U.S. Immigration and Customs Enforcement

ICE Health Service Corps (IHSC)
Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement

All-Hazards Emergency Preparedness and Response Guide

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Date signed: 30 December 2016

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Foreword

This *IHSC All-Hazards Emergency Preparedness and Response Guide* supplements the following IHSC Directive:

- IHSC Directive: 03-05, *All-Hazards Emergency Preparedness and Response.*

This Guide explains concepts, assigns responsibilities, and details procedures for all-hazards emergency preparedness and response activities in IHSC-staffed medical clinics.

The intended audience is IHSC health staff supporting healthcare operations in Immigration and Customs Enforcement (ICE)-owned or contracted detention facilities.

I. Introduction

A. Purpose

The purpose of this Guide is to provide IHSC health staff with general guidance, tools, and resources to support sites in developing site-specific plans and procedures in order to implement a timely, effective, integrated, and coordinated response to emergencies that have the potential to disrupt routine medical clinic operations. Health staff must be prepared to provide public health and medical services for any type of emergency or disaster.

Each IHSC-staffed medical clinic will have procedures that establish authorities and responsibilities for emergency actions and identify resources to support the actions. Emergency planning considerations will be different for each facility, and IHSC-staffed medical clinics must integrate their emergency preparedness plan as a supplement to the overall facility emergency plan and ICE field office continuity plan.

B. The Emergency Management Cycle

The four phases of emergency management include: mitigation, preparedness, response, and recovery.

Table 1: Four Phases of Emergency Management

Mitigation	Actions that prevent an emergency, reduce the chance of it happening, or reduce the damaging effects.
Preparedness	Plans or procedures to save lives and help response operations; tests, trainings, and exercises.
Response	Actions taken during an emergency situation.
Recovery	Actions to return to routine operations (steady state) following an emergency.

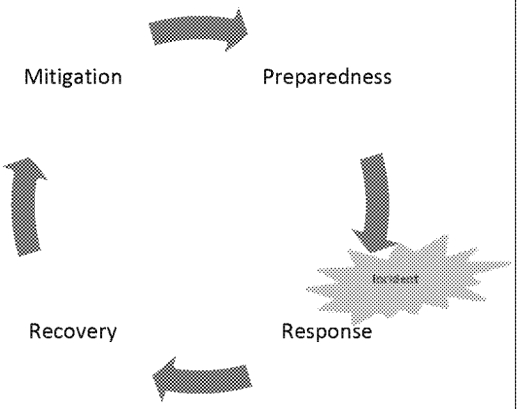


Figure 1: Phases of Emergency Management Flow Diagram

C. All-H Preparedne

All-hazards encompasses all conditions, environmental or m potential to cause injury or death; damage to or loss of equipment, infrastructure services, or property; or alternately causing functional degradation to societal,

economic, or environmental aspects. Hazards can include, but are not limited to, natural disasters, severe weather, pandemics, chemical spills, and active shooter incidents.

An all-hazards approach to preparedness focuses on response activities common to many hazards (e.g., communication procedures, staff recall, evacuation, and triage). All-hazards preparedness supplements specific preparedness and planning required to appropriately respond to specific threats in specific locations.

The health services administrator (HSA) should ensure that health staff review policies and guidance, receive training, and exercise response activities in order to prepare for and respond to all hazards, and implement hazard-specific emergency procedures. At a minimum, staff at all sites must plan for, receive training on, and be prepared to respond to the following hazards:

- Outbreak, epidemic, or pandemic events;
- Heavy smoke/fire;
- Explosions;
- Chemical, biological, radiological, or nuclear (CBRN) emergencies;
- Suspicious items/packages;
- Power outages;
- Active shooter incidents;
- Chemical spills;
- Worker strikes;
- Hunger strikes;
- Hostage situations;
- Bomb threats;
- Escape emergencies;
- Demonstrations/disturbances;
- Facility lockdowns;

- Natural disasters (e.g., weather, earthquake); and
- Severe staffing shortages.

D. Program Goals

- IHSC staff will understand all components of their emergency action plan, including the medical staff's role within the overall facility emergency plan and the field office continuity plan.
- IHSC staff will be prepared to respond to any emergency.
- IHSC preparedness and response activities will be coordinated with intra- and inter-agency partners.
- IHSC will maintain a resilient organization and workforce.

E. Responsibilities

Public Health, Safety, and Preparedness Unit (PHSP)

- Provide oversight for the IHSC All-Hazards Emergency Preparedness and Response Program.
- Review the IHSC All-Hazards Emergency Preparedness and Response Directive and Guide each year, and update as necessary.
- Develop, review, and update tools and resources to assist facilities with their preparedness efforts.

Health Services Administrator

- Responsible for ensuring implementation and oversight of PHSP activities in the medical and dental clinics, including all hazards emergency preparedness and response activities.
- Delegate resources to ensure PHSP activities are accomplished and accounted for.
- Establish a medical clinic emergency action plan that details how health staff will respond to emergency situations in coordination with, and as a supplement to, the overall facility emergency plan and ICE field office continuity plan.

- Ensure that all health staff are familiar with and have access to the facility emergency plan and the ICE field office continuity plan.
- Ensure the medical response is integrated into the overall facility emergency response and the field office emergency response.
- Verify that health staff understand their roles and responsibilities during an emergency and comply with emergency preparedness plans prior to and during an emergency.
- Review and update the IHSC-staffed medical clinic emergency action plan annually, and as needed, and ensure that it is available upon request.
- Ensure that pharmacies and drug storage areas are secure at all times in accordance with IHSC Directive: 09-02, *Pharmaceutical Services and Medication Management.*
- Ensure that health staff conduct regularly scheduled medical rounds during a facility lockdown.
- Ensure that health staff follow shelter-in-place procedures in coordination with facility staff, maintaining supplies for a minimum of three days for emergencies that require a shelter-in-place response.
- Ensure that evacuation route posters with directional arrows to exits are posted within the medical clinic.
- Facilitate the integration of health staff into the facility incident management structure during any emergency that extends beyond the IHSC-staffed medical clinic.
- Apply National Incident Management System (NIMS) principles for emergency preparedness and response activities.
- Define the chain of command for an emergency response.
- Maintain emergency equipment and supplies.

Compliance Officer

- Primary lead for coordinating PHSP activities with the HSA, including all hazards emergency preparedness and response activities.

- Serves as a key liaison with PHSP Unit staff

Health Staff

Prior to an incident, health staff must:

- Know their roles and responsibilities.
- Understand how they fit into the overall facility emergency plan and ICE field office continuity plan.
- Be prepared to execute IHSC-staffed medical clinic emergency procedures.
- Maintain personal and family preparedness.

During an incident, health staff must:

- Provide prompt and appropriate medical care during any emergency situation.
- Respond within the established chain of command.
- Prioritize staff, detainee, and visitor health and safety.
- Protect clinic property, facilities, and equipment.
- Maintain and restore essential healthcare services as quickly as possible.

