Long Term Care Preparedness Toolkit

BASE PLAN

In Partnership with the Southwest Healthcare Preparedness Coalition and the following partners:

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Contents

Introduction

The Minnesota Long Term Care (LTC) Preparedness Toolkit was developed to assist with emergency preparedness planning for this specialized health care population. LTC facilities, as they are referred to in the toolkit, include nursing homes, skilled nursing facilities, and assisted living facilities.

Members of the Minnesota Department of Health, Care Providers of Minnesota, Aging Services of Minnesota, and regional representation from the Health Care Preparedness Program developed this tool to assist LTC facilities in emergency preparedness. Latest revisions to this toolkit took place in the fall of 2016 with additional input from individuals representing LTC facilities. The primary focus of the revision is the updated CMS emergency preparedness requirements which were released September 2016 with the implementation beginning in November 2017.

See Appendix A for CMS Emergency Preparedness Checklist for Effective Healthcare Facility Planning

This toolkit can be used by LTC facility owners, administrators, and staff. Information includes: sample templates, forms, and suggested resources to develop and/or enhance facility emergency preparedness plans within LTC throughout the state of Minnesota. It should not be viewed as a static document but one that provides a foundation for an All Hazards approach to preparedness, planning, and response activities.

It is recommended that not one person at any facility be charged in preparing this plan. Rather, it is suggested that an internal committee be formed from various disciplines within the facility to work on this plan. This toolkit serves as a base template that can be customized to the needs of each facility. The tools in this document are important items you will need to address prior to an event occurring.

Overview of All Hazards Approach to Planning

Recent events such as Hurricane Sandy, the Red River floods of 2009 and other events have stressed all types of health care facilities and shown that better planning is needed. Because different types of events present different challenges to health care entities, an all hazards approach to planning is proven to be most efficient and most beneficial. An all hazards response plan must be based on the hazards that are most likely to affect a facility and it is important in directing how a response may unfold and what the correct response actions would be. In order to identify the most likely hazards, a hazard vulnerability analysis should be completed (see section 3 for more information on the Hazard Vulnerability Analysis info).

All Hazards

Hazards may be thought of as extreme events. Hazard vulnerability analysis is often based on an “all hazards approach.” This means that one begins with a list of all possible disasters, regardless of their likelihood, geographic impact, or potential outcome. The list may be the result of a committee brainstorming session, research, or other methodology, and should be as comprehensive as possible.

It may be helpful to divide the potential hazards into categories to focus the thought process. Typical categories may include natural hazards, technological hazards, and human events. These are certainly not requirements, and should not be considered to be constraining. There is overlap between the categories as well. For example, a transportation accident may be considered to be a technological hazard rather than a human event.

Once the complete hazards listing is developed, look at it critically for items that might be appropriately grouped together as one hazard category. Organize the list into categories.

Finally, a prioritization process should be undertaken to determine the course of emergency planning. The realistic factors of time and money play a role in decisions of preparedness, and facilities must choose to apply their limited resources where they will have the most impact. To work toward this end, each identified hazard will be evaluated for its probability of occurrence, risk to the organization, and the organization’s current level of preparedness.

Probability

Disasters, by nature, are not predictable. Still, familiarity with the geographic area and research will identify those for which the facility must be most prepared. It is important to consider both expected occurrences as well as unlikely scenarios.

Regularly occurring natural disasters are typically well known within a community. The community will often be able to provide data that include hundred-year flood plains, weather information for the locale, etc. The weather bureau may also be able to provide input. In addition, community emergency planning agencies may have already done a community-based hazard vulnerability analysis. This may not provide a complete solution, but it will provide a start.

Nursing homes and long term care facilities have become increasingly dependent on technology to provide their normal services. As a result, a failure of a given technological system can put a facility into an internal state of disaster. Beyond the walls of a facility itself, technology in the community can fail or lead to an incident creating victims in need of medical care or otherwise affecting the health care facility. External transportation failures can lead to unavailability of supplies, which can also be disastrous. In order to determine the probability of these events, examine the internal technology in the facility and the availability of backup systems to compensate for failure. Service records and system failure reports can be used to evaluate the likelihood that these incidents may occur. Types of industry in the community should also be considered in this assessment for a technological disaster with broad community impact.

Establishing the probability of occurrence of these events is only part objective and statistical—the remainder can best be considered intuitive or highly subjective. Each hazard should be evaluated in terms that will reflect its likelihood. The tool presented in this document, for example, uses the qualitative terms of *high, medium, low,* or *no probability of occurrence*. A factor may be used, but is not required, to quantitatively assess the probability.

Risk

Risk is the potential impact that any given hazard may have on the organization. Risk must be analyzed to include a variety of factors, which may include, but are not limited to the following:

Threat to human life
Threat to health and safety
Property damage
Systems failure
Economic loss
Loss of community trust/goodwill
Legal ramifications

The threat to human life and the lesser threat to health and safety are considered to be so significant that they are given separate consideration on the hazard vulnerability analysis document. Consider each possible disaster scenario to determine if either of these human impact threats is a factor.

The remaining three categories on the analysis tool classify risk factors as to their disruption to the organization in high, moderate, or low classification. From the bulleted list above, property damage, systems failure, economic loss, loss of community trust, and legal ramifications are all considered together to determine the level of risk.

Property damage in a disaster situation may be a factor more often than not, although the degree of damage may vary. Seismic activity may virtually destroy a building, or render it uninhabitable. In the most severe scenario of this type, the property damage will also include equipment and supplies within the facility. Other hazards may impact only a portion of the building, for example, flooding only in the basement. Perhaps severe weather resulted only in a few broken windows.

Systems failure may have been the cause of the emergency in the first place. A major utility failure may require backup equipment or service that is significantly less convenient, or may not be sustainable for a lengthy time. Even though an alternate system is available, the failure will typically cause a facility to implement emergency plans. Systems failure, however, is not necessarily an isolated occurrence. It can be the result of another hazard, such as flooding damage to an emergency generator.

In any disaster, economic loss is a possibility that deserves consideration. If a facility cannot provide services because of disaster, revenue will be affected. It may result from damage to the physical plant or equipment, inability to access the facility due to transportation or

crowd control issues, or a negative public relations impact. Long term care entities are businesses like any other, and economic disruptions can be managed for only a limited time. Each hazard must be analyzed for its adverse financial impact.

An issue of loss of goodwill has the potential for legal ramifications in the aftermath of a disaster. If errors were made in the management of the emergency, if lives were lost or injuries occurred, the facility could face legal action. It is advisable to consult risk management and/or the facilities legal counsel if questions exist in this area.

Preparedness

Finally, an evaluation of the organization's current level of preparedness to manage any given disaster should be undertaken. This process should involve the input of community agencies. The health care facility will not be responding to an emergency in a vacuum, and there may be community resources to support the facility.

Long term care facilities have done disaster planning for many years and are well prepared to manage many types of emergencies. However, the scope of current emergency planning has expanded and the typical organization will find at least some hazards from the all-hazards list for which improvements are needed. The current status of emergency plans and the training status of staff members to respond to any given hazard is a factor to consider in evaluating preparedness.

The health care organization may carry insurance to compensate for losses suffered because of some emergencies. Backup systems may also be thought of as insurance protecting against certain occurrences. The availability of insurance coverage or backup systems should be factored into the determination of the current preparedness status.

The hazard vulnerability analysis tool in this document evaluates the organization's preparedness level as good, fair, or poor. An alternative way of approaching this issue is to evaluate each hazard based on the amount of improvement needed, for example, slight, moderate, or major. Both systems will yield similar results.

Planners within the organization should evaluate this section critically and realistically. Failure to do so may result in a false sense of security, which may result in an increased impact on some of the risk factors discussed above. Appropriate evaluation of preparedness will direct the organization's effort and resources earmarked for emergency management.

Plain Language

Utilization of plain language decreases staff confusion and ensures transparency for residents and visitors. The linked toolkit offers suggestions for how to utilize plain language in emergency overhead paging.

Minnesota Hospital Association. (2011). Plan Language Emergency Overhead Paging. St. Paul, MN. Plain Language Emergency Overhead Paging Implementation Toolkit

Hazard Vulnerability Analysis Tool

The hazard vulnerability analysis tool is simply that -- a tool. It is provided as a resource and a starting point for organizations to evaluate their vulnerability to hazards. It may be modified or changed in any way that is appropriate for individual facility use.

This document uses a quantitative method to evaluate vulnerability, which is also not required. The facility may find a qualitative method equally as effective.

Using this tool, each potential hazard is evaluated as described above and scored as appropriate in the areas of probability, risk, and preparedness. The factors are then multiplied to give an overall total score for each hazard. Note that a hazard with no probability of occurrence for a given organization is scored as zero and will automatically result in a zero for the total score.

Listing the hazards in descending order of the total scores will prioritize the hazards in need of the facility's attention and resources for emergency planning. It is recommended that each organization evaluate this final prioritization and determine a score below which no action is necessary. The focus will then be on the hazards of higher priority. Establishing a cutoff value, however, does introduce risk to the organization for those hazards falling below. The facility has determined that there is some probability and risk of the event occurring, and has chosen to exclude it from the planning process. It must be noted that the acceptance of all risk is at the discretion of the organization.

Hazard Vulnerability Analysis Instructions

Evaluate every potential event in each of the three categories of probability, risk, and preparedness. Add additional events as necessary.

Issues to consider for probability include, but are not limited to:

Known risk
Historical data
Manufacturer/vendor statistics

Issues to consider for risk include, but are not limited to:

- Threat to life and/or health
- Disruption of services
- Damage/failure possibilities
- Loss of community trust
- Financial impact
- Legal issues

Issues to consider for preparedness include, but are not limited to:

- Status of current plans
- Training status
- Insurance

- Availability of back-up systems
- Community resources

Multiply the ratings for each event in the area of probability, risk and preparedness. The total values, in descending order, will represent the events most in need of organization focus and resources for emergency planning. Determine a value below which no action is necessary. Acceptance of risk is at the discretion of the organization.

Facilities are to review and update their HVA annually.

Sample HVA Tool

Note: an electronic HVA can also be accessed through your regional health care coalition. Below is a screenshot of what the electronic HVA looks like.

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%*
Tornado								0%
Severe Thunderstorm								0%
Snow Fall								0%
Blizzard								0%
Ice Storm								0%
Temperature Extremes								0%
Proximity to Airport								
Proximity to Train Tracks								
Proximity to MOA								
Proximity to Downtown								
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%

See Appendix B for Hazard Vulnerability Analysis Tool

Emergency Operations Plan Tool

The following tools serve as specific components that will allow your organization to plan and prepare to meet the needs of both your residents and staff in the event of an incident.

Each tool will be preceded by a descriptor of the tool and instructions where necessary. These tools when taken as a whole are the basis of an Emergency Operations Plan (EOP).

Once the EOP has been developed, it is also the role of the team to be sure that this plan is shared with appropriate staff and that internal training is conducted. This training should be incorporated into regularly scheduled trainings as staff changes do occur and keeping current on any material requires periodic review.

For an EOP to maintain viability and usefulness, it needs to be updated on a scheduled basis. As each facility grows and changes, the EOP also needs to be modified to reflect those changes. Once these tools are completed, your EOP will be well on the way to serving each facility's need to care for staff and residents.

Incident Command System

In any emergency response, it is critical that clear lines of authority (chain of command) exist within the facility. This ensures that there is timely and efficient decision-making and communication. It is important to define a chain of command, designate a facility incident commander, and clarify their authority and decision-making ability. This is an important aspect of the disaster plan.

Disaster planning needs to start at the top of the organization. Bring the leaders of the organization into the planning process from the very beginning to identify and agree upon the best course of action for the health care facility, its residents and staff. Organization leaders should discuss the financial and clinical implications of the various proposed response strategies. This may include items such as closing to new admissions or agreeing to be a "surge" or overflow setting for the local hospital. Medical and administrative priorities need to match, and your facility's leadership team needs to be clear about its role and authority.

Incident Command Systems (ICS) can be used at organizations both large and small — it can even be used by just one person. If you have a small organization, the same person may fill multiple spots on the ICS organizational chart. Assure through practice and exercise that one designated person is not disproportionately overburdened with her or his roles in an emergency. It is recommended that, at a minimum, frontline staff obtain the basics of ICS by taking ICS 100, ICS 200, and ICS 700. These courses and more can be found at: Federal Emergency Management Agency Training Website .

Benefits of Utilizing Incident Command in Health Care

Common terminology and clear text

The use of common terminology provides for a clear message and sharing of information. It avoids the use of codes, slang, or discipline specific verbiage that may not be clearly understood by all planning and response partners. Common terminology helps to define the organizational structure: as an example, the identification of sections, section chiefs,

and branch directors. Another key benefit of common terminology is the ability to share resources in the response, such as personnel to oversee incident management or operations. By using consistent terminology, the opportunity to develop memorandums or agreements to share personnel is enhanced.

Modular organization

The ICS structure begins from the top and expands as needed by the event. Positions within the structure are activated as dictated by the incident size or complexity. As complexity increases, the ICS organization expands. Only those functions or positions necessary for an incident are activated. This will be clearly demonstrated in subsequent sections that detail the incident management team along with their roles and responsibilities.

Management by objectives

The Incident Commander initiates the response and sets the overall command and control objectives. The mission of the response is defined for all members of the response team through a clear understanding of the organization's policy and direction. This includes an assessment of the incident from the current situation to projected impacts. To meet the overall mission, or command objectives, individual sections will establish incident objectives as well as the strategies to achieve these objectives through clear tactics. Because emergency response is not "business as usual," clearly defined objectives will allow staff to focus on the roles in the response, avoiding duplication of efforts or omission of critical actions.

Incident action planning

The development of objectives is documented in the Incident Action Plan (IAP). A written plan provides personnel with direction for taking actions based on the objectives identified in the IAP and reflects the overall strategy for incident management while providing measurable strategic operations for the operational period. To ease this process, ICS forms are designed and developed for nursing homes and are contained within the California Nursing Home ICS Guidebook.

Manageable span of control

A key concept in ICS is maintaining a span of control that is both effective and manageable. Because emergency events are not business as usual situations, the span of control for operations that are not routine should be kept at an effective number. Within ICS, the optimum span of control is one supervisor to five reporting personnel. If the number falls outside these ratios, the incident management team should be expanded or consolidated.

Pre-designated incident locations and facilities

In the planning stages, planners should determine the location of their response and coordination sites, including the coordination and command sites. Within ICS, sites are identified for both scene and regional coordination, such as helicopter landing zones, staging areas, command posts, and emergency operations centers. Planners within the

nursing home or long-term care facility should identify sites for ICS management, staging areas for receipt of supplies and equipment, evacuation sites if the infrastructure is unsafe, and so on.

Resource management

Resources are assets that are used in the response. Examples include personnel, equipment, food, communications, supplies, vehicles, etc. When making requests for assistance from other health care facilities, local emergency management, regional health care coalitions and other state partners have a clear picture of current and needed resources. This level of awareness allows those providing the support to provide the necessary assets through a clear understanding of current capability.

Integrated communications

There are three elements within integrated communications: modes, plans and networks. The modes include the hardware systems that transfer information, such as radios, cell phones, and pagers. Plans are developed in advance and outline how to best use the available modes through a clear and concise communication policy and procedure (for example, determining who can use radios and what information should be communicated). Networks are identified within the jurisdiction and will determine the procedures and processes for transferring information internally and externally.

Common command structure

The ICS provides for a common command structure that identifies core principles for an efficient chain of command. *Unity of Command* dictates that each person within the response structure reports to only one supervisor. A *single command* exists when a single agency or discipline responds to an event; for example, the fire service at a warehouse fire is commanded by a fire captain or chief. When multiple agencies or disciplines are working together at a scene, there is a *unified command* structure that allows for coordination in response actions. For nursing homes, this may occur when the facility is the scene of the incident, such as a fire. The nursing home administration and the fire command work together in a unified command structure.

Basic ICS Job Action Overview

The organization chart is the base to ICS and is utilized when a response to any incident is necessary. Specific personnel placed in the various roles are determinant on the skills and position with the organization.

Incident Commander: Leads the response, appoints section leaders, approves plans and key actions (CEO, administrator, Director of Nursing (DON), nursing supervisor.)

Operations Section: Handles key actions including first aid, search and rescue, fire suppression, securing the site (DON, Department supervisors, nursing supervisor, direct care staff.)

Planning Section: Gathers information, thinks ahead, makes and revises action plans and keeps all team members informed and communicating. (Safety committee, Continuity of operations planning team, etc.)

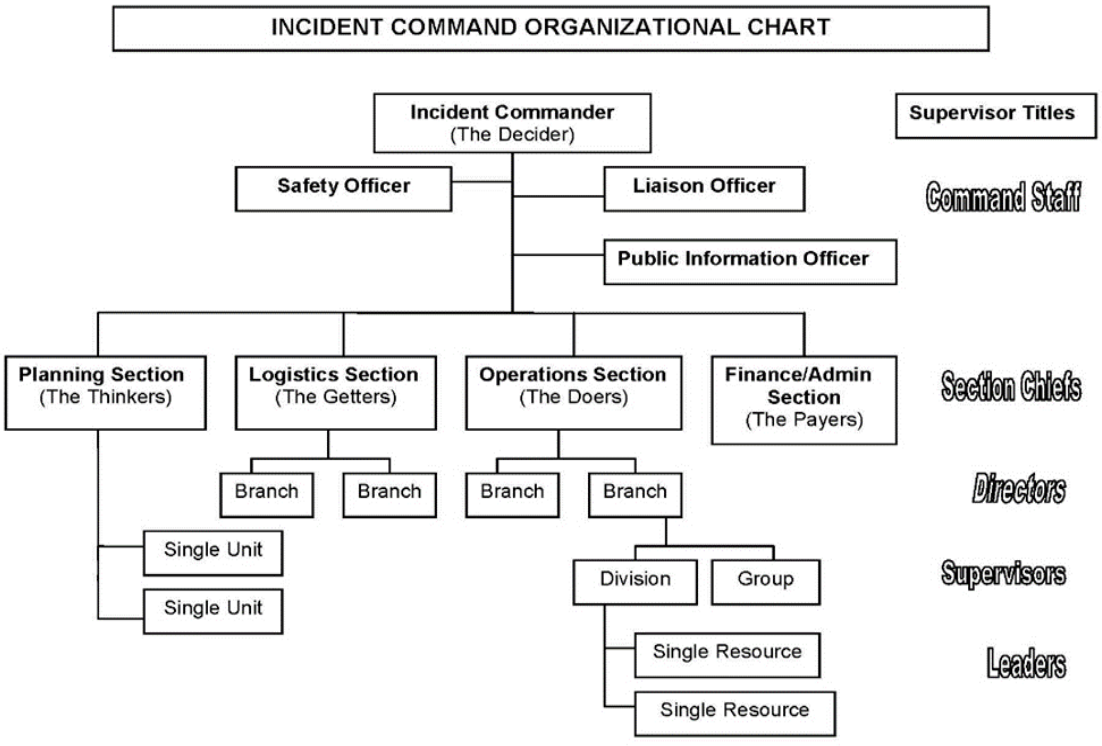
Logistics Section: Finds, distributes, and stores all necessary resources (maintenance supervisor, purchasing, human resources director)

Finance Section: Tracks all expenses, claims, activities, and personnel time and is the record keeper for the incident (controller, accounts department, payroll.)

