

24 HOUR EMERGENCY ACTION PLAN

Reporting Period:

From : _____ Hours

To: _____ Hours

NOTE: *Actions assigned herein should begin during this operational period and units should report progress at the EOC Briefing at _____ Hours.*

Time and Date Prepared:

PREPARED BY PLANNING SECTION CHIEF:

DISTRIBUTION:
All EOC Sections and Units
Other

APPROVED BY EOC INCIDENT MANAGER:

Potential Bioterrorism Agents

The information in this chart is meant to be a quick reference guide; please consult other references, expert opinion, and check drug dosages particularly for pregnancy and children.

Disease	Incubation	Symptoms	Signs	Diagnostic tests	Transmission and Precautions	Treatment (Adult dosage)	Prophylaxis
Anthrax (inhaled and cutaneous)	2-6 days Range: 1 day to 8 weeks	Inhalation: Flu-like symptoms, nausea, vomiting, abdominal pain, fever, respiratory distress Cutaneous: initial itching papule; fever	Inhalation: fever, followed by abrupt onset of respiratory failure, confusion Widened mediastinum on chest X-ray (adenopathy), bloody pleural effusions, Atypical pneumonia Cutaneous: initial itching papule, 1-3 cm painless ulcer, then necrotic center; lymphadenopathy	Gram stain (“boxcar” shape) Gram positive bacilli in blood culture ELISA for toxin antibodies to help confirm Chest CT	Aerosol inhalation <i>No person-to-person transmission</i> Standard precautions	Mechanical ventilation Antibiotic therapy (inhalation) Ciprofloxacin 400 mg IV q 8-12 hr OR Doxycycline 200 mg IV initial, then 100 mg IV q 8-12 hr PLUS Rifampin 10 mg/kg/d po (up to 600 mg day) OR Clindamycin 1200-2400 mg/day IM or IV	Ciprofloxacin 500 mg or Doxycycline 100 mg po q 12 hr ~ 8 weeks Amoxicillin in pregnancy and children (if susceptible) Vaccine if available

Potential Bioterrorism Agents

Disease	Incubation	Symptoms	Signs	Diagnostic tests	Transmission and Precautions	Treatment (Adult dosage)	Prophylaxis
Botulism	12-72 hours Range: 2 hrs – 8 days	Difficulty swallowing or speaking (symmetrical cranial neuropathies) Symmetric descending weakness Respiratory dysfunction No sensory dysfunction No fever	Dilated or un-reactive pupils Drooping eyelids (ptosis) Double vision (diplopia) Slurred speech (dysarthria) Descending flaccid paralysis Intact mental state	Mouse bioassay in public health laboratories (5 – 7 days to conduct) ELISA for toxin	Aerosol inhalation Food ingestion <i>No person-to-person transmission</i> Standard precautions	Mechanical ventilation Parenteral nutrition Trivalent botulinum antitoxin available from State Health Departments and CDC	Experimental vaccine has been used in laboratory workers

Potential Bioterrorism Agents

Disease	Incubation	Symptoms	Signs	Diagnostic tests	Transmission and Precautions	Treatment (Adult dosage)	Prophylaxis
Plague	1-3 days by inhalation	Sudden onset of fever, chills, headache, myalgia Pneumonic: cough, chest pain, dyspnea, fever Bubonic: painful lymph nodes	Pneumonic: Hemoptysis; radiographic pneumonia -- patchy, cavities, confluent consolidation, hemoptysis, cyanosis Bubonic: typically painful, enlarged lymph nodes in groin, axilla, and neck	Gram negative coccobacilli and bacilli in sputum, blood, CSF, or bubo aspirates (bipolar, closed “safety pin” shape on Wright, Wayson’s stains) ELISA, DFA, PCR	<i>Person-to-person transmission in pneumonic forms</i> Droplet precautions until patient treated for at least three days	Streptomycin 30 mg/kg/day in two divided doses x 14 days Gentamicin 3-5 mg/kg/day IV/IM in q 8 hr dosage Tetracycline 2-4 g per day Ciprofloxacin 400 mg IV q 12 hr	Asymptomatic contacts or potentially exposed Doxycycline 100 mg po q 12 h Ciprofloxacin 500 mg po q 12 h Tetracycline 250 mg po q 6 hr All x 7 days Vaccine production discontinued
Tularemia “pneumonic”	3-5 days Range: 1-14 days	Fever, cough, chest tightness, pleuritic pain Hemoptysis rare	Community-acquired, atypical pneumonia Radiographic: bilateral patchy pneumonia with hilar adenopathy (pleural effusions like TB) Diffuse, varied skin rash May be rapidly fatal	Gram negative bacilli in blood culture on BYCE (Legionella) cysteine- or S-H-enhanced media Serologic testing to confirm: ELISA, microhemagglutination DFA for sputum or local discharge	Inhalation of agents <i>No person-to-person transmission but laboratory personnel at risk</i> Standard precautions	Streptomycin 30 mg/kg/day IM divided bid for 14 days Gentamicin 3-5 mg/kg/day IV in three equal divided doses x 10-14 days Ciprofloxacin possibly effective 400 mg IV q 12 hr (change to po after clinical improvement) x 10-14 day	Ciprofloxacin 500 mg po q 12 hr Doxycycline 100 mg po q 12 hr Tetracycline 250 mg po q 6 hr All x 2 wks Experimental live vaccine

