Baldwin Park – Medical Center Wide – Policies and Procedures

Location: **Medical Center Wide – 6200's**	Old Policy Number:	On-Line Number: **MCW 6206**
Section: **EOC - Emergency**	Effective Date: **7/97**	Page: **1 of 13**
Title: **Evacuation Procedures and Assembly Points**	Review / **Revision Date**: **8/98, 12/01, 1/03, 1/06, 8/06, 9/06, 10/11, 9/14, 6/17, 11/19**	
Accountable Department or Committee/Owner: **Environmental Health and Safety**	☑ Medical Center Wide ☐ Department Specific	☑ Non-Clinical ☐ Clinical
Approved by: **Environment of Care Committee – 11/19/19** **Medical Executive Committee – 11/25/19**		

REFERENCES:

- The Joint Commission, Emergency Management Standards
- Title 22 California Code of Regulations (CCR) 70741, 70746, 70743, 70443(g)
- Title 19 California Code of Regulations (CCR) 2403 *et seq.*

POLICY:

To ensure the safe and orderly evacuation of the Kaiser Permanente facility of its patients, employees and visitors in the event of a disaster, internal or external.

SCOPE:

This policy applies to any individual of the workforce including, but not limited to, the following:

- All workforce members of the Kaiser Foundation Health Plans, Kaiser Foundation Hospitals, and their subsidiaries as well as their vendors, subcontractors, volunteers, agents, and directors
- All physicians and non-physician employees of the Southern California Permanente Medical Group

PROCEDURE:

1. Activation of Evacuation Plan
    a. The decision to evacuate will be made following an earthquake or other emergency event that significantly compromises the overall safety in a building.
    b. When it is determined that some or all of the facility may not be suitable for occupancy, partial or total evacuation may be warranted.
        1) A Code Triage is called in response to the disaster or emergency situation.
        2) The decision to evacuate is the responsibility of the Hospital Command Center (HCC) staff, led by the Incident Commander and in consultation with the Medical Center Administrative Team (MCAT).
    c. Evacuation can be partial or total.
        1) Partial evacuation is defined as the movement from one area to another location within the medical center.
        2) Total evacuation is defined as the movement from one area to outside of the medical center.
    d. Partial versus total evacuation:
        1) Evacuations are dangerous, disrupt patient care, and should be undertaken only for the gravest situations.
        2) Partial evacuation or re-location of staff, patients and visitors is preferable. This is accomplished by:
            A. Choosing to re-locate to the closest, safe "life safety compartment." Modern buildings, especially hospitals, are built to be compartmentalized into life safety units to reduce the need for total evacuation of facilities.

B. Choose destination horizontally first and then vertically (up or down) depending upon safety factors and the nature of the emergency.
C. The last option to be considered is total evacuation and providing needed medical care outside the building until an alternative can be found.

e. Evacuation criteria:
The factors upon which a decision to evacuate include, but are not limited to:
1) Structural integrity of the building
2) Emergency (life threatening) conditions such as fire and chemical spills
3) Impending disaster which is expected to compromise the medical center (i.e., imminent flood)

f. Evacuation routes are posted at all exits and next to elevators on each floor.

2. Method of Evacuation
   a. Each nursing unit and department shall establish viable routes of evacuation and a common meeting point.
   b. Use of the stairwells should be used in lieu of the elevators if there is any doubt about the operability of the elevators, **but always use stairwells in the event of a fire or earthquake**.
   c. Employees shall be familiar with the configuration of all exit corridors and the locations of all stairwells surrounding their work areas.
   d. Each department shall maintain a current census of employees to assist in ensuring that all persons are accounted for after the evacuation. A work schedule or deployment roster may be used for this purpose.
   e. Each nursing unit shall identify all available equipment and techniques to assist in the relocation of non-ambulatory patients.
   f. Ambulatory patients shall be moved first, followed by less critical patients. The more critical, non-ambulatory patients (such as those in the Critical Care Unit) should be moved last.
   g. Each area providing patient care shall individually ensure that patient records move and remain with the patients at all times.
3. Evacuation Staging Areas
   a. If there is a total evacuation, the HCC will be relocated in a safe location determined by the Safety Officer or designee. Facilities and/or Plant Services staff will obtain alternate HCC containers (in the cargo trailer located in the hammerhead area of the loading docks) and proceed to designated alternate HCC location. Facilities and/or Plant Services will also set up a tent for alternate HCC usage.
   b. Triage and all treatment areas (Immediate, Delayed and Minor) along with Labor Pool, Medical Labor Pool, and the Patient Information Center shall be re-established (and identified by signs) in an alternate location.
   c. Report to Baldwin Park Medical Center Primary HCC on the fourth floor or the assigned alternate HCC location.
   d. Attachment A identifies all designated evacuation assembly points.
   e. Supplies to be taken to alternative HCC site are three grey containers in cargo trailer marked Alternate HCC Containers, #1, #2, and #3. The containers have all of the materials for the HCC with the exception of a television monitor.
4. Communications
   a. Instruction to evacuate all or part of the building may be given using the overhead paging system (if in operation). Alternatives are:
      1) Designated runners deployed by the HCC and supplied from the Labor Pool
      2) Hand-held, battery operated microphones or bullhorns
   b. Once outside, the HCC will maintain communications with support functions by:
      1) Use of runners
      2) Hand-held radios

