

California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies

Long-Term Care Health Facilities Operational Tools

[Cover photograph to be inserted]

California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies

Foundational Knowledge

Volume I: Hospitals

Volume II: Government-Authorized Alternate Care Sites

Volume III: Payers

Volume IV: Community Care Clinics

Volume V: Long-Term Care Health Facilities

Volume VI: Licensed Healthcare Professionals (available 2010)

Hospitals Operational Tools Manual

Government-Authorized Alternate Care Sites Operational Tools Manual

Community Care Clinics Operational Tools Manual

Long-Term Care Health Facilities Operational Tools Manual

Licensed Healthcare Professionals Operational Tools Manual (available 2010)

Foundational Knowledge Training Guide

Hospitals Training Guide

Government-Authorized Alternate Care Sites Training Guide

Payers Training Guide

Community Care Clinics Training Guide

Long-Term Care Health Facilities Training Guide

Licensed Healthcare Professionals Training Guide (available 2010)

Reference Manual

Table of Contents

Introduction	3
Long-Term Care Health Facility Surge Preparedness Self-Assessment Tool	5
Sample Hazard Vulnerability Analysis	15
Business Continuity Plan Checklist.....	21
Sample Business Continuity Plan Template	24
Standard Operating Procedure Template for Equipment, Plant, and Utilities	31
Sample Memoranda of Understanding	33
Disaster Preparedness Plan Tool	50
Interfacility Transfer Report	55
Patient Transfer Summary.....	57
Patient Transfer Information Form.....	59
Emergency Evacuation Decision-Making Tool	61
Facility Damage Report (Limited Assessment)	64
Facility System Status Report.....	69
Security Assessment / Vulnerability Tool.....	77
Facility Security Plan Process Flow	79
Sample Lock-Down Policy and Procedure.....	81
Acceptance and Assignment of Augmented Staff during Healthcare Surge Process Flow.	85
Staffing Component Considerations for Development of Memoranda of Understanding....	87
List of Potential Community-Level Staffing Resources during Healthcare Surge	89
Sample Policy for Surge Capacity Staffing Emergency Plan	94
Staff Assignment Tracking Sheet	98
Skills and Abilities Assessment Tool.....	100
Skills and Abilities Checklist	102
Basic Plan for Augmenting Nurse Staffing during Healthcare Surge	106
Volunteer Application for Clinical Staff.....	108
Temporary Emergency Credentialing and/or Competency Assessment Process Flow	113
Credential Verification Log for Licensed Healthcare Professionals	115
Volunteer Application for Non-Clinical Staff	117
Non-Clinical Support Matrix	122
Considerations for Staff Support Provisions	124
Policy for Workforce Resilience	127
Sample Policy for Dependent Care.....	131
Sample Tracking Form for Dependent Care	135
Sample Family Emergency Plan.....	138

Sample Family Emergency Supply List 141

Pandemic Flu Planning Checklist 144

Family Emergency Health Information Sheet 147

Emergency Planning Checklist Recommendations 150

Pharmaceutical Storage Checklist 155

Detailed Supplies and Equipment List 157

Supplies and Equipment Storage Checklist 165

Staging Recommendations Checklist 168

Patient Tracking Forms 170

Paper-Based Intra-Facility Tracking Process 174

Patient Valuables Deposit Form 176

Patient Valuables Control Log 179

Sample Registration Log 181

Sample Paper-Based Face Sheet 183

Short-Form Medical Record 185

Workers' Compensation Process Flow 188

Sample Charge Capture Form 190

Advancing and Expediting Payment Table 192

Patient Transfer Table 194



The *Long-Term Care Health Facilities Operational Tools Manual* contains tools that assist long-term care health facilities in healthcare surge planning for management, delivery of care, and administrative functions. The manual was designed to provide single-source direct access to the tools included within *Volume V: Long-Term Care Health Facilities* of the *Standards and Guidelines Manual*.

The audience for these tools includes:

- Administrators
- Medical Directors
- Legal counsel
- Compliance staff
- Department managers and supervisors
- Nursing staff
- Allied health staff

Using the Operational Tools Manual:

- Standards and Guidelines Manual:** The tools are referenced by tool name throughout *Volume V: Long-Term Care Health Facilities*.
- Operational Tools Manual:** The tools in the *Long-Term Care Health Facilities Operational Tools Manual* are organized in order of presentation in *Volume V: Long-Term Care Health Facilities*.
- Each tool within the *Long-Term Care Health Facilities Operational Tools Manual* includes a cover page which contains:
 1. Tool name
 2. Description
 3. Instructions

California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies

Long-Term Care Health Facilities Operational Tools

[Cover photograph to be inserted]

Long-Term Care Health Facility Surge Preparedness Self-Assessment Tool



Description

California's long-term care health facilities constitute a diverse group of healthcare facilities. The level of preparedness and the particular surge planning needs of any given facility will vary across the types of licensed facilities and across individual facilities. The Long-Term Care Health Facility Surge Preparedness Self-Assessment Tool is designed to guide a long-term care health facility in assessing its current surge preparedness level and to assist long-term care health facility staff and leadership in identifying ways to advance their facility's surge preparedness. The level of surge preparedness in any long-term care health facility can be described by the following continuum:

Level 1:	"Starting to plan for Surge"	Basic internal emergency plan
Level 2:	"Surge plan in progress"	Surge awareness with limited planning with external stakeholders
Level 3:	"Integrated community-wide surge planning"	Internally and externally integrated community surge plan, exercised and annually updated

This continuum is mirrored in the Long-Term Care Health Facility Surge Preparedness Self-Assessment Tool, which can also be found in *Volume V: Long-Term Care Health Facilities* Section 1.6, "Surge Preparedness Self-Assessment Guide."

Instructions

Using the Long-Term Care Health Facility Surge Preparedness Self-Assessment Tool, identify your facility's current stage of surge planning efforts:

1. Starting to plan for surge (Level 1):

- Facility staff are not yet familiar with issues surrounding surge.
- Facility leadership and planning staff have not yet considered the impact of surge events in facility emergency operations plans.

- Facility leadership and planning staff want to update emergency operations plans to incorporate surge issues and reflect the potential regulatory flexibility during surge events.

2. Surge plan in progress (Level 2):

- Facility leadership and staff are aware of many topics surrounding healthcare surge and have begun to incorporate surge issues into emergency operations plans.
- Facility leadership and/or planning staff wish to develop a deeper understanding of surge issues or consider more advanced surge topics.
- Facility leadership and/or planning staff want to move the facility's surge planning efforts to a more advanced stage.

3. Integrated community-wide surge planning (Level 3):

- Facility emergency operations plans address detailed aspects of surge planning.
- Facility leadership and/or planning staff regularly update surge plans and routinely train staff on surge-related policies and procedures.
- Facility leadership and/or planning staff exercise facility surge plans and incorporate corrective actions into plan revisions.
- The long-term care health facility is fully integrated in community-wide planning efforts and works closely with community partners in both the public and private sectors.

After identifying the facility's current stage of surge planning preparedness, use the charts on the following pages to identify which specific chapters or tools can best assist you in advancing your level of surge planning from one stage to the next. Review all items across all categories to identify gaps in current surge plans.

Long-Term Care Health Facility Surge Preparedness Self-Assessment Tool

Starting to Plan for Surge		
Checkbox	Topics to consider when starting to plan for a healthcare surge:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
A. Is your organization aware of healthcare surge as an issue that should be addressed in your facility's emergency preparedness plan?		
<input type="checkbox"/>	Recognize surge planning as a necessary business activity	<i>Foundational Knowledge; Long-Term Care Health Facilities</i> pp. 12-16 and Training Materials
<input type="checkbox"/>	Create awareness of surge planning concepts and principles among staff and leadership	<i>Foundational Knowledge; Long-Term Care Health Facilities</i> Training Materials
B. Do you understand the basic principles and definitions underlying a surge response?		
<input type="checkbox"/>	Understand the shift from individual care to population-based care during a healthcare surge	<i>Foundational Knowledge</i> Section 8; <i>Long-Term Care Health Facilities</i> pp. 28-31 and Training Materials
<input type="checkbox"/>	Understand the California Standardized Emergency Management System (SEMS) and federal National Incident Management System (NIMS)	<i>Foundational Knowledge; Long-Term Care Health Facilities</i> pp. 32-35 and Training Materials
<input type="checkbox"/>	Understand how your facility will connect to SEMS/NIMS during an emergency	<i>Long-Term Care Health Facilities</i> pp. 35-36, Operational Tools, and Training Materials
C. Have you considered how a healthcare surge would impact your operations and incorporated a surge response into your existing policies and procedures?		
<input type="checkbox"/>	Develop a facility Hazard Vulnerability Analysis	<i>Long-Term Care Health Facilities</i> pp. 56-60 and Operational Tools
<input type="checkbox"/>	Consider potential needs for increased staffing during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 148-150, 164-169, and Operational Tools
<input type="checkbox"/>	Understand how to submit staffing requests through the SEMS/NIMS structure	<i>Long-Term Care Health Facilities</i> pp. 123-127 and Training Materials

Starting to Plan for Surge

Checkbox	Topics to consider when starting to plan for a healthcare surge:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
<input type="checkbox"/>	Develop a "just in time" training and orientation packet to provide to augmented staff during a healthcare surge	<i>Long-Term Care Health Facilities</i> p. 121 and Training Materials
<input type="checkbox"/>	Develop an employee health and safety plan as part of emergency preparedness planning	<i>Long-Term Care Health Facilities</i> pp. 171-172
<input type="checkbox"/>	Understand workers' rights and workforce protections in effect during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 170-172 and Training Materials
<input type="checkbox"/>	Understand Workers' Compensation applicability to facility employees and volunteers during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 240-241, Operational Tools, and Training Materials
<input type="checkbox"/>	Understand the impact of a healthcare surge on facility supply chains and resource usage	<i>Long-Term Care Health Facilities</i> pp. 187-188
<input type="checkbox"/>	Understand potential off-label use of supplies and pharmaceuticals to compensate for shortages during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 187, 196, and Training Materials
<input type="checkbox"/>	Consider a healthcare surge's impact on the long-term care health facility's ability to comply with public health reporting requirements	<i>Long-Term Care Health Facilities</i> pp. 225-232
<input type="checkbox"/>	Understand existing flexibility of licensing requirements during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 50-52 and Training Materials
<input type="checkbox"/>	Understand regulatory flexibility to accommodate facility expansion during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 75-76 and Training Materials
<input type="checkbox"/>	Understand existing statutory flexibility for scope of practice and liability protections	<i>Long-Term Care Health Facilities</i> pp. 133-135, and Training Materials
<input type="checkbox"/>	Understand existing flexibility of HIPAA requirements during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 232-233 and Training Materials
D. Have you considered how a surge response might impact your facility's finances?		
<input type="checkbox"/>	Understand the range of funding sources available to long-term care health facilities	<i>Long-Term Care Health Facilities</i> pp. 234-241 and Training Materials
<input type="checkbox"/>	Understand the importance of revenue stream maintenance during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp.

Starting to Plan for Surge		
Checkbox	Topics to consider when starting to plan for a healthcare surge:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
		235 and Training Materials
<input type="checkbox"/>	Understand the impact of patient transfer on insurance coverage and claims reimbursement during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 249-251, Operational Tools, and Training Materials
<input type="checkbox"/>	Understand health plans' responses to previous healthcare surge events	<i>Long-Term Care Health Facilities</i> pp. 254-265
<input type="checkbox"/>	Understand public assistance available through FEMA and the Small Business Administration	<i>Long-Term Care Health Facilities</i> pp. 252-253, Operational Tools, and Training Materials
<input type="checkbox"/>	Understand the importance of the recovery phase of an emergency management program	<i>Long-Term Care Health Facilities</i> pp. 71-74

Surge Plan in Progress		
Checkbox	Topics to consider when starting to plan for a healthcare surge:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
A. Have you developed policies and procedures that support an effective surge response?		
<input type="checkbox"/>	Consider the impact of facility policy (e.g., credentialing and/or competency assessment guidelines) on the efficiency of care during a healthcare surge	<i>Foundational Knowledge</i> Section 8; <i>Long-Term Care Health Facilities</i> pp. 155-156.
<input type="checkbox"/>	Develop a facility emergency operations plan	<i>Long-Term Care Health Facilities</i> pp. 32-45 and Training Materials
<input type="checkbox"/>	Incorporate Federal and state requirements into the facility emergency operations plan	<i>Long-Term Care Health Facilities</i> pp. 50-52 and Training Materials

Surge Plan in Progress

Checkbox	Topics to consider when starting to plan for a healthcare surge:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
<input type="checkbox"/>	Integrate Incident Command System (ICS, NH-ICS) principles into facility emergency plan	<i>Long-Term Care Health Facilities</i> pp. 39-42, Operational Tools, and Training Materials
<input type="checkbox"/>	Incorporate an infection control plan (including a pandemic influenza plan) into the facility emergency operations plan	<i>Long-Term Care Health Facilities</i> pp. 99-102 and Training Materials
<input type="checkbox"/>	Develop procedures to evaluate structural safety following an emergency	<i>Long-Term Care Health Facilities</i> pp. 86-91, Operational Tools, and Training Materials
<input type="checkbox"/>	Develop procedures to evaluate facility system functionality during an emergency	<i>Long-Term Care Health Facilities</i> pp. 91-99 and Operational Tools
<input type="checkbox"/>	Consider key criteria for creation of a government-authorized alternate care site by local and regional government	<i>Long-Term Care Health Facilities</i> pp. 45-47 and Training Materials
<input type="checkbox"/>	Develop a facility security plan to address increased traffic during healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 106-116, Operational Tools, and Training Materials
<input type="checkbox"/>	Develop written policies and procedures to direct triage services and facility use during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 75-76
<input type="checkbox"/>	Develop plans for paper-based patient tracking systems for use during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 209-214, Operational Tools, and Training Materials
<input type="checkbox"/>	Develop downtime procedures for patient registration and medical record documentation procedures	<i>Long-Term Care Health Facilities</i> pp. 219-224 and Operational Tools
<input type="checkbox"/>	Incorporate patient transfer scenarios (in and out) into emergency operations plan	<i>Long-Term Care Health Facilities</i> pp. 249-251 and

Surge Plan in Progress

Checkbox	Topics to consider when starting to plan for a healthcare surge:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
		Training Materials
<input type="checkbox"/>	Develop medical waste management plan	<i>Long-Term Care Health Facilities</i> pp. 102-104 and Training Materials
<input type="checkbox"/>	Develop mass fatality management plan	<i>Long-Term Care Health Facilities</i> pp. 104-106 and Training Materials
<input type="checkbox"/>	Develop policy on use of personal protective equipment	<i>Long-Term Care Health Facilities</i> pp. 196-199 and Training Materials
<input type="checkbox"/>	Develop facility fatality response plan for mass casualty events	<i>Long-Term Care Health Facilities</i> p. 106 and Training Materials
<input type="checkbox"/>	Develop policies and procedures to integrate augmented staff into facility operations during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 119-121, 131-132, 133-135, Operational Tools and Training Materials
<input type="checkbox"/>	Develop plan for equipment and supply storage	<i>Long-Term Care Health Facilities</i> pp. 201-203, Operational Tools, and Training Materials
<input type="checkbox"/>	Develop facility policies and procedures to comply with reporting, licensing, and privacy requirements during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 50-52, 225-233 and Training Materials
<input type="checkbox"/>	Develop policies and procedures to govern documentation and billing submission during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 245-246, Operational Tools, and Training Materials
<input type="checkbox"/>	Develop policies and procedures for patient valuables tracking during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 215-218 and

Surge Plan in Progress

Checkbox	Topics to consider when starting to plan for a healthcare surge:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
		Operational Tools
B. Are you prepared for an effective surge response?		
<input type="checkbox"/>	Execute Memoranda of Understanding with neighboring facilities or staffing services	<i>Long-Term Care Health Facilities</i> pp. 74, Operational Tools, and Training Materials
<input type="checkbox"/>	Identify facility space that can be converted for use as patient treatment areas	<i>Long-Term Care Health Facilities</i> pp. 45-47, 75
<input type="checkbox"/>	Make advance arrangements for support provisions for staff during a healthcare surge	<i>Long-Term Care Health Facilities</i> pp. 172-174, Operational Tools, and Training Materials
<input type="checkbox"/>	Acquire personal protective equipment for healthcare surge stockpile	<i>Long-Term Care Health Facilities</i> pp. 199-200, and Training Materials
<input type="checkbox"/>	Develop a plan to acquire pharmaceuticals during a surge event	<i>Long-Term Care Health Facilities</i> pp. 183-185, 206-207, Operational Tools, and Training Materials
<input type="checkbox"/>	Acquire supplies and equipment for a healthcare surge stockpile	<i>Long-Term Care Health Facilities</i> pp. 187-196, 206-207, and Operational Tools
C. Have you made plans for business recovery after the surge event?		
<input type="checkbox"/>	Develop business continuity plan	<i>Long-Term Care Health Facilities</i> pp. 61-69 and Operational Tools
<input type="checkbox"/>	Develop a checklist for recovery planning activities	<i>Long-Term Care Health Facilities</i> pp. 71-73
D. Have you fully trained your staff on surge response issues?		

Surge Plan in Progress		
Checkbox	Topics to consider when starting to plan for a healthcare surge:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
<input type="checkbox"/>	Conduct awareness training on Surge Planning principles for administrative and clinical staff	<i>Foundational Knowledge; Long-Term Care Health Facilities Training Materials</i>

Involved in Integrated Community-wide Surge Planning:		
Checkbox	Topics to consider when starting to plan for a healthcare surge:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
A. Is your surge plan updated and exercised?		
<input type="checkbox"/>	Organize training simulations for clinical staff to practice decision-making under conditions of limited resources and information	<i>Foundational Knowledge Section 8</i>
<input type="checkbox"/>	Revise emergency operations plan annually	<i>Long-Term Care Health Facilities pp. 32-45</i>
<input type="checkbox"/>	Run exercises of emergency operations plan and integrate corrective actions into plan revisions	<i>Long-Term Care Health Facilities pp. 32-45</i>
<input type="checkbox"/>	Incorporate surge planning into the long-term care health facility culture	<i>Long-Term Care Health Facilities pp. 32-45 and Training Materials</i>
B. Are your surge planning efforts coordinated with community-wide surge planning efforts?		
<input type="checkbox"/>	Integrate facility planning with community-wide preparedness planning	<i>Foundational Knowledge; Long-Term Care Health Facilities pp. 42-45</i>
<input type="checkbox"/>	Integrate isolation and decontamination planning with community-wide efforts	<i>Foundational Knowledge; Long-Term Care Health Facilities pp. 99-102</i>

Involved in Integrated Community-wide Surge Planning:

Checkbox	Topics to consider when starting to plan for a healthcare surge:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
<input type="checkbox"/>	Integrate facility fatality response plan with community-wide planning efforts	<i>Foundational Knowledge; Long-Term Care Health Facilities</i> pp. 105-106
<input type="checkbox"/>	Integrate workforce expansion plans with community-wide planning efforts	<i>Foundational Knowledge; Long-Term Care Health Facilities</i> pp. 117-118
<input type="checkbox"/>	Integrate procurement of supply, equipment, and pharmaceutical stockpiles with community-wide planning efforts	<i>Foundational Knowledge Long-Term Care Health Facilities</i> pp. 205-208
<input type="checkbox"/>	Work with health plan partners to revise contract language to streamline reimbursement policies and procedures during a healthcare surge	<i>Foundational Knowledge; Long-Term Care Health Facilities</i> pp. 234-244

Sample Hazard Vulnerability Analysis



Description

The Hazard Vulnerability Analysis is the needs assessment for an organization's emergency preparedness program. Conducting a Hazard Vulnerability Analysis involves identifying all hazards that may impact a facility and its surrounding community, assessing the probability of hazard occurrence and the consequence for the organization associated with each hazard, and analyzing the findings to create a prioritized comparison of hazard vulnerabilities. The vulnerability is related to both the impact on organizational function (staff, suppliers, operational systems, infrastructure, and the like) and the likely service demands created by the hazard impact.

Facilities can use this information to assess which hazards are most likely to impact their specific facility and to focus preparedness and mitigation activities on those hazards with the highest relative threat.

The Sample Hazard Vulnerability Analysis can also be found in *Volume V: Long-Term Care Health Facilities* Section 4.5, "Developing a Hazard Vulnerability Analysis."

Instructions

Within the analysis there are four categories used to calculate the potential impact of each hazard which include:

- Probability
- Magnitude
- Mitigation
- Risk

The first three categories use a point system, ranging from zero to three. For each hazard, a point estimate of zero (N/A) to three (high) is given. The risk associated with each hazard, or the relative threat of each hazard to the organization, can be calculated using the following equation: Risk = Probability X Severity, where Severity is Magnitude - Mitigation.

Issues to consider for **probability** include:

- Known risk
- Historical data
- Manufacturer/vendor statistics

Issues to consider for **magnitude** include:

- Human Impact:
 - Potential for staff death or injury
 - Potential for patient death or injury
- Property Impact:
 - Cost to replace
 - Cost to set up temporary replacement
 - Cost to repair
 - Time to recover
- Business Impact:
 - Business interruption
 - Employees unable to report to work
 - Customers unable to reach facility
 - Company in violation of contractual agreements
 - Imposition of fines and penalties or legal costs
 - Interruption of critical supplies
 - Interruption of product distribution
 - Reputation and public image
 - Financial impact/burden

Issues to consider for **mitigation** include:

- Preparedness
 - Status of current plans
 - Frequency of drills
 - Training status
 - Insurance
 - Availability of alternate sources for critical supplies/services
- Internal Response:
 - Time to marshal an on-scene response
 - Scope of response capability
 - Historical evaluation of response success
 - Types of supplies on hand
 - Volume of supplies on hand
 - Staff availability
 - Coordination with any medical office buildings (e.g., doctors' offices and clinics)
 - Availability of back-up systems
 - Internal resources ability to withstand disasters/survivability
 - Types of agreements with community agencies/drills
 - Coordination with proximal healthcare facilities
 - Coordination with treatment specific facilities
- External Response:
 - Coordination with local and state agencies
 - Community resource

Sample Hazard Vulnerability Analysis

Hazard Vulnerability Analysis - Natural Hazards

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	<i>Likelihood this will occur</i>	<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interruption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resources</i>	<i>Community/Mutual Aid staff and supplies</i>	<i>Relative threat*</i>
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Hurricane								0%
Tornado								0%
Severe Thunderstorm								0%
Snow Fall								0%
Blizzard								0%
Ice Storm								0%
Earthquake								0%
Tidal Wave								0%
Temperature Extremes								0%
Drought								0%
Flood, External								0%
Wild Fire								0%
Landslide								0%
Dam Inundation								0%
Volcano								0%
Epidemic								0%
AVERAGE SCORE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY
0.00 0.00 0.00

Hazard Vulnerability Analysis - Technologic Events

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	Possibility of death or injury	Physical losses and damages	Interruption of services	Preplanning	Time, effectiveness, resources	Community/Mutual Aid staff and supplies	Relative threat*
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Electrical Failure								0%
Generator Failure								0%
Transportation Failure								0%
Fuel Shortage								0%
Natural Gas Failure								0%
Water Failure								0%
Sewer Failure								0%
Steam Failure								0%
Fire Alarm Failure								0%
Communications Failure								0%
Medical Gas Failure								0%
Medical Vacuum Failure								0%
HVAC Failure								0%
Information Systems Failure								0%
Fire, Internal								0%
Flood, Internal								0%
Hazmat Exposure, Internal								0%
Supply Shortage								0%
Structural Damage								0%
AVERAGE SCORE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY
0.00 0.00 0.00

Hazard Vulnerability Analysis – Human-Related Events

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	<i>Likelihood this will occur</i>	<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interruption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resources</i>	<i>Community/Mutual Aid staff and supplies</i>	<i>Relative threat*</i>
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Mass Casualty Incident (trauma)								0%
Mass Casualty Incident (medical/infectious)								0%
Terrorism, Biological								0%
VIP Situation								0%
Infant Abduction								0%
Hostage Situation								0%
Civil Disturbance								0%
Labor Action								0%
Forensic Admission								0%
Bomb Threat								0%
AVERAGE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY
0.00 0.00 0.00

Hazard Vulnerability Analysis - Events Involving Hazardous Materials

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	<i>Likelihood this will occur</i>	<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interruption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resources</i>	<i>Community/ Mutual Aid staff and supplies</i>	<i>Relative threat*</i>
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Mass Casualty Hazmat Incident (<i>From historic events at your MC with >= 5 victims</i>)								0%
Small Casualty Hazmat Incident (<i>From historic events at your MC with < 5 victims</i>)								0%
Chemical Exposure, External								0%
Small-Medium Sized Internal Spill								0%
Large Internal Spill								0%
Terrorism, Chemical								0%
Radiologic Exposure, Internal								0%
Radiologic Exposure, External								0%
Terrorism, Radiologic								0%
AVERAGE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY
0.00 0.00 0.00



Description

Business continuity planning is an essential component of a comprehensive emergency management program. Business continuity planning involves formulating an action plan that enables an organization to perform its routine day-to-day operations in the event of an unforeseen incident. The overall purpose of business continuity planning is to:

- Identify the essential functions required to be prepared at all times.
- Resume vital functions within a specified time after the incident occurs.
- Return to normal operations as soon as practical and possible.
- Train staff and familiarize them with emergency operations.

The business continuity planning process should cover these main areas:

- **Business Planning:** Determines which aspects of the long-term care health facility's operations are most essential to its ability to provide care. This preliminary analysis phase assesses the potential risk and impact on facility operations, identifies recovery requirements, and lists alternative strategies.
- **Technical Support:** Determines the feasibility of the plan from a technical standpoint and ensures that different departments have the equipment and technical support to provide care.
- **Implementation:** Ensures that facility staff are able and willing to implement the plan.

A business continuity plan should consider various types of disasters, levels of casualties, and varied durations of interruption of operations. It should detail the actions to be taken based on the level of damage that the facility has sustained, rather than on an individual type of loss. The Business Continuity Plan Checklist summarizes areas to consider when developing a business continuity plan.

The Business Continuity Plan Checklist can also be found in *Volume V: Long-Term Care Health Facilities* Section 4.6, "Business Continuity and Business Recovery Planning."

Instructions

Review the following checklist when developing or evaluating a long-term care health facility's business continuity plan.

Business Continuity Plan Checklist

Sample Business Continuity Plan Checklist: Areas to Consider When Developing a Business Continuity Plan	
<input type="checkbox"/>	Identify essential functions within facility that must be maintained during an emergency. These essential functions will drive the business continuity plan.
<input type="checkbox"/>	Clearly define individual responsibilities, including who has the authority to initiate the business continuity plan procedures.
<input type="checkbox"/>	Identify staff that live in close proximity to the long-term care health facility and identify any staff members that may experience difficulty reaching the facility during an emergency.
<input type="checkbox"/>	Provide instruction on when, where, and how to use the backup site including, but not limited to:
<input type="checkbox"/>	<ul style="list-style-type: none"> • Procedures for establishing information systems processing in an alternate location, including arrangements for office space
<input type="checkbox"/>	<ul style="list-style-type: none"> • Replacement equipment
<input type="checkbox"/>	<ul style="list-style-type: none"> • Telecommunications
<input type="checkbox"/>	<ul style="list-style-type: none"> • Supplies
<input type="checkbox"/>	<ul style="list-style-type: none"> • Transportation
<input type="checkbox"/>	<ul style="list-style-type: none"> • Housing
<input type="checkbox"/>	<ul style="list-style-type: none"> • Food and water
<input type="checkbox"/>	Issue notification to personnel at the selected backup site.
<input type="checkbox"/>	Maintain a list of contacts with work, home, cellular phone, and pager numbers.
<input type="checkbox"/>	Identify vital system software documentation at the backup site.
<input type="checkbox"/>	Develop procedures for retrieving and restoring medical record information and data from off-site storage.
<input type="checkbox"/>	Maintain a list of vendor contact personnel.

**Sample Business Continuity Plan Checklist:
Areas to Consider When Developing a Business Continuity Plan**

<input type="checkbox"/>	Identify the site of remote storage and related information.
<input type="checkbox"/>	Maintain a current listing of hardware and software.
<input type="checkbox"/>	Compile backup equipment requirements (contracts, compatibility, timeliness, availability).
<input type="checkbox"/>	Establish interim procedures to be followed until systems are restored and procedures for catching up when systems are back in operation.
<input type="checkbox"/>	Evaluate maximum outage tolerable for each major system and develop a restoration priority listing indicating the order in which to restore systems.
<input type="checkbox"/>	Verify that a copy of the business continuity plan is stored off-site.

DRAFT



Description

Business continuity planning involves formulating an action plan that enables an organization to perform its routine day-to-day operations in the event of an unforeseen incident. The Sample Business Continuity Plan Template may assist a long-term care health facility in building a business continuity plan. The template contains key elements that will enable an organization to perform its routine day-to-day operations in the event of an unforeseen incident. The elements include critical personnel and entity contact information, roles and responsibilities, critical vendor contact information, critical recovery functions, minimal resource requirements for the functions, dependent activities/entities of the function, vital records information, site requirements for business relocation, emergency notification protocols, security strategies, designated plan coordinator and review date.

The Sample Business Continuity Plan Template can also be found in *Volume V: Long-Term Care Health Facilities* Section 4.6, "Business Continuity and Business Recovery Planning."

Instructions

Business continuity planners should follow the Sample Business Continuity Plan Template and collect the elements as instructed below. The elements include critical personnel and entity contact information, roles and responsibilities, vendor contact information, critical recovery functions, minimal resource requirements for the functions, dependent activities/entities of the function, vital records information, site requirements for business relocation, emergency notification protocols, security strategies, designated plan coordinator and review date.

Sample Business Continuity Plan Template

Section 1 – Critical Contact Information: Identify personnel, entities*, and vendors that are critical to maintaining business operations following an emergency.

