution Type
Ebola	S, A, C
Smallpox	S, A, C
Pneumonic Plague	S, D
Inhalation anthrax	S
Venezuelan equine encephalitis	S
Botulism	S
Brucellosis	S
Q Fever	S
Tularemia	S

S: Standard
A: Airborne
C: Contact
D: Droplet

Hand washing is particularly important in the setting of possible exposure to biological agents; hands should be washed after contact with items potentially contaminated or following routine patient care protocol (i.e., after contact with blood, body fluids, lesions, or tissue or other materials potentially containing organisms).

G. Post-Exposure Management

- Appropriate post-exposure management needs to be made immediately available to exposed individuals (managed by OMS in concert with NIH leadership);
- Follow-up should be tailored both to the specific pathogen to which individuals were exposed as well as to the therapy administered.

Section 2. **Bomb Threat**

Safety Alert

Never touch a suspected bomb.
If you suspect a bomb is in your area,
turn off all types of radios and transceiver equipment
and call the police immediately.

Most injuries seen after high-explosive detonations are conventional blunt, penetrating, and thermal injuries. Primary blast-injuries occur as a direct effect of changes in atmospheric pressure. Persons within close range of the blast wave can experience subtle, or delayed, potentially life-threatening problems which are often neglected.

Should you receive a bomb threat, please do the following:

- Remain calm;
- Keep the caller on the telephone for as long as possible;
- Have someone else listen on the speaker phone and record the conversation if possible;
- If the caller does not offer information on the bomb's location, ask for this information;
- Tell the caller that the building is occupied and that serious injury or death to innocent people could result if this information is not obtained;
- Listen for strange or unusual noises in the background which might be helpful in providing clues as to who the caller is — this might include music, running water, traffic sounds, or other noises;
- Determine whether the voice is male or female, familiar or unfamiliar, and listen for accents, impairments, nervousness, or other potential clues as to who the caller might be;
- **Do not use the manual fire alarm stations** to report a bomb threat.

Provide the NIH Police with the following information:

- The time and place of the bomb threat and the source of threat if possible;
- Identity of the area, if possible;
- Your name, work place, and phone number.

If the location of a suspected bomb is not known:
The Police will search the building. They may ask for assistance from employees in threatened areas. Employees can aid in the search by checking for suspicious objects. Because the Police will want to keep a log of the areas covered in the search, please inform the Police of your actions.

If a bomb is known and confirmed to be present:
You may be requested to evacuate the threatened area, or the Police may order the evacuation of the entire building, as described in Chapter 4; Section 14 of the Building Evacuation Plan. The Police will direct evacuation. When the threat is over and the building is secure, you will be advised when you may return to your work area.

Section 3. Casualties Resulting from a CC Disaster

To get help for life-threatening emergencies in the CC:

- Summon help for medical emergencies by dialing the Cardiopulmonary Resuscitation (CPR) Team (more commonly known as a "Code Blue") on extension 111, using any house phone.
- Be prepared to provide the Page Operator the information on your location and the type of emergency (i.e., adult or child). The Page Operator will immediately alert the CPR Team and announce the "Code Blue" and the location over the public address system. Dialing extension 111 for the CPR Team automatically summons help from the NIH Fire Department/Rescue Squad and the Police Department.
- The CPR Team will triage casualties in a location deemed to be safe but near the emergency scene. In conjunction with the Fire Department, the casualties will be transported to a local hospital or to the Occupational Medical Service (OMS) in Building 10, Room 6C306, for further evaluation and treatment.
- If needed, OMS will activate their general emergency plan to manage the casualties received in their area.

In the event of mass casualties, a Triage Area will be established in collaboration with the Fire Department.

Section 4. Chemical Threat

Potential sources of exposure to chemical agents at the NIH include acts of terrorism and inadvertent release of chemicals during a laboratory accident. The distinction between chemical and biological agents requires specialized expertise. The initial personnel to enter the scene of a chemical incident should be members of the NIH fire department HAZMAT team. They can quickly determine what type(s) of agents is/are present. The members of the NIH Fire Department HAZMAT team can perform basic triage to ensure that the most severely affected individuals are the first to be rescued from the area. Emergency medical personnel wearing appropriate personal protective equipment will perform a more detailed health assessment.

A. Key points in the response are:

- Minimizing exposure of staff, patients and visitors;
- Containing whatever agents have been disseminated in the smallest area possible;
- Rapid identification of the agent(s);
- Rapid decontamination, where appropriate;
- Institution of medical care and administration of antidotes, where appropriate.

