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» PREAMBLE TO THE CC EMERGENCY MANAGEMENT PLAN

The Clinical Center (CC) at the National Institutes of Health (NIH) in Bethesda, Maryland, is the nation's largest hospital solely devoted to the conduct of clinical research. The CC's clinical research mission supports national and international emergency preparedness efforts by rapidly translating scientific observations and laboratory discoveries into new approaches for diagnosing, treating, and preventing disease.

Because of the Clinical Center's unique mission and lack of infrastructure to support an influx of disaster casualties (e.g., an emergency room, facilities to triage patients), the Clinical Center is not designated by Montgomery County Maryland as a recipient hospital during local emergencies. Nonetheless, as a founding member of the Bethesda Hospitals' Emergency Preparedness Partnership (see below), the Clinical Center provides critical assistance during local and national emergency events.

The three healthcare facilities located in Bethesda, Maryland – The National Naval Medical Center (NNMC), The Clinical Center at the National Institutes of Health (CC/NIH), and the Suburban Hospital and the NIH National Library of Medicine – recognized that their substantial and complementary strengths provided a unique opportunity to create a plan that would provide emergency preparedness resources that far outstrip what any of the four institutions could provide independently. By working together to form an emergency response team from these four diverse institutions, and by linking this collaboration to municipal, regional, and federal emergency response teams, these institutions create a flexible, effective, efficient emergency preparedness model that can be exported to numerous other sites around the nation. In fact, we have recently published a description of the first three years' experience with the Partnership to provide a template for other similarly situated academic, federal, and private hospitals.¹ These three institutions exist in close proximity to each other – literally across the street from each other (i.e., across Rockville Pike and Old Georgetown Road) and have significant individual strengths in physical resources, in flexible human resources, in acute care, in trauma management, in subspecialty care, and in basic and translational science. In addition, each institution recognizes its individual obligation to protect and preserve the health and well being of its community members. In the post 9/11 era the public expects both rational, effective preparation and response.

The rationale for the collaborative includes:

- The immediate proximity of the three institutions to each other;
- Their complementary strengths;
- Their location relative to the seat of the US Federal Government;
- The preexisting mature emergency preparedness plans/procedures at each institution;
- The fact that the three institutions have the necessary physical, human and intellectual resources to be able to coordinate emergency healthcare for thousands of regional inhabitants;

The three goals of the collaboration are:

- To respond rapidly and successfully to any emergency situation;
- To integrate the collaborative response with other community, regional, and national responses; and;
- To create collaborative structures and processes to serve as an exportable model for other similar centers in the Nation.

THE BHEPP has strengthened the Clinical Center's emergency preparedness efforts by extending the resources available to the CC in the event of a disaster. For example, if the Clinical Center facility were compromised to the extent that made caring for patients unsafe, the Partnership collaboration would allow for movement of patients to either of the Partnership hospitals thereby assuring continuity of operations. One example of the benefit of the partnership approach is the remarkable surge capacity that the approach engenders. If we face a substantial community catastrophic event, the three institutions will discharge all patients who can be safely discharged. Patients who require continued hospitalization can be transferred from the National Naval Medical Center and the Suburban Hospital Healthcare System to the Clinical Center (since we do not have an Emergency Room), allowing both of the other facilities to use their capacities for surge. In addition to this "internal surge" capacity among the three Partnership hospitals, the Department of Health and Human Services recognized the utility of the partnership approach and awarded the Clinical Center a 250 bed contingency hospital to facilitate the expansion of available beds in the event of a local or regional event. This contingency station can be used to provide additional surge capacity for the Partnership. We estimate that could easily surge by 400 to 500 beds, if necessary. Similarly, timely and efficient resource-sharing (supplies, equipment and staff) is a central goal of the Partnership. The Partnership also has enhanced the Clinical Center's capacity to test our emergency preparedness process by conducting yearly full scale and comprehensive disaster exercises.

1. Henderson DK, Malanoski MP, Corapi G, et al. The Bethesda Hospitals' Emergency Preparedness Partnership: A Model for Trans-Institutional Collaboration of Emergency Responses. *Disaster Medicine and Public Health Preparedness*. 2009:in press.

