

LOCAL DISASTER RESPONSE PLAN: PERIOPERATIVE SERVICES - CHW

DOCUMENT SUMMARY/KEY POINTS

- This Local Disaster Response Plan is part of the Children's Hospital at Westmead Disaster Response Plan. It is to be used in the event of a major incident occurring.
- It covers areas specific to Perioperative Services including Operating Theatres, Anaesthetics, Todman Recovery, Middleton and CSSD.
- In the event of a disaster the Hospital Disaster Response Plan will be activated by the Hospital's Disaster Controller (HDC) and local plans will then become active.
- The Nurse Manager (NM) Perioperative Services (or their delegate) is called the Local Area Commander in this document.
- The Local Area Commander attends the Hospital briefing with information about the state of their area.
- The Local Area Commander directs the response of the area to follow the hospital response and communicates with the HDC through the Emergency Operations Centre (EOC previously called the Disaster Control Centre) in **Committee Room 1** on level 4.
- The Operating Suite internal management will be coordinated by the Floor Manager and Duty Anaesthetist with input from other senior nursing and medical staff as delegated
- These plans include Business Continuity Plans (BCP previously called COSOPS) for loss of essential services such as water, electricity, computers, phones etc.
- Department/Unit Managers are responsible for the ongoing development of the Local Disaster Response Plan. The plan should be reviewed every 2 years.
- Exercises to test the Local Disaster Response Plan should be undertaken every 2 years.
- Local Disaster Response Plans are located:
 - on the intranet under '[eDisaster](#)'.
 - as a hard copy in the area
 - in the Emergency Operations Centre (EOC).

Approved by:	SCHN Policy, Procedure and Guideline Committee	
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Team Leader:	Staff Specialist	Area/Dept: Perioperative Service

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Introduction

A disaster is defined as a major incident in which the destructive effects of natural and man-made forces overwhelm the ability of a given area or community to meet the demand for healthcare.

In the event of a major incident or disaster, CHW's Disaster Response Plan will be activated at organisational level, with departments activating their local Disaster Response Plans. If the required response is beyond the hospital's resources, then the response is escalated to Western Sydney LHD and the State if necessary. For disasters specifically involving children CHW is activated as part of Sydney Children's Hospitals Network (SCHN) disaster response.

The aim of this local plan is to make sure staff in each area know their own local roles, specific actions and how this connects in with the CHW Disaster Response Plan.

Notification

A disaster response is activated by the Hospital Disaster Controller (HDC). A disaster response is activated if:

- The Western Sydney LHD or the State Emergency Operations Centre calls the hospital HDC and advises of a need for a response.
- Staff within the hospital witness or hear about a major event. If this happens:
 - Look at the Emergency Flip Chart
 - Call 444 and identify the problem and its location to switchboard
 - Switchboard will contact the HDC
 - HDC looks at all the information and decides on when the Disaster Response Plan is activated.

To activate the CHW Disaster Response Plan there are a series of pages. The Disaster Response may start at any stage:

Alert	An event has occurred and we need to work out what response may be needed. The request to attend a briefing is sent.
Call Out	An event has occurred and the response is needed now. The request to attend a briefing is sent.
Stand-down	The event and the response is controlled and the hospital can return to business as usual

Disaster / Downtime Box

There are two Disaster/Downtime Boxes available for Perioperative Services. These are located:

- Theatres Reception Desk
- Middleton Reception Area

These boxes contain:

- A copy of the CHW Disaster Response Plan and the Local Disaster Response Plan – Perioperative Services
- Situation Reports
- Paper based admission forms
- Theatre List Templates for Elective and Emergency lists
- Mass Casualty Admissions template
- Paper copies of other electronic forms which may be required (e.g. pharmacy order forms)

Roles and Responsibilities (print and laminate each role on a card)

In a disaster response the **Emergency Operations Centre (EOC)** is opened in Committee Room 2 on level 4. (This was previously called the Disaster Control Centre (DCC)). This is where the team of controllers run the disaster response. They are led by the **Hospital Disaster Controller (HDC)**.

In each ward, department or area of the hospital, the local disaster response is run by the Local Area Commander who is the person who is usually in charge. A commander is the person in charge of the scene.