B. Immediate Response

- Dial 911 immediately to report the event and the exact location of the incident;
- Do not approach the scene;
- NIH Fire Department will provide care to victims;
- If deemed safe and appropriate, move all victims to a controlled and safe location;
- Do not allow anyone suspected of being contaminated to leave the immediate controlled area until cleared by the NIH Fire Department;
- Reassure victims that help is on the way;
- Do not attempt to clean up any suspect material;
- Follow directions of the NIH Fire Department concerning evacuation;
- Make a list of all individuals who may have been in the room and in the area when the exposure occurred and give this list to the first responders.

C. Containing Disseminated Agents

- Seal the room off if possible to prevent material from leaving the room;
- Close access door to your unit;
- Move away from the presumed chemical agent and seal the room behind you, if possible, or, move to a location in the room that is as far from the exposure source as possible. The vapor of all chemical warfare agents, with the exception of hydrogen cyanide, is heavier than air. Standing provides a relative degree of protection from chemical warfare agent vapors, as the concentration that an individual will be exposed to when standing may be significantly lower than when lying down;
- Secure perimeter, isolate area and deny entry to non-essential personnel.

D. Identification of Agents

Identification of the agent(s) is performed by first responders and collaborating government agencies.

Category	Common Name
Nerve Agent	Tabun Sarin Soman
Vesicants	Sulfur mustard Lewesite Phosgene oxime
Pulmonary agents	Phosgene Chlorine
Cyanides	Hydrogen cyanide Cyanogen chloride

E. Quick Reference of Agents

	Nerve Agents	Blister Agents (Vesicants)	Pulmonary Agents	Cyanide	Riot Agents
Effects	**Vapor:** small pupils, runny nose, shortness of breath **Liquid:** sweating, vomiting **Both:** Convulsions, apnea	Redness of skin blisters, irritation of eyes, cough, shortness of breath	Shortness of breath, coughing	Loss of consciousness, convulsions	Burning, stinging of eyes, nose, airway and skin
Onset	**Vapor:** seconds **Liquid:** minutes to hours	Hours (immediate pain after exposure to Lewesite	Hours	Seconds	Seconds
Antidote(s)	• Atropine • Pralidoxime chloride	• None (decontaminate immediately)	• None	• Amyl nitrite • Sodium nitrite • Sodium thiosulfate	• None

F. Decontamination

First responders will provide instructions about where to go and what to do for decontamination.

- Decontamination procedures vary for different types of exposures and will be managed by the NIH Fire Department;
- Exposed individuals should follow first responders' instructions concerning decontamination procedures;
- Exposed individuals should remove contaminated clothing and wash their skin with soap and water, while waiting for first responders.

G. Medical Care

- Appropriate basic and advanced life support needs to be made available by emergency medical personnel wearing appropriate personal protective equipment to exposed individuals.

Antidotes, if appropriate, need to be administered to exposed individuals by emergency medical personnel wearing appropriate personal protective equipment.

Section 5. Civil Disturbance/Demonstration

If a civil disturbance or demonstration occurs in your area:

- Do not attempt to manage the crowd;
- Remain calm;
- Call the NIH police by dialing extension 911; give the police officer your name, building and room number, phone extension, and the nature of the incident;
- If it is necessary for you to leave the premises in order to avoid injury, do so in a calm manner.

Section 6. Explosion Emergency

Explosions occurring in the NIH Clinical Center may be accidental or the result of a terrorist act. It is important to remember that the release of biological, radiological and chemical agents often occur in the context of an explosion. The presence of fire spreading from the explosion site is another factor to consider.

Make a list of individuals who may have been in the room and in the area when the explosion occurred and give this list to the first responders.

A. Immediate Response

- Dial 911 immediately to report the event and the exact location of the incident;
- Do not approach the scene;
- NIH Fire Department will provide care to victims;
- If deemed safe and appropriate, move all victims to a controlled and safe location;
- Do not allow anyone suspected of being contaminated to leave the immediate controlled area until cleared by the NIH Fire Department;
- Reassure victims that help is on the way;
- Do not attempt to clean up any suspect material;
- Follow directions of the NIH Fire Department concerning evacuation;
- Make a list of individuals who may have been in the room and in the area when the explosion occurred and give this list to the first responders.

B. Containing Damage

- Seal the room off to prevent fire and or biological, chemical or radiological agents from leaving the room;
- Close access doors to the unit;
- Follow the instructions of the first responders concerning leaving the building. In some instances it may be preferable to remain in the building.

C. Rapid Determination of Biological, Chemical, and/or Radiological Agents

- First responders and collaborating government agencies perform identification of contaminants.

D. Medical Care

- First responders perform the initial triage and determine if the area is safe. Basic and advanced life support to victims is provided by emergency medical responders wearing personal protective equipment.