F. Acronyms

AAR – After action report

AED – Automated external defibrillator

AHEPR – All-hazards emergency preparedness and response

CBRN – Chemical, biological, radiologic, or nuclear

CDC – Centers for Disease Control and Prevention

COOP – Continuity of operations

CPR – Cardiopulmonary resuscitation

DHS – Department of Homeland Security

EMR – Emergency medical response

ENS – Enterprise Notification System

EPI – Employee Preparedness Initiative (DHS)

ESA – Essential support activity

FEMA – Federal Emergency Management Agency

HHS – Department of Health and Human Services

ICS – Incident Command System

MCI – Mass casualty incident

MEF – Mission essential function

NIMS – National Incident Management System

RPM – Respirations, perfusion, mental status

G. Definitions with Expanded Information

All-Hazards – A grouping classification encompassing all conditions, environmental or man-made, that have the potential to cause injury, illness, or death; damage to or loss of equipment, infrastructure services, or property; or alternately causing functional degradation to societal, economic, or environmental aspects.

Continuity of Operations – An effort within individual executive departments and agencies to ensure that primary mission essential functions continue to be performed during a wide range of emergencies, including localized acts of nature, accidents, and technological or attack-related emergencies.

Disaster – Any emergency or event which exceeds or threatens to exceed the routine capabilities of the clinic.

Emergency – Any significant disruption of normal facility procedure, policy, or activity caused by riot, strike, escape, fire, medical emergency, natural disaster, or other serious incident (IHSC operational definition).

Emergency Management – Coordination and integration of all activities necessary to build, sustain, and improve the capabilities to prepare for, respond to, recover from, or mitigate against threatened or actual disasters or emergencies, regardless of the cause.

Essential Functions – Functions that implement the clinic's core mission and goals. The extended loss of these functions, following an emergency, would create a threat to life/safety, or irreversible damage to the clinic, staff, detainees, or visitors.

Essential Support Activities – Critical functions that an organization-level government must continue during continuity activation, but do not meet the threshold for mission essential functions (MEFs) or primary MEFs. The field office essential support activities generally map to the MEFs.

Hazard Risk Assessment – A systematic process to identify potential hazards and analyze what could happen if a hazard occurs. The term hazard risk assessment is used interchangeably with the term hazard vulnerability analysis.

Local Emergency Management Agency – A local entity responsible for creating the framework within which communities reduce vulnerability to hazards and cope with disasters.

Local Emergency Medical Services – A system that provides emergency medical care (ambulance).

Man-Down Drill – A simulated emergency affecting one individual who needs immediate medical intervention. It involves life-threatening situations commonly experienced in correctional settings (NCCHC definition).

Mass Casualty Drill – A simulated emergency involving multiple casualties that requires triage.

Medical Surge – Describes the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community (through numbers or types of patients). It encompasses the ability of healthcare organizations to survive a hazard impact and maintain or rapidly recover operations that were compromised, a concept known as medical system resiliency (HHS definition).

Medical Surge Capacity – Refers to the ability to evaluate and care for a markedly increased volume of patients—one that challenges or exceeds the normal operating capacity (HHS definition).

Medical Surge Capability – Refers to the ability to manage patients requiring unusual or very specialized medical evaluation and care. Surge requirements span the range of specialized medical services (expertise, information, procedures, equipment, or personnel) that are not normally available at the location where they are needed (HHS definition).

Mission Essential Functions – The limited set of organization-level government functions that must be continued throughout or resumed rapidly after a disruption of normal activities.

National Incident Management System – A systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work together seamlessly and manage incidents involving all threats and hazards—regardless of cause, size, location, or complexity—in order to reduce loss of life, property, and harm to the environment.

Preparedness – Actions taken to plan, organize, equip, train, and exercise and sustain capabilities.

Recovery – The development, coordination, and execution of service- and site-restoration plans; the reconstitution of government operations and services; individual, private sector, nongovernmental, and public assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify lessons learned; post-incident reporting; and development of initiatives to mitigate the effects of future incidents.

Resilience – The ability to adapt to changing conditions and to withstand and rapidly recover from disruption due to emergencies.

Response – Actions to save lives and property and stabilize the situation.

Special Needs Detainees – Detainees whose mental and/or physical condition requires different accommodations or arrangements than a detainee without special needs would receive. Special needs detainees include but are not limited to those detainees who are chronically ill or infirm, those with disabilities, and those who are addicted to or in withdrawal from drug or alcohol .

Tabletop Exercise – An activity that involves key personnel discussing simulated scenarios in an informal setting. This type of exercise can be used to assess plans, policies, and procedures, or assess the systems needed to guide the prevention of, response to, and recovery from a defined incident.

II. Mitigation

A. Overview

Mitigation includes actions that prevent an emergency, reduce the chance of it happening, or reduce the damaging effects. It begins by identifying hazards that might affect operations, and then uses that information to reduce the severity and/or likelihood of potential threats.

B. Hazard Risk Assessment

The HSA or designee must review the facility, community, and ICE field office hazard risk assessment, if available, and use it to prioritize mitigation and emergency preparedness efforts. If the facility, community, or ICE field office hazard risk assessment is not available, it is recommended that the HSA or designee develops one at the facility in conjunction with the facility administrator or designee, the ICE field office, and the local emergency management agency.

A hazard risk assessment (also referred to as "hazard vulnerability analysis") is a tool used to evaluate the potential risks for a facility, agency, or jurisdiction, and it helps focus emergency planning efforts. A hazard risk assessment involves identifying likely hazards; assessing the likelihood a specific hazard will occur; estimating the potential impact on people, operations, and property; and evaluating the organization's and facility's ability to mitigate, prepare for, respond to, and recover from a specific hazard.

Local emergency management agencies can provide guidance on potential risks in your geographic area (Emergency Management Agencies | FEMA.gov). For an overview of hazard risk assessments, access the OSHA Training Institute | Hazard and Vulnerability Assessment. Kaiser Permanente also offers a Kaiser | Hazard and Vulnerability Assessment Tool for medical centers that can be adapted for other clinical settings.

III. Preparedness

A. Overview

Preparedness is everyone's responsibility, and preparedness activities build capacity to manage the effects of an emergency. The NIMS defines preparedness as, "a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action in an effort to ensure effective coordination during incident response."