Local Area Commander

For perioperative services, this would be the NM Perioperative Services or their assigned delegate. Coordination of case prioritisation and theatres utilisation will be coordinated by the Theatres Floor Manager and Duty Anaesthetist as usual. The NM may ask for assistance from the Department Head of Anaesthetics and the NUMs of Middleton, Anaesthetics/Recovery, Operating Theatres and CSSD. At times where these individuals are not on site, the Local Area Commander will be the senior nursing staff member in charge for that shift, along with the anaesthetist on call.

In the event of a local disaster, the Local Area Commander should ensure the alarm has been raised if they are in the area of the incident by dialling the emergency extension 444 and advising the Switchboard of the situation (who will then notify the Hospital Disaster Controller).

These roles are written in a card style so they can be printed and laminated for use.

Local Area Commander

As Local Area Commander you:

- Ensure the alarm has been raised if the incident is in your area. Notify the Hospital Disaster Controller by dialling the emergency extension 444 and advise the Switchboard of the situation
- Lead the disaster response in your area appropriate to the situation by commencing information collection and local disaster response planning using the prompts (on back).
- Account for all staff, patients and visitors within your area and assure their safety.
- Arrange for a representative with the collected information to attend the briefing.
- Follow directions of the Hospital Disaster Controller and be the contact person for your area. Direct all questions to them.
- Directs any requests for help or questions to the Emergency Operations Centre (EOC).
- Send Situation Reports each hour to the EOC (or as directed by the HDC) –see [Appendix 1](#).

Back of Card for LAC:

Disaster Response Planning

ETHANE

Exact Location	Internal / External Where if external and implications for timeline
Type of Incident	Transport, chemical, fire, bombing, environmental, etc.
Hazards	Identifiable risks to your staff
Available Resources	Staff location (work versus home, mobility) Infrastructure available/functional Other facilities that may be helpful (e.g. PICU, GNICU, Westmead Hospital, Westmead Private, etc.)
Number of casualties	Expected casualties and information on severity/type
Extra resources	Required/expected

Front of Card for Area Representative:

Area Representative

- Attend the briefing on behalf of the Local Area Commander.
- Sign in at the briefing with the main contact number for your area and the person to contact.
- Give HDC information on your area's current work load and resources which could be made available. Identify resources your area is likely to need during the disaster response.
- Take instructions from HDC back to your Local Area Commander.
- Attend further update briefings.

Back of Card for Area Representative:

Disaster Response Planning

ETHANE

Exact Location	Internal / External Where if external and implications for timeline
Type of Incident	Transport, chemical, fire, bombing, environmental, etc.
Hazards	Identifiable risks to your staff
Available Resources	Staff location (work versus home, mobility) Infrastructure available/functional Other facilities that may be helpful (e.g. PICU, GNICU, Westmead Hospital, Westmead Private, etc.)
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Extra resources	Required/expected

Perioperative Services Disaster Response Planning Framework

Both information gathering and responses to requests for information during disaster situations can be achieved with the following prompt:

ETHANE

Exact Location	Internal / External Where if external and implications for timeline
Type of Incident	Transport, chemical, fire, bombing, environmental, etc
Hazards	Identifiable risks to your staff
Available Resources	Staff location (work versus home, mobility) Infrastructure available/functional Other facilities that may be helpful (e.g. PICU, GNICU, Westmead Hospital, Westmead Private, etc.)
Number of casualties	Expected casualties and information on severity/type
Extra resources	Required/expected

Note that theatres and Todman/Middleton Recovery will potentially also provide support for care of critically ill patients from PICU and NICU, meaning that resource considerations must keep these additional requirements in mind.

Once information has been gathered, utilise the following prompt to ensure coverage of as many elements as possible (and to allow preparations to be in place for unexpected additional requirements):

- **Danger** Disaster
- **Safe Care** Situations
- **Command** Can
- **Communications** Challenge
- **Assessment** All
- **Triage** Talented
- **Planning** People
- **Review** Repeatedly

Meaning:

- **Danger** Confirm no danger for yourself/colleagues/patients.
- **Safe Care** Make sure you can deliver ongoing safe care to those patients currently in theatres.
- **Command** Put coordination systems in place.
- **Communications** Assess what communication is and isn't feasible and designate runners to keep reliable communication within theatres and with the hospital coordinators occurring.

- **Assessment** What are the key jobs right now and what are they likely to be over the next few hours?
- **Triage** Triage the work as it arrives.
- **Planning** Start the plan for the ongoing workload early.
- **Review** Regularly reassess using the same steps.