Potential Bioterrorism Agents

Disease	Incubation	Symptoms	Signs	Diagnostic tests	Transmission and Precautions	Treatment (Adult dosage)	Prophylaxis
Smallpox	12-14 days Range:7-17 days	High fever and myalgia; itching; abdominal pain; delirium Rash on face, extremities, hands, feet; confused with chickenpox which has less uniform rash	Maculopapular then vesicular rash -- first on extremities (face, arms, palms, soles, oral mucosa) Rash with hard, firm pustules (“intra-dermal blisters”) Rash is synchronous on various segments of the body	Electron microscopy of pustule content PCR Public health lab for confirmation Rule out chicken pox with DFA	<i>Person-to-person transmission</i> Airborne precautions Negative pressure Clothing and surface decontamination	Supportive care Vaccinate care givers Experimental: cidofovir (useful in animal studies)	Vaccination (vaccine available from CDC)

Emergency Response Organization Contact List

Procedure: Call each person starting at the top of the list until successful contact is achieved. The highest ranked individual will determine whether or not to activate the Emergency Response Team.

If you cannot reach one of the people you call, leave a message and call the next person. *At a minimum make sure you call the pager number listed before going to the next person on the list.* Note the name of the person you could not reach and call again after you finished with calling the other people on the list. When you have completed the list for first time, brief the Incident Manager on the status of callouts.

Date of Last Update: _____ Approved By: _____

Name	Office #	Home #	Cell #	Contacted by Phone? Yes / No	Pager #	Email
Position						
Executive Director						
Medical Director						
Nursing Director						
Operations/ Office Manager						

Emergency Response Organization Contact List

Name	Office #	Home #	Cell #	Contacted by Phone? Yes / No	Pager #	Email
Position						
HR Director						
Finance Director						
Facilities Director						
Risk Manager						
Safety Manager						
Public Information Officer						

Emergency Response Organization Contact List

Mental Health Officer						
Finance Officer						
Security Officer						
ERT Member						
Planning Officer						
Legal Counsel						

DECISION TOOL FOR OPENING AND CLOSING CLINIC

Date: _____

This tool is not meant to generate a score. Rather, it is intended to assist a clinic management in considering the full range of factors in making a decision to close or open the clinic for operations and the level of operations the clinic could support. Place an X for each applicable item and evaluate the ability of the clinic to remain open.

Facility	Impact on Clinic Capability				
	Open		Neutral		Close
Permanent/Immediate loss of clinic facility					
Loss of clinic building for 1 day					
Loss of clinic for 1 hour or less					
Loss of clinic offices and patient care areas					
Loss of maintenance / building and grounds staff					
Earthquake – apparent structural damage					
Earthquake – suspected structural damage / unknown level of damage					
Earthquake – non-structural damage					
Utilities					
Loss of phones (landline and cellular)					
Loss of computer access for more than 1 day					
Loss of building heating/cooling for more than 1 day					
Loss of utilities/power shortage					
Staff					
Loss of Clinic management					
Loss of Medical / Nursing Director					
ENVIRONMENTAL CONDITIONS					
Street flooding cuts off clinic					

DECISION TOOL FOR OPENING AND CLOSING CLINIC

Facility	Impact on Clinic Capability				
	Open		Neutral		Close
General flooding					
Earthquake damages roadways					
WMD / Hazmat release near clinic					
Loss of clinic budget – financial constraints					
Wild-land fire					
Transportation accident requires evacuation					
Violent weather					
Internal/External Violence or Threat					
Terrorism threat/bomb threat					
Workplace violence					
Civil disorder nearby					
Security intrusion					
Government Actions					
Operational Area (County) declares disaster					
Governor proclaims a State of Emergency in Operational Area					
President Declares a disaster in area served by clinic					
State of War Declaration					
Need for Clinic Response					
Operational Area (County) requests clinic remain open					
Community Residents / Clients request open clinic					
Mass casualties nearby					
Surge of injured and ill					
Board of Directors directive					