Public Information Officer: Provides reliable information to staff, visitors and families, the news media and concerned others as approved by the Incident Commander. (Social Worker, Administration Personnel)

Safety Officer: Ensures safety of staff, residents, and visitors; monitors and corrects hazardous conditions. Has authority to halt any operation that poses immediate threat to life and health.

Liaison Officer: Serves as the primary point of contact for supporting agencies assisting the facility. (Social Worker, Administration Personnel)



Depending on the size of the facility, one person may occupy multiple positions within the section. You do not need to activate all positions – only activate what you need for the incident. This is your basic Incident Command. If part of a larger system i.e.: health organization, you will need to know where your ICS fits within that organization's structure.

See Appendix C for ICS Organization Chart and Job Action Sheets

An online version of the Heath Care Incident Command system (HICS) specifically designed with the Long Term Care facility in mind is located at Southern Maine Regional Resource Center .

The following table is a list of persons that can be used to fill a role in the ICS Organization Chart:

Incident Command Position	Facility Role
Incident Commander	Administrator/CEO
Medical Director/Specialist	Medical Director/Nurse Consultant
Public Information Officer	Administrator/Media Relations
Liaison Officer	Community Specialist/Assistant Administrator
Safety Officer	Maintenance
Operations Section Chief	Director of Nursing/Nursing Supervisor
Resident Services Branch Director	Director of Staff Development
Nursing Unit Leader	Nursing Supervisor/Charge Nurse
Admit/Transfer and Discharge Unit Leader	Nursing Supervisor/Charge Nurse/Admissions
Infrastructure Branch Director	Housekeeping supervisor
Dietary Unit Leader	Dietary supervisor
Environmental Unit Leader	Housekeeping
Physical Plant/Security Leader	Maintenance
Planning Section Chief	Assistant administrator
Situation Unit Leader	Admissions
Documentation Unit Leader	Medical Records
Logistics Section Chief	Chief Finance Officer/Assistant Administrator
Services Branch Director	Accounts Manager
Communications Unit Leader	Maintenance
IT/IS Unit Leader	IT/IS staff
Supply Unit Leader	Purchasing
Staffing/Scheduling Unit Leader	Human Resources/Staffing
Transportation Unit Leader	Maintenance/Activity Staff/Rehab
Finance/Admin Section Chief	Chief Finance Officer/Accounting
Time Unit Leader	Payroll/Billing
Claims Unit Leader	Risk Manager/Quality Manager

Organization Information and Contact Information

For an EOP to be functional, it is dependent on current and accurate information. Key to any response is the ability to know who to notify and how to get in touch with these personnel. For this reason, having current and accurate organizational information along with current information regarding key staff is essential. An effective response cannot occur without personnel. The following information needs to be maintained and updated periodically so timely communications and response can occur. The following information is broken out into three separate areas:

- **Organizational Information:** contains the contact information for facility ownership and leadership.

- **Emergency Contact Roster-Internal:** contains the contact information for supervisors/leaders within the organization.
- **External Contact Information-External:** contains emergency contacts, contractors, and outside support services

See Appendix D for Contact lists

Facility-Specific Information

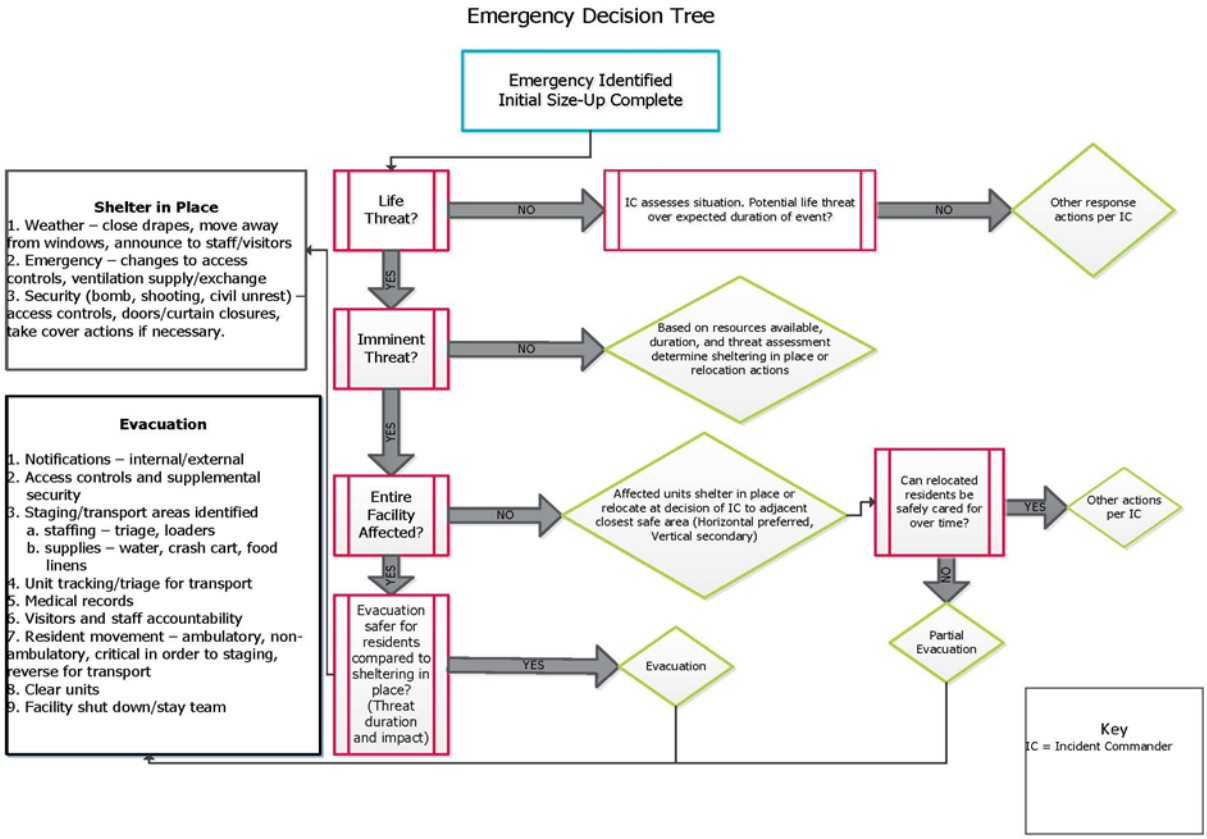
This information is made up of the location and characteristics of the facility and the people associated with it. As with any response, it is important to understand the physical features of a facility in order to maintain safety and efficiency. It is also important to understand the occupancy and certain specific information regarding the occupants. The facility-specific information provides descriptions of the facility and some baseline information regarding staff and residents. The information contained should be reviewed and updated annually.

See Appendix E for Facility Specific Information

Decision Making

During an unplanned event knowing what needs to be done to ensure the safety of the residents as well as the staff can be extremely stressful. The facility should have a clearly delineated decision making tree.

Sample Decision Making Tree

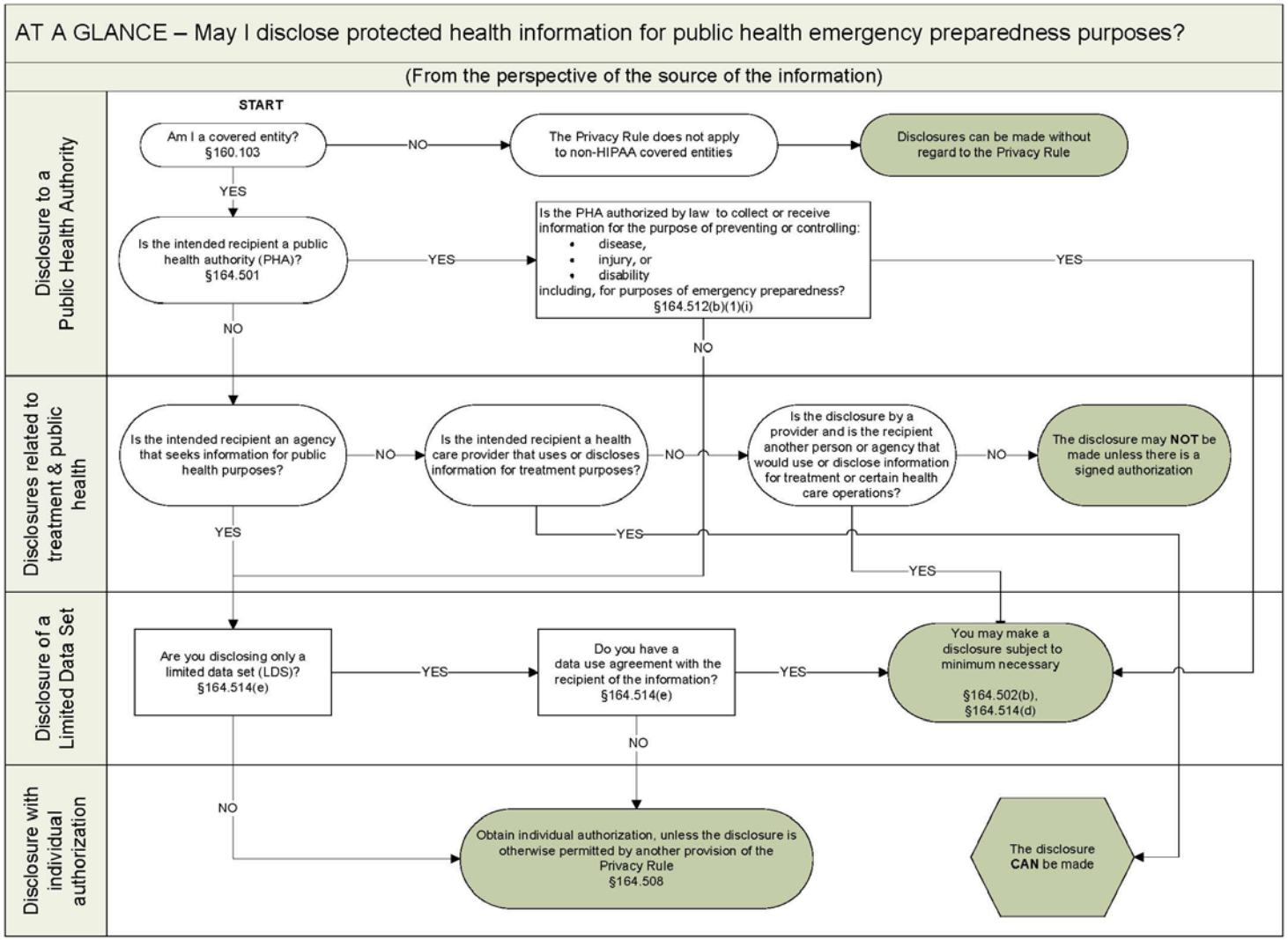


HIPAA in Emergent Situations

During emergent situations, the decision to share private patient/resident health care information is difficult. To ensure that there is continuity of care there may be situations where it is necessary to waive HIPAA.

See Appendix F for HIPAA Waiver toolkit.

Disclosure of private health information decision tree



Ethical Guidelines

The Institute of Medicine's Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations offers a useful framework which fundamentally relies on the principle of justice.

Ethical Values:

Fairness – who receives what and at what point
Professional Duty – do no harm, do not abandon
Stewardship – allocating scarce resources; utilitarianism
Ethical Process Elements:

Transparency – communication to stakeholders
Consistency – nondiscrimination
Proportionality – elevating response during emergency
Accountability – acting upon duty to respond
During an emergency the following events require incorporation of sound ethical considerations:

- Triaging—Workforce members should be prepared to prioritize which residents to evacuate first prior to or during a crisis.
- Allocation of Resources—Workforce members should know what resources are available during a crisis, where supplies are stored, and have the tools needed to determine how scarce resources will be issued.
- Standards of Care—Workforce members should be prepared to adjust their standards of care during an emergency. Considerations include ensuring individuals are trained to provide care normally outside of their professional practice.

Evacuation Plan

While evacuation is typically not preferred, there may be times when this option is safest for the residents and staff. Due to the varied abilities of nursing home residents, evacuation can be a daunting task without appropriate consideration and planning ahead of time. Prior planning regarding how residents will be transported, who will provide the transportation, what specialty types of vehicles will be needed and where they will come from all need to be prearranged in order to maximize the safety of residents and staff. Evacuation planning also includes determining what supplies, food, water, medications, and other physical items will be needed in order to maintain safety. Pre-determined locations should be identified where residents can be taken that will adequately meet their needs. Identifying pre-determined locations and having discussions ahead of time will ensure a smooth transition. Two sample memoranda are provided to serve as templates (See Appendix I). Additionally, it should be noted that having an evacuation agreement with more than one facility would be appropriate. Traditionally, facilities often choose the closest like facility with which to partner. However, a

second facility some distance away may be prudent in the event that the closest facility may be similarly affected and unable to handle the transfer request.

The following pages are specifically dedicated to looking at evacuation needs. If additional evacuation and shelter-in-place planning resources are desired, please refer to the Minnesota Department of Health website.

Transportation Plan

The transportation plan should describe how the residents will be transported to the sheltering facilities. It should include as an attachment any contracts or Memorandums of Agreement with transportation companies, churches or ambulance services, or other transportation modality. The transportation plan should include:

The number and types of vehicles required.
How the vehicles will be obtained.
Who will provide the drivers.
Medical support to be provided for the patient or resident during transportation. The following support needs should be considered:

- Residents who are independent in ambulation.
- Residents who require assistance with ambulation.
- Residents who are non-ambulatory.
- Residents with cognitive impairments.
- Residents with equipment/prosthetics (equipment/prosthetics should accompany residents and should be securely stored in the designated mode of transportation).

Estimation of the time to prepare residents for transportation.
Estimation of the time for the facility to prepare for evacuation.
Estimation of time for the patient or resident to reach the sheltering facility.
Detailed route to be taken to each sheltering facility if possible.
Description of what items must be sent with the patient or resident such as:

- The patient's medical record, which contains medications the patient is taking, dosage, frequency of medication administration, special diets, special care, etc.
- A three-day supply of medications (if possible).
- Special medical supplies the patient may need.
- Other items such as clothing, incontinence diapers, etc.

The medical records should be provided to the receiving facility and remain with the receiving facility until the patient or resident is transferred back to the sending facility or to another facility.
Records should be maintained of which residents are transported to which facilities.

Evacuation Destination Information

The Sheltering Plan should describe where the residents will be transported. The receiving facility should be appropriate for the level of care required for the residents being evacuated. The plan should include as an attachment any contract, memorandum of agreement, or transfer

agreement the facility has with a receiving facility. The following should also be included in the plan:
Sleeping plan
Feeding plan
Medication plan
Accommodations for relocated staff
Number of relocated residents that can be accommodated at each receiving facility

Staffing Plan

The Staffing Plan should include how the relocated residents will be cared for at the sheltering facility as well as the number and type of staff that is needed at the evacuating facility to help evacuate the residents. The Staffing Plan should include:

Description of how care will be provided to relocated residents
Identification of number and type of staff needed to evacuate the facility and to accompany residents to the sheltering facility
Plan for relocating facility staff

- A contingency plan if facility staff cannot make it into the shelter due to their own family's needs.

Attachments and Documents

The following documents should be included as attachments to the Evacuation Plan:

Sheltering agreements between the facility and the receiving facility (must be update annually)
Transportation agreements between the facility and ambulance companies, bus services, churches, etc. (must be updated annually)
Documentation of any coordination between law enforcement, fire departments, etc.

See Appendix G for evacuation plans, checklists and transportation agreements.

Sheltering in Place

In certain situations, such as a tornado or chemical incident, your facility may be better off to stay and shelter in place. The facility needs to plan for sheltering in place. In an emergency, your facility may be without telephone or other communications, electric power, or water and sewer service for several days. The facility must be able to exist on its own for at least 72 hours without outside assistance. Your plan should include provisions for resident care (monitoring of medical conditions), facility safety and security, food, water, medications, contact with first responders (fire, police, EMS, etc.), public health, transportation, staff, lighting, temperature control, waste disposal, and medical supplies.

The sheltering in place plan is not to be specific to the event requiring sheltering, instead, the plan should contain the following:

- Plan in place describing how three days of non-perishable meals are kept on hand for residents and staff. The Plan should include special dietary requirements.
- Plan in place describing how 72 hours of potable water is stored and available to residents and staff.
- Plan in place identifying 72 hours of necessary medications that are stored at the facility and how necessary temperature control and security requirements will be met.
- Plan in place to identify staff that will care for the residents during the event including any transportation needs that the staff might have and how the facility will meet those needs.
- Plan in place for an alternative power source, such as an onsite generator, and describe how 72 hours of fuel will be maintained and stored. Alternate power source plan provides for necessary testing of the generator.
- Plan in place describing how the facility will dispose of or store waste and biological waste until normal waste removal is restored.
- Emergency Communications Plan in place, such as for cell phones, hand held radios, pager, satellite phone, laptop computer for instant messaging, HAM radio, etc.
- Adequate planning considerations given to the needs of residents, such as dialysis patients.
- Adequate planning considerations given to residents on oxygen.
- Adequate planning considerations given to residents using durable medical equipment such as masks, nasal cannulas, colostomy equipment, g-tube, etc.