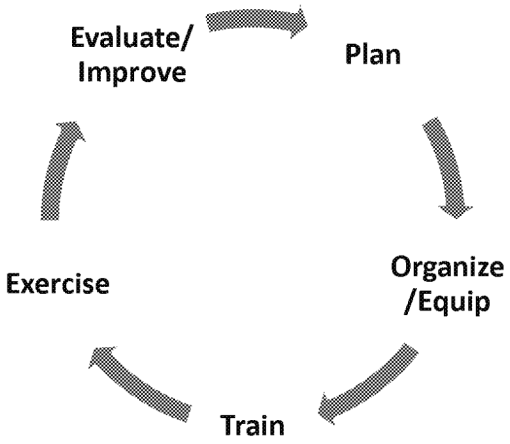


Figure 2: Preparedness Flow Diagram

Plan: Planning makes it possible to manage any hazard or incident by developing local procedures and contingency plans.

Organize/Equip: Identify what competencies and skill sets people should possess, and identify and acquire standard and/or surge equipment.

Train: Provide staff with knowledge, skills, and the abilities needed to perform key response activities.

Exercise: Provide an opportunity to practice in a low risk environment. Exercises are opportunities to identify strengths, gaps, and shortfalls within plans, policies, and procedures, and to address areas for improvement prior to a real-world incident.

Evaluate/Improve: Collect lessons learned, develop improvement plans, and track corrective actions to address gaps and deficiencies identified in exercises or real-world events.

After action reports (AARs) and corrective actions should be referred to during the planning stage and used to assess whether response capabilities improved when compared to previous exercises or real-world events.

B. Plans and Procedures

The HSA should develop a medical clinic all-hazards emergency action plan that details how health staff should respond and provide medical services during an emergency. This plan must be site specific and the HSA must ensure that contingency procedures are in place. This plan must be flexible and integrated with the facility emergency plan and the ICE field office continuity plan; it is recommended that this plan

be prepared as a supplement to the facility emergency plan and field office continuity plan.

The response activities below are integrated in the all-hazards approach, and plans and procedures should be in place that address these response activities.

All-Hazards Emergency Preparedness Activities

- Recognizing a hazard
- Communication
- Continuity of operations
- Incident management
- Emergency medical response
- Mass casualty/triage
- Evacuation
- Shelter in-place
- Isolation
- Cohorting
- Medical equipment/supplies management
- Pharmaceuticals management
- Medical surge
- Mass prophylaxis
- Transportation
- Medical information management
- Management of detainees and staff with special needs

The HSA should ensure that hazard-specific emergency response procedures are in place for the following hazards.

Hazards

- Outbreak, epidemic, or pandemic
- Heavy smoke/fire
- Explosion
- Chemical, biological, radiological, or nuclear (CBRN) emergencies
- Suspicious item/package
- Power outage
- Active shooter
- Hunger strike
- Hostage situation
- Bomb threat
- Escape emergency
- Demonstrations/disturbances
- Facility lockdown
- Natural disaster (e.g., weather, earthquake)
- Severe staffing shortage
- Worker strike
- Chemical spill

C. Emergency Equipment

The HSA should ensure that the necessary emergency equipment is available and maintained so health staff are prepared to respond during an emergency.

First Aid Kits

The HSA should determine the number, contents, location, protocols, and procedures for monthly inspections of first aid kits in the medical clinic. The HSA or designee must maintain documentation of first aid kit checks at the facility for a minimum of three years. The HSA or designee must ensure that first aid kits are readily available and that health staff know the location of first aid kits throughout the facility.

Automated External Defibrillator

The HSA should determine the number, contents, and location of automated external defibrillators (AEDs) in the medical and dental clinics. The HSA must ensure physician oversight of AEDs in the medical clinic and ensure that daily operational checks are performed for all AEDs located in the medical and dental clinics. The HSA or designee must ensure the AED checks are documented and must maintain that documentation at the facility for a minimum of three years. The HSA or designee must ensure that health staff know the location of all AEDs in the facility and the oversight responsibility for each AED.

Emergency Medical Response Cart/Bag

Emergency medical response carts/bags are used to respond to medical emergencies at the facility. Some facilities might maintain emergency medical response bags, while others might use response carts (or both). A healthcare provider should check the security lock number daily to ensure the emergency cart/bag and supplies are intact. A healthcare provider should inventory the supplies and medications contained in the emergency medical response cart and bags monthly and after each use. A healthcare provider should maintain documentation of these checks at the facility for a minimum of three years. A healthcare staff member should notify the pharmacy for replacement if medications are missing or expired.

Evacuation Bags

The HSA should ensure that evacuation bags are ready in the event of an evacuation so that health staff can provide medical care, if necessary. The HSA or designee should prepare, pack, store, and inventory evacuation bags monthly, immediately after use, and when new items are added. The HSA or designee should check the security lock number weekly to ensure the integrity of the bags. The HSA or designee should document these checks and maintain documentation at the facility for a minimum of three years.

Mass Casualty Bags

The HSA or designee should prepare, pack, store, and inventory mass casualty bags monthly, immediately after use, and when new items are added. The HSA or designee should check the security lock number weekly to ensure the integrity of the bags. The HSA or designee should document these checks and maintain documentation at the facility for a minimum of three years.

Fire Extinguishers

Reference IHSC Directive: 05-05, *Safety and Security,* and the associated guide for detailed information about the use of fire extinguishers.

D. Personal Preparedness

The availability of dedicated and resilient health staff is critical to respond to and recover from an emergency. Health staff should be prepared to take care of their family members and themselves during an emergency situation. Examples of personal preparedness activities include:

- Develop and maintain a family preparedness plan to prepare your family and home for a potential emergency.

- Familiarize yourself with IHSC directives, the medical clinic emergency action plan, the facility emergency plan, the ICE field office continuity plan, and community emergency plans.

- Maintain awareness of alternate routes and modes of transportation to get to and from work.

The following resources can help staff improve personal preparedness:

- FEMA Ready.GOV
- CDC Emergency Preparedness and You
- HHS | Public Health Emergency - PHE
- ICE Employee Assistance Program
- ICE | Workplace Safety and Health
- ICE National Emergency Management Division (NEMD)
- OSHA Emergency Preparedness and Response | Resilience Resources

E. Tests, Trainings, and Exercises

Effective incident management depends on preparedness activities in advance of an incident or threat. The HSA or designee must conduct initial, annual, and periodic emergency preparedness and response tests, trainings, and exercises for health staff. The tests, trainings, and exercises will be based on guiding principles in the Homeland Security Exercise and Evaluation Program.

Tests

Tests can help verify that systems and equipment perform as they are intended. Examples of tests might include testing fire alarms, methods of communication (i.e., personnel roster/phone tree or ENS), or the operation of emergency equipment, such as AEDs.

Trainings

The HSA must ensure that orientation and annual training that includes all-hazards emergency preparedness and response is implemented and documented in accordance with IHSC Directive *01-04 Medical Education and Development*. Types of training include: classroom, self-study, on-the-job, briefings, seminars, and workshops.

Periodic trainings to keep up-to-date with preparedness and response procedures are also important.