» PART A. EMERGENCY MANAGEMENT PLAN OVERVIEW

SECTION 1. PURPOSE

The NIH 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 public health threat, 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., The CC does not provide emergency medical service as described in the Preamble). Nonetheless, the CC can provide critical assistance in response to a local, regional or federal emergency through its strategic planning, resources and assets, scope of services provided and collaboration with its partners.

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 CC Director or designee is responsible for managing the CC 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 is consonant with the CC-EMP. It is the responsibility of the Department Head to conduct a through inventory assessment during and throughout the emergency and have a report ready for the command center upon request.

Inventory Assessment should include (but not limited to)

Personal Protective Equipment: Hospital Epidemiology Service, Materials Management Department

Disposable supplies (i.e. batteries, IV tubing, IV fluids, blood tubes etc): Materials Management Department

Water Potable and Non Potable: Office Research Services

Fuel: Office Research Services

Food for Patients: Nutrition Department

Pharmaceuticals: Pharmacy Department

Food for Employees/Visitors: Eurest

Linen and Cleaning Supplies: Housekeeping Department

Transfusion supplies and Reagents: Department of Transfusion Medicine

Reagents and disposable lab supplies: Department of Laboratory Medicine

» PART B. MITIGATION

SECTION 1. HAZARD VULNERABILITY ASSESSMENT (HVA)

The CC-EMP is based on an organization-wide Hazard Vulnerability Assessment (HVA). The HVA identifies the impact of potential hazards, threats, and adverse events on the operations of the hospital. Incidents may interrupt phases of or the entire operations of the Clinical Center. They may range from a departmental incident to a full-scale disaster. The HVA also outlines the appropriate staff responses including clinical interventions. Information collected during this assessment will drive improvements to the CC-EMP and guide resources allocation.

The Clinical Center's HVA indicates the following types of incidents are most likely to occur:

- **Utility Failure**
- **Infectious Outbreak**
- **Commuter Failure**

» PART C. 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 a variety of emergency situations. The Clinical Center 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)
- Inclement Weather
- Medical Assistance to the Community
- Power Loss/Utility Failure
- Radiological Threat
- Requests for Shelter
- Structural Damage
- Telecommunication Loss

The incident-specific Management Plans are located in Part E 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 these policies and procedures and be capable of demonstrating the ability to alert and respond to emergencies.

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; marshaling areas (i.e., adjacent fire zones or smoke compartments) 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

The Department Head or Section Chief needs to ensure the training is documented as part of 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

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

Emergency Management (disaster) drills are conducted 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 organizations 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 SYSTEMS

A) Fire Alarm Pull Stations

Fire alarm pull stations are located throughout the facility. These manually-operated pull stations should be used by any building occupant to report fires, the odor of smoke, and other major hazardous incidents (e.g., chemical spill). Do NOT use the pull station to report bomb threats.

B) Audiovisual and Auditory Fire Alarm System

The fire alarm system serves as an early notification system for all occupants of the facility. The system 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 manual pull stations, automatic 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.

The fire alarm announcements are different depending on your location. The emergency message announced in all patient care areas states: "... A *Code Red* has been reported in your area. Please start your *Code Red* procedure." In public and laboratory areas, the message will state, "... There has been a fire emergency reported in your area. While this is being verified, please close all doors and evacuate the area."

The Fire alarm system can also be used during a Code Yellow (reference Part D section 2) to give specific instructions to the occupants. Occupants must follow these instructions. If you have questions, regarding the instructions announced via the fire alarm, contact your section chief, department head or call the CC Command 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 "Code Red Emergency" followed by the room number or area where the emergency exists.
- Medical emergencies are announced on the central paging system as "Code Blue" followed by the room number or area where the emergency exists.
- 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.

- If a child is known or suspected of being abducted from the CC, call the NIH Police immediately. Follow the instructions of the NIH Police. The response may include the announcement to alert staff of the situation.
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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.

» PART D. GENERAL RESPONSE

SECTION 1. GENERAL PROCEDURES FOR REPORTING AN EMERGENCY

Dial 911 if there is an immediate threat (e.g., security incident) or hazardous situation involving fire, odor of smoke, arcing of equipment, explosive, chemical, biological, radiological, or other threats, dial 911. You reach the NIH Emergency Communications Center. NIH emergency responders (police or fire fighters) are linked to the Emergency Communication Center at all times.

