Australian Standard®

Planning for emergencies—Health care facilities

This Australian Standard was prepared by Committee HT/13, Hospital Emergency Procedures. It was approved on behalf of the Council of Standards Australia on 25 April 1997 and published on 5 June 1997.

The following interests are represented on Committee HT/13:

Australasian College for Emergency Medicine

Australian College of Health Service Executives

Australian Healthcare Association

Australian Nursing Federation

Department of Human Services, Vic.

Institute of Hospital Engineering

National Safety Council of Australia

Queensland Health

St John Ambulance, Australia

Additional interests participating in preparation of Standard:

Safety Institute of Australia

South Australian Ambulance Service

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PREFACE

This Standard was prepared by the Standards Australia Committee HT/13 on Hospital Emergency Procedures as a revision of AS 4083—1992, *Emergency responses for health care facilities*.

The Standard deals with emergencies which could arise within the health care facility and are usually attended to, in the first instance, by the facility's staff. It also caters for health care facilities which may participate in responses to emergencies external to the facility. The objective of this Standard, therefore, is to assist health care facilities in effective planning for both internal and external emergencies.

It is intended that this Standard apply to all health care facilities. However, the size, function and location of the health care facility will impact upon how the Standard should be implemented.

Emergency management for health care facilities includes the elements of prevention, preparedness, response and recovery. Emergency health planning occurs at facility, local, State/Territory and national levels. An 'all hazard, all agency' comprehensive approach to emergency management requires facilities to plan in cooperation with other agencies and their community, and should recognize the scope of emergency management, including mass casualty, public health, mental health and recovery planning. Further development of this comprehensive approach to emergency health management is intended in a future revision of this Standard.

Emergencies relate to a large range of potential and actual situations of varying scales requiring immediate action. The term 'emergency' is utilized in this Standard in preference to the term 'disaster'. For the purposes of this Standard, disasters are regarded as a subset of emergencies.

The principal differences between this edition and the 1992 edition are that some procedures, particularly in the area of responses to fire/smoke, have been clarified.

Account has been taken of AS 3745—1995, *Emergency control organization and procedures for buildings*, AS 3677—1989, *Colour identification for emergency services at a major disaster*, and AS 2220.1—1989, *Emergency warning and intercommunication systems in buildings*, Part 1: *Equipment design and manufacture*. Attention is also drawn to CS-FP 001—1995, *Competency Standard—Fire Emergency Response, the Australian Emergency Manual—Disaster Medicine*, and to relevant State/Territory legislation, including Occupational Health and Safety legislation.

The term 'informative' has been used in this Standard to define the application of the appendix to which it applies. An 'informative' appendix is only for information and guidance.

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FOREWORD

To ensure a continuum of optimum patient care, health care facilities require special planning to cope with emergencies which can arise internally, or as part of, or in response to, an external emergency.

The facility's staff are frequently outnumbered by patients with varying levels of disability. Clearly, the majority of patients would have little familiarity with building layout or the location of emergency equipment, and would not be aware of emergency procedures or would not have had training in such matters. Because many of the patients are non-ambulant, they depend very much upon others for assistance. Further, in emergency situations, visitors to the health care facility are also a consideration.

It follows that staff must communicate discreetly in the presence of patients and visitors during an emergency and avoid the use of words that may create anxiety and panic. To that end, various standardized colour codes may be used to assist staff in responding to various emergencies.

Unlike office buildings, health care facilities typically have special environmental problems such as the presence of oxygen, either reticulated or stored in cylinders, flammable gases and liquids and the conservation of medical records and supplies. The repercussions of isolating essential services such as power, suction and medical gases to assist with an emergency may be extremely serious for patients who are dependent on these services.

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Planning for emergencies—Health care facilities

S E C T I O N 1 S C O P E A N D G E N E R A L

1.1 SCOPE This Standard sets out the procedures for health care facilities in the planning for, and responses to, internal and external emergencies. It also specifies response colour codes for use in a specific emergency.

NOTE: Interpretation of this Standard should take account of the size and functions of the health care facility.

1.2 REFERENCED DOCUMENTS The following documents are referred to in this Standard:

AS
2700 Colour standard for general purposes
3677 Colour identification for emergency services at a major disaster

1.3 DEFINITIONS For the purpose of this Standard, the definitions below apply.

1.3.1 Armed person—a person who is in possession of an offensive weapon or instrument.

NOTE: Where it is strongly suspected that a person is carrying a weapon or instrument, he or she should be treated as an armed person.

1.3.2 Confrontation—a situation involving high risk of injury to personnel by a person (or persons) who may or may not be armed.

1.3.3 Emergency—any event, which arises internally or from external sources, and which may adversely affect persons or the community generally, and requires an immediate response.

1.3.4 Emergency coordination centre (ECC)—the coordination centre during an emergency.

1.3.5 Emergency coordinator—the person who is in overall charge of emergency management, planning and operations. This may or may not be the person in charge of the health care facility, depending upon local circumstances and timing.

NOTE: Some health care facilities may wish to use terms other than ‘emergency coordinator’.

1.3.6 Emergency officer—a person available on-site, with clearly defined responsibilities in relation to the health care facility’s emergency plans.

NOTE: Some health care facilities may wish to use terms other than ‘emergency officer’.

1.3.7 Emergency plan—a documented scheme of assigned responsibilities, actions and procedures, required in the event of an emergency.

1.3.8 Evacuation point—a number of designated places where patients, visitors and staff may be taken/assembled in the event of an evacuation.

1.3.9 External emergency—an event which arises externally to the health care facility and may necessitate allocation of resources to an external site or preparation for reception of a significant number of victims (or both).

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