3) Wireless phones

Request additional radios from Environmental Health and Safety (EH&S). There are 18 handheld radios in the EH&S Director's office. Two of these radios are pre-assigned to HCC. Security will be responsible for obtaining and distributing the radios.

c. If no other system is available, Kaiser Permanente Amateur Radio Network should be used for both internal and external communications. Coordinate this with the HCC.

d. The Liaison Officer, supported by Information Technology (IT), is responsible to establish emergency communications to the outside by bringing the Amateur Radio equipment to the relocated HCC. Vehicles in the parking lot may be used as power sources for these radios.

5. Types of Evacuation

a. Familiarity with several types of evacuation is necessary in any hospital. Evacuation is movement, either horizontal or vertical, from a dangerous or potentially dangerous area, to one of comparative safety. These areas should be separated by fire walls, fire doors or corridor cut-off. All vertical openings for movement, like stairwells and elevator shafts, should be properly enclosed. There are three types of evacuation. Each may be a separate and complete operation, or both may have to be used in successive stages if circumstances so require.

b. Horizontal evacuation is **ALWAYS** preferred over vertical evacuation. The Medical Center's structural fire protection features include "Fire Separation" on all floors, basement through 6th floor. Additionally, each floor is subdivided into compartments by rated walls and barriers designed to forestall the movement of smoke. Whenever evacuation is needed, move patients from the danger area to the adjacent "smoke compartment," typically beyond the nearest set of rated fire doors.

c. If further evacuation becomes necessary, patients, visitors and employees should then be evacuated vertically using the stairs, preferably going down. Go upwards during vertical evacuation only when necessary. **DO NOT USE THE ELEVATORS.**

Horizontal Evacuation

This type of evacuation takes place when fire or heavy smoke from a single room or area threatens to spread to adjoining areas. All patients should be moved laterally using beds, carts, wheelchairs, stretchers, blankets, or other conveyances if necessary, to the nearest and safest protected area. Patients in immediate danger should be moved first, including those who might be separated from safety if the fire enters the corridor. Next, move ambulatory patients, since they will take up less space in the safe area. Ambulatory patients should be instructed to line up outside their rooms, form a chain by holding hands, and follow a lead nurse into the safe area. Next, move the non-ambulatory patients, using beds or other means described above. The rooms should be checked for stragglers and all windows and doors closed. Re-check the patients in the safe area for accountability. When horizontal evacuation is ordered, the personnel in the receiving area should assist in the evacuation. If you have fire doors, close them and remain alert for further instructions.

Vertical Evacuation

This is the downward, or if necessary, upward, movement to a safe area. Safety can be found one floor below the fire, but two floors is recommended. Ambulatory patients should again form a chain by holding hands and follow a lead nurse. Carts, wheelchairs, stretchers, evacuation chairs, med sleds, and blankets can be used to move non-ambulatory patients. The best stairway or fire escape carrying positions are the two-man swing carry and the four-man stretcher carry which will be explained later.

Total Evacuation

This means vacating **ALL** floors to a place of safety. Cause would be possible conflagration or dense smoke and fumes. A place of safety might mean the basement or leaving the building. It would be necessary to use all stairways. Use serviceable elevators only when directed by the Fire Department. This action must be undertaken, floor by floor with help above and below to keep traffic moving quickly and properly by stair and elevator.

