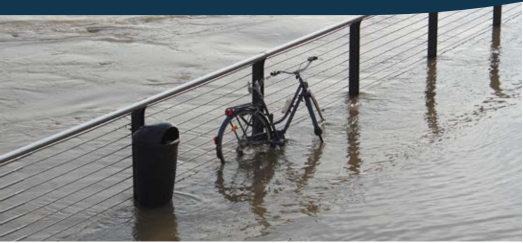
RACGP

Information for general practitioners working in evacuation centres



Acknowledgement

The development of this resource has been undertaken by The Royal Australian College of General Practitioners (RACGP) in collaboration with Healthy North Coast (North Coast Primary Health Network [PHN] and Sydney North Health Network [Northern Sydney PHN]). We acknowledge the contributions of Wentworth Healthcare, the provider of the Nepean Blue Mountains PHN.

The RACGP acknowledges the significant contributions from members of the project working group. We also take the opportunity to recognise all general practitioners (GPs) who have generously volunteered their time and expertise working in evacuation centres and supporting communities in time of emergency and disaster.

Foreword

Emergencies and disasters have a significant impact on the health and wellbeing of people and communities.[1] As essential healthcare providers, GPs play a critical role in supporting individuals and communities before, during and in the aftermath of these events.

As outlined in the RACGP position statement The vital role of general practitioners in disasters and emergencies, general practice has not historically been well integrated into emergency planning, nor effectively utilised; however, work is increasing to improve systems of integration. This is because the Federal Government is responsible for general practice, whereas emergency planning is largely managed by state and territory governments. Overwhelmingly, the experience of GPs and general practice teams working in disaster-impacted areas has been hampered because GPs are not consistently embedded into the wider healthcare response.

PHNs, which are funded by and report to the Federal Government, are increasingly prioritising and playing an important role in disaster planning and response. PHNs are currently best placed to connect GPs to the broader disaster health management response and to evacuation centres as needed.

This resource is made up of two parts:

- *Key recommendations for the inclusion of GPs into evacuation centres*, which aims to support agencies responsible for evacuation centres to effectively integrate GPs and their teams into these centres
- *Information for GPs working in evacuation centres*, which is a resource for GPs on providing care in evacuation centres.

The RACGP appreciates the disaster management space is constantly evolving. We will continue to refine and update this resource and any supporting materials as required.

1. About this resource

It is essential that people can continue to access medical care during emergencies and disasters. Evacuation centres may be required as critical infrastructure during emergencies and disasters to provide for the immediate needs of displaced residents, potentially also including access to medical care. GPs and their teams can play a vital role in assisting with the provision of that care.

This resource provides GPs with:

- an overview of how evacuation centres are set up and function
- the potential role of GPs in evacuation centres
- practical advice for working in evacuation centres.

A supporting resource has been developed to provide guidance on the inclusion of GPs and general practice teams in the planning process for establishing evacuation centres. Together, these resources aim to ensure GPs are included in disaster management planning and response, and support their preparation to work in an evacuation centre.

For the purposes of this document, the following terms may be used interchangeably:

- 'emergency' and 'disaster'
- 'LHD' (local health district) and 'LHN' (local hospital network).

2. Background

GPs are the key health providers supporting communities before, during and after a disaster event. The long-term connection GPs have with locals, combined with a high demand for general practice services during and following disaster situations, makes GPs crucial to disaster planning and response arrangements. Despite this, there are often no formal arrangements in place to utilise GPs to their full capacity during the response phase of a disaster.

Although many localities have coordinated and well-resourced disaster response mechanisms implemented by local emergency services and LHNs, general practice has not been consistently included and integrated as part of disaster planning and response.

The RACGP continues to advocate for the involvement of GPs in disaster and emergency response plans to ensure a clear, consistent and planned general practice response in future emergencies and disasters. GPs and their teams must be appropriately funded and resourced to undertake disaster planning and response activities. This will ensure the best healthcare is available to support the health and wellbeing of communities impacted by disasters.