In addition to dialing 911 for a fire or hazardous materials emergency, **ACTIVATE THE NEAREST FIRE ALARM MANUAL PULL STATION**. This will alert all occupants within the emergency zone, automatically release the hold-open devices on the fire doors, as well as notify the NIH Fire Department of the event. Any building occupant can use the Pull stations to report fires or other major hazardous incidents except bomb threats.

Dial 111 for life-threatening medical emergencies in the Bldg 10 complex only (“Code Blue” situations). The Code Team does not respond to other buildings at NIH.

SECTION 2. CODE YELLOW

Code Yellow is the term that indicates that the CC activated its emergency response procedures to a significant event that adversely impacts the operation of the hospital. The Clinical Center Director and/or his designee will initiate the code yellow based on information provided to him/her from the site of the event, by CC Department(s) involved, NIH Fire Dept, NIH Police, Office of Facility Management, and/or the Office of Research Facilities (NIH). Staff will be notified about the activation by a variety of communication media (email, verbal instructions from supervisors, public announcement or written memoranda). 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 Hospital Communication Center and direct operations of the emergency from that location (see Part D; Section 6).

Conclusion of the Code Yellow will be decided by the CC Director, and his/her designee, following discussions with the, CC Departments involved, NIH FD, NIH Police, Facilities, ORF, and communication will be conveyed to the CRC employees. (See Section 15 Termination of Event)

SECTION 3. EMERGENCY PHONE NUMBERS

Fire and Police Department	911
Medical “Code Blue” Team	111
Engineering/Maintenance	108
STAT Overhead Page (Clinical Center only)	112

SECTION 4. ORGANIZATIONAL COMMUNICATION REGARDING AN EMERGENCY

Upon activation of the Emergency management plan the Clinical Center Director, or his/her designee activate the command center and determine the level of response required based on the event. (see Code Yellow – part D section 2). The CC Director will direct communication based on the event. Communication will be delivered in the most efficient and effective route possible, include but are not limited to: email, land line telephones, runners, paper, cell phones, NIH Alert, overhead announcements and the Fire Alarm System.

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

During business hours

Clinical Center Director’s Office	301-496-4114
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After business hours

Nursing Administrative Coordinator	Via the page operator: 301-496-1211
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Admissions	301-496-3141
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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 301-496-3141

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

See Part E Section 12 for Telecommunication Loss

SECTION 5. EMERGENCY MANAGEMENT PLAN ACTIVATION

The Clinical Center director (or designee) in consultation with the NIH Officer in Charge (police or fire), and/or ORF 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
- Chief of Clinical Center Communications
- 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.

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 designees) 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.

The decision to terminate the Code Yellow will be made by CC Director or his/her designee, in consultation with the CC Departments involved, NIH Officer in charge (FD, PD) and ORF. Communication of this information will be disseminated through the CC organization.

SECTION 6. ESTABLISHMENT OF THE EMERGENCY MANAGEMENT COMMAND CENTER

Emergency incidents are managed via use of the Emergency Management Command Center (EMaCC) as necessary. The Clinical Center Incident Commander is the Director, of the Clinical Center, or his/her designee. The organizational chart is used to identify critical roles in response activities. This system also uses job action sheets to express the mission and responsibilities of the different positions in the organizational charts.

Clinical Center personnel will be assigned to execute duties outlined for each position(s). The collective activities of all the activated positions will satisfy the emergency response(s) required for each disaster incident.

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

- Directors Conference Room (CRC 6-3551)
- Medical Board Room (CRC 4-2551)
- Duke Conference Room (B1-L410)

The location of EmaCC 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 may be required to report to the EMaCC depending on the level of response and type of emergency. Key personnel will receive their assigned roles and responsibilities from the Command Team members 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 Division of the Police
- Nursing Service Chiefs
- Nutrition Department
- Office of Clinical Center Communications
- Pharmacy Department
- Psychiatry
- Safety
- Social Work Department

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 following equipment should be available to the EMaCC:

- 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 or tags
- Laptops (4)
- Network hookup and other wireless communications
- Patient care unit location list
- Telephones (regular/cell)
- Television

- Walkie-talkies
 - Writing boards/Flipcharts/Pens
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SECTION 7. COMMUNICATIONS WITH EXTERNAL ENTITIES

Clinical Center Communications, in collaboration with the NIH Office of Communication, and at the direction of the Emergency Leader, coordinates the release of all information to press, radio and television reporters, and the public. CC Leadership will notify the Partnership Hospitals of the current situation and keep them updated throughout the event. 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.

