Region 4A/B Hospital
Preparedness Program

2025 Region 4A/B EVAC 1-2-3®
Education Program
Training Manual

Introduction

2025 Region 4A/B EVAC 1-2-3® Evacuation Education Program and Toolkit

The Region 4A/B Hospital Evacuation Education Program Toolkit provides a variety of information for hospitals / health care facilities to tailor education to meet the needs of their facility while standardizing the information and processes on the use of the EVAC 1® portion of the EVAC 1-2-3® System. The 2025 Education and Training program and Tabletop Simulation was developed to heighten the participants' understanding and ability to respond to hazards that may result in a Health Care Facility (HCF) evacuation. Training was structured around the EVAC 1-2-3® training kits and supplies, which were purchased for each of the 13 4A/B Hospitals with Hospital Preparedness Program (HPP), BP4 funding (2022-2023). Using the EVAC 1-2-3® training kit, the Training/TTX introduced and/or expanded knowledge of the EVAC 1-2-3® system. Specifically, the EVAC-1® module materials were presented to Hospital Leadership, Department Leaders and Front-line personnel, providing an opportunity for the participants to utilize the training kits in a simulation of a HCF hazard(s), response and evacuation.

Facilities are encouraged to access the MRPC 4A/B website and use the information provided in a classroom setting, skills day, as a facility learning management program or patient care unit drills or games.

- **Training Toolkit Manual**
  The training program toolkit manual below is divided into two parts:
  - **Part 1** information and notes for trainers and leaders on the principles and planning for evacuation are included in this manual based on the ***Evacuation Principles and Planning: EVAC 1-2-3 System use on Patient Care Units Presentation***. A narrated video is also available for trainers and staff on the MRPC website HPP | MRPC Region 4AB. .
  - **Part 2** provides information and logistics for using the EVAC 1-2-3 Tabletop Kit and tagging system. Training videos from the Disaster Management System (DMS) and Region 4A/B trainings are also available.

- **Region 4A/B MRPC Evacuation Program and Toolkit resources**
  Presentations, Videos, and tools used for this program may be accessed from the 4A/B MRPC Web site HPP | MRPC Region 4AB.
  These include:
  - **2025 Evacuation Planning and Principles** Stand Alone Power Point Presentation: ***Evacuation Principles and Planning: EVAC 1-2-3 System Use on Patient Care Units -*** This presentation includes 3 videos.
    - Learning Management Systems
    - Facility presentation with or without simulation
  - Narrated Video Overview of Evacuation Principles and Planning and Introduction to EVAC 1-2-3®
  - EVAC-1® Region 4A/B Supplies and Evac Tagging Video
  - EVAC 1-2-3® DMS Evacuation System for Hospitals
  - EVAC-1® Tabletop Exercise/Simulation PowerPoint

Manuals and Tools:

- Train the Trainer Guidance Manual (PDF)
- SitMan (PDF) as reference for Trainers during Exercise/Simulation
- Job Action Sheet SAMPLE (pdf) * based on Evacuation Subgroup approval
- Census Form SAMPLE (pdf) * based on Evacuation Subgroup approval
- Game pieces/equipment (PDF)
- Evaluations (blank pdf)
- CEU Application SAMPLE (pdf)

➢ **Additional Resources**

Links to additional resources:

- Disaster Management Systems EVAC 1-2-3 Evacuation System for Hospitals https://youtu.be/iuGktl-884s
- Hospital Evacuation Toolkit | Mass.gov www.mass.gov/lists/hospital-evacuation-toolkit

➢ **Logistics and Planning for Educators:**

- Determine the type of education program. Skills Day, Hospital Learning Management, EVAC Tag Training, Simulation Exercise
  - Simulation will require additional space, supplies, and teaching assistance
- Coordinate with Emergency Management or other leaders as applicable to review any changes the facility has made to be included in the presentation and the location of supplies and kits.
- Based on attendance and type of presentation ensure adequate supplies are available, trainer has access to the program, toolkit, and hospital EVAC Kit. Speak with your Emergency Manager. Supplies are listed in Part 2.
- Plan for CEU submission if applicable
- Tailor the Evaluation Form to meet your facilities need and attendance.
- Provide Sign in Sheets and a Certificate of Completion.