Critical Personnel and Entities

Entities could include governmental agencies and members of the long-term care health facility's Incident Command structure.

Position	Name	Work Phone	Cell Phone	Home Phone	Personal e-mail	Site and Alternate Site Responsibilities
Critical Position #1:						
Alternate 1:						
Alternate 2:						
Alternate 3:						
Critical Position #2:						
Alternate 1:						
Alternate 2:						
Alternate 3:						
Critical Position #3:						
Alternate 1:						
Alternate 2:						
Alternate 3:						
Critical Position #4:						
Alternate 1:						
Alternate 2:						
Alternate 3:						

Critical Vendors

The business continuity plan should identify at least one contact for each vendor and provide both a work phone number and a cell phone number. If possible, contact information should be documented for at least two contacts per vendor. The service or supply provided by the vendor should also be documented.

Vendor	Location	Contact	Work Phone	Cell Phone
Vendor Name				
Alternate Contact:				
Vendor service: Comments:				
Vendor Name				
Alternate Contact:				
Vendor service: Comments:				
Vendor Name				
Alternate Contact:				
Vendor service: Comments:				
Vendor Name				
Alternate Contact:				
Vendor service: Comments:				

Section 2 – Essential Functions and Recovery Objectives: Identify the essential functions that are critical to business continuity and the corresponding rationale for selecting these functions. Recovery objectives outline why continuity of these functions will promote overall business continuity following a catastrophic event.

Essential Functions	Recovery Objectives
Function 1	
Function 2	
Function 3	
Function 4	
Function 5	
Function 6	
Function 7	

Section 3 – Minimum Resource Requirements: Identify the minimum resources needed to complete the critical functions identified above.

Minimum Resource Requirements		
	Minimum	Full Function
Function 1		
• Space Requirements		
• Equipment Requirements		
• Supply Requirements		
• Essential Services Requirements		
• Personnel Requirements		
Function 2		
• Space Requirements		
• Equipment Requirements		
• Supply Requirements		
• Essential Services Requirements		
• Personnel Requirements		

Minimum Resource Requirements		
	Minimum	Full Function
Function 3		
• Space Requirements		
• Equipment Requirements		
• Supply Requirements		
• Essential Services Requirements		
• Personnel Requirements		
Function 4		
• Space Requirements		
• Equipment Requirements		
• Supply Requirements		
• Essential Services Requirements		
• Personnel Requirements		
Function 5		
• Space Requirements		
• Equipment Requirements		
• Supply Requirements		
• Essential Services Requirements		
• Personnel Requirements		
Function 6		
• Space Requirements		
• Equipment Requirements		
• Supply Requirements		
• Essential Services Requirements		
• Personnel Requirements		
Function 7		
• Space Requirements		
• Equipment Requirements		

Minimum Resource Requirements		
	Minimum	Full Function
• Supply Requirements		
• Essential Services Requirements		
• Personnel Requirements		

Section 4 – All Agencies, Divisions, and Vendors upon which Function Is Dependent:
Identify the activities upon which the above functions are dependent for completion.

Essential Function	Dependent Activity/Entity	Business Continuity Plan (BCP) in place?	Comments
Function 1		Y/N	
Function 2		Y/N	
Function 3		Y/N	
Function 4		Y/N	
Function 5		Y/N	
Function 6		Y/N	
Function 7		Y/N	

Section 5 – Vital Records: Identify the type or category of vital record (e.g., electronic medical record, financial record), a brief description of record, and the location where the record is backed-up or stored for emergencies.

Name/Number	Description	Location

Section 6 – Alternate Site for Function: Identify alternate site(s) for essential long-term care health facility function(s). The number and location of alternate sites will depend on the facility and the emergency. Some functions can be moved to other locations within the facility and others may need to be moved to an entirely new facility.

Functions	Alternate Site
Function 1	
Function 2	
Function 3	
Function 4	
Function 5	
Function 6	
Function 7	

Section 7 – Designated Plan Coordinator: Identify a Business Continuity Plan Coordinator. This may be someone from the facility's Incident Command or a specifically designated Business Continuity Plan Coordinator.

Name	Work Phone	Pager or Cell Phone #	Home Phone	Personal Email
Alternates:				

Section 8 – Review Date: Record the last date when the business continuity plan was reviewed. The plan should be reviewed periodically based on staff and vendor turnover and other changes within the environment.

Source: Adapted from Enterprise Business Continuity Planning, Department of Administrative Services, State of Oregon.

Standard Operating Procedure Template for Equipment, Plant, and Utilities



Description

Standard operating procedures to maintain essential equipment, infrastructure, and utilities should be developed as part of a long-term care health facility's business continuity planning. It is essential to involve facility engineering personnel in the planning process in order to ensure a safe environment is maintained for both personnel and patients. Areas within the expertise of engineering that must be included in the planning process include:

- Alarm systems
- Electrical backup power
- Elevators and other vertical transport
- Heating
- Ventilation and air conditioning
- Room/hood exhaust
- Steam distribution
- Internal transport system
- Medical gases system
- Roads and grounds
- Waste and debris
- Water delivery/portability

Development of procedures in these specific areas is critical to the recovery of business operations. The Standard Operating Procedures Template for Equipment, Plant, and Utilities can be used in business continuity planning for equipment, plant, and utilities.

The Standard Operating Procedures Template for Equipment, Plant, and Utilities can also be found in *Volume V: Long-Term Care Health Facilities* Section 4.6.1, "Development of Standard Operating Procedures for Maintaining Infrastructure during a Healthcare Surge."

Instructions

Review the Standard Operating Procedures Template for Equipment, Plant, and Utilities and consider the content during the development of patient management planning processes.

Standard Operating Procedure Template for Equipment, Plant, and Utilities

1. Description of the threat or catastrophic emergency
2. Impact on mission-critical systems
3. Operating units and key personnel with responsibility to manage this threat/catastrophic emergency
4. Mitigation and preparedness activities for the threat/catastrophic emergency
 - a. Hazard reduction strategies and resource issues
 - b. Preparedness strategies and resource issues
5. Response to and recovery from the threat/catastrophic emergency
 - a. Hazard control strategies
 - b. Hazard monitoring strategies
 - c. Recovery strategies
6. Internal and external notification procedures by entity type
7. Specialized staff training
8. Review date

Source: Veterans Health Administration Center for Engineering & Occupational Safety and Health in its Emergency Management Program Guidebook, 2002, provide extensive guidance around hazardous waste management (<http://www1.va.gov/emshq/page.cfm?pg=114>).



Description

Memoranda of Understanding should be considered as one option by which long-term care health facilities can address business continuity and business recovery issues during the surge planning process. Memoranda of Understanding can be developed with nearby long-term care health facilities, other neighboring healthcare providers, external vendors, or other community partners. Memoranda of Understanding can also be established at the community level so that all community participants establish in advance the ways they will assist each other during a healthcare surge or other emergency.

The following Sample Memoranda of Understanding is referenced in *Volume V: Long-Term Care Health Facilities* Section 4.6.3, "Memoranda of Understanding for Business Continuity and Business Recovery," Section 5.2.1, "Transferring Patients to Other Healthcare Facilities," and Section 10.6 "Memoranda of Understanding with Vendors and Suppliers."

Instructions

Use one or both of the Sample Memoranda of Understanding to develop a community-wide Memoranda of Understanding, in conjunction with other healthcare providers within the county.

Sample Memoranda of Understanding (A)

[California County] Healthcare Coalition Mutual Aid Memorandum of Understanding for Healthcare Facilities

I. Introduction and Background

The healthcare providers located within [California County] are all susceptible to a disaster that could exceed the resources of any one individual organization. Disasters can result from incidents generating an overwhelming number of patients, or smaller groups of patients whose specialized medical requirements exceed the resources of the impacted provider (e.g., hazmat injuries, pulmonary, trauma surgery), or from incidents such as building or plant problems, terrorist acts, bomb threats, etc., that impact an organization's operational capability. The scope of this plan encompasses participating healthcare providers located within [California County]. Attachment A reflects the list of healthcare providers who were invited to participate in this Memoranda of Understanding.

II. Purpose of Mutual Aid Memorandum of Understanding

The mutual aid concept is well established and is considered standard in most emergency response disciplines, including fire services, emergency medical services (EMS), and law enforcement. The purpose of this mutual aid agreement is to assist healthcare providers achieve an effective level of disaster medical preparedness by authorizing the exchange of personnel, pharmaceuticals, supplies, equipment, and information. In addition, healthcare providers participating in this agreement are committed to assisting each other with transfer and receipt of patients in the event a facility is rendered incapable of patient care and must relocate its patients.

This Mutual Aid Memorandum of Understanding (MOU) is a voluntary agreement between the participating [California County] healthcare providers. This document only addresses the relationship between and among healthcare providers and is intended to augment, not replace, each organization's disaster plan. Moreover, this document does not replace but rather supplements the National Incident Management System (NIMS) or the Standardized Emergency Management System (SEMS), which, has set up standardized organizational structures, including the Incident Command System (ICS).

By signing this Memorandum of Understanding, healthcare providers are evidencing their intent to abide by the terms of the MOU as described below. The terms of this MOU are to be incorporated into each healthcare organization's disaster plan.

III. Definition of Terms

Command Center:	An area established within a healthcare facility during an emergency that is the facility's primary source of administrative authority and decision-making
Donor Healthcare Facility:	The healthcare provider that provides personnel, pharmaceuticals, supplies, equipment, and/or information to the Emergency Operations Center (EOC) or a facility experiencing a medical disaster
Impacted Healthcare Facility:	A healthcare provider that has exceeded its capability to manage a disaster with its own internal resources. This is also referred to as the recipient healthcare facility when pharmaceuticals, supplies, equipment, and/or information are requested or as the patient transferring healthcare facility when the evacuation of patients is required.
Medical Disaster:	An event that a provider cannot appropriately resolve solely by using its own resources and may involve temporarily utilizing medical and support personnel, pharmaceuticals, supplies, or equipment, and/or information from another facility. This type of event may also necessitate the need for transport of patients to other participating healthcare facilities.
Emergency Operations Center (EOC):	A communication center at the local, Operational Area, or regional response level with network capabilities allowing for the immediate determination of available healthcare facility resources at the time of a disaster. The EOC is operational 24-hours a day and requires daily maintenance. The EOC may assume a command/control function during a disaster. Logistics coordinated by the EOC include identifying the number and specific location where personnel, pharmaceuticals, supplies, equipment, patients, and/or information should be sent, how to enter the security perimeter; estimated time interval between arrival and estimated return date of borrowed supplies, etc.
Patient Accepting Healthcare Facility:	The healthcare provider that accepts transferred patients from a facility experiencing a medical disaster. When patients are evacuated, the receiving facility is referred to as the patient accepting healthcare facility.
Patient Transferring Healthcare Facility:	The healthcare facility that evacuates patients to a patient accepting facility in response to a medical disaster.

Recipient Healthcare Facility:	The healthcare facility where the disaster occurred and has requested personnel or materials from another provider. Also referred to as the patient-transferring healthcare facility when involving evacuating and/or transferring patients during a medical Disaster
Emergency Preparedness Committee:	A committee designed to develop and implement preparedness plans and response protocols for disaster management. Representatives on this committee include, but are not limited to, Emergency Medical/Ambulance Services, Fire Response Services, Law Enforcement, Healthcare Facilities, State and county Emergency Management and Health Departments, Medi-flight, etc.
Regional Trauma Advisory Board:	A committee designed to address and respond to concerns related to the trauma management system within a defined geographic region.
MHOAC:	Medical/Health Operational Area Coordinator (MHOAC). An individual jointly appointed by the Local Health Officer and EMS Director who is responsible in the event of a disaster or major incident where mutual aid is requested, for obtaining and coordinating services and allocation of resources within the Operational Area (county).
Healthcare Facility Liaison:	An individual located at a healthcare facility designated by the healthcare facility's Incident Commander to communicate with the MHOAC.
Disaster Control Facility:	A community communication and information center that has <i>communication</i> capabilities allowing for the immediate determination of available healthcare facility resources at the time of a disaster. The <i>Control Facility</i> is operational 24 hours a day.
Medical Reserve Corps (MRC):	A group of credentialed volunteers which include medical and public health professionals such as physicians, nurses, pharmacists, emergency medical technicians, dentists, veterinarians, epidemiologists, and infectious disease specialists.
EMSystem:	An internet-based system used by healthcare facilities to report facility status and bed availability in real-time.
Healthcare Coalition Executive Council (HCEC):	The Executive Council is a policy group comprised of representatives from hospitals, clinics, long-term care, mental health, EMS, OES, and public health to evaluate and approve processes related to mutual aid not specified within this document.

IV. General Terms of this Agreement

1. Agreement to Share Resources: To the best of their ability, each healthcare provider participating in this MOU agrees to share the following resources during a disaster:

- a. Personnel
- b. Equipment
- c. Supplies
- d. Pharmaceuticals
- e. Information

Reimbursement: The default process for reimbursement of utilized resources is located in Attachment B. However, during any disaster where reimbursement is an issue, the HCEC reserves the right to call together a special meeting of the HCEC Policy Group to establish a mutually agreed upon modification to the current process and fee schedule.

2. Standardized Communication and Coordination Systems: It is strongly encouraged that each healthcare provider participating in this MOU agree to implement and adopt the following systems:

- a. An incident command and control system consistent with the National Incident Management System and the California Standardized Emergency Management System
- b. A universal emergency code system consistent for all healthcare facilities in [California County]. The emergency code system currently in place at most facilities consists of the following:

- i. Code Red – Fire
- ii. Code Blue – Medical Emergency / Cardiac Respiratory Arrest
- iii. Code Yellow – Bomb Threat
- iv. Code Orange – Hazardous Material Spill/Release
- v. Code Pink – Infant Abduction
- vi. Code Purple – Child Abduction
- vii. Code Triage – Internal/External Disaster
- viii. Code Silver – Person with a Weapon or hostage situation
- ix. Code Grey – Combative Person
- x. Code White – Medical Emergency Pediatrics

- c. A facility may choose to implement other codes in addition to the universal codes

- d. Standardized triage tags and documentation packs
 - e. Utilization of standard communication systems such as EMSsystem, satellite phones, ham radios, Med-Net, and the HEAR system. Through the Emergency Preparedness Committee, facilities will collaborate on communication system priorities that ensure dedicated, secure, and reliable methods to communicate with the EOC and other healthcare facilities
3. Implementation of Mutual Aid Memorandum of Understanding: Only the Incident Commander at each healthcare facility has the authority to begin implementing the procedures as outlined in this MOU. This is achieved by contacting the MHOAC. The EOC may be activated through the direction and authority of [California County] Office of Emergency Services.
 4. Hospital Command Center: The facility's command center is responsible for informing the MHOAC of its situation and of any needs or available resources. The Healthcare Facility's Incident Commander or designee is responsible for requesting personnel, pharmaceuticals, supplies, equipment, information or authorizing the evacuation of patients. Via the EOC, the healthcare facility's Incident Commander or designee will coordinate, both internally and with the donor/patient-accepting healthcare facility, all of the logistics involved in implementing this Mutual Aid MOU.
 5. Exercise Coordination: Each healthcare provider will participate in drills that include communicating to the MHOAC a set of data elements or indicators describing the healthcare facility's resource capacity. The MHOAC will serve as an information center for recording and disseminating the type and amount of available resources at each healthcare facility. During a disaster drill or disaster, each healthcare facility will report to the MHOAC the current status of its indicators. By signing this agreement, healthcare facilities agree to participate in two (2) community-wide emergency response drills per year.
 6. Public Relations: Each healthcare provider is responsible for developing and coordinating with other facilities and relevant organizations its media response to the disaster. Healthcare facilities are encouraged to develop and coordinate the outline of their response prior to any disaster.
 7. Education & Training: Each healthcare provider is responsible for disseminating the information regarding this MOU to relevant facility personnel.
 8. Alternate Care Site: Each healthcare provider agrees to assist in the operations of alternate care sites as a regional medical response.

9. Daily Collection of Data: Each healthcare provider agrees to provide key indicators to a web-based communication system that is managed by [California Region]. Each facility also agrees, if requested, to participate in daily and quarterly reporting as determined by needs of the community and state.
 10. Divert Status: The DCF will not place any healthcare facilities on divert because of information gathered during a disaster. Diversion of ambulance patients will continue to be governed by the current EMS policy and procedure for System Saturation.
 11. Patient Information: During disasters each healthcare facility agrees to provide relevant patient information as necessary to assist with the public health function response.
- V. Standard Operating Procedures Governing Medical Operations, the Loaning of Personnel, Transfer of Pharmaceuticals, Supplies or Equipment, or the Evacuation of Patients.

NOTE: This agreement recognizes there are pre-existing informal assistance and/or sharing networks among healthcare facilities which may supersede this MOU. The process below is designed to augment current processes, not necessarily to replace them.

Medical Operations/Loaning Personnel

1. Communication of Request: The request for the transfer of personnel initially can be made verbally to the MHOAC. The request, however, must be followed-up with written or electronic documentation. The recipient healthcare facility will identify to the MHOAC the following:
 - a. The type, by job function, and number of needed personnel
 - b. An estimate of how quickly the request should be met
 - c. The location and contact person to whom personnel should report
 - d. An estimate of how long the personnel will be needed
 - e. The entry point for donated personnel at the recipient hospital

The MHOAC will maintain a database of credentialed personnel, as well as a map of each healthcare facility with designated parking and entry areas. Credentials will be provided to the recipient healthcare facility for their records at the conclusion of the disaster response, or the recipient hospital may contact the MHOAC at anytime to verbally verify the credentials of a MRC responder.

2. Documentation: The arriving personnel will be required to present their donor healthcare facility's picture identification and/or MRC badges at the site designated by the recipient healthcare facility's command center. The recipient healthcare facility will be responsible for the following:
 - a. Meeting the arriving personnel (usually by the recipient healthcare facility's security department or designated entrance)
 - b. Confirming the donated personnel's picture ID badge
 - c. Providing additional identification (e.g., "visiting personnel" badge, to the arriving personnel)

The recipient healthcare facility will accept the professional credentialing determination of the donor healthcare facility (via MRC) but only for those services for which the personnel are credentialed at the donor healthcare facility. The recipient healthcare facility will notify the MHOAC of personnel arrival.

3. Demobilization Procedures: The recipient healthcare facility will provide and coordinate any necessary demobilization procedures and post-event stress debriefing. The recipient healthcare facility is responsible for providing the loaned personnel assistance with transportation necessary for their return to the donor healthcare facility.

Transfer of Pharmaceuticals, Supplies, or Equipment

1. Communication of Requests: The request for the transfer of pharmaceuticals, supplies, or equipment initially can be made verbally to the MHOAC. The request, however, must be followed-up with a written or electronic communication. The recipient healthcare facility will identify to the MHOAC the following:
 - a. The quantity and type of needed item
 - b. Location to which the supplies should be delivered

The donor healthcare facility will identify if or to what extent the request can be honored and how long it will take them to fulfill the request. Since response time is a central component during a disaster response, decision and implementation should occur quickly.

2. Documentation: The recipient healthcare facility's security office or designee will document and confirm the receipt of the material resources. The documentation will detail the following:

- a. The items involved
- b. The condition of the equipment prior to the loan (if applicable)
- c. The responsible parties for the received material

The donor healthcare facility is responsible for tracking the borrowed inventory through its standard requisition forms.

3. Transporting of pharmaceuticals, supplies, or equipment: The recipient healthcare facility is responsible for coordinating the transporting of materials both to and from the donor facility. This coordination may involve government and/or private organizations, and the donor facility may also offer transport. The recipient healthcare facility will notify the MHOAC of arrival of donated equipment or supplies.

Transfer/Evacuation of Patients

1. This MOU is entered into by and between the healthcare facilities in [California County] to set forth guidelines under which each facility will transfer or accept patients in the event of a partial or total facility evacuation in an emergency situation. Evacuation of any of the participating healthcare facilities would occur only in extreme emergencies, which would render the participating healthcare facility or a portion of the participating healthcare facility unusable for patient care. Examples of such situations requiring evacuation and transfer of patients to other healthcare facilities would include but not be limited to a major fire, building damage, environmental hazard, etc.
2. Agreements:
 - a. Subject to medical capability and space availability, each healthcare facility agrees to accept a transferring facility's emergent patients in the event of an emergency evacuation.
 - b. The receiving healthcare facility will provide applicable medically necessary healthcare services as may be required by patients transported to the receiving healthcare facility. Each of the healthcare facilities will follow its standard procedures for admission of patients and its standard protocols for providing care to patients.
 - c. The transferring healthcare facility will be responsible for arranging for transportation of any evacuated patients to the receiving healthcare facility. The transferring healthcare facility is

- responsible for arranging transportation of patients from the receiving facility back to the originating facility.
- d. The transferring healthcare facility will provide the receiving healthcare facility with as much advance notice as possible of any patients requiring evacuation to a receiving healthcare facility by contacting the DCF and activating the MHOAC. The MHOAC, in turn, will notify the Regional Disaster Medical Health Specialist (RDMHS).
 - e. The transferring healthcare facility will send to the receiving healthcare facility at the time of transfer such identifying administrative medical and related information as may be necessary for the proper care of the transferred patient.
 - f. The transferring healthcare facility will send with each patient at the time of transfer (or as soon thereafter as possible) all of the patient's personal effects and any information relevant thereto. In the event that the personal effects cannot be sent with an alert and competent patient, the transferring healthcare facility may elect to secure such personal effects until the crisis is over. The transferring healthcare facility will remain responsible for such items until receipt thereof is acknowledged by the receiving healthcare facility.
 - g. This MOU does not require a transferring healthcare facility to transfer patients to any healthcare facility. The transferring healthcare facility may transfer patients to facilities other than healthcare facilities.
 - h. The receiving healthcare facility may discharge patients in accordance with its standard processes.
 - i. The transferring healthcare facility agrees to readmit patients when capability and capacity are restored at the transferring healthcare facility. The receiving healthcare facility agrees to transfer the patients back.

VI. Term and Termination

As to each participating healthcare facility, the terms of this Agreement will commence on the date this Agreement is approved by the HCEC, and will continue in full force and effect for five (5) years of date of last signatory unless terminated or modified by mutual written agreement by all participating healthcare facilities. An individual facility may elect to terminate its participation in this MOU by providing thirty (30) days written notice to other participating healthcare facilities of its intent to terminate.

Sample Memoranda of Understanding (B)

Recitals:

This Memorandum of Understanding (MOU) is a voluntary agreement among the [California County] Skilled Nursing and/or Long Term Care Facilities for the purpose of providing mutual aid care and treatment of residents at the time of a disaster. Nothing in this MOU is intended to create any legal relationship among the organizations other than that of independent entities agreeing with each other solely for the purpose of assisting each other during disasters or other critical situations.

This MOU is not a legally binding contract but rather a voluntary agreement. It signifies the belief and commitment of the undersigned facilities that as a result of any emergency or disaster, regardless of cause, which exceed the effective response capabilities of the impacted facility, the affected participant may request assistance from another participant as is more generally set forth herein.

This document is intended to *augment*, not replace, each facility's disaster plan. No participant shall be *required* to provide medical supplies, equipment, services or personnel to another facility that are *needed to meet its own internal needs*. The document supplements the rules and procedures governing interaction with other organizations during a disaster. The disaster may be an "external" or "internal" event for one or more facilities and assumes that each affected facility's emergency management plan has been fully implemented. The terms of this MOU are to be incorporated into the facility's emergency management plan.

By signing this MOU, each facility is evidencing its intent to abide by the terms of the MOU in the event of a disaster. The facilities participating in this MOU agreement of mutual-aid concur to make a reasonable attempt to comply with the following:

(Failure to comply with the MOU does not give rise to legal liability or cause of action.)

1. Evacuation/Surge of an Undersigned Facility:

- 1.1 If a disaster affects an undersigned facility(s) resulting in partial or complete facility evacuation, the other undersigned facilities agree to participate in the distribution of residents from the affected facility.
- 1.2 In the event of an evacuation, the evacuating facility will contact their designated area coordinator, who will in turn contact the Emergency Medical Services Disaster Operations Center (EMSDOC) Medical Operations Center (MOC), per established protocol, policy, and/or guidelines.

- 1.3 Request for the transfer of residents; The request for the transfer of residents initially can be made verbally. The request however must be followed up with a written document of communication. The transferring facility, to the extent possible in an emergency situation, will provide to the accepting facility the following:
- The number of residents needing to be transferred
 - The general nature of their illness or condition
 - Resident medications and/or specialized equipment needed
 - Any type of specialized services required
- 1.4 Documentation: The transferring facility, to the extent possible in an emergency situation is responsible for providing the receiving facility with:
- The resident's medical record and/or accepted completed report form (including emergency/family contact information and physician contact information)
 - Insurance information
 - Other resident information necessary for the care of the resident
 - Resident medications and medication schedule with times of last meds given
 - Specialized equipment necessary for the care of the resident
- 1.5 Transfer of Residents: The transferring facility is responsible for tracking the destination of all residents transferred out. The transferring facility is responsible for notifying both the resident's family or guardian and the resident's attending or personal physician of the situation. In the event a resident is routed to a different facility than originally assigned, the final receiving facility will notify the original transferring facility of the change. This will help ensure proper resident tracking.
- 1.6 Supervision: The recipient facility will designate the admitting service, the admitting physician for each resident, and, if requested, will provide at least temporary courtesy privileges to the resident's original attending physician, per the recipient facility's policy and procedure. Emergency privileges for physicians and other health care providers will be granted in accordance with The California Association of Health Facilities standards.

2. Medical Supplies and Pharmaceuticals:

- 2.1 In the event that medical supplies and/or pharmaceuticals and equipment are requested, the undersigned facilities will share, to the extent possible, the requested supplies to help ensure that residents in the [California County] area receive necessary treatment during a disaster. Reusable equipment will be returned to the facility of origin as soon as possible – dependent upon termination of event and return of transferred residents.

- 2.2 The above supply sharing will occur, in cooperation with the MOC, at the involved undersigned facilities. Requests initially can be made verbally but must be followed up with a written request by the Area Coordinator.
- 2.3 Documentation: Documentation should detail the items involved in the transaction condition of the material prior to the loan (if applicable), and the party responsible for the material. Details can be provided to Area Coordinators for documentation.
- 2.4 Authorization: The recipient facility will have supervisory direction over all donor borrowed medical supplies, pharmaceuticals and equipment, once they are received by the recipient facility, until returned to donating facility. Items lost or damaged in transit will be the divided responsibility of both donor and receiving facilities.

3. Medical Operations/Loaning Personnel:

- 3.1 Communication of Request: The request for the transfer of personnel can initially be made verbally and should be followed by written documentation of the request. Requests will be made in a standardized format. A request and documented response will occur prior to the arrival of personnel at the recipient facility. The recipient facility will identify to the donor facility the following:
- The type and number of requested personnel
 - An estimate of how quickly the request is needed
 - The location where they are to report
 - An estimate of how long the personnel will be needed
- 3.2 Documentation: The arriving personnel will be required to present their donor facility identification badge at the check-in site designated by the recipient facility's command center. A picture I.D. can be accepted if arriving personnel's credentials are verified by employer. The recipient facility will be responsible for the following:
- Meeting the arriving donated personnel
 - Providing adequate identification (e.g., "visiting personnel" badge) to the arriving donated personnel
 - Directing arriving personnel to where they will be working and what they will be doing
 - Providing arriving personnel with minimal but adequate orientation to facility and equipment to be able to function within their scope of practice

- 3.3 **Staff Support:** The recipient facility shall provide food, housing and/or transportation for donor healthcare facility personnel asked to work for extended periods and for multiple shifts. The costs associated with these forms of support will be borne by the recipient healthcare facility.
- 3.4 **Financial Liability:** The recipient facility will reimburse the donor facility for the actual salaries and benefits of donated personnel if the personnel are not being employed for the care of transferring (*donor*) facility residents, and are employees being paid by the donor facility. The reimbursement will be made within ninety (90) days following receipt of the invoice.

The following fixed rate components for the evacuee's use of site and facilities will be charged by receiving facility on a per day basis. "Day" is defined as a 24 hour period, or any part thereof, beginning at 12:00 a.m. and ending at 11:59 p.m.

Daily use of facility and grounds: \$175.00 per day
 Related services: \$ negotiable

TOTAL DAILY RATE: \$175.00 per day

Note: Additional expenses may be incurred by residents with extensive needs and shall be billable accordingly.

- 3.5 **The Medical Director/Medical Staff:** The recipient facility will be responsible for providing a mechanism for granting emergency privileges for physicians, nurses, and other licensed healthcare providers to provide services at the recipient facility.
- 3.6 **Demobilization procedures:** The recipient facility will provide and coordinate any necessary demobilization procedures and post-event stress debriefing.
- 3.7 Any documentation done during an evacuation/surge period will be copied and sent with the patient upon their return to their facility of origin.

4. Miscellaneous Provisions:

- 4.1 In the event of an emergency situation the undersigned facilities will voluntarily provide staff assistance, if feasible, to participating facilities.
- 4.2 Any party may propose amendments to this MOU by providing written notice to the [California County] Skilled Nursing Facility Disaster Preparedness Task

Force:

[Task Force address]

- 4.3 An undersigned facility may at any time terminate its participation in the Mutual-Aid Agreement by providing thirty-day (30-day) written notice to the [California County] Skilled Nursing Facility Disaster Preparedness Task Force:
[Task Force address]
- 4.4 All compensation for equipment or supplies provided to the recipient facility pursuant to this Memoranda of Understanding will be paid by the recipient facility within 90 days of its receipt of an invoice from the transferring facility for such supplies.