During an emergency event where there is hazardous material and/or waste is involved the NIH Fire Department will have authority and in coordination with the NIH Police will restrict access to the area until the area is deemed safe.

SECTION 9. ASSURING ADEQUATE STAFFING AND SUPPLIES DURING AN EMERGENCY

A) Staffing

In the event of 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. 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. Hospital workers and other individuals in critical positions are issued a "NIH-Red Alert Critical" identification card or sticker, in addition to their NIH employee badge. This will act as a visual

identification for emergency personnel to verify the name of the individual from your identification, contact your Administrative Officer or supervisor.

Each area and/or department will assess staffing requirements in their specific area, and send information, as requested to the command center. Those individuals who are present and available for other assignments will be assigned to the Labor Pool to assist as appropriate. Assignments will be made based on each individual's skill set and level of training. Assignments will be made giving highest priority to the safety of both the patients and staff in the hospital.

B) Supplies

During an emergency event staff should follow standard operating procedures to monitor, obtain and replenish medical and non-medical supplies during the response and recovery phases of the emergency. An inventory of critical supplies and stockpiles managed by the various departments is available on the emergency management web page, through the Clinical Center Safety Office, and in the Incident Command Center. If necessary the Emergency Leader or his/her designee may also seek assistance through partnerships with local hospitals and federal agencies. In the event of a regional or prolonged disaster in which deliveries from external sources are not available, each Department Head should report current supply levels and projected depletion rates to the Operations Sections Chief. The Operations Section Chief, in conjunction with the Medical Care/Clinical Services Section Chief and the Patient Care Section Chief will determine the appropriate course of action including clinical interventions needed to maintain operations.

SECTION 10. MANAGEMENT OF PERSONNEL DURING AN METROPOLITAN COMMUTING FAILURE

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.

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 expansive Clinical Center facility, in excess of 3 million square feet, can provide sufficient refuge to patients and staff thereby negating the need to transfer patients to external 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) or to Suburban Hospital or Walter Reed National Military Medical Center. The patient care unit transferring the patient is responsible for assuring the patient's medical record, personnel 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. SURGE AREA

In the event of an external situation that results in mass casualties or large influx of patients into the Partnership Hospitals from the local community, the Clinical Center Director, in collaboration with the Partnership, will activate the CC Surge group to receive inpatients from the partnership hospitals, in an effort to relieve partnership hospital inpatient census to more efficiently treat the casualties at site of the event. The surge group will work under the direction of the Internal Medicine Team.

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 emergency responders (police or fire officer in charge) 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's 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 emergency evacuations, the Chief of Facilities Management (or designee for the Occupant Emergency Coordinator), under the direction of the (Fire or Police) 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 Emergency Responders 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. 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 attained 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 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 fire alarm system.
- During an evacuation, staff should remain calm and follow the directions given by the NIH Emergency Responders.

C) Evacuation Levels

The facility is divided into fire and smoke rated compartments with an automatic fire alarm system and sprinkler protection. These engineering features allow for zone evacuations in an incremental fashion. If conditions are dire, one or more levels of evacuation may be initiated at the same time under the direction of the Fire Officer in Charge. The four levels of evacuation are listed below.

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 different fire zone (i.e. marshalling area) on the same floor

Marshalling areas are used as temporary holding or staging areas for patients, staff, and visitors. Health care workers need to confirm their patient census in the marshalling area and after each subsequent stage of an evacuation.

Persons in marshalling areas should be prepared to relocate to a more remote area or zone if dire conditions persist. *Horizontal movement to an even more remote zone 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: Elevators shall be used for vertical evacuation only under the direction of the Fire Officer in Charge.

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 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 another zone by the Fire Officer in Charge or by health care workers when they believe the hazard is imminent. 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. 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 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;
- critical medications are transported with the patient;
- 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

Health care workers will know that there is an emergency in a zone adjoining their patient care unit (e.g., CRC atrium or patient care unit), when amber lights located near the work stations in the patient care unit start to flash as part of the fire alarm system. Staff in the patient care unit with the flashing amber lights should remove equipment and obstructions from the corridor, close all doors on the unit, and determine a safe exit in preparation for an evacuation.