➢ **Objectives and Capabilities for the Program:**

Exercise Objectives	Capability
Identify and summarize events that may lead to a Health Care Facility (HCF) evacuation	- Continuity of Health Care Service Delivery
Describe how a HCF evacuation operates under the Hospital Incident Command/Unified Command System	- Foundation for Health Care and Medical Readiness - Health Care and Medical Response Coordination - Continuity of Health Care Service Delivery
Increase Staff's understanding and comfort level of HCF evacuation procedures for: ambulatory, non-ambulatory patients, visitors, and hospital personnel	- Continuity of Health Care Service Delivery - Health Care and Medical Response Coordination
Advance the standardization of EVAC 1-2-3 in MRPC Region 4A/B Hospitals	- Foundation for Health Care and Medical Readiness - Continuity of Health Care Service Delivery - Health Care and Medical Response Coordination

Part 1:

Power Point for Training, Learning Management

Approximately 45 – 50 minutes should be allotted for this presentation. Learning management program can be completed in 30 minutes

These notes provide details that may be helpful to trainers when presenting the ***Evacuation Principles and Planning***: ***Evac 1-2-3 System Use on Patient Care Units.***

Slide #1: *Title Slide*

Add additional Leadership names to this slide if there is additional facility information added.

Slide #2: *Welcome and Housekeeping*

Remove this slide for learning management system presentation. Review and inform attendees: silencing devices, restrooms, food, "Real World" emergency information and any other facility information pertinent to the program.

Slide #3: *Acknowledgements*

The materials for ***Evacuation Principles and Planning - Evac 1-2-3 System Use on Patient Care Units*** were developed and made possible through the Metro Regional Preparedness Coalition. Information is included on the slide.

Slide #4: *Region 4a/B Hospitals*

Large Region - covers hospitals from South Shore Hospital in Weymouth, BI Lahey in Burlington, and U Mass Memorial in Marlborough.

Slide #5-6: *Purpose / Objectives and Goals*

This information is also located on the Evaluation.

Slide #7: *Hospital Supplies and EVAC 1-2-3 training kit*

Presenter should review with Emergency Management the status of the EVAC kits and locations prior to the program. This is highlighted for trainer identification and should be a priority before the program.

Slide # 8: *Why Health Care Facilities Need An Evacuation Plan*

This slide shows one example of weather and climate related emergencies and disasters. This does not cover man-made disasters… technology disruptions and cyber events, hazardous material events, and infrastructure emergencies that happen every day! Ask the audience if they have had any specific events in the facility that impacted operations and patient care. (Examples: flooding, fire, law enforcement, power outages)

Slide #9: *Hazard Vulnerability Analysis (HVA)*

Yearly regulatory (Joint Commission/CMS) requirement for Health Care Facilities. Assessment of external and internal emergencies and disasters that would impact the hospitals ability to provide

care to the community, a determination of the readiness and preparedness of the hospital staff, (supplies, staff knowledge and response, effect on business continuity) vendors, and community responders. The HVA breaks the analysis down into 4 categories: Naturally Occurring, Man-Made, Hazardous Material, and Infrastructure Events. Facilities review After Action Reports and activations of the Emergency Operations Plan in addition to events in their communities and region to complete the HVA

Slide # 10 - 11: *Two links to Massachusetts Hospital evacuations. Norwood & Brockton*

The presentation must be in Slide Show Mode to run these videos. Click on the screen.

Slide # 12-20: *Brockton Hospital Scenario*

These slides from Brockton Hospital Leaders describe the timeline and resources related to the 10 Alarm fire and subsequent evacuation of 160 patients. Discuss the impact to your facility, # of patients received and/or impact over the next eighteen months of recovery.

Slide #21: *The Environment of Care*

Health Care Facilities / Hospitals are highly regulated and due to these regulations the building construction and emergency systems in place allow hospitals to "shelter in place" throughout the facility providing safe refuge for staff, patients, and visitors that are **not immediately in danger**.

Sprinklers, fire and smoke doors, smoke detectors, ceiling tiles, ceiling pipe insulation all provide patient care units and unit leaders time to respond and assess their response to the emergency and plan next steps following safety protocols.