See Appendix H for Facility Shelter in Place plan, Supply and Equipment lists, and checklists.

Memorandums of Understanding

Health care facilities should consider memorandums of understanding (MOUs) with organizations that can provide them resources and services during emergencies and disasters. MOUs are established between hospitals, other health care providers and/or emergency response agencies to identify their agreements to collaborate, communicate, respond and support one another during a disaster or other public health emergency. Understandings regarding the incident command structure, patient and resource management, processes and policies in place for requesting and sharing of staff, equipment and consumable resources, as well as payment, are generally addressed in a local mutual aid MOU.

MOUs help facilities demonstrate and document compliance with Joint Commission and State and Federal expectations for collaborative planning and disaster response. MOUs are also a documentation asset when seeking federal reimbursement through FEMA after a disaster.

MOUs are also used by facilities to document agreements with other organizations and agencies to provide transportation, consumables (e.g., water, food), equipment, personnel and many other resources and services that may be needed during a disaster event. These MOUs help to document a facility's ability to respond and to sustain operations.

Examples include MOUs with:

- Local hospitals for patient transfer, supplies, equipment, pharmaceuticals, and personnel.
- Local nurse registry agencies, temporary agencies, and security personnel providers.
- Other local health care providers including clinics and long term care facilities for personnel, supplies, equipment, and transportation.
- Vendors and suppliers for health care and non-health care resources, including linen and fuel.
- County government for services including transportation and security; for supplies; and for assistance in managing the treatment and transportation of staff and patients.
- Third party payors to suspend lag time for payments

See Appendix I for MOU templates

Recovery Plan

Disaster and crisis planning are primarily focused on preparing and responding, however, another critical component is the recovery phase. At this point the worst of the immediate and acute crisis has passed, and a facility can focus on returning to standard operations. From a facilities standpoint, recovery often means taking a look at the infrastructure of the facility and making determinations if the facility is still operable and capable of taking care of the residents. Recovery should be coordinated with others such as local emergency management, financial personnel, public health, food delivery services, utilities, etc. In other words, recovery involves taking a complete look not just at the physical structure, but also those types of needs that support the safe and effective operation of your facility.

See Appendix J for consideration checklists for re-opening

Staff Care Plan

During a crisis or disaster, additional help is often needed. One way to assist in making it easier for staff to stay at or report in to work, is to have a staff care plan. A staff care plan includes pre-determined arrangements for staff members' family and loved ones. Having this information available allows staff to feel comforted that arrangements are made for their loved ones and often increases the likelihood that staff will remain at or report in to work.

See Appendix K for Staff Care Plan documentation

Exercise, Evaluation and Improvement Planning

For any plan to be useful, it needs to be tested periodically to determine if it works or if weaknesses appear once the plan is tested. Unless the plan is tested routinely, it is not truly a functional piece of work, which is the goal of having an emergency operations plan. Finding out during a crisis that the plan has real weaknesses is not the time to face that kind of risk. For this reason, there should be an exercise plan which includes both an evaluation piece and improvement planning.

The Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Requirements state that LTC facilities must offer training on emergency procedures at least once annually and must complete at least two exercises annually: one full-scale exercise that is community- or facility-based and one additional exercise of the facility's choice. See link for requirements: CMS Emergency Preparedness Requirements by Provider Type.

See Appendix L for Exercise, Evaluation, and Improvement Planning Checklist

Regional Resources and Support Agencies

The following map will assist health care facilities in determining to which region they belong.

See Appendix M for links to color coded regional and coalition specific contact information.

List of Appendixes and Annexes

Appendix/Annex	Description
Appendix A	CMS Emergency Preparedness Checklist for Effective Health Care Facility Planning
Appendix B	Facility Hazard Vulnerability Analysis
Appendix C	Organization Chart/Job Action Sheets/ICS Quick Start Guide
Appendix D	Facility Contact Lists
Appendix E	Facility Specific Information
Appendix F	HIPPA Waiver Toolkit
Appendix G	Evacuation Plan and Checklists, Transportation Agreements
Appendix H	Facility Shelter in Place Plan, Supply and Equipment Lists, and Checklists
Appendix I	MOU Templates
Appendix J	Recovery Checklists
Appendix K	Staff Care Plan Documentation
Appendix L	Exercise, Evaluation, and Improvement Planning Checklist and AAR/IP
Appendix M	Regional Contacts and Important Resources
Annex A	Apartment Evacuation Policy
Annex B	Behavioral Health-Psychological First Aid
Annex C	Bioterrorism Threats
Annex D	Bomb Threat Policy
Annex E	Chemical Spills
Annex F	Communications
Annex G	Electrical Power Outage Policy
Annex H	Elevator Policy
Annex I	Emergency Notification of Administrator
Annex J	Fire Policy
Annex K	Health and Humidity Policy
Annex L	Loss of Telephone Service Policy

The attachments contained within the Appendixes and Annexes are considered templates. To make the documents facility specific, facilities will need to adapt the templates.

Acronyms

Acronym	Description
AAR	After Action Report
BT	Bioterrorism
CDC	Centers for Disease Control and Prevention
COOP	Continuity of Operations Plan
DOC	Department Operations Center
EM	Emergency Management
EMS	Emergency Medical Services

Acronym	Description
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
FEMA	Federal Emergency Management Agency
HICS	Hospital Incident Command System
HHS	Health and Human Services
HPP	Hospital Preparedness Program or Health Care Preparedness Program
HSEEP	Homeland Security Exercise & Evaluation Program
HSEM	Homeland Security & Emergency Management
HVA	Hazard Vulnerability Analysis
HVAC	Heating, Ventilation & Air Conditioning
IAP	Incident Action Plan
IC	Incident Command or Infection Control
ICS	Incident Command System
IMT	Incident Management Team
IMS	Incident Management System
IP	Improvement Plan
IT	Information Technology
JAS	Job Action Sheets
LTC	Long-term Care
MDH	Minnesota Department of Health
MHA	Minnesota Hospital Association
MOU	Memo of Understanding
OSHA	Occupational Safety and Health Administration
PFA	Psychological First Aid
PHPC	Public Health Preparedness Consultant
PICEs	Potential Injury Creating Events
PIO	Public Information Officer
POC	Point of Contact
PPE	Personal Protective Equipment
RHPC	Regional Healthcare Preparedness Coordinator

Appendix A: CMS Emergency Preparedness Checklist

Not Started	In Progress	Completed	Tasks
			Develop Emergency Plan: Gather all available relevant information when developing the emergency plan. This information includes, but is not limited to: • Copies of any state and local emergency planning regulations or requirements • Facility personnel names and contact information • Contact information of local and state emergency managers • A facility organization chart • Building construction and Life Safety systems information • Specific information about the characteristics and needs of the individuals for whom care is provided
			All Hazards Continuity of Operations (COOP) Plan: Develop a continuity of operations business plan using an all-hazards approach (e.g., hurricanes, floods, tornadoes, fire, bioterrorism, pandemic, etc.) that could potentially affect the facility directly and indirectly within the particular area of location. Indirect hazards could affect the community but not the facility and as a result interrupt necessary utilities, supplies or staffing. Determine all essential functions and critical personnel.
			Collaborate with Local Emergency Management Agency: Collaborate with local emergency management agencies to ensure the development of an effective emergency plan.
			Analyze Each Hazard: Analyze the specific vulnerabilities of the facility and determine the following actions for each identified hazard: • Specific actions to be taken for the hazard • Identified key staff responsible for executing plan • Staffing requirements and defined staff responsibilities • Identification and maintenance of sufficient supplies and equipment to sustain operations and deliver care and services for 3-10 days, based on each facility's assessment of their hazard vulnerabilities. (Following experiences from Hurricane Katrina, it is generally felt that previous recommendations of 72 hours may no longer be sufficient during some wide-scale disasters. However, this recommendation can be achieved by maintaining 72-hours of supplies on hand, and holding agreements with suppliers for the remaining days.). • Communication procedures to receive emergency warning/alerts, and for communication with staff, families, individuals receiving care, before, during and after the emergency • Designate critical staff, providing for other staff and volunteer coverage and meeting staff needs, including transportation and sheltering critical staff members' family
			Collaborate with Suppliers/Providers: Collaborate with suppliers and/or providers who have been identified as part of a community emergency plan or agreement with the health care facility, to receive and care for individuals. A surge capability assessment should be

			included in the development of the emergency plan. Similarly, evidence of a surge capacity assessment should be included if the supplier or provider, as part of its emergency planning, anticipates the need to make housing and sustenance provisions for the staff and or the family of staff.
			Decision Criteria for Executing Plan: Include factors to consider when deciding to evacuate or shelter in place. Determine who at the facility level will be in authority to make the decision to execute the plan to evacuate or shelter in place (even if no outside evacuation order is given) and what will be the chain of command.
			Communication Infrastructure Contingency: Establish contingencies for the facility communication infrastructure in the event of telephone failures (e.g., walkie-talkies, ham radios, text messaging systems, etc.).
			Develop Shelter-in-Place Plan: Due to the risks in transporting vulnerable patients and residents, evacuation should only be undertaken if sheltering-in- place results in greater risk. Develop an effective plan for sheltering-in-place, by ensuring provisions for the following are specified: * • Procedures to assess whether the facility is strong enough to withstand strong winds, flooding, etc. • Measures to secure the building against damage (plywood for windows, sandbags and plastic for flooding, safest areas of the facility identified. • Procedures for collaborating with local emergency management agency, fire, police and EMS agencies regarding the decision to shelter-in-place. • Sufficient resources are in supply for sheltering-in-place for at least 7 days, including: o Ensuring emergency power, including back-up generators and accounts for maintaining a supply of fuel o An adequate supply of potable water (recommended amounts vary by population and location) o A description of the amounts and types of food in supply o Maintaining extra pharmacy stocks of common medications o Maintaining extra medical supplies and equipment (e.g., oxygen, linens, vital equipment) • Identifying and assigning staff who are responsible for each task • Description of hosting procedures, with details ensuring 24-hour operations for minimum of 7 days • Contract established with multiple vendors for supplies and transportation • Develop a plan for addressing emergency financial needs and providing security
			Develop Evacuation Plan: Develop an effective plan for evacuation, by ensuring provisions for the following are specified: * • Identification of person responsible for implementing the facility evacuation plan (even if no outside evacuation order is given) • Multiple pre-determined evacuation locations (contract or agreement) with a “like” facility have been established, with suitable space, utilities, security and sanitary facilities for individuals receiving care, staff and others using the location, with at least one facility being 50 miles away. A

			back-up may be necessary if the first one is unable to accept evacuees. • Evacuation routes and alternative routes have been identified, and the proper authorities have been notified Maps are available and specified travel time has been established • Adequate food supply and logistical support for transporting food is described. • The amounts of water to be transported and logistical support is described (1 gal/person). • The logistics to transport medications is described, including ensuring their protection under the control of a registered nurse. • Procedures for protecting and transporting resident/patient medical records. • The list of items to accompany residents/patients is described. • Identify how persons receiving care, their families, staff and others will be notified of the evacuation and communication methods that will be used during and after the evacuation • Identify staff responsibilities and how individuals will be cared for during evacuation and the back-up plan if there isn't sufficient staff. • Procedures are described to ensure residents/patients dependent on wheelchairs and/or other assistive devices are transported so their equipment will be protected and their personal needs met during transit (e.g., incontinent supplies for long periods, transfer boards and other assistive devices). • A description of how other critical supplies and equipment will be transported is included. • Determine a method to account for all individuals during and after the evacuation • Procedures are described to ensure staff accompany evacuating residents. • Procedures are described if a patient/resident becomes ill or dies in route. • Mental health and grief counselors are available at reception points to talk with and counsel evacuees. • Procedures are described if a patient/resident turns up missing during an evacuation: o Notify the patient/resident's family o Notify local law enforcement o Notify Nursing Home Administration and staff • Ensure that patient/resident identification wristband (or equivalent identification) must be intact on all residents. • Describe the process to be utilized to track the arrival of each resident at the destination. • It is described whether staff's family can shelter at the facility and evacuate.
			Transportation & Other Vendors: Establish transportation arrangements that are adequate for the type of individuals being served. Obtain assurances from transportation vendors and other suppliers/contractors identified in the facility emergency plan that they have the ability to fulfill their commitments in case of disaster affecting an entire area (e.g., their staff, vehicles and other vital equipment are not "overbooked," and vehicles/equipment are kept

			in good operating condition and with ample fuel.). Ensure the right type of transportation has been obtained (e.g., ambulances, buses, helicopters, etc.). *
			Train Transportation Vendors/Volunteers: Ensure that the vendors or volunteers who will help transport residents and those who receive them at shelters and other facilities are trained on the needs of the chronic, cognitively impaired and frail population and are knowledgeable on the methods to help minimize transfer trauma. *
			Facility Reentry Plan: Describe who will authorizes reentry to the facility after an evacuation, the procedures for inspecting the facility, and how it will be determined when it is safe to return to the facility after an evacuation. The plan should also describe the appropriate considerations for return travel back to the facility. *
			Residents & Family Members: Determine how residents and their families/guardians will be informed of the evacuation, helped to pack, have their possessions protected and be kept informed during and following the emergency, including information on where they will be/go, for how long and how they can contact each other.
			Resident Identification: Determine how residents will be identified in an evacuation; and ensure the following identifying information will be transferred with each resident: • Name • Social security number • Photograph • Medicaid or other health insurer number • Date of birth, diagnosis • Current drug/prescription and diet regimens • Name and contact information for next of kin/responsible person/Power of Attorney) Determine how this information will be secured (e.g., laminated documents, water proof pouch around resident's neck, water proof wrist tag, etc.) and how medical records and medications will be transported so they can be matched with the resident to whom they belong.
			Trained Facility Staff Members: Ensure that each facility staff member on each shift is trained to be knowledgeable and follow all details of the plan. Training also needs to address psychological and emotional aspects on caregivers, families, residents, and the community at large. Hold periodic reviews and appropriate drills and other demonstrations with sufficient frequency to ensure new members are fully trained.
			Informed Residents & Patients: Ensure residents, patients and family members are aware of and knowledgeable about the facility plan, including: • Families know how and when they will be notified about evacuation plans, how they can be helpful in an emergency (example, should they come to the facility to assist?) and how/where they can plan to meet their loved ones. • Out-of-town family members are given a number they can call for information. Residents who are able to participate in their own evacuation are aware of their roles and responsibilities in the event of a disaster.
			Needed Provisions: Check if provisions need to be delivered to the facility/residents -- power, flashlights, food, water, ice, oxygen, medications -- and if urgent action is needed to obtain the necessary resources and assistance.

			Location of Evacuated Residents: Determine the location of evacuated residents, document and report this information to the clearing house established by the state or partnering agency.
			Helping Residents in the Relocation: 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 • Include the resident in assessing problems • Encourage staff to introduce themselves to residents • Encourage family participation
			Review Emergency Plan: Complete an internal review of the emergency plan on an annual basis to ensure the plan reflects the most accurate and up-to- date information. Updates may be warranted under the following conditions: • Regulatory change • New hazards are identified or existing hazards change • After tests, drills, or exercises when problems have been identified • After actual disasters/emergency responses • Infrastructure changes • Funding or budget-level changes Refer to FEMA (Federal Emergency Management) to assist with updating existing emergency plans. Review FEMA's new information and updates for best practices and guidance, at each updating of the emergency plans.
			Emergency Planning Templates: Healthcare facilities should appropriately complete emergency planning templates and tailor them to their specific needs and geographical locations.
			Collaboration with Local Emergency Management Agencies and Healthcare Coalitions: Establish collaboration with different types of healthcare providers (e.g. hospitals, nursing homes, hospices, home care, dialysis centers etc.) at the State and local level to integrate plans of and activities of healthcare systems into State and local response plans to increase medical response capabilities. *
			Communication with the Long-Term Care Ombudsman Program: Prior to any disaster, discuss the facility's emergency plan with a representative of the ombudsman program serving the area where the facility is located and provide a copy of the plan to the ombudsman program. When responding to an emergency, notify the local ombudsman program of how, when and where residents will be sheltered so the program can assign representatives to visit them and provide assistance to them and their families.
			Conduct Exercises & Drills: Conduct exercises that are designed to test individual essential elements, interrelated elements, or the entire plan: • Exercises or drills must be conducted at least semi-annually • Corrective actions should be taken on any deficiency identified.

			Loss of Resident's Personal Effects: Establish a process for the emergency management agency representative (FEMA or other agency) to visit the facility to which residents have been evacuated, so residents can report loss of personal effects. *

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements.

*Task may not be applicable to agencies that provide services to clients in their own homes

Revised September 2016

Appendix B: Hazard Vulnerability Analysis Tool

Kaiser Permanente has developed a Hazard Vulnerability Analysis tool which is available for download as a planning resource. Individuals or organizations using this tool are solely responsible for any hazard assessment and compliance with applicable laws and regulations.

Download the Kaiser Permanente HVA Tool

Appendix C: ICS Organization Chart and Job Action Sheets

Long Term Care Organization Chart:

Depending on the size of the facility, one person may occupy multiple positions within the section. You do not need to activate all positions – only activate what you need for the incident. This is your basic Incident Command, if part of a larger system i.e.: health organization, you will need to know where your ICS fits within that organizations structure

These titles are universal and not subject to local change.

Incident Management System Basic Job Action Sheets

Customize these sheets as needed based on the type and number of staff at your facility. Note: more than one person could be assigned management duties and staff that will be assigned the duties must be trained on these responsibilities. You should develop Management Duties vs. Staff Duties for each area. The managers all report to the “Incident Commander.” All duties to be performed are disaster-specific, so some items might not be applicable to your situation.