5. Financial & Legal Liability:

- 5.1 The recipient facility will assume legal responsibility for the personnel, equipment, medical supplies and pharmaceuticals from the donor facility during the time the personnel, equipment, supplies, and pharmaceuticals are at the recipient facility. The recipient facility will reimburse the donor facility, to the extent permitted by federal law, for all of the donor facility's costs determined by the donor facility's regular rate. Costs include all use, breakage, damage, replacement, and return costs of borrowed materials, for personnel injuries that result in disability, loss of salary, and reasonable expenses, and for reasonable costs of defending any liability claims, except where the donor facility has not provided preventive maintenance or proper repair of loaned equipment which resulted in resident injury. Reimbursement will be made within 90 days following receipt of the invoice.
- 5.2 The recipient facility assumes the legal and financial responsibility for transferred residents upon arrival into the accepting facility. Upon admission the recipient facility is responsible for liability claims originating from the time the resident is admitted to the recipient facility until discharge. Reimbursement for care should be negotiated with each facility's insurer under the conditions for admissions without pre-certification requirements in the event of emergencies.

6. Indemnity Clause:

Each party to this Agreement shall defend, indemnify, and hold harmless all other parties to this Agreement from and against any and all liability, loss, expense, attorneys fees, or claims for injury or damages arising out of the performance of this Agreement, but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the

negligent or intentional acts or omissions of the party, its officers, agents, or employees.

7. Conformance with Rules and Regulations Permits and Licenses:

- 7.1.1 All parties shall be in conformity with all applicable federal, state, county, and local laws, rules, and regulations, current and hereinafter enacted, including facility and professional licensing and/or certification laws and keep in effect any and all licenses, permits, notices, and certifications as are required. All parties shall further comply with all laws applicable to wages and hours of employment, occupational safety, and to fire safety, health, and sanitation.
- 7.1.2 All undersigned parties certify that they possess and shall continue to maintain or shall cause to be obtained and maintained, at no cost to other parties, all approvals, permissions, permits, licenses, and other forms of documentation required for it and its employees to comply with all existing foreign or domestic statutes, ordinances, and regulations, or other laws, that may be applicable to performance of services hereunder.

Term of the Agreement

The term of this agreement shall be effective from January 1, 2009 through December 31, 2009. This agreement shall be reviewed every three (3) years under the terms and conditions then in effect, this agreement shall be renewed automatically, unless either party gives the other party written notice of intention, not to renew, no less than thirty (30) days prior to the expiration date of the then current term.

Effective Date, Future Amendment and Construction

Development of operational procedures, forms, and other tools to operationalize this MOU shall be conducted by the SNF Disaster Preparedness Area Coordinators and participants through the Skilled Nursing Facility Disaster Preparedness Task Force. Updates to those procedures, forms, or tools do not require revision of this MOU.

This Memorandum of Agreement is in no way meant to affect any of the participants' rights, privileges, titles, claims, or defenses provided under federal or state law or common law.

This MOU may not be assigned and shall be governed under California law and may be amended upon written consent of the participants. This MOU contains the entire agreement of the subject matter contained herein and shall give rights to no other parties except where expressly stated. In the event a court of competent jurisdiction deems one or more provisions

invalid, the remaining provisions shall remain in full force and effect. Waiver of any breach shall not operate to be a waiver of any other or subsequent breach. The participants shall maintain the confidentiality of resident and other records as required by law.

Any proposed updates or changes that are made to this MOU during a review by the Skilled Nursing Facility Disaster Preparedness Task Force will be provided to all participant facilities for review. Thirty (30) days after all participants have been provided this information, the proposal will take effect as an accepted addendum if no response has been received by those participants. Otherwise – any revisions or requests will be further reviewed by the ‘task force’ and re-submitted for participants’ review prior to revision.

IN WITNESS AND AGREEMENT WHEREOF, we have set our hands and seals that date below written.

Informational Addendum:

(Re: Facility participation) Participation by the Department of Veterans Affairs is limited by certain statutory obligations that take precedence over the responsibilities under this MOU. The Stafford Act (42 U.S.C. 5121 et seq) requires the Federal Government to respond to major disasters and emergencies initiated by Presidential declaration and may direct any Federal agency to use its authorities and resources to support State and local assistance efforts. The FEMA Interim Federal Response Plan [42 U.S.C. 5170a (1) and 5192(a) (1); Executive orders 12148, 12673] requires Federal agencies to respond to the FEMA Directors request to provide assistance to support State and local efforts. The VA’s ability to assist the local facilities under this MOU is also subject to participation in the National Disaster Medical Systems which provides resources for natural and man-made disasters and supports resident treatment requirements for armed conflict. Under 38 USC 8111(a) (1), the Secretary of Veterans Affairs is required to maintain a contingency capacity of hospital beds to assist the Department of Defense in a time of war or national emergency. Finally, 38 USC 1784 requires VA to assist non-veteran residents referred to a VA facility on a humanitarian basis outside the Stafford Act.



Description

22 CCR 72551 requires licensed skilled nursing facilities, as a condition of licensure, to develop and maintain a written disaster and mass casualty program in consultation with county or regional and local planning offices. The plan must be reviewed at least annually and revised as necessary. Licensed long-term care health facilities must document that all new employees are oriented to the plan and procedures at the beginning of their employment. Further, licensed facilities must conduct a disaster drill every 6 months and participate in all local and state disaster drills and text exercises when requested.

CDPH Licensing & Certification has prepared the Disaster Preparedness Plan Tool to assist long-term care health facilities and facility surveyors in evaluating a nursing facility's Disaster Preparedness Plan.

The Disaster Preparedness Plan Tool can also be found in *Volume V: Long-Term Care Health Facilities* Section 4.2, "California Code of Regulations Title 22, Division 5: Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies."

Instructions

Complete the Disaster Preparedness Plan Tool to evaluate the completeness of the long-term care health facility's emergency operations plan.

Disaster Preparedness Plan Tool

FACILITY NAME: _____

DATE OF REVIEW _____

All SNF, NF and SNF/NF are required by Federal regulations to “have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents” [CFR 483.75 (m) F Tag 517]. California’s Health and Safety Code (H&S) and California’s Code of Regulations - Title 22, (T22) specify the “details” that are required in the facility emergency plan. To help you prepare for the external disaster plan review during the annual survey process, DHS has prepared the following optional self assessment tool for your use. For comments or questions regarding this tool, please contact Kathy Clark, Disaster Preparedness Coordinator, Licensing & Certification at Kathy.Clark@cdph.ca.gov.

- 1) YES ___ NO ___ Was the plan developed and revised with the advice and assistance of local emergency authorities? T 22 §72551(a)

- 2) When was the plan last reviewed? T 22 §72551 (c) _____

- 3) How is staff trained to the plan? CFR 42§ 483.75 (m), T 22 §72551 (c)

- 4) YES ___ NO ___ Are disaster drills held at six-month intervals? T22 §72551(e)

- 5) YES ___ NO ___ Is there a written report of the facility’s participation? T §22 72551 (e)
Date of last two disaster drills _____ and _____.

- 6) How does the plan address: T22 §72551 (b) (1)

Sources of emergency utilities (power, gas, water):

Sources of emergency food:

Sources of essential medical supportive materials:

What does your plan identify as “essential medical supportive materials” (i.e., medications, O₂, battery packs for equipment)?

How does the plan make provisions for the distribution of water in the event of a loss of normal supply? CFR §483.70(h) (1)

What provisions have been made to ensure infection control practices are maintained in the absence of adequate water supplies?

7) What is the plan’s provision for recalling off-duty staff? T 22 §72551(b) (2)

8) What are the lines of authority and staff assignments in the event of an emergency? T 22 §72551(b) (2) (3)

9) How does the plan describe the moving of patients from damaged areas of the facility to undamaged areas? T 22 §72551 (b) (6)

10) How does the plan address the conversion of useable space for the immediate care of emergency admissions? T 22 §72551(b) (4)

11) What transportation will be provided for residents who need to be transferred in an emergency? T 22 §72551 (b) (6)

12) YES ___ NO ___ Does the plan contain evacuation routes, emergency phone numbers of physicians, fire, police, local emergency services, state agencies and relatives who need to be notified during an emergency? H&S code 1336.3, T 22 § 72551 (b) (9)

13) What procedures are in place for maintaining a record of resident relocation? T 22 § 72551 (b) (8)

14) What procedure is in place to assure that all pertinent personal and medical information shall accompany each resident who is moved, transferred, discharged, or evacuated? T22 § 72551 (b) (10)

15) What arrangements have been made for emergency housing where indicated? What agreements are in place with other facilities to provide temporary care for residents in an emergency? H&S Code 1336.3 (b), T22 § 72551 (b) (6)

16) How does the plan address security of the facility during a disaster?
T22 § 72551(b)(11)

17) YES ___ NO ___ Does the plan contain procedures for the emergency discharge of residents who can be discharged without jeopardy into the community? T22 §72551(b)(7)

18) YES ___ NO ___ Does the plan provide for the prompt medical assessment and treatment of residents who may have suffered adverse health consequences or require emergency care related to the disaster? H&S Code 1336.3(a) (3), T22 § 72551 (a) (12)

19) YES ___ NO ___ Does the plan include the assignment of a public relations liaison to release information to the public? T22 § 72551 (b) (13)

Additional Comments:

CDPH/Licensing and Certification 10/07



Description:

To maintain continuity of care following patient transfer, long-term care health facilities should send important medical information with their patients to the receiving healthcare facility. Important documents include care plans, physician orders or physician order monthly recaps, medication administrations records (MARs), and contact information for family members or other responsible parties. A patient's life-sustaining treatment status (or "DNR" status) should be clearly documented. At a minimum, it is recommended that the patient face sheet, MAR, and care plan be transmitted with a patient during transfer, even in an emergency.

The nature of the emergency and the operations of a particular long-term care health facility will dictate how patient information is transmitted. Decisions around procedures for the transfer of patient information during a healthcare surge must be made on a facility-by-facility basis after considering the specific operations of the long-term care health facility. The process for photocopying documents and/or transferring records should be established in the facility surge plan and responsibility assigned to specific staff members.

The Interfacility Transfer Report is one template for summarizing or transmitting patient health information during a healthcare surge. Long-term care health facilities may adapt these forms, as needed, for use during a healthcare surge. As an option, the Interfacility Transfer Report could be printed on envelopes, which can be used to transmit additional patient health documents during a healthcare surge.

The Interfacility Transfer Report can also be found in *Volume V: Long-Term Care Health Facilities* Section 5.2.1, "Transferring Patients to Other Healthcare Facilities."

Instructions

The licensed healthcare professional responsible for the patient or other designated staff member should fill out the Interfacility Transfer Form as completely as possible, prior to transferring a patient to another facility.

Interfacility Transfer Report

INTERFACILITY TRANSFER REPORT																				
Transfer Date:		Patient Name: Age:																		
Transferred From:		D. O. B.: Sex:																		
Address:		Marital Status: Religion:																		
Telephone #	Fax:	Social Security:																		
Transferred From:		Medicare: MediCal:																		
Address:		Transported By:																		
Telephone #:	Fax:	Trasporter:																		
		Address:																		
		Telephone #: Fax #:																		
Diagnoses		Attending Physician:																		
		Phone #:																		
		Diet Order:																		
		<table border="0"> <tr> <td>Incontinent</td> <td>Disabilities</td> <td>Impairments</td> </tr> <tr> <td><input type="checkbox"/> Bowel</td> <td><input type="checkbox"/> Amputation</td> <td><input type="checkbox"/> Mental</td> </tr> <tr> <td><input type="checkbox"/> Bladder</td> <td><input type="checkbox"/> Paralysis</td> <td><input type="checkbox"/> Speech</td> </tr> <tr> <td><input type="checkbox"/> Saliva</td> <td><input type="checkbox"/> Contractures</td> <td><input type="checkbox"/> Hearing</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Decubitis Ulcer</td> <td><input type="checkbox"/> Vision</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Sensation</td> </tr> </table>	Incontinent	Disabilities	Impairments	<input type="checkbox"/> Bowel	<input type="checkbox"/> Amputation	<input type="checkbox"/> Mental	<input type="checkbox"/> Bladder	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Speech	<input type="checkbox"/> Saliva	<input type="checkbox"/> Contractures	<input type="checkbox"/> Hearing		<input type="checkbox"/> Decubitis Ulcer	<input type="checkbox"/> Vision			<input type="checkbox"/> Sensation
Incontinent	Disabilities	Impairments																		
<input type="checkbox"/> Bowel	<input type="checkbox"/> Amputation	<input type="checkbox"/> Mental																		
<input type="checkbox"/> Bladder	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Speech																		
<input type="checkbox"/> Saliva	<input type="checkbox"/> Contractures	<input type="checkbox"/> Hearing																		
	<input type="checkbox"/> Decubitis Ulcer	<input type="checkbox"/> Vision																		
		<input type="checkbox"/> Sensation																		
Medications	Last Given	Additional Comments																		
		Vital Signs																		
		Temperature																		
		Mobility																		
		Functional CAP																		
		Date of last BM																		
		PPD:																		
		Chest X-ray																		
Treatments	Last Given	Comments:																		
		Pneumonia and Flu Shot Record																		
Signature	Date	Time:																		



Description:

To maintain continuity of care following patient transfer, long-term care health facilities should send important medical information with their patients to the receiving healthcare facility. Important documents include care plans, physician orders or physician order monthly recaps, medication administrations records (MARs), and contact information for family members or other responsible parties. A patient's life-sustaining treatment status (or "DNR" status) should be clearly documented. At a minimum, it is recommended that the patient face sheet, MAR, and care plan be transmitted with a patient during transfer, even in an emergency.

The nature of the emergency and the operations of a particular long-term care health facility will dictate how patient information is transmitted. Decisions around procedures for the transfer of patient information during a healthcare surge must be made on a facility-by-facility basis after considering the specific operations of the long-term care health facility. The process for photocopying documents and/or transferring records should be established in the facility surge plan and responsibility assigned to specific staff members.

The Patient Transfer Summary is one template for summarizing or transmitting patient health information during a healthcare surge; it is based on the "Situation-Background-Assessment-Recommendation" or SBAR approach to clinical communication. Long-term care health facilities may adapt this form, as needed, for use during a healthcare surge. As an option, the Patient Transfer Summary could be printed on envelopes, which can be used to transmit additional patient health documents during a healthcare surge.

The Patient Transfer Summary can also be found in *Volume V: Long-Term Care Health Facilities* Section 5.2.1, "Transferring Patients to Other Healthcare Facilities."

Instructions

The licensed healthcare professional responsible for the patient or other designated staff member should fill out the Patient Transfer Summary as completely as possible, prior to transferring a patient to another facility.

Patient Transfer Summary

Patient Transfer Summary {Name of Facility}, {Facility Address}, {Facility Phone Number}	
Situation	
Date: ___/___/___	Reason for Transfer:
Patient Name:	
Date of Birth: ___/___/___ Age:	
Weight:	
Limitation of Treatment: Y / N (If Yes, limitation is attached)	
Background	
Medical History:	Treatment already provided by transferring facility:
Allergies:	Isolation Precautions: Y / N (e.g., history of MRSA) If Yes, specify:
Assessment	
Baseline Vital Signs:	Current Vital Signs:
Ventilator settings (if applicable):	
Tracheotomy Tube size and type:	
Summary of situation, patient condition, etc:	
Recommendation	
Please evaluate for:	
LVN/RN Contact:	Respiratory Care Contact:



Description:

To maintain continuity of care following patient transfer, long-term care health facilities should send important medical information with their patients to the receiving healthcare facility. Important documents include care plans, physician orders or physician order monthly recaps, medication administrations records (MARs), and contact information for family members or other responsible parties. A patient's life-sustaining treatment status (or "DNR" status) should be clearly documented. At a minimum, it is recommended that the patient face sheet, MAR, and care plan be transmitted with a patient during transfer, even in an emergency.

The nature of the emergency and the operations of a particular long-term care health facility will dictate how patient information is transmitted. Decisions around procedures for the transfer of patient information during a healthcare surge must be made on a facility-by-facility basis after considering the specific operations of the long-term care health facility. The process for photocopying documents and/or transferring records should be established in the facility surge plan and responsibility assigned to specific staff members.

The Patient Transfer Information Form is one template for summarizing or transmitting patient health information during a healthcare surge. Long-term care health facilities may adapt this forms, as needed, for use during a healthcare surge. As an option, the Interfacility Transfer Report could be printed on envelopes, which can be used to transmit additional patient health documents during a healthcare surge.

The Patient Transfer Information Form can also be found in *Volume V: Long-Term Care Health Facilities* Section 5.2.1, "Transferring Patients to Other Healthcare Facilities."

Instructions

The licensed healthcare professional responsible for the patient or other designated staff member should fill out the Patient Transfer Information Form as completely as possible, prior to transferring a patient to another facility.

Patient Transfer Information Form

PATIENT TRANSFER INFORMATION	
PATIENT NAME: _____ DATE OF BIRTH: _____ ROOM NUMBER: _____	
PHYSICIAN REQUESTING TRANSPORT: _____ DR.'S PHONE #: _____ DR.'S FAX #: _____	
DECISION MAKER: _____ <input type="checkbox"/> PATIENT <input type="checkbox"/> SURROGATE: NAME _____ / PHONE # _____	
ADVANCE DIRECTIVE INFORMATION: The following documents are included: <input type="checkbox"/> Durable Power of Attorney (DPAHC) <input type="checkbox"/> Declaration to Physicians (California Natural Death Act Declaration) <input type="checkbox"/> Preferred Intensity of Care/Treatment <input type="checkbox"/> Other statements of preference for care <div style="background-color: #e6f2ff; padding: 10px; margin-top: 10px;"> <input type="checkbox"/> Prehospital Do Not Resuscitate (DNR) form <input type="checkbox"/> Physician's DNR Orders from transferring facility <input type="checkbox"/> Patient if Full Code </div>	
NOTE: <input type="checkbox"/> This patient is a HOSPICE patient	
TRANSFERRING FACILITY: _____ PHONE #: _____ TRANSFERRING NURSE: _____ EXT: _____ TRANSFER DATE: _____ TIME: _____ DESTINATION: _____	



Description:

During a healthcare surge, routine methods of transportation may not be available. Emergency Medical Services Agency vehicles and other ambulance transport may be occupied elsewhere and be unavailable to long-term care health facilities, so transportation arrangements may need to be improvised when facility evacuation becomes necessary.

Depending on a patient's health status, different transportation methods may be necessary. Patients' acuity might also determine the facility to which they should be transferred. The following Emergency Evacuation Decision-Making Tool summarizes a patient's level of care and the corresponding transportation and shelter type required.

The Emergency Evacuation Decision-Making Tool can also be found in *Volume V: Long-Term Care Health Facilities* Section 5.2.1, "Transferring Patients to Other Healthcare Facilities."

Instructions

Long-term care health facilities and facility personnel should use this table to guide emergency evacuation decisions.

Emergency Evacuation Decision-Making Tool

EMERGENCY EVACUATION DESTINATION CATEGORIES for MEDICALLY FRAGILE PATIENTS and RESIDENTS		
LEVEL OF CARE	SHELTER TYPE	TRANSPORT TYPE
<p>LEVEL I - Acute Care / Ventilator</p> <p>Description: Patients are usually transferred from inpatient medical treatment facilities and require a level of care only available in a hospital or Extended Care Facility (ECF).</p> <p>Examples:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bedridden, totally dependent, difficulty swallowing <input type="checkbox"/> Requires dialysis <input type="checkbox"/> Ventilator-dependent <input type="checkbox"/> Requires electrical equipment to sustain life <input type="checkbox"/> Critical medications requiring daily lab monitoring <input type="checkbox"/> Requires continuous intravenous therapy <input type="checkbox"/> Terminally ill 	<p>Like Facility</p> <p>Hospital</p> <p>ECF</p>	<p>Advanced Life Support</p> <p>Ambulance</p>
<p>LEVEL II - Subacute / Skilled Nursing</p> <p>Description: Patients have no acute medical conditions but require medical monitoring, treatment, or personal care beyond what is available in public shelters.</p> <p>Examples:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bedridden, stable, able to swallow <input type="checkbox"/> Requires continuous intravenous therapy <input type="checkbox"/> Terminally ill <input type="checkbox"/> Wheelchair-bound requiring complete assistance <input type="checkbox"/> Insulin-dependent diabetic unable to monitor own blood sugar or to self-inject <input type="checkbox"/> Requires assistance with tube feedings <input type="checkbox"/> Draining wounds requiring frequent sterile dressing changes <input type="checkbox"/> Oxygen dependent; requires respiratory therapy or assistance with O₂ <input type="checkbox"/> Incontinent; requires regular catheterization or bowel care 	<p>Medical Treatment Unit</p> <p>Temporary Infirmary</p> <p>Skilled Nursing Facility</p>	<p>Basic Life Support</p> <p>Wheelchair Van</p> <p>Car</p> <p>Van</p> <p>Bus</p>



Description

It is recommended that long-term care health facilities develop plans to guide decision-making related to operating or abandoning a degraded environment. Plans should identify a person within the organization to perform an immediate assessment and include a list of “fatal deficiencies/flaws” that would trigger immediate evacuation.

During or following a catastrophic emergency, a high-level assessment of the long-term care health facility should be conducted to ensure that the facility has maintained its structural integrity. The long-term care health facility should be checked to ensure the following:

- Capability to provide essential patient care (routine care as well as management of injuries or disaster-related conditions, if any)
- Integrity of structure with no obvious damage and availability of access to all areas
- Availability of essential services such as power, water, gas and communications
- Availability of adequate staff, supplies, and equipment for 72 hours following an emergency (e.g., food, water, medicines, O₂, hygiene, and fuel)
- Ability to function without assistance for 72 hours

The systematic approach of the Facility Damage Report will assist long-term care health facilities in making a prudent decision on whether to evacuate their facility due to structural damage or deficiencies.

The Facility Damage Report (Limited Assessment) can also be found in *Volume V: Long-Term Care Health Facilities* Section 5.4.3, "Facility Post-Disaster Status Assessment."

Instructions

Complete the Facility Damage Report to assess the structural integrity of a long-term care health facility during or following a catastrophic emergency. This tool should be completed by the long-term care health facility representative in consultation with the CDPH Licensing and Certification District Office.

Facility Damage Report (Limited Assessment)

Facility Name & Type: _____
Address: _____
Date and Time Report Given: _____ Census: _____
Contact Person: _____ Title/Location: _____
Preferred Contact Method: _____ Preferred Contact Number: _____

Complete the worksheet through interview or fax to facility for completion and return ASAP.			
#	Answer:	Questions:	Comments:
1	Y/N Partial	Can you provide essential patient care? (routine care plus management of injuries or disaster-related conditions, if any)	
2	Y/N Partial	Is your facility intact? (structural integrity intact, no obvious damage, access to all areas)	
3	Y/N Partial	Are essential services intact? (power, water, gas, communication)	
4	Y/N Partial	Do you have adequate staff, supplies, and equipment for the next 72 hours? (food, water, medicines, O2, hygiene, fuel)	
5	Y/N Unsure	Can you function without assistance for the next 72 hours?	

If the answer to any question is “partial” or “no,” the CDPH Licensing & Certification District Office will ask the facility to describe its plan for resolving the issue. If facility is preparing to evacuate, the District Office will obtain patient list and evacuation destination(s) and complete a facility transfer summary. A summary report will then be sent to CDPH's Disaster Preparedness Coordinator and/or Field Branch Chief.

Source: California Department of Public Health Licensing and Certification Program, Emergency Preparedness & Response Plan



Description

The Facility On-Site Damage/Operability Report is a comprehensive assessment that will aid in the decision to keep a long-term care health facility open or evacuate patients and staff. During a catastrophic emergency, the long-term care health facility should be inspected to determine the following:

- Structural integrity
- Availability of communications and elevators (if applicable)
- Availability of water: from utility, drinking and hot
- Functionality of building systems such as electricity, emergency power, fuel reserve, heating and cooling, and sewage disposal
- Availability of supplies including food, medications, linens and other items
- Availability of resources for administration, nursing, dietary, environmental services, social services, and activities

The Facility On-Site Damage/Operability Report can also be found in *Volume V: Long-Term Care Health Facilities* Section 5.4.3, "Facility Post-Disaster Status Assessment."

Instructions

Complete all sections of this report to assess the structural integrity and operability of a long-term care health facility. A partial to total evacuation should be considered if the overall damage assessment is yellow or red. This tool should be completed by the long-term care facility representative in consultation with the CDPH Licensing & Certification District Office.

Facility On-Site Damage/Operability Report (Comprehensive Assessment)

Facility On-Site Damage/Operability Report (Comprehensive Assessment)

Facility Name: _____ Date of Visit: _____

Address: _____ Evaluator Names: _____

City: _____

Overall Damage Assessment: GREEN YELLOW RED
 (See OSHPD Placards*)

AVAILABLE EXAM ROOMS: MALE FEMALE

PATIENT EVACUATION ORDERED BY: _____ TITLE: _____

TYPE OF EVACUATION: TOTAL PARTIAL

BUILDING	YES	NO
PARTIAL COLLAPSE		
TOTAL COLLAPSE		
PHOTOS TAKEN		

COMMUNICATIONS	YES	NO
EXTERNAL		
INTERNAL		
ELEVATORS OPERATIONAL		

WATER AVAILABILITY	YES	NO
FROM UTILITY		
DRINKING WATER		
HOT WATER		

BUILDING SYSTEMS	YES	NO
ELECTRICITY		
EMERGENCY POWER		
FUEL RESERVE		
HEAT/ COOLING		
SEWAGE DISPOSAL		

SUPPLIES	YES	NO
FOOD		
MEDICATIONS		
MEDICAL SUPPLIES		
OTHER SUPPLIES		

STAFF AVAILABILITY	YES	NO
ADMINISTRATION		
NURSING		

EVALUATOR COMMENTS AND DIAGRAM (IF NECESSARY):

Recommend Referral To: _____

*Green: Habitable, minor or no damage

Yellow: Damage which represents some degree of threat to occupants

Red: Not habitable, significant threat to life safety

Source: California Department of Public Health, Licensing and Certification, Emergency Preparedness & Response Plan

DRAFT



Description

The Facility System Status Report was adapted from the Hospital Incident Command System (HICS) Form 251. This form provides a tool to thoroughly assess a long-term care health facility's status for the operational period of the incident. Per HICS instructions, it should be completed by the person(s) designated as the Infrastructure Branch Director at the start of the operational period, as conditions change, or more frequently as indicated by the situation. Additional guidance, including instructions, is available in the HICS Guidebook which can be found through the Emergency Medical Services Authority website, <http://www.emsa.ca.gov>.

The Facility System Status Report can also be found in *Volume V: Long-Term Care Health Facilities* Section 5.4.3, "Facility Post-Disaster Status Assessment."

Instructions

Purpose: Record facility status for operational period for incident.

Origination: Infrastructure Branch Director

Original to: Situation Unit Leader

Copies to: Operations Section Chief, Business Continuity Branch Director, Planning Section Chief, Safety Officer, Liaison Officer, and Documentation Unit Leader

Print legibly and enter complete information.

- 1. OPERATIONAL PERIOD DATE/TIME:** Identify the operational period during which this information applies. This is the time period established by the facility's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
- 2. DATE PREPARED:** Use the international standard date notation YYYY-MM-DD, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as 2006-02-14.
- 3. TIME PREPARED:** Use the international standard notation hh:mm, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as 17:04. Use local time.
- 4. BUILDING NAME:** Provide name or other identifier of building for which this status report is being prepared.

5. **SYSTEM STATUS CHECKLIST:** For each system listed, use the following definitions to assign operational status:

Fully functional: 100% operable with no limitations

Partially functional: Operable or somewhat operable with limitations

Non-functional: Out of commission

Comment on location, reason, and time/resource estimates for necessary repair of any system that is not fully operational. If inspection is completed by someone other than as defined by policy or procedure, identify that person in the comments.

6. **CERTIFYING OFFICER:** Use proper name and identify the position or title of the person preparing this form.

7. **FACILITY NAME:** Use when transmitting the form outside of the facility.

WHEN TO COMPLETE: At start of operational period, as conditions change, or more frequently as indicated by the situation.

HELPFUL TIPS: Data may be obtained from inspections by Infrastructure Branch personnel. The long-term care health facility determines overall facility functionality.

DRAFT

Facility System Status Report

FACILITY SYSTEM STATUS REPORT			
1. Operational Period Date/Time:	2. Date Prepared:	3. Time Prepared:	4. Building Name:
5. SYSTEM STATUS CHECKLIST			
COMMUNICATION SYSTEM	OPERATIONAL STATUS	COMMENTS (If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)	
Fax	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional		
Information Technology System (email, registration, patient records, time card system, intranet, etc.)	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional		
Nurse Call System	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional		
Paging - Public Address	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional		
Radio Equipment	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional		
Satellite System	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional		

FACILITY SYSTEM STATUS REPORT

Telephone System, External	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Telephone System, Proprietary	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Video/Television/Internet/Cable	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
INFRASTRUCTURE SYSTEM	OPERATIONAL STATUS	COMMENTS <i>(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)</i>
Campus Roadways	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Fire Detection/Suppression System	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Food Preparation Equipment	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Ice Machines	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	

FACILITY SYSTEM STATUS REPORT

Laundry/Linen Service Equipment	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Structural Components (building integrity)	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
PATIENT CARE SYSTEM	OPERATIONAL STATUS	COMMENTS <i>(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)</i>
Digital Radiography System (e.g., PACS)	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
SECURITY SYSTEM	OPERATIONAL STATUS	COMMENTS <i>(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)</i>
Door Lock-down Systems	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Surveillance Cameras	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	

FACILITY SYSTEM STATUS REPORT

Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
UTILITIES, EXTERNAL SYSTEM	OPERATIONAL STATUS	COMMENTS <i>(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)</i>
Electrical Power (Primary Service)	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Sanitation Systems	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Water <i>(Include reserve supply status)</i>	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Natural Gas	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Propane	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	

UTILITIES, INTERNAL SYSTEM	OPERATIONAL STATUS	COMMENTS <i>(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)</i>
Air Compressor	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Electrical Power (Backup Generator)	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	(Fuel supply status)
Elevators/Escalators	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Heating, Ventilation, and Air Conditioning (HVAC)	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Oxygen	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	(Reserve supply status)
Medical Gases, Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Steam Boiler	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Sump Pump	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	

FACILITY SYSTEM STATUS REPORT

Well Water System	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Vacuum (for patient use)	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Water Heater and Circulators	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
6. CERTIFYING OFFICER:		
7. FACILITY NAME:		



Description

Heightened security during a healthcare surge is needed to protect long-term care health facility personnel, patients, visitors, and the facility and its assets. If long-term care health facilities cannot maintain a secure environment during a healthcare surge, then evacuation may become necessary. It is recommended that a Security Assessment and Vulnerability Report be completed by security personnel prior to an emergency to ensure the well-being and safety of patients and personnel during a mass medical emergency.