Slide #22: *Who is in Charge? Foundation of Incident Command System (ICS)*

Multiple slides discuss the importance of the staff / charge RN / Dept. Leader** (*fill in the title your hospital uses for this position*) that are ultimately responsible for the patient care unit's response in an emergency. Onsite leadership and hospital HICS or leadership team members will work with the charge RN.

In HICS the Charge RN or Department Leader is identified as the ***UNIT LEADER***. Unit Leader is used throughout the presentation and in the tabletop simulation scenario. It is extremely important that the Unit Leader (Charge RN/Dept Leader) understand their responsibilities. This training reinforces the importance of the **Unit Leader** focusing on their specific area in an event that may result in an evacuation of a patient care unit, the hospital or the decision to shelter in place and prepare for evacuation.

The administrator on site will work with the Fire Department or Law Enforcement Leaders under the Incident Command System to manage the response to the emergency and eventually establish a Unified Command.

Make sure staff understand on each shift who they report to.

Slide #23: *Hospital Incident Command System (HICS) Organization Chart*

The Incident Command System (ICS) is applicable to all hospitals, health care, fire, police public health, schools and towns. On the Patient care unit the **Unit Leader** works with the hospital

leadership but if the emergency is on your unit – YOU are the incident commander until leaders arrive.

All hands on deck – all staff on the unit should be helping to respond to the emergency – staff can be sent away/demobilized once you or on site leadership feel that there is enough manpower.

Slide #24: *Integration of HICS with Unified Command (UC)*

The slide explains the plan for Unified Command development when there are multiple stakeholders / agencies or cross jurisdictions. **The Unit Leader** plays an important role in reporting up information about the census, type of patients, needed and available resources to the Incident Commander and Unified Command. **The Unit Leader** is extremely important as they know the patients and staff on the unit.

Unified Command will work with hospital leadership to identify the risks, hazards, immediate or long term threats. They will assess additional evacuation routes, assembly points and the ability to shelter in place for the event which are all part of the Emergency Operations Plan.

Slide #25: *Sheltering-In-Place*

Examples of events where sheltering in place strategies are used. This is not a one-time assessment – HICS and Unified Command will continue to assess and determine if there are options to "improve" or strengthen the response keeping everyone safe (board windows, exhaust fans) move patients or continue to prepare for evacuation/relocation. The **Unit Leader** is a valuable resource ensuring the Patient Care Unit is preparing or responding if applicable and reporting important information to the Incident Commander, Emergency Operations Center, or Unified Command.

Slide #26: *Sequence of Evacuation*

The timeframe of an evacuation may be different depending on the nature of the threat and how much time can be taken to prepare moving patients or sheltering in place. EMS and transport resources will also affect these decisions.

The picture in the slide shows the Emergency Operations Center. These are the leaders working together to coordinate and document the response activities, patient care, and resources needed as the emergency unfolds and will continue to plan ahead based on information from the unit leaders and departments. Unified Command and HICS will assess the plan for patient movement based on the infrastructure (elevators for example) available during the event.

-**Immediate or Emergent #1 Life Safety** – Move Immediately! (Examples: Fire in a patient room, flood damaging ceiling tiles and pouring fluids into the room below) Some strategies may be to move the patients that are ambulatory quickly out of the way. Critical care areas may need to triage "easiest" patient to move first if there is limited time available or move the "most acute" patient first if there is time and no immediate threat or danger to the unit/other patients… this is part of the initial assessment and actions.

- **Rapid / Urgent:** There is time to prepare and move - limited but available and allows for a more orderly and coordinated plan for movement. Example: Heating or Air-conditioning systems are affected by an emergency and due to the internal and external temperatures in addition to the

inability to repair the problem patients such as NICU, Critical Care, and Nurseries may need to be evacuated to another facility until repairs can be completed.

- Gradual / Planned: There **is** time to prepare. This may be a phased evacuation over hours and potentially days. Example: Coastal hospitals in Florida start planning and moving patients as Hurricanes approach.

- **Prepare Only:** This may be an order by Unified Command or HICS in order to be ready to go. The **Unit Leader** will focus and delegate assignments to ready the unit for movement.

Slide #27: *Decision Point: Shelter-in-Place, Relocate, Evacuate*

Based on the emergency, **Unit Leaders** will assess the current situation to help with decision making. As described in the previous slide – Life Safety emergencies call for immediate action. Can we shelter in place? Moving a patient in immediate danger and closing all doors on the unit to prevent smoke, fire, violence to affect other patients and staff? Rooms closing doors are sheltering in place.