6. Patients are Evacuated by:
   If the fire is in, or threatens, a nursing unit and the person or nurse in charge considers removal of patients necessary, **DON'T WAIT FOR SPECIAL INSTRUCTIONS,** but observe the following:
   a. Horizontal Evacuation
      1) Remove patients from the unit to the next unit beyond the fire doors (self closing during fire drills) on the same floor. **EACH PATIENT'S CHART AND MEDICATION(S) SHOULD ACCOMPANY THE PATIENT.**
      2) Be certain that all doors are closed.
      3) If there are visitors present, request them to remain with their relatives until the emergency is over and to help where needed.
   b. For Orthopedic (Traction) Cases
      1) Use a gurney.
      2) For a fracture that requires traction or body cast, disconnect traction keeping as much tension intact as possible and make ready for evacuation.
      3) When a patient is on a Stryker Frame, leave patient in Stryker Frame and make patient ready for evacuation.
      4) One employee is to remain with each orthopedic traction case at all times, if patient's activity is restricted to bed rest.
   c. Vertical or Total Evacuation
      1) Station someone near the fire doors to make certain that they remain closed for effective smoke control.
      2) With the Professional Exchange Report or the Bed Occupancy Sheet, account for the whereabouts of each patient.
   d. Carry Patients as a Last Resort
      1) Fold top bedding on each side over the patient.
      2) Loosen all lower bedding down to the mattress all the way around.
      3) Roll each side of lower bedding making a grasping spot for four or six people to lift patient.
      4) Carry patients on this bedding.
         A. Post someone at the exist doors to maintain order.
         B. Supply each patient with a blanket.
         C. Give non-ambulatory patients a wet towel to cover their face.
         D. Have Environmental Services Attendant, orderly or other employees remain with each group of patients to avoid panic and provide guidance.
         E. Instruct ambulatory patients to form a chain by holding hands and lead them to a safer area as directed by a competent authority.
         F. Use safe elevators, as directed by the Fire Department, to evacuate non-ambulatory patients, using wheelchairs, gurneys and beds. Non-ambulatory patients may also be rolled in blankets and dragged along the floor by holding the corner of the blanket.
         G. Med sleds and evacuation chairs are also available to remove non-ambulatory patients. They are located on floors 2 through 6 in the Medical Center, and floors 2 and 3 in the MOBs. An EVAC sign designates their locations.

e. To Evacuate Patients, do the following:
   1) In a hospital fire, the first duty of the employees is to remove the patient(s) who may be in immediate danger. This may require moving one person or many.
   2) Three factors may dominate the situation in handling patients in an emergency:
      A. The nature of the emergency
      B. The weight and condition of the patient
      C. The strength and adaptability of the rescuer
   3) Of all the possible equipment for evacuation, the **BLANKET** is more important than any other. It can be used to smother fire and drag patients from a room or down the stairs. It can be made into a stretcher (with or without poles) for carrying in halls or on stairs. Eight or ten infants can be carried easily and safely on it.
   4) There should be no uncertainty in bed fires. The rule is to **get the patient on the floor**. In an oxygen-enriched fire, **FIRST SHUT OFF THE OXYGEN, AND THEN GET THE PATIENT ON THE FLOOR.** In both situations, if you throw a blanket on the floor, you can use it to smother the fire or drag the patient.
   5) People on fire have the impulse to run, if they are able. Someone in this predicament should be instructed and assisted to lie on the ground and roll until the flames are out.
   6) If there is any question of responsibility in removing someone from traction, it is better to remove them from traction, than to have them perish.
   7) In case of fire, patients may move themselves to the floor. They will get out of bed if they can. If the patient is supposed to be in the room and you can't see or feel him/her, look under the beds, in the closets or elsewhere.

f. Points to Remember:
   1) Be calm.
   2) Report fire immediately by dialing x3333 or activating the nearest pull station.
   3) **Do not shout "Fire."**
   4) Do not inform patients of a fire unless absolutely necessary.
   5) Assure patients, if they are aware of the fire, that there will be plenty of help to assist them.
   6) Use proper exits. Do not use center stairways except when indicated by competent authority during evacuation procedures.
   7) Do not block stairways and exists.
   8) Close doors to prevent the spread of fire and smoke.
   9) Do not use the dumbwaiters or trash chutes.
   10) Do not use elevators.
   11) Do not call Communications Operator, except to report a fire or for emergency.
   12) Place wet blankets or towels under closed doors to help confine fire and smoke.
   13) Keeps doors in corridors and stairways closed.
   14) Do not turn off lights.
   15) Do not leave your unit.
   16) Supervisor, Nursing Care Coordinators and Team Leaders are totally responsible for their areas and the duties of their employees.
   17) Employees who are not in their assigned areas at the time the Fire Alarm is heard should return to their assigned area at once via the stairways.
   18) Be sure you know the exact location of the fire alarm boxes and the fire fighting equipment in your area. Familiarize yourself with the correct extinguishers and the method of operation of this equipment.