The Security Assessment/Vulnerability Tool can also be found in *Volume V: Long-Term Care Health Facilities* Section 5.8, "Security Planning."

Instructions

Complete all sections of the Security Assessment/Vulnerability Tool to identify potential gaps in security and vulnerability at your facility.

Security Assessment / Vulnerability Tool

Security Assessment / Vulnerability Tool				If No,		
#	Recommendation:	Yes	No	Why / Action Plan	By Whom	By When
1	The facility has a security plan, which identifies: designated security staff					
2	...additional security staff who can be deployed					
3	...protocols to provide security staffing in a sustained emergency					
4	Security staff have: vests for identification purposes					
5	...designated assignments					
6	...periodic training					
7	...job action sheets					
8	The facility has a "lock-down" protocol.					
9	The facility has a protocol for the identification of staff that will enter the facility during a lock-down.					
10	The facility has a protocol for the identification of others such as fire, law enforcement, public health, etc. who will enter the facility during a lock-down.					
11	The facility has established a plan to set up a security perimeter and has the cooperation of law enforcement in the establishment and enforcement of this perimeter.					
12	There are designated ingress and egress routes into and out of the facility.					
14	The security plan includes signage that is ready to be posted.					
15	The facility has a plan to call-in security staff.					
16	Traffic flow patterns have been established in cooperation with law enforcement.					
17	The facility has public address systems to communicate with potential crowds outside the facility.					
18	Security knows where to direct media.					
19	Security has a log for all persons entering the facility through the security perimeter at which people log in time of entrance and time of departure.					
20	There is a protocol developed in collaboration with law enforcement on when and how to search persons or their belongings and who will be responsible for this function.					
21	There is a plan for communications with and among security personnel.					
22	There is a plan for armed security personnel.					



Description

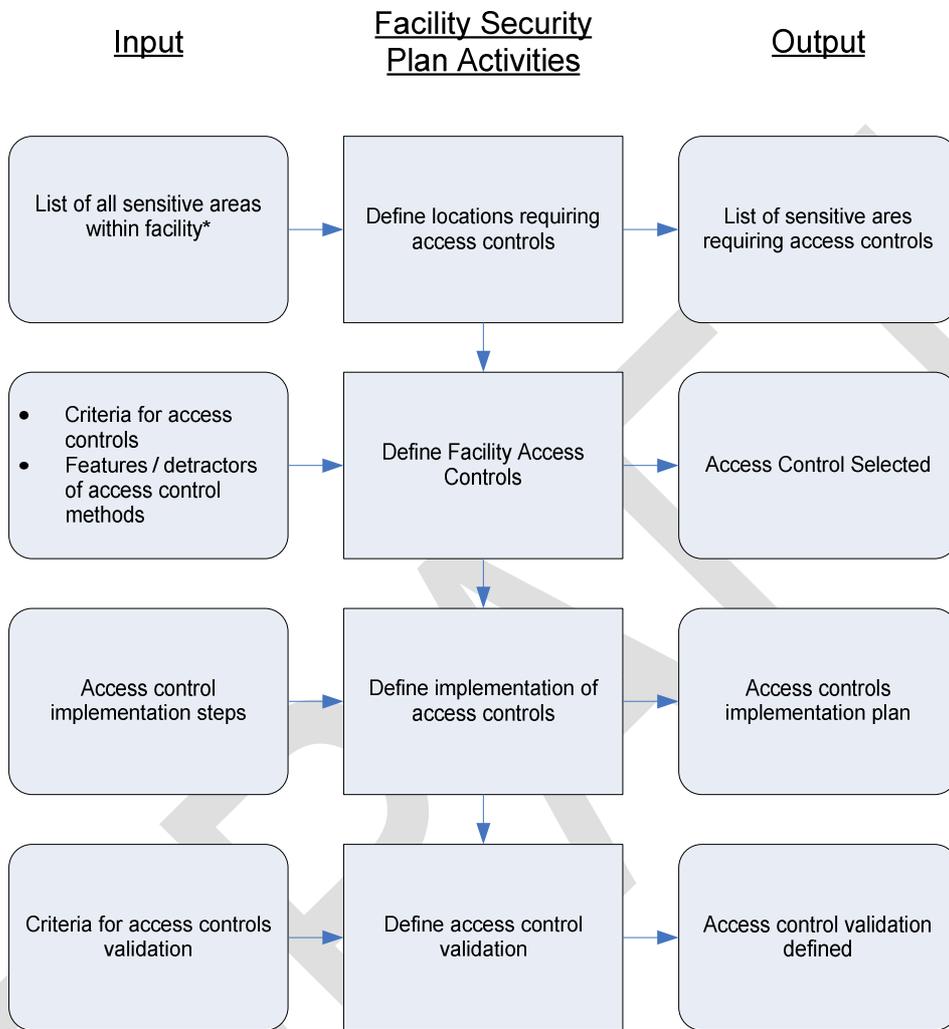
The Facility Security Plan Process Flow can help facilities identify and secure sensitive areas within their facilities that may require restricted access during a healthcare surge.

The Facility Security Plan Process Flow can also be found in *Volume V: Long-Term Care Health Facilities* Section 5.8.2, "Lock-Down vs. Restricted Access/Visitation."

Instructions

Review the Facility Security Plan Process Flow and identify the areas in the facility that may require additional security during an emergency.

Facility Security Plan Process Flow





Description

In a lock-down situation, the primary goal is to isolate and control access to the facility while caring for the safety of the patients, visitors, staff, and property. The Sample Lock-Down Policy and Procedure provides guidance when the need to lock-down a facility exists for any reason. This type of situation could involve mass contamination, picketing, demonstrations, acts of violence, sit-ins, passive resistance, civil disobedience, gang activity, or other disturbances.

This tool can also be found in *Volume V: Long-Term Care Health Facilities* Section 5.8.2, "Lock-Down vs. Restricted Access/Visitation."

Instructions

Consider the following Sample Lock-Down Policy and Procedure when developing plans to isolate and control access to a long-term care health facility during a mass medical emergency.

Sample Lock-Down Policy and Procedure

I. PURPOSE: To provide procedures and guidance when the need to lock-down the facility exists for any reason. This type of situation could involve mass contamination, picketing, demonstrations, acts of violence, sit-ins, passive resistance, civil disobedience, gang activity, or other disturbances.

II. POLICY: The primary goal in a lock-down situation is to isolate and control access to the facility while caring for the safety of patients, visitors, staff, and property.

III. RESPONSIBILITIES

A. **LAW ENFORCEMENT:** Management of a civil disturbance itself will be accomplished by law enforcement.

B. **SECURITY:** Security staff, augmented if necessary, will conduct the internal response in the event of a lock-down and will take measures to control access to and from the facility, whenever possible.

C. **STAFF:** All staff should separate themselves, if at all possible, from any involvement in a civil disturbance.

IV. PERSONNEL: This policy applies to all staff members

V. PROCEDURES

A. GENERAL CIVIL DISTURBANCE:

1. Regardless of how peaceful the intent or how righteous the cause of a civil disturbance, because of the strong emotional nature of the issues involved, these manifestations, on many occasions, end in rioting, violence, and destruction/looting of property.
2. Based on the nature of the disturbance, it will be managed by security staff until the decision is made that management of the situation requires the activation of the Facility Incident Command System.
3. Upon becoming aware of a civil disturbance situation, the facility Administrator or senior administrative person in the facility will be notified immediately.

B. MASS CONTAMINATION

1. In a mass contamination situation, the risk of contaminated individuals/equipment entering the facility may require the total closure of operations of all or part of the facility.
2. In a mass contamination situation, only individuals or equipment that are KNOWN to be free of contamination will be allowed in the building.

C. ACTIVATION/NOTIFICATION

1. The decision to initiate lock-down will be made by the Administrator, if available, based on information provided by security and other staff members. In accordance with the policy established in the emergency management plan, the following individuals, in order of position rank, may initiate lock-down in the absence of the Administrator:
 - a. Administrator-on-call
 - b. Safety Officer or designee
 - c. Emergency management Chairperson
 - d. Operations supervisor during off-hours and weekends

2. Announcement/Notification:

- a. Upon specific guidance from the Administrator or designee, a designated staff member will announce the civil disturbance three times via the public address system (if available) or by some other method. The proper announcement is:

"<<Code Name for Lock-Down>> Nature and Location of Disturbance"

Repeat the statement every 15 minutes for the first hour or as often as the Incident Commander directs.

- b. When directed by the Incident Commander, the designated staff member will contact the appropriate law enforcement office and request immediate assistance.
- c. The designated staff member will contact the Public Information Officer with updates on facility status.
- d. When so directed by the Incident Commander or the senior administrative individual in the facility, the "All Clear" will be announced three times as follows:

"<<Code Name for Lock-down>>, Location, ALL CLEAR"

3. Upon announcement of lock-down, the Incident Command Center and other designated portions of the Incident Command System organization will be activated. This will normally include, at a minimum, a portion of the planning section and the Public Information Officer.

D. SECURITY OPERATIONS:

1. In the case of a civil disturbance, the senior security representative present will immediately assess the situation and provide that information to the Administrator or Incident Commander.
2. In the case of a mass contamination situation, the Infection Control Coordinator or designated clinical staff member will assess the situation and recommend appropriate action.
3. If required, security augmentation will be initiated either through recall of off-duty security, appointing other available staff to perform security duties, or by obtaining augmentation from security companies.
4. Security will immediately commence locking all exterior doors and will advise staff to close ground-floor window coverings, if possible.
5. A single entry point will be established. Staff guarding other exterior doors will be instructed to not allow anyone in or out of those doors. A security representative or other designated individual will allow individuals with legitimate reason into and out of the single entry point based on the situation. In the case of mass contamination, only those individuals KNOWN to be free of contamination will be allowed in the building.
6. If anyone exits the building, a staff or security member must ensure the door is firmly closed and locked after the individual.
7. Security representatives will provide escorts for staff members to and from the parking areas. In the case of mass contamination, anyone leaving the building, including security representatives, must be determined to be free of contamination before being allowed to reenter the building.

E. COMMAND CENTER OPERATIONS:

1. All information from local law enforcement, fire departments, and other sources will be provided to the Incident Command Center.
2. Actions to be taken will be based on the evaluation of this information by the Incident Commander.
3. The Incident Commander will determine what information will be disseminated to facility staff.
4. The Public Information Officer will coordinate all releases of information to the media.
5. In the case of mass contamination, the decontamination procedures will be initiated.
6. In the event of an extended disturbance causing all or part of the staff to remain in the facility, provisions will be made for housing and feeding these individuals.

F. FACILITY OPERATIONS:

1. In patient care areas, access will be limited to staff and others authorized by the Incident Commander to be in those areas.
2. Based on guidance provided by the Incident Commander, visiting hours may be reduced or eliminated and any visitors will be strictly controlled.
3. Staff will be informed to avoid the area and to not involve themselves in the disturbance.

G. POST-CRISIS MANAGEMENT

After cancellation of the lock-down, a debriefing by a crisis intervention team and/or mental health professionals should be provided as needed for all individuals involved in managing the disturbance.

LOCK-DOWN CHECKSHEET

MISSION: The primary goal in a lock-down situation is to isolate and control an emergency situation while caring for the safety of the patients, visitors, staff, and property. The following checksheet should be filled out by security, or other appropriate staff, to confirm that lock-down has been completed.

- _____ Staff discovering the situation requiring lock-down will promptly notify their supervisor, who will pass the information to the Administrator or designee.
- _____ Staff will isolate the situation by locking all exterior doors to units and closing all ground-floor windows.
- _____ Staff will not allow any entry or exit from other than through the single entry point, which will be controlled by security.
- _____ Only individuals KNOWN to be free of contamination will be allowed to enter the building in a mass contamination event.
- _____ If exiting the building, staff must request an escort to and from the parking areas.
- _____ Staff will not become involved in any manner with the civil disturbance.
- _____ Staff will allow law enforcement to quell the civil disturbance.

Source: This policy and procedure sample was adapted from CODE CD - Lock-Down for Scripps, San Diego.

Acceptance and Assignment of Augmented Staff during Healthcare Surge Process Flow



Description

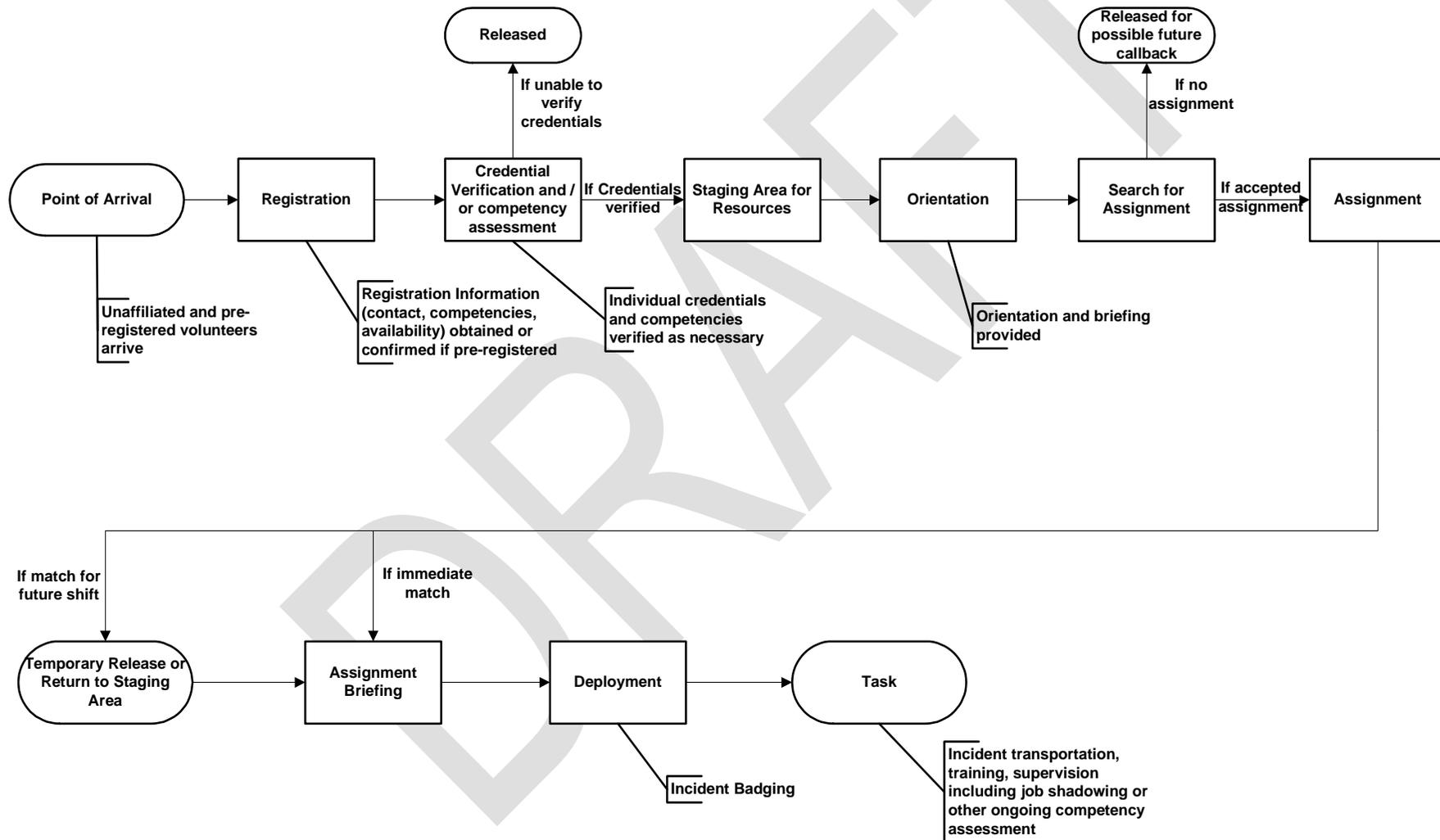
The Acceptance and Assignment of Augmented Staff during Healthcare Surge Process Flow is designed to assist planners and staffing coordinators at existing facilities in understanding the process by which augmented staff are accepted and deployed. Although the acquisition process for various types of augmented staff may differ depending on the volunteer organization, the acceptance and deployment process would essentially remain the same.

The Acceptance and Assignment of Augmented Staff during Healthcare Surge Process Flow can also be found in *Volume V: Long-Term Care Health Facilities* Section 6.1, "Process Flow for Acceptance and Assignment of Additional Staff during Healthcare Surge."

Instructions

Review the Acceptance and Assignment of Augmented Staff during Healthcare Surge Process Flow to determine the appropriate method of accepting and deploying augmented staff during a healthcare surge.

Acceptance and Assignment of Augmented Staff during Healthcare Surge



Staffing Component Considerations for Development of Memoranda of Understanding



Description

In order to support the delivery of care during a healthcare surge, it may be necessary to invoke pre-established Memoranda of Understanding with neighboring healthcare facilities. Memoranda of Understanding between long-term care health facilities and other organizations, such as hospitals, will contain sections including, but not limited to: patient transfer; supplies, equipment, and pharmaceuticals; and personnel.

The Staffing Component Considerations for Development of Mutual Aid/Mutual Assistance Memoranda of Understanding specifies areas to consider when drafting the staffing or personnel components of Memoranda of Understanding.

The Staffing Component Considerations for Development of Mutual Aid/Mutual Assistance Memoranda of Understanding can also be found in *Volume V: Long-Term Care Health Facilities* Section 6.2, "Staffing Component Considerations for Development of Mutual Aid Memoranda of Understanding with Neighboring Healthcare Facilities."

Instructions

Review the personnel sharing components presented in the Staffing Component Considerations for Development of Mutual Aid/Mutual Assistance Memoranda of Understanding and consider incorporating them into a Memoranda of Understanding. Modify the language as appropriate for a particular long-term care health facility.

Staffing Component Considerations for Development of Mutual Aid/Mutual Assistance Memoranda of Understanding:

The following are areas long-term care health facilities should consider when developing Memoranda of Understanding with neighboring healthcare facilities:

1. **Communication of Request:** The request for the transfer of personnel initially can be made verbally. The request, however, must be followed up with written documentation. This should ideally occur prior to the arrival of personnel at the recipient healthcare facility. The recipient healthcare facility will communicate the following to the donor healthcare facility:
 - a. The type and number of requested personnel
 - b. An estimate of how quickly the request is needed
 - c. The location to which personnel are to report
 - d. An estimate of how long the personnel will be needed
2. **Documentation:** The arriving personnel will be required to present a healthcare facility identification badge at the check-in site designated by the recipient healthcare facility's command center. The recipient healthcare facility will be responsible for the following:
 - a. Meeting the temporarily reassigned personnel
 - b. Providing adequate identification (e.g., "visiting personnel" badge) to the arriving reassigned personnel
3. **Staff Support:** The recipient long-term care health facility shall provide food, housing, and/or transportation for temporarily reassigned personnel asked to work for extended periods and for multiple shifts. The costs associated with these forms of support will be borne by the recipient healthcare facility.
4. **Financial liability:** If the personnel are employees being paid by the donor healthcare facility, the recipient healthcare facility will reimburse the donor healthcare facility for the salaries and benefits of the donated personnel at the donated personnel's rate as established at the donor healthcare facility. The reimbursement will be made within 90 days following receipt of the invoice.
5. **Demobilization procedures:** The recipient healthcare facility will provide and coordinate any necessary demobilization procedures and post-event stress debriefing.
6. **Emergency credentialing and/or competency assessment procedures:** The Medical Director, Administrator, or designee of the recipient healthcare facility will be responsible for providing a mechanism for verifying the credentials and/or verifying the competency of nurses and other licensed healthcare providers before they provide services at the recipient healthcare facility.

List of Potential Community-Level Staffing Resources during Healthcare Surge



Description

The staffing sources identified in the List of Potential Community-Level Staffing Resources during Healthcare Surge are community-level resources, and each staffing source may not be available or relevant to long-term care health facilities. As a long-term care health facility develops a facility surge plan and participates in community-wide planning activities, it will be important for long-term care representatives to understand that these resources are available to the community as a whole.

The List of Potential Community-Level Staffing Resources during Healthcare Surge can also be found in *Volume V: Long-Term Care Health Facilities* Section 6.3, "Requesting Staff through the Standardized Emergency Management System."

Instructions

Long-term care health facilities should review the List of Potential Community-Level Staffing Resources during Healthcare Surge when developing surge plans and participating in community surge planning efforts.

List of Potential Community-Level Staffing Resources during Healthcare Surge

List of Potential Community-Level Staffing Resources during Healthcare Surge	
Organization Brief Background & History	Additional Information May Be Found at:
<p>California Medical Assistance Team (CaIMAT)</p> <p>Three 120-person California Medical Assistance Teams (CaIMATs) have been created under state control to respond to catastrophic disasters. Each CaIMAT consists of volunteers drawn from the private, not-for-profit, and state and local government healthcare delivery sectors.</p> <p>The CaIMATs will maintain caches that contain medical supplies, medical equipment, tents, pharmaceuticals, and interoperable (compatible) communications.</p> <p>The CaIMAT program will be supported on-site by an Emergency Medical Services Authority-led Mission Support Team for administrative direction, logistical direction, and re-supply.</p>	<p>http://www.emsa.ca.gov/def_comm/viii092706_d.asp</p>
<p>Community Emergency Response Teams (CERT)/Neighborhood Emergency Response Teams (NERT)</p> <p>The Community Emergency Response Team program educates people about disaster preparedness for hazards that may impact their area and trains them in basic disaster response skills, such as fire safety, light search and rescue, team organization, and disaster medical operations. Using the training learned in the classroom and during exercises, Community Emergency Response Team members can assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help. Community Emergency Response Team members also are encouraged to support emergency response agencies by taking a more active role in emergency preparedness projects in their community.</p> <p>The Community Emergency Response Team concept was developed and implemented by the Los Angeles Fire Department. The Whittier Narrows earthquake in 1987 underscored the area-wide threat of a major disaster in California and confirmed the need for training civilians to meet their immediate needs. As a result, the Los Angeles Fire Department created the Disaster Preparedness Division and the Community Emergency Response Team program to train citizens and private and government employees.</p>	<p>http://www.citizencorps.gov/cert</p> <p>Information is available for the national organization as well as links to the local chapters.</p>

List of Potential Community-Level Staffing Resources during Healthcare Surge

Organization Brief Background & History	Additional Information May Be Found at:
<p>Disaster Medical Assistance Team (DMAT)</p> <p>A Disaster Medical Assistance Team (DMAT) is a group of professional and para-professional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide medical care during a disaster or other event. Each team has a sponsoring organization, such as a major medical center; public health or safety agency; or nonprofit, public, or private organization that signs a Memorandum of Agreement with the federal Department of Health and Human Services.</p> <p>DMATs are designed as a rapid-response element to supplement local medical care until other federal or contract resources can be mobilized or the situation is resolved. DMATs deploy to disaster sites with sufficient supplies and equipment to sustain themselves for a period of 72 hours while providing medical care at a fixed or temporary medical care site.</p> <p>In catastrophic incidents, DMAT responsibilities may include triaging patients, providing high-quality medical care despite the adverse and austere environment often found at a disaster site, and preparing patients for evacuation.</p> <p>DMATs are principally a community resource available to support local, regional, and state requirements. However, as a national resource they can be federalized.</p>	<p>http://www.ndms.dhhs.gov/teams/dmat.html</p>
<p>Disaster Service Workers</p> <p>Disaster Service Workers include public employees and can include any unregistered person pressed into service during a state of war emergency, a state of emergency, or a local emergency by a person having authority to command the aid of citizens in the execution of his or her duties.</p> <p>Disaster Service Workers are organized and designated by local, county, or state government. As described in Section 7.1.4, "Liability Protections during a Healthcare Surge," the designation of Disaster Service Worker provides certain immunities and protections to that individual.</p> <p>Disaster Service Workers are not strictly a "staffing source", but long-term care health facilities should be aware of the Disaster Service Worker designation and the immunities attached.</p>	<p>http://www.oes.ca.gov/Operational/OESHome.nsf/PDF/Disaster%20Service%20Worker%20Volunteer%20Program%20(DSWVP)%20Guidance/\$file/DSWguide.pdf</p>

List of Potential Community-Level Staffing Resources during Healthcare Surge

Organization Brief Background & History	Additional Information May Be Found at:
<p>California Disaster Health Care Volunteers</p> <p>California Disaster Health Care Volunteers is an electronic database of healthcare personnel who volunteer to provide aid in an emergency. The California Medical Volunteer system: (1) registers health volunteers, (2) applies emergency credentialing standards to registered volunteers, and (3) allows for the verification of the identity, credentials, and qualifications of registered volunteers in an emergency.</p>	<p>http://www.hrsa.gov/esarvhp/guidelines/default.htm</p> <p>California Medical Volunteer https://medicalvolunteer.ca.gov/</p>
<p>Los Angeles County Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR VHP)</p> <p>Medical professionals that pre-register and are accepted into the Los Angeles County Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR VHP) can be deployed rapidly and effectively to help following a disaster. The Volunteer Center of Los Angeles is working in partnership with the Los Angeles County Department of Health Services, Emergency Medical Services Agency, and Department of Public Health (including the Health Alert Network) to provide volunteer registration and assist in volunteer accreditation of health professionals.</p> <p>Physicians, dentists, podiatrists, clinical psychologists, physician assistants, or advanced practice registered nurses who wish to be on the Surge Capacity Team or the Alternate Care Site Team will have their information forwarded to CheckPoint Credentials Management for further credentialing.</p> <p>All other medical and mental health professionals do not require additional credentialing.</p> <p>As required by the national Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR VHP) program, all potential volunteers are screened using the Federal Exclusion List.</p>	<p>Los Angeles Emergency System for the Advance Registration of Volunteer Health Professionals http://www.vcla.net/esar</p>
<p>Medical Reserve Corps</p> <p>The Medical Reserve Corps program was created after President Bush's 2002 State of the Union Address, in which he asked all Americans to volunteer in support of their country. The Medical Reserve Corps organizes medical and public health professionals who serve as volunteers to respond to natural disasters and emergencies. These volunteers assist communities nationwide during emergencies and for ongoing public health efforts.</p> <p>There is no "typical" Medical Reserve Corps unit. Each unit organizes in response to their area's specific needs. At the local level, each Medical Reserve Corps unit is led by a Medical Reserve Corps Unit Coordinator who matches community needs for emergency medical response and public health initiatives with volunteer capabilities. Local coordinators are also responsible for building partnerships, ensuring the sustainability of the local unit, and managing the volunteer resources.</p>	<p>http://www.medicalreservecorps.gov/HomePage</p>

List of Potential Community-Level Staffing Resources during Healthcare Surge

Organization Brief Background & History	Additional Information May Be Found at:
<p>American Red Cross</p> <p>The mission of American Red Cross Disaster Services is to ensure nationwide disaster planning, preparedness, community education, mitigation, and response that will provide the American people with quality services delivered in a uniform, consistent, and responsive manner. The American Red Cross responds to disasters such as hurricanes, floods, earthquakes, and fires or other situations that cause human suffering or create human needs that those affected cannot alleviate without assistance. It is an independent, humanitarian, voluntary organization and not a government agency. All Red Cross assistance is given free of charge, made possible by the generous contribution of people's time, money, and skills.</p> <p>The most visible and well-known of Red Cross disaster relief activities are sheltering and feeding, often at community shelters or alternate care sites, but it is not expected that Red Cross volunteers would serve in a long-term care health facility or other existing healthcare facility.</p>	<p>http://www.redcross.org</p> <p>Information is available for both the national chapter as well as links to local chapters.</p>

DRAFT

Sample Policy for Surge Capacity Staffing Emergency Plan



Description

Long-term care health facilities should develop a policy on surge capacity staffing for inclusion in the facility's emergency operations plan. The Sample Policy for Surge Capacity Staffing Emergency Plan provides guidelines for long-term care health facilities to consider when developing surge staffing plans. Primary recommendations include:

- Key roles and functions
- During healthcare surge actions
- Post-event/recovery

Long-term care health facilities can adapt this Sample Policy to the particular needs of their organization.

The Sample Policy for Surge Capacity Staffing Emergency Plan can also be found in *Volume V: Long-Term Care Health Facilities* Section 6.4, "Sample Policy for Surge Capacity Staffing Emergency Plan."

Instructions

Use the Sample Policy for Surge Capacity Staffing Emergency Plan to develop facility-specific staffing plans that can be used during a healthcare surge.

Sample Policy for Surge Capacity Staffing Emergency Plan

I. Purpose: Provide guidelines for staffing during a surge in the patient census or other critical staffing shortage.

II. Policy:

- A. It is the policy of [Facility Name] to maintain a state of readiness in the event of a health disaster or staffing emergency.
- B. The Emergency Staffing Plan will be activated by the Logistics Section Chief if the emergency operations plan is activated or by the nursing supervisor until the emergency operations plan is activated.
- C. This plan will be activated when there is a patient surge that overwhelms the current staffing resources and renders the facility unable to comply with regulated staffing ratios.
- D. The emergency operations plan and incident management team positions of the Incident Command System (ICS) will be activated during a surge event to manage and coordinate emergency staffing.