- Horizontal or Lateral movement is most often the first action. Moving to another room on the unit, moving to another smoke compartment on the unit or moving to another unit that is horizontal and beyond the smoke and fire doors.
- Vertical Movement: Understanding the danger or hazards below and above a unit is important information when planning for vertical movement. Staff available to assist with evacuation equipment and ambulatory patients will be needed. Information from leadership, (*engineering, public safety and the fire department fill in this role in your facility)* will be used to make this decision. The fire department may need to use specific stairwells in an event and will re-route stairwell traffic
- Do not use elevators unless told to do so by the Fire Department or Public Safety
- Always move toward a Marked Exit and follow exit pathways. KNOW Your Stairwells!

Slide #28: *Unit / Department Level Preparation*

The **Unit Leader** will direct the patient care unit when preparing for an evacuation.

- Communicate / Huddle: bring **all** staff on the unit together to provide information on what is known and instruct them to remain on the unit to act as the labor pool. If they are from another department (environmental services, food and nutrition….) and there is time - have staff call their leader and let them know where they are.
- Plan to delegate, most patient care units are divided by assignments. DELEGATE! Have the staff determine the capabilities and resources needed for their assignment – report back to you the **unit leader**. Focus on a very basic understanding of mobility, acuity, special needs, and discharge potential.
- If there is a Unit Coordinator (delegate or assign this role) – have them print out or provide a census of the unit. Working with other "labor pool" members – assemble patient charts. The UC or another staff person will ensure the census and patient movement is documented as patients leave the floor. Consider a sign in sheet for staff in the area – tracking their movement is important especially if they are accompanying patients to another site.
- Other labor pool members may help by clearing hallways and relocating unneeded equipment to storage areas. They may be helpful in gathering and bagging belongings to

go with the patient and obtaining wheelchairs, moving beds, or walking patients to other areas of refuge.

- Plan that only essential equipment will move with the patient. Venodyne boots will not be moved. IV's may need to be locked off. Oxygen may need to be obtained at the Assembly Point. Medications may need to be removed from the PYXIS/Omnicell and placed in plastic bags to accompany the patient to the assembly area. These are important questions to ask leadership for unit preparation.

The literature discusses that the best practice is to keep staff and patients together at the Assembly Point whenever possible as patients and staff are familiar with each other, unit leadership is available and this can decrease the chaos in the area.

Slide 29: *Evacuation Devices and Patient Movement*

These are examples of evacuation equipment commonly used in facilities**,** *speak with your emergency manager to clarify your facilities equipment and location***.** The alternate evacuation pictures show additional options for immediate evacuation.

Slide 30: *Preparation for Evacuation – Focus on Efficiency: Mobility and Acuity Needs*

Using the red, yellow, and green colors this grid shows the most acute patients with the highest resource needs as red and those with the least resource needs as green. Review these categories with the understanding that the type of scenario or emergency will drive the actual movement decisions. Understanding these principles helps the Unit Leader and staff assess the unit and patient needs.

Refer to the study by Boston Hospitals describing the ambulatory ability of patients admitted. Example: Patient walks into the hospital, they are placed in a wheelchair and a bed and minimally walk while admitted. Upon discharge they will walk with or without assistance. During an evacuation of an area or unit we may send patients with staff to walk to the next room, compartment or unit to ensure their safety.

Slide 31 – 36: *Patient Movement and Flow*

Depending on the time available for this program you may go through each slide or move forward to Slide 36 to discuss Evacuation Movement and Flow.

This slide provides an overview of the initial actions by the **Unit Leader** and Team moving horizontally to an area of refuge (holding area) sheltering in place awaiting direction. The next steps of Vertical Movement are coordinated with on-site hospital leadership and the fire department. HICS and Unified Command may be activated at this time.

As patients and staff arrive to the Assembly Area – patients that may be discharged should be identified and separated from patients awaiting transport to another destination.