Specific points in this planning discussion are:

- Is there a need to stop new operative cases commencing?
- Should cases allowing patient discharge from hospital be prioritised to generate hospital beds?
- What is the potential peak load on the operating theatres?
- What are the potential expected casualties and the implications for theatres/recovery?
- Will areas of theatre be required as a resource for other areas (e.g. recovery to accommodate PICU/NICU patients)?
- Likely duration of incident?
- If the potential disaster is likely to truly necessitate enacting the disaster plan, an individual could be delegated to start establishing locations of all staff not on duty and their ability to attend the hospital

Note that by its nature this is a circular process until the “Stand Down” order is in place. Note also that for the purposes of the operating suite, while the general hospital “Stand Down” order may be given, the workload of theatres may well remain high for many subsequent days.

In delegating roles, keep in mind the following principles:

- People should be in similar roles as their day to day work entails
- People given roles should be given specified time frames to provide a report back to either the team running operations in the operating suite or the local area commander

Communication Strategy

Communication between your area and the Emergency operations Centre (EOC) is important so the HDC knows what is happening around the hospital. This includes what is affected in your area, how many patients related to the disaster there are, what resources you have available and what resources you need for safe functioning. This communication happens through the briefing and at least every hour via the Situation Report from each area.

Requests for support or equipment are made by calling the EOC.

Discussions with outside organisations (NETS, SCH, other hospitals, police etc.) need to be channelled through the EOC.

Briefing

At each briefing you will get information from the HDC about the progress of the disaster and any specific jobs your area needs to take on.

Disaster Situation Reports

Regular written updates are sent from each area to the EOC each hour using the Disaster Situation Report at the end of this document (see [Appendix 1](#)). This is a record of what you are doing and what you need as the disaster response continues. The HDC puts this information together to get a picture of the hospital.

Communication between wards

Simple communication between other parts of the hospital takes place as usual.

Public and Media Enquiries

All enquiries from the public or from the media should be directed to Switch (on 9) who will send it on to the appropriate area. No comment should be made in regards to the situation in your area.

The Social Work team manage family enquiries in the event of lots of patients arriving from an incident outside the hospital. Put family calls through to switch so they can be directed to them.

The Public Relations Department manages information sent to the media and also information sent to all staff in the hospital. This will appear on the message window on all computers accompanied by a notification alarm. Keep an eye on these screen pop ups for information updates.

Vital Functions

Coordination Functions

- Theatres coordination will be managed by the Nursing Floor Manager and Duty Anaesthetist as usual.
- These two roles will be supported as required by the NM Perioperative Services, the Dept Head of Anaesthetics and NMs for Todman/Anaesthetics, Middleton and the Theatre Suite.
- To aid documentation of decisions one Executive Support Officer will be assigned to accompany the Nursing Floor Manager to document events. This includes recording times for key events and reasons for triage decisions.
- The first preference for attendance at the Disaster Briefing will be the Duty Anaesthetist in conjunction with the NM Perioperative Services or their delegate. The Nursing Floor Manager should remain in the Operating Suite to continue to coordinate theatre activities.

Anaesthetics Department

- Exact numbers of staff to enlist will depend upon the nature of the disaster (note for many internal disasters, increased staffing is not required as part of the response)
- During hours, initial staffing may well not be difficult to arrange. Out of hours responses will require more coordination
- As an initial guide, in addition to the duty or on call anaesthetist, a minimum of 4 anaesthetic consultants should be arranged to attend, in addition to all available fellows and 4 registrars
- Planning should commence to have the same amount of staff ready to work a full 12 hour night shift (with additional registrars to replace the fellows)
- Clearly some responses will potentially require the full complement of theatres to be involved. The aim should be to have 1 consultant or fellow available per theatre
- The Head of Department or their delegate will coordinate the plan for ongoing staffing of theatres

Nursing Staff

1.1.1 *Scrub/Scout*

- In the event that a number of casualties will require (or potentially require) surgery, staffing in theatres will need to match the predicted demand
- At minimum, staffing for four operating rooms will be required, including a mix of skill level appropriate for orthopaedic surgery, neurosurgery and general surgery
- Depending on the immediate need, other staff may potentially be sent home to rest as additional staffing resources may be required overnight and in the subsequent days to follow
- The planning of nursing staff will be under the direction of the Local Area Commander (NM or their delegate)

1.1.2 *Anaesthetics*

- As stated above, a minimum of four operating theatres will need to be staffed, potentially more depending on number of expected casualties
- For anaesthetics, an additional two staff will be required to cover radiology (CT/MRI)
- Depending on the immediate need, other anaesthetic nurses may be sent home to rest as additional staffing resources may be required overnight and in the subsequent days to follow
- The planning of nursing staff will be under the direction of the Local Area Commander (NM or their delegate).