Section 7. Fire Emergency

If you discover a fire, smoke or an explosion

Remember **R.A.C.E.**

Rescue	Move persons in immediate danger to safety and notify others in the area;
Alarm	Activate the alarm by pulling the nearest fire alarm pull station and dialing extension 911 – tell the Fire Department your location (building, floor and room number), name, telephone number, and the nature of the emergency;
Confine	Confine the fire by closing doors. If possible, turn off all gas and electrical appliances;
Evacuate	Proceed to nearest refuge area or exit and then direct the Fire Department to the scene of the emergency.
or	
Extinguish	Only if you can do so without endangering yourself or others.

Follow the directions of the NIH Fire Department Officer in Charge.

Fire Involving a Patient

- Pull the fire alarm and dial 911 to report;
- Remove the patient from the fire if possible. If the patient's clothing or bedding is on fire, extinguish the fire with anything at hand. The method used will vary according to the circumstances;
- Wrap the patient in a blanket, sheet, or towel to smother the flames. Then remove the patient from the room and call for help;
- Flames near a patient may be put out with a towel or similar object. A pitcher of water at bedside can be used to extinguish a small fire;
- A fire extinguisher can be used, but precious seconds may be lost while obtaining one;
- Depending upon the type of extinguisher, exercise care if the patient is connected to electrical equipment;
- If a patient's mattress is involved, remove the patient as quickly as possible. Call for help. Try to extinguish the fire. Confine fire by closing door to room, evacuate as necessary and await arrival of fire department personnel;
- Shut off any oxygen.

Fire In or Near a Patient Room

- Remove patients from the room to a safer area. Close the door as you leave;
- Call for help, activate the fire alarm pull station, and call 911;
- Close other patient care room doors.
  Shut off oxygen (at the corridor valve) for the room involved;
- Extinguish the fire if possible.

Fire Elsewhere in a Laboratory, Clinical Service Areas, or Office

- Remove anyone in immediate danger;
- Pull the fire alarm and dial 911 to report;
- Close door to room of fire origin;
- Turn off oxygen to room of fire origin;
- Alert other personnel in the immediate area;
- Make a general announcement over the Department page system indicating the location of the fire;
- Remove obstructing items from corridor;
- Confine the fire by closing all corridor access doors;
- Extinguish the fire if possible.

Section 8. **High Winds (Tornado/Hurricane)**

A. Definitions

Tornado watch: issued when weather conditions exist for possible tornado.
Tornado warning: issued when a tornado sighting in the area has been confirmed, including its location, time of detection, speed and direction of movement.

B. Activating the Tornado/Hurricane Emergency Warning

The decision to activate any protective plan rests with the Clinical Center Director. The NIH Grounds Maintenance and NIH emergency Responders monitor weather conditions that affect the Washington area. In case of a tornado warning, the NIH would respond as part of the surrounding community and take the actions below.

The Director may choose to warn occupants of the possibility of damage. To do so, when warranted by metropolitan and federal weather and emergency response authorities, the CC Director, or designee, will request that the page operator make the following announcement: "A tornado (or hurricane) warning is in effect for the area. Please prepare to take protective measures." Nurse Managers/Charge Nurses and Department Heads should then review with staff their plans for evacuation and protection against injury. Patients, visitors, and staff should be restricted to the interior of the facility until a tornado warning is cancelled.

C. Activation of the Tornado/Hurricane Emergency Plan

The decision to declare an emergency rests with the Director, Clinical Center, or the Senior Administrator On-Call. A Tornado/Hurricane Emergency shall be declared when a tornado/hurricane has been sighted, or it is determined that conditions exist for the passage of a tornado/hurricane system within 10 miles on either side of the hospital within 30 minutes.

Following activation of the emergency plan for a tornado/hurricane, the Emergency Leader (the Director of the Clinical Center or the most senior administrative staff in-house) will authorize the announcement of the following information:

> ***"A tornado (or hurricane) emergency is imminent. Patients, visitors and staff are requested to move to designated areas in the hospital."***

Patients, visitors, and personnel will move to the safest areas as designated in the patient care units and departments.

D. Protective Measures

In the event of a tornado or hurricane, all occupants must evacuate areas of the hospital that could be damaged by high winds. Areas generally considered safest during a tornado/hurricane include those that are free of glass, away from potential missiles, and the exterior walls of the CC. It is imperative to take shelter in the interior hallways of the building.

E. Management of Patients

Patients should be moved from their rooms into the respective patient unit corridors, and the doors to all patient rooms securely shut. Patients should be shielded and padded with blankets, pillows, and mattresses.