PHNs are Federal Government-funded organisations tasked with improving healthcare coordination and ensuring that the health needs of their local communities are met. PHNs should be integral to emergency response planning, coordination and recovery, including the engagement of GPs. However, there is currently no national uniform approach or support for PHNs to undertake disaster planning.

It should be noted that, at the time of publishing this document, the involvement of PHNs in disaster health management is rapidly increasing. Some PHNs have developed their own disaster planning, training and educational resources, including the involvement of GPs and general practice teams in evacuation centres.

3. Overview of evacuation planning

The decision to evacuate a population and activate evacuation centres depends on many factors.

When the impact of a hazard does not allow sufficient time for a warning to be issued, such as an earthquake or flash flood, evacuations will be immediate. Some are pre-warned or managed evacuations, whereby a planned evacuation occurs ahead of a potential hazard, such as a bushfire or a slower-onset flood or inundation. Some are self-managed evacuations or relocations, whereby residents are asked to leave early during dangerous conditions, such as catastrophic bushfire and smoke conditions.

Evacuation planning currently involves LHNs/LHDs and other emergency responders. The involvement of GPs varies across regions, but is largely overlooked. GP involvement has tended to be managed in an ad hoc way during the chaos of the response.[1] The Australian Institute for Disaster Resilience *Evacuation planning handbook* lays out

a set of key principles on the evacuation planning process. In most cases, evacuation centres will be managed by a local government or state government organisation. In some states and territories, the Australian Red Cross may play a significant role.

3.1 Evacuation centres

The purpose of an evacuation centre is to temporarily house evacuees who do not have other accommodation following withdrawal from an area of risk. Evacuation centres:

- are established outside the area at risk
- must meet the immediate needs of a population impacted by disaster
- should be safe and secure places of shelter providing basic needs until evacuees can return to their place of residence.

Facilities are considered as potential evacuation centres if they meet minimum requirements in terms of the provision of food, water, sanitation, personal space, accessibility and, if possible, sleeping facilities.[2]

A full list of requirements for evacuation centres can be found in the Australian Institute for Disaster Resilience *Evacuation planning handbook*.

3.2 Registering to work in an evacuation centre

GP engagement in evacuation centres will normally be facilitated via PHNs. If you are prepared to work in an evacuation centre, you and other general practice team members should declare your interest to your local PHN before a disaster or emergency occurs.

Although each PHN will have a different process for engaging and preparing GPs, they will typically create a volunteer register that will be used when an evacuation is required. The GP register allows for appropriate planning and training to occur before an evacuation centre is activated. See *Recommendation 6: Training to prepare for work in an evacuation centre* for more detail.

3.3 Evacuation centre activation

The police and other emergency response agencies, such as fire services or state emergency services, hold the legislative authority to order and enforce an evacuation. The decision to evacuate is usually made in consultation with various agencies.

3.4 Chain of command in evacuation centres

The management and operation of evacuation centres involve multiple organisations and services. The roles and responsibilities of all supporting organisations and chains of command should be clearly documented. When GPs and their teams are providing healthcare services in evacuation centres, they should be linked into these chains of command, which will usually be through the PHN, which sits under the LHN disaster management team. This will minimise disruption to service delivery and ensure that effective communication with other services is maintained.

4. Role of GPs

4.1 GP deployment to an evacuation centre

The trigger for GP deployment to an evacuation centre will usually be determined by LHNs, who will communicate a request for GP assistance to the relevant PHN.

GPs on the volunteer register will be contacted to determine their willingness and ability to assist at an evacuation centre. If multiple evacuation centres are being established, you may be able to nominate the centre you wish to attend; however, this may not always be possible.

Depending on the local community context, the ongoing effects of the disaster, the range of other medical health services available in the community and the availability of GP staff, each shift could involve a team rather than an individual clinician. These teams may include medical, nursing and/or other support staff as available. Other healthcare services may also be included in the evacuation centre, such as allied health, as available and appropriate.

GPs should receive an orientation to the evacuation centre and be set up with basic supplies to perform their duties. You will be expected to bring your own prescriber's/doctor's bag, water, snacks and any personal items that may be needed.