g. Patients are Carried in this Fashion:

1) Where one of these carries may be suitable for one person, it may not be suitable for someone else. Find one that you can handle best. If you practice often enough, the patient's weight and height will not be important factors. Whenever you are reporting to a room for action, never pass by something you may need.
2) Another factor is the height of the bed. Patients in variable height beds in the "low" position and in low beds should be removed with the one-two or three-man cradle or kneel drop on a blanket, as described on the following pages.
3) On all carries, patients must be "hugged" firmly. The carrier should use his own body and that of the patient to sustain the patient's weight over the whole of the carrier's arms alone. When one carries a heavy bag or package, he does not transport it with his arms extended the full length from his body. He hugs the object to his side where the process is then part "lift" and part "press" with a degree of functional assistance from the object against the body resistance. Often in carrying groceries, for example, a person will take his hands away from the bottom of the bag so that it is really suspended between the pressure of his arms.
4) Basically, there are six removals or carries: the pack strap carry for one person, the hip carry for one person, the cradle drop for one person, the extremity carry for two persons, the bedding lift for two persons. The rest are variations of these depending upon the personnel available and the weight and condition of the patient.
   A. Pack Strap Carry: For one person
      - Face patient with your back toward the foot of the bed.
      - Grip the nearest wrist with the nearest hand, palm down.
      - Raising the patient's wrist slightly, slip your free hand under his/her raised wrist and grasp patient's other wrist, palm up.
      - Pull patient to sitting position by taking one step backward.
      - Never letting loose of the patient's wrist, raise the patient's nearest wrist and slip under patient's arm, so that you are now standing between the patient's arms.
      - Placing your back squarely against the patient's chest so that your shoulders are lower than the patient's armpits, you pull the arms over your shoulders and close them on your chest.
      - Exerting a downward pull on the arms, lean forward slightly, bending only your shoulders.
      - Turn both your body and feet sharply toward the head of the bed. It is not necessary to drag or lift the patient. Your forward momentum will roll the patient out on your back without shock.

      This is a good carry for turning in any direction or close quarters, or where there is fire on both sides of doorway. To unload in a corridor:
      - Place the patient's shoulder against the wall.
      - Lean against patient and drop on your knee against the wall.
      - Lean against patient as they slide down the wall. Use your own balance. The patient is locked between body of rescuer and the wall.

   B. Ship Carry: For one person
      - Face the patient, grasp farthest wrist, palm down with hand closest to the patient's head.
      - Raise arm and make a half turn toward head of bed placing patient's hand over head and down over shoulder.
      - With free hand, reach behind patient's wrist.
      - With knees slightly bent and feet apart, reach back with free hand and grasp both knees. The patient is securely held by the armpit and knee.
      - Draw patient up on hips before leaving bedside; if the patient is carried on buttocks, he/she may slide down.

- To unload the patient in corridor, place the patient's buttocks against the wall and drop knee closest to the wall and let patient slide down wall to the floor.

C. Cradle Drop: For one person
- First, double a blanket lengthwise on the floor parallel to the bed.
- Slide arm nearest to patient's head under the neck and grasp shoulders.
- Slide free arm under knees and grasp firmly.
- Place your knee or thigh, depending on height of the bed, against the bed close to the patient's thigh. Both feet are flat on the floor about six inches from bed.
- The patient is pulled from the bed; no lifting is necessary. Pull with both hands, push with knee or thigh against the bed.
- The moment the patient starts to leave the bed, drop on knees nearest the head. When the patient is clear of the bed, the extended knee supports the knee of the patient and the arm under the arm and shoulders of the patient. The cradle formed by knee and arm protects the back.
- Let the patient slide gently to the blanket and pull the blanket from the room.