Incident Command

POSITION ASSIGNED TO:	
Reporting to:	CEO/Other Oversight Management Structure
Command Center Location	
Telephone:	

Mission: Organize and direct the facility's emergency operations. Give overall direction for facility operations and make evacuation and sheltering in place decisions.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Assume role of Incident Commander and activate the Nursing Home Incident Command System (NHICS)
		Notify your usual supervisor of the incident activation of NHICS.
		Determine the following prior to the initial NHICS team meeting. (This will comprise the first components of the facility's Incident Action Plan).
		1. Nature of the problem (incident type, injury/illness type, etc.) 2. Safety of staff, residents and visitors 3. Risks to personnel and need for protective equipment 4. Risks to the facility 5. Need for decontamination 6. Estimated duration of incident 7. Need for modifying daily operations 8. NHICS team required to manage the incident 9. Need to open up the facility's Incident Command Center (ICC) location 10. Overall community response actions being taken 11. Need to communicate with state licensing agency 12. Status of local, county, and state Emergency Operations Centers (EOC)
		Determine need for and appropriately appoint Command Staff and Section Chiefs, or Branch/Unit/Team leaders as needed; distribute corresponding Job Action Sheets and position identification.
		Brief all appointed staff of the nature of the problem, immediate critical issues and initial plan of action. Designate time for next briefing.

Time Completed	Initials	Action
		Assign clerical personnel to function as the ICC recorder(s). Document all key activities, actions, and decisions on a continual basis.
		Communicate to Command Staff and Section Chiefs how personnel time is to be recorded. Determine if Finance/Administration has any special preferences for submission at this time.
		Define and document specific existing or potential safety risks and hazards, which Section or Branch may be affected, and steps to mitigate the threat. This is the first step in an ongoing process continued by the Safety Officer and included in the subsequent briefing meetings.
		Receive status reports from and develop an Incident Action Plan with Section Chiefs and Command Staff to determine appropriate response and recovery levels. During initial briefing/status reports, the following information may be needed: • Initial facility damage survey report across sections. • Evaluate the need for evacuation. As appropriate to the incident, verify transportation plans. • Obtain resident census and status and request a projection report for 4, 8, 12, 24 & 48 hours from time of incident onset. Adjust projections as necessary. Assign to Planning Section Chief. • Identify the operational period and ICC shift change. • As appropriate to the incident, authorize a resident prioritization assessment for the purposes of designating appropriate early discharge (e.g. dialysis, vent –dependent). • Ensure that appropriate contact with outside agencies has been established and facility status and resource information provided through the Liaison Officer. • Seek information from Section Chiefs regarding on-hand resources of medical equipment, supplies, medications, food, and water as indicated by the incident. • Assess generator function and fuel supply. • Review security and facility surge capacity as appropriate, especially if serving as a host site or in case the local emergency management office requests beds.

Time Completed	Initials	Action
		Oversee and approve revision of the Incident Action Plan developed by the Planning Section Chief. Ensure that the approved plan is communicated to all Command Staff and Section Chiefs.
		Communicate facility and incident status and the Incident Action Plan to CEO or designee, or to other executives and/or Board of Directors members on a need-to-know basis.
		Draft initial message for Public Information Officer (PIO) for notification to family members, responsible parties, and/or other interested persons regarding facility and resident status.

Ongoing

Time Completed	Initials	Action
		Ensure staff, resident, and media briefings are being conducted regularly.
		Evaluate overall nursing home operational status, and ensure critical issues are addressed.
		Ensure incident action planning for each operational period and a reporting of the Incident Action Plan at each shift change and briefing.
		Review /revise the Incident Action Plan with the Planning Section Chief for each operational period.
		Ensure continued communications with local, regional, and state response coordination centers through the Liaison Officer and others.
		Authorize resources as needed or requested by Section Chiefs.
		Set up routine briefings with Section Chiefs to receive status reports and update the action plan regarding the continuance and termination of the action plan.
		Approve media releases submitted by PIO.
		Observe all staff, volunteers, and residents for signs of stress and inappropriate behavior. Report concerns to Human Resources. Provide for staff rest periods and relief.

Liaison Officer

POSITION ASSIGNED TO:	
Reporting to:	Incident Command
Command Center Location	
Telephone:	

Mission: Function as the incident contact person in the nursing home for representatives from other agencies, such as the local emergency management office, police, and the licensing agency.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Receive appointment from Incident Commander. Obtain Job Action Sheet.
		Notify your usual supervisor of your NHICS assignment.
		Obtain briefing from Emergency Incident Commander and note time for next meeting.
		Establish contact with local, county and/or state emergency organization agencies to share information on current status, appropriate contacts, and message routing.
		Communicate information obtained and coordinate with Public Information Officer.
		Obtain initial status and information from the Planning Section Chief to provide as appropriate to external stakeholders and local and/or county Emergency Operations Center (EOC)EOC, upon request: • Resident Care Capacity – The number of residents that can be received and current census. • Nursing Home's Overall Status – Current condition of facility structure, security, and utilities. • Any current or anticipated shortage of critical resources including personnel, equipment, supplies, medications, etc. • Number of residents and mode of transportation for residents requiring transfer to hospitals or receiving facilities, if applicable.

Time Completed	Initials	Action
		• Any resources that are requested by other facilities (e.g., personnel, equipment, supplies). • Media relations efforts being initiated, in conjunction with the PIO.
		Establish communication with other nursing homes as appropriate, the local EOC, and/or local response agencies (e.g., public health department). Report current facility status.
		Keep local EOC liaison officer updated as to critical issues and unmet resource needs.
		Document all key activities, actions, and decisions on a continual basis.

Ongoing

Time Completed	Initials	Action
		Attend all command briefings and Incident Action Planning meetings to gather and share incident and facility information. Contribute inter-facility information and community response activities and provide Liaison goals to the Incident Action Plan.
		Request assistance and information as needed through the facility's network or from the local and/or regional EOC.
		Obtain the following information from the Planning Section Chief and be prepared to report to appropriate authorities the following data: • Number of new residents admitted and level of care needs. • Current resident census • Number of residents hospitalized, discharged home, or transferred to other facilities • Number dead
		Communicate with Logistics Section Chief on status of supplies, equipment and other resources that could be mobilized to other facilities, if needed or requested.

Public Information Officer

POSITION ASSIGNED TO:	
Reporting to:	Incident Command
Command Center Location	
Telephone:	

Mission: Serve as the conduit for information to internal and external stakeholders, including staff, visitors and families, and the news media, as approved by the Incident Commander.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Receive appointment from Incident Commander. Obtain Job Action Sheet.
		Notify your usual supervisor of your NHICS assignment.
		Obtain briefing from Emergency Incident Commander and note time for next briefing.
		Decide where a media briefing area might be located if needed (away from the facility's Incident Command Center and the resident care activity areas). Coordinate designation of such areas with Safety Officer.
		Contact external Public Information Officers from community and governmental agencies and/or their designated websites to determine public information and media messages developed by those entities to ensure consistent messages from all entities.
		Develop public information and media messages to be reviewed and approved by the Incident Commander before release to families, news media, and the public. Identify appropriate spokespersons to contact families or to deliver press briefings as needed.
		Assess the need to activate a staff and/or family member "hotline" for recorded information concerning the incident and facility status and establish the "hotline" if needed.
		Attend all command briefings and incident action planning meetings to gather and share incident and nursing home information.

Time Completed	Initials	Action
		Monitor incident/response information through the internet, radio, television and newspapers.
		Establish communication with other nursing homes as appropriate, local Emergency Operations Center (EOC), and/or local response agencies (e.g., public health department). Report current facility status.
		Document all key activities, actions, and decisions on a continual basis.

Ongoing

Time Completed	Initials	Action
		Coordinate with the Operations regarding: • Receiving and screening inquiries regarding the status of individual residents. • Release of appropriate information to appropriate requesting entities.
		Continue to attend all Command briefings and incident action planning meetings to gather and share incident and nursing home information. Contribute media and public information activities and goals to the Incident Action Plan.
		Continue dialogue with external community and governmental agencies to get public information and media messages. Coordinate translation of critical communications into languages for residents as appropriate.
		Continue to develop and revise public information and media messages to be reviewed and approved by the Incident Commander before release to the news media and the public.
		Develop regular information and status update messages to keep staff informed of the incident, community, and facility status. Assist in the development and distribution of signage as needed.

Safety Officer

POSITION ASSIGNED TO:	
Reporting to:	Incident Command
Command Center Location	
Telephone:	

Mission: Ensure safety of staff, residents, and visitors, monitor and correct hazardous conditions.

Have authority to halt any operation that poses immediate threat to life and health.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Receive appointment from Incident Commander. Obtain Job Action Sheet.
		Read this entire Job Action Sheet and review emergency organizational chart.
		Put on position identification (garment, vest, cap, etc.).
		Notify your usual supervisor of your NHICS assignment.
		Determine safety risks of the incident to personnel, the physical plant, and the environment. Advise the Incident Commander and Section Chiefs of any unsafe condition and corrective recommendations.
		Communicate with the Logistics Chief to procure and post non-entry signs around unsafe areas.
		Ensure the following activities are initiated as indicated by the incident/situation: • Evaluate building or incident hazards and identify vulnerabilities • Specify type and level of Personal Protective Equipment to be utilized by staff to ensure their protection, based upon the incident or hazardous condition • Monitor operational safety of decontamination operations if needed

Time Completed	Initials	Action
		• Contact and coordinate safety efforts with the Operations to identify and report all hazards and unsafe conditions to the Operations Section Chief.
		Work with Incident Command staff in designating restricted access areas and providing signage.
		Assess nursing home operations and practices of staff, and terminate and report any unsafe operation or practice, recommending corrective actions to ensure safe service delivery.
		Ensure implementation of all safety practices and procedures in the facility.
		Initiate environmental monitoring as indicated by the incident or hazardous condition.
		Attend all command briefings and Incident Action Planning meetings to gather and share incident and facility safety requirements.
		Document all key activities, actions, and decisions on a continual basis.

Ongoing

Time Completed	Initials	Action
		Continue to assess safety risks of the incident to personnel, the facility, and the environment. Advise the Incident Commander and Section Chiefs of any unsafe condition and corrective recommendations.
		Ensure proper equipment needs are met and equipment is operational prior to each operational period.
		Continue to attend all command briefings and incident action planning meetings to gather and share incident and facility information. Contribute safety issues, activities and goals to the Incident Action Plan.

Operations

POSITION ASSIGNED TO:	
Reporting to:	Incident Command
Command Center Location	
Telephone:	

Mission: Organize and direct activities relating to the Operations Section. Carry out directives of the Incident Commander. Coordinate and supervise the branches within the Operations Section. Oversee the direct implementation of resident care and services, dietary services, and environmental services. Contribute to the Incident Action Plan.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Receive appointment from Incident Commander. Obtain Job Action Sheet.
		Notify your usual supervisor of your NHICS assignment.
		Obtain briefing from Emergency Incident Commander and designate time for next meeting.
		Assess need to appoint Branch Directors: • Resident Services • Infrastructure
		Transfer the corresponding Job Action Sheets to Branch Director. If a Branch Director is not assigned, the Planning Chief keeps the Job Action Sheet and assumes that function.
		Brief Branch Directors on current situation and develop the section's initial projection/status report. Establish the Operations Section chain of command and designate time and location for next section briefing. Share resident census and condition information gained at initial Command briefing. Communicate how personnel time is to be recorded.
		Establish Operations Section Center (in proximity to Incident Command area, if possible).
		Serve as primary contact with nursing home Medical Director.

Time Completed	Initials	Action
		Meet with Resident Services Branch Director and Nursing Services Unit Leader and communicate with Medical Director to plan and project resident care needs.
		Document all key activities, actions, and decisions on a continual basis.

Ongoing

Time Completed	Initials	Action
		From information reported by Branch Directors, inform Incident Command of facility's internal factors which may contribute to the decision to evacuate or shelter in place: • Resident acuity • Physical structure
		Implement resident evacuation at the direction of the Incident Commander with support of Branch Directors and other Section Chiefs.
		Meet regularly with the Incident Commander, Command Staff and other Section Chiefs to update status of the response and relay important information to Operations Section's Staff.
		As the incident requires, in preparation for movement of residents within the facility or to a staging area, work with Logistics to assist in the gathering and placement of transport equipment (wheelchairs, canes, stretchers, walkers, etc).
		Designate times for briefings and updates with Branch Directors to develop and update section's projection/status report.
		Coordinate personnel needs with Logistics .
		Coordinate supply and equipment needs with Logistics
		Provide situation reports and projections to the Planning Section within stated time frames.
		Coordinate financial issues with the Finance/Administration Section.

Time Completed	Initials	Action
		Ensure that this Section's branches are adequately staffed and supplied.
		Observe all staff, volunteers, and residents for signs of stress and inappropriate behavior. Report concerns to Human Resources. Provide for staff rest periods and relief.

Planning

POSITION ASSIGNED TO:	
Reporting to:	Incident Command
Command Center Location	
Telephone:	

Mission: Gather and analyze incident-related information. Obtain status and resource projections from all section chiefs for long range planning and conduct planning meetings. From these projections, compile and distribute the facility's Incident Action Plan. Coordinate and supervise the units within the Planning Section.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Receive appointment from Incident Commander. Obtain Job Action Sheet.
		Notify your usual supervisor of your NHICS assignment.
		Obtain briefing from Emergency Incident Commander and designate time for next meeting.
		Assess need for the following Unit Leaders and appoint as needed: • Situation Status • Documentation
		Transfer the corresponding Job Action Sheets to Unit Leader. If a unit leader is not assigned, the Planning Chief keeps the Job Action Sheet and assumes that function.
		Brief all unit leaders on current situation and develop the section's initial projection/status report. Designate time and location for next section briefing. Communicate how personnel time is to be recorded.
		Establish a Planning/Information Section Center.
		Facilitate and conduct incident action planning meetings with Command Staff, Section Chiefs, and other key personnel as needed to plan for the next operational period.

Time Completed	Initials	Action
		Coordinate preparation and documentation of the Incident Action Plan and distribute copies to the Incident Commander and all Section Chiefs.
		Call for status and resource projection reports from all Section Chiefs for scenarios 4, 8, 24 & 48 hours from time of incident onset. Adjust time for receiving these reports as necessary.
		Direct Situation Unit Leader to document and update projection/status reports from all sections.
		Document all key activities, actions, and decisions on a continual basis.

Ongoing

Time Completed	Initials	Action
		Meet regularly with the Incident Commander, Command Staff and other Section Chiefs to update status of the response and relay important information to Planning Section's Staff.
		Ensure that personnel and equipment are being tracked.
		Designate times for briefings and updates with group supervisors to develop and update section's projection/status report.
		Ensure that this Section's groups are adequately staffed and supplied.
		Observe all staff, volunteers, and residents for signs of stress and inappropriate behavior. Report concerns to Human Resources. Provide for staff rest periods and relief.

Logistics

POSITION ASSIGNED TO:	
Reporting to:	Incident Command
Command Center Location	
Telephone:	

Mission: Organize and direct those operations associated with maintenance of the physical environment, and adequate levels of personnel, food, and supplies to support the incident objectives. Coordinate and supervise the branches within the Logistics Section. Contribute to the Incident Action Plan.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Receive appointment from Incident Commander. Obtain Job Action Sheet.
		Notify your usual supervisor of your NHICS assignment.
		Obtain briefing from Emergency Incident Commander and designate time for next meeting.
		Assess need to appoint Branch Directors and/or Unit Leaders and distribute corresponding Job Action Sheets. Refer to Nursing Home Incident Command System organizational chart. Transfer the corresponding Job Action Sheets to persons appointed.
		If a function is not assigned, the Logistics Chief keeps the Job Action Sheet and assumes that function.
		Brief Branch Directors on current situation and develop the section's initial projection/status report. Establish the Logistics Section chain of command and designate time and location for next section briefing. Communicate how personnel time is to be recorded.
		Establish Logistics Center.
		Maintain communications with Operations Section Chief and Branch Directors to assess critical issues and resource needs.
		Ensure resource ordering procedures are communicated to appropriate Sections and their requests are timely and accurately processed.

Time Completed	Initials	Action
		Attend damage assessment meeting with Incident Commander, Environmental Services Unit Leader, and the Safety Officer.
		Document all key activities, actions, and decisions on a continual basis.

Ongoing

Time Completed	Initials	Action
		From information reported by Branch Directors, inform Incident Command of facility's internal factors which may contribute to the decision to evacuate or shelter in place: • Transportation and Status of Destination Locations • Supplies • Access to Staff
		Meet regularly with the Incident Commander, Command Staff and other Section Chiefs to update status of the response and relay important information to Logistics Section's Staff.
		Obtain needed material and fulfill resource requests with the assistance of the Finance/Administration Section Chief and Liaison Officer.
		Ensure the following resources are obtained and tracked: • Staff • Resident care supplies • Communication hardware • Food and water
		Obtain information and updates regularly from Branch Directors and Unit Leaders.
		Ensure that this Section's groups are adequately staffed and supplied.
		Observe all staff, volunteers, and residents for signs of stress and inappropriate behavior. Report concerns to Human Resources. Provide for staff rest periods and relief.

Finance/Administration

POSITION ASSIGNED TO:	
Reporting to:	Incident Command
Command Center Location	
Telephone:	

Mission: Monitor the utilization of financial assets and the accounting for financial expenditures. Supervise the documentation of expenditures and cost reimbursement activities. Coordinate and supervise the units within the Finance/Admin Section. Contribute to the Incident Action Plan.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Receive appointment from Incident Commander. Obtain Job Action Sheet.
		Notify your usual supervisor of your NHICS assignment.
		Obtain briefing from Incident Commander and designate time for next meeting.
		Assess need for the following Unit Leaders and appoint as needed:
		1. Procurements
		2. Cost
		3. Employee Time
		4. Compensation/Claims
		5. Business Continuity
		Transfer the corresponding Job Action Sheets to Unit Leaders. If a unit leader is not assigned, the Finance/Admin Chief keeps the Job Action Sheet and assumes that function.
		Brief unit leaders on current situation and develop the section's initial projection/status report. Designate time for next section briefing. Communicate how personnel time is to be recorded.