4.2 Providing care in an evacuation centre

An evacuation centre should not be a makeshift hospital. GPs should only manage cases they feel comfortable managing in an evacuation centre, considering the limitations of their setting, resources and scope of practise. Triage of evacuees may be required, especially in larger mass-casualty evacuation centres.

4.2.1 Services that should be provided in an evacuation centre

GPs provide holistic, comprehensive healthcare for patients. Most patients in evacuation centres will present with a combination of healthcare needs across physical and mental health domains. These needs may be exacerbated because evacuees will likely feel vulnerable, stressed and traumatised by the uncertainty of the emergency experience.[3] An important role will be to undertake a broad range of medical assessments across mental, physical and social health as required while maintaining an understanding of the likely health effects of disasters during the relevant period after the disaster.

The services you can provide in an evacuation centre setting include those listed below.

Acute healthcare activities

- Surveillance and early recognition of emerging healthcare needs, including infectious or communicable diseases (eg COVID-19, influenza, gastroenteritis, scabies, wound infections etc). If seeing a number of cases, this would possibly require early notification and discussion with the public health unit
- Minor acute injuries (eg wounds, animal and insect bites, lacerations, soft tissue injuries, eye irritations, inflammatory skin conditions and rashes)
- Acute infections (eg cellulitis, upper respiratory conditions including otitis media/externa and tonsillitis)
- Non-severe respiratory conditions (eg croup, bronchiolitis, community-acquired pneumonia and asthma and chronic obstructive pulmonary disease)
- Gastroenteritis, urinary tract infections
- Chronic wound management where routine care is due and usual point of care is unavailable or there is acute deterioration
- Arthralgias and myalgias, including acute gout
- Medical emergencies as required at the time (eg withdrawal seizures, hypoglycaemia etc), noting the preference is to avoid these situations in an evacuation centre and, where possible, to refer at-risk patients early to other services for acute care management

Mental health

- Management of distress, including provision of psychological first aid (PFA)
- Mental health first aid (MHFA) for deterioration of pre-existing mental health conditions such as anxiety or depression
- Trauma-informed care (TIC), acknowledging evacuees have experienced a traumatic event
- Referral to an onsite mental health team, or an individual’s local GP or other local community psychologists, where available

Pregnant people and young children

- Antenatal care and conditions
- Breastfeeding and bottle-feeding issues
- Review, management and referral of babies, infants and young children

Chronic conditions

- Management of people with exacerbations or deterioration of chronic or pre-existing medical conditions, particularly those at higher risk, such as people with:
  - diabetes (especially those with poor glycaemic control), gestational diabetes, type 1 diabetes
  - hypertension (especially those with an increased risk of myocardial infarction or stroke)
  - respiratory conditions exposed to environmental triggers, such as increased aerosolised particulate matter, contaminated water etc
  - older age (especially if any heat hazard, cognitive impairment, risk of falls, multiple comorbidities etc are present)

Vaccinations

- If available, consider diphtheria–tetanus combination (ADT) vaccine in those with an immediate indication to administer. This may include recent injuries, especially where patients may be involved in clean-up activities.
- Where the close proximity of a number of people will increase the risk of spread of an infectious disease, awareness of vaccine-preventable diseases during the disaster will be important in an evacuation centre setting. Although it may not be practical to carry other vaccines onsite due to cold chain considerations, awareness of the potential risk of, along with knowledge of appropriate response to, the following will be important:
  - influenza
  - pneumococcal disease
  - COVID-19
  - locally relevant vaccine-preventable conditions such as measles.