F. Management of Staff

- Staff working in rooms off the north corridors should evacuate their rooms and close their doors securely. They should sit or lie on the floor against interior walls of the north corridor, and cover themselves if possible with coats, sheets, or other materials.
- Staff on the B-l, B-2, B-3, and first and second floors of the building must use common sense and discretion in finding a safe site during a tornado/hurricane. In general, staff members should move toward the center of the building or find shelter along the interior halls of the building, and stay clear of glass.
- It is advised that supervisory staff members identify and publicize areas to which they could report during a tornado or hurricane. The following are general guidelines:
    - Staff in the clinics should move into the examination rooms along the elevator shaft, and shut the door securely. Laboratory staff should move into the laboratories flanking the elevator shaft.
    - Staff in the first floor on the west end of the Clinic (e.g., Nuclear Medicine, Diagnostic Radiology, and Outpatient Departments) should move into the rooms off the interior hallways of the clinic and shut the doors securely.

- Staff on the first floor on the east end of the Clinic (i.e., the 100 block of the C wing) should move into the Lipsett Amphitheater if possible, or into the interior rooms along the northeast corner of the building, and shut the doors securely.
- Staff in the second floor of the Clinic should move to interior hallways and away from glass windows in their office or lobby areas. They may move to the interior hall alongside the Department of Laboratory Medicine, the north corridor or similar area sheltered from windows or glass.

G. Management of Visitors

Staff in the Clinical Center will aid visitors in taking protective measures against injury by directing them to interior hallways and designated shelters.

H. Deactivation

The Senior Administrative person in charge during the emergency shall continue to monitor the storm. They will determine when the alert shall be lifted.

The administrator shall initiate deactivation of the emergency plan by making the following public announcement:

"Tornado/Hurricane Emergency has ended.
Please return to your normal activities."

Section 9. Power Loss/Utility Failure

If you lose electrical power at anytime, call the Clinical Center Maintenance Unit on 301-496-5862 or the Division of Engineering Services on the extension 108.

Depending on your patient population, you should implement clinical interventions to ensure the health and safety of the patients. This may involve manual ventilation, aborting a procedure, changing batteries in medical equipment, consolidating patients and visitors for better accountability, or providing extra blankets, skullcaps or fans in case of temperature extremes.

Note: You may need to use the emergency "red" phone if you or the party you are calling has an inoperative phone. For the exact locations and dialing instructions of all emergency phones, please refer to the Emergency Section in the front of the NIH Telephone Directory.

Provide maintenance with the following information:

- Your name, room number, and telephone number;
- Your assessment of damage to life-support equipment if present;
- The location of this equipment.

Additionally, you may contact the following persons during normal hours to assist you:

Office Facility Management	301-496-2862
Biomedical Engineering	301-496-1311
Environmental Safety Officer	301-496-5281

If the outage occurs after normal working hours, supervisory staff should contact the Nurse Administrative Coordinator or Senior Administrator On-Call by contacting the page operator on 301-496-1211.

Section 10. Radiological Threat

Radiation release from an explosion can be associated with direct radiation from the dispersed radioactive source, inhalation radioactive injury and contamination of wounds by radioactive material. Ingestion of radioactive material is less common in this context. The NIH Fire Department in collaboration with the Radiation Safety Branch will respond to such an incident.

A. Key points in the response are:

- Minimizing exposure of staff, patients and visitors;
- Containing the disseminated radioactive source in the smallest area possible;
- Rapid identification of the radioactive source;
- Rapid decontamination, where appropriate;
- Post exposure medical management.

B. Immediate Response

- Immediately retreat to a safe location;
- Call 911 immediately to report the event, exact location of reporting unit, and suggested safe access route;
- Do not attempt to approach the scene;
- First responders will provide care to victims;
- Reassure victims, if possible, that help is on the way;
- Have all able victims move to a safe location;
- Have all able victims remove their own clothing and wash contaminated skin areas with soap and water;
- Keep contaminated clothing away from patients, staff and visitors.
- Do not attempt to clean up any suspect material;
- Follow the instructions of the first responders concerning evacuation;
- Make a list of all individuals who may have been in the room and the area when the exposure occurred and give this list to first responders.

C. Containing Disseminated Agents

- Seal the room off if possible to prevent further dissemination of radioactive source;
- Close access door to your unit;
- Secure perimeter, isolate area and deny entry to non-essential personnel;
- Follow the instructions of the first responders concerning leaving the building.

In some instances the first responders may prefer to have you stay in the building to avoid spreading contamination.

D. Identification of Agents

- Members of the Radiation Safety Branch are responsible for identification of the radioactive source.

E. Decontamination

- First responders will provide instructions about where to go and what to do for decontamination;
- Exposed individuals should follow first responders' instructions concerning decontamination procedures.