Slide 37: *Patient Assessment and Tagging: Acuity and Transport Needs*

Continuing with red, yellow, green indicators think about acuity and the type of transport that will be needed based on the patients acuity. Depending on the event (single HCF vs. multiple or a regional event) transportation resources may be limited or adjusted to manage the emergency. Staff may need to accompany patients and/or the EMS crew may change staffing to meet demand. EMS may

take patients sitting or on a stretcher if minimal assistance and basic life support is indicated. Busses, vans, and private vehicles may also be used for transportation.

Slide 38: *Communication is Key*

Hospitals and health care facilities all have their own process for emergencies and Codes. Speak with your emergency manager if you are not aware of the system in your facility.

Trusted Communication: It is important that **Unit Leaders** understand the difference between rumors and trusted information. Your patients will need information from you and others providing care so that they are aware of the "plan" during the emergency and will follow direction to decrease chaos. Families calling patients, TV's, twitter, Instagram may provide information that is not accurate. **Unit Leaders** should plan for huddles to update staff so they can update the patients, use the nurse call systems to broadcast a floor/unit message. Overhead messaging may also be used. Remember if the emergency activates the fire alarm system (strobes, lights) it may be hard to hear the communication in the building if it is available.

Slide 39: *Video on EVAC 123 – Focus on EVAC 1*

This 3 minute video provides an overview of EVAC Tags and the process for labelling, placing on the patient doors, Ambulatory status, SBAR abbreviated patient information, type of transportation needed.

Slide 40: *Thank You, Questions, And Evaluations*

Provide Evaluations if applicable to your program. Take a 10 minute break if moving to the simulation following the training.

Part 2:

EVAC 1-2-3 Training Kit and Tag Overview

- Plan for 60 – 75 minutes when using the tabletop scenario located on the MRPC Website HPP | MRPC Region 4AB. Under education resources.
- Plan for 30 – 60 minutes for Tag Training. This will depend on the amount of patients you will assess and plan to move. This will also depend on if you have staff complete tags vs. talking through the patient information.
- Additional information https://youtu.be/iuGktl-884s Disaster Management Systems EVAC 1-2-3 Evacuation System for Hospitals and the MRPC Website Videos on tags and supplies

EVAC 1-2-3 Training Kits®

Disaster Management Systems: EVAC 1-2-3®:

HICS / NHICS Compliant patient accountability system. Integrates with your facility's evacuation plan and provides patient tracking and record keeping. Developed to simplify patient tracking in the event of an evacuation.

https://www.triagetags.com/hospitals-clinics/patient-evacuation

Disaster Management Systems: EVAC 1-2-3®

Hospital / Facility Evacuation Simplified in a Portable, Self-Contained Training Kit

No need to shut down a wing of your hospital for drills anymore. In this kit, staff prepare and evacuate 10 patients using our Evac123® Patient Evacuation System.

Key Features:

- ► Teaches How To Prioritize Patients
- ► Teaches Resource Management
- ► Conduct Countless Exercises

Contents:

- Roll-Out Vinyl Map w/ Tube (36" x 60")
- 2 Destination Facility Maps
- 10 Oversize Patient Cards
- 4 Oversize Transport Cards
- 4 Inject Cards
- Quick Start Guide
- Patient Binder w/ Labels
- Evac123® Tag Pack (DMS-05854)
- Evacuation Receipt Holder Pack (DMS-05855)
- Transportation Receipt Holder Pack (DMS-05858)
- Destination Receipt Holder Pack (DMS-05859)

https://www.triagetags.com/hospitals-clinics/patient-evacuation/evac123-tabletop-training-kit

STEP 1: For Simulation Training the educator will gather equipment for the program. Plan for 45 – 60 minute set up time which will be determined by the planned attendance.

The 2025 Educational Training Program focused on ***Evacuation Principles and Planning: EVAC 1-2-3 System Use on Patient Care Units.***

- Tabletop Training Kit and Pediatric Tabletop add-on-set
- EVAC 1 Clipboard - EVAC 2 – 3 Clipboards and receipt holders will be covered during future training programs.
- EVAC 1 Tags
- EVAC 1 Receipt Holder
- Sign In Sheet
- CEU information and evaluation form if applicable.
- EVAC 123 Unit Map
- EVAC Patient Cards, Chart, Labels, and Equipment Game Pieces
- Markers and Pens Regional tools: Census Form, Job Action Sheet

The Pediatric Training Kit has been developed by DMS for patients from NICU to adult. Some of the DMS videos continue to state that the program is not designed for NICU the vendor will be updating their information. All MRPC videos and information includes the use of EVAC 1 for all pediatric patients, Newborn -> 17 years of age.