Exercises

Exercises build on training by practicing and exercising policies and procedures, equipment, communications, coordination, and decision-making. Exercises should be designed to engage team members and get them working together to manage the response to a hypothetical incident.

When possible, health staff should conduct exercises in collaboration with the facility staff, other Enforcement and Removal Operations (ERO) field office staff, IHSC field medical coordinators, and local, state, and federal government partners. Exercises provide health staff with an opportunity to assess, practice, and improve performance. Staff members who are not present during an exercise should review the after action report.

Discussion-based exercises include the following:

- Seminars;
- Workshops; and
- Tabletop exercises.

Operations-based exercises include the following:

- Drills, which are used to test specific functions (e.g., evacuation or notification of an emergency);
- Functional exercises, which are used to evaluate capabilities by simulating an emergency without moving people and equipment (e.g., establishing an emergency response team or exercising triage procedures); and
- Full-scale exercises (e.g., mass disaster exercises that include an operations center, security, and medical staff, or community exercises that include multiple agencies at multiple levels).

Evaluation and Improvement Planning

Evaluation provides an opportunity to document strengths and opportunities for improvement related to emergency preparedness. The HSA or designee should coordinate a debriefing with staff who participated in the test, training, or exercise. The HSA or designee should also write an AAR to document the test, training, or exercise, the accomplishments, and opportunities for improvement. The HSA or designee should also develop a corrective action plan and monitor progress toward improving on deficiencies. The HSA or designee should include as many of the participants as possible in the debriefing, and share the AAR with all health staff, including those that did not participate. Completed AARs are maintained locally and should be submitted to the PHPS Unit.

F. Monitoring

The PHSP Unit periodically gathers information from the HSAs to verify emergency preparedness procedures are in place and to ensure the medical clinic is meeting the test, training, and exercise requirements.

IV. Response

A. Overview

The response phase encompasses activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs.

Response priorities include:

- Ensure life safety;
- Contain hazards to facilitate protection of life;
- Protect critical infrastructure, facilities, vital records, and other data; and
- Maintain and restore essential healthcare services as quickly as possible.

B. Recognizing a Hazard or Disaster

The HSA or designee should be aware of the facility and ICE ERO area of responsibility (AOR) emergency notification procedures, and should ensure that the medical clinic and health staff are incorporated into these emergency communication plans. The HSA or designee should maintain open communication with the Warden and Assistant Field Office Director (AFOD) to ensure health staff are notified of potential or real emergencies.

The HSA or designee should also arrange for emergency notifications through the local jurisdiction (e.g., local emergency management automated notification systems).

C. Communication

Communication procedures should detail who is responsible for maintaining and updating the emergency contact list, and how federal and contract health staff will be contacted prior to and during an emergency. This includes notification procedures for health staff in the medical clinic, within the facility, and health staff off-site. The HSA or designee should maintain and update the emergency contact information routinely, and it must be readily available to key staff both on-site and off-site. Communication procedures must also detail how health staff will communicate during an emergency (e.g., in-person verbal communication, radios, phone).

Staff should reference their site's personnel roster and continuity communications procedures and IHSC COOP: ICE Supplement for more information.

Personnel Notification

Personnel Roster

The HSA or designee should compile and maintain contact information for all staff that can be used to notify health staff and maintain accountability prior to, during, or after an emergency. The HSA or designee should maintain and update the information routinely, and review it at least monthly. Information should include the following: name, position title, home phone, cell phone, and preferred method of contact during off hours. The list will contain sensitive contact information and must be treated confidentially. Procedures to maintain and use personal contact information should comply with contracting requirements for contacting contract staff.

ICE Enterprise Notification System

The ICE Enterprise Notification System (ENS) may be used to quickly disseminate emergency messages to health staff and to perform accountability. The HSA should ensure that all staff have updated their profiles with work-related information in Active Directory and should encourage staff to enter their personal contact information in the ENS system so that they can be reached in a timely manner. Staff who cannot be reached via ENS (or if ENS is not available) should be contacted directly using personal contact information.

Accountability Procedures

The same communication methods used for personnel notification can be used to account for personnel during an emergency. This can include in-person accountability, text messaging, phone calls, email, ENS, or radios. The HSA or designee must know who is in the building in the event of an emergency and must be able to account for health staff by taking a head count and using a roster or checklist.

External Notification

External notification procedures detail who is responsible for notifying and maintaining communication with ICE, ERO, IHSC Headquarters (HQ), and other stakeholders. At a minimum, the HSA or designee should maintain primary and alternate contact information for the following entities:

- ERO Field Office Director;
- ERO Deputy Field Office Director;

- ERO Assistant Field Office Director;
- IHSC Assistant Director;
- IHSC Deputy Assistant Director (DAD) of Clinical Services;
- IHSC DAD of Administration;
- IHSC Chief of Staff;
- IHSC Chief, Health Operations Unit;
- IHSC Chief, Public Health, Safety, and Preparedness Unit;
- Facility Safety Officer;
- Facility Administrator;
- Local Health Department;
- Local hospitals;
- Local emergency management services; and
- Local emergency management agency.

Methods of Communication

During a response, health staff should use one or more of the following methods to communicate:

- In-person, verbal communication;
- ENS;
- Phone; and/or
- Radios.

Health staff should also identify back-up options for communication.

Media Inquiries

Health staff should refer all media inquiries and communications through the supervisory chain to the ICE Office of Public Affairs.

D. Incident Management

The HSA should ensure that health staff receive training and exercise skills to respond to emergencies in a coordinated manner. The NIMS and Incident Command System (ICS) were developed to create a flexible and standardized approach to incident management and should be incorporated into IHSC medical clinic emergency operations procedures.

The HSA or designee must designate a clear chain of command during an emergency to manage the medical clinic response. The HSA or designee will serve as the Medical

Team Commander and should designate staff members for roles/teams based on the activities required for the medical response.

For incidents that require coordination and management beyond the facility, the HSA or designee should coordinate closely with IHSC HQ.

Recommended medical clinic response roles/teams include:

1) Medical Team Commander

   The Medical Team Commander must:

   a. Activate medical clinic response procedures.
   b. Serve as lead for the medical clinic response.
   c. Ensure timely and clear notification and communication.
   d. Assign leads for each medical response activity.
   e. Assign staff to medical response roles or teams.
   f. Coordinate communication.

2) Deputy Medical Team Commander

   The Deputy Medical Team Commander must:

   a. Serve as a back-up and provide support to the Medical Team Commander; is qualified to activate and manage the medical clinic response if the Medical Team Commander is absent.

3) Medical Liaison

   The Medical Liaison must:

   a. Serve as a liaison between the medical activities and the overall facility response.

4) Triage Team

   The Triage Team must:

   a. Ensure the triage location is safe.
   b. Follow Simple Triage and Rapid Treatment (START) or JumpSTART triage procedures with multiple casualties.

c. Identify casualties that require transportation.