F. Post-Exposure Management

- First responders perform the initial triage and determine if the area is safe; Basic and advanced life support to victims is provided by emergency medical responders wearing personal protective equipment.

Section 11. Structural Damage

Call the NIH Fire Department on extension 911 after seeking a safe area; also call Division of Engineering Services on extension 108.

Additionally:

- Avoid injury by seeking refuge;
- Clear all staff members out of the threatened area;
- For more help, call the Office of Facility Management at 301-496-2862.

Section 12. Telecommunication Loss

In the event that telephone service is interrupted, staff should use the red-colored telephones. Staff will know that a phone is inoperative if they do not have a dial tone or hear a busy signal. A busy signal on any NIH phone means that phone is not working. The red-colored phones (214 exchange numbers) provide continuous communication in the CC in the event of a disruption of the 496, 594, 402 or other NIH telephone exchanges.

Dialing procedures for red phones (214 exchange)

Use the **214-exchanges** when your phone and/or other NIH phones (451, 402, 435, 443, 480, 496, 594, and 827-exchanges) are not operational. Follow the instructions below:

To dial from a red phone to a house phone	Dial 7 digit number
To dial from a red phone to a red phone	Dial 214 + 4 digit number (do not dial area code)
To dial from a house phone to a red phone	Dial 9 + 301 + 7 digit number
To dial from a red phone to an outside local number	Dial 9 (wait for second dial tone) then area code + number
To dial from a red phone to an outside long distance number	Dial 9 (wait for second dial tone) then dial 1 + area code + number

When using the red phone for NIH pagers dial 214-1813 and follow the voice activated instructions.
To reach the NIH operator from a red phone dial “0”.

All staff members are required to know the locations and be familiar with the dialing procedures for the red-colored phones in their department.

The NIH Radio Amateur Club may also assist during extended communication failures. The Office of the Director and the Environmental Safety Office are responsible for contacting, and coordinating with, the NIH Radio Club.

External Disasters

Section 13. Community Disasters with Casualties: Role of the CC

In the event of a disaster in which a request is made to the Clinical Center for on-site medical assistance, the Clinical Center Director shall notify the NIH Director's Office. The NIH Director may contact the PHS Emergency Coordinator, by whose decision the Disaster Medical Assistance Team (DMAT)/Bethesda Section or the Commissioned Corps Readiness Force (CCRF) can be activated.

The PHS Emergency Coordinator approves the activation of DMAT and CCRF. The DMAT and CCRF are groups of medical and health professionals who have volunteered to assist in the event of a disaster. The Bethesda Unit is composed primarily of volunteer staff from the NIH.

Section 14. Metropolitan Commuting Failure (Inclement Weather or Road Block)

If a weather-related or other emergency arises before the workday begins, the Office of Personnel Management (OPM) will provide an announcement regarding the operating status of the Federal Government to the media by 6:00 a.m., whenever possible. As soon as the status is determined, it will also be posted on OPM's website at *http://www.opm.gov* and a recorded message will be provided by OPM's Office of Communications on 202-606-1900. The announcements which will be used by OPM are:

a. Federal agencies are OPEN;

b. Federal agencies are operating under an **unscheduled leave** policy;

c. Federal agencies are operating under an **adjusted home departure** policy;

d. Federal agencies are operating under an **adjusted home departure/unscheduled leave** policy; and

e. Federal agencies are CLOSED.

If during the workday severe weather conditions or other emergencies arise, OPM may authorize an adjusted work dismissal policy and the release of employees will be guided by their normal departure from work. Employees are not to rely on media announcements for early dismissal. If it becomes necessary to dismiss employees during the workday, the Office of Human Resource Management (OHRM) will notify employees of the decision as soon as possible.

Essential/emergency employees are expected to report to work on time in the event of an adjusted home departure announcement. If they are already at work when notification of an adjusted work dismissal is received, they are to remain at work through the end of their tour. Employees are designated as emergency employees if they provide services that are vital to public health, safety, or welfare; national defense; or the operation of essential facilities. These employees receive annual notification of their emergency status. All staff should discuss their section's severe weather plan and emergency status with their direct supervisor. Each supervisor will develop a plan for staffing and communication to meet the needs of their area.

Section 15. Requests for Shelter

Should you receive a call requesting shelter for victims of a community disaster, refer the call to: Office of the Director, CC, on 301-496-4114

or

Senior Administrator On-Call (During off-hours, call Admissions, Outpatient Department on 301-496-3315 or call the page operator on 301-496-1211.)

The Clinical Center Director, or designee, will refer requests for shelter to the Montgomery County's Division of Emergency Management. The County has a plan and resources for providing shelter assistance to victims of flood, severe weather, structural damage, or other disasters.