Speak with your Emergency Manager / NICU - Pediatric patient care leadership for additional guidance.

STEP 2: The Toolkit as described above will provide a "unit map", Patient Cards, Evacuation Tags and a Recept Holder.

When planning a simulation exercise ensure there is room for the map on the tables being used. In this picture 2 tables are placed together to provide space for the map and other tools that may be used for the program.

If simulating with patients on a patient care unit team, leaders may opt to pick 2 – 3 patients from an assigment and discuss the mobility, resources and other patient care information that would be needed to complete an Evacuation Tag

STEP 3: Review additional tools available on the MRPC Website and speak with the planning team regarding the use of these tools for your training.

- Show the Evacuation Tag Video located on the MRPC Website
- Additional Optional training tools for simulation training

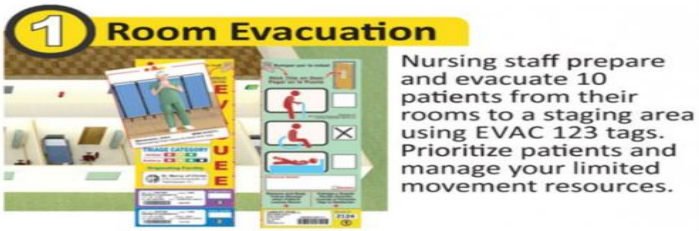
- Disaster Scenario
- Unit Census Report
- Job Action Sheets for Unit Leaders
- Game pieces/equipment and resources

Step 4: The EVAC 1-3 Training Kit provides 10 patient cards and a limited amount of tags and labels corresponding to the EVAC patient cards. The EVAC 1 Clipboard contains the Evacuation Tags and the Tag Receipt Holder.

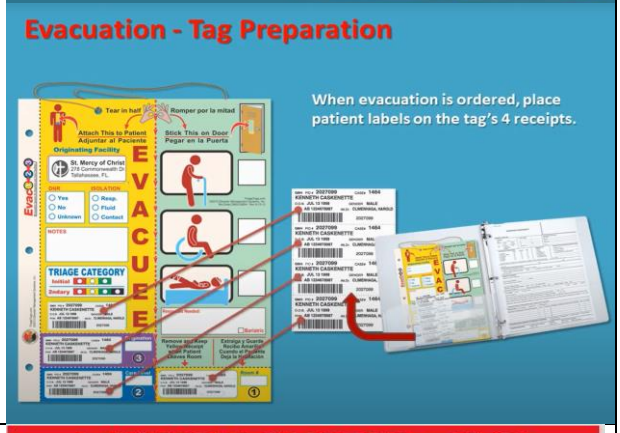
4 Patient Labels and a Hospital Label will be needed for the Evacuation Tag.

Hospitals are encouraged to pre-stage tags in the Patient Chart labeled with the Hospital information / label in place.

Patient labels will be placed on the tag when evacuation has been ordered or is planned. Demonstrate this in training.
Hand write patient information if labels are not available.



If time is limited – decrease the amount of patients (5 – 7) Ensure all staff are reviewing the tag and assessing the patient cards.



Step 5: Overview of the Evacuation Tag and Tagging.
Review this information and tagging videos to determine the tools you will use for your training.

Skills days and simulation exercises – staff will benefit from the video review prior to the drill or game. Speak with your Emergency Manager to obtain Evacuation Tags for staff trainings.

Sharpie Markers label tags better than regular pens. Plan accordingly.

Complete all information if time allows (Rapid / Urgent Evacuation)

Triage Assessment is the initial assessment of acuity on the patient unit.

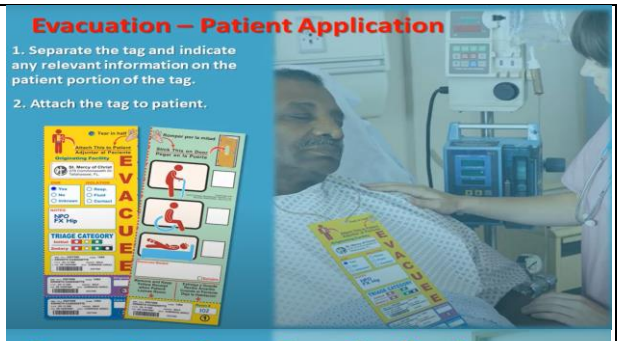
Step 6: The Evacuation Tag has two parts and is perforated. The Left side is for Patient Application and the Right side is for Room Door Application.