III. Personnel: This policy applies to all staff members.

IV. Procedures:

- A. When the decision to activate the emergency staffing plan is made, the following roles will be implemented.
 - 1. Incident Commander – Mission: To organize and direct Emergency Operations Center. The role of the Incident Commander is to provide and give overall direction. The role will be assumed by the staff available to maintain smooth facility operations. The Incident Commander needs to activate the Emergency Staffing Plan and is responsible for the overall management and coordination of the response in conjunction with other team leader leaders. Specific responsibilities include:
 - i. Communicate with the Unified Command to ensure the facility is incorporated in the SEMS/NIMS system.
 - ii. Communicate with the facility's corporate headquarters and sister long-term care health facilities to leverage information and sharing (if applicable).
 - iii. Coordinate activities with other long-term care health facilities, if indicated.
 - iv. Coordinate release of appropriate information to media representatives.
 - v. Collaborate with medical staff by reviewing all potential patient discharges and transfers to lower levels of care and establishing a priority list.
 - vi. Collaborate with team members and finance staff to authorize the utilization of the financial resources necessary to maintain essential staffing levels.
 - vii. Implement financial incentives and staffing plans to meet patient care needs.
 - viii. Optimize use of existing staff in the long-term care health facility to promote safe patient care.
 - ix. Coordinate and communicate the prioritization of non-essential meetings and tasks.
 - x. Collaborate with team members for notification to CDPH Licensing & Certification.

2. Planning/Communication Chief – Mission: To ensure distribution of critical information and data. Compile resource projections from all team leaders and determine short- and long- term staffing needs. Document and email or distribute daily action plans.
 - i. Maintain a message center to coordinate communication for the long-term care health facility.
 - ii. Act as custodian of all logged and documented communications relating to the catastrophic emergency.
 - iii. Identify and coordinate public relations activities in conjunction with the Incident Commander.
 - iv. Maintain current information on staffing needs of the long-term care health facility.
3. Finance Chief – Mission: Monitor the utilization of financial assets. Oversee the procurement of supplies and services necessary to carry out the long-term care health facility's medical mission. Supervise the documentation of expenditures relevant to the incident. This role will be assumed by a designee from the Finance Department.
 - i. Maintain records of expenditures to be presented on a "cost-to-date" basis during incident debriefing.
 - ii. Identify cost centers utilized to respond to the incident and separate these expenditures from normal operating expenses.
 - iii. Prepare financial reports necessary for reimbursement if appropriate.
4. Logistics/Materials Management – Mission: Organize and direct operations associated with maintenance of the physical environment and adequate levels of food, shelter and supplies to support the medical objectives. The role will be assumed by a designee from Materials Management or similar Department.
 - i. Establish and/or maintain an inventory of existing materials, supplies, and food.
 - ii. Obtain materials, supplies, and food during the catastrophic emergency
 - iii. Coordinate the physical environment needed to provide additional patient care and treatment areas.
 - iv. Coordinate transportation of supplies and equipment within [Long-Term Care Health Facility] or with other sources as indicated.
 - v. Work with security to identify additional needs for patient or staff safety and for parking for additional staff.
 - vi. Collaborate with all staff, contractors, and external vendors to assure patient care needs can be met.
5. Clinical Staff – Mission: Promote patient flow with clinical staff and set priorities during a health care surge. Role will be assumed by the Medical Director or Director of Nursing.
 - i. Provide communication to clinical staff as indicated.
 - ii. Discuss specific concerns with nursing staff as needed.
 - iii. Provide support to employees through Human Resources or other designated support staff. Larger facilities might consider establishing an Employee Assistance Program.

B. Patient care areas are to be designated under the direction of the Incident Commander and response team in collaboration with nursing leaders.

Note: Staffing will be based on patient acuity.

1. All monitored areas (portable and fixed) will be fully utilized based on patient need.
2. Infection control professionals will be consulted, if indicated.

C. All departments will maintain an emergency staffing plan.

1. Staffing personnel will maintain a current list of all licensed patient care staff.
2. Staffing personnel will contact affiliated facilities and supplemental staffing agencies requesting personnel.
3. Staffing personnel will verify license, Basic Life Support (BLS) certification status, and core competencies for all supplemental and/or volunteer nursing and respiratory care staff. Advanced Life Support (ALS) certification status should be noted, when relevant.
4. Each department will activate the following action steps in coordination with staffing personnel, based on patient demand/acuity.
 - i. Call all off-duty staff to report to work (each patient care area will maintain an emergency staff roster).
 - ii. Offer incentives for staff to work overtime.
 - iii. Inform Incident Commander of actual and available staff for deployment.
 - iv. Provide basic orientation to supplemental staff.
5. All exempt licensed staff will be available to provide direct patient care and support.
6. All non-patient care staff not involved in the critical operations of the long-term care health facility may be assigned to patient care support duties as needed.
7. During a healthcare surge:
 - i. All team members will observe co-workers for signs of stress and report concerns to the appropriate unit leaders (on-duty manager or supervisor). Where appropriate, referral to Human Resources, designated support staff, or an Employee Assistance Program (EAP) will be made.
 - ii. Support staff through recognition of efforts on an ongoing basis.
 - iii. Communicate status of catastrophic emergency to employees frequently, to keep them informed.
 - iv. If needed, patient transfer agreements will be implemented by the Incident Commander. Notify the Operational Area Emergency Operations Center of intent to transfer patients and to request assistance in patient placement.

B. Post-Healthcare Surge/Recovery Procedure for Long-Term Care Health Facility Leadership:

1. Debrief staff at scheduled charge nurse meetings.
2. Acknowledge contributions of staff.
3. Revise policy and plan based on lessons learned.



Description

The Staff Assignment Tracking Sheet assists staff coordinators at long-term care health facilities in assigning roles and responsibilities prior to and during a healthcare surge. For facilities that have pre-defined agreements (e.g., Memoranda of Understanding) with neighboring healthcare facilities or volunteer organizations, this sheet will enable augmented staff to be assigned roles prior to a healthcare surge. In the event that augmented staff do not arrive from predetermined sources or additional staff arrive as walk-in volunteers, this sheet, in conjunction with the healthcare surge staffing plan and job action sheets, will allow staff coordinators to assign and track responsibilities during a healthcare surge.

The Staff Assignment Tracking Sheet can also be found in *Volume V: Long-Term Care Health Facilities* Section 6.5.1, "Staff Assignment Tracking Sheet."

Instructions

The Staff Assignment Tracking Sheet can be used to track all staff members who may provide assistance during a surge, both internal staff as well as external staff such as volunteers. For each staff person assigned to a role in the clinic, the staffing coordinator will document:

- Name
- Assigned staff identification number (if applicable)
- Assigned roles and responsibilities during the healthcare surge
- Name of the individual to whom the person reports (supervisor)
- The time the staff member reported to work
- The time the staff member concluded work
- The location within the facility the staff member is assigned



Description

Because some emergencies may necessitate that long-term care health facility staff operate outside their usual duties or scope of practice, it is recommended that long-term care health facilities maintain an inventory of skills/experiences beyond the normal licensing scope for each staff member. The Skills and Abilities Assessment Tool is designed to facilitate that inventory and assist staffing coordinators in planning and allocating personnel resources during a healthcare surge. Facility planners should complete a skills inventory for existing staff and pre-registered volunteers to identify staff with experiences, skills, or competencies beyond their licensed capacity that may be useful during a healthcare surge. Understanding the abilities of staff during an emergency will enable better decisions on what tasks should be performed by each staff member, if a flexing of scope of practice regulations is authorized.

This tool can also be found in *Volume V: Long-Term Care Health Facilities* Section 7.1.2, "Flexed Scope of Practice."

Instructions

Facility staffing coordinators or medical staff representatives should identify existing staff and pre-registered volunteers who may useful skills, competencies or experience beyond their license or credentials.

Identify staff members or pre-registered volunteers as either credentialed or non-credentialed. In the column marked 'Current Position Title,' indicate the staff member or pre-registered volunteer's current position. In the column marked 'Competencies/Skills Beyond Licensing,' identify any known skills that may be relevant during a healthcare surge that are not part of the staff member's current scope of practice. Two examples are provided.

When complete, this plan should be included as part of a long-term care health facility's emergency operations plan.



Description

During a healthcare surge, long-term care health facilities may wish to recruit and/or accept volunteers and staff who are not pre-registered with the facility. In this situation, the augmented staff and volunteers will not have completed a skills and abilities assessment in advance of reporting to work or volunteer. The Skills and Abilities Checklist was developed to serve as a "just-in-time" skills and ability assessment during a healthcare surge. Long-term care health facilities may adapt the following checklist to meet a facility's needs and use it to evaluate the skills and abilities of staff and volunteers who present to the facility during a healthcare surge. Facilities should note that the Skills and Abilities Checklist is intended as a self-reported inventory of skills, and the facility has an obligation to verify the self-reported skills before assigning responsibilities and to provide ongoing supervision.

The Skills and Abilities Checklist can also be found in *Volume V: Long-Term Care Health Facilities* Section 7.1.2, "Flexed Scope of Practice."

Instructions

Facility staffing coordinators should provide the Skills and Abilities Checklist to all temporary staff and un-registered volunteers who have not completed the Skills and Abilities Assessment attached to the facility emergency operations plan.

Skills and Abilities Checklist

Skills and Abilities Checklist				
<u>Self-Report</u>	<u>Skill</u>	<u>Evaluator Name</u>	<u>Evaluator Signature</u>	<u>Date</u>
<input type="checkbox"/>	Grooming and dressing			
<input type="checkbox"/>	Bathing			
<input type="checkbox"/>	Oral hygiene - brushing a patient's teeth/dentures			
<input type="checkbox"/>	Mouth care for an unconscious patient			
<input type="checkbox"/>	Incontinent Care			
<input type="checkbox"/>	Assisting with elimination			
<input type="checkbox"/>	Bowel and bladder retraining			
<input type="checkbox"/>	Assisting a patient with a bedpan/urinal			
<input type="checkbox"/>	Assisting a patient with using the bathroom			
<input type="checkbox"/>	Body mechanics			
<input type="checkbox"/>	Ambulation			
<input type="checkbox"/>	Serving and recording meals			
<input type="checkbox"/>	Environmental comfort			
<input type="checkbox"/>	Giving a patient a bed bath			
<input type="checkbox"/>	Assisting a patient with eating			
<input type="checkbox"/>	Making both an unoccupied and an occupied bed			
<input type="checkbox"/>	Sit-to-stand lift			
<input type="checkbox"/>	Dependent lifts			

Skills and Abilities Checklist

<u>Self-Report</u>	<u>Skill</u>	<u>Evaluator Name</u>	<u>Evaluator Signature</u>	<u>Date</u>
<input type="checkbox"/>	Bed-to-wheelchair transfers			
<input type="checkbox"/>	Wheelchair-to-commode transfers			
<input type="checkbox"/>	Positioning: Prone/Supine/Fowlers			
<input type="checkbox"/>	Applying/releasing restraints			
<input type="checkbox"/>	Moving patients from bed to chair			
<input type="checkbox"/>	Assisting ambulation			
<input type="checkbox"/>	Use of gait belt			
<input type="checkbox"/>	Use of back support			
<input type="checkbox"/>	Taking/recording patient temperature, pulse, respirations, and blood pressure			
<input type="checkbox"/>	Reporting/charting			
<input type="checkbox"/>	Post-mortem care			
<input type="checkbox"/>	CPR Certification			
<input type="checkbox"/>	AED Certification			
<input type="checkbox"/>	Intravenous fluids			
<input type="checkbox"/>	Triage			
<input type="checkbox"/>	Physical assessment			
<input type="checkbox"/>	Oxygenation			
<input type="checkbox"/>	Infection control, including airborne precautions and respiratory hygiene techniques			
<input type="checkbox"/>	Donning and doffing of personal protective equipment			

Skills and Abilities Checklist

<u>Self-Report</u>	<u>Skill</u>	<u>Evaluator Name</u>	<u>Evaluator Signature</u>	<u>Date</u>
<input type="checkbox"/>	Restorative care			
<input type="checkbox"/>	Resident rights			
<input type="checkbox"/>	Diabetes care			
<input type="checkbox"/>	Dialysis			
<input type="checkbox"/>	IV insertion			
<input type="checkbox"/>	Gastric tubes			
<input type="checkbox"/>	Indwelling urinary catheters			
<input type="checkbox"/>	Ostomy assessment/management			
<input type="checkbox"/>	Wound assessment/management			
<input type="checkbox"/>	Fracture/sprain/strain management			
<input type="checkbox"/>	Nasogenic tubes			
<input type="checkbox"/>	Behavioral health			
<input type="checkbox"/>	Crutch training			
<input type="checkbox"/>	Isolation and precautions			
<input type="checkbox"/>	Burns			
<input type="checkbox"/>	Responder self care			
<input type="checkbox"/>	Relieve choking			
<input type="checkbox"/>	Recognize life-threatening emergencies			
<input type="checkbox"/>	Advanced life support			

Basic Plan for Augmenting Nurse Staffing during Healthcare Surge



Description

It is essential that long-term care health facilities plan for nursing shortages, which may include the augmentation of nursing staff. In developing a facility emergency management plan, there are many staffing strategies that can be considered and implemented, if necessary. Long-term care health facilities with bargaining units/unions are encouraged to utilize a collaborative approach when developing staffing plans. Planning for extraordinary emergencies should focus on maintaining the highest and best use of nursing skills needed to respond to the specific emergency, maintaining the maximum number of caregivers available to provide care, and minimizing the stresses that will challenge nurse-to-patient ratios.

In developing nurse staffing strategies during extraordinary circumstances, long-term care health facilities should consider the following issues:

- Patient and caregiver safety
- Nursing fatigue
- Nursing support and nurses' facility support
- Nursing availability and training
- The transition back to normal nurse-to-patient ratios as recovery from the emergency occurs

Long-term care facilities can adapt the Basic Plan for Augmenting Nurse Staffing during Healthcare Surge to address nurse staffing issues at their facility during a healthcare surge.

The Basic Plan for Augmenting Nurse Staffing can also be found in *Volume V: Long-Term Care Health Facilities* Section 7.2, "Augmenting Nurse Staffing."

Instructions

Review the Basic Plan for Augmenting Nurse Staffing during Healthcare Surge and consider incorporating relevant recommendations into a long-term care health facility's emergency operations plan and/or surge plans.

Basic Plan for Augmenting Nurse Staffing during Healthcare Surge

Long-term care health facilities should consider the following strategies for staffing licensed nurses during a healthcare surge:

- Extend shifts from eight to 12 hours or from 12 hours to 16 hours.
- Call back off-duty staff and per diem staff.
- Define and prioritize essential tasks to be performed by nursing staff during a surge event. Eliminate non-essential tasks and concentrate staff on performing essential patient care.
- Reassign staff from less acute areas to areas of greater need (e.g., clustering patients of similar levels of acuity and re-assigning staff across acuity levels, or, in a facility with multiple levels of care, reassigning staff across departments/levels of care).
- Reassign long-term care health facility or system nursing administrative staff with administrative roles (i.e., nursing supervisors) to patient care roles.
- Augment nursing staff by activating Memoranda of Understanding with local nurse registry agencies, temporary agencies, and other facilities within the healthcare system.
Note: Long-term care health facilities should be aware of the limitations of Memoranda of Understanding. If all healthcare organizations establish Memoranda of Understanding with a single temporary agency and then all are affected by a healthcare surge or emergency, the temporary agency may not have sufficient staff to meet the need of all facilities. Or, a long-term care health facility may establish a Memorandum of Understanding with one neighboring healthcare facility, but, if that facility is also affected by the emergency, assistance may not be available. For these reasons, community-wide Memoranda of Understanding and other community planning efforts are recommended.
- Credential and/or assess competency of self-presenting/convergent nurses to perform clinical duties for lower acuity patients.
- Use the Standardized Emergency Management System (SEMS) structure to request additional nursing resources. For more information, see Section 3.1, "How Emergency Response Works in California: the Standardized Emergency Management System."



Description

The Volunteer Application for Clinical Staff may serve as the emergency credentialing and privileging form for long-term care health facilities (if one has not already been developed).

The Volunteer Application for Clinical Staff can also be found in *Volume V: Long-Term Care Health Facilities* Section 7.4.3, "Volunteer Application for Clinical Staff."

Instructions

1. For clinical staff who present at a long-term care health facility, a designated facility representative will provide him/her with the following application form.
2. All clinical staff must present proper identification including a valid photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
 - a. A current medical facility photo identification card
 - b. A current license to practice (if applicable)
 - c. Identification indicating that the individual is a member of the California Medical Assistance Team (CaMAT) or a Disaster Medical Assistance Team (DMAT)
 - d. Documentation indicating that the individual has been granted authority to render patient care in emergency circumstances by a federal, state, or municipal entity.
 - e. Attestation by a current staff member with personal knowledge regarding the practitioner's identity.
 - f. The completed application form is then given to the Medical Director, Administrator, Director of Nursing, or other designated individual for review and determination of the practitioner's duties and area of assignment.

Concurrently, the designated long-term care health facility representative will initiate the primary source verification process. This process must be completed within 72 hours from the time the practitioner presented to the organization.

Volunteer Application for Clinical Staff

VOLUNTEER APPLICATION FOR CLINICAL STAFF		
APPLICATION DATE: / /		DATE YOU CAN START: / /
PERSONAL INFORMATION		
Last Name:		First Name: Middle Initial:
Is there any additional information about a change of your name, use of an assumed name, or use of a nickname that will assist us in checking your work and educational records? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, explain:		
<u>Current Address</u> Street: City: State: Zip:		<u>Alternate Address</u> Street: City: State: Zip:
Phone number: ()		Pager/Cell Phone: ()
Other Phone: ()		Are you 18 years or older? <input type="checkbox"/> No <input type="checkbox"/> Yes
Birth Date (mm/dd/yyyy):		Birth Place (City, State):
EMERGENCY CONTACTS		
Give name, telephone number, and relationship of two individuals who we may contact in the event of an emergency.		
Name	Telephone Number	Relationship
1.	()	
2.	()	
DEPENDENTS		
List any dependents for whom you are responsible.		
Name	Place of Residence, Telephone Number	Relationship
1.		
2.		
3.		
LICENSURE/CERTIFICATION/REGISTRATION INFORMATION (If Applicable)		

Do you now have or have you previously had a healthcare-related license, certification, and/or registration? No Yes

If Yes, license, certification and/or registration type(s):

Issuing State(s):

Is your license/certification/registration currently in good standing? No Yes

If No, explain why not:

Has your license/certification/registration ever been revoked or suspended? No Yes

If Yes, explain reason(s), date of revocation(s) or suspension(s), and date of reinstatement(s):

Current Place of Practice

Street:

City:

Zip:

State:

Location of Internship/Residency

Street:

City:

Zip:

Year/Month of Graduation:

State:

Medical License Number:

National Provider Identification number (NPI):

Drug Enforcement Administration (DEA) number:

AVAILABILITY & AFFILIATION

Indicate your availability:

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Times of day you may be available: _____

Are you registered with a volunteer organization? If Yes, select below:

- California Disaster Healthcare Volunteers Medical Reserve Corps (MRC)
 California Medical Assistance Team (CalMAT) Other: _____
 Disaster Medical Assistance Team (DMAT)

EDUCATION & VOCATIONAL TRAINING

	High School	College/University	Graduate/Professional	Vocational/Business
School Name, City & State				
No. Years/Last Grade Completed				
Diploma/Degree				

Do you have any experience, training, qualifications, or skills which would assist labor pool coordinators in assigning an appropriate position? No Yes

-If Yes, specify.

Check the boxes below for each age group for which you have expertise in providing age-appropriate nursing care:

- Newborn/Neonate Infant (30 days - 1 yr) Toddler (1 - 3 yrs)
- Preschooler (3 - 5 yrs) School age children (5 - 12 yrs) Adolescents (12 - 18 yrs)
- Young adults (18 - 39 yrs) Middle adults (39 - 64 yrs) Older adults (64+)

My experience is primarily in: (Indicate number of years.)

- Critical Care year(s): _____
- Emergency Medicine year(s): _____
- Home Care year(s): _____
- Med/Surg year(s): _____
- Pediatrics year(s): _____
- Outpatient year(s): _____
- Surgery year(s): _____
- Trauma year(s): _____
- Other (specify): _____ year(s): _____

Do you speak, write, and/or read any languages other than English? No Yes

If Yes, identify which other language(s) and rate your proficiency in these languages:

Language	Fluent	Speak	Read	Write
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VERIFICATION OF TRUTHFULNESS AND UNDERSTANDING REGARDING VOLUNTEER AGREEMENT

_____ I attest that the information I provide and the representations I make are truthful, complete, accurate, and free of any attempt to mislead.
Initials

_____ By completing this form, I attest that I am of sound physical and mental capacity and capable of performing in an emergency/disaster setting. I acknowledge that emergency/disaster settings can pose significant psychological and physical hardships and risks to those volunteering their services and the emergency/disaster settings often lack the normal amenities of daily life and accommodations for persons with disabilities. In agreeing to volunteer my services, I agree to accept such conditions and risks voluntarily.
Initials

_____ I understand that I am required to abide by all rules and practices of this facility and affiliated entities as well as all applicable state and federal laws and regulations.
Initials

_____ I agree to serve as a volunteer without compensation or payment for my services. I agree to hold the [Clinic Name] and any of its entities or subdivisions harmless from any claims of civil liability, including but not limited to claims of malpractice or negligence, criminal liability, injury, or death.
Initials

Signature of Volunteer:

Date: / /

TO BE COMPLETED BY FACILITY REPRESENTATIVE

_____ Proper identification was verified and copied.

- Government issued photo identification (all applicants)
- A current healthcare facility photo identification card
- A current license to practice (if applicable)

If applicant unable to present license, 2 witnesses from applicant's current place of practice may attest to applicant's qualifications to practice.

- Identification indicating that the individual is a member of the California Medical Assistance Team (CaMAT) or a Disaster Medical Assistance Team (DMAT)
- Documentation indicating that the individual has been granted authority to render patient care in emergency circumstances by a federal, state, or municipal entity.
- Attestation by current staff member(s) with personal knowledge regarding the practitioner's identity.

Witness 1 Signature _____ Date _____

Witness 2 Signature _____ Date _____

To be completed by Administrator or authorized designee.

I authorize this individual to volunteer.

Signature of Administrator:

Date: / /

Temporary Emergency Credentialing and/or Competency Assessment Process Flow



Description

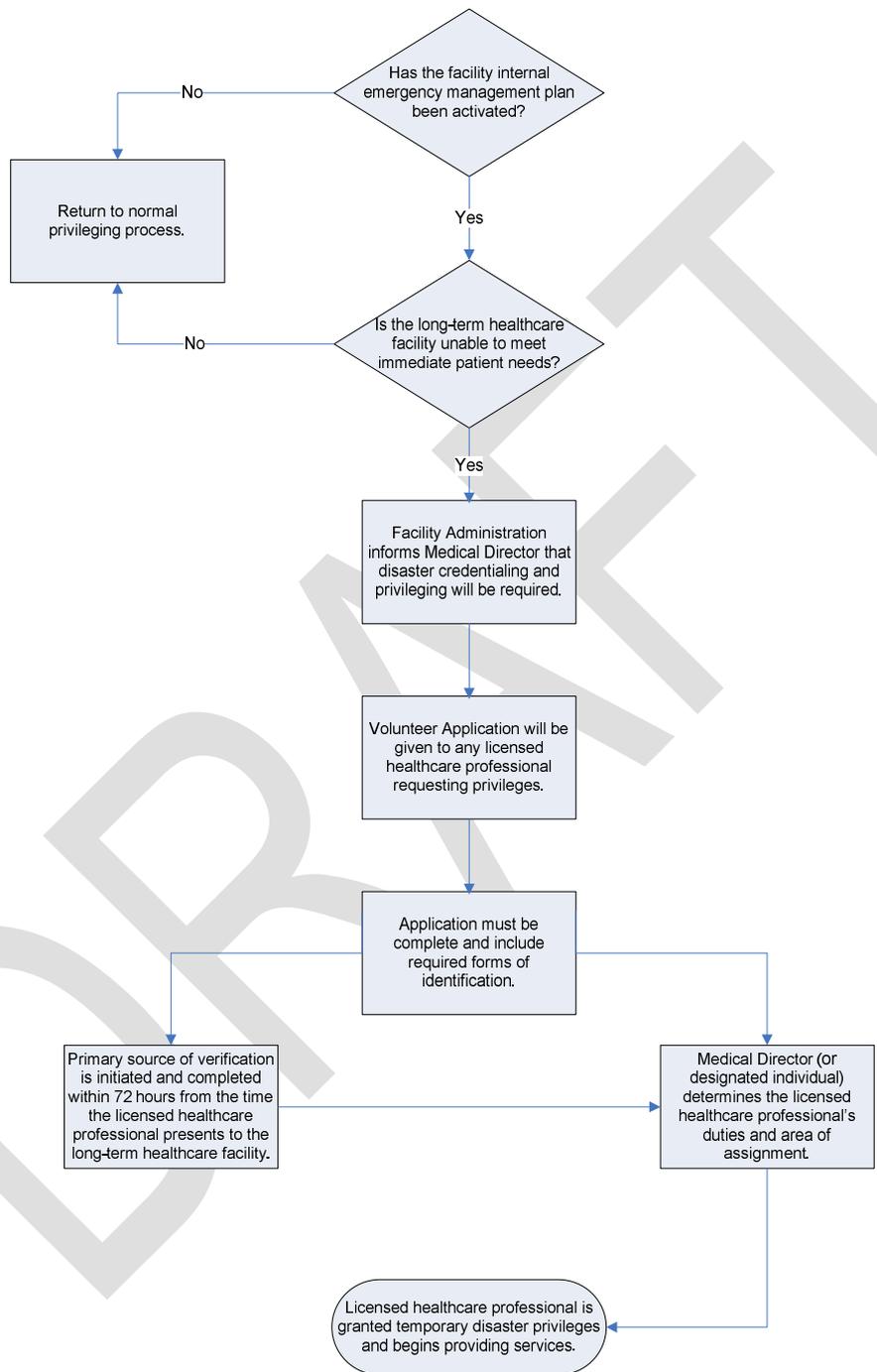
The Temporary Emergency Credentialing and/or Competency Assessment Process Flow Diagram depicts the process by which long-term care health facilities can conduct the emergency credentialing and/or competency assessment process. It also provides clinicians with guidance on the process in which they may participate should they have the opportunity to provide services at a healthcare facility at which they are not currently credentialed.

The Temporary Emergency Credentialing and/or Competency Assessment Process Flow can also be found in *Volume V: Long-Term Care Health Facilities* Section 7.4.4, "Temporary Emergency Credentialing and/or Competency Assessment Process Flow Diagram."

Instructions

Begin at "Has the facility internal emergency management plan been activated?" and continue through the process flow to reach resolution on granting of temporary disaster privileges.

Temporary Emergency Credentialing and/or Competency Assessment Process Flow



Credential Verification Log for Licensed Healthcare Professionals



Description

The Credential Verification Log for Licensed Healthcare Professionals provides long-term care health facilities with a template to document the healthcare professionals who have been granted temporary emergency privileges and have provided the appropriate and required identification.

The Credential Verification Log for Licensed Healthcare Professionals can also be found in *Volume V: Long-Term Care Health Facilities* Section 7.4.5, "Credential Verification Log for Licensed Healthcare Professionals."

Instructions

For each licensed independent health professional who presents at a long-term care health facility to apply for emergency credentials, a designated facility representative will take the following information:

- Professional's full name
- Presence (by checking off the applicable box) of the identification requirements; a government-issued photo identification (e.g., a driver's license) is required in order to qualify for emergency credentials.
- Compare the government-issued photo identification against the other forms of identification indicating what authority the individual has to render patient care.
- If the healthcare professional submits other forms of identification, such as documentation indicating that the individual has been granted authority to render patient care in emergency circumstances (e.g., proof of volunteer participation in the California Disaster Healthcare Volunteers) or presentation by a current staff member with personal knowledge regarding the professional identity, these should be specified in the box labeled "Other."

Once the practitioner's identity and ability to practice has been verified, and the facility representative determines the duties and area of assignment for each health professional, this information should be documented in the column labeled "Declared Competencies."



Description

The Volunteer Application for Non-Clinical Staff may serve as the personnel verification form for long-term care health facilities (if one has not already been developed).

The Volunteer Application Form for Non-Clinical Staff should be used in registering all support staff volunteers. This form will serve as a tool to verify identification of volunteers, capture needed emergency information, and identify skills of volunteer staff.

The Volunteer Application for Non-Clinical Staff can also be found in *Volume V: Long-Term Care Health Facilities* Section 8.1, "Verification of Non-Clinical Staff."

Instructions

1. For all non-clinical volunteers who present at a facility to provide service, the Human Resources department representative should provide him/her with the following application form.
2. Each professional or volunteer must present to the Human Resources department representative with proper identification including a valid photo identification issued by a state or federal agency (i.e., driver's license or passport and at least one of the following below to grant temporary work during the emergency:
 - a. A current picture facility identification card that clearly identifies professional designation
 - b. A current license and/or certification to work
 - c. Identification indicating that the individual is a member of the California Medical Assistance Team, Disaster Medical Assessment Team, Medical Reserve Corps or other recognized state or federal organization or group.
 - d. Documentation indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (if applicable)
 - e. Identification by current facility employee(s) who possess personal knowledge regarding the non-employee/volunteer's ability to act as a licensed independent healthcare professional during a disaster (if applicable)
3. Completed application form is then given to the Human Resources director or other designated individual for review and determination of the professional's duties and area of assignment.