Chapter Six

Recovery

Section 1. Continuing Operations Following an Emergency

The Clinical Center has mechanisms in place to restore operational capabilities of each site to pre-emergency levels. At the conclusion of an emergency, the Emergency Leader, in collaboration with the NIH Fire Department will assemble a team to assess the status of the Clinical Center to determine if the facility can provide a safe environment for patient care and operational functions. The assessment team will consider the following issues:

- Structural soundness of all buildings;
- Potential for environmental accidents (e.g., leakage of hazardous waste or fuel);
- Presence of employee support mechanisms (e.g., crisis counseling, flexible work hours, cash advances, day care);
- Functioning of communications;
- Status of equipment and supplies;
- Adequacy of staffing.

Section 2. Incident Critiques

After a hazardous incident that requires activation of the CC emergency plan, the CC Safety Officer will organize an interdisciplinary team to review the Clinical Center's response to the emergency. The results of this critique will be communicated with the Clinical Center Director and other entities, as appropriate.

Attachment I

Definitions

After-work hours: the hours from 5:00 p.m. to 8:30 a.m. on weekdays and the full period on weekends and holidays.

Areas of refuge: (i.e., elevator lobbies) fire-safe marshaling locations for controlled evacuation of personnel. They are located in the lobbies where the B, C, D corridors intersect with the north and south corridors on each floor of Building 10. Refuge in the Clinic is located in the lobby adjacent to Elevators 26-28. All refuge has access to stairwells for a vertical evacuation.

CC: Clinical Center

CC-EMP: Clinical Center Emergency Management Plan

CCRF: Commissioned Corps Readiness Team

Code Yellow: the code that will be announced over the central paging system to alert staff that the Clinical Center Emergency Management Plan has been activated

CPR: Cardiopulmonary Resuscitation Team

Disaster threat: a situation threatening the CC, the NIH reservation, or the community, which may require implementing the emergency Management plan

DMAT: Disaster Medical Assistance Team

Emergency Communication Center: refers to the communication center established by the Office of the Director, CC from which information and instructions are relayed during an emergency

External disaster: an emergency situation (i.e., fire, epidemic, explosion, transportation accident, civil disturbance, radiation hazard, severe weather condition, or natural disaster) that does not occur on the NIH Reservation

Fire barriers: located at specified areas of the building, enhance protection from fire or smoke found in an adjoining space or unit. These barriers (e.g., floors, walls, and doors) are constructed with fire-resistant materials that create compartments within the building and provide for safe refuge for a specific time period.

HAZMAT: Hazardous Materials Team

Horizontal evacuation: the movement of persons to a refuge/staging area (fire safe location) on the same floor

HVA: Hazard Vulnerability Assessment

Internal disaster: an emergency occurring within the CC. The disaster may be a fire, explosion, structural collapse, hazardous material incident, civil disturbance, or bomb threat.

NIH: National Institutes of Health

OMS: Occupational Medicine Service

OPM: Office of Personnel Management

PHS: Public Health Service

Vertical evacuation: the movement of persons on one level to a safer location on another level of the building

Work hours: the hours from 8:30 a.m. to 5:00 p.m., Monday through Friday, except holidays

Attachment II

Emergency Numbers

Listed below are individuals who are specially trained and can marshal resources for particular emergencies.

Type of emergency	First contact	Follow-up contact
Disaster (any situation posing an immediate threat or casualties requiring immediate attention)	911 NIH Emergency Communications Center	Office of the Director 301-496-4114 or after work hours Admissions Coordinator 301-496-3315
Fire / Rescue	911 NIH Emergency Communications Center	File Occurrence Report to Deputy Director for Clinical Care Safety Officer for Incident Review
Medical (Code Blue)	111 Cardiopulmonary Resuscitation Team	Outside of the CC, call 911 as first contact
Biohazardous incident	911 NIH Emergency Communications Center	On-call Epidemiologist 301-496-2209 or signal 301-496-1211
Hazardous materials	911 NIH Emergency Communications Center	Environmental Safety Officer 301-496-5281 or signal 301-496-1211
Security incident: Criminal or suspicious behavior, civil disturbance	911 NIH Emergency Communications Center	File Occurrence Report to Deputy Director for Clinical Care Safety Officer for Incident Review
Bomb threat	911 NIH Emergency Communications Center	File Occurrence Report to Deputy Director for Clinical Care Safety Officer for Incident Review
Loss of critical utility	108 Power Plant or CC Maintenance on 496-5862	CC Facility Management 301-496-2862 or signal 301-496-1211
Structural damage	911 **and** CC Maintenance on 496-5862	CC Facility Management 301-496-2862 or signal on 301-496-1211
Loss of telephone service	**Use emergency red phones** ("214" phone numbers are listed in the front of the NIH phone directory)	Help Desk on 611 and after hours 301-435-DUTY