1.1.3 *Recovery (Todman and Middleton)*

- Recovery will need to remain fully staffed until the exact demand is established as the units may be required to support PICU and hold pre-operative patients

- Todman and Middleton NUMs will need to liaise to determine staffing across both areas and potentially pool staff according to demand
- The planning of nursing staff will be under the direction of the Local Area Commander (NM or their delegate)

Operations Assistants, Porters, Cleaners

- In the event of a high number of expected casualties requiring surgery, porters and operations assistants may be required to assist in transferring patients from ED to theatres; the Local Area Commander will liaise with ED at the Disaster briefing to determine the need
- The Floor Manager will need to review staffing over the twenty-four hour period during the immediate disaster period and also subsequent days, to ensure that there is ample staffing to accommodate additional workload after-hours and overnight
- The planning of operations assistants, porters and cleaning staff will be under the direction of the Local Area Commander (NM or their delegate)

CSSD

- Additional staff may be required particularly after-hours and overnight to ensure theatres can continue to meet surgical demand
- The NUM of CSSD will liaise with the Local Area Commander to determine the expected impact on CSSD and staffing resources required

Receptionists / Clerical Staff

Additional clerical staff may be required during the disaster particularly after-hours and overnight to ensure theatres can continue to meet surgical demand and clear communication processes occur.

Sequence for Out –of-Hours Activation

- The above planning refers to the situation where the Disaster Response Plan is activated within standard operating hours.
- In the event of an out-of-hours activation the principles of disaster management for the operating suite do not change:
 - Ensure current patients are managed safely.
 - Aim to keep people working in their normal roles.
 - Start future planning early.
- Once the Disaster Response Plan is activated, the After Hours Theatres Nursing Floor Manager (or their delegate) will:
 - Notify the on call anaesthetist if they are not already on site.
 - Notify the Operating Suite Nursing Manager so that they can attend.

- Call in the on call nursing staff to staff at least one additional operating theatre.
- Return to managing the current and immediately anticipated workload.
- The On Call Anaesthetist will:
 - Notify the Department Head of Anaesthesia.
 - Call both the Liver Transplant anaesthetics consultant and fellow on call and the Cardiac Anaesthesia anaesthetics consultant on call to attend.
- The baseline aim is to rapidly be able to staff four operating theatres while more information becomes available.
- Where possible the first disaster briefing should be attended by the On Call Anaesthetics consultant while the After Hours Theatres Nursing Floor Manager continues to manage the operating suite (though they may send a delegate).
- As soon as possible all management of broader staffing of the operating suite should be taken over by the Nursing Manager for the Operating Suite and the Department Head for Anaesthesia, leaving the on call anaesthetist and Floor Manager to coordinate the workload of theatres.

Documentation

In a disaster a record is kept in all areas of all actions taken in the form of a running log. At the end of the disaster these notes are collected by the Emergency Operations Centre (EOC). Each action should be dated, timed and signed.

Business Continuity Plans

In addition to the general hospital BCPs outlined in the table below, there is expanded information relevant to theatres described first.

Power Outage

Note that theatres 4 and 5 are equipped with the uninterrupted power supply (UPS). Confirm power supply is still operational in these operating rooms first.

1. Confirm affected areas:
 - a. Check each operating room for power supply, as well as Todman Recovery, Middleton Ward, CSSD, then office areas.
 - b. Check power points in the following order: Blue → Red → White.
2. The Power Failure Trolley is kept in the anaesthetic bay of theatre 6 and contains a variety of lighting sources and power cables.
3. In addition, each operating room has a Power Box which contains extension leads and a multi-plug power board to allow items in the operating theatre to be run from working power points if there is a fail in one of the individual systems (blue, red or white).