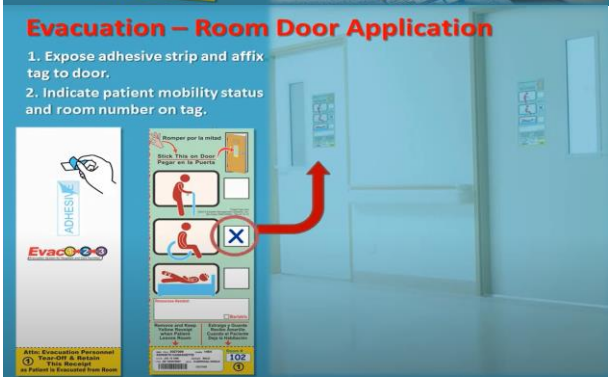
Information should be completed on the patient portion prior to attach to the patient. A cotton string is attached to the tag.

Speak with your Emergency Manager regarding the use of th cotton string on Behavioral Health Patients and Pediatric Patients.

Health Care Facilities may opt to place information for adult behavioral health patients with a patient observer or attached to the chart. Some facilities have patient care areas that are ward type units and may not have doors to a patient room. Facilities are assessing their plans but training suggestions have included placing the door tag on a monitor or IV pole.

The Room Door Application will be provide information on the mobility status and the appropriate box and room number should be labeled.





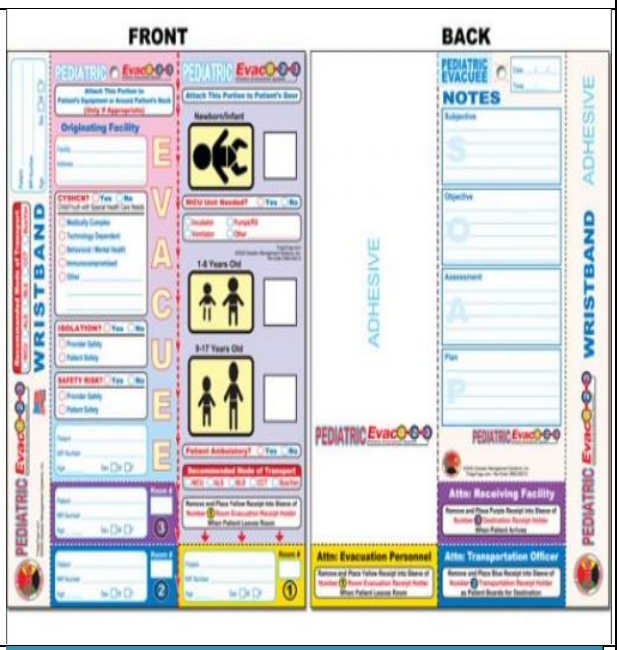
Pediatric Tags have a patient wrist band in addition to the evacuation tag. Region 4A/B Facilities are assessing their plans. Suggestions include placing the information on Incubators or cribs if moved with the patient, alternatives include placing the band on parents or staff transporting patients.

Pediatric Tags covers Newborn – 17 years old with an identification area for NICU.

Special health care needs should be identified in addition to isolation and safety requirements.

SOAP notes should be completed on the patient portion. Adult tags use SBAR.

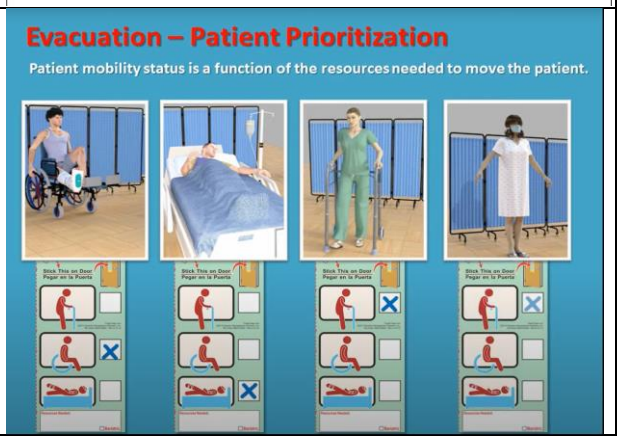
Type of transport and Ambulation status for older children will assist with the determination of transport resources needed.