Clinic Communications Equipment Inventory

Equipment Type	Number of Items	Location in Clinic	Date of Testing / Maintenance	Staff Contact
Telephone				
Clinic Phone System		Phones throughout clinic. Digital switchboard located:		
Fax Machines				
Analog telephone jacks				
Analog telephones				
Cellular telephones				
Satellite telephones				
Computer				
Email		Computers throughout clinic. Server location:		
Satellite Internet Connectivity				
Telemedicine				
Videoconference – camera and video monitor				
Radio-based				
Amateur Radio		Location of radio:		Operator contact information:
Handheld radios / Walkie – Talkie				
Other Radios				
EMS – Ambulance				
800 Mhz				

Damage Assessment

Name of Person Performing Survey _____ Phone: _____

Building Name/Location: _____

Date: _____ Time: _____ Hours

Preliminary Damage Survey

Building/Item	Description of Damage	DMGED	DESTR	LIFE	URGNT	INFO ONLY	NOTES
Building Structure - outside [Wall(s)-doors-glass- and parking lot]							
Room / Areas – inside [Ceiling / doors / blocked routes]							
Natural Gas System – city							
Stored Water – facility							
Heating – [gas / electric]							
Venting							
Air Conditioning							
Elevators – occupants?							
Stairwells							
Fire Alarm System							
Emergency Call System							
Emergency Lighting							
Security System							

Damage Assessment

Building/Item	Description of Damage	DMGED	DESTR	LIFE	URGNT	INFO ONLY	NOTES
Telephone System							
Fire Sprinkler System							
Emergency Paging System							
Infectious Waste Storage Area							
Lab Area – Chemical							
Refrigerators / Freezers – Dry Ice?							

Damage Assessment

Instructions for Preliminary Damage Survey

This form is used to record and report the preliminary damage assessment.

- DATE / TIME:** Identify Date and Time form completed.
- NAME / PHONE:** Identify Name and Phone Number of individual completing or responsible for form.
- FACILITY NAME:** Name of facility damaged or best description of facility/location.
- DAMAGED:** Check block if property is damaged.
- DESTROYED:** Check block if property is destroyed.
- LIFE:** Check block if deaths have occurred at site.
- URGENT:** Check block if URGENT Operations Section attention is required at location.
- INFO ONLY:** Check block if information provided does not require action or future assessment.
- NOTES:** Can the businesses still operate (even at reduced capacity?)

Damage Assessment

Name of Person Performing Survey _____ Phone: _____

Date: _____ Time: _____ Hours

Damage or Near Term Protective Measures

Location or Address of Protective Work	Description of Damage and Protective Measures	Estimated Cost			
		Equipment	Supplies	Staff	SUB-TOTAL
TOTAL THIS PAGE					

Damage Assessment

Instructions for Damage - Protective Measures Form

Estimate the cost of emergency measures taken to protect life and property, e.g., sandbagging, warning flashers, demolition, decontamination etc.

- DATE / TIME:** Identify Date and Time form completed.
- NAME / PHONE:** Identify Name and Phone Number of individual completing or responsible for form.
- LOCATION:** Enter location of protective measures.
- DESCRIPTION OF PROTECTIVE MEASURES:** Enter description of protective measures.
- ESTIMATED COSTS FOR EMERGENCY EXPENDITURES:** Estimate the costs to include equipment, supplies, and personnel overtime.

Damage Assessment

Name of Person Performing Survey _____ Phone: _____

Date: _____ Time: _____ Hours

Long Term Building Repair/Replacement Costs

NAME/ BUILDING ADDRESS	DESCRIPTION OF DAMAGE	ESTIMATED COST
Total This Page		

PAGE _____ OF _____

Damage Assessment

Damage - Buildings

Estimate costs to repair buildings.

DATE / TIME: Identify Date and Time form completed.

NAME / PHONE: Identify Name and Phone Number of individual completing or responsible for form.

LOCATION: Enter location of public buildings damage.

DESCRIPTION OF BUILDING DAMAGE: Enter description of public buildings damage.

ESTIMATED COSTS FOR EMERGENCY EXPENDITURES: Estimate the costs to include equipment, vehicles, and overtime. Also estimate cost to replace to pre-disaster condition.