4. Contact Biomedical Engineering.
5. Note that most items critical to delivery of patient care have a battery back-up supply (assuming full charge):
 - c. Anaesthetics machines – 2 hours.
 - d. Philips Monitors – 2 hours for Recovery and Anaesthetic Bays – note there is no battery back-up for monitors on Anaesthetic Machines inside theatres.
 - e. Braun Pumps – 6 hours.
 - f. Baxter Pumps – 1 hour.
6. Turn off all suction and scavenging when theatres are not in use.
7. Minimise suction in all theatres that are in use.

Loss of Wall Oxygen Supply

In addition to utilising the perioperative services disaster response prompts, enact the following:

1. All anaesthetics machines have a cylinder supply which is checked in the daily machine checks. Depending on flow rates this will provide supply for hours.
2. Recovery areas should utilise the cylinder supply already available to both clinical areas.
3. No new cases should be commenced.

Loss of Hospital Suction

1. Contact Biomedical Engineering.
2. Proceed through checks as per Power Outage plan.
3. Note that portable suction has been removed from theatres. Assess if portable suction is available from other care areas via the HDC.

Communications Loss

1. In the event of loss of communications (either phone or Intranet/Internet) the first step after standard responses is to establish communication pathways via the DCC.
2. The Local Area Commander or their delegate is to report to DCC and obtain alternate communications devices (radio or alternate phone system).

Fire

After following the standard perioperative services disaster response prompts:

1. Cease non-essential surgery/procedures
2. Follow the hospital fire plan

Business Continuity Plans (BCPs)

What to do if essential services are lost:

Activate Business Continuity Plan and call switch 444

The following BCPs are generic and apply to a number of clinical areas. (Note: BCPs were previously called COSOPS.)

Risk	Consequences of Resource Failure	Contingency Strategy Options	Responsibility for implementing this strategy
Wall oxygen supply failure	Wall oxygen/air not available, patient safety at risk.	<ul style="list-style-type: none"> Use oxygen cylinders/air. Stock adequate supply of regulators of cylinder oxygen 	LAC/NM, Biomedical Engineering
Wall suction supply failure	Wall suction not available, patient safety at risk.	<ul style="list-style-type: none"> Source supply of portable suction units. Use portable suction and other suction devices. Replace drain suction with manual vacuum or drainage bottles. 	LAC/NM.
Bed failure	Unable to adjust beds. Unable to use special purpose beds	<ul style="list-style-type: none"> For operating theatre beds, position to complete surgery if possible. Consider transfer onto theatre portable beds where feasible. Source external lifting equipment and alternative beds from supplier. Extra store of pillows for positioning. 	LAC/NM, Clinical Products Coordinator.

Risk	Consequences of Resource Failure	Contingency Strategy Options	Responsibility for implementing this strategy
Computer failure	<p>Loss of computerised data</p> <p>Unable to record or access patient medical records, medical record numbers, results or order tests</p> <p>Loss of access to rosters, patient labels, patient movements.</p>	<p>Assess level of failure</p> <ul style="list-style-type: none"> • Loss of network interconnectivity • Loss of individual programs • Phones connected to the computer fail when computers down. • Phones connected to wall outlets take 10 minutes to reboot when computer system fails. • No computer systems <p>Access Local Emergency Response Box.</p> <ul style="list-style-type: none"> • Distribute paper forms as indicated in the box. • Minimise number of tests during the downtime and use paper forms to order • Results phoned through to doctor. Hard copy available in lab if phones fail. <p>Electronic Documents</p> <ul style="list-style-type: none"> • Important hospital policies available on C drive of computer at front desk. • Hospital documents are available in hard copy after-hours Nurse Manager Office (Level 3) <i>(NB: may not be the only area needing a hard copy. Ensure documents are replaced promptly)</i> 	LAC/NM. IT.
Lighting failure	<p>Low light levels may result in inability to carry out tasks safely.</p> <p>Difficulties in patient care and observations.</p>	<ul style="list-style-type: none"> • Clean and maintain windows and fittings. • Utilise electrical power supply to source torches and lanterns. • Clear areas and corridors of all hazards. • Check adequacy of emergency lighting. 	LAC/NM. All recovery and theatre staff. Engineering and Maintenance
Air conditioning failure	<p>Extreme patient/ staff discomfort (particularly in operating theatre settings).</p>	<ul style="list-style-type: none"> • Utilise fans where appropriate. • Rotate staff through operative areas. 	LAC/NM.