The patient care units should be alert for possible further orders or for the announcement that the "Code Red 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. Individuals who are the designated floor and area occupant emergency coordinators shall assist visitors and employees in moving to exits and evacuation routes. Individuals should leave the zone in alarm via the closest stairs.

Staff should assist individuals with disabilities to one or two levels below the zone in emergency. 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.

SECTION 15. TERMINATION OF EVENT

As soon as possible, Hospital Command will instruct Medical Center staff to return to their normal operations. The return to normal operations will be communicated via an "all clear" message sent by way of email, telephones, fire alarm address system, or other means. Once the "all clear" message is sent, emergency operations cease and the

Medical Center returns to normal operations.

>> PART E. INCIDENT SPECIFIC RESPONSE

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 day
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 TRANSCIEVER EQUIPMENT
AND CALL THE POLICE IMMEDIATELY.*

Most injuries seen after high-explosive detonations are conventional blunt, penetrating, and thermal injuries. Primary blast injuries occurring as a direct effect of changes in atmospheric pressure caused by the blast wave; can cause 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 PULL 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 Part D; Section 14, 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, or 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 casualty event, a Triage Area will be established in collaboration with the Fire Department. Information about the location of the Triage Area will be communicated to staff by the Fire Department or by the Emergency Leader.

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 agent(s) 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;
- Emergency eyewash and shower stations are located throughout the laboratory areas.

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.

If you or others feel threatened because of an immediate risk for or act of violence, contact the NIH Police on 911.

Call the NIH Critical Incident and Violence Intervention League (C-I-V-I-L) by dialing 301-402-4845 if you:

- You need help assessing the potential seriousness of a threatening situation;
- You are experiencing a threatening situation at work and need intervention from trained staff;

- You become aware of a workplace situation involving intimidating, harassing, or other unproductive/dangerous behaviors and need consultation; or
 - A situation involving threats or aggressive acts already has occurred and you need assistance managing the aftermath and its effect on staff; or
 - You need help in addressing your own aggressive reactions to a workplace situation
-

SECTION 6. EARTHQUAKE

An earthquake is ground shaking caused by a sudden movement of rock in the Earth's crust. Such movements occur along faults, which are thin zones of crushed rock separating blocks of crust. When one block suddenly slips and moves relative to the other along a fault, the energy released creates vibrations called seismic waves that radiate up through the crust to the Earth's surface, causing the ground to shake.

Earthquakes may last only a few seconds or may continue for up to several minutes. They can occur at any time of the day or night and at any time of the year. They are caused by stress that builds up over time as blocks of crust attempt to move but are held in place by friction along a fault.

What to Do During an Earthquake

Stay as safe as possible during an earthquake. Minimize your movements to a few steps to a nearby safe place and if you are indoors, stay there until the shaking has stopped and you are sure exiting is safe.

Defend in place, remain in work space and report to your supervisor for instructions, protect patients and families as possible. Only call 911 for true Medical or Facility Emergencies, as to not overwhelm the communication systems Wait for instructions from Clinical Center, who will communicate with the staff as soon as practical. CC Leadership will be in direct communication with the Authority Having Jurisdiction (AHJ).

If indoors

- **DROP** to the ground; take **COVER** by getting under a sturdy table or other piece of furniture; and **HOLD ON** until the shaking stops. If there isn't a table or desk near you, cover your face and head with your arms and crouch in an inside corner of the building.
- Stay away from glass, windows, outside doors and walls, and anything that could fall, such as lighting fixtures or furniture.
- Stay inside until the shaking stops and it is safe to go outside. Research has shown that most injuries occur when people inside buildings attempt to move to a different location inside the building or try to leave.

- Be aware that the electricity may go out or the sprinkler systems or fire alarms may turn on.
- DO NOT use the elevators.

If outdoors

- Stay there.
- Move away from buildings, streetlights, and utility wires.
- Once in the open, stay there until the shaking stops. The greatest danger exists directly outside buildings, at exits and alongside exterior walls..