D. Two Man Extremity Carry: Used by two rescuers
Teams of rescuers can evacuate large areas with this carry.
- Bring patient to sitting position.
- One person locks arms around patient's chest.
- The other person grips both legs at ankles and swings one leg off bed and steps in between them.
- Both people swing patient off bed at signal in unison.

E. Bedding Lift: Used by two rescuers
Good for post-op, abdomen wound and burn patients.
- Loosen patient bedding, and using as a stretcher, lower patient to the floor.
- One rescuer can now move the patient safely thus freeing the other rescuer to help other patients.

F. Three-man Horizontal Carry: Used by three rescuers
Used for body casts, large patients or stroke patients.
- Each rescuer slips arm under patient and grips him/her firmly at each of the following spots: the knees, the hips and the shoulders.
- Working in unison, pull patient to the edge of the bed, lift and turn to face you.
- Carry patient as a unit.

G. Other Methods

i. Semi-Ambulatory and Ambulatory Patients:
- Reassure patient to prevent panic.
- Tie a draw sheet as a belt around the patient's waist. Holding this belt firmly will provide safety if the patient stumbles.
- A chair can be used to drag a patient from a room.

ii. Ankle Floor Removal:
- If you find a patient lying on the floor, place a blanket open full length parallel to the body. For the purpose of removal, it makes no difference whether the patient is lying face up or down.
- The rescuer takes the ankle furthest from the blanket and places it on top of the other ankle.

- Then press down on top ankle and pull up on bottom ankle, which will roll patient over on the blanket.
- Pull patient from the room.

iii. Hemodialysis Patient Evacuation

Hemodialysis Registered Nurse (RN) will take the following steps:

- Disconnection procedure from dialyzer:
  a. Blood return with NSS, then air rinse.
     1) Stop the pump. (If power failure has occurred, prepare for manual return.)
     2) Double clamp arterial line and separate at junction.
     3) Attach arterial tubing to 250 cc NSS and displace blood with pump or manually.
     4) Infuse saline until complete return, and then clamp tubing on both sides of connection.
     5) Discontinue pump and separate venous tubing on needle (or cannula), leaving clamps on.
        a) Cannulas: reconnect arterial and venous cannula with Teflon connector. Remove cannula clamps and re-establish flow. Dress with 4 x 4's and kling bandage.
        b) Fistulas: remove arterial needle, apply tourniquet for hemostasis. Apply pressure dressing of 4 x 4's and coban when bleeding slows. Repeat same with venous needle.
     6) Evaluate patient's condition: blood pressure, ambulatory status (dizzy, steady, etc.).
  b. When time does not allow for blood return from the dialyzer and immediate removal to safety is required:
     1) Stop blood pump.
     2) Double clamp the arterial and venous lines and cut lines between the two clamps. SECURE ACCESS!!!
     3) Move to safety – ambulate, use wheelchair, or carry as condition requires.
     4) Reconnect cannulas and remove needles when the patient has been moved to a safe place.
     5) Evaluate condition and discharge or transfer as necessary.

7. Evacuation Sites
   a. The HCC will re-establish functioning within a secondary designated location.
   b. Triage and all treatment areas (Immediate, Delayed, and Minor) along with Labor Pool, Medical Labor Pool, and the Patient Information Center shall be re-established (and identified by signs) if it is appropriate and safe.
   c. See Designated Evacuation Assembly Points (Attachment 1).
   d. Supplies to be taken to alternate HCC site – three grey containers are in cargo trailer marked Alternate HCC Containers #1, #2, and #3 (cargo trailer is located in the hammerhead area of the loading dock). The containers have all of the materials for the HCC with the exception of a television monitor.

ATTACHMENTS:

Attachment 1: Designated Evacuation Assembly Points (A-F)
Attachment 2: Evacuation Map Assembly Points (A-F)

ATTACHMENT 1
DESIGNATED EVACUATION ASSEMBLY POINTS:
(See Reflective Signage with Lettering A-F)