Time Completed	Initials	Action
		Discuss with Employee Time Unit Leader how to document facility-wide personnel work hours worked relevant to the emergency.
		Assess the need to obtain cash reserves in the event access to cash is likely to be restricted as an outcome of the emergency incident.
		Participate in Incident Action Plan preparation, briefings, and meetings as needed: • Provide cost implications of incident objectives • Ensure Incident Action Plan is within financial limits established by Incident Command • Determine if any special contractual arrangements/agreements are needed
		Identify and document insurance company requirements for submitting damage/claim reports.
		Document all key activities, actions, and decisions on a continual basis.

Ongoing

Time Completed	Initials	Action
		Coordinate emergency procurement requests with Logistics.
		Maintain cash reserves on hand.
		Consult with state and federal officials regarding reimbursement regulations and requirements; ensure required documentation is prepared accordingly.
		Meet regularly with the Incident Commander, Command Staff and other Section Chiefs to update status of the response and relay important information to Finance/Admin Section Staff.
		Approve and submit to Incident Command a "cost-to-date" incident financial status report every 8 hours (prepared by the Cost Unit Leader, if appointed) summarizing financial data relative to personnel, supplies, and miscellaneous expenses.

Time Completed	Initials	Action
		Ensure that required financial and administrative documentation is properly prepared.
		Process invoices received.
		Maintain routine, non-incident related administrative oversight of financial operations.
		Observe all staff, volunteers, and residents for signs of stress and inappropriate behavior. Report concerns to Human Resources. Provide for staff rest periods and relief.

Department Considerations for Jobs

Other departments within the organization will have personnel assigned within the ICS structure depending on their roles, talents, and current need. There are items each department should consider as they assign personnel:

Dietary/Food Services Unit Leader

Name: _____ Date: _____

Title: _____ Reports to: _____

Management Duties

Time Completed	Initials	Item
		Oversee kitchen management
		Notify staff if there will be an evacuation
		Ensure gas appliances are turned off before departure
		Contact dietary/food service staff whom need to report to duty
		Supervise movement and separation of food stores to designated area(s)
		Supervise loading of food in the event of an evacuation
		Supervise closing of the kitchen
		Ensure preparation of food and water to be transported to the receiving facility
		Ensure disposable utensils, cups, straws, napkins are packed
		Ensure adequate food is available and packed for staff going to receiving facility
		Brief Commander as needed

Housekeeping Unit Leader

Name: _____ Date: _____

Title: _____ Reports to: _____

Staff Duties as assigned by Manager

Time Completed	Initials	Item
		Brief supervisor as needed
		Ensure cleanliness of resident's environment
		Ensure provision of housekeeping supplies for three days
		Clear corridors of any obstructions such as carts, wheelchairs, etc
		Ensure adequate cleaning supplies and toilet paper is available
		Check equipment (wet/dry vacuums, etc.)
		Secure facility (close windows, lower blinds, etc.)
		Perform clean-up, sanitation and related preparations
		Assist with moving residents to departure areas as needed
		Ensure adequate supplies of linens, blankets, and pillows
		Ensure emergency linens are available for soaking up spills and leaks
		Supervise loading of laundry and housekeeping supplies into transportation vehicles

Infrastructure and Maintenance Services Unit Leader

Name: _____ Date: _____

Title: _____ Reports to: _____

Staff Duties as assigned by Manager

Time Completed	Initials	Item
		Brief supervisor as needed
		Ensure communications equipment is operational and extra batteries are available
		Check and ensure safety of surrounding areas (secure loose outdoor equipment and furniture)
		Secure exterior doors and windows
		Check/fuel emergency generator and switch to alternative power as necessary
		Alert Department Heads of equipment supported by emergency generator
		If pump or switch on emergency generator is controlled electrically, install manual pump or switch
		Ensure readiness of buildings and grounds
		Call fire department if applicable
		Conduct inventory of vehicles, tools and equipment and report to administrative service
		Fuel vehicles
		Identify shut off valves and switches for gas, oil, water, and electricity and post charts to inform personnel
		Close down/secure facility in event of evacuation
		Ensure all needed equipment is in working order

Time Completed	Initials	Item
		Document and report repairs/supplies needed for the building
		Ensure emergency lists are posted in appropriate areas
		Monitor fuel supplies and generators
		Be watchful for potential fire hazards, water leaks, water intrusion, or blocked facility access
		Determine need for additional security.*
		Ensure supplies and equipment are safe from theft.*
		Identify and mitigate outdoor threats to facility. *

* If your facility does not have dedicated Security Staff- otherwise, these duties would be assigned to Security.

Nursing Department Unit Leader

Name: _____ Date: _____

Title: _____ Reports to: _____

Time Completed	Initials	Item
		Brief supervisor as needed
		Ensure delivery of resident medical needs
		Assess special medical situations
		Coordinate oxygen use
		Relocate endangered residents
		Ensure availability of medical supplies
		Secure patient records
		Maintain resident accountability and control
		Supervise residents and their release to relatives, when approved
		Ensure proper control of arriving residents and their records
		Screen ambulatory residents to identify those eligible for release
		Maintain master list of all residents, including their dispositions
		Contact pharmacy to determine: • Cancellation of deliveries • Availability of backup pharmacy • Availability of 3-days of medical supplies
		Assist with patient transportation needs
		Supervise emergency care
		Use Medication Administration Records (MAR) to verify patient/resident locations

Time Completed	Initials	Item
		Ensure adequate medications and medical supplies are available
		Periodically check medications and medical supplies
		Review and prioritize patient/resident care requirements
		Coordinate staffing needs
		Supervise patient/resident transfer from the building

Patient Services Unit Leader

Name: _____ Date: _____

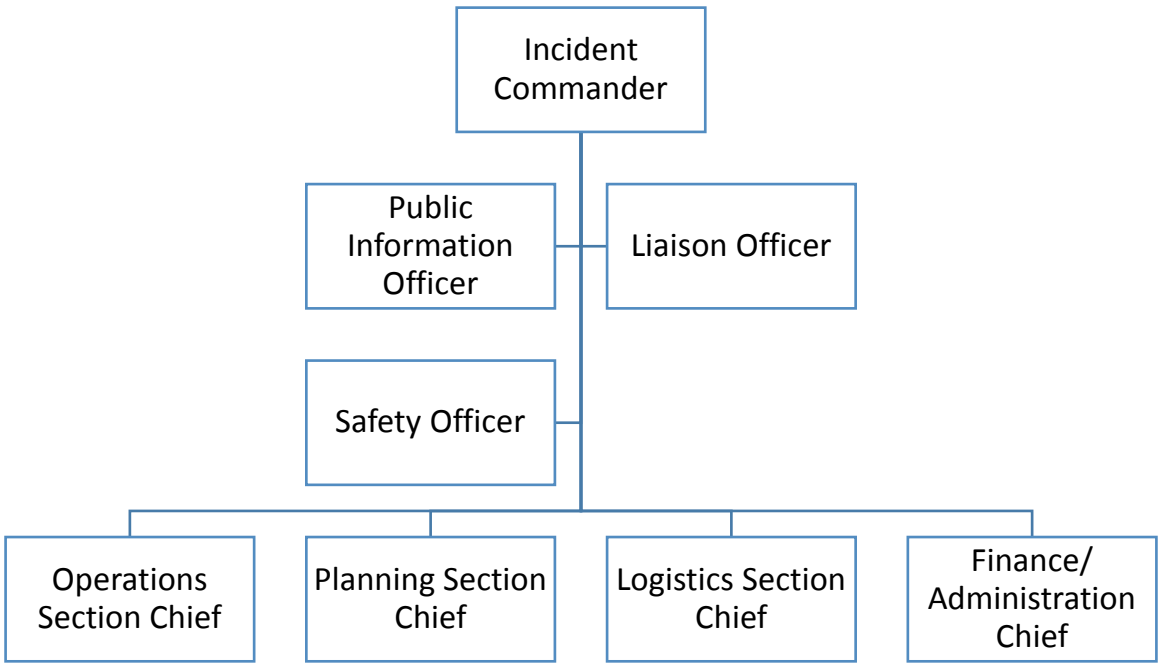
Title: _____ Reports to: _____

Time Completed	Initials	Item
		Brief supervisor as needed
		Notify resident families/responsible parties of disaster situation and document this notification
		Coordinate information release with senior administrator
		Monitor telephone communication
		Answer telephones and direct questions/requests to appropriate areas
		Order supplies as directed (Coordinate with Nursing/Medical Services)
		Cancel special activities (i.e., trips, activities, family visits, etc.), deliveries and services
		Make arrangements for emergency transportation of residents
		Contact additional staff when authorized
		Monitor and document costs associated with the incident
		Secure non-patient records
		Supervise and/or assist in clearing hallways, exits
		Coordinate movement of residents
		Assist in transport of residents from rooms to departure areas
		Assist in transfer of residents to transportation vehicles
		Ensure adequate trained staff is available for emotional needs of patient and staff
		Ensure appropriate staff are available to provide bedside treatments

HICS Incident Action Plan (IAP) Quick Start

HICS: Combined HICS 201-202-203-204-215A

Incident Name:	
Operational Period:	
Situation Summary	



HICS 201, 203

Incident Name:	
Operational Period:	
Current Hospital Incident Management Team (fill in additional positions as appropriate)	
Health and Safety Briefing Identify potential incident health and safety hazards and develop necessary measures (remove hazard, provide personal protective equipment, warn people of the hazard) to protect responders from those hazards.	

Incident Objectives	

Appendix D: Facility Contact Lists

Organizational Information

Organization: _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Phone Number: (___) _____ **Fax:** (___) _____

Owner of LTC Community/Organization

Name: _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Phone Number: (____) _____ **Fax:** (____) _____

Cell Phone Number: (___) _____

E-mail: _____

Administrator/Executive Director

Name:

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Phone Number: (___) _____ **Fax:** (___) _____

Cell Phone Number: (____) _____

E-mail: _____

Emergency Contact Roster - Internal

Emergency Contact Roster will be placed:

1.

2.

Training provided to notify staff where the rosters are and when to utilize

Facility Command Center Location:

Alternate Facility Command Center Location:

Command Center Telephone Number(s):

Administrator

Name:_____

Work #:_____

Cell #: _____

Home #: _____

Email: _____

Other:_____

Medical Director

Name:_____

Work #:_____

Cell #: _____

Home #: _____

Email: _____

Other:_____

Director of Nursing

Name:_____

Work #:_____

Cell #: _____

Home #: _____

Email: _____

Other:_____

Director of Environmental Services

Name:_____

Work #:_____

Cell #: _____

Home #: _____

Email: _____

Other:_____

Plant Maintenance Supervisor

Name:_____

Work #:_____

Cell #: _____

Home #: _____

Email: _____

Other:_____

Dietary/Food Services Director

Name:_____

Work #:_____

Cell #: _____

Home #: _____

Email: _____

Other:_____

Security Director

Name:_____

Work #:_____

Cell #: _____

Home #: _____

Email: _____

Other:_____

Safety Director

Name:_____

Work #:_____

Cell #: _____

Home #: _____

Email: _____

Other:_____

Public Information Officer

Name:_____

Work #:_____

Cell #: _____

Home #: _____

Email: _____

Other:_____

Behavioral Health/Social Work

Name:_____

Work #:_____

Cell #: _____

Home #: _____

Email: _____

Other:_____

Others

Name:_____

Work #:_____

Cell #: _____

Home #: _____

Email: _____

Other:_____

Emergency Contact Roster - External

Organization	Point of Contact
Fire	
Law Enforcement	
Emergency Medical Services	
City Emergency Manager (If applicable)	
County Emergency Management	
Local Emergency Room or Hospital	
Regional Hospital Resource Center	
Local Public Health Office	
Minnesota Department of Health – Compliance Monitoring	
Minnesota Department of Health – Office of Emergency Preparedness	
Aging Services of Minnesota / Care Providers	

Physicians

Name	Office #	Cell	Pager

Appendix E: Facility Specific Information

Building Information

Facility Name and Address: _____
_____
_____
_____

Number of Floors: _____

Water Source: _____

Sewer and Septic: _____

Location of Sprinkler: _____

System Control Panel: _____

Location of Power Shutoff: _____

Location of Generator: _____

Closest Major Highway/Road: _____

Closest Railroad: _____

Other Modes of Potential
Transportation i.e. Harbor: _____

Any Known Hazards
(i.e. propane tanks, high voltage concerns): _____

Are you within 10 miles of a nuclear facility: YES NO _____

Are you within 50 miles of a nuclear facility: YES NO _____

Do you have any locked units: YES NO _____

ATTACH A FLOOR PLAN OF THE BUILDING IF POSSIBLE

Personnel Information

Average number of staff per shift:

Days: _____

Evenings: _____

Overnights: _____

Average number of staff in each department:

Department	**Number of Staff**
Administration	
Nursing	
Dietary	
Housekeeping	
Maintenance	
Recreation	
Social Services	
Human Resources	

Resident Information	**Census Number**	**Date Updated/Initials**
Licensed Bed Number		
Average Census		
Average Number of Ambulatory Residents		
Average Number of Non-Ambulatory Residents		
Any Ventilator or Life Support Residents		

Facility Preparation List

Physical Plant Risk Assessment is completed _____ (indicate frequency – quarterly, biannually, annually).

Physical Plant Risk Assessment Schedule: _____

_____

Photographs of buildings needed for insurance purposes have been taken on _____ **and are located** _____

(Include all sides of the building including roof areas)

Date Completed	Initials	Item
		Clearly marked gas and water shut-off valves with legible instructions how to shut off each
		Available tools to facilitate prompt gas shut-off
		Check gas shut off-valves and generators to insure proper operation
		Evaluate heating, ventilating, and air conditioning function and control options
		Assess ducted and non-ducted return air systems
		Preventive maintenance of HVAC system
		Location of ramp used to evacuate residents to buses or other vehicles
		Community's evacuation plan in area accessible to the public (if applicable

Appendix F: HIPAA Waiver Toolkit

HIPAA Waivers for Disasters

Is the HIPAA Privacy Rule suspended during a national or public health emergency?

1. No.

2. CAUTION: State law may be much stricter than federal law
   a. Pre-emption analysis needs to be done regarding all of the exceptions below.
   b. The stricter law to protect privacy (whether federal or state) pre-empts.
   c. Thus in some states, the exceptions listed below will not be legal.

3. The Secretary of HHS may waive certain provisions of the Rule under the Project Bioshield Act of 2004 (PL 108-276) and Section 1135(b)(7) of the Social Security Act.

4. What provisions may be waived?
   a. If the President declares an emergency or disaster and the Secretary declares a public health emergency, the Secretary may waive sanctions and penalties against a covered hospital that does not comply with certain provisions of the HIPAA Privacy Rule.
   b. Following are the waivable provisions:
      i. Patient's right to agree or object
         1. The requirements to obtain a patient's agreement to speak with family members or friends involved in the patient's care (45 CFR 164.510(b)).
         2. The requirement to honor a request to opt out of the facility directory (45 CFR 164.510(a)).
      ii. Notice: The requirement to distribute a notice of privacy practices (45 CFR 164.520).
      iii. Restrictions by patients:
         1. The patient's right to request privacy restrictions (45 CFR 164.522(a)).

5. The patient's right to request confidential communications (45 CFR 164.522(b))
   When and to what entities does the waiver apply?

   a. If the Secretary issues such a waiver, it only applies:
      i. In the emergency area and for the emergency period identified in the public health emergency declaration.
      ii. To hospitals that have instituted a disaster protocol. The waiver would apply to all patients at such hospitals.
      iii. For up to seventy-two hours from the time the hospital implements its disaster protocol.

iv. In a pandemic infectious disease, the waiver is in effect until the termination of the declaration of the public health emergency.

b. When the Presidential or Secretarial declaration terminates, a hospital must then comply with all the requirements of the Privacy Rule for any patient still under its care, even if seventy-two hours has not elapsed since implementation of its disaster protocol.

c. Regardless of the activation of an emergency waiver, the HIPAA Privacy Rule permits disclosures for treatment purposes and certain disclosures to disaster relief organizations. For instance, the Privacy Rule allows covered entities (CEs) to share protected health information (PHI) with the American Red Cross so it can notify family members of the patient's location (45 CFR 164.510(b)(4)).

6. **Resource**: *See* Public Health Uses and Disclosures

Does the HIPAA Privacy Rule permit CEs to disclose protected health information, without individuals' authorization, to public officials responding to a bioterrorism threat or other public health emergency?

1. Yes.
   a. The Rule recognizes that various agencies and public officials will need PHI to deal effectively with a bioterrorism threat or emergency.
   b. To facilitate the communications that are essential to a quick and effective response to such events, the Privacy Rule permits CEs to disclose needed information to public officials in a variety of ways.

2. CEs may disclose PHI, without the individual's authorization, to a **public health authority** acting as authorized by law in response to a bioterrorism threat or public health emergency (*see* 45 CFR 164.512(b)), public health activities).

3. The Privacy Rule also permits a CE to disclose PHI to **public officials** who are reasonably able to prevent or lessen a serious and imminent threat to public health or safety related to bioterrorism (*see* 45 CFR 164.512(j)), to avert a serious threat to health or safety).

4. In addition, disclosure of PHI, without the individual's authorization, is permitted:
   a. Where the circumstances of the emergency implicates law enforcement activities (*see* 45 CFR 164.512(f));
   b. National security and intelligence activities (*see* 45 CFR 164.512(k)(2)); or
   c. Judicial and administrative proceedings (*see* 45 CFR 164.512(e)).

5. **Resource**: *See* Disclosures in Emergency Situations

Can healthcare information be shared in a severe disaster?