What to Do After an Earthquake

- **Expect aftershocks.** These secondary shockwaves are usually less violent than the main quake but can be strong enough to do additional damage to weakened structures and can occur in the first hours, days, weeks, or even months after the quake.
- **Protect Patients.** Move them away from windows, falling glass or plaster, cover them with blankets, place patients in bed, ensure that all beds and wheelchairs, and gurneys are in locked position.
- **Inspect Work area.** Let your supervisor know of any areas of damage, windows, buckling of floors or walls, light fixtures that have fallen, or any visible cracks.
- **Listen for Instructions.** These may come by email, overhead page or fire alarm announcements. Since these are unexpected events inspecting the entire building will take time. Remain in your workspace unless you deem that it is unsafe, or there are hazards that prevent you from doing such. Report your location to your supervisor or the NIH Police by calling 911.
- **If your immediate area has sustained substantial damage, refer to section D: General Response for Activating the Emergency Plan, and Code Yellow.**
- Attachment IV provides a useful checklist to assist you in inspecting your work area following any Emergency.

For additional information FEMA website:

<http://www.fema.gov/hazard/earthquake/index.shtm>

SECTION 7. 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 8. FIRE EMERGENCY

A) Roles of Staff, Contractors, Visitors and Volunteers during a fire emergency

The Division of the Fire Marshal determines the roles of all employees, Licensed Independent Practitioners (i.e., medical staff), volunteers, contractors and students near the point of and away from the point of fire origin. The roles determine the specific content for fire evacuation drills and information used to orient new employees.

Employees: Employees have defined roles for response to fire emergencies based on the nature of their work. Employees assigned to a specific work site have primary responsibility for implementing the emergency procedures in their area. In order to be aware of and competent to complete an effective response, the Division of the Fire Marshal develops, implements and monitors performance of employees during fire safety drills.

Drills are conducted in each fire zone of the hospital and target responsible staff and others as feasible. The NIH maintains drawings of each fire zone in the facility. Each drawing outlines the location of evacuation routes and locations of pull stations, stairs, and fire extinguishers. The drawings are referred to during the drills to instruct employees on steps that must be implemented to minimize immediate danger from a fire, removal of patients to a safe marshal area, evacuation to another level or section of the building, and evacuation of the building.

In areas housing patients that would be difficult to move without likely risk for an adverse medical event, the training focuses on ‘defend-in-place’ strategies for fires at or near the point of origin. Defend-in-place is based on the protection provided by rated barriers (doors and walls) and suppression systems that effectively limit the spread of smoke and flames until the NIH Fire Department responds and clears the emergency.

Areas housing staff and ambulatory patients concentrate on removal of all occupants to a remote fire zone of the building or to the outdoors using the designated fire exit routes.

Medical Staff, Contractors and Volunteers: Employees and contractors (e.g., housekeeping and maintenance) who work in various areas of the facility function in the manner described for medical staff and volunteers. Specifically, these occupants are not present much of the time and do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located in at the time an alarm sounds and to render assistance under the direction of the manager or designee for the area as needs arise.

B) How to report and respond to a 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** Leave the fire zone in alarm by moving horizontally or going down the stair to a safe area.
- EXTINGUISH** Only if you can do so without endangering yourself or others.

FOLLOW the Directions of the NIH Fire Department Officer in Charge

- 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, Assembly 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 any oxygen or flammable gas;
- Alert other personnel in the immediate area;
- Remove obstructing items from corridor;
- Confine the fire by closing all corridor access doors;

- Extinguish the fire if possible.
- Evacuate the zone in alarm and exit by the nearest stairs or emergency egress routes identified by the red EXIT signs.

C) How to Use Fire Extinguisher

Remember P.A. S. S.

1. Pull pin from the extinguisher handle
2. Aim the hose at the flames starting at the perimeter
3. Squeeze the handle
4. Spray the fire starting at the perimeter using a sweeping action.

Most areas are provided ABC extinguishers that can be used on most types of fires. Water extinguishers are available in patient care areas for small fires (e.g., trash can) or fires involving patients. The Division of the Fire Marshal trains employees on when and how to use an extinguisher. All employees who use an extinguisher also need to follow the fire response procedures by calling 911 and outlined above for R.A.C.E.

SECTION 9. 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 or designee may choose to warn occupants of the possibility of tornado/hurricane damage. To do so, the Director or designee should 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 with windows should move to an interior wall such as the north corridor or service areas in patient care units. They should sit or lie on the floor against interior walls, and cover themselves if possible with coats, sheets, or other materials.
- Staff on the B-1, 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 (e.g., Surgical Services, and Clinical Pathology) should move to interior hallways alongside Clinical Pathology or into the north corridor, making sure that cross corridor doors bordering the glass-paned lobbies are securely shut. Staff in Housekeeping, Materials Management Department, and other B-1 and B-2 level offices and work areas should move into the elevator lobbies in the center of the building.
- All occupants should move away from of the glass atrium, windows, bridge walkways and stair enclosures in the CRC. Occupants should seek refuge in interior areas of the facility on the same level.