Volunteer Application for Non-Clinical Staff

VOLUNTEER APPLICATION FOR NON-CLINICAL STAFF		
APPLICATION DATE: / /		DATE YOU CAN START: / /
PERSONAL INFORMATION		
Last Name:		First Name: Middle Initial:
Is there any additional information about a change of your name, use of an assumed name, or use of a nickname that will assist us in checking your work and educational records? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, explain:		
<u>Current Address</u> Street: City: State: Zip:		<u>Alternate Address</u> Street: City: State: Zip:
Phone number: ()		Pager/Cell Phone: ()
Other Phone: ()		Are you 18 years or older? <input type="checkbox"/> No <input type="checkbox"/> Yes
Birth Date (mm/dd/yyyy):		Birth Place (City, State):
EMERGENCY CONTACTS		
Give name, telephone number, and relationship of two individuals whom we may contact in the event of an emergency.		
Name	Telephone Number	Relationship
1.	()	
2.	()	
DEPENDENTS		
List any dependents for whom you are responsible.		
Name	Place of Residence, Telephone Number	Relationship
1.		
2.		
3.		
AVAILABILITY, AFFILIATION, & EXPERIENCE		

Indicate your availability:

- Sunday
 Monday
 Tuesday
 Wednesday
 Thursday
 Friday
 Saturday

Times of day you may be available: _____

Are you registered with a volunteer organization? If Yes, select below:

- California Disaster Healthcare Volunteers
 Medical Reserve Corps (MRC)
 California Medical Assistance Team (CalMAT)
 Other: _____
 Disaster Medical Assistance Team (DMAT)

Check the areas in which you are experienced and can provide services.

- Ability to supervise children
 Administrative/ clerical duties
 Computer skills
 Facilities management (e.g., electrical, plumbing, maintenance)
 First aid (e.g., wound care)
 Other – specify: _____

EDUCATION & VOCATIONAL TRAINING

	High School	College/University	Graduate/Professional	Vocational/Business
School Name, City & State				
No. Years/Last Grade Completed				
Diploma/Degree				

Do you speak, read, and/or write any languages other than English? No Yes

If Yes, identify which other languages and rate your proficiency in these languages:

Language	Fluent	Speak	Read	Write
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VERIFICATION OF TRUTHFULNESS AND UNDERSTANDING REGARDING VOLUNTEER AGREEMENT

Initials	I attest that the information I provide and the representations I make will be truthful, complete, accurate, and free of any attempt to mislead.
Initials	I acknowledge by completing this form that I am of sound physical and mental capacity, and capable of performing in an emergency setting. I acknowledge that emergency settings can pose significant psychological and physical hardships and risks to those volunteering their services and the emergency settings often lack the normal amenities of daily life and accommodations for persons with disabilities. In agreeing to volunteer my services, I agree to accept such conditions and risks voluntarily.
Initials	I understand that I am required to abide by all rules and practices of this facility and affiliated entities as well as all applicable state and federal laws and regulations.
Initials	I agree to service as a volunteer, without compensation or payment for my services. I agree to hold the State of California and any of its entities or subdivisions harmless from any claims of civil liability, including but not limited to claims of malpractice or negligence, criminal liability, injury, or death.

Signature of Volunteer Applicant:

Date: / /

TO BE COMPLETED BY ASSIGNED DESIGNEE - STAFF VERIFICATION

Proper identification was verified and copied.

- Government-issued photo identification (All Applicants)
- Certification to work

To be completed by Administrator or authorized designee.

I authorize this individual to volunteer.

Signature of Administrator:

Date: / /

DRAFT



Description

The Non-Clinical Support Matrix provides long-term care health facilities with a template and guidelines for determining inpatient non-clinical staffing needs for a long-term care health facility operating in healthcare surge. The Matrix was adapted from the Wisconsin State Expert Panel in its guidance on healthcare surge capacity.

This tool can also be found in *Volume V: Long-Term Care Health Facilities* Section 8.2, "Non-Clinical Support Matrix."

Instructions

Long-term care health facilities should consider the staffing levels necessary to care not only for patients but also for staff, patients' family members, and visitors who may come to the long-term care health facility with the surge of patients. The following non-clinical departments in a long-term care health facility should plan for this surge in demand for their services:

- Environmental Services (e.g., maintenance, housekeeping, laundry)
- Food Services
- Materials Management
- Activities
- Social Services
- Security
- Transportation
- Admissions
- Billing/Medical Records
- "Runners"

Each department should complete its own staff utilization matrix. It is recommended that departments collaborate to determine how to best allocate and assign staff across departments.

Non-Clinical Support Matrix

Non-Clinical Support Matrix				
Level	Number of Patients Expected	Complex/Critical Rooms	Basic and Supportive Rooms	Staff Support Functions
I	1-10			
II	11-25			
III	26-50			
IV	51-100			
V	>100			

DRAFT



Description

The Considerations for Staff Support Provisions tool is intended to lay out issues that a healthcare facility should consider for its staffing plans and strategies, and it is designed to serve as a starting point for healthcare surge planners when outlining necessary policies and provisions to support staff during a healthcare surge.

The Considerations for Staff Support Provisions can also be found in *Volume V: Long-Term Care Health Facilities* Section 9.3, "Support Provisions for Staff."

Instructions

Review the Considerations for Staff Support Provisions and consider incorporating relevant recommendations into a long-term care health facility's emergency operations plan and/or surge plans.

Considerations for Staff Support Provisions

Purpose: The following information provides guidelines for long-term care health facilities to assist in developing policies and provisions to support staff during a healthcare surge.

Staff Support Considerations

Long-term care health facilities should consider the following issues in developing staffing plans and strategies:

- Some staff will not be able to report to work due to the fact that they, or their family and friends, may have been directly involved in the incident.
- Normal care providers may not be able to provide services during an incident so dependent care options (i.e., childcare, eldercare, care for family members with disabilities) should be offered to enable staff members to report to work.
- Some staff may have concerns about the shelter and care of their pets. Considerations should be made to plan for pet care during a healthcare surge. Designated kennel or housing provisions should be identified in the emergency operations plan. Service animals would not be subject to pet care provisions. Service animals must be allowed to accompany patients, visitors, and/or staff throughout the facility.
- Long-term care health facilities should consider the provision of rooms for staff to rest or sleep, showers, and personal items (e.g., blankets, pillows, sheets, towels, soap, shampoo). In the case of a biological incident, there may be the need for work quarantine in addition to staff working longer shifts or not being able to go home. Long-term care health facilities may want to consider availability of sleeping accommodations and showers in local hotels, churches, and similar organizations.
- Long-term care health facilities should designate areas for staff to eat and have refreshments.
- Staff may be away from home for extended shifts and need to communicate with family members and other loved ones. Long-term care health facilities should make telephones available to call home and computer access for email.
- For staff working extended shifts or not able to go home, there may be the need for laundry services or the provision of scrubs. Staff members should consider having an “emergency kit” readily available with personal items such as underwear, socks, toiletries, a supply of medications, etc.
- Long-term care health facilities should encourage staff to have a family emergency plan so that family members are aware of what will happen and who is responsible for various duties if a family member, who works at the long-term care health facility, needs to work longer shifts or is quarantined at the facility. Tools for staff family emergency plans are discussed in Section 9.4, “Staff Family Emergency Plan.” Long-term care health facilities may want to encourage staff to designate the facility as their family meeting place in the event of an emergency.
- Long-term care health facilities should consider back-up provisions for essential services such as food services, laundry, and housekeeping, especially if these services are out-sourced, the incident affects the ability of the contractor to continue to provide these

services, and/or if the healthcare surge of patients and visitors overwhelms the capacity of these contractors.

Based on these recommendations, the following staff support provisions should be considered by long-term care health facilities when developing a surge plan:

- Behavioral/mental healthcare for staff
- Behavioral/mental healthcare for dependents
- Dependent care (i.e., childcare, eldercare, and care for family members with disabilities)
- Meal provisions for 3-7 days
- Water provisions for 3-7 days
- Pet care
- Designated rooms for resting/sleeping
- Designated restrooms and showers
- Personal hygiene provisions (blankets, pillows, sheets, towels, soap, shampoo, etc.)
- Designated eating areas
- Email/telephone access to communicate with family
- Clothing or laundry services for staff and dependents
- Emergency kits (underwear, socks, toiletries, a supply of medications, etc.) for staff to store at the place of work
- Family emergency plan



Description

In order to meet the overarching obligation to support and safeguard the health and safety of their workforce, it is recommended that long-term care health facilities develop a workforce resiliency policy, which includes incident stress management and dependent care. Since it is unlikely that staff will report for duty or remain at work during an emergency if they are concerned about the safety and welfare of their family, providing dependent care and other staff support provisions may alleviate these concerns and assist long-term care health facilities in maintaining the workforce, thereby reducing the need to augment staff with volunteers and temporary staff.

The Policy for Workforce Resilience offers guidelines for dealing with needs and training to optimize workforce resilience in the event of a disaster. It provides minimum standards for facilities to incorporate into current workforce resiliency policies. The long-term care health facility workforce during a time of healthcare surge could consist of paid employees or volunteers.

The Policy for Workforce Resilience can also be found in *Volume V: Long-Term Care Health Facilities* Section 9.3, "Support Provisions for Staff."

Instructions

Review the Policy for Workforce Resilience for guidance on how to prepare for maximizing employee personal resilience and professional performance during a healthcare surge. Consider incorporating relevant recommendations into a long-term care health facility's emergency operations plan and/or surge plans.

Policy for Workforce Resilience during Emergencies

Purpose:

This policy offers guidelines for optimizing workforce resilience in the event of an emergency. It provides minimum standards for facilities to incorporate into current workforce resiliency policies. This policy applies to all facility staff (paid employees or volunteers) during a time of healthcare surge.

Rationale:

The response to an emergency will pose substantial physical, personal, social, and emotional challenges to healthcare professionals. Long-term care health facility staff and their families will be at personal risk for as long as the emergency continues in their community. Special planning is therefore needed to ensure that long-term care health facilities are prepared to help employees maximize personal resilience and professional performance.

Planning for workforce resilience will become especially important in the case of pandemic emergencies. During a pandemic, the occupational stresses experienced by healthcare workers are likely to differ from those faced in the aftermath of other emergencies. Globally and nationally, a pandemic might last for more than one year, and disease outbreaks in local communities may last for 5 to 10 weeks.

Staff Needs

Physical:

- Rest areas for staff members are located in (list departments and areas).
- Provisions for showers are available in (list locations).
- Food will be served or provided (list location, frequency, times).
- Healthcare in case of illness or injury will be provided (list location and schedule).
- Transportation to and from work will be provided (list schedule, vendor, etc.).

For pandemic: (describe what will happen if the employee is too sick to be at work)

Personal:

- Telephones for personal calls are located (list locations and rules).
- Televisions, radios, and internet access for keeping apprised of events are located (list locations and rules).
- Childcare is provided at (list location, rules, providers, schedule, etc.).
- Care for family members with disabilities or elderly family members is provided at (list location, rules, providers, schedule, etc.).
- Pet care is provided at (list location, rules, providers, schedule, etc.).

For pandemic: Guide sheets should be provided for staff to deal with sickness in their homes.

Emotional:

- Management will provide all staff members with regular updates of emergency status and response activities within the organization. Supervisors will brief staff at least once per shift.
- Managers and supervisors will be alert to recognize worker distress.
- Management will provide a stress control team to help staff members deal with stress.
- Management will arrange for a chaplain or other appropriate religious services.

For pandemic: Counseling will include techniques for addressing the stigma that staff members may face for working with vulnerable or infectious individuals. Stress control teams will be trained in infection control precautions.

Training

There are four main categories of training in preparation for staff support during an emergency: training for all staff members, department-specific training, training for ad hoc counselors, and information packets or other handouts.

1. All employees will receive training in the following areas:
 - Signs of distress
 - Traumatic grief
 - Psychosocial effects of management of mass fatalities
 - Stress management and coping strategies
 - Strategies for building and sustaining personal resilience
 - Behavioral and psychological support resources
 - Strategies for helping children and families in times of crisis
 - Strategies for working with highly agitated patients
 - Stressors related to pandemic influenza and other specific hazards
2. Department-specific training will be developed by department managers as appropriate based on the type of services provided.
3. If there are not enough behavioral health specialists available for response to staff needs in an emergency, (affiliate or contractor name) will provide basic counseling training to selected individuals to assist in meeting staff emotional needs.
4. (Affiliate or contractor name) has developed information regarding workforce resilience that will be available for distribution to staff members and their families.

Deployed Workers

In the event of a major emergency, especially one that lasts for multiple weeks, staff may be asked to work at other long-term care health facilities or other locations in the community. Within your own facility or at these other locations, staff members may be asked to use transferable skills to do work that is not in their current job description or scope of practice.

Deployment within the organization

- Pre-deployment, staff will be briefed on stress management, coping skills, and resilience.
- Supervisors will develop job description (just-in-time) training sheets that outline tasks for a borrowed worker or volunteer.
- Supervisors will ascertain competency of borrowed workers to do assigned tasks.
- Volunteers will be trained in the specific areas to which they are assigned until adequate education is provided.
- All deployed staff have a responsibility to advise their supervisor when they have been assigned a task for which they have no training or skills. Supervisors should train the employee to the task, if appropriate, or assign the task to someone else.
- A buddy system will be established to help employees support each other.
- Staff will be trained on self-help activities.

Deployment outside of the organization

Local, tribal, state, and/or federal government may require assistance and request that healthcare workers be deployed to other sites. ___(contact person)___ is responsible for coordinating all external deployment of employees.

- (Contact person) will coordinate with the Incident Commander to determine how many staff members can be spared and then will send a call for volunteers for deployment.
- Pre-deployment, staff will be briefed on:
 - Status of community or agency to which they are temporarily re-assigned
 - Work that is expected of them
 - Stress management, coping skills, and resilience
 - Self-help activities
 - Approximate duration of temporary reassignment



Description

In the event of an extended emergency response or civil disturbance where staff must remain at the facility for long periods, offering dependent care to staff members is a viable alternative if no responsible person is available to provide care to family members. Staff member's dependents, including children and elderly or disabled persons, will be housed in the dependent care area, which will be located in a designated area within the facility, for the duration of the disturbance or until other arrangements are made.

The Sample Policy for Dependent Care provides guidance to long-term care health facilities on the policies and procedures that should be in place in the event it becomes necessary to house staff member's children and elderly or disabled family members during a healthcare surge.

The Sample Policy for Dependent Care can also be found in *Volume V: Long-Term Care Health Facilities* Section 9.3, "Support Provisions for Staff."

Instructions

Review the Sample Policy for Dependent Care and consider incorporating relevant recommendations into a long-term care health facility's emergency operations plan and/or surge plans.

Sample Policy for Dependent Care

Purpose:

This procedure outlines the process by which a long-term care health facility can provide shelter and food for dependents of staff and volunteers during an emergency situation.

Definition:

Dependent care area is located in [facility-designated area].

Policy:

In the event of an extended emergency response or civil disturbance during which staff will remain at [Facility Name] for long periods, dependents (including children, elderly family members, and family members with disabilities) may be brought with the staff member and housed in the designated dependent care area if a responsible person is not available at home to provide care.

Responsibilities:

A Dependent Care Unit Leader should be assigned and be responsible for coordinating the dependent care area activities.

Procedure:

- A. Mobilization: Upon request by the Operations Chief or the Incident Commander, the Dependent Care Unit Leader shall mobilize sufficient staff and resources to activate a dependent care area.
- B. Safety requirements: Prior to activation of the dependent care area, the Dependent Care Unit Leader, with assistance from safety and security staff, shall conduct a safety inspection of the area to remove any unsafe objects and to secure any equipment that could pose a safety hazard.
- C. Staff:
 1. The Dependent Care Unit Leader will oversee other staff or volunteers, registration of dependents, and administration of medications.
 2. Staff and volunteers shall sign in and out when reporting to assist.
 3. Staff shall monitor the area continuously to respond to dependents' needs and address any safety issues.
 4. If additional assistance is needed, staff will communicate those needs through the command structure. Supplementary support for dependents may be available from the American Red Cross or similar organizations.
- D. Supplies: Dependent care area supplies shall be requested through the Materials Supply Unit Leader.

- E. Food: Meals and snacks for dependents shall be arranged by the Nutritional Supply Unit Leader.
- F. Registration:
1. Post signs indicating "Dependent Care Area – Responsible Adult Must Register Dependent."
 2. Assign each family a family number.
 3. Register all dependents with a dependent care registration form (e.g., Sample Tracking Form for Dependent Care) and be assigned a dependent number. Establish the dependent number by adding a letter (A, B, C, D, etc.) to the family number for each dependent in a given family.
 4. Apply an armband/wristband to each dependent upon arrival with name and department of the responsible staff member.
 5. Take a picture of each dependent with person responsible for them and attach to dependent care registration form (e.g., Sample Tracking Form for Dependent Care).
 6. Special sign-in and sign-out procedures shall be provided for minor or incompetent dependents.
 - i. Implement a positive identification system for all children younger than 10.
 - ii. Provide matching identification for retrieving guardian to show upon release of child.
 7. Tag medications, bottles, food, and other belongings with dependent's name and dependent number and store appropriately.
 8. Assign each dependent to a dependent care provider and record on form. (See "Sample Tracking Form for Dependent Care" below for an example of a tool that could be used to register dependents).
- G. Medications:
1. Ensure that dependents taking medications have a supply to last for the estimated length of stay.
 2. Arrange for a licensed nurse to dispense medications as appropriate.
- H. Psychological Support: Arrange for the Psychological Support Unit Leader to make routine contact with dependents and respond to specific incidents or individual needs.
- I. Documentation:
1. Document all care provided to individual dependents (e.g., medications, psychological services, toileting, or dressing).
 2. Document all other actions and decisions and report routinely to the Dependent Care Unit Leader.
- J. Checking out of Dependent Care Area:
1. When dependent leaves area, consult picture of dependent and responsible person.
 2. Check identification, verify name, and obtain signature of responsible person picking up dependent.

3. Retrieve and send all medications and personal items with dependent.
4. Collect armbands/wristbands.

DRAFT



Description

In the event of an extended emergency response or civil disturbance where staff must remain at the facility for long periods, dependents, including children, elderly, and disabled persons, may be brought to the long-term care health facility by staff members. If no responsible person is available at home to provide care, these dependents will be housed in the dependent care area, which will be located in a designated area within the facility, for the duration of the disturbance or until other arrangements are made.

The Sample Tracking Form for Dependent Care allows facilities to track the individuals for whom they provide dependent care during a healthcare surge and to monitor the healthcare services provided to individuals while they are under dependent care.

The Sample Tracking Form for Dependent Care can also be found in *Volume V: Long-Term Care Health Facilities* Section 9.3, "Support Provisions for Staff."

Instructions

Use the Sample Tracking Form for Dependent Care to track the individuals for whom the facility provides dependent care during a healthcare surge and to monitor the healthcare services provided to individuals while they are under dependent care. Complete all applicable fields in the form.

Sample Tracking Form for Dependent Care

Sample Tracking Form For Dependent Care		
Check In Date		Time
Check Out Date		Time
Staff Name	Relationship to Dependent	Family Number
Dependent Name	Age	Dependent Number
Staff's Department		Extension
Other Family, Relative, etc. we can call in an emergency		
Name		Phone Number
Name		Phone Number
Special Needs		
Allergies		
Food		
Toileting		
Medical Conditions		
Medications you brought		
Name	Dose	Times to be given
Name	Dose	Times to be given
People who may pick up Dependent		
Name		Relationship
Name		Relationship
Name		Relationship
For Dependent Care Area Staff Only		
<u>Dependent Care Staff:</u>		
<ul style="list-style-type: none"> • Apply armband/wristband with name and registration number on each dependent. • Tag all medications, bottles, food and other belongings and store appropriately. • Photograph dependent with person responsible and attach photo to this form. • Use reverse side of this form to document care provided to this dependent. • Retain forms in dependent care area until "All Clear" is announced, then route to the Command Center. 		
Dependent Care Providers Assigned		
Name of Person Picking up Dependent		
Signature of Person Picking up Dependent		
Check In Date		Time
Check Out Date		Time

Staff Name	Relationship to Dependent	Family Number
Dependent Name	Age	Dependent Number
Staff's Department	Extension	
Other Family, Relative, etc we can call in an emergency		
Name	Phone Number	
Name	Phone Number	
Special Needs		
Allergies		
Food		
Toileting		
Medical Conditions		
Medications you brought		
Name	Dose	Times to be given
Name	Dose	Times to be given
People who may pick up dependent		
Name	Relationship	
Name	Relationship	
Name	Relationship	
For Dependent Care Area Staff Only		
<u>Dependent Care Staff:</u>		
<ul style="list-style-type: none"> • Apply armband with name and registration number on each dependent. • Tag all medications, bottles, food and other belongings and store appropriately. • Photograph dependent with person responsible and attach photo to this form. • Use reverse side of this form to document care provided to this dependent. • Retain forms in dependent care area until "All Clear" is announced, then route to the Command Center. 		
Dependent Care Providers Assigned		
Name of Person Picking up Dependent		
Signature of Person picking up dependent		



Description

It is unlikely that staff will report for duty or remain at work during an emergency if they are concerned about the safety and welfare of their family. Therefore, long-term care health facilities should encourage staff to develop a plan with their families for what could happen in the event of an emergency.

The Sample Family Emergency Plan can be used by staff and their family members to collect information to be used in an emergency or disaster. This form was taken from the federal Department of Homeland Security website at <http://www.ready.gov>.

The Sample Family Emergency Plan is referenced in *Volume V: Long-Term Care Health Facilities* Section 9.4, "Staff Family Emergency Plan."

Instructions

Distribute the Sample Family Emergency Plan to staff and encourage them to complete as part of a family emergency planning. Staff should keep a copy of this plan in their emergency supply kit or another safe place where they can access it in the event of a disaster.

Sample Family Emergency Plan



Family Emergency Plan



Prepare. Plan. Stay Informed.



Make sure your family has a plan in case of an emergency. Before an emergency happens, sit down together and decide how you will get in contact with each other, where you will go and what you will do in an emergency. Keep a copy of this plan in your emergency supply kit or another safe place where you can access it in the event of a disaster.

Out-of-Town Contact Name: _____	Telephone Number: _____
Email: _____	
Neighborhood Meeting Place: _____	Telephone Number: _____
Regional Meeting Place: _____	Telephone Number: _____
Evacuation Location: _____	Telephone Number: _____

Fill out the following information for each family member and keep it up to date.

Name: _____	Social Security Number: _____
Date of Birth: _____	Important Medical Information: _____
Name: _____	Social Security Number: _____
Date of Birth: _____	Important Medical Information: _____
Name: _____	Social Security Number: _____
Date of Birth: _____	Important Medical Information: _____
Name: _____	Social Security Number: _____
Date of Birth: _____	Important Medical Information: _____
Name: _____	Social Security Number: _____
Date of Birth: _____	Important Medical Information: _____

Write down where your family spends the most time: work, school and other places you frequent. Schools, daycare providers, workplaces and apartment buildings should all have site-specific emergency plans that you and your family need to know about.

Work Location One	School Location One
Address: _____	Address: _____
Phone Number: _____	Phone Number: _____
Evacuation Location: _____	Evacuation Location: _____
Work Location Two	School Location Two
Address: _____	Address: _____
Phone Number: _____	Phone Number: _____
Evacuation Location: _____	Evacuation Location: _____
Work Location Three	School Location Three
Address: _____	Address: _____
Phone Number: _____	Phone Number: _____
Evacuation Location: _____	Evacuation Location: _____
Other place you frequent	Other place you frequent
Address: _____	Address: _____
Phone Number: _____	Phone Number: _____
Evacuation Location: _____	Evacuation Location: _____

Important Information	Name	Telephone Number	Policy Number
Doctor(s):			
Other:			
Pharmacist:			
Medical Insurance:			
Homeowners/Rental Insurance:			
Veterinarian/Kennel (for pets):			

Dial 911 for Emergencies



Make sure your family has a plan in case of an emergency. Fill out these cards and give one to each member of your family to make sure they know who to call and where to meet in case of an emergency.

ADDITIONAL IMPORTANT PHONE NUMBERS & INFORMATION

Family Emergency Plan 

EMERGENCY CONTACT NAME: _____
TELEPHONE: _____

OUT-OF-TOWN CONTACT NAME: _____
TELEPHONE: _____

NEIGHBORHOOD MEETING PLACE: _____
TELEPHONE: _____

OTHER IMPORTANT INFORMATION: _____

Ready 

DIAL 911 FOR EMERGENCIES

ADDITIONAL IMPORTANT PHONE NUMBERS & INFORMATION

Family Emergency Plan 

EMERGENCY CONTACT NAME: _____
TELEPHONE: _____

OUT-OF-TOWN CONTACT NAME: _____
TELEPHONE: _____

NEIGHBORHOOD MEETING PLACE: _____
TELEPHONE: _____

OTHER IMPORTANT INFORMATION: _____

Ready 

DIAL 911 FOR EMERGENCIES

ADDITIONAL IMPORTANT PHONE NUMBERS & INFORMATION

Family Emergency Plan 

EMERGENCY CONTACT NAME: _____
TELEPHONE: _____

OUT-OF-TOWN CONTACT NAME: _____
TELEPHONE: _____

NEIGHBORHOOD MEETING PLACE: _____
TELEPHONE: _____

OTHER IMPORTANT INFORMATION: _____

Ready 

DIAL 911 FOR EMERGENCIES

ADDITIONAL IMPORTANT PHONE NUMBERS & INFORMATION

Family Emergency Plan 

EMERGENCY CONTACT NAME: _____
TELEPHONE: _____

OUT-OF-TOWN CONTACT NAME: _____
TELEPHONE: _____

NEIGHBORHOOD MEETING PLACE: _____
TELEPHONE: _____

OTHER IMPORTANT INFORMATION: _____

Ready 

DIAL 911 FOR EMERGENCIES



Description

It is unlikely that staff will report for duty or remain at work during an emergency if they are concerned about the safety and welfare of their family. Therefore, long-term care health facilities should encourage staff to develop a plan with their families for what could happen in the event of an emergency.

The Sample Family Emergency Supply List provides staff and their family members with a list of items to consider when developing an emergency supply kit. This checklist was taken from the federal Department of Homeland Security website at <http://www.ready.gov>.

The Sample Family Emergency Supply List is referenced in *Volume V: Long-Term Care Health Facilities* Section 9.4, "Staff Family Emergency Plan."

Instructions

Distribute the Sample Family Emergency Supply List to staff and encourage them to complete when accumulating a family emergency supply kit as part of a family emergency plan.

Sample Family Emergency Supply Kit

- 
- Recommended Items to Include in a Basic Emergency Supply Kit:**
- Water, one gallon of water per person per day for at least three days, for drinking and sanitation
 - Food, at least a three-day supply of non-perishable food
 - Battery-powered or hand crank radio and a NOAA Weather Radio with tone alert and extra batteries for both
 - Flashlight and extra batteries
 - First aid kit
 - Whistle to signal for help
 - Dust mask, to help filter contaminated air and plastic sheeting and duct tape to shelter-in-place
 - Moist towelettes, garbage bags and plastic ties for personal sanitation
 - Wrench or pliers to turn off utilities
 - Can opener for food (if kit contains canned food)
 - Local maps



Additional Items to Consider Adding to an Emergency Supply Kit:

- Prescription medications and glasses**
- Infant formula and diapers**
- Pet food and extra water for your pet**
- Important family documents such as copies of insurance policies, identification and bank account records in a waterproof, portable container**
- Cash or traveler's checks and change**
- Emergency reference material such as a first aid book or information from www.ready.gov**
- Sleeping bag or warm blanket for each person. Consider additional bedding if you live in a cold-weather climate.**
- Complete change of clothing including a long sleeved shirt, long pants and sturdy shoes. Consider additional clothing if you live in a cold-weather climate.**
- Household chlorine bleach and medicine dropper** – When diluted nine parts water to one part bleach, bleach can be used as a disinfectant. Or in an emergency, you can use it to treat water by using 16 drops of regular household liquid bleach per gallon of water. Do not use scented, color safe or bleaches with added cleaners.
- Fire Extinguisher**
- Matches in a waterproof container**
- Feminine supplies and personal hygiene items**
- Mess kits, paper cups, plates and plastic utensils, paper towels**
- Paper and pencil**
- Books, games, puzzles or other activities for children**





Description

It is unlikely that staff will report for duty or remain at work during an emergency if they are concerned about the safety and welfare of their family. Therefore, long-term care health facilities should encourage staff to develop a plan with their families for what could happen in the event of an emergency.

The Pandemic Flu Planning Checklist provides staff and their family members with a list of items to consider helping plan for a pandemic influenza. This checklist was adapted from materials developed by the federal Department of Health and Human Services available at <http://www.pandemicflu.gov>.

The Pandemic Flu Planning Checklist is referenced in *Volume V: Long-Term Care Health Facilities* Section 9.4, "Staff Family Emergency Plan."

Instructions

Distribute the Pandemic Flu Planning Checklist to staff and encourage them to complete as part of a family emergency plan.

Pandemic Flu Planning Checklist for Individuals & Families

1. To plan for a pandemic

- Store a two week supply of water and food. During a pandemic, if you cannot get to a store, or if stores are out of supplies, it will be important for you to have extra supplies on hand. This can be useful in other types of emergencies, such as power outages and disasters.
- Periodically check your regular prescription drugs to ensure a continuous supply in your home.
- Have nonprescription drugs and other health supplies on hand, including pain relievers, stomach remedies, cough and cold medicines, fluids with electrolytes, and vitamins.
- Talk with family members and loved ones about how they would be cared for if they got sick, or what will be needed to care for them in your home.
- Volunteer with local groups to prepare and assist with emergency response.
- Get involved in your community as it works to prepare for an influenza pandemic.

2. To limit the spread of germs and prevent infection

- Teach your children to wash hands frequently with soap and water, and model the current behavior.
- Teach your children to cover coughs and sneezes with tissues, and be sure to model that behavior.
- Teach your children to stay away from others as much as possible if they are sick. Stay home from work and school if sick.