5) Treatment/Medical Services Team

The Treatment/Medical Services Team must:

a. Provide medical services and treatment within the clinic's capabilities and resources.

6) Medical Supplies Team

The Medical Supplies Team must:

a. Coordinate with the HSA regarding supply shortages.
b. Procure supplies, as necessary.

7) Pharmacy Team

The Pharmacy Team must:

a. Monitor medication needs and distribute the medications, as needed.
b. Assist the HSA to maintain accountability and security for controlled substances.
c. Procure pharmaceuticals, as necessary.

8) Mortuary Team

The Mortuary Team must:

a. Serve as a liaison to EMS and community mortuary response teams.
b. Understand and communicate procedures following single death or mass casualty responses.

9) Transport Team

The Transport Team must:

a. Coordinate the transportation of detainees to medical facilities based on their level of priority.

The medical clinic response and incident command structure must be integrated with the facility's response and incident command structure. The HSA must ensure that the medical clinic's roles are clear, including how the medical clinic fits into the facility incident response structure. **Figure 3** below shows one example of how the medical clinic might integrate with the facility incident command structure.

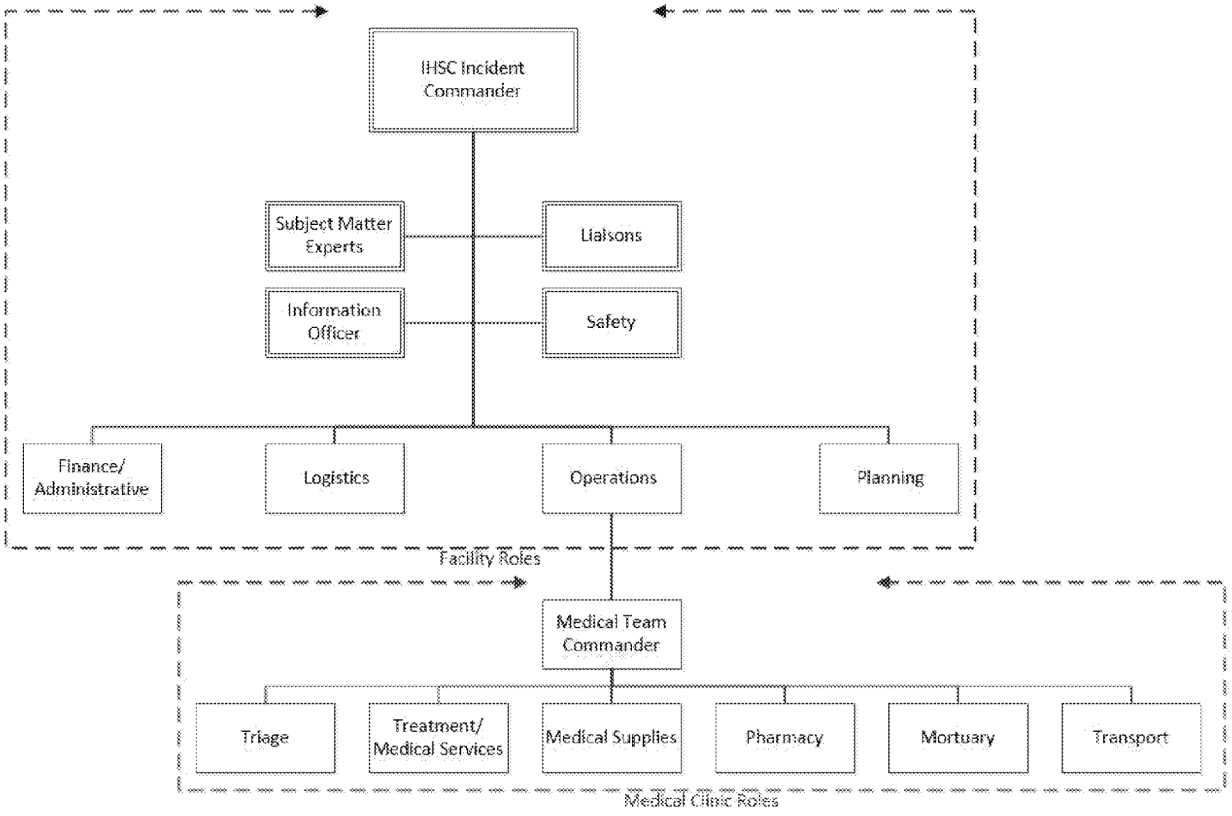


Figure 3: Example of a possible ICS structure at an IHSC-staffed facility

The HSA must ensure that health staff are knowledgeable of the facility incident command organization structure and medical clinic response structure prior to an emergency, and must ensure that the incident command organizational structure is easily accessible and visible to all health staff.

E. Continuity of Operations

If an IHSC-staffed medical clinic or IHSC-staffed facility experiences major damage, loss of staff, a dangerous response environment, or other problems that limit the ability of the clinic or facility to operate, operations might be suspended until the conditions change. Reference ICE Directive 14001.2 Continuity of Operations Policy.

- The HSA or designee should establish procedures detailing how health staff will maintain continuity of operations during an incident in coordination with the overall facility emergency plan and the ICE ERO field office continuity plan for the AOR in which the facility is located.

- The HSA or designee should complete the IHSC Continuity Checklist - Supplement. This template will serve as the medical clinic's continuity procedures and will be an addendum to the ICE field office continuity plan. The procedures should be integrated with the facility emergency plan and the ERO field office continuity plan and the HSA should provide the facility and field office point of contact for continuity planning with a copy.

- Contingencies should be in place for staffing and alternate sites of care.

- Procedures should outline essential support activities (ESAs) that in turn support ICE's mission essential functions (MEFs).

- The IHSC COOP Plan - ICE Supplement details IHSC HQ continuity procedures and is a supplement to the ICE Continuity Plan. Health staff must be familiar with the IHSC COOP Plan - ICE Supplement in addition to site-specific procedures.

- The HSA should ensure that all staff are familiar with and have access to the most current facility emergency plan and the ICE ERO field office continuity plan for the respective AOR.

F. Emergency Medical Response

Health staff should be prepared to provide 24-hour emergency health services to detainees, visitors, and staff. In life threatening emergency situations only, healthcare personnel may provide emergency healthcare services to health staff, facility staff, and visitors.

- Health staff should be prepared to respond to emergencies within a four minute response time.
- The HSA should maintain a list of ambulance and hospital services.
- Health staff should coordinate with security for the immediate transfer of detainees for emergency medical care and notification to appropriate ICE staff.
- Upon the detainee's return to the facility, health staff should ensure that the documentation of treatment given off-site and any follow-up instructions are incorporated into the health record.

- The HSA or designee should ensure that healthcare personnel are prepared and competent to provide the following emergency services at IHSC-staffed facilities:
    - Initial assessment and referral, as appropriate;
    - Coordination of transportation with security staff; and
    - Basic Life Support (BLS) in accordance with the most current American Heart Association Guidelines.