Attachment III

Key Personnel Contact Information

All personnel listed below can be contacted via the NIH page operator.
For on-campus calls dial 301-496-1211.
To call NIH pagers from off-campus dial 1-800-NIH-BEEP

Name	*Title*	*Work Phone Number*
Adams, Ronald	Senior Administrative Officer, CC	301-594-3020
Ayres, Elaine	Office of the Director, CC	301-594-3019
Bowen, Raymond	Office of Facilities Management, CC	301-496-2862
Byram, Deb	Senior Administrative Officer, CC	301-496-1231
Cearnal, Laura	Patient Representative, CC	301-496-2626
Eldridge, Larry	Office of the Director	301-496-7828
Evans, DrPh,Michele	Environmental Safety Officer, CC	301-496-5281
Gallin, M.D., John	Director, CC	301-496-4114
Gordon, Richard	Chief Information Officer, CC	301-496-1958
Gormley, Maureen	Chief Operating Officer, CC	301-496-2897
Haines, DVM, Mark	Veterinarian, CC	301-435-5304
Hastings, Ph.D., Clare	Chief, Nursing and Patient Care Services, CC	301-435-3489
Henderson, M.D., David	Deputy Director for Clinical Care, CC	301-496-3515
Jones, Sydney	Chief, Office of Procurement Management, CC	301-402-1433
Jones, Walter	Deputy Director for Management and Operations, CC	301-496-3227
Lacasse, Lisa	Acting Chief Financial Officer, CC	301-496-5177
Lee, Laura	Special Assistant to Deputy Director for Clinical Care, CC	301-496-8025

Manuel, Fred	Office of Facilities Management, CC	301-496-2862
McGowan, Colleen	Senior Administrative Officer, CC	301-435-2868
Mekelberg, Robert	Senior Administrative Officer, CC	301-451-4703
Piringer, Patricia	Special Assistant to the Director, CC	301-496-2435
Ray, Lynda	Chief, Administrative Management and Planning, CC	301-435-8225
Runyon, Patty	Administrative Officer, CC	301-496-7725
Weymouth, Jan	Space and Program Management Officer, CC	301-496-2925
Wilson, James	Chief, Office of Facilities Management, CC	301-496-2862

Clinical Center Department Heads and Office Chiefs

Department	*Department Head/Office Chief*	*Work Phone Number*
Ambulatory Care Services	Karen Kaczorowski	301-496-2341
Anesthesia and Surgical Services	Zena Quezado, M.D.	301-496-5666
Clinical Bioethics	Ezekial Emanuel, M.D., Ph.D.	301-496-2429
Communications	Colleen Henrichsen	301-496-2563
Critical Care Medicine	Henry Masur, M.D.	301-496-9320
Department of Laboratory Medicine	Thomas Fleisher, M.D.	301-496-5668
Department of Networks and Applications	Richard Gordon	301-496-1958
Department of Clinical Research Informatics	Steve Rosenfeld, M.D.	301-496-3825
Diagnostic Radiology	King Li, M.D.	301-496-7700
Equal Employment Opportunity Office	Ellen Williams	301-496-1584
Hospitality Services	Denise Ford	301-451-9868

Housekeeping/Fabric Care	Henry Primas	301-496-2417
Materials Management	Frank Labosco	301-496-4661
Medical Records	Trish Coffey	301-496-2292
Nuclear Medicine	Ronald Neumann, M.D.	301-496-6455
Nursing and Patient Care Services	Clare Hastings, R.N., Ph.D.	301-435-3489
Nutrition	Pamela Brye, Acting	301-496-4981
Office of the Director	Maureen Gormley	301-496-2897
Office of Financial Resource Management	Lisa Lacasse, Acting	301-496-5177
Office of Human Resources Management	Thomas Reed	301-496-6219
Patient Recruitment and Public Liaison	Dottie Cirelli	301-402-6417
Positron Emission Tomography (PET)	Bill Eckelman, Ph.D.	301-496-6455
Pharmacy	Charles Daniels, Ph.D.	301-496-4363
Rehabilitation Medicine	Lynn Gerber, M.D.	301-496-4300
Social Work	Adrienne Farrar, Ph.D.	301-496-2381
Spiritual Ministry	Ray Fitzgerald, Ph.D.	301-496-3407
Transfusion Medicine	Harvey Klein, M.D.	301-496-9702