Prescribing and dispensing

- Provision and review of prescription medicines for continuity of routine chronic disease management. It is important to prevent the disruption of usual medicines that may have been disrupted due to:
  - reduced access or adherence to medicines due to evacuating without them or destruction in the disaster
  - reduced access to usual medicines and medical supplies, particularly those requiring special authorisation
  - acute exacerbations of chronic disease (eg increased blood pressure in those with hypertension, deterioration in glycaemic control in those with diabetes or deterioration of respiratory conditions particularly due to increased particulate matter from fire smoke)
- Provision of medicines for acute conditions, including tonsillitis and cellulitis, noting that local conditions following the disaster may mean that different organisations may be involved or specific specialist advice may be needed to manage appropriately (eg colonisation of wounds may not be due to the usually expected organisms)

Occasionally, in certain circumstances, administration of medicines where pharmacy services are unavailable due to inaccessibility or service disruption, or when the safe storage of a particular patient's medicines onsite is necessary (see *Medicines management in evacuations centre*)

Dispensing of medicines needed to manage acute care needs, such as wounds exposed to flood water. Takeaway packs may be stored securely at the evacuation centre to use as clinically indicated and in line with local practises/specialist advice, noting limitations to prescribing as per *Services that should not be provided in an evacuation centre*

Transfer of care

- Referral to other services, including:
  - services operating within the evacuation centre (eg St John's Ambulance, mental health, alcohol or other drug (AOD), welfare/pastoral care)
  - the patient's usual GP (possibly via telehealth)
  - another local, operational general practice
  - a local hospital emergency department for higher-acuity care
  - a relevant specialist or allied health provider (face-to-face or via telehealth), including pharmacists, physiotherapists, psychologists, community nursing and occupational therapists

High-acuity injuries resulting from an emergency event should not be transferred to an evacuation centre for management by a GP. However, evacuation centres may be housing evacuees with unrecognised or emerging high-acuity injuries and medical conditions that then require triage and transfer for specialist care in a timely manner.

4.2.2 Services that should not be provided in an evacuation centre

GPs have a variety of skills and experience, with some specialising in areas such as anaesthetics, obstetrics, palliative care and family planning. GPs should provide care that fits within their usual scope of practice.

In situations where GPs with additional specialised training are available, the services that can be provided safely in an evacuation centre may expand. Consideration should be given to the evacuation

centre's available resources, monitoring capability, patient privacy, infection control measures and the ability to respond to any complications or adverse reactions arising from this care.

On some occasions, telephone consultation with a specialist may enable further safe management in an evacuation centre. If in doubt, refer to a health service in a more appropriate setting. GPs attending evacuation centres are able to determine whether patients require additional healthcare that cannot be provided safely in an evacuation centre (or that is outside the scope of practice in an evacuation centre setting) and should be transferred to the relevant hospital or health service for assessment and management.

However, the following services are considered inappropriate in most scenarios and should be avoided whenever possible by GPs working in an evacuation centre:

- provision of high-acuity acute care that would normally require emergency department referral or tertiary healthcare services
- management of AOD withdrawal, including providing replacement prescriptions for methadone
- provision of routine care of a stable chronic condition that can be, and usually is, attended to by the patient's usual GP or usual local outpatient department
- delivery of babies (unless it is unplanned, within the scope of practice of the GP and unavoidable in the situation)
- fracture management that requires imaging, plastering or specialist intervention unless unavoidable due to the situation and resources (eg plaster) are available
- management of patients with severe chronic conditions, including those that may sometimes be managed at home, but with particular specialised equipment (eg respiratory ventilator support at night); these patients should be relocated to an appropriate tertiary healthcare facility
- any service that is non-urgent and likely to be time consuming or use limited resources, impeding the care provided to other evacuees
- any service outside the scope or comfort of the attending GP

4.2.3 Documentation of clinical consultations at evacuation centres

As part of providing care in an evacuation centre, you will need to document clinical consultations.

It is important to note in the initial hours or days of an evacuation centre's operation, it may be challenging to take any record of clinical consultations. The benefit of providing emergency care to a patient may outweigh any risks from not documenting the encounter.

The way clinical care is documented will depend on the level of access to appropriate resources, including power and the internet. This may not be known until the evacuation centre is operational.