G. Mass Casualty Response/Triage

Health staff might need to alter standards of care and provide mass care depending on the hazard. The triage system should be implemented in the event of an internal disturbance or other disaster (natural or man-made) which results in multiple casualties and the suspension of normal clinic operations. Triage is the process of prioritizing or sorting of sick or injured people for treatment according to the seriousness of the condition or injury, and tagging accordingly. Once triage is complete, the persons will be routed to receive the appropriate care.

Persons should be triaged at the scene of the emergency or a nearby triage site. If that is not possible, the medical clinic should be used to triage persons and provide care. If the scope of the disaster or other circumstances prohibits the use of the medical clinic, an alternative triage area should be designated by the HSA, Clinical Director (CD), or designee in coordination with the facility Incident Commander.

During an emergency response involving multiple casualties, the response should be led by the Medical Team Commander, and clinic personnel should be divided into response teams.

Team assignments may vary depending on the changing nature of the situation; it is critical that team members be trained on multiple team roles in the event that they are assigned an alternate role or their role changes during the incident. All staff must assist with the clinic set-up for mass casualty response.

Once set-up is complete, the triage and direct treatment/medical care of persons and pronouncements of death or impending death for triage purposes should be implemented. If there is no CD on-site, a staff physician or medical provider should be designated to oversee these activities.

Triage should be accomplished utilizing the Simple Triage and Rapid Treatment (START) and JumpSTART triage methods. First responders use the START triage system as the gold standard primary triage method to quickly classify adult victims during a mass casualty incident (MCI) based on the severity of their injuries. The START triage system relies on making a rapid assessment (i.e., less than one minute) of every person to determine which of the four assessment categories persons should

be classified as to enable a visibly identifiable category for rescuers. It also provides for on-scene personnel to quickly evaluate the situation and call in the appropriate extra resources and assign them specific tasks.

The JumpSTART Pediatric MCI triage tool was developed specifically for the triage of children in a multi-casualty/disaster setting and to address the potential problems in assessing children. For example, a child with apnea is more likely to have a primary respiratory problem than an adult and capillary refill may not adequately reflect peripheral hemodynamic status in a cool environment or obeying commands may not be an appropriate gauge of mental status for younger children. JumpSTART triage objectives provide a method to optimize the primary triage of injured children in a multi-casualty incident setting, providing the effectiveness of resource allocation for all victims and reducing the emotional burden on triage personnel having to make rapid life-or-death decisions about injured children.

Under both START and JumpSTART triage methods, casualties are classified into four categories based on rapid assessments of their respirations, perfusion, and mental status (RPM). Triaged persons are assigned an assessment classification by following either the START or JumpSTART color-coded triage cards or algorithms. These categories and associated color-coded tags include the following color, description, and assessment parameters for the triaged adult or pediatric person.

COLOR	DESCRIPTION	ASSESSMENT (ADULTS)
Black	Deceased	No respirations after head tilt
Red	Immediate	Any of the following: breathing but unconscious, respirations >30, capillary refill >2 sec, no radial pulse, control bleeding
Yellow	Delayed	Respirations <30, capillary refill under 2 sec, can follow simple commands
Green	Minor	All walking wounded

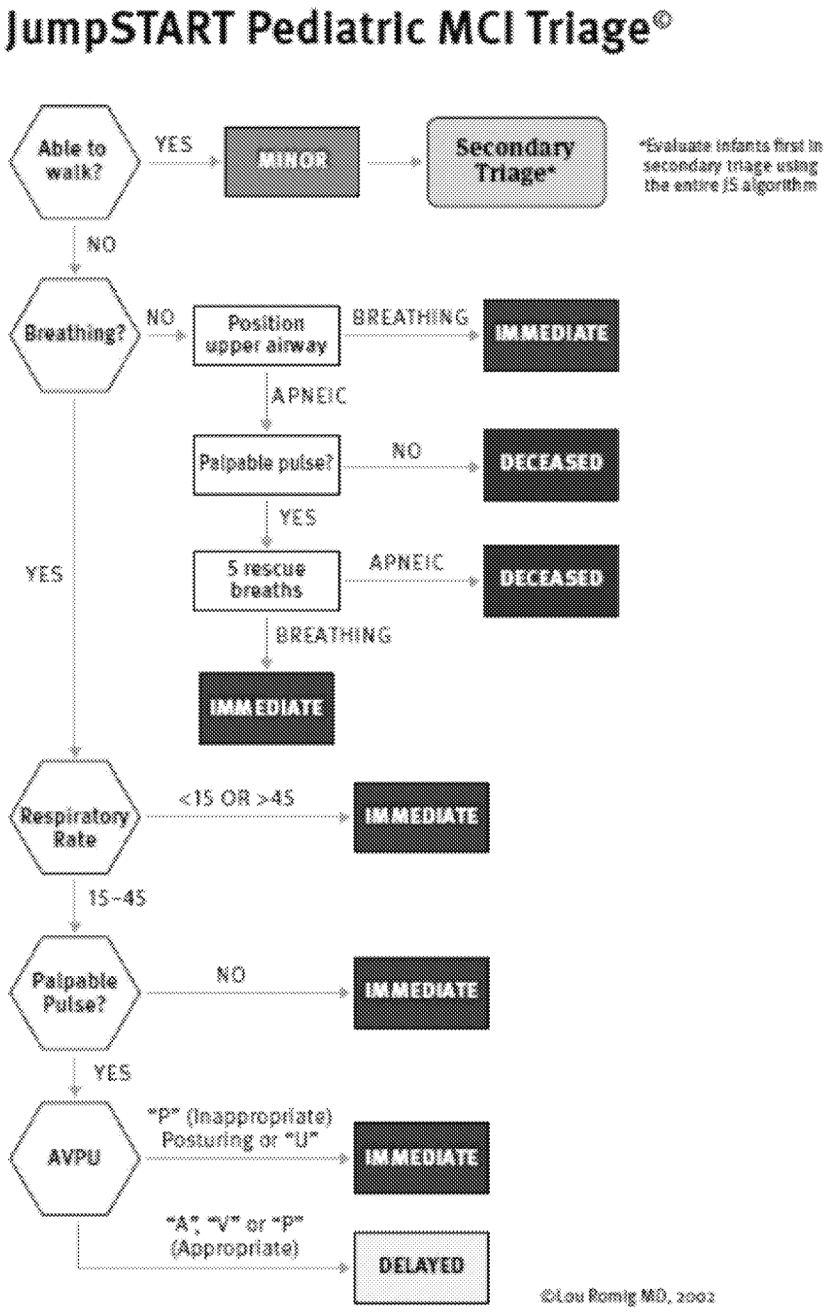
Explanation of triage categories:

Deceased - Victim unlikely to survive given the severity of injuries, level of available care or both. Palliative care and pain relief should be provided.