3. Items to have on hand for an extended stay at home

Examples of food and non-perishables	Examples of medical, health, and emergency supplies
<ul style="list-style-type: none"> <input type="checkbox"/> Ready-to-eat canned meats, fish, fruits, vegetables, beans and soups <input type="checkbox"/> Protein or fruit bars <input type="checkbox"/> Dry cereal or granola <input type="checkbox"/> Peanut butter or nuts <input type="checkbox"/> Dried Fruit <input type="checkbox"/> Crackers <input type="checkbox"/> Canned juices <input type="checkbox"/> Bottled water <input type="checkbox"/> Canned or jarred baby food and formula <input type="checkbox"/> Pet food <input type="checkbox"/> Other nonperishable foods 	<ul style="list-style-type: none"> <input type="checkbox"/> Prescribed medical supplies such as glucose and blood-pressure monitoring equipment <input type="checkbox"/> Soap and water, or alcohol-based (60-95%) hand wash <input type="checkbox"/> Medicines for fever, such as acetaminophen or ibuprofen <input type="checkbox"/> Thermometer <input type="checkbox"/> Anti-diarrheal medication <input type="checkbox"/> Vitamins <input type="checkbox"/> Fluids with electrolytes <input type="checkbox"/> Cleansing agent/soap <input type="checkbox"/> Flashlight <input type="checkbox"/> Batteries <input type="checkbox"/> Portable radio <input type="checkbox"/> Manual can opener <input type="checkbox"/> Garbage bags <input type="checkbox"/> Tissues, toilet paper, disposable diapers



Description

It is unlikely that staff will report for duty or remain at work during an emergency if they are concerned about the safety and welfare of their family. Therefore, long-term care health facilities should encourage staff to develop a plan with their families for what could happen in the event of an emergency.

The Family Emergency Health Information Sheet can assist staff and their family members to collect and organize health and personal contact information. These sheets were adapted from materials developed by the federal Department of Health and Human Services available at <http://www.pandemicflu.gov>.

The Family Emergency Health Information Sheet is referenced in *Volume V: Long-Term Care Health Facilities* Section 9.4, "Staff Family Emergency Plan."

Instructions

Distribute the Family Emergency Health Information Sheet to staff and encourage them to complete as part of a family emergency plan.

Family Emergency Health Information Sheet

1. Family Member Information:

Family Member	Blood Type	Allergies	Past/Current Medical Conditions	Current Medications / Dosages

2. Emergency Contacts:

Contacts	Name/Phone Number
Local personal emergency contact	
Out-of-town personal emergency contact	

Contacts	Name/Phone Number
Medical Providers near: <div style="text-align: right; padding-right: 20px;"> Work: School: Home: </div>	
Family physician(s)	
State public health department (See list on www.pandemicflu.gov/state/statecontacts.html)	
Pharmacy	
Employer contact and emergency information	
School contact and emergency information	
Religious/spiritual organization	
Veterinarian	



Description

The federal Centers of Medicare and Medicaid Services have prepared a checklist to assist long-term care residents and their families prepare for emergencies. The Emergency Planning Checklist Recommendations can be used to assist residents and their families when developing a family emergency plan, and could also be adapted to offer recommendations to long-term care health facility staff and their families.

The Emergency Planning Checklist Recommendations is referenced in *Volume V: Long-Term Care Health Facilities* Section 9.4, "Staff Family Emergency Plan."

Instructions

Distribute the Emergency Planning Checklist Recommendations to staff, patients, and family members and encourage them to complete as part of a family emergency plan.

Emergency Planning Checklist Recommendations

EMERGENCY PLANNING CHECKLIST RECOMMENDED TOOL FOR PERSONS IN LONG-TERM CARE FACILITIES & THEIR FAMILY MEMBERS, FRIENDS, PERSONAL CAREGIVERS, GUARDIANS & LONG-TERM CARE OMBUDSMEN		
Part I: For Long-Term Care Residents, Their Family Members, Friends, Personal Caregivers, & Guardians		
Target Date	Date Completed	
		<ul style="list-style-type: none"> • Emergency Plan: Prior to any emergency, ask about and become familiar with the facility's emergency plan, including: <ul style="list-style-type: none"> ✓ Location of emergency exits ✓ How alarm system works and modifications for individuals who are hearing and/or visually impaired ✓ Plans for evacuation, including: <ul style="list-style-type: none"> ▪ How residents/visitors requiring assistance will be evacuated, if necessary ▪ How the facility will ensure each resident can be identified during evacuation (e.g., attach identification information to each resident prior to evacuation) ▪ Facility's evacuation strategy ▪ Where they will go ▪ How their medical charts will be transferred ▪ How families will be notified of evacuation ✓ Will families be able to bring their loved one home rather than evacuating, which is often less traumatic than a move to a new facility? ✓ How family members can keep the facility apprised of their location and contact information (e.g., address, phone number, e-mail address), so the facility will be able to contact them, and family members will be able to check with the facility to meet their loved one following an emergency ✓ How residents and the medicines and supplies they require will be prepared for the emergency, have their possessions protected and be kept informed during and following the emergency ✓ How residents (if able) and family members can be helpful (for example, should family members come to the facility to assist?) ✓ How residents, who are able, may be involved during the emergency, including their roles and responsibilities. Note: It is important for staff to know each resident personally, and whether involving him/her in the emergency plan will increase a sense of security or cause anxiety.. For example, residents may have prior work or personal experience that could be of value (health care, emergency services, military, amateur

		ham radio operators, etc.) Provide the opportunity for residents to discuss any fears and what actions may help to relieve their anxiety (e.g., a flashlight on the bed, water beside the bed, etc.).
		<ul style="list-style-type: none"> • Helping Residents in a Relocation: Suggested principles of care for relocated residents include: <ul style="list-style-type: none"> ✓ Encourage the resident to talk about expectations, anger, and/or disappointment ✓ Work to develop a level of trust ✓ Present an optimistic, favorable attitude about the relocation ✓ Anticipate that anxiety will occur ✓ Do not argue with the resident ✓ Do not give orders ✓ Do not take the resident's behavior personally ✓ Use praise liberally ✓ Be courteous and kind ✓ Include the resident in assessing problems ✓ Encourage family participation ✓ Ensure staff in the receiving facility introduce themselves to residents

Part II: For Long-Term Care Ombudsmen

Targeted Date	Date Completed	
		<ul style="list-style-type: none"> • State Ombudsman Responsibilities: <ul style="list-style-type: none"> ✓ Become generally familiar with state emergency plans pertinent to long-term care facilities, including the state or federal agency that may be established to serve as a clearinghouse for facility evacuations: know the name, telephone number and e-mail of the person to whom long-term care facility evacuations and evacuees' names should be reported. If no clearinghouse has been established, advocate for one. ✓ At least annually, ensure that all regional ombudsman coordinators and local ombudsmen and/or representatives read, are familiar with and have the opportunity to discuss resources, such as the two recommended CMS emergency preparedness checklists pertaining to long-term care facilities: the <i>CMS Emergency Preparedness Checklist – Recommended Tool for Effective Health Care Facility Planning</i> and this <i>CMS Emergency Planning Checklist – Recommended Tool for Persons Living In Long-Term Care Facilities, Their Family Members, Friends, Personal Caregivers, Guardians, & Long-Term Care Ombudsmen</i>. ✓ Maintain at home and office hard copies of current regional ombudsman contact information, including cell phones. ✓ Prior to an anticipated disaster, if the state ombudsman program has regional coordinators and/or other program representatives in the areas likely to be affected, call them to make sure they have assigned representatives to carry out the responsibilities listed in the section below

		<p>pertaining to local ombudsman programs.</p> <ul style="list-style-type: none"> ✓ Immediately following a disaster, contact regional ombudsman coordinators/representatives in the affected areas to provide support and resources, as needed and feasible.
		<ul style="list-style-type: none"> • Regional Ombudsman Coordinator & Representative Responsibilities (for states with regional/local ombudsman programs and/or representatives) <ul style="list-style-type: none"> ▶ Prior to any emergency, ombudsmen: <ul style="list-style-type: none"> ✓ Become generally familiar with the local emergency plans and the roles of local, county and state agencies in a disaster, especially as pertaining to long-term care facilities. ✓ Read and become familiar with emergency plans of facilities in the region for which the regional program has responsibility. If a state or regional clearing house for evacuations has been established, know the agency, phone number and e-mail where facility evacuations will be reported. ✓ Maintain, at home and office, hard copies of current contact information for facilities, other ombudsmen and appropriate agencies, especially the local emergency management agency. ▶ Prior to an anticipated emergency and following an emergency: <ul style="list-style-type: none"> ✓ The regional ombudsman program coordinator assigns a representative to check on each facility covered by the program and reviews the responsibilities listed below with representatives assigned to facilities. ✓ Assigned representatives check on assigned facilities to assure that residents' rights are protected prior to, during and after evacuation and provide information about conditions and any evacuation to the regional ombudsman coordinator; regional coordinator provides information to the state ombudsman office. Exception: <i>when the ombudsman lives in an area under mandatory evacuation; however, if possible, the ombudsman should contact the facility by telephone, even if the area is under evacuation order. (Some states may have other specific procedures in place which ombudsman representatives would be required to follow.)</i> ✓ Ombudsman representatives visit residents as soon as possible after the disaster, whether they have been sheltered in the facility or transferred to another location. (If they have been transferred out of the region, state ombudsman and regional coordinators coordinate visitation by ombudsman representatives in the receiving region.) <ul style="list-style-type: none"> ▪ Discuss and record their immediate status/needs. If the state and local ombudsman coordinator decide a form is needed, use appropriate form to record information (a sample form is attached) and send a copy of the form to whomever they specify. ▪ Take urgent action to help obtain the resources and assistance residents need to be safe and, if they have been evacuated, find their loved ones and relocate to an area/facility or other setting of their preference. (Note: the ombudsman is not responsible for providing resources but instead should be aware of available

resources and work to ensure they are provided to residents.)

- ✓ Track, if possible, the impact of the disaster on the residents
- ✓ Determine whether the facility has reported the names and destination of any evacuated residents to the clearinghouse (if state or region has established a clearinghouse), and is prepared to handle transfer trauma and support facility staff in handling resident trauma. As provided in Part I, above, suggested principles of care for the relocated residents include:
 - Encourage the resident to talk about expectations, anger, and/or disappointment
 - Work to develop a level of trust
 - Present an optimistic, favorable attitude about the relocation
 - Anticipate that anxiety will occur
 - Do not argue with the resident
 - Do not give orders
 - Do not take the resident's behavior personally
 - Use praise liberally
 - Be courteous and kind
 - Include the resident in assessing problems
 - Encourage staff in the receiving facility to introduce themselves to residents
 - Encourage family participation
- ✓ Counsel residents about their rights to:
 - Be informed regarding the status of the relocation
 - Be provided information on alternative living arrangements and the options available
 - Be assessed for eligibility for funding and supports to safely return to live in their home or community
 - Visit other facilities to help them better decide where to live
 - Seek representation by an ombudsman or other representative/advocate available in the area
 - Expect to receive adequate care and treatment services during the relocation
 - Meet with the facility staff to express any concerns
 - Seek a review of any relocation changes with which they disagree
 - Expect that their rights, while a resident of any facility, will not be violated

(Note: Adapted from WI Ombudsman Program brochure for residents of facilities scheduled for closure)



Description

After considering how to procure pharmaceuticals during a healthcare surge, long-term care health facilities must then plan for how they will receive, organize, store, and access the medications once on-site. During a healthcare surge, it may become necessary to obtain drugs from different sources and in different quantities than during normal operations. This may pose operational challenges; long-term care health facilities may need to re-package bulk deliveries of drugs and/or expand their storage capacity to accommodate larger than normal deliveries. If the facility is damaged or reconfigured to expand patient care areas, normal procedures for processing patient medications may become impossible.

The Pharmaceutical Storage Checklist below addresses the issues and processes that long-term care health facilities are strongly encouraged to consider for storing and accessing pharmaceuticals at the facility during a healthcare surge, including:

- Inventory Management
- Environmental Management
- Security
- Ease of Access

The Pharmaceutical Storage Checklist can also be found in *Volume V: Long-term Care Health Facilities* Section 10.2.1, "Storage and Inventory Management of Pharmaceuticals."

Instructions

Check off all completed tasks. Note that some tasks may not apply to every long-term care health facility.

Pharmaceutical Storage Consideration Checklist

Inventory Management

- A process for local repackaging of pharmaceuticals if they arrive in bulk containers
- A process for properly labeling repackaged pharmaceuticals

Environmental Management

- A process for monitoring the environment to meet United States Pharmacopeia (USP) standards (e.g., temperature, humidity, pests)
- A process for maintaining adequate room temperature ranges between 68° and 77°F, the range required for most medications, as specified in the Strategic National Stockpile guidelines
- A process to ensure that the manufacturer's storage guidelines are met

Security (*assuming a heightened state of facility security*)

- A process for ensuring the security of the pharmaceuticals (e.g., locks, security personnel)
- A process for controlling access into the building or area
- A process for controlling access within the building
- A process for identifying and tracking patients, staff, and visitors
- A process for monitoring facilities with security cameras
- A process for ensuring security locks on pharmaceuticals are in place
- A process for working with local authorities prior to a healthcare surge to address heightened security needs
- A process for working with private security entities prior to a healthcare surge to address heightened security needs

Ease of Access

- A process for staging the layout of pharmaceuticals to ensure ease of access (e.g., what is needed in the first 24 hours)



Description

The Detailed Supplies and Equipment List provides planners with a guide for ordering specific supplies and equipment. This list should not be considered comprehensive but should be used as a guide when considering the types of supplies and equipment that are needed during a catastrophic emergency.

There are supplies and equipment that are unique to the pediatric population. For more detailed information on the emergency care of a pediatric population, refer to http://www.emsa.ca.gov/def_comm/vii032807_a.asp.

The Detailed Supplies and Equipment List can also be found in *Volume V: Long-term Care Health Facilities* Section 10.3.2, "Inventory Based - Detailed Supplies and Equipment List."

Instructions

The Detailed Supplies and Equipment List has four columns:

1. **Current Supply:** Stock on hand.
2. **Total Potential Requiring Treatment:** An estimate of the long-term care health facility's surge capacity.
3. **Package Size** (e.g., 100/box, or simply 100)
4. **Cache Quantity:** Quantity that may be accessible from affiliated healthcare providers or city/county caches, beyond the facility on-hand supply

The long-term care health facility should consider the following when determining which supplies and equipment to stock:

- Which supplies and equipment would the long-term care health facility specifically choose to stock?
- Which supplies and equipment should be considered for an all-hazard catastrophic emergency?
- Which supplies and equipment are also part of the long-term care health facility's supply inventory?

Detailed Supplies and Equipment List

Detailed Supplies and Equipment List				
BANDAGES AND DRESSINGS	Current Supply	Total Potentially Requiring Treatment	Package Size (if applicable)	Cache Quantity
Adhesive strip, 1" X 3"				
Alcohol pads				
Bandage elastic (Ace wrap) 2"				
Bandage elastic (Ace wrap) 4"				
Bandage elastic (Ace wrap) 6"				
Bandage, gauze non sterile (kerlix) 4" X 10'				
Bandage, gauze non sterile 4X4				
Bandage 4X4 sterile				
Bandage 2X2 sterile				
Triangular bandage				
Adhesive bandages (e.g. Band-Aids)				
Eye pad, oval sterile				
Eye Shields				
Morgan Lens				
Petroleum Gauze 5" X 9" (Xeroform)				
Vaseline gauze				
Gauze Pad 5" X 9" sterile				
Tape 1" paper				
Tape 1" silk				
Tape 1" transparent				
First Aid tape roll				
Dressing (abd pad)				

ORTHOPEDIC SUPPLIES	Current Supply	Total Potentially Requiring Treatment	Package Size (if applicable)	Cache Quantity
Splint, cardboard 12"				
Splint, cardboard 18"				
Splint, cardboard 24"				
Splint, cardboard 34"				
Splint, fiberglass 3"				
Splint, fiberglass 4"				
Splint, fiberglass 5"				
Leg splint				
Arm sling				
Arm splint- small / medium / large				
IV SETS, NEEDLES AND SYRINGES	Current Supply	Total Potentially Requiring Treatment	Package Size (if applicable)	Cache Quantity
IV Start Kits				
IV catheter, 18 gauge				
IV catheter, 20 gauge				
IV catheter, 22 gauge				
IV catheter, 24 gauge				
IV administration set, adult				
IV administration set, pediatric				
IV piggyback tubing				
Needle disposable, 18 gauge				
Needle disposable, 22 gauge				
Needle disposable, 25 gauge				
Syringe, 1ml				
Syringe, 3 ml				
Syringe, 5 ml				
Syringe, 10 ml				
Syringe, 20 ml				
Syringe, 35cc, for wound irrigation				
Irrigation kit				

Syringe/needle, 3 ml, 22gauge X 1 ½"				
Syringe/needle, 1 ml, 25 gauge X 5/8"				
Syringe/needle 1 ml, 29 gauge X ½"				
Insulin syringes				
Sharps container				
AIRWAY MANAGEMENT SUPPLIES	Current Supply	Total Potentially Requiring Treatment	Package Size (if applicable)	Cache Quantity
Bag-valve-mask, adult				
Bag-valve-mask, pediatric				
Airway adjunct, OP Airway				
Airway adjunct, NP Airway				
Cricothyrotomy / Shiley 4				
Endotracheal tube, cuffed 8mm				
Endotracheal tube, cuffed, 7.5mm				
Endotracheal tube, cuffed 7mm				
Endotracheal tube, cuffed, 6mm				
Endotracheal tube, cuffed 2.5mm				
Endotracheal tube, cuffed 3mm				
Endotracheal tube, cuffed, 4mm				
Endotracheal tube, cuffed, 4.5mm				
Endotracheal tube, cuffed, 5mm				
Endotracheal tube, cuffed, 5.5mm				
Endotracheal tube, non-cuffed, 2.5mm				
Endotracheal tube, non-cuffed, 3mm				
Endotracheal tube, non-cuffed, 4mm				
Endotracheal tube, non-cuffed, 5mm				
ETT Holders				
Intubation kit, incl. Blades, medium handle, stylet and case – including magill forceps				
Intubation kit (Pediatrics) , incl. Blades, medium handle, stylet and case – including magill forceps				
Nasal cannula, adult				
Nasal cannula, pediatric				
O2 mask with tubing, pediatric				

02 mask with tubing, adult				
02 mask - non-rebreather, adult				
Nebulizers – hand held				
Nebulizers – masks				
Ventilator circuits				
Suction machine, portable				
Suction catheters 10 French				
Suction catheters 12 French				
Suction catheters 14 French				
Yankauer suction				
Suction tubing				
Suction Canisters				
NG Tubes				
Thoracostomy Tubes, assorted sizes				
Pleurivac & Heimlich valves				
INFECTION CONTROL SUPPLIES	Current Supply	Total Potentially Requiring Treatment	Package Size (if applicable)	Cache Quantity
Cover/Isolation gowns				
Splash guard for wound irrigation				
Masks surgical				
Surgical masks with shield, latex free				
Face shield with eye shield				
Masks N-95				
Patient exam gloves, small				
Patient exam gloves, medium				
Patient exam gloves, large				
Gloves -non latex, small				
Gloves -non latex, medium				
Gloves -non latex, large				
Shoe covers				
Surgical caps				
Antibacterial hand wash				
Alcohol- Isopropyl				

Anti-septic Foam Alcohol				
Betadine scrub				
Hydrogen peroxide				
Germicidal wipes				
Anti-septic germicide prep solution (Iodine)				
Chlorine bleach				
Thermometer covers				
CPR face mask				
Wipes, disposable				
MISCELLANEOUS SUPPLIES	Current Supply	Total Potentially Requiring Treatment	Package Size (if applicable)	Cache Quantity
Bags, plastic 30 gallon, 8 mil				
Garbage bags				
Biohazard red bags, large				
Biohazard red bags, small				
Batteries, C for laryngoscope handle				
Batteries, D for flashlights				
Blankets lightweight				
Clipboards				
Diapers, disposable large				
Diapers, disposable medium				
Diapers, disposable small				
Diapers, disposable, large, peds				
Diapers, disposable, medium, peds				
Diapers, disposable, small, peds				
Diapers, disposable, infant				
Emesis basins, plastic				
Facial tissues				
Flashlights				
Gloves work type leather/canvas				
OB kits, disposable				
Paper towels				
Patient ID bands				

Styrofoam cups				
Dressing paper for tables				
General first-aid kit				
Medication cups / dosage spoons / syringes				
Cotton tip applicators				
General sponges				
4 x 4 gauze sponges				
3 x 3 gauze sponges				
Face shields, disposable				
Scissors				
Duct tape				
Petroleum jelly				
Oral rehydration solution (e.g., Pedialyte) 12 oz bottles				
Body lotion				
Colostomy bags				
Feminine products				
Hospital ID Bracelets				
Lancing device, single device				
disposable under-pads (e.g. Chux)				
Urinary drainage bags				
Ambu bag- adult, pediatric, infant				
Bulb syringe				
Re-sealable plastic bags (e.g. Ziploc bags)				
Disposable ice packs / cold packs				
Baby wipes				
Tongue depressors, non sterile				
NON-DISPOSABLE MEDICAL SUPPLIES	Current Supply	Total Potentially Requiring Treatment	Package Size (if applicable)	Cache Quantity
Blood Pressure multi-cuff kit with adult, pediatric, infant and thigh cuff				
Glucometer kit with lancets, test strips and battery				
Portable Otoscope/Ophthalmoscope set with batteries				
Pulse Oximetry, portable				

Stethoscope				
Tourniquets 1"				
Forceps / tweezers				
Goggles				
Oxygen mask with regulators / wrench				
Wash basins				
Cloth towels large				
Cloth towels small				
Bed pans				
Bedside commodes				
Bucket 2 gallon				
Pillows				
Non mercury thermometer				
Neck brace				
Trauma/paramedic scissors				

DRAFT



Description

Whether in preparation for a healthcare surge or during a surge, there are many planning considerations to ensure that supplies and equipment can be accessed and used immediately. The Supplies and Equipment Storage Checklist lists considerations for supplies and equipment storage across six major categories:

- Inventory management
- Environmental management
- Security
- Caches
- Transport
- Ease of access

The Supplies and Equipment Storage Checklist can also be found in *Volume V: Long-Term Care Health Facilities* Section 10.5, "Storage and Inventory Management for Supplies and Equipment."

Instructions

Check off all completed tasks. Note that some tasks may not apply to every long-term care health facility.

Supplies and Equipment Storage Checklist

Inventory Management

- A process for monitoring and maintaining preventive maintenance requirements:
 - Batteries
 - Ventilator seals
 - Electrical equipment
- A process for returning stock to vendors for replacement or credit, if applicable
- A process for monitoring the obsolescence of equipment (e.g., automated external defibrillators)
- Considerations for storing large amounts of supplies and equipment:
 - Is storage space limited on-site?
 - Can supplies and equipment be stored at other off-site locations (e.g., warehouses, other facilities in health system)?

Environmental Management

- A process for monitoring storage conditions (e.g., temperature) of supplies and equipment

Security *(assuming a heightened state of facility security)*

- A process for ensuring the security of the supply and equipment caches
- A process for controlling access into the building or area
- A process for controlling access within the building
- A process for identifying and tracking patients, staff, and visitors
- A process for monitoring facilities with security cameras
- A process for working with local authorities prior to a healthcare surge to address heightened security needs
- A process for working with private security entities prior to a healthcare surge to address heightened security needs

Caches External to a Facility

- A process for ensuring the security of the supply and equipment caches
- A process for controlling access into the area
- A process for controlling access within the area
- A process for working with local authorities prior to a healthcare surge to address heightened security needs
- A process for working with private security entities prior to a healthcare surge to address heightened security needs

Transport

- A process for obtaining the caches and transporting them to the desired locations
- A process for loading supplies and equipment in an efficient manner (e.g., loading docks)

Ease of Access

- A process for staging the layout of supplies and equipment to ensure ease of access (e.g., what is needed in the first 24 hours)

Staging Recommendations Checklist



Description

Most long-term care health facilities have limited storage capacity, so emergency supplies, when stocked, are often stored in the least convenient available space, including offsite storage facilities. During a healthcare surge, this storage plan could result in delays in care as long-term care health facilities try to retrieve their supplies from various storage locations.

Both emergency supplies and routine supplies are often stored in batches (i.e., like items stored with like items in the same location). While this is an efficient means of monitoring and replenishing inventory under routine operating procedures, it may not be optimal in an emergency response.

The Staging Recommendations Checklist summarizes steps that long-term care health facilities should take when planning for staging their resources.

The Staging Recommendations Checklist can also be found in *Volume V: Long-Term Care Health Facilities* Section 10.5.2, "Staging Considerations."

Instructions

Check off all completed tasks. Note that some tasks may not apply to your facility.

Staging Recommendations Checklist

- Develop a process for determining which items will be needed first. Use the concept of last in, first out.
- Develop a staging plan that does not place one type of material all in one place.
- Develop a plan for how the materials will be moved (e.g., deployable cart).
- Develop a plan for how items will be set up once they are taken out of storage (e.g., tents, tables, carts, and provisions for temperature control, such as ice, ice chests, etc.).
- Develop a plan that considers that space is often a limiting factor.
- Develop a plan that considers alternate sites to stage supplies and equipment (e.g., offsite storage space).
- Develop a plan that considers using pushcarts for moving materials efficiently and incorporate into staging plan.
- Label pushcarts with all materials and expiration dates.
- Keep medical supplies without expiration dates separate from medical supplies that have expiration dates.
- Cover supplies and equipment for protection from the elements to reduce spoilage and the need to repackage materials.



Description

Tracking persons seeking treatment within the healthcare system and after transfer to other care facilities during a healthcare surge is a high priority for healthcare facilities, government-authorized alternate care sites, and the community. Paper-based processes reduce compatibility issues when sharing data and total cost associated with purchasing new technology. Although significant efforts are under way to develop robust electronic patient tracking systems for emergency purposes, manual back-up processes should be maintained in case of system failures.

Patient tracking forms can be used to track individuals seeking medical attention within a facility and the disposition of those transferred to other facilities during a healthcare surge. The Patient Tracking Forms could also be used by a long-term care health facility to track patients as they are transferred to other facilities. Additionally, these forms could serve as an intake log or be used to report facility census and bed capacity to the Operational Area Emergency Operations Center.

The Patient Tracking Forms can also be found in *Volume V: Long-Term Care Health Facilities* Section 11.1.1, "Patient Tracking Forms."

Instructions

Print legibly and enter complete information for each of the following fields.

1. **INCIDENT NAME:** If the incident is internal to the long-term care facility, the name may be given by the treating facility's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local Emergency Operations Center, etc.).
2. **DATE/TIME PREPARED:** Use the international standard date notation YYYY-MM-DD, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as 2006-02-14. Use the international standard notation hh:mm, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 pm is written as 17:04. Use local time.
3. **OPERATIONAL PERIOD DATE/TIME:** Identify the operational period during which this information applies. This is the time period established by the treating facility's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.

4. **PATIENT DATA:** For each patient, record as much identifying information as available: medical record number, triage tag number, name, sex, date of birth and age. Identify area to which patient was triaged. Record disposition of patient and time of disposition.
 - **LAST NAME:** Patient's last name
 - **FIRST NAME:** Patient's first name
 - **SEX:** "M" for male and "F" for female
 - **DOB/AGE:** Patient's date of birth as YYYY-MM-DD; If time permits, record age as well.
 - **MR #/Triage #:** Medical record number and/or triage number assigned to at the long-term care health facility
 - **TIME IN:** Time the patient was received at the long-term care health facility. Use the international standard date notation YYYY-MM-DD. Use the international standard notation hh:mm. Use local time.
 - **LOCATION:** The area or zone to which a patient is triaged
 - **DISPOSITION:** The specific area, facility, or location to which the patient is transferred or discharged
 - **TIME OUT:** Time of patient transfer or discharge. Use the international standard date notation YYYY-MM-DD. Use the international standard notation hh:mm. Use local time.
 - **FAMILY NOTIFICATION:** As soon as time allows, family members should be notified of their loved one's location and condition. Note the date and time of the notification and the name of the staff member placing the call.
5. **AUTHORIZATION SIGN OFF:**
6. **CLINICAL PROVIDER:**
7. **SUBMITTED BY:** Full name of person verifying the information and submitting the form
8. **AREA ASSIGNED TO:** Triage area where these patients were first seen
9. **DATE/TIME SUBMITTED:** Indicate date and time that the form is submitted to the situation unit leader.
10. **FACILITY NAME:** Long-term care health facility name; use when transmitting the form outside of the treating facility.
11. **PHONE:** Long-term care health facility phone number.
12. **FAX:** Long-term care health facility fax number.

WHEN TO COMPLETE: Hourly and at end of each operational period or the length of time specified in the incident action plan, upon arrival of the first patient and until the disposition of the last.

Patient Tracking Form 1

PATIENT TRACKING FORM									
1. INCIDENT NAME: _____			2. DATE/TIME PREPARED: _____			3. OPERATIONAL PERIOD DATE/TIME: _____			
4. PATIENT TRACKING DATA:									
Last Name	First Name	Sex	DOB/Age	MR #/ Triage #	Time in	Location	Disposition	Time Out	Notification of Family
5. AUTHORIZATION SIGN OFF: _____					6. CLINICAL PROVIDER: _____				
7. SUBMITTED BY: _____			8. AREA ASSIGNED TO: _____			9. DATE/TIME SUBMITTED: _____			
10. FACILITY NAME: _____					11. PHONE: _____			12. FAX: _____	

Source: Adapted from Hospital Incident Command System, <http://www.emsa.ca.gov/hics/hics.asp>

Patient Tracking Form 2

PATIENT TRACKING FORM						
1. INCIDENT NAME			2. DATE/TIME PREPARED		3. PATIENT TRACKING MANAGER	
4. PATIENT EVACUATION INFORMATION						
Patient Name	Medical Record#	Disposition Home or Transfer	Evacuation Triage Category Immed Delayed Minor Expired		Accepting Hospital	Time Hospital Contacted & Report given
Transfer Initiated (Time/Transport Co.)	Med Record Sent Yes No	Medication Sent Yes No	Family Notified Yes No	Arrival Confirmed Yes No	Admit Location Floor ICU ER	Expired (time)
Patient Name	Medical Record#	Disposition Home or Transfer	Evacuation Triage Category Immed Delayed Minor Expired		Accepting Hospital	Time Hospital Contacted & Report given
Transfer Initiated (Time/Transport Co.)	Med Record Sent Yes No	Medication Sent Yes No	Family Notified Yes No	Arrival Confirmed Yes No	Admit Location Floor ICU ER	Expired (time)
Patient Name	Medical Record#	Disposition Home or Transfer	Evacuation Triage Category Immed Delayed Minor Expired		Accepting Hospital	Time Hospital Contacted & Report given
Transfer Initiated (Time/Transport Co.)	Med Record Sent Yes No	Medication Sent Yes No	Family Notified Yes No	Arrival Confirmed Yes No	Admit Location Floor ICU ER	Expired (time)
5. SUBMITTED BY			6. AREA ASSIGNED TO		7. DATE/TIME SUBMITTED	
8. FACILITY NAME						

Source: Adapted from Hospital Incident Command System (HICS) Form 255

Paper-Based Intra-Facility Tracking Process



Description

The Paper-Based Intra-Facility Tracking Process is an example of the type of process that could be instituted at a facility for the purpose of tracking patients as they move through a facility when electronic systems are unavailable.