Consider the following options for documenting clinical consultations:

When electronic devices (eg smartphones, tablets or computers), internet and/or electricity are not available

- Use paper forms, which could be provided by the PHN. At least two copies are required (using carbon paper, a photocopier or other method). One copy would be kept by the consulting GP and included in their usual practice records and one copy would be provided to the patient to be passed on to their usual GP. It is important to maintain confidential storage of paper records at all times.

When internet, electricity and electronic devices are available

- Consultations can be recorded electronically on a local device. This may be on a template provided by the PHN or via a secure web form if no clinical information system software is available.
- If access to a clinical information system is available and a patient has a My Health Record, the consultation could be documented in the form of an Event Summary and uploaded to the patient's record. It is then not necessary to provide a hard copy to the patient, unless feasible and requested by them. If a patient does not have a My Health Record, a copy of the consultation notes should be provided to the patient via a printed or emailed copy.

It may sometimes be necessary to maintain a deidentified list with the details of each consultation for tracking and administrative purposes. Some

jurisdictions will require a copy to be provided to the local health authority (either as a complete record or as part of a summary list of patients consulted in the evacuation centre) for recording in the emergency medical system as a record of events. Any patient data is confidential and transfer to any other party needs to be carefully managed.

4.2.4 End-of-shift handover

You can use an end-of-shift patient list form to handover to incoming clinicians or provide a verbal handover briefing at the end of your shift.

4.3 Provider number considerations

Normally, practitioners need a provider number for each location they work from. Arrangements are in place to support GPs working in disaster-affected areas.

4.3.1 Provider number mobility for GPs in disaster-affected areas

In an emergency or disaster-affected area, it is more than likely that provider numbers will become transferable. This allows GPs registered at a location in a disaster-affected area (provided they are an unrestricted provider not working under a 3GA training placement and/or 19AB exemption) to work in evacuation centres or other locations if they are displaced from their practice.

Provider numbers become transferable once a disaster has been declared and can be used in other locations as required. If Services Australia does not implement temporary provider number mobility, GPs working at different locations will need to apply for a temporary provider number via the Services Australia website (see *Emergency provider numbers for GPs coming into disaster-affected areas*).

4.3.2 Emergency provider numbers for GPs coming into disaster-affected areas

Arrangements are in place to expedite access to provider numbers for GPs who are registered at locations outside of disaster-affected areas and who wish to support provision of care in a disaster-affected area (including at an evacuation centre or an existing medical practice).

Expedited process:

1. The medical practitioner completes, signs and emails the application form to provider.registration@servicesaustralia.gov.au.
2. The medical practitioner calls **132 150** and advises they will be working in a disaster-affected area and require their application to be processed as a priority.
3. A Services Australia service officer will locate their application and arrange for its urgent assessment. The service officer will also call the medical practitioner back to advise of the outcome/provider number.

4.4 Medicolegal coverage for GPs working in evacuation centres

GPs providing services in an evacuation centre will be doing so independent from the practice they typically work from, and the GP would therefore not be covered under the practice's policy. Provided GPs work within the limits of their skills and experience when providing services (paid or voluntary) in an evacuation centre, they should be covered by their individual medical indemnity insurance policy (subject to the terms, conditions and exclusions in the policies).

It is recommended all GPs providing services in an evacuation centre confirm the details of their medical indemnity insurance policy in advance, including coverage when considering providing services in an evacuation centre.

It is unlikely the general practice's insurance policy will cover the entire practice team while working outside of the practice. Non-GP staff may be covered by the evacuation centre's public liability insurance policy. Practice teams should seek advice from their medicolegal provider.

4.5 Requirements for paper scripts

It is more than likely electronic prescribing software will not be available in the evacuation centre and you will need to provide paper prescriptions. Ideally, there will be a supply of paper prescription pads with the ability to create multiple copies for record keeping purposes. Alternatively, GPs can choose to supply

their own prescription pads. Prescriptions are deemed valid if they are written on blank paper and include the following mandatory information:

- the prescriber's name, practice address (or address of evacuation centre) and prescriber number
- the patient's name, date of birth and address
- whether the prescription is for a Pharmaceutical Benefits Scheme (PBS) or Repatriation PBS (RPBS) medicine or private script
- the name, strength and form of the medicine
- the dose and instructions for use
- the quantity and number of repeats
- the prescriber's signature
- the date the prescription is written
- the patient's Medicare number and any entitlement details, including Commonwealth concession, pension or healthcare card details or veterans' entitlement number.