Immediate - Victim can be helped by immediate intervention and transport. Requires medical attention within 60 minutes for survival.

Delayed - Victim's transport can be delayed. Includes serious and potentially life-threatening injuries, but victim's status is not expected to deteriorate significantly over several hours.

Minor - Victim with relatively minor injuries, status unlikely to deteriorate over days. May be able to assist in his or her care.



For further guidance see START Adult Triage and JumpSTART Pediatric MCI Triage.

The HSA must ensure that health staff periodically practice triage procedures in response to a variety of hazards (e.g., building collapse, chemical spill, active shooter, internal disturbance, explosive incident).

In order to implement a rapid response, the HSA should maintain mass casualty bags. The bag contents must be customized to meet the specific needs of the facility. An

inventory list must be maintained in the medical clinic emergency action plan. The HSA or designee must prepare, pack, store, and inventory mass casualty bags monthly, immediately after use, and when new items are added. The HSA or designee should check the security lock number weekly to ensure the integrity of the bags. The HSA or designee must document these checks and maintain documentation at the facility for a minimum of three years. Reference Section III (D), Emergency Equipment, Mass Casualty Bags in this guide for more information.

H. Evacuation

An evacuation of the medical clinic might be necessary due to a hazard (e.g., fire) or order by the facility administrator or HSA. Evacuation route maps will be posted in each work area, and must include:

- Emergency exits;
- Primary and secondary routes;
- Location of fire extinguishers;
- Fire alarm pull stations' locations; and
- Assembly points.

Evacuation procedures should describe the actions employees should take before and while evacuating, such as shutting windows, turning off equipment, and closing doors behind them.

The HSA or designee should ensure that evacuation bags are maintained and ready for use in the event of an evacuation. Reference Section III (D), Emergency Equipment, Evacuation Bags in this Guide for more information about evacuation bags.

Reference IHSC Directive: 05-05, *Safety and Security*, and the associated guide for information regarding Occupational Safety and Health Administration (OSHA) requirements for safe exits. Also reference the facility and ERO field office continuity plans.

I. Shelter-in-Place

Shelter-in-place means to take immediate shelter where you are. It can also mean to seal the room (i.e., prevent outside air from entering), depending on the specific hazard or threat.

- The HSA or designee must identify shelter-in-place locations for health staff in coordination with the facility administrator.
- Sites must maintain a stock of medical supplies for a minimum of three days so they are prepared if they must shelter-in-place at the facility.

J. Isolation

The HSA or designee should develop a contingency plan for isolation if routine procedures are not possible. *See* IHSC Directive: 05-06, *Infectious Disease Public Health Actions*, and the *Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms;* IHSC Directive: 03-17, *Medical Housing Units* regarding requirements for MHU oversight and levels of staffing.

K. Cohorting/Social Distancing

The HSA or designee should develop a contingency plan for cohorting if routine procedures are not possible. *See* IHSC Directive: 05-06, *Infectious Disease Public Health Actions*, and the *Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms*.

L. Medical Equipment and Supplies Management

- The HSA or designee should establish a contingency plan for obtaining medical equipment and supplies if the availability, delivery services, or normal procurement channels are disrupted.
- The DHS Strategic Sourcing Page provides information about procurement for medical supplies, personal protective equipment (PPE), and medical countermeasures for both routine and emergency situations. The HSA must be familiar with routine and emergency procurement procedures.
- The HSA or designee should implement a process to effectively and efficiently inventory existing medical equipment and supplies, as well as anticipate needs during emergencies.
- The HSA should coordinate with the facility and the field office regarding a stockpile of supplies for employees, visitors, and detainees during emergencies.
- The HSA or designee should coordinate with local and state public health authorities to plan for the availability of stockpile supplies.
- The HSA or designee should ensure that appropriate medical equipment, and medical and non-medical supplies are stored in mass casualty and evacuation bags.
- The HSA or designee should implement a process for storing, maintaining, and regularly checking equipment.
- The HSA or designee should develop a list of required documents, PPE, medical equipment, and communications equipment for emergency responses.
- Reference Section 5, Emergency Medical Equipment in this Guide for more information about mass casualty and evacuation bags.

DHS Strategic Sourcing Program: DHS-Wide Blanket Purchase Agreements

Medical Supplies

The DHS-Wide Blanket Purchase Agreements (BPAs) for Medical Supplies simplify the purchasing of medical items at prices that leverage the purchase volume of DHS. To streamline offerings and ensure lower prices, products are grouped into three categories:

- Category 1: General medical supplies; includes items for IV/maintenance, medication administration, medical supplies and equipment for austere environments, trauma management, splinting/immobilization, operational medical supplies and equipment, respiratory management, cardiology, PPE, and training materials.
- Category 2: AEDs/heart monitors (with accessories).
- Category 3: Medical supply kits; includes Emergency Medical Responder (EMR) bags (First Responder), EMR bag refills, individual first aid kits (IFAK), and Basic Life Support (BLS) (medical backpack).

Personal Protective Equipment

The Personal Protective Equipment (PPE2) contract vehicles directly support the Avian Influenza/Pandemic Influenza and Emerging Threats Countermeasures for DHS Workforce Protection Program, Personal Preparedness Equipment. These contracts provide DHS and its components with the tools to support and sustain the safety of DHS employees and contractors. This includes the acquisition, storage, and delivery mechanisms for PPE in order to prepare and protect the entire DHS workforce. These contracts to procure PPE supplies support both the operational and pandemic needs of DHS. The wide array of countermeasure commodities consists of six major categories:

- Garments;
- Gloves;
- Eye protection (Goggles or Face Shields);
- Hand sanitizer;
- Respirators (e.g., N95); and
- Surgical masks.

M. Pharmaceuticals Management

- The HSA or designee (e.g., pharmacist) shall establish a contingency plan for obtaining pharmaceuticals if the availability, delivery services, or normal procurement channels are disrupted.

- The DHS Strategic Sourcing Page provides information about the procurement for medical countermeasures for both routine and emergency situations. The HSA should be familiar with routine and emergency procurement procedures.
- The HSA or designee should implement a process to effectively and efficiently inventory pharmaceuticals, as well as anticipate needs during emergencies.
- The HSA or designee should implement a process to secure controlled substances in the medical clinic during an internal disturbance or other emergency situation.
- The HSA or designee should develop contingencies for providing essential healthcare services to detainees when pharmaceuticals are limited in supply and delivery services are disrupted.
- The HSA or designee should coordinate with local and state public health authorities to plan for the availability of stockpile supplies.
- The HSA or designee should ensure that appropriate pharmaceuticals are stored in mass casualty and evacuation bags.
- Reference IHSC Directive: 09-02, *Pharmaceutical Services and Medication Management and* IHSC Directive: 03-16, *Medication Administration*, and the *IHSC Medication Administration Guide*.