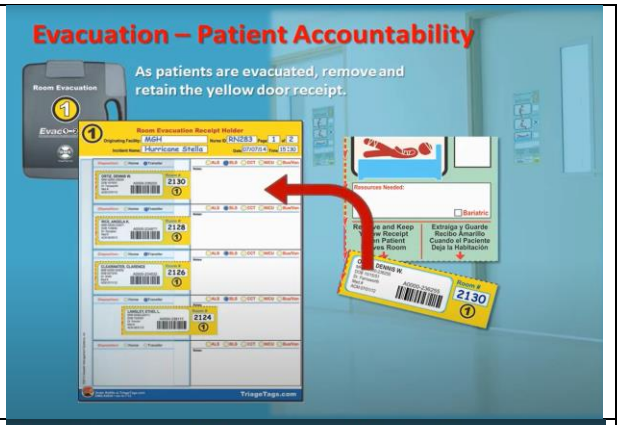
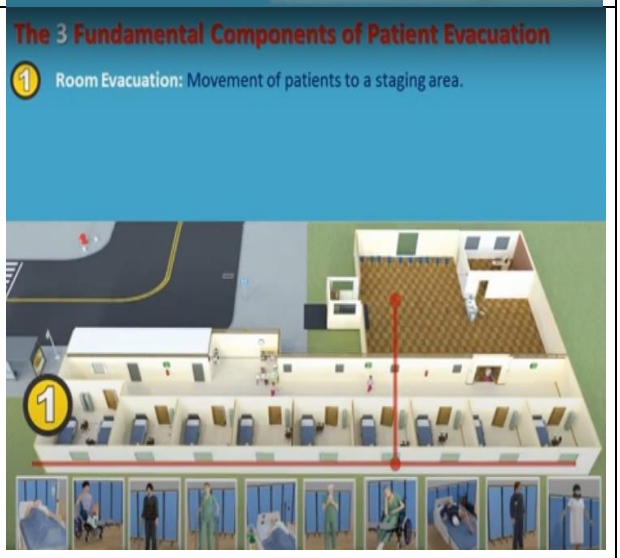


Step 7: Patient prioritization will be dependent on the type of evacuation and resources available and needed to move patients.

The Evacuation training kit patient cards provide a very basic picture of the patient and their transport needs.

Patient care Units and Unit Leaders will need to provide this information to HICS and Unified Command Team.



Step 8: As patients are evacuated the **Unit Leader** will ensure that the yellow door receipt is removed from the door tag and placed in the EVAC 1 Room Evacuation Receipt Holder indicating the time of patient movement and initial assessment of transport resources needed. **Disposition** is indicated on the receipt holder allowing for information on patient status = Home or transfer. This allows for patient accountability for all patients on the unit. This information will accompany the unit leader to the Assembly or Staging Area based on the Scenario.	
Step 9: Facilities using the EVAC Unit Map will move patients to the Staging or Assembly areas located at the top of the map. Use the resource game pieces to further plan resources that may be moved with the patient or needed at the Assembly Area. Best practice indicates that staff should stay with their patients to decrease the chaos in the assembly point. **HICS and Unified Command may have patients remain on their unit if safe to do so and move as transport resources become available. Lessons learned from Hurricane Sandy in New York showed the benefits of this practice "the unit may be the safest place to be" while waiting for transportation resources.** **Unit accountability and the use of the Evacuation Receipt Holder is an important role and should be delegated and continuously reviewed by the Unit Leader or Department Leader.**	
Step 10: The Unit Leader / Department Director will confirm all patients have been evacuated - checking every room, bathroom and closet. Using the patient census if available and the EVAC 1 Receipt Holder ensure all patients have left the unit and the yellow receipts have been removed from the door portion of the EVAC Tag. The location of where the patient moved may be written on the notes. **This information will be used in the Assembly Area for EVAC 2 and the Emergency Operations Center.**