1. Yes
2. Providers and health plans covered by the HIPAA Privacy Rule can share patient information in all of the following ways:
    a. **Treatment:** Healthcare providers can share patient information as necessary to provide treatment, which includes.
        i. Sharing information with other providers (including hospitals and clinics);
        ii. Referring patients for treatment (including linking patients with available providers in areas where the patients have relocated); and
        iii. Coordinating patient care with others (such as emergency relief workers or others that can help in finding patients appropriate health services).
    b. Providers can also share patient information to the extent necessary to seek **payment** for these healthcare services.
    c. **Notification**: Healthcare providers can share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the individual's care of the individual's location, general condition, or death.
        i. The healthcare provider should get verbal permission from individuals, when possible; but if the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest.
        ii. Thus, when necessary, the hospital may notify the police, the press, or the public at large to the extent necessary to help locate, identify, or otherwise notify family members and others as to the location and general condition of their loved ones.
        iii. In addition, when a healthcare provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.
    d. **Imminent Danger**: Providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public—consistent with applicable law and the provider's standards of ethical conduct.
    e. **Facility Directory**: Healthcare facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and general condition.
3. Of course, the HIPAA Privacy Rule does not apply to disclosures if they are not made by entities covered by the Privacy Rule. Thus, for instance, the HIPAA Privacy Rule does not restrict the American Red Cross from sharing patient information.
4. **Resource**: *See* Disclosures Required by Law

When does the Privacy Rule allow CEs to disclose PHI to law enforcement officials?

1. The Privacy Rule is balanced to protect an individual's privacy while allowing important law enforcement functions to continue.
    a. The Rule permits CEs to disclose PHI to law enforcement officials, without the individual's written authorization, under specific circumstances.
    b. For a complete understanding of the conditions and requirements for these disclosures, providers need to review the exact regulatory text at the citations provided.
2. Disclosures for **law enforcement purposes** are permitted as follows:
    a. To comply with a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, or a grand jury subpoena.
        i. The Rule recognizes that the legal process in obtaining a court order and the secrecy of the grand jury process provides protections for the individual's private information.
3. *See* 45 CFR 164.512(f)(1)(ii)(A)-(B).
    a. To respond to an **administrative request**, such as an administrative subpoena or investigative demand or other written request from a law enforcement official.
        i. Because an administrative request may be made without judicial involvement, the Rule requires all administrative requests to include or be accompanied by a written statement that the information requested is relevant and material, specific and limited in scope, and de-identified information cannot be used 2) *See* 45 CFR 164.512(f)(1)(ii)(C).
    b. To respond to a request for PHI for purposes of identifying or locating a **suspect, fugitive, material witness or missing person**; but the CE must limit disclosures of PHI to name and address, date, and place of birth, social security number, ABO blood type and Rh factor, type of injury, date and time of treatment, date and time of death, and a description of distinguishing physical characteristics.
        i. Other information related to the individual's DNA, dental records, body fluid or tissue typing, samples, or analysis cannot be disclosed under this provision, but may be disclosed in response to a court order, warrant, or written administrative request
        ii. *See* 45 CFR 164.512(f)(2).
4. This same limited information may be reported to law enforcement:
    a. About a **suspected perpetrator** of a crime when the report is made by the victim who is a member of the CEs workforce (45 CFR 164.502(j)(2)).
    b. To **identify or apprehend** an individual who has admitted participation in a violent crime that the CE reasonably believes may have caused serious physical harm to a victim, provided that the admission was not made in the course of or based on the individual's request for therapy, counseling, or treatment related to the propensity to commit this type of violent act (45 CFR 164.512(j)(1)(ii)(A), (j)(2)-(3)).

5. To respond to a request for PHI about a **victim of a crime**, and the victim agrees.
    a. If, because of an emergency or the person's incapacity, the individual cannot agree, the CE may disclose the PHI if law enforcement officials represent that the PHI is not intended to be used against the victim, is needed to determine whether another person broke the law, the investigation would be materially and adversely affected by waiting until the victim could agree, and the CE believes in its professional judgment that doing so is in the best interests of the individual whose information is requested (45 CFR 164.512(f)(3)).

6. Where **child abuse victims or adult victims of abuse, neglect, or domestic violence** are concerned, other provisions of the Rule apply:
    a. Child abuse or neglect may be reported to any law enforcement official authorized by law to receive such reports and the agreement of the individual is not required (45 CFR 164.512(b)(1)(ii)).
    b. Adult abuse, neglect, or domestic violence may be reported to a law enforcement official authorized by law to receive such reports (45 CFR 164.512(c)):
        i. If the individual agrees;
        ii. If the report is required by law; or
        iii. If expressly authorized by law, and based on the exercise of professional judgment, the report is necessary to prevent serious harm to the individual or others, or in certain other emergency situations (*see* 45 CFR 164.512(c)(1)(iii)(B)).
        iv. Notice to the individual of the report may be required (*see* 45 CFR 164.512(c)(2)).

7. To report PHI to **law enforcement** when required by law to do so.
    a. *See* 45 CFR 164.512(f)(1)(i).
    b. For example, state laws commonly require healthcare providers to report incidents of gunshot or stab wounds, or other violent injuries; and the Rule permits disclosures of PHI as necessary to comply with these laws.

8. To alert law enforcement to the **death** of the individual.
    a. When there is a suspicion that death resulted from criminal conduct (*see* 45 CFR 164.512(f)(4)).
    b. Information about a decedent may also be shared with medical examiners or coroners to assist them in identifying the decedent, determining the cause of death, or to carry out their other authorized duties (45 CFR 164.512(g)(1)).

9. To report PHI that the CE in good faith believes to be evidence of a **crime** that occurred on the CEs premises (45 CFR 164.512(f)(5)).

10. When responding to an **off-site medical emergency**, as necessary to alert law enforcement about criminal activity, specifically, the commission and nature of the crime, the location of the crime or any victims, and the identity, description, and location of the perpetrator of the crime.

a. *See* 45 CFR 164.512(f)(6).
b. This provision does not apply if the CE believes that the individual in need of the emergency medical care is the victim of abuse, neglect, or domestic violence.

11. When consistent with **applicable law and ethical standards**:

    a. To a law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public (45 CFR 164.512(j)(1)(i)); or
    b. To identify or apprehend an individual who appears to have escaped from lawful custody (45 CFR 164.512(j)(1)(ii)(B)).

12. For certain other **specialized governmental law enforcement purposes**, such as:

    a. To federal officials authorized to conduct intelligence, counter- intelligence, and other national security activities under the National Security Act (45 CFR 164.512(k)(2)) or to provide protective services to the President and others and conduct related investigations (45 CFR 164.512(k)(3));
    b. To respond to a request for PHI by a correctional institution or a law enforcement official having lawful custody of an inmate or others if they represent such PHI is needed to provide healthcare to the individual; for the health and safety of the individual, other inmates, officers, or employees or others at a correctional institution or responsible for the transporting or transferring inmates; or for the administration and maintenance of the safety, security, and good order of the correctional facility, including law enforcement on the premises of the facility (45 CFR 164.512(k)(5)).

13. Except when required by law, the disclosures to law enforcement summarized above are subject to a **minimum necessary** determination by the CE (45 CFR 164.502(b), 164.514(d)).

    a. When reasonable to do so, the covered entity may rely upon the representations of the law enforcement official (as a public officer) as to what information is the minimum necessary for their lawful purpose (45 CFR 164.514(d)(3)(iii)(A)).
    b. Moreover, if the law enforcement official making the request for information is not known to the CE, the CE must verify the identity and authority of such person prior to disclosing the information (45 CFR 164.514(h)).

14. **Resource**: *See* Disclosures for Law Enforcement Purposes

DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES (45 CFR 164.512(b))

Background

1. The HIPAA Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to PHI to carry out their public health mission.

2. The Rule also recognizes that public health reports made by CEs are an important means of identifying threats to the health and safety of the public at large, as well as individuals.

3. The Rule permits CEs to disclose PHI without authorization for specified public health purposes.

How the Rule Works

1. General Public Health Activities.
    a. The Privacy Rule permits CEs to disclose PHI, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability (*see* 45 CFR 164.512(b)(1)(i)). This would include, for example,
        i. The reporting of a disease or injury;
        ii. Reporting vital events, such as births or deaths; and
        iii. Conducting public health surveillance, investigations, or interventions.
    b. Also, CEs may, at the direction of a public health authority, disclose PHI to a foreign government agency that is acting in collaboration with a public health authority (*see* 45 CFR 164.512(b)(1)(i)).
    c. CEs who are also a public health authority may use, as well as disclose, PHI for these public health purposes (*see* 45 CFR 164.512(b)(2)).
        i. A "public health authority" is an agency or authority of the United States government, a State, a territory, a political subdivision of a State or territory, or Indian tribe that is responsible for public health matters as part of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with, a public health agency (*see* 45 CFR 164.501).
        ii. Examples of public health authorities include:
            1. State and local health departments;
            2. The Food and Drug Administration (FDA);
            3. The Centers for Disease Control and Prevention (CDC); and
            4. The Occupational Safety and Health Administration (OSHA).

2. Generally, CEs are required reasonably to limit the PHI disclosed for public health purposes to the minimum amount necessary to accomplish the public health purpose.
    a. CEs are not required to make a minimum necessary determination for public health disclosures that are made pursuant to an individual's authorization, or for disclosures that are required by other law (*see* 45 CFR 164.502(b)).
    b. For disclosures to a public health authority, CEs may reasonably rely on a minimum necessary determination made by the public health authority in requesting the PHI (*see* 45 CFR 164.514(d)(3)(iii)(A)).
    c. For routine and recurring public health disclosures, CEs may develop standard protocols, as part of their minimum necessary policies and procedures, that address the types and amount of PHI that may be disclosed for such purposes (*see* 45 CFR 164.514(d)(3)(i)).

3. Other Public Health Activities.

    a. The Privacy Rule recognizes the important role that persons or entities other than public health authorities play in certain essential public health activities.
    b. Accordingly, the Rule permits CEs to disclose PHI, without authorization, to such persons or entities for the public health activities discussed below.
    c. **Child abuse or neglect**. CEs may disclose PHI to report known or suspected child abuse or neglect, if the report is made to a public health authority or other appropriate government authority that is authorized by law to receive such reports.
        i. For instance, the social services department of a local government might have legal authority to receive reports of child abuse or neglect, in which case, the Privacy Rule would permit a CE to report such cases to that authority without obtaining individual authorization.
        ii. Likewise, a CE could report such cases to the police department when the police department is authorized by law to receive such reports (*see* 45 CFR 164.512(b)(1)(ii)).
    d. **Quality, safety, or effectiveness of a product or activity regulated by the FDA.** CEs may disclose PHI to a person subject to FDA jurisdiction, for public health purposes related to the quality, safety, or effectiveness of an FDA-regulated product or activity for which that person has responsibility. Examples of purposes or activities for which such disclosures may be made include, but are not limited to:
        i. Collecting or reporting adverse events (including similar reports regarding food and dietary supplements), product defects or problems (including problems regarding use or labeling), or biological product deviations;
        ii. Tracking FDA-regulated products;
        iii. Enabling product recalls, repairs, replacement, or lookback (which includes locating and notifying individuals who received recalled or withdrawn products or products that are the subject of lookback); and
        iv. Conducting post-marketing surveillance.

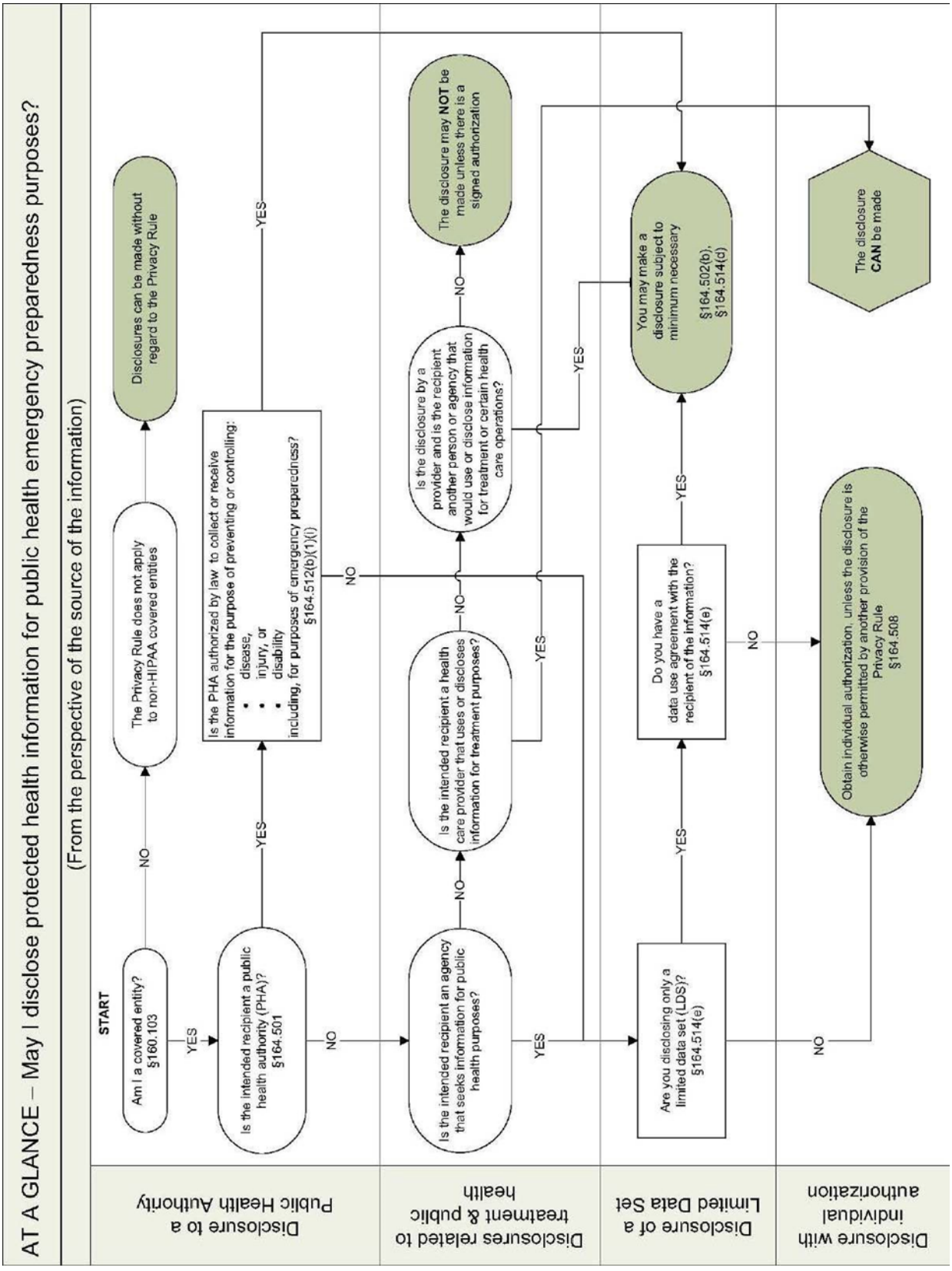
v. The "person" subject to the jurisdiction of the FDA does not have to be a specific individual.
    1. Rather, it can be an individual or an entity, such as a partnership, corporation, or association.
    2. CEs may identify the party or parties responsible for an FDA-regulated product from the product label, from written material that accompanies the product (known as labeling), or from sources of labeling, such as the Physician's Desk Reference.
    3. *See* 45 CFR 164.512(b)(1)(iii).

e. **Persons at risk of contracting or spreading a disease**. A CE may disclose PHI to a person who is at risk of contracting or spreading a disease or condition if other law authorizes the CE to notify such individuals as necessary to carry out public health interventions or investigations.
    i. For example, a CE may disclose PHI as needed to notify a person that (s)he has been exposed to a communicable disease if the CE is legally authorized to do so to prevent or control the spread of the disease.
    ii. *See* 45 CFR 164.512(b)(1)(iv).

f. Workplace medical surveillance.
    i. A CE who provides a healthcare service to an individual at the request of the individual's employer, or provides the service in the capacity of a member of the employer's workforce, may disclose the individual's PHI to the employer for the purposes of workplace medical surveillance or the evaluation of work-related illness and injuries to the extent the employer needs that information to comply with OSHA, the Mine Safety and Health Administration (MSHA), or the requirements of State laws having a similar purpose.
    ii. The information disclosed must be limited to the provider's findings regarding such medical surveillance or work-related illness or injury.
    iii. The CE must provide the individual with written notice that the information will be disclosed to his or her employer (or the notice may be posted at the worksite if that is where the service is provided) (*see* 45 CFR 164.512(b)(1)(v)).

Resources and Frequently Asked Questions

1. Privacy Rule FAQs
2. General information on Privacy of Health Information/HIPAA


AT A GLANCE – May I disclose protected health information for public health emergency preparedness purposes?
(From the perspective of the source of the information)
Disclosure to a Public Health Authority
Disclosures related to treatment & public health
Disclosure of a Limited Data Set
Disclosure with individual authorization
START
Am I a covered entity? §160.103
NO
YES
The Privacy Rule does not apply to non-HIPAA covered entities
Disclosures can be made without regard to the Privacy Rule
Is the intended recipient a public health authority (PHA)? §164.501
YES
NO
Is the PHA authorized by law to collect or receive information for the purpose of preventing or controlling:
• disease,
• injury, or
• disability
including, for purposes of emergency preparedness? §164.512(b)(1)(i)
YES
NO
Is the intended recipient an agency that seeks information for public health purposes?
NO
YES
Is the intended recipient a health care provider that uses or discloses information for treatment purposes?
NO
YES
Is the disclosure by a provider and is the recipient another person or agency that would use or disclose information for treatment or certain health care operations?
NO
YES
The disclosure may NOT be made unless there is a signed authorization
Are you disclosing only a limited data set (LDS)? §164.514(e)
YES
NO
Do you have a data use agreement with the recipient of the information? §164.514(e)
YES
NO
You may make a disclosure subject to minimum necessary §164.502(b), §164.514(d)
Obtain individual authorization, unless the disclosure is otherwise permitted by another provision of the Privacy Rule §164.508
The disclosure CAN be made

Appendix G: Evacuation Plan and Checklists. Transportation Agreements

Estimated Number and Types of Vehicles Needed to Evacuate

Vehicle	Supplied By	Date of Contact	MOU Signed Date / Initials	Next Review Date
Ambulance				
Ambulance				
Bus				
Bus				
Bus				
Bus				
Medi-van/care cab				
Medi-van/care cab				
Medi-van/care cab				
Other (Describe)				
Other (Describe)				
Other (Describe)				

Transportation Agreement/Contract Contacts

(Include copies of agreement in the plan)

Company Name	
Contact Person	
Office	
Cell	
Type and # of vehicles	

Evacuation Logistics

Based on your residents' needs, levels of mobility, cognitive abilities, and health status, your LTC community should develop evacuation logistics as part of your Disaster Plan. The following table is an example of such a logistics plan.