Medical Countermeasures

The Medical Countermeasure II (MCM2) DHS-wide contract vehicle directly supports the Pandemic Influenza and Emerging Threats Countermeasures for the DHS Workforce. Antiviral medications have a finite shelf life and therefore, periodic acquisition is necessary to maintain a predetermined level of available antivirals in the DHS stockpile.

N. Mass Prophylaxis

Health threats might require the prophylaxis of a large number of detainees in a short period of time to prevent disease transmission. Mass prophylaxis requires communication and collaboration with all affected stakeholders. IHSC Deputy Assistant Director (DAD) of Clinical Services, the CD, HSA, Associate Medical Directors, Regional Clinical Directors, and IHSC Infectious Disease Consultant or designee will consult and decide whether mass prophylaxis is warranted. The local health department may recommend mass prophylaxis or the Secretary of HHS may recommend mass prophylaxis with an emergency declaration.

The ICE Pandemic Workforce Protection Plan outlines the roles of IHSC staff, should the Secretary of DHS activate the plan. IHSC medical personnel who are authorized to dispense or administer medications should be available to dispense or administer medical countermeasures (MCM) for detainees housed in facilities with IHSC medical staffing, in accordance with the scope of their licenses. IHSC administrative and non-medical personnel should be available to support the logistics of MCM distribution for detainees and health surveillance activities, with the approval of the IHSC Assistant Director or designee.

Mass Prophylaxis Considerations:

- Identification of site(s) to administer prophylaxis.
- Clinic layout and patient flow.
- Staffing needs.
- Pharmaceuticals and supplies (procurement and inventory tracking).
- Information/educational sheets.
- Staff training.

O. Medical Information Management

The HSA should discuss the preservation, security, and maintenance of essential records, data, and sensitive information during an emergency with the IHSC records manager. To the extent possible, the HSA or designees should protect medical records from fire, damage, theft, and public exposure. If the clinic is evacuated, provide security to ensure privacy and safety of medical records.

Paper documentation may be necessary when there is a system outage, defined as the electronic health record being down for greater than or equal to two hours. Please reference the IHSC eCW User Guide: Paper Documentation for more information.

P. Detainees and Staff with Special Needs

Detainees or health staff who are elderly or have disabilities may have conditions that put them at increased risk during an emergency. For IHSC policy and procedural guidance for determining and providing care to ICE detainees determined to have special needs, see IHSC Directive: 03-11, *Special Needs Patients*. Also reference Enforcement and Removal Operations Policy No. 11304: *Assessment and Accommodations for Detainees with Disabilities*. For assistance related to reasonable accommodations for staff please reach out to the ICE points of contact for reasonable accommodations.

Refer to the Rehabilitation Act of 1973 for additional guidance relative to federal agency obligation under the Rehabilitation Act of 1973 (Public Law 93-112).

V. Recovery

A. Overview

Recovery includes actions to restore essential services and resume normal operations following an emergency. The emergency response should shift to recovery when services, procedures, and staffing return to normal.

B. Medical equipment, supplies, pharmaceuticals

The HSA or designees should check inventories and restock equipment, supplies, and pharmaceuticals following the initial response phase of an emergency.

C. Mental Health First Aid/Responder Health & Safety

Following an emergency event, detainees and responders might experience distress or anxiety. Health staff should monitor for and respond to the mental health needs of detainees following an emergency or disaster. Reference IHSC Directive: 07-02, *Behavioral Health Services (Overview)*, for more information.

Health staff/responders should be directed to the ICE Employee Assistance Program after an emergency. The CDC website, CDC Coping with a Disaster or Traumatic Event, also contains useful reference material.

D. After Action Report

The HSA or designee should coordinate a debriefing with staff following an emergency response. The HSA or designee shall also write an AAR to document the event, including accomplishments and opportunities for improvement related to the response. The HSA or designee should also develop a corrective action plan and monitor the progress towards improving on deficiencies. The HSA or designee should include as many of the participants as possible in the debriefing, and should share the AAR with all health staff. The AAR should be used to inform preparedness activities at the site. Completed AARs are maintained locally and should be sumitted to the PHP

VI. Privacy

The medical clinic emergency preparedness and response procedures shall include a statement prohibiting unauthorized disclosure, such as “The contents and provisions of these procedures must be restricted to employees at this facility. These procedures must not be discussed or referred to in the presence of detainees. At no time will emergency response procedures or copies be shared with unauthorized recipients.”

VII. No Private Right.

This document provides only internal ICE policy guidance, which may be modified, rescinded, or superseded at any time without notice. It is not intended to, does not, and may not be relied upon to create or diminish any rights, substantive or procedural, enforceable at law or equity by any party in any criminal, civil, or administrative matter. Likewise, no limitations are placed by this guidance on the otherwise lawful enforcement or litigative prerogatives of ICE.

VIII. References and Resources

U.S. Department of Homeland Security

1) Homeland Security Exercise and Evaluation Program
2) FEMA Guide for All-Hazard Emergency Operations Planning
3) FEMA.gov | Federal Emergency Management Agency
4) FEMA ICS Resource Center
5) National Incident Management System (NIMS)
6) DHS Strategic Sourcing

U.S. Immigration and Customs Enforcement

1) ICE Directive 14001.2 ICE Continuity of Operations Plan (COOP) Policy
2) ICE Directive 14005.1 ICE Occupant Emergency Plan (OEP)
3) ICE Pandemic Workforce Protection Plan
4) ICE Anthrax OPLAN
5) ICE Directive 14014.1 Crisis Action Plan
6) ICE Homeland Security Investigations | Office of Intelligence | National Emergency Management Division
7) ERO Policy No. 11304 Assessment and Accommodations for Detainees with Disabilities

ICE Health Service Corps

1) IHSC Directive: 03-11, *Special Needs Patients*
2) IHSC Directive: 05-02, Occupational Health
3) IHSC Directive: 05-04, *Environmental Health*
4) IHSC Directive: 05-05, *Safety and Security*
5) IHSC Directive: 05-06, *Infectious Disease Public Health Actions*
6) IHSC Directive: 03-05, *All-Hazards Emergency Preparedness and Response*
7) IHSC Continuity of Operations Plan (COOP): ICE Supplement

Occupational Safety and Health Administration

1) OSHA How to Plan for Workplace Emergencies and Evacuations
2) OSHA Safety and Health Topics | Emergency Preparedness and Response

Other

1) Emergency Preparedness and Response | CDC
2) Agency for Healthcare Research and Quality, Altered Standards of Care in Mass Casualty Events
3) National Fire Protection Agency
4) American Heart Association
5) National Emergency Medical System Standards
6) START Adult Triage
7) JumpSTART Pediatric MCI Triage