Donation Tracking Form

Forward completed form to Finance Section

Quantity	Item Description	Category	Donor	Donor Contact	Est Value	Disposition / Use

Emergency Response Objectives

Date:

Management Approval: _____

Signature Required

Operational Period From: _____ **Hours**

To: _____ **Hours**

Section:

Objectives:

Weather Forecast for this Operational Period:

Employee Time Sheet

Section / Unit:

Date:

Submit copies to:

Finance Section

Last Name	First Name	Position	Location	Date/Time IN	Date/Time OUT

EOC Personnel Schedule for 24 Hour Operations

Facility Name: _____

Date: _____

	Shift 1			Shift 2		
	From:	To:	Hours	From:	To:	Hours
Position	Name			Name		
Incident Manager						
Safety Officer						
Security Officer						
Public Information Officer						
Operations Chief						
Planning Chief						
Logistics Chief						
Support Staff						
Status Board Keeper						
Communications Coordinator						

Finance Situation Report

Prepared by:

Date:

Report Period:

Incident:

Purchases during this report period [Cost Unit]					
Beginning Balance \$					
	Item and Supplier	Mgmt Approval (Initial)	Quantity	Unit Cost	TOTAL COST
1					
2					
3					
4					
5					
6					
9					
10					
11					
12					
13					
14					
15					
Totals					

Claims (Claims Unit)				
Name	Dept.	Nature of Claim	Disposition	Est. Cost
Total Estimated Cost				

Finance Situation Report

Finance Section Tasks for this Operating Period	Assigned to:

General Activity Log

Date/Time	Activity

Please print your name and position

Media Contact Form

Date	Approved by <i>Initial of Incident Manager or PIO</i>	Media Outlet	Reporter Name and contact information	Subject/Content	Staff Interviewed
Time					

Offsite Agency Contact and Notification List

Confirm with the Incident Manager, which Agencies need to be contacted then call them in order recording the person taking the call.

Agency	Telephone	Email	Contact Person	Date/Time Contacted
County EOC / Warning Center	717-367-2451			
Med/Health Op Area Coordinator				
<Name of County> Division of Epidemiology: Bioterrorism Emergency Number				
CDC Emergency Response Office				
Nearest Hospital Emergency Department				
Nearest Clinic / Medical Group				
Local EMS Agency				
<Name of County> Health Department (general)				
<Name of County> County Medical Society				
<Name of County> Office of Emergency Services Director				

Offsite Agency Contact and Notification List

Agency	Telephone	Email	Contact Person	Date/Time Contacted
Regional Amateur Radio Contact				
Media – Television				
Media – Radio				
Media – Newspaper				
Other Numbers				

Patient Tracking Form

Date/ Time	Patient Name	Pt. or Tag Number	Sex	Age	Destination	Released To	Triage Ldr Initials

Planning Situation Report

(Completed by Planning Section Chief / Submit to Incident Manager / Distribute to All EOC Sections)

Date:	Time	Report Number	Reporting Period	From: Hours
Prepared by:			Incident:	
Section Chief Shift 1:				
Section Chief Shift 2:				

EOC Activation	Date/Time	By

Damage Assessment Summary

ITEM	Source	Number
STAFF DEATHS		
STAFF INJURIES		

CATEGORY	EST. EMERGENCY COSTS	ESTIMATED REPAIR/ RESTORATION COSTS	SOURCE OF INFORMATION
MAIN CLINIC FACILITY			
OTHER BUILDINGS			
EQUIPMENT			
OTHER			

Weather Summary

Current Conditions:		Forecast:	
Temperature	Precipitation/Wind	Temperature	Precipitation/Wind
Other Environmental Conditions			

Status of Planning Objectives

Objective	Completed	In-progress	Waiting

Standard Situation Report

(Completed by EOC Section Chiefs)

Section/Branch/Unit:

Date:	Time:	Report #	Reporting Period
			From:
			To:
Prepared by:		Incident:	
Unit Leader Shift 1:		Unit Leader Shift 2:	

Resource Status Summary			
Resources/Notes	Personnel	Medical Supplies/Equipment	Other Utilities, Communications etc
Losses			
Currently Committed			
Available Now			
Available in 2 Hours			
Assistance Requested			
Staging area for receipt of personnel and supplies			
Special Needs			

Casualties/Illness					
	Major	Minor	Contaminated	Infected/Isolated	Waiting Transport
Number of Casualties/Ill					
Current Capacity					

Priority Problems			
Problem/Location by Priority	Personnel Needs	Medical Supply/ Equipment Needs	Other Resource Needs
1.			
2.			
3.			

Support Services Contact List

Agency	Telephone	Mutual Aid Agreement Y/N	Email	Contact Person
EMS Provider				
Fire Service				
HAZMAT Team				
Law Enforcement				
PA Forum for Primary Health Care				
Gas or Propane				
Telephone				
Equipment Provider				
Equipment Repair				
Service Provider				
Information Technology Support				
Medical Supply and Equipment				

Support Services Contact List

Agency	Telephone	Mutual Aid Agreement Y/N	Email	Contact Person
Vendor				
Vendor				
Vendor				
Vendor				
Facilities Maintenance				
Vendor				
Vendor				
Transportation				
Food Service				
Equipment Rental (Pumps, tents, etc.)				