Risk	Consequences of Resource Failure	Contingency Strategy Options	Responsibility for implementing this strategy
Telephone failure	No internal or external telephone communications.	Assess level of failure <ul style="list-style-type: none"> • Phones connected to the computer fail when computers down. • Phones connected to wall outlets take 10 minutes to reboot when computer system fails. • In the event of a power failure –Powerfail phones take 10 minutes to reboot then work for several hours. Powerfail phones in area identified on list in Emergency box, and on http://chw.schn.health.nsw.gov.au/ou/switchboard/resources/major_incidents/powerfail_extensions.php • Collect dedicated mobile for theatres from Switch. This has numbers pre-programed for all ward and other key areas. • Use chute if working for communication with laboratory. • A small number of 2 way radios are available for ADON, Security and Registrars if all phones fail. • Appoint a runner to communicate with Emergency Operations Centre (EOC). 	LAC/NM. Information Services Security Information Services
PathNet failure (computerised pathology reporting system)	Unable to obtain results directly.	<ul style="list-style-type: none"> • See Computer failure above 	LAC/NM.
PACS failure (computerised radiological reporting system)	Unable to obtain results directly.	<ul style="list-style-type: none"> • Xrays may be visualised through Syngo on regular PCs • Xrays may be visualised on dedicated PACS machines –ED PICU. • Xrays may be visualised in Radiology Dept 	LAC/NM. PACS administrator
Pan room – sluice failure	Unable to clean bed pans/urinals adequately.	<ul style="list-style-type: none"> • Contact adjoining wards and share resources. • Ensure adequate supply of pans/urinals and covers. • Empty waste water into toilets. • Restrict use of pans to essential. • Encourage commodes to be used over the toilet. • Cover used pans/ urinals. • Use alternative methods of cleaning. 	LAC/NM. Infection Control
Lift failure	Unable to transport patient to different levels within the facility.	<ul style="list-style-type: none"> • Utilise ramps to transfer patients. • Only do critical transfers. • Use functional lift on another electrical grid in the facility. • Contact Maintenance and Engineering Department for information on functional lifts or lifts on generator power. 	LAC/NM. Maintenance and engineering

Risk	Consequences of Resource Failure	Contingency Strategy Options	Responsibility for implementing this strategy
Emergency fire alarm failure	No automatic notification of fire. Unable to summon or provide assistance automatically.	<ul style="list-style-type: none"> Implement patrols of the ward area. Use emergency phone extension 444. Follow fire evacuation procedures in Hospital Emergencies flip chart and Disaster Management manual. Standardise verbal notification procedure in theatres. 	LAC/NM.
Evacuation	If remaining in the ward is unsafe arrange for evacuation of patients, family and staff	<ul style="list-style-type: none"> Ensure safety of patients in individual theatres and recovery areas. Evacuate to adjacent area. This is isolated by fire doors. Depending on areas involved, consider whether recovery areas or inside theatres and bays are the best first option. Evacuation outside hospital may be necessary if adjacent area becomes unsafe. 	LAC/NM.
Fax/copier failure	Unable to receive or send patient or equipment information. Unable to copy documents.	<ul style="list-style-type: none"> Contact adjoining wards and utilise their fax/copier. Compile list of functional copiers/faxes near locality. Appoint runner or courier. Contact IT for urgent replacement/repair. 	LAC/NM.
Patient call button failure	Patients unable to use call system for assistance.	<ul style="list-style-type: none"> Relevant to Middleton waiting area – all areas to have direct observation by nursing staff. 	LAC/NM.
Failure of call button in treatment room or bathroom.	Staff unable to be notified of a patient emergency.	<ul style="list-style-type: none"> Staff or parent to accompany patient in treatment room or bathroom. Parents to be alerted of the need to seek out nursing staff rather than pressing call button 	LAC/NM.
Duress alarm failure	Staff unable to contact security immediately	<ul style="list-style-type: none"> Use emergency phone extension 444 Phone security 	LAC/NM.
Defibrillator failure	Unable to defibrillate patients.	<ul style="list-style-type: none"> Confirm additional defibrillators in theatre complex are functional. Notify biomedical engineering to service/replaced the faulty unit. 	LAC/NM. Biomedical Engineering
Refrigeration failure	Drugs and medical supplies requiring refrigeration may become unusable. Implants may become unusable.	<ul style="list-style-type: none"> Refrigerators to have access to emergency power supply. Confirm functionality of blood fridge and tissue fridge. Use thermometers to monitor temperature. Use "eskiies" (portable coolers) and ice. Remove unnecessary items from general refrigerators. Utilise fridges in adjoining or nearby areas that is functional. Ice Supply 	Engineering LAC/NM. Liaise with blood bank.