Unit/Department	Primary Evacuation Area	Alternate Evacuation Area
ADMINISTRATION	A	UPS PARKING
AMBULATORY STAFF EDUCATION	D	BROKEN HORN
ANESTHESIA	E	BROKEN HORN
CAFETERIA	D	BROKEN HORN
CALL CENTER	D	BROKEN HORN
CARDIOLOGY	F	BROKEN HORN
CRITICAL CARE (CCU)	A	UPS PARKING
CENTER FOR HEALTHY LIVING	C	UPS PARKING
CONFERENCE ROOMS	D	BROKEN HORN
CONSTRUCTION	F	BROKEN HORN
DIAGNOSTIC IMAGING	A	UPS PARKING
EMERGENCY DEPT	A	UPS PARKING
EMPLOYEE HEALTH	A	UPS PARKING
ENDOCRINOLOGY	B	UPS PARKING
ENDOSCOPY	F	BROKEN HORN
ENVIRONMENTAL HEALTH & SAFETY	A	UPS PARKING
ENVIRONMENTAL SERVICES	F	BROKEN HORN
FOOD & NUTRITION	B	UPS PARKING
GASTROENTEROLOGY	F	BROKEN HORN
GENERAL SURGERY	F	BROKEN HORN
GIFT SHOP	D	BROKEN HORN
HEAD & NECK	F	BROKEN HORN

Unit/Department	Primary Evacuation Area	Alternate Evacuation Area
HEALTHCONNECT	A	UPS PARKING
HEMATOLOGY/ ONCOLOGY	E	BROKEN HORN
HEALTH INFORMATION / MEDICAL RECORDS	D	BROKEN HORN
INFECTION CONTROL	C	UPS PARKING
INFORMATION TECHNOLOGY	A	UPS PARKING
INFUSION CENTER	E	BROKEN HORN
INTERNAL MEDICINE	F	BROKEN HORN
IQM – DISCHARGE PLANNING	D	BROKEN HORN
LABOR & DELIVERY	A	BROKEN HORN
LABORATORY	B	UPS PARKING
MAIL ROOM	D	BROKEN HORN
MATERNAL AND CHILD HEALTH	E	BROKEN HORN
MEDICAL OFFICE BUILDING, BALDWIN PARK (MOB I)	C	UPS PARKING
MEDICAL OFFICE BUILDING, BALDWIN PARK (MOB II)	C	UPS PARKING
MEDICAL STAFF OFFICE	A	UPS PARKING
MED SURG 2E	B	UPS PARKING
MED SURG 4E	B	UPS PARKING
MED SURG 4W	B	UPS PARKING
MED SURG 5E	B	UPS PARKING
MED SURG 5W	B	UPS PARKING
NEPHROLOGY	F	BROKEN HORN
NEUROLOGY	D	BROKEN HORN
NEONATAL INTENSIVE CARE UNIT (NICU)	E	BROKEN HORN
NURSING STAFFING OFFICE	B	UPS PARKING
OB/GYN	E	BROKEN HORN

Unit/Department	Primary Evacuation Area	Alternate Evacuation Area
ONCOLOGY	E	BROKEN HORN
OPERATING ROOMS	E	BROKEN HORN
PACU	E	BROKEN HORN
PAIN MANAGEMENT	F	BROKEN HORN
PATHOLOGY	F	BROKEN HORN
PERI OP	A	BROKEN HORN
PHARMACY – INPATIENT, 24 HR, 2ND FLOOR, & OPERATIONS	B	UPS PARKING
PHYSICAL THERAPY	F	BROKEN HORN
PLANT SERVICES	F	BROKEN HORN
PROCEDURAL RECOVERY (PRA)	E	BROKEN HORN
PUBLIC AFFAIRS	A	UPS PARKING
PULMONARY	F	BROKEN HORN
QUALITY	F	BROKEN HORN
RESPIRATORY	A	UPS PARKING
REVENUE CYCLE	C	UPS PARKING
RISK MANAGEMENT/ PATIENT SAFETY/ WORKPLACE SAFETY	F	BROKEN HORN
STEP DOWN UNIT (SDU)	A	UPS PARKING
SECURITY/ PARKING	A	UPS PARKING
SOCIAL WORK	D	BROKEN HORN
STAFF EDUCATION	C	UPS PARKING
STERILE PROCESSING	E	BROKEN HORN
SUPPLY CHAIN	A	UPS PARKING
SURGERY COORDINATION CENTER	E	BROKEN HORN
TELECOMMUNICATIONS	A	UPS PARKING

Unit/Department	Primary Evacuation Area	Alternate Evacuation Area
URGENT CARE	C	UPS PARKING
VASCULAR SURGERY	F	BROKEN HORN
ALL OTHER DEPARTMENTS	E	BROKEN HORN

ATTACHMENT 2

EVACUATION MAP ASSEMBLY POINTS (A-F)