Clinical Directors

Institute	*Point of Contact*	*Work Phone Number*
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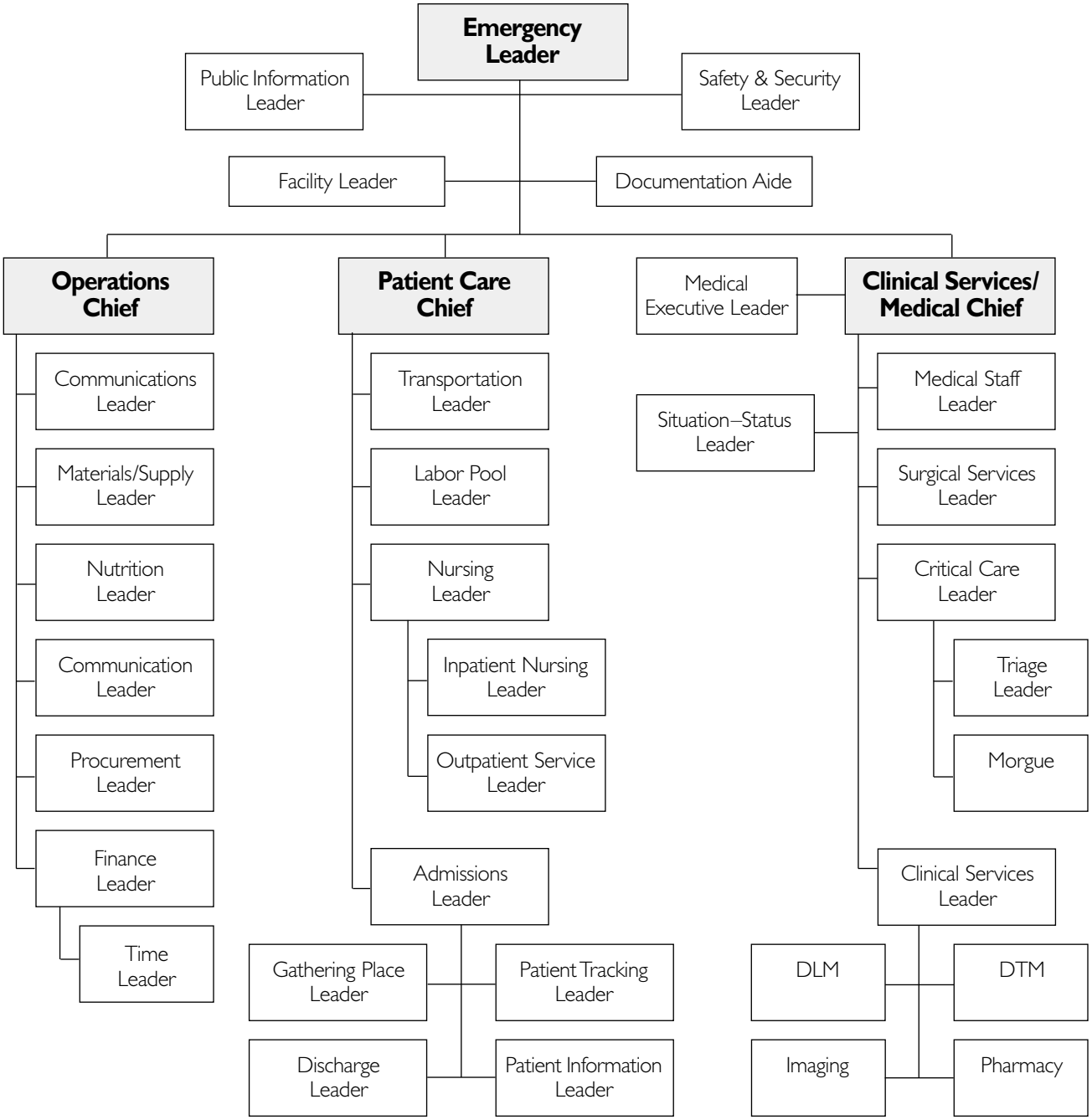
NIAAA	David T. George, M.D., Acting	301-496-9706
NIAID	Clifford Lane, M.D.	301-496-7196
NICHD	Stephen Kaler, M.D.	301-496-8368
NIDA	Jean Cadet, M.D.	410-550-2953
NIDCD	Carter Van Waes, M.D., Ph.D., Acting	301-402-4216
NIDDK	James Balow, M.D.	301-496-4181
NIDR	Raymond Dionne, D.D.S., Ph.D.	301-496-0294
NIEHS	Perry Blackshear, M.D.	919-541-4899
NIMH	David Rubinow, M.D.	301-496-4588
NINDS	Henry McFarland, M.D.	301-496-1801
NINR	Melinda Tinkle, Ph.D., RCN, WHNP, Acting	301-402-3583

Attachment IV

Organizational Communication Structure