Risk	Consequences of Resource Failure	Contingency Strategy Options	Responsibility for implementing this strategy
Infusion pumps/syringe driver failure	Difficult to accurately give fluids and medications.	<ul style="list-style-type: none"> • Stock and use burettes. • Consider alternative administration routes. • Charge batteries when not in use. • Source loan units. • Check and repair failed equipment. 	LAC/NM.
Failure of patient monitoring device (including glucometer failure, ECG recorder failure, Doppler failure)	Unable to identify changing patient condition, arrhythmias and oxygen saturation. Potential for decreased accuracy in blood glucose readings	<ul style="list-style-type: none"> • Prioritise patients for monitoring. • Increased medical and nursing observation of vulnerable patients. • Identify and position compliant monitors ensuring access to emergency power. • Utilise battery operated oximeters. • Identify and replace non-compliant equipment. • Check and repair failed machinery. • Source loan units • Use manual equipment as appropriate. Use clinical judgement. • Source battery operated Doppler. • Charge battery when not in use. 	LAC/NM.
Transport monitors do not function. (Failure of patient monitoring device (including glucometer failure & ECG recorder failure))	Unable to monitor critically ill patients. Unable to identify arrhythmias and oxygen saturation. Potential for decreased accuracy in blood glucose readings Failure to diagnose cardiac rhythm abnormalities.	<ul style="list-style-type: none"> • Limit movement of these patients. • Assess monitor capability. • Ensure 1 compliant transport monitor available in central location. • Charge batteries. • Check and repair failed machinery. Prioritise patients for monitoring. • Increased medical and nursing observation of vulnerable patients. • Identify and position compliant monitors ensuring access to emergency power. • Utilise battery operated oximeters. • Identify and replace non-compliant equipment. • Check and repair failed machinery. • Source loan units • Use manual equipment as appropriate 	LAC/NM Biomedical Engineering
Staffing demand increased	Increased manual tasks and safety requirements may influence work load.	<ul style="list-style-type: none"> • Estimate staffing numbers required for a 24-hour and 48 hour windows. • Obtain additional staff or reduce elective operating. • Liaise with agencies for extra staff if required, including post-event. 	LAC/NM.

Appendix 1 Disaster Situation Report

the children's hospital at Westmead

Disaster Situation Report – Periop Services

- Please email a copy to Disaster@chw.edu.au OR take a copy to the briefing
- Arrange for a 'runner' to take a copy to the Emergency Operations Centre (EOC).

Name of Ward or Department : _____

Date: ____ / ____ / ____

Time: ____ : ____

Local Area Commander (name) : _____ **Page/Ext:** _____

1. Locations in Use:

Theatres:	<i>In Use</i> _____	Cardiac Cath _____
	<i>Available</i> _____	Interventional Radiology _____
MRI	_____	CT _____
Todman:	Needing Care: _____	Ready for Ward: _____
Middleton:	Needing Care: _____	Ready for Ward: _____

2. Workforce:

	Number of staff		
	Required	On site	Off Site
Anaesthesia			
- Consultants			
- Fellows			
- Registrars			
Recovery / Anaesthetic nursing			
Middleton			
Surgical/scrub			
Clerical			
Porters			
CSSD			
Radiology			

3. Surgical Specialties:

On site: Ortho / General / Neuro / Cardio / Plastics / Burns / ENT / Eyes & Dental / Radiology

Off Site: Ortho / General / Neuro / Cardio / Plastics / Burns / ENT / Eyes & Dental / Radiology

4. Infrastructure Risks:

Electrical <input type="checkbox"/>	Communication <input type="checkbox"/>
Gases <input type="checkbox"/>	Water <input type="checkbox"/>
Suction <input type="checkbox"/>	Amenities <input type="checkbox"/>

5. Comments :

Appendix 2: Changes to Theatre Utilisation in a Mass Casualty Incident

A mass casualty incident, where requirements may exceed what we have during standard operations, would require a change to how we use our operating spaces. In such a situation the operating suite may be required to provide more than just perioperative care. It may be necessary for initial assessment and resuscitation of casualties to occur within the operating suite as well as subsequent stabilisation prior to transfer to intensive care.