The Paper-Based Intra-Facility Tracking Process can also be found in *Volume V: Long-Term Care Health Facilities* Section 11.1.2, "Paper-Based Intra-Facility Patient Tracking Process."

Instructions

Facilities should consider the intra-facility tracking process as an option for tracking patients if no current process exists.

Paper-Based Intra-Facility Patient Tracking Process

Procedure:

Prior to the healthcare surge, a long-term care health facility will maintain a supply of index cards and determine a method for housing those cards (e.g., "bed board," index card box).

1. At the point of a healthcare surge, a designated person will be responsible for completing a card for each patient currently in-house. The following information will be recorded on the card:
 - a. Patient name
 - b. Date of birth/Age
 - c. Major medical conditions
 - d. Physical location of the patient (e.g., Room 20, Bed 2)
 - e. Condition (e.g., critical, stable)
 - f. Life-sustaining treatment election (e.g., DNR Status, Physician's Order for Life-Sustaining Treatment)
 - g. Presence and/or location of care plan
 - h. Need for and location of any special equipment or supplies
 - i. List of current medications and location of drugs
 - k. Name and contact information for family member, durable healthcare power of attorney, legal representative, or other responsible party
2. A card will also be initiated at the point of registration for every patient that is treated, triaged, admitted, or discharged once the healthcare surge begins.
3. At midnight each night, a designated staff person(s) will make rounds in the patient care areas to collect newly created cards and ensure that the current location of the patient is documented on the card. At the same time, the location of each patient who already had a card will be verified.
4. The updated and newly collected cards will be filed back into the index card box or other collection device in the patient care area so updates can easily be made the following day.



Description

Most long-term care health facilities have procedures in place to track patient valuables upon admission, as safeguards for patient money and valuables are a condition of licensure under 22 CCR 72529 and 22 CCR 73557. Planners should evaluate existing procedures related to patient valuables tracking to determine how they might be streamlined for use in a surge event.

Patients should be strongly encouraged to arrange with family members or others to secure their valuables. During the admitting process, a designated staff member should advise the patient that valuables such as jewelry, credit cards, and cash (more than \$50) will not be properly secured in the facility. For situations when valuables must be stored in the long-term care health facility, a process for inventorying patient valuables must be established. Long-term care health facilities should use the Patient Valuables Deposit Form as a template to develop inventory forms for use during a healthcare surge.

The Patient Valuables Deposit Form can also be found in *Volume V: Long-Term Care Health Facilities* Section 11.2.2, "Inventorying Valuables"

Instructions

In the event a patient must store valuables with the long-term care facility for safekeeping, a designated facility staff member should inventory the valuables and complete a Patient Valuables Deposit Form in the presence of the patient. A medical records number or other patient identifier should be included on the Patient Valuables Deposit Form. The long-term care health facility staff should:

1. Inventory and document valuables on the form.
2. Describe jewelry generically:
 - “Yellow metal” is used to describe gold.
 - “White metal” is used to describe silver.Precious and semi-precious stones should be described by color and not by the type of stone.
 - Example: A man’s gold Timex watch with five diamonds would be described as “Man’s yellow metal watch with five clear stones, Timex.”
3. Conduct the inventory in the presence of the patient. If the patient is not able to sign the form or observe the inventorying of valuables, a friend or family member may do so. If a friend or family member is not present, another staff member must witness the process.
4. List credit cards individually by account number.

5. Document personal blank checks, including the total number of blank checks.
6. Record currency by denomination and also the total amount. Large amounts of currency being held (more than \$50) should be set aside for deposit in a trust bank account, whenever possible. Record "none" if no currency is deposited. The space for currency should not be left blank.
7. Visually assess the patient for valuables such as jewelry, rings, necklaces, earrings, etc., and encourage the patient to include all items in the inventory.
8. Whenever possible, record serial numbers for personal property, including hearing aids and other personal medical equipment. If practical, a serial number can be assigned and/or engraved on the personal item.
9. Have a witnessing staff member verify the inventory and document its accuracy by signing the Patient Valuables Deposit Form. This should be performed prior to placing the valuables into a patient valuables envelope.
10. Write the control number from the patient valuables envelope on the Patient Valuables Deposit Form.
11. Have the patient, family member, or friend sign the Patient Valuables Deposit Form. If they are not available or able to sign, note in the signature slot that the patient is unable to sign.
12. Place the valuables into the patient valuables envelope, along with the original copy of the Patient Valuables Deposit Form, and seal it in the presence of the patient and the witnessing staff member.
13. Provide a second copy of the Patient Valuables Deposit Form to the patient and include a third copy in the patient's chart.
14. Update a patient valuables control log that is kept near the storage place for patient valuables (e.g., a safe) and have a witnessing staff member initial the log.
15. Deposit the envelope in a secured container in the presence of a witnessing staff member.



Description

Most long-term care health facilities have procedures in place to track patient valuables upon admission, as safeguards for patient money and valuables are a condition of licensure under 22 CCR 72529 and 22 CCR 73557. Planners should evaluate existing procedures related to patient valuables tracking to determine how they might be streamlined for use in a surge event.

Patients should be strongly encouraged to arrange with family members or others to secure their valuables. During the admitting process, a designated staff member should advise the patient that valuables such as jewelry, credit cards, and cash (more than \$50) will not be properly secured in the facility. For situations when valuables must be stored in the long-term care health facility, a process for inventorying patient valuables must be established.

The Patient Valuables Control Log can be used to document, track, and audit valuables deposited or removed from the facility's secured locations.

The Patient Valuables Control Log can also be found in *Volume V: Long-Term Care Health Facilities* Section 11.2.4, "Patient-Valuables Control Log."

Instructions

Complete all applicable fields upon deposit/removal of patient valuables. This Patient Valuables Control Log should indicate:

- Date and time the deposits or releases occurred
- Staff person releasing the valuables
- Patient's name
- Witnessing staff member's initials
- Control number of the patient valuables envelope.



Description

During an emergency, computerized systems for completing registration and obtaining medical records numbers within long-term care health facilities may become unavailable. Paper-based procedures may be necessary to maintain administrative functions that are critical to business continuity and sustaining operations during a healthcare surge.

The Sample Registration Log can be used by long-term care health facilities to prepare for times during a healthcare surge when computerized systems are unavailable. During a healthcare surge, registration staff should manually complete the Sample Registration Log or similar form, which will provide a source of information from which manual admissions and registrations can be entered retroactively into the computer once the system becomes available.

The Sample Registration Log can also be found in *Volume V: Long-Term Care Health Facilities* Section 11.3.1, "Sample Paper-Based Registration Procedures."

Instructions

Complete log for all registered patients. Multiple logs at each registration/access point may be needed.

- **Medical Record Number:** Enter patient medical record number if available.
- **Triage or Other Tracking Number:** Enter patient triage number, or other applicable tracking number.
- **Last Name:** Enter patient's last name.
- **First Name:** Enter patient's first name.

Sample Registration Log

#	Medical Record Number	Triage or Other Tracking Number	Last Name	First Name
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				

Sample Paper-Based Face Sheet



Description

During an emergency, computerized systems for completing registration and obtaining medical records numbers within long-term care health facilities may become unavailable. Paper-based procedures may be necessary to maintain administrative functions that are critical to business continuity and sustaining operations during a healthcare surge.

The Sample Paper-Based Face Sheet can be used by long-term care health facilities to prepare for times during a healthcare surge when computerized systems are unavailable. During a healthcare surge, registration staff should manually complete the Sample Paper-Based Face Sheet or similar form, which will provide a source of information from which manual admissions and registrations can be entered retroactively into the computer once the system becomes available.

The Sample Paper-Based Face Sheet can also be found in *Volume V: Long-Term Care Health Facilities* Section 11.3.1, "Sample Paper-Based Registration Procedures."

Instructions

Registration personnel should fill-out the form as completely as possible upon patient registration during a healthcare surge.

Sample Paper-Based Face Sheet

FACE SHEET	
ADMISSION DATE:	COMMENTS:
RESIDENT NAME:	
DATE OF BIRTH:	
Medical Record #	
PHYSICIAN:	
DATE OF LAST TETANUS: Good for 10 years	
DATE OF LAST FLU VACINATION:	ALLERGIES:
DATE OF LAST PNEUMOVAX: Good for 5 years	
<input type="checkbox"/> DPAHC	
<input type="checkbox"/> PRIMARY CONTACT #1	
<input type="checkbox"/> GUARDIAN/CONSERVATOR	
NAME:	RELATIONSHIP:
PHONE NUMBER:	ANY RESTRICTIONS ON NOTIFICATION:
TO NOTIFY WITH EMERGENCIES OR PROBLEMS	
OTHER FAMILY MEMBERS OR FRIENDS:	
FUNERAL HOME PREFERENCE (IF KNOWN):	
CODE STATUS:	

Source: Adapted from John C. Fremont Healthcare District, Ewing Wing



Description

During an emergency, established methods for collecting medical record information electronically may be unavailable. Therefore, paper-based methods for capturing medical record information may become necessary. Furthermore, it may be reasonable to expect that most healthcare resources will be devoted to patient care, so administrative functions may need to be reduced to minimum requirements under healthcare surge conditions.

The sample Short-Form Medical Record is an example of the type of patient medical record that could be implemented during a healthcare surge when electronic systems for documenting the provision of care are unavailable. The Short-Form Medical Record should be utilized to capture pertinent assessment, diagnosis, and treatment information. This form is not expected to meet existing medical records documentation requirements, rather, it serves as a recommended set of elements that can be considered as acceptable documentation during healthcare surge.

The Short-Form Medical Record can also be found in *Volume V: Long-Term Care Health Facilities* Section 11.3.2, "Minimum Requirements for Medical Record Documentation."

Instructions

This Short Form Medical Record should be completed for all patients, both existing patients and for new patients transferred from nearby facilities. This form allows for a more complex medical history than may usually be recorded upon admission to a long-term care health facility. Intake personnel should use discretion in completing the form and complete as many fields as is appropriate for any given patient. It is acceptable for some fields to be left blank. For example, measurement of pupil size may be appropriate for a patient with a traumatic brain injury (TBI) but not for a patient without TBI.

Demographics

Patient Demographic Information – include patient name, date of birth, parent/guardian, medical record number, known allergies and primary physician. If patient labels are used within an organization, and they are available, a label can be affixed in place of handwriting the information.

History

- Chief Complaint - enter patient's primary complaint upon admission
- Significant Medical History - enter notes on patient's medical history, as applicable.
- Glasgow Coma Scale - enter score for each area
- Field Triage Category - enter category
- Site Triage Category - enter category
- Pupil Size - enter pupil size
- Reactive - circle yes/no
- Pain - circle patient's level of pain
- Temp - indicate patient's temperature
- Pulse - indicate patient's pulse
- Respiration - enter patient's rate of respiration
- Blood Pressure - enter patient's systolic and diastolic blood pressure
- Intake - enter patient fluid intake
- Output - enter patient fluid output
- Special Dietary Needs - enter patient's special dietary needs
- Medications - indicate medications the patient is currently taking including name, dose, route, and time
- Last Menstrual Period - indicate last period
- Pregnancy Status - indicate status

Physical Exam

- Physical Exam - This section should be utilized to capture comments relative to the assessment of the patient's cardiovascular, pulmonary and other body systems.

Re-Assessment

- This section is to be completed as a secondary assessment prior to a procedure. It includes a place for a set of vital signs and any lab results.

Procedure/Disposition. This section of the form includes space to document the following:

- Pre- and post-procedure diagnosis
- Procedure performed
- Findings
- Condition of the patient post procedure
- A check box to indicate if discharge instructions were provided in printed form and/or verbally
- Dietary restrictions
- Activity restrictions
- Discharge medications
- Follow-up visit information
- Condition on discharge/transferred to
- Date, time, and physician's signature authorizing discharge
- Time admitted
- Physician order notes/other notes

Short Form Medical Record

Demographic	Patient Name: _____ DOB/Age: _____ Parent / Guardian: _____ Primary Physician: _____ DIN: _____ MRN: _____ Allergies: _____ <input type="checkbox"/> NKA																																													
History	Chief Complaint: _____ Significant Medical History: _____ Last Menstrual Period: _____ Pregnancy Status: _____ <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: left;">Glasgow Coma Scale</th> </tr> <tr> <td style="width: 50%;">Eye</td> <td style="width: 50%;"></td> </tr> <tr> <td>Motor</td> <td></td> </tr> <tr> <td>Verbal</td> <td></td> </tr> <tr> <td>Total</td> <td></td> </tr> </table> Field Triage Category: _____ Site Triage Category: _____ Pupil Size L: _____ Reactive: <input type="checkbox"/> Yes <input type="checkbox"/> No Pupil Size R: _____ Reactive: <input type="checkbox"/> Yes <input type="checkbox"/> No Circle pain (Adult): 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain) Circle pain ¹ (Child/Other) <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="text-align: center;">0 NO HURT</td> <td style="text-align: center;">1 LITTLE BIT</td> <td style="text-align: center;">2 LITTLE MORE</td> <td style="text-align: center;">3 EVEN MORE</td> <td style="text-align: center;">4 WHOLE LOT</td> <td style="text-align: center;">5 WORST</td> </tr> </table>		Glasgow Coma Scale		Eye		Motor		Verbal		Total		0 NO HURT	1 LITTLE BIT	2 LITTLE MORE	3 EVEN MORE	4 WHOLE LOT	5 WORST																												
Glasgow Coma Scale																																														
Eye																																														
Motor																																														
Verbal																																														
Total																																														
0 NO HURT	1 LITTLE BIT	2 LITTLE MORE	3 EVEN MORE	4 WHOLE LOT	5 WORST																																									
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Time recorded:</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> <tr> <td>Temp:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Pulse:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Respiration:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Blood Pressure:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Notes:</td> <td colspan="3"></td> </tr> </table>	Time recorded:				Temp:				Pulse:				Respiration:				Blood Pressure:				Notes:				<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: left;">Intake</th> <th colspan="2" style="text-align: left;">Output</th> </tr> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Total</td> <td></td> <td>Total</td> <td></td> </tr> </table>	Intake		Output														Total		Total	
Time recorded:																																														
Temp:																																														
Pulse:																																														
Respiration:																																														
Blood Pressure:																																														
Notes:																																														
Intake		Output																																												
Total		Total																																												
	Special Dietary Needs: _____ <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4" style="text-align: center;">Medications</th> </tr> <tr> <th style="width: 50%;">Name</th> <th style="width: 15%;">Route</th> <th style="width: 15%;">Dose</th> <th style="width: 20%;">Time Frequency</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table> Physician initials: _____ Nurse initials: _____ Other initials: _____		Medications				Name	Route	Dose	Time Frequency																																				
Medications																																														
Name	Route	Dose	Time Frequency																																											
Physical Exam	Cardiovascular: _____ Pulmonary: _____ Neurological: _____ Other Significant Findings: _____ Physician initials: _____																																													
Re-Assessment	Date: _____ Time: _____ System Review: Temp: _____ Pulse: _____ Respiration: _____ Blood Pressure: _____ Lab Results: _____ X-ray Results: _____ Physician initials: _____ Nurse initials: _____ Other initials: _____																																													
Procedure / Disposition	Pre-Procedure DX: _____ Post-Procedure DX: _____ Procedure: _____ Findings: _____ Condition of Patient Post Procedure: <input type="checkbox"/> Critical <input type="checkbox"/> Guarded <input type="checkbox"/> Stable Discharge Instructions (YES/NO): Written _____ Verbal _____ Diet: <input type="checkbox"/> Regular <input type="checkbox"/> Soft <input type="checkbox"/> Liquid <input type="checkbox"/> Other: _____ Activities: <input type="checkbox"/> No Restrictions <input type="checkbox"/> Restrictions as Follows: _____ Discharge Medications: _____ Follow-Up Visit: When _____ NA: _____ Condition at discharge: ___ Critical ___ Guarded ___ Stable ___ Fair ___ Deceased ___ Temp ___ Pulse ___ Respiration ___ Blood Pressure Discharge: <input type="checkbox"/> Home <input type="checkbox"/> Shelter <input type="checkbox"/> ACS <input type="checkbox"/> SNF <input type="checkbox"/> Deceased Date: _____ <input type="checkbox"/> Transfer: _____ <input type="checkbox"/> Other: _____ Time: _____ Admitted: <input type="checkbox"/> Time admitted: _____ Physician order: _____ Notes: _____ Physician initials: _____ Nurse initials: _____ Other initials: _____																																													

Wong, DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Schwartz P: *Wong's Essentials of Pediatric Nursing*, ed. 6, St. Louis, 2001, p.1301.



Description

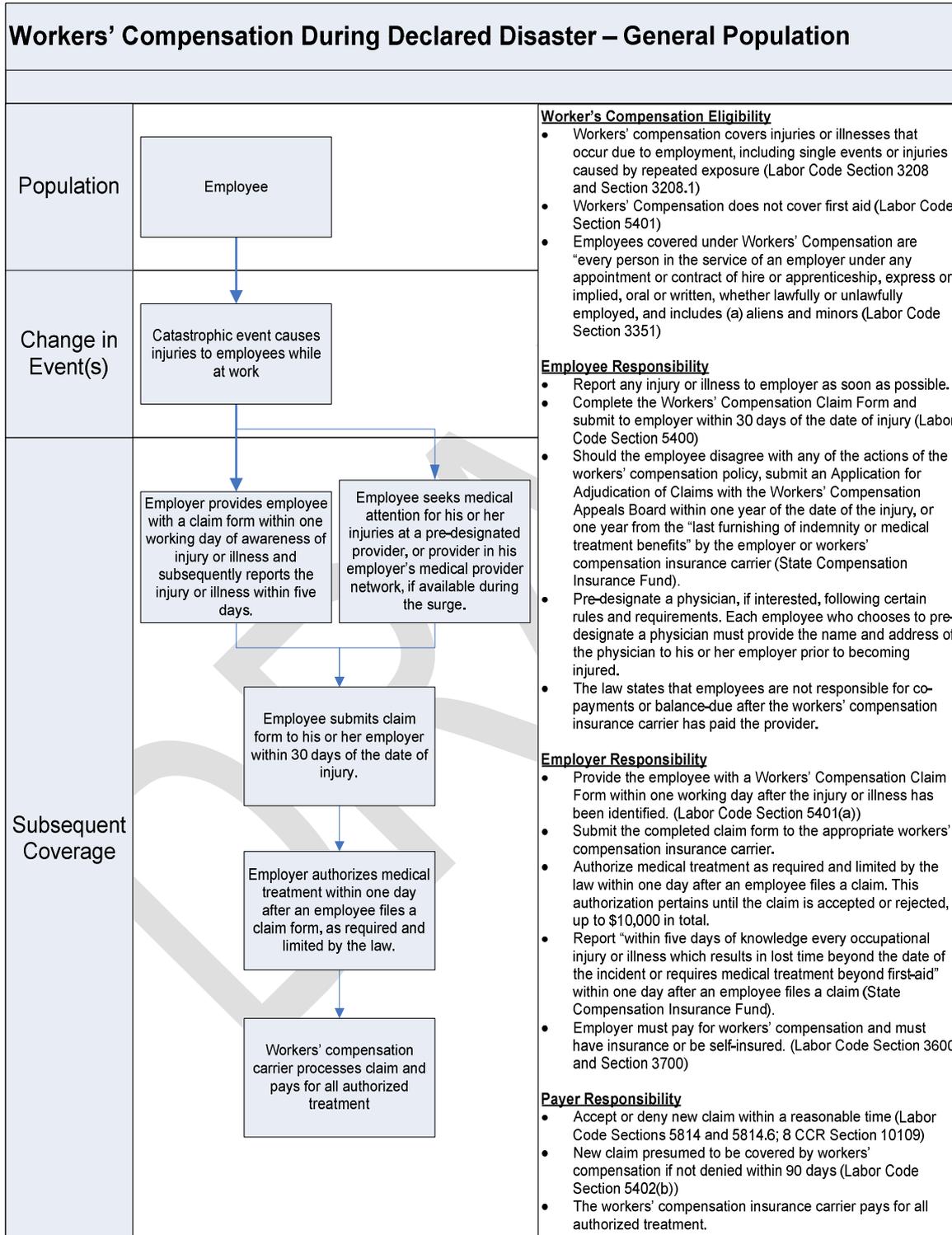
The Workers' Compensation Process Flow depicts how Workers' Compensation Insurance may play a role during a healthcare surge for general employees and Disaster Service Workers.

The Workers' Compensation Process Flow can also be found in *Volume V: Long-Term Care Health Facilities* Section 12.1.4, "Workers' Compensation for Employees and Volunteers."

Instructions

Employees, employers, and payers can refer to the Workers' Compensation Process Flow for the rules and requirements that must be followed to submit claims to Workers' Compensation Insurance.

Workers' Compensation Process Flow





Description

During a healthcare surge, electronic systems routinely used for charge capture may be unavailable. As a result, paper-based processes for capturing charges may be the only method available. Furthermore, it may be reasonable to expect that most healthcare staff will be devoted to patient care and may not be able to adhere to existing charge capture protocols. Maintaining accurate charge capture information will enable facilities to properly bill for services, receive accurate and appropriate reimbursement, maintain cash flow, and support business continuity efforts during a healthcare surge.

The Sample Charge Capture Form is provided as a template for long-term care health facilities to consider for use during healthcare surge. The form focuses on capturing only the most critical information for effective charge capture.

The Sample Charge Capture Form can also be found in *Volume V: Long-Term Care Health Facilities* Section 12.2.1, "Minimum Required Data Elements and Templates for Charge Capture."

Instructions

Use the Sample Charge Capture Form to develop paper-based charge capture forms for use during a healthcare surge.

Sample Charge Capture Form

Provider Facility Name and Address:				
Provider ID Number:				
Patient Name			Medical Record Number	
Date of birth	Sex	Insurance Provider	Insurance ID number / SSN	
Begin Period of Care		End Period of Care		Total Period of Care
date		date		# of days
Attending physician's Name and Phone Number				
Name of Former Facility:				
Daily Medications:				
(name, dosage, and frequency)				
Current Diagnosis				
(Primary)			(Secondary)	
Patient's General Condition:				
<input type="checkbox"/> Bowel Incontinent	<input type="checkbox"/> Amputation	<input type="checkbox"/> Mental Impairment	<input type="checkbox"/> Confined to wheel chair	<input type="checkbox"/> Spoon fed
<input type="checkbox"/> Bladder Incontinent	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Speech Impairment	<input type="checkbox"/> Ambulatory with assistance	
<input type="checkbox"/> Saliva Incontinent	<input type="checkbox"/> Contractures	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Ambulatory	
	<input type="checkbox"/> Decubitis Ulcer	<input type="checkbox"/> Vision Impairment		
		<input type="checkbox"/> Sensation Impairment		



Description

The Advancing and Expediting Payment Table outlines the potential opportunities for advancing and expediting payment from a range of payers. In many cases, payers do not have a formalized policy or procedure for advancing or expediting payments, but may have established a practice for doing so on an “as needed” basis. Facilities in need of expedited or advanced payment options will likely need to contact their health plan or program representative directly to discuss advancing and expediting payments and establish Memoranda of Understanding and protocols in advance or at the time funds are needed.

The Advancing and Expediting Payment Table can also be found in *Volume V: Long-Term Care Health Facilities* Section 12.2.4, "Advancing and Expediting Payment."

Instructions

Providers should review and understand the table for guidance on options available by payer type with respect to advancing and expediting payment during a healthcare surge.

Advancing and Expediting Payment Table

Advancing and Expediting Payment		
Payer	Option Available	Examples
Medi-Cal	Advance Payments	Medi-Cal has a process in place for advancing payment to participating health care providers under certain conditions. Requests for advance payments will be considered on a case-by-case basis and will depend on the circumstances surrounding the healthcare surge.
Medicare Part A	Accelerated Payments	Cash flow problems can be resolved through accelerated payments rather than through suspension of the mandatory payment floor which requires intermediaries to hold payment for electronic claims for thirteen days. In the past, intermediaries have been asked to immediately process any requests for accelerated payments or increases in periodic interim payment for providers. Intermediaries have also been authorized to increase the rate of the accelerated payment to 100 percent and extend the repayment period to 180 days on a case-by-case basis. ⁱ
Medicare Part B	Advance Payments	Cash flow problems can be resolved through advance payments rather than through suspension of the mandatory payment floor which requires intermediaries to hold payment for electronic claims for thirteen days. In the past, intermediaries have been asked to immediately process any requests for advance payments or increases in periodic interim payment for providers. Intermediaries have also been authorized to increase the rate of the advance payment to 100 percent and extend the repayment period to 180 days on a case-by-case basis. ⁱⁱ
Private Payer	Informal Agreements	Some private payers may have established informal processes in order to advance payment to contracted providers in times of financial need. This advance payment process can be used when providers are experiencing cash flow inadequacies, when the payer is experiencing payment delays, or when a long-term care health facility's business operations are temporarily challenged. The amount of the advance can vary depending on facility need, volume, previous payment history, contractual parameters, and repayment factors. Upon facility request, private payers will typically offer one of two options: 1) advance a lump-sum amount for a specified period of time to be repaid in full when the agreed period elapses or 2) advance an agreed amount based upon previous payment history and facility need, to be reconciled against future claim submissions. Contracted long-term care health facilities in good standing in need of expedited or advanced payment options will likely need to contact their plan or program representatives directly to discuss advancing and expediting payments and/or establish Memoranda of Understanding and protocols in advance or at the time funds are needed.

ⁱ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers," http://questions.cms.hhs.gov/cqibin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605

ⁱⁱ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers," http://questions.cms.hhs.gov/cqibin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605



Description

During a healthcare surge, public health issues or specific medical needs may require that patients be transferred between healthcare facilities (e.g., hospital to long-term care health facility, between two long-term care health facilities). The Patient Transfer Table outlines commercial health plans and public payers' coverage rules and requirements for reimbursement related to patient transfers during a healthcare surge. This information should be used as a reference tool during emergency planning.

The Patient Transfer Table can also be found in *Volume V: Long-Term Care Health Facilities* Section 12.3.1, "Patient Transfer and Coverage Rules during a Healthcare Surge."

Instructions

Facilities providing medical care should review the Patient Transfer Table for guidance on how to receive payment for patient transfer during healthcare surge.

Patient Transfer Table

Patient Transfer Table		
Payer	Scenario	Examples
Medicare	Evacuation to/from facility	<p>Ambulance transportation charges for patients who were evacuated from and returned to originating long-term care health facilities were included on the claims submitted by the originating long-term care health facilities.</p> <p>Following a recent disaster, charges for ambulance transportation were paid according to the usual payment guidelines. The regulatory requirements must be met (for example, the vehicle must be an ambulance, the crew must be certified, the patient must need ambulance transport, and the transport must be to an eligible destination). For example, Part B of the Medicare program covers only local ambulance transportation to and from the nearest appropriate skilled nursing facility (SNF), as long as the beneficiary is not a SNF resident in a covered Part A stay whose transport would be subject to consolidated billing rules. If there are exceptional circumstances that require transport outside the locality, Medicare can pay for this transport, but only if the destination is still the nearest SNF with appropriate facilities. In any case, the ambulance transport must be medically necessary.ⁱⁱⁱ</p> <p>Recommended Approach</p> <p>From a claims perspective, in using the catastrophic/disaster-related Healthcare Common Procedure Coding System (HCPCS) modifier, an institutional provider should designate any service line item on the claim that is disaster-related. If all of the services on the claim were disaster-related, the institutional provider can use the disaster-related (DR) condition code to indicate that the entire claim is disaster-related.^{iv}</p>

Patient Transfer Table

Payer	Scenario	Examples
Other	Patient Transfer	<p>Transportation resources can be broadly classified as traditional medical (e.g., ambulances, gurney vans, wheelchair cars) and nonmedical (e.g., school or transit buses, vanpools). Traditional medical resources are generally funded through either direct fee-for-service billing or reimbursement from disaster relief funds. In order to be eligible for the latter, it is critical that resources be requested through the proper channels and in accordance with SEMS/NIMS. The request should come through the logistics branch of the appropriate Emergency Operations Centers, either at the city, county, or regional levels, generally progressing from city to region. The requests must be accompanied by a mission tasking number.</p> <p>In times of declared emergency, a variety of resources are required for an appropriate response and recovery. It is expected that these resources will be compensated or reimbursed. Resources should be requested through the California Standardized Emergency Management System (SEMS). A mission tracking number needs to be assigned which links the request to the event and, thus, to the reimbursement.</p> <p>Nonmedical transportation resources will generally only be reimbursed through available disaster relief funds. As is the case for medical resources, it is critical that resources be requested through the proper channels and in accordance with SEMS/NIMS.</p>

ⁱⁱⁱ Medicare Hurricane FAQs, https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=6090

^{iv} U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers," http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605