Evacuation Plan

Transportation

- **Residents who are independent in ambulation**: will be accompanied by a designated staff member to the designated mode of transportation.
- **Residents who require assistance with ambulation:** will be accompanied by designated staff member to the designated mode of transportation.
- **Residents who are non-ambulatory:** will be transferred by designated staff members via the designated mode of transportation.
- **Residents with cognitive impairments:** will be accompanied by an assigned staff member via the designated mode of transportation.
- **Residents with equipment/prosthetics:** equipment/prosthetics should accompany residents and should be securely stored in the designated mode of transportation.

Medical Records

At a minimum, each resident will be evacuated with the Critical Resident Information.

Medications

Each resident will be evacuated with a minimum of a 3-day supply of medications. If medications require refrigeration, indicate plan to keep medications cool.

Estimated Evacuation Time

Calculate based on the number of residents and estimated time for each based on assistance required.

Resident Tracking

Indicate who is responsible for keeping the log of residents' locations post-evacuation (some situations may require residents going to numerous locations).

Resident Justification

Indicate who is responsible for making a final check and head count of residents to ensure all residents have been evacuated.

Evacuation Checklists

Preparedness: Items potentially needed for evacuation

Check off	Item
	Appropriate ramp to load residents on buses or other vehicles
	First aid kit(s)
	Medical record of some type for residents
	Special legal forms, such as signed treatment authorization forms, do not resuscitate orders, and advance directives
	Clothing with each resident's name on their bag
	Water supply for trip- staff and residents (one gallon/resident/day)
	Emergency drug kit
	Non-prescription medications
	Prescription medications and dosages labeled), to include physician order sheet
	Communications devices: cell phones, walkie-talkies (to communicate among vehicles), 2 way radios, pager, Blackberry, satellite phone, laptop computer for instant messaging, CB radio (bring all you have)
	Air mattresses or other bedding (blankets, sheets, pillows)
	Facility checkbook, credit cards, pre-paid phone cards
	Cash, including quarters for vending machines, laundry machines, etc
	Copies of important papers: insurance policies, titles to land and vehicles, etc.
	List of important phone numbers
	Emergency prep box: trash bags, baggies, yarn, batteries, flashlights, duct tape, string, wire, knife, hammer and nails, pliers, screwdrivers, fix-a-flat, jumper cables, portable tire inflator, tarps, batteries, etc.
	Non perishable food items- staff and residents
	Disposable plates, utensils, cups, straws
	Diet cards
	Rain ponchos
	Battery operated weather radio and extra batteries, to include hearing aid batteries and diabetic pump batteries
	Hand sanitizer
	Incontinence products
	Personal wipes
	Toiletry items (comb, brush, shampoo, soap, toothpaste, toothbrush, lotion, mouthwash, deodorant, shaving cream, razors, tissues)
	Denture holders/cleansers
	Toilet Paper
	Towels
	Latex Gloves
	Plastic Bags
	Bleach sterilizing cleaner
	Coolers
	Lighters

Check off	Item
	Office supplies, such as markers, pens, pencils, tape, scissors, stapler, note pads, etc.
	Laptop computer with charger; Flash drives or CDs with medical records
	Maps – County and State
	Insect Repellant
	Vehicle Emergency Kit (Safety Triangles, road flares, engine oil, transmission fluid, funnels, jumper cables, tow rope or chain, tool kit, etc.)

Response: Prior to Evacuation

Date/Time Completed	Initials	Item
		Determination made of number of residents that must be transported by ambulance, van, car, bus or other method
		Transport services contacted and necessary transportation arranged.
		Receiving facilities contacted and arrangements made for receipt of residents.
		Contact made with facility's medical director and/or the patient's physician
		Necessary staff contacted for assistance in transporting residents and caring for residents at the receiving facility.
		County Emergency Management Agency contacted and informed of the status of the evacuation.
		Roster made of where each patient will be transferred and notify next of kin when possible.
		Residents readied for transfer, with the most critical residents to be transferred first. Include:
		a. change of clothes
		b. 3 day supply of medications
		c. 3 day supply of medical supplies
		d. patient's medical chart to include next of kin
		e. patient identification, such as a picture, wrist band, identification tag, or other identifying document to ensure residents are not misidentified
		Adequate planning considerations given to needs of residents, such as dialysis patients.
		Adequate planning considerations given to residents on oxygen.
		Adequate planning considerations given to residents using durable medical equipment such as masks, nasal cannulas, colostomy equipment, g-tube, etc.

Sample Resident Profile

Resident Name: _____ AKA _____

DOB _____HT _____WT_____M/F _____

Assistive Devices Used *(Circle all that apply)*

Dentures Partial or Full

Cane

Walker

Wheelchair

Eyeglasses

Hearing Aid

*Oxygen Indicate Concentration*_____

Resident

Current Photo

Emergency Contact Information

Name: _____Relationship _____

Address: _____Phone _____

Physician

Name: _____

Address: _____ Phone_____

Pertinent Medical Information:

_____

_____

_____

_____

Medications:

Name_____Dosage_____

Name_____Dosage_____

Name_____Dosage_____

Name_____Dosage_____

Name_____Dosage_____

Name_____Dosage_____

Allergies:

_____
_____

Medical Devices:

_____
_____

Pet _____Name_____

Age _____

Sheltering Facility Agreement/Contract Contacts

(Include copies of agreement in the plan)

Company Name	
Contact Person	
Office	
Cell	
Pager	
Will Accept # and Type of Residents	

Appendix H: Facility Shelter-in-Place Plan. Supply and Equipment Lists, and Checklists

Shelter-in-Place Checklists

This checklist is not disaster-specific, so all items will not necessarily be applicable depending on the nature of the disaster

Preparedness

Date Completed	Initials	Item
		Plan in place describing how three days of non-perishable meals are kept on hand for residents and staff. The Plan should include special diet requirements.
		Plan in place describing how 72 hours of potable water is stored and available to residents and staff.
		Plan in place identifying 72 hours of necessary medications that are stored at the facility and how necessary temperature control and security requirements will be meet.
		Plan in place to identify staff that will care for the residents during the event and any transportation requirements that the staff might need and how the facility will meet those needs.
		Plan in place for an alternative power source to the facility such as an onsite generator and describe how 72 hours of fuel will be maintained and stored.
		Alternate power source plan provides for necessary testing of the generator.
		Plan in place describing how the facility will dispose of or store waste and biological waste until normal waste removal is restored.
		Emergency Communications Plan in place, such as for cell phones, hand held radios, pager, Blackberry, satellite phone, laptop computer for instant messaging, HAM radio, etc.
		Adequate planning considerations given to needs of residents, such as dialysis patients.
		Adequate planning considerations given to residents on oxygen.
		Adequate planning considerations given to residents using durable medical equipment such as masks, nasal cannulas, colostomy equipment, g-tube, etc.

Shelter-in-Place Supply and Equipment Checklist

Check	Item
	Emergency Placards
	Non perishable food items- staff and residents
	Disposable plates, utensils, cups and straws
	Battery operated weather radio and extra batteries
	Hand sanitizer
	Drinking water (one gallon per day per person)
	Ice
	Backup generators
	Diesel fuel to supply generators for power and for cooling systems
	Backup supply of gasoline so staff can get to and from work
	Extra means for refrigeration
	Food (staff and residents)
	Medicines – Specific Lists could be made to indicate specific medications and needed quantity
	Medical Supplies- Specific Lists could be made to indicate specific types of medical supplies needed.
	Medical equipment-Specific Lists could be made to indicate specific type and quantity of medical equipment such as oxygen tanks.
	Battery operated weather radio, flashlights and battery operated lights
	Extra batteries, to include hearing aid batteries and diabetic pump batteries
	Toiletry items for staff and residents (comb, brush, shampoo, soap, toothpaste, toothbrush, lotion, mouthwash, deodorant, shaving cream, razors, tissues)
	Hand sanitizer
	Incontinence products
	Personal wipes
	Denture holders/cleansers
	Toilet paper
	Towels
	Latex gloves
	Plastic bags
	Bleach/sterilizing cleaner
	Plastic sheeting for covering broken windows, etc.
	Duct tape
	Hammers
	Nails
	Coolers
	Lighters
	Extension Cords
	Office supplies, such as markers, pens, pencils, tape, scissors, stapler, note pads, etc. – Think of the thinks you would need to do business – Office in a box
	Laptop computer with charger; Flash drives or CDs with medical records, portable printer if possible

Response

Notes: Some actions are dependent upon the nature of the disaster.

Date / Time Completed	Initials	Item
		Condition of residents being monitored continuously, particularly those with respiratory problems, and provide oxygen or suitable assistance.
		Windows and exterior doors are closed
		Air intake vents and units in bathrooms, kitchen, laundry, and other rooms closed
		Heating, cooling, and ventilation systems that take in outside air, both central and individual room units turned off. (Units that only re-circulate inside air may have to be kept running during very cold or very hot weather to avoid harm to residents)
		Food, water, and medications covered and protected from airborne contamination and from contact with waste materials, including infectious waste.
		Contact with emergency authorities regarding the hazard and internal conditions.
		Contact public health authorities for advice regarding the need for decontamination, and the means for doing it.
		Standby vehicles with pre-filled fuel tanks stationed on the highest point of ground nearby. (Flooding or High Water)
		Trained staff available who can remain at the facility for at least 72 hours, especially to manage non-ambulatory residents or others with additional needs.
		Support teams available on standby with communications equipment in order to assist in getting additional supplies.
		Medical equipment, medicines, refrigerators, stoves, food and water, supplies, beds, desks and chairs moved to a second floor location or raised off the floor to ensure protection against possible flooding.

Appendix I: MOU Templates

Sample Memoranda of Agreements

Agreement to Provide Facilities for Temporary Shelter

(Sample MOU use for an alternate site)

THIS AGREEMENT (Agreement) is entered into as of this _____ day of ____ 20_____ by and between, (the FACILITY) and _____, (the SHELTER) for the provision of physical facilities to serve as a temporary shelter for the residents of the FACILITY in the event of the need for emergency evacuation of the FACILITY.

RECITALS

A. The FACILITY is a [type of facility], with census at full capacity of [number of residents]
B. The SHELTER is a [describe], that has the capacity to temporarily accommodate [number of residents], and the Facility's staff who care for those residents.

AGREEMENT

In consideration of the mutual promises in this Agreement, The FACILITY and the SHELTER agree as follows:

1. **Nature of Services.** The SHELTER is not a nursing facility, health care facility, or residential facility licensed by the State of Minnesota.
   1.1. The SHELTER will provide the following physical facilities to the FACILITY on a temporary basis:
      1.1.1. Space sufficient to accommodate ___ beds, sleeping arrangements, residents, and the FACILITY staff who provide care for the residents.
      1.1.2. Restrooms
      1.1.3. Electricity to provide light and to supply power to necessary medical devices and/or equipment to care for the residents.
      1.1.4. A potable water source or space to accommodate water reserves.
   1.2. The SHELTER's physical facilities will only include the aforementioned services and do not include:
      1.2.1. Staffing
      1.2.2. Supplies
      1.2.3. Medical care
      1.2.4. Food or water (other than city services)
      1.2.5. Clothing
      1.2.6. Beds or linen
      1.2.7. Transportation

1.3. The FACILITY will be responsible for providing food, clothing, beds, linen, appropriate medical and other supplies, transportation, appropriate equipment, staff, and medication (if appropriate) or arranging for these services and provisions.

2. **Availability of SHELTER.** As part of the emergency nature of the services required by the FACILITY, the SHELTER agrees to be available as provided in the AGREEMENT at any time, 24hours/day, seven days/week.
   2.1. The FACILITY will designate a contact person (or designee) who will notify the SHELTER of the need for its services.
   2.2. The SHELTER will designate a contact person (or designee) who will ensure that the SHELTER is available for use by the FACILITY in the case of an emergency at any time, 24 hours/day, seven days/week.
   2.3. In the alternative, the SHELTER and the FACILITY will agree on a designated contact person or designee who will have access to the SHELTER in the event of an emergency at any time, 24 hours/day, seven days/week.
   2.4. In the event of an emergency, the services of the SHELTER will be necessary only until it has been deemed safe for the residents to return to the FACILITY, or the residents have been placed in an alternative setting.
   2.5. The FACILITY agrees to make a good faith effort to utilize the SHELTER only as long as necessary and make a good faith effort to transfer residents to alternative placement as quickly as safely possible.
3. **Insurance coverage.** The SHELTER agrees to maintain premises liability insurance.

4. **Indemnification.** The SHELTER and the FACILITY agree to indemnify and hold each other harmless for all claims and damages for all negligent acts or omissions arising out of or as a result of the performance of this AGREEMENT.

5. **Fees.** The FACILITY agrees to pay the SHELTER at a rate of $_____.00 per month to maintain the SHELTER in a position to accommodate all the terms of this AGREEMENT.
   5.1. The FACILITY agrees to reimburse the SHELTER for additional expenses incurred during the use of its facilities.

6. **Entire Agreement.** This Agreement contains the entire Agreement between parties.
   6.1. Any amendments to this Agreement must be made in writing and signed by both parties.

7. **Applicable Law.** This Agreement and any disputes relating to it shall be construed under Minnesota law.
   7.1. If any of the provisions in this Agreement are determined to be in violation of State or Federal law, said provisions shall be interpreted so as to be in compliance with such law or said provisions shall fall out of this Agreement, but otherwise, the Agreement shall be unaffected and shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the date stated above.

[NAME OF FACILITY]

By: _____

Its: Administrator _____

[NAME OF SHELTER]

By: _____

Its: _____

Sample Mutual Aid Transfer Agreement Between LTC Facilities

"The following long-term care community agree to accept residents from other facilities (specify) in the event of a disaster. A disaster is any event, natural, man-made or technological, that the community determines that a partial or full evacuation is necessary.

"This transfer would not exceed the receiving community's total bed capacity on a long-term basis.

"All facilities involved in a transfer during a disaster will be responsible for contacting the Minnesota Department Health for decisions regarding Medicare/Medicaid reimbursement and any other issue.

"The facilities involved in transferring residents during a disaster will mutually determine the beds available, whether special needs and resident choice can be accommodated.

"All employees of the transferring community will remain employees of the transferring community for the purpose of worker's compensation insurance.

"The receiving community will distribute community policies and procedures and information on emergency plans to employees of the transferring community. The receiving community will assign all employees to work with the transferring community personnel.

"Medical records will be evacuated as discussed in each community's emergency plan.

"This agreement will renew automatically annually unless prior written 30-day notice is given."

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the date stated above.

[NAME OF FACILITY]

By: _____

Its: Administrator _____

[NAME OF SHELTER]

By: _____

Its: _____

Appendix J: Recovery Checklists

Recovery Checklist: Prior to Re-opening

Date Completed	Initials	Item
		Recovery operations coordinated with county emergency management agency.
		Recovery operations coordinated with local jurisdictions/agencies to restore normal operations.
		Recovery operations coordinated with authorities to perform search and rescue if necessary
		Recovery operations coordinated with applicable jurisdiction to reestablish essential services.
		Crisis counseling for provided residents/families as needed.
		Local and state authorities provided with a master list of displaced, injured or deceased residents.
		Next-of-kin notified of displaced, injured or deceased residents.
		Insurance agent contacted.
		Hazard evaluation conducted prior to re-entry, to include potential structural damage, environmental concerns and items that can affect staff, volunteers, residents and appropriate personnel.
		Inventory taken of damaged goods.
		Protective measures taken for undamaged property, supplies and equipment.
		Access- safe access and egress assured for staff, deliveries, and ambulances.
		Building declared safe for occupancy by appropriate regulatory agency.
		Building- Fire-fighting services available including sprinklers, standpipes, alarms, etc.
		Building- Pest control/containment procedures in effect.
		Building- Adequate environmental control systems in place.
		Internal communication system functional and adequate.
		Internal Communications- Emergency call system functional and adequate.
		Internal Communications- Fire alarms system(s) functional and adequate.
		Internal Communications- Notifications made to staff regarding status of communication system(s).
		External Communications- functional to call for assistance (to fire, police, etc.).
		External Communications- Notifications made to staff regarding status of communication system(s).
		Dialysis Patients- water supply and other system components adequate and functional.
		Dietary- adequate facilities, personnel & supplies onsite.

Date Completed	Initials	Item
		Dietary- adequate refrigeration for storage of food and dietary supplies.
		Dietary- food approved for re-use by appropriate agency if applicable
		Electrical Systems- Main switchboard, utility transfer switches, fuses and breakers operational.
		Electrical Systems- transformers reviewed.
		Electrical Systems- emergency generators, backup batteries and fuel available where needed. Transfer switches in working order. Sufficient fuel available for generators.
		Equipment & supplies located in flooded or damaged areas approved or not approved for reuse.
		Equipment & supplies- including oxygen- adequate available onsite.
		Equipment & supplies- plan in place to replenish.
		Equipment & supplies- equipment inspected and cleared prior to patient use.
		Equipment & supplies- ability to maintain patient care equipment that is in use.
		Equipment & supplies-flashlights and batteries (including radio and ventilator batteries) available.
		Facilities/Engineering- Cooling Plant operational
		Facilities/Engineering-Heating Plant operational
		Facilities/Engineering- Distribution System (ductwork, piping, valves and controls, filtration, etc) operational.
		Facilities/Engineering- Treatment Chemicals (Water treatment, boiler treatment) operational.
		Infection Control- Procedures in place to prevent, identify, and contain infections and communicable diseases.
		Infection Control-Procedures and mechanisms in place to isolate and prevent contamination from unused portions of facility .
		Infection Control- adequate staff and resources to maintain a sanitary environment.
		Infection Control- process in place to segregate discarded, contaminated supplies, medications, etc. prior to reopening of facility.
		Information Technology /Medical Records – systems or backup systems in place.
		Management- adequate management staff available
		Personnel- adequate types and numbers available.
		Security- adequate staff available.
		Security- adequate systems available.
		Waste Management- System in place for trash handling.
		Waste Management- System in place for handling hazardous and medical waste.
		Water systems- potable water for drinking, bathing, dietary service, patient services.
		Water systems- sewer system adequate
		Water systems- available and operational for fire suppression

Recovery Checklist: Re-opening the Facility

Date Completed	Initials	Item
		Repairs and maintenance complete
		Emergency exits, fire extinguishers, carbon monoxide detectors, smoke alarms and other critical systems are working
		Back-up generator working
		Air conditioning/heat working
		Adequate, rested staff available
		Counselors available to staff and residents
		Adequate medical, clinical, personal care, food and water , and building supplies delivered and available
		Residents' families notified of re-opening
		Local authorities (police and fire) notified
		State authorities MDH – Compliance Monitoring notified
		Check to see if other services in community are up and running such as local hospital and pharmacy

Appendix K: Staff Care Plan Documentation

Disaster Family Care Plan (Staff)

Name: _____

Department: _____

Location/Shift: _____

In the event of a major emergency in which I will not be able to go home and care for my family or pets, please call the individual(s) listed below and provide them with the instructions regarding the emergency.