While flexibility is paramount, the below steps represent the preferred plan for the operating suite on such an occasion.

1. Patient Reception, Triage and Allocation

All patients should arrive to the operating suite via the theatres reception area as per usual. The nurse managing the floor, duty anaesthetist or their delegate will need to be at this location to facilitate triage and transfer of the patient to the most appropriate area.

2. Patient Tracking and Planning

The whiteboard usually used to show staffing of theatres for elective operating days will be utilised to display the following information, with meetings occurring in the CNS room with visibility of the board:

- Rooms in use for Mass Casualty Incident (MCI).
- Current case in progress.
- Next case planned for each MCI room.
- Scrub/scout and anaesthetics staff in each MCI room.
- Surgical teams currently in each MCI room.

3. Todman Recovery – Acute Care Area

Todman Recovery may be needed for the care of patients overflowing from other areas including the emergency department and PICU. The preferred arrangement will be:

- The side of Todman closest to the hospital central ramp area (on the same side as the NUM's office) will be utilised for patients requiring ongoing resuscitation and assessment who will be heading into the operating suite.
 - Ongoing resuscitation may require the input of staff from emergency, surgical staff and use of mobile X-ray to supplement the oversight of involved anaesthetists and Todman nursing/recovery staff.
- The side of Todman closest to the Todman kitchen area will be utilised for PICU patients. These may be patients who have had their operation and intended to go to PICU, or patients overflowing from PICU. Care of these patients will involve the help of PICU staff.

4. Middleton Ward – General Recovery Area

Recovery of all patients who do not need acute resuscitation or PICU-level care will occur in Middleton ward. This will involve Middleton staff supplemented by other staff from the operating suite as required.

Appendix 3 Quick Check Sheet for Theatre Floor Manager

Quick Check Room Status

- This is to quickly record the state of individual theatres and does not replace the Disaster Situation Report (Appendix 1) which is for broader updates on current status and planning to update the Hospital Disaster Coordinator.
- For each operating room and anaesthetics bay, record the time until the room is empty in minutes. If the space is empty, leave it blank or write "0".

Date: ___/___/___

Time: ___ : ___

Current Situation:

		Time To Free (mins)			Time to Free (mins)			Time to Free (mins)
OT 1	Room		OT 4	Room		OT 7	Room	
	Bay			Bay			Bay	
OT 2	Room		OT 5	Room		OT 8	Room	
	Bay			Bay			Bay	
OT 3	Room		OT 6	Room		OT 10	Room	
	Bay			Bay			Bay	
OT 9	Room		Plaster Room			Comments		
	Bay							

	Time To Free (mins)		Time To Free (mins)
C. cath room		CT	
IR Room		MRI 3 T	
IR Bay		MRI 1.5 T	

Operating rooms free: Now: _____ Within 2 hours: _____
 Anaesthetic bays free: Now: _____ Within 2 hours: _____

Todman: Needing Care: _____ Ready for Ward: _____
 Middleton: Needing Care: _____ Ready for Ward: _____

Appendix 4: Disaster Situation Documentation

- During an emergency, a contemporaneous record of events must be maintained.
- The key purpose of this is to allow accurate review of key points during the disaster situation.
- This role will be assigned to an appropriate Executive Support Officer, or another appropriately qualified individual, by the Nursing Floor Manager at the time the Disaster Response Plan is activated.
- The key elements of this role are:
 - Stay by the side of the Nursing Floor Manager.
 - Document key events and decisions during the Disaster Situation. The documentation format is left to the discretion of the individual in the position but must include the following information:
 - Date of all entries.
 - Time of all entries.
 - When recording that a key communication has occurred, details of the person who contacted the Nursing Floor Manager should also be obtained.
 - Timing of disaster meetings within the operating suite should also be documented.
 - Key timeline events should include (but are not limited to):
 - Timing of notification of potential operating theatre cases.
 - The time at which patients have been sent for.
 - The time at which key decisions (such as sending for a patient) are made or changed (and if they are changed, what information prompted this).
 - The timing of handover of coordination responsibilities.
- Individuals in this position may also be asked to help manage the phone call traffic for the Nursing Floor Manager.
- The goal of the documentation is that any person reading this record after the events could understand what decisions were made and why during the disaster situation.

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