When a prescription is issued, the details listed above must be included in the clinical consultation notes.

4.6 Authority PBS prescriptions

For Authority Required (STREAMLINED) PBS prescriptions, prescribers need to add the four- or five-digit streamlined authority code from the schedule. These prescriptions do not require prior authority from Services Australia or the Department of Veterans Affairs.

For Authority Required PBS prescriptions, GP prescribers need to obtain an authority approval number by calling the Services Australia Telephone Authority Applications service on **1800 888 333** or online via Health Professional Online Services (HPOS) (further information available here). It should be noted that the Services Australia Telephone Authority Applications line experiences frequent delays and requires you to be on hold.

At times when prescribers call the hotline, they may hear an emergency message. In such cases, emergency provision arrangements are in place to prescribe an Authority Required item. These arrangements are outlined by Services Australia here.

All Authority Required PBS prescriptions must be written on an Authority PBS/RPBS prescription form, one item per form.

4.7 Emergency access to prescription medicines in disaster-affected areas

Federal and state/territory arrangements are in place to allow patients continued access to their essential PBS/RPBS medicines if they are affected by a natural disaster or emergency.

Although the following may vary between disasters, usual arrangements include:

- that in most states and territories, patients can access a three-day supply of most medicines without a prescription from a pharmacist
- 'owing prescriptions', whereby a pharmacist can dispense a medicine on confirmation from the prescribing GP, noting that the prescription must be received by the pharmacy within 7 days
- 'continued dispensing' of previously dispensed medicines where there is an immediate need for the medicine and the PBS prescriber is not contactable.

Further information on these arrangements is available on the PBS website.

4.8 Providing care via telehealth

Exemptions to the '12-month rule' in areas of natural disaster

Patients in disaster-affected areas are exempt from the existing relationship requirement ('12-month rule') for telehealth. This means patients do not need to have had a face-to-face consult with the treating GP or practice in the previous 12 months to access Medicare Benefit Schedule (MBS)-subsidised telehealth services.

A person is exempt from the '12-month rule' if, at the time of accessing a telehealth service, they are living in a local government area that is declared by a state or territory government to be a natural disaster area.

Because GPs in evacuation centres should only be providing care from centres for evacuees in the centre, all telehealth services required by non-evacuation centre patients should be provided by their usual GP or other service provider.

PHNs should consider promoting GP telehealth services provided by the PHN for cases where a person's regular GP is not accessible physically or via telehealth.

5. Further resources

The RACGP appreciates the disaster management space is constantly evolving and we will continue to refine and update this resource and any supporting materials as required to ensure GPs and their teams are supported to work in evacuation centres.

If you are interested in being involved in disaster preparation and response in your area, contact your local PHN as a starting point.

Other useful resources include:

- HealthPathways
- Phoenix Australia | Disaster mental health hub
- Australian Institute for Disaster Resilience | *Evacuation planning handbook*
- Australian Institute for Disaster Resilience | *Australian Disaster Resilience Glossary*
- *Australian Inter-service Incident Management System*
- Major Incident Medical Management Support
- RACGP | *Managing emergencies in general practice*
- RACGP | *Emergency planning and response factsheets*
- RACGP Providing care and support during disasters webpage
- Emergency Response Planning Tool (ERPT)

6. Support services for GPs

RACGP GP support program

The RACGP GP support program offers free, confidential, specialist support to GPs to help them cope with professional and personal stressors impacting their mental health and wellbeing.

The service is available to all RACGP members who are registered medical practitioners at locations across Australia, including in regional and remote areas.

Appointments for face-to-face or telephone counselling during business hours can be made by calling **1300 361 008** (office hours 8.30 am – 6.00 pm, Monday to Friday) and via the same number for 24-hour/seven-day-a-week crisis counselling.