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 10. 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 Listing 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 at 301-496-2862
Biomedical Engineering at 301-496-1311
Environmental Safety Officer at 301-496-5281

If the outage occurs after normal working hours, supervisory staff should contact the Senior Administrator On Call by contacting the Admissions Department, Outpatient Department at 301-496-3141.

SECTION 11. 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 12. 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 13. TELECOMMUNICATION LOSS

In the event that telephone service is interrupted, staff should use the red-colored telephones. Staff will know that a house phone is inoperative if they do not have a dial tone or hear a very rapid busy signal. The one exception is when you dial a red phone (214 exchange) and the other party is using the phone. In this case, you will hear a “familiar” busy signal since the red phones do not have voice mail or other programming options. The red-colored phones (214 exchange numbers) provide redundant communication in the CC in the event of a disruption of the 496, 594, 402 or other NIH telephone exchanges. Additional information on the red phones including locations and phone numbers is in the Emergency Listing of the NIH Telephone and Service Directory.

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, 541, and 827-exchanges) are not operational. Follow the instructions below:

To dial from a red phone to a house phone	Dial 9 and wait for 2nd dial tone. Then dial 301 + 7 digit number
To dial from a red phone to a red phone	Dial 310 + 214 + 4 digit number
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 line	Dial 9 and wait for the 2nd dial tone. Then dial (area code) + number

*When using the **red phone** for NIH pagers dial 301-214-1813 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 location of the red-colored phones in their department. Further instructions for dialing and periodic testing of the red phones is available at <http://internal.cc.nih.gov/AdminPolicies/pdf/Emergency Backup Telephone System, 5-16-06.pdf>.

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 1. 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. Additionally the NIH CC Director may be in contact with the Navy/Suburban points of contact to activate a collaborative response.

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 2. 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.

Instruction to law enforcement officers is listed on the back of the NIH Critical Red Alert Identification Cards. If the metropolitan area is experiencing a commuter failure related to actions by the Department of Homeland Security, employees should display their critical red alert identification card to law enforcement. The identification card will assist you in your effort to report to the NIH for work.

SECTION 3. 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 by dialing Admissions, Outpatient Department on 301-496-3141 during off-hours.

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.

» PART F. 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 an 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 pm to 8:30 am on weekdays and the full period on weekends and holidays.

CC: Clinical Center

CC-EMP: Clinical Center Emergency Management Plan

CCRF: Commissioned Corps Readiness Force

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 Team: 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: to 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 am to 5:00 PM , 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 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)	Verison Help Desk by dialing 301- 402-9935.

» 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 pages from off campus dial 1-800-NIH-BEEP

<i>First Contact</i>	<i>Title</i>	<i>Work Phone Number</i>
Adams, Ronald	Senior Administrative Officer, CC	301-594-3020
Bowen, Raymond	Office of Facilities Management, CC	301-496-2862
Byram, Deb	Chief, Office of Space and Facility Management	301-496-1231
Cearnal, Laura	Patient Representative, CC	301-496-2626
Evans, Michele	Environmental Safety Officer, CC	301-496-5281
Gallin, John	Director, CC	301-496-4114
Gormley, Maureen	Chief Operating Officer, CC	301-496-2897
Hastings, Clare	Chief, Nursing and Patient Care Services, CC	301-435-3489
Henderson, David	Deputy Director for Clinical Care, CC	301-496-3515
Jones, Sydney	Chief, Office of Procurement Management, CC	301-402-1433
Jones, Walter	Diversity Management and Minority Outreach, CC	301-496-3227
Joyce, Maria	Chief Financial Officer, CC	301-496-5177
Konishi, Nyna	Administrative Officer, CC	301-496-5939
Lee, Laura	Special Assistant to Deputy Director for Clinical Care, CC	301-496-8025
Manuel, Fred	Office of Facilities Management, CC	301-496-2862
McKeeby, Jon	Chief Information Officer, CC	301-496-3826
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
Portney, Lisa	Veterinarian, CC	301-435-5304
Pollack, John	Spiritual Ministry	301-496-3227
Ray, Lynda	Chief, Administrative Management and Planning, CC	301-435-8225