Alternate Caregiver #1:
Name: _____

Address: _____

Daytime Phone: _____

Evening Phone: _____

Cell Phone: _____

Alternate Caregiver #2:
Name: _____

Address: _____

Daytime Phone: _____

Evening Phone: _____

Cell Phone: _____

Location of children or other dependents:

Name	School/Daycare Facility	Telephone/Cell Phone Numbers	Medications	Allergies

Other pertinent information:

_____

Signature and Date

Appendix L: Exercise, Evaluation, and Improvement Planning Checklist. AAR-IP

Exercise, Evaluation, and Improvement Planning Checklist

Plans, policies and procedures are tested at least annually in one or more exercises that are evaluated and result in corrective actions for plan improvement.

Emergency Response Plan

Date	Initials	Tasks
		Review and update your facilities Hazard and Vulnerabilities Assessment (HVA) annually.
		Review your Emergency Operations Plan (EOP) for updating to meet your current needs and identify gaps annually.
		Review and update all Memorandums of Understanding (MOU) with response services such as sheltering facilities, transportation, and emergency medical services (EMS), annually.
		Distribute the EOP to your staff and identify where it is located in your facility. Include distribution and coordination with appropriate emergency response partners.

Providing Trained Staff

Date	Initials	Tasks
		Identify staff for emergency roles and responsibilities. Update their personal contact information as needed.
		Have your staff update their personal family emergency plans annually.
		Conduct training seminars and workshops annually to familiarize staff with the EOP especially the Evacuation Plan part of the EOP.
		Plan an announced staff notification drill then conduct unannounced drills once each quarter. After each drill, evaluate the numbers contacted and how quickly they responded and try to improve on the next drill.
		Identify the equipment and methods used for communication with your staff, patients, and emergency responders during an incident.
		Update emergency response contact information: phone numbers, and contracted sheltering facilities annually.

Test all equipment

Date	Initials	Tasks
		Phones, computer systems, alarms, general addressing systems, 2-way radios, 800 MHz radios, ham radios (all that apply)
		Facility power generators, emergency lighting systems, flashlights

Conduct exercises to demonstrate plans and procedures in an exercise or real response

Date	Initials	Tasks
		Identify equipment, plans, or procedures that need to be tested or demonstrated
		Identify staff who would gain experience in their response role.
		Plan one or more drills for testing equipment, notification procedures, and other standard operating procedures annually.
		Plan a seminar to share the EOP and any policy, plan, or procedural changes with your staff.
		Plan a workshop to bring together key staff to develop or improve a procedure or plan.
		Plan a tabletop discussion exercise to demonstrate how your all-hazard plans, policies, or procedures would apply to a specific type of incident and for your staff to gain experience. Evaluate and improve your plan.
		Plan a functional exercise to demonstrate a part of your plan, test a procedure, and give additional experience to your staff. Evaluate and improve your plan
		Hold a full-scale exercise with your response staff and/or with other response partners to test your planned response to a specific type of incident. Evaluate and improve your plan.
		Develop a one-year or multiple-year training and exercise plan to provide a timeline for accomplishing your training goals
		Track the completion of corrective actions from your exercise after action reports in a facility-wide improvement plan.

Annex A: Apartment Evacuation Policy & Procedure

PURPOSE: To evacuate all apartment residents to safety in the event of a disaster.

PROCEDURE: In the event it becomes necessary to evacuate the entire building, or a specific wing, the following procedure will be followed:

1. The Administrator or designated person will notify the apartment residents in the event of a disaster.
2. Nursing personnel will direct the C.N.A.'s or staff to evacuate the residents.
3. Nursing staff will knock on the apartment door and notify the tenants/residents on what to do, if no one answers the door, go on to the next apartment and report to the Administrator anyone who was not home.
4. The Administrator will then take the master key to ensure there is no one left in the apartment.
5. The nursing staff will be responsible for bringing the apartment residents files in the event of disaster.
6. A designated person will notify family members what has transpired and where the apartment residents are located.

Annex B: Behavioral Health

The resource linked below, Psychological First Aid Field Operations Guide for Nursing Homes, is a guidance document to assist with providing behavioral health support to persons in nursing homes in the immediate aftermath of a disaster.

Psychological First Aid Field Operations Guide for Nursing Homes

Annex C: Bioterrorism Threats

Reporting Requirements and Contact Information

In the event a bioterrorism (BT) event is suspected, local emergency response systems should be activated. Notification should immediately include local infection control personnel and the LTC community's administration, and prompt communication with the local and state health departments, FBI field office, local police, CDC, and medical emergency services. **Each LTC community should include a list containing the following telephone notification numbers in its readiness plan:**

INTERNAL CONTACTS:

INFECTION CONTROL

ADMINISTRATION/PUBLIC AFFAIRS

EXTERNAL CONTACTS:

LOCAL HEALTH DEPARTMENT

REGIONAL EPIDEMIOLOGIST

STATE HEALTH DEPARTMENT

FBI FIELD OFFICE
BIOTERRORISM EMERGENCY NUMBER, CDC Emergency Response Office 770/488-7100
CDC HOSPITAL INFECTIONS PROGRAM 404/639-6413

Detection of Outbreaks Caused by Agents of Bioterrorism

BT occurs as covert events, in which persons are unknowingly exposed and an outbreak is suspected only upon recognition of unusual disease clusters or symptoms. BT may also occur as announced events, in which persons are warned that an exposure has occurred. A number of announced BT events have occurred in the United States during 1998-1999, but these were determined to have been "hoaxes;" that is, there were no true exposures to BT agents. A healthcare facility's BT Readiness Plan should include details for management of both types of scenarios: suspicion of a BT outbreak potentially associated with a covert event and announced BT events or threats. The possibility of a BT event should be ruled out with the assistance of the FBI and state health officials.

Infection Control Practices for Patient Management

Agents of BT are generally not transmitted from person to person; re-aerosolization of these agents is unlikely. **All** persons, including symptomatic patients with suspected or confirmed BT-related illnesses, should be managed utilizing **Standard Precautions**. Standard Precautions are designed to reduce transmission from both recognized and unrecognized sources of infection, and are recommended for all persons receiving care, regardless of their diagnosis or presumed infection status. **For certain diseases or syndromes (e.g., smallpox and pneumonic plague), additional precautions may be needed to reduce the likelihood for transmission.**

Standard Precautions prevent direct contact with all body fluids (including blood), secretions, excretions, nonintact skin (including rashes), and mucous membranes. Standard Precautions routinely practiced by healthcare providers include:

Handwashing

Hands are washed after touching blood, body fluids, excretions, secretions, or items contaminated with such body fluids, whether or not gloves are worn. Hands are washed immediately after gloves are removed, between contacts, and as appropriate to avoid transfer of microorganisms to others and the environment. Either plain or antimicrobial-containing soaps may be used according to policy.

Gloves

Clean, non-sterile gloves are worn when touching blood, body fluids, excretions, secretions, or items contaminated with such body fluids. Clean gloves are put on just before touching mucous membranes and nonintact skin. Gloves are changed between tasks and between procedures on the same person if contact occurs with contaminated material. Hands are washed promptly after removing gloves.

Masks/Eye Protection or Face Shields

A mask and eye protection (or face shield) are worn to protect mucous membranes of the eyes, nose, and mouth while performing procedures and care activities that may cause splashes of blood, body fluids, excretions, or secretions.

Gowns

A gown is worn to protect skin and prevent soiling of clothing during procedures and care activities that are likely to generate splashes or sprays of blood, body fluids, excretions, or secretions. Selection of gowns and gown materials should be suitable for the activity and amount of body fluid likely to be encountered. Soiled gowns are removed promptly and hands are washed to avoid transfer of microorganisms to others.

Post Exposure Management

The need for decontamination depends on the suspected exposure and in most cases will not be necessary. The goal of decontamination after a potential exposure to a BT agent is to reduce the extent of external contamination of the residents and contain the contamination to prevent further spread.

Decontamination should only be considered in instances of gross contamination. Decisions regarding the need for decontamination should be made in consultation with state and local health departments. Decontamination of exposed individuals prior to receiving them in the healthcare facility may be necessary to ensure the safety of residents and staff while providing care.

When developing BT Readiness Plans, facilities should consider available locations and procedures for patient decontamination.

Depending on the agent, the likelihood for re-aerosolization, or a risk associated with cutaneous exposure, clothing of exposed persons may need to be removed. After removal of contaminated clothing, patients should be instructed (or assisted if necessary) to immediately shower with soap and water. **Potentially harmful practices, such as bathing residents with bleach solutions, are unnecessary and should be avoided.** Clean water, saline solution, or commercial ophthalmic solutions are recommended for rinsing eyes. If indicated, after removal at the decontamination site, patient clothing should be handled only by personnel wearing appropriate personal protective equipment, and placed in an impervious bag to prevent further environmental contamination.

Development of Bioterrorism Readiness Plans should include coordination with the FBI field office. The FBI may require collection of exposed clothing and other potential evidence for submission to FBI or Department of Defense laboratories to assist in exposure investigations.

Prophylaxis and post-exposure immunization

Recommendations for prophylaxis are subject to change. However, up-to-date recommendations should be obtained in consultation with local and state health departments and CDC. Communities should ensure that policies are in place to identify and manage health care workers exposed to infectious residents. In general, maintenance of accurate occupational health records will facilitate identification, contact, assessment, and delivery of post-exposure care to potentially exposed healthcare workers.

Annex D: Bomb Threat Policy and Procedure

Purpose: The purpose of this policy is to inform staff of precautions to be taken in the event of a bomb threat.

The current national situation of increased bombings, bomb threats, and bomb scares must be given immediate consideration. In the past, the vast majority of bomb threats were hoaxes. However, the current trend nationally is that more of the threats are materializing.

Upon receipt of a bomb threat, it is impossible to know if it is real or a hoax. Therefore, precautions need to be taken for the safety of our residents and employees.

Procedure: If you receive a bomb threat over the phone, follow these procedures:

1. Keep the caller on the line as long as possible.
2. Ask the caller to repeat the message.
3. Ask the caller his/her name.
4. Ask the caller where the bomb is located.
5. Record every word spoken by the person making the call.
6. Record time call was received and terminated.
7. Inform the caller that the building is occupied and the detonation of a bomb could result in death or serious injury to many innocent people.
8. Complete the bomb threat form, attached, to record the caller's characteristics.

If possible, during the call, try to notify the charge nurse immediately. The charge nurse shall:

1. Call the Police Department at 9-1-1.
2. Call the Administrator if not present.
3. Organize staff to evacuate residents upon police or administrative order.

Once the Police have arrived:

- Keys shall be available so that searchers can inspect all rooms. Employee lockers will be searched. If padlocked, padlock will be cut off.
- The Administrator or designee shall remain with the Search Commander during the entire search to provide assistance and counsel during the search.
- If a suspected bomb is located within the building, the responsibility for investigation will be that of the law enforcement officials having jurisdiction over such matters.

Bomb Threat Telephone Procedure Form

Use the following template in the situation of a potential bomb threat

- Homeland Security: Bomb Threat Checklist (PDF)

Annex E: Chemical Spills

Purpose: To inform staff of action to be taken in the event of an outdoor chemical spill.

Policy: The following action will be taken in the event of an outdoor chemical spill.

1. Shut down outside intake ventilation.
2. Close all doors to the outside and close and lock all windows.
3. Maintenance staff should set all ventilation systems to 100% recirculation so that no outside air is drawn into the building. When this is not possible, ventilation systems should be turned off. This is accomplished by pulling the fire alarm.
4. Turn off all heating systems.
5. Turn off all air conditioners and switch inlets to the "closed" position. Seal any gaps around window type air conditioners with tape and plastic sheeting, wax paper or aluminum wrap.
6. Turn off all exhaust fans in kitchens and bathrooms.
7. Close as many internal doors as possible in the building.
8. Use tape and plastic food wrapping, wax paper or aluminum wrap to cover and seal bathroom exhaust fan grills, range vents, dryer vents, and other openings to the outside.
9. If the gas or vapor is soluble or partially soluble in water, hold a wet cloth over your nose and mouth if gases start to bother you. For a higher degree of protection, go into the bathroom, close the door and turn on the shower in a strong spray to wash the air.
10. If an explosion is possible outdoors, close drapes, curtains or shades over windows. Stay away form external windows to prevent injury from flying glass.
11. Tune into the Emergency Broadcasting System on the radio or television for further information and guidance.

Law enforcement agencies will make a determination regarding possible evacuation of residents

Annex F: Communications Plan

The following resource from the American Health Care Association and the National Center for Assisted Living is a guidance document on how to write a communications and media plan.

Emergency Preparedness Requires a Communications Plan

Annex G: Electrical Power Outage Policy and Procedure

Purpose: It is the policy of this facility to provide auxiliary power to designated areas within the facility to operate life-support equipment should our normal power supply fail.

The facility has an emergency generator that should be automatically activated in the event of a power outage. The generator operates on natural gas (diesel, etc.), and as long as the gas lines are not damaged or disrupted, the generator is capable of providing the facility with a minimal supply of electricity.

Procedure: In the event of a power outage, the following steps should be followed:

1. Immediately identify any residents that require oxygen concentrators or other life support equipment. Move the resident to areas supplied with emergency power (outlets that are red).
2. Gather all flashlights and other needed supplies. Check on all residents to ensure their safety. Calm any residents experiencing distress.
3. Make sure back up phones are available (cell phone)

Facility Generator DOES NOT...

- Provide Heat or Water
- Provide Power to Laundry or Kitchen
- Operate Fire Alarm System (this is on its own battery back-up system)
- Operate the phone system

Areas Equipped with Emergency Lighting:

- Front Lobby
- Hallways
- Break room
- Laundry Room
- Boiler Room
- Stairways

Annex H: Elevator Policy and Procedure

PURPOSE: To provide facility staff a course of action to follow in the event the elevator should become stuck between floors.

PROCEDURE:

1. Obtain the key to open the elevator maintenance room.
2. Locate and shut off power to the elevator. This will return elevator to the ground floor.
3. Take key with a red tag, located to the left of the power shut off.
4. Put key in hole at the top of the elevator door and turn. This opens the first door.
5. Push the latch on the second door and push open at the same time, the person on the elevator can also help push door open.
6. Turn on power to the elevator.
7. If the power is not restored, push the reset button, which is in the panel on the left.
8. If this does not work contact the Maintenance Supervisor, if not available contact the Elevator company at _____

Annex I: Emergency Notification of Administrator

The Business Office Manager during normal business hours, or the Charge Nurse at any other time shall notify the Administrator. In the following situations, the Administrator is to be notified immediately, if possible, on a 24-hour basis:

- Death involving unusual circumstances or family dispute;
- Emergency requiring immediate services or repair authorization;
- Fire of any size or nature;
- Missing resident;
- Formal Division of Health Inspection or Annual Survey;
- Urgent resident/family problems;
- Any situation involving violence by staff or resident.

Absence of Administrator

In the absence of the Administrator from the facility, the Director of Nursing shall be the designated "Person-in-Charge."

If the Administrator and Director of Nursing are absent from the facility, there shall be two persons in charge of the facility. The charge nurse on duty shall be in charge of staff and all resident care delivery. The Business Office Manager shall be in charge of all business matters.

If the Administrator cannot be reached, a board member shall be contacted. The President of the Board of Directors should be contacted first. If the President cannot be reached, contact the Vice-President.

If the Vice-President cannot be reached, the Secretary shall be notified. If none of the latter persons cannot be reached, attempts should continue to inform any one of the other board members.

Annex J: Fire Policy & Procedure

Purpose: The primary purpose of the Fire Policy and Procedure is to provide a course of action for all personnel to follow in the event of a fire.

Procedure:

R - Rescue anyone in immediate danger.

A - Alert other staff members of the fire and location over the intercom system. Pull the nearest fire **alarm**. The Person in Charge shall contact the fire department by calling 911.

C - Contain the fire. Close all doors and windows adjacent to the fire. Close all fire doors. Shut off all fans, ventilators and air conditioners, as these will feed the fire and spread smoke throughout the building.

E - Extinguish if the fire is small. The extinguisher should be aimed low at the base of the fire, and move slowly upward with a sweeping motion.

- Never aim high at the middle or top of the flames as this will cause the fire to spread.
- If you cannot extinguish the fire, **evacuate** the building immediately.

Special Note: The most common cause of death in a fire is smoke, and not the flames. Keep low to the floor and avoid inhaling too much smoke.

Duties of Personnel:
Person In Charge:

1. Call the fire department at 9-1-1. Give exact location of the fire and its extent.
2. Call the Administrator.
3. Assist with residents if evacuation is necessary.
4. Assign a staff member to meet the fire department in order to direct them to the fire. Assign a staff member to keep a roster of residents if evacuation is necessary. Assign a staff member to answer the telephone and relay messages and instructions.

Nursing, Dietary, and Housekeeping/Laundry Personnel:

1. Remove residents from immediate danger.
2. Close all doors and windows.
3. Turn off fans, ventilators, air conditioners, and other equipment.
4. Stay close to residents to provide