DRS4DRS

DRS4DRS is an independent program providing free and confidential support and resources to doctors and medical students across Australia, by doctors.

Confidential telephone advice is available 24/7 for any doctor or medical student in Australia via each state/territory helpline and referral service.

State/territory	Phone
Australian Capital Territory	1300 374 377
New South Wales	02 9437 6552
Northern Territory	08 8366 0250
Queensland	07 3833 4352
South Australia	08 8366 0250
Tasmania	1300 374 377
Victoria	1300 330 543
Western Australia	08 9321 3098

TEN – The Essential Network for Health Professionals

The TEN online e-mental health hub, developed by the Black Dog Institute, connects frontline healthcare workers with services to help manage burnout and maintain good mental health.

CRANAplus Bush Support Services

CRANAplus Bush Support Services (telephone **1800 805 391**) provides a free and confidential 24-hour/seven-day-a-week telephone counselling service for rural and remote health practitioners. The service is staffed by psychologists, including two Aboriginal psychologists. CRANAplus membership is not required to access the service.

Community support services

Other available support services include the following:

Service	Phone
Lifeline	13 11 14
beyondblue	1300 224 636
Mensline	1300 789 978

7. Common terms and definitions

All-hazard approach	A consistent management approach to all types of emergencies and disasters and civil defence regardless of the hazard type[4] Hazards can include natural hazards, such as bushfires and floods, or man-made hazards, such transport incidents and terrorism
Combat agency	The agency identified as primarily responsible for controlling the response to a particular emergency
Command	The internal direction of the members and resources of an agency in the performance of the organisation's roles and tasks Command operates vertically within an organisation[4]
Disaster	A serious disruption to the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts The scale of the event is characterised by impacts that overwhelm local capacity and resources and requires external assistance Note, there are jurisdictional legislative variations[4]
Emergency	An event, actual or imminent, that endangers or threatens to endanger life, property or the environment and that requires a significant and coordinated response The scale of the event is such that can be managed within the capacity and resources of local authorities Note, there are jurisdictional legislative variations[4]
Evacuation centre	Physical site providing emergency shelter for people, and sometimes animals, displaced by a hazard. The aim is to provide basic human needs of safety, shelter, warmth, light, food, water and sanitation, and to address immediate healthcare needs. The full range of activities in any evacuation centre will vary according to local community context, including: the availability of local healthcare services, personnel and resources; the particular hazard and disaster(s); the length of operation of the evacuation centre; and political and socioeconomic issues Evacuation centres are usually run via government agencies but, on occasion, may be set up on an ad hoc basis by individuals and communities
Functional area coordinator	Refers to the nominated coordinator of a functional area whose role is to coordinate the provision of support and resources for an emergency response and initial recovery operations. This person has the authority to commit the resources of participating and supporting organisations within a functional area, if agreed to by those organisations
General practitioner (GP)	A medical doctor who has undertaken specialist training in general practice GPs are trained to treat a range of medical conditions, focusing on the whole person, ranging from emergency medicine through to chronic disease management. They provide ongoing clinical care in the local community across all phases of a disaster
General practice team	All people who work or provide care within the practice (eg GPs, receptionists, practice managers, nurses, allied health professionals)[5] In an evacuation centre setting, this practice team may consist of members from one general practice, or the team may consist of members from multiple different practices