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	301-496-5666
Clinical Bioethics	Ezekiel Emanuel	301-496-2429
Communications	Sara Byars	301-402-6202
Critical Care Medicine	Henry Masur	301-496-9320
Department of Laboratory Medicine	Thomas Fleisher	301-496-5668
Department of Clinical Research Informatics and Network Applications	Jon McKeeby	301-496-3826
Diagnostic Radiology	David Bluemke	301-496-7700
Hospitality Services	Denise Ford	301-451-9868
Housekeeping/Fabric Care	Rob Mekelberg	301-496-2417
Materials Management	Frank Labosco	301-496-4661

Medical Records	Trish Coffey	301-496-2292
Nuclear Medicine	Ronald Neumann	301-496-6455
Nursing and Patient Care Services	Clare Hastings	301-435-3489
Nutrition	David Folio	301-496-4981
Office of the Director	Maureen Gormley	301-496-2897
Office of Financial Resource Management	Maria Joyce	301-496-5177
Office of Human Resources Management	Bonnie Tuma, Acting	301-496-6219
Patient Recruitment and Public Liaison	Dinora Dominguez	301-402-6417
Positron Emission Tomography (PET)	Peter Herscovitch	301-496-6455
Pharmacy	Robert DeChristoforo	301-496-4363
Rehabilitation Medicine	Leighton Chan	301-496-4300
Social Work	Adrienne Farrar	301-496-2381
Spiritual Ministry	John Pollack	301-402-2142
Transfusion Medicine	Harvey Klein	301-496-9702

Clinical Directors

<i>Institute</i>	<i>Point of Contact</i>	<i>Work Phone Number</i>
Clinical Center	David K. Henderson	301-496-3515
NCCAM	Robert Nussenblatt, Acting	301-496-3123

NCI	William Dahut	301-496-4251
NEI	Frederick Ferris	301-496-6583
NHGRI	William A. Gahl	301-402-2739
NHLBI	Richard Cannon	301-496-9895
NIA	Josephine Egan	410-550-8414
NIAAA	Markus Heilig	301-435-9386
NIAID	Clifford Lane	301-496-7196
NIAMS	Richard Siegel	301-496-3761
NICHD	Forbes Porter	301-496-8368
NIDA	Carlo Contoreggi	410-550-1477
NIDCD	Carter Van Waes	301-402-4216
NIDCR	James Melvin	301-402-1706
NIDDK	James Balow	301-496-4181
NIEHS	Darryl Zeldin, Acting	919-541-4899
NIMH	Maryland Pao	301-594-0859
NINDS	Avindra Nath	301-496-1561
NINR	Leorey Saligan	301-451-1685

» ATTACHMENT IV. Unit/Area Assessment following Emergency

Upon completion of the any Emergency you should complete a thorough assessment of your work area. Please consider the following areas:

Communication:

- Are Phones working properly
- Red Phone working properly
- CRIS working properly
- IT systems functioning properly
- Paging Systems (including nurse call)
- Call Lights
- Panic Alarms

Resources:

- Any damage to Supplies
- Any Structural Damage to work areas
- Falling debris
- Broken Glass
- Damage to Equipment
- Scanners, Xrays, MRI working intact and working properly
- Pneumatic Tube system working properly
- Able to access Omni Cell and Pyxis normally – all door open/close properly

Security and Safety:

- Any doors broken
- Card Key Access working properly
- Any Hazardous Conditions? (ie Chemical spills, etc)

Staff/Patients

- All staff, patient, visitors accounted for following the earthquake
- Any injuries

Utilities

Electrical

- Any plugs not working?
- Any short circuits noted
- Any arching of Equipment

HVAC

- Does Air seem to be moving and blowing normally

Medical Air and Suction, Oxygen

- Working Properly?

Structural Damage

- Any Ceiling Tiles that have fallen or broken
- Cracking in doors, walls, ceilings or floors?
- Broken Windows or Glass

Water

- Any disruption in service
- Change in pressure

Phone Numbers for Assistance	
For Medical or Structural Emergency	911
Engineering/ Maintenance	301-435-8000
NIH Safety	301-496-2346
Clinical Center Safety	301-496-5281
NIH Police non-Emergency	301-496-5685