Health services functional area coordinator (HSFAC)	The HSFAC is a local district or state-level coordinator of the functional area of health. Under emergency management arrangements, the local HSFAC is responsible for providing health support in a disaster to the LHD in support of the local emergency plan. There is a corresponding role at the state/territory level. Functional area coordinators also exist for other services, such as welfare The HSFAC would make the decision that GPs are needed to attend an evacuation centre, and the LHD would then liaise with the PHN
State/territory health services functional area supporting plan (HEALTHPLAN)	State/territory health services functional area supporting plans support the state/territory emergency management plans
Local health districts/local health networks (LHDs/ LHNs)	LHDs/LHNs are established to operate public hospital services and institutions and provide health services to communities within geographical areas or a defined patient population, as determined by the state or territory government In a disaster, LHD/LHNs are responsible for preparation and response to local disasters, including producing the LHD health services functional area supporting plan (HEALTHPLAN), where PHNs can be incorporated
Primary health networks (PHNs)	PHNs are independent organisations that are funded by the Australian Government Department of Health and Aged Care to coordinate primary healthcare in their region PHNs assess the needs of their community and commission and support health services so that people in their region can get coordinated healthcare where and when they need it In a disaster, PHNs form the linkage between the LHD and GPs and other primary care health professionals in disasters. They are the path to an integrated inclusion of GPs into disasters PHNs will usually have a disaster and management 'lead' role within their organisation. Note, this role is evolving and usually not well defined in emergency response plans
PHN disaster and emergency operations manager (or equivalent)	The PHN officer responsible for disaster management within the PHN
State/territory emergency management plans	All states and territories have their own emergency management plan, which is comprehensive plan detailing how the states/territories will plan for, respond to and recover from disasters and emergencies, as well as the roles and responsibilities of various agencies and organisations **NSW:** State emergency management plan (EMPLAN) **Qld:** Queensland emergency risk management framework **Vic:** State emergency management plan (SEMP) **WA:** State emergency management plan **SA:** State emergency management plan **Tas:** Tasmanian emergency management arrangements (TEMA) **NT:** Territory emergency plan (TEP) **ACT:** ACT emergency arrangements

8. Acronyms

AIIMS	Australian Inter-service Incident Management System
AUSMAT	Australian medical assistance teams
CDU	Counter Disaster Unit
DHM	Disaster health management
DM	Disaster manager
DVR	Disaster victim registration
EAP	Employee assistance program
EOI	Expression of interest
HSFAC	Health services functional area coordinator
LEMCs	Local emergency management committees
MIMMS	Major Incident Medical Management Support
MHFA	Mental health first aid
NBMLHD	Nepean Blue Mountains Local Health District
NSLHD	Northern Sydney Local Health District
PFA	Psychological first aid
PHN	Primary health network
SES	State emergency service
SOPs	Standard operating procedures
TIC	Trauma-informed care
WSFA	Welfare services functional area

9. References

1. Wood P. Local GPs who were sidelined at evacuation centres want to be added to bushfire plans. Australian Broadcasting Corporation, 2020. Available at https://www.abc.net.au/news/2020-01-07/bushfire-emergency-sees-local-doctors-call-for-addition-to-plan/11843974 [Accessed 11 April 2022].
2. NSW Government. State emergency management plan: evacuation management guidelines. NSW Government, 2014. Available at: https://www.opengov.nsw.gov.au/download/19473 [Accessed 23 January 2024].
3. Australian Institute for Disaster Resilience (AIDR). Evacuation planning handbook. AIDR, 2023. Available at https://knowledge.aidr.org.au/resources/handbook-evacuation-planning/ [Accessed 13 July 2023].
4. Australian Institute for Disaster Resilience (AIDR). Australian disaster resilience glossary. AIDR, n.d. Available at https://knowledge.aidr.org.au/glossary/?wordOfTheDayId=&keywords=evacuation centre&alpha=&page=1&results=50&order=AZ [Accessed 4 April 2023].
5. The Royal Australian College of General Practitioners (RACGP). RACGP Standards for general practices (5th edition) factsheet: definition of a clinical team for the purposes of accreditation. RACGP, n.d. Available at https://www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20standards/5th%20edition/Definition-of-general-practice-factsheet.pdf [Accessed 10 July 2023].

Disclaimer

The information set out in this publication is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular patients or circumstances. Nor is this publication exhaustive of the subject matter. It is no substitute for individual inquiry. Compliance with any recommendations does not guarantee discharge of the duty of care owed to patients. The RACGP and its employees and agents have no liability (including for negligence) to any users of the information contained in this publication.

© The Royal Australian College of General Practitioners 2022

This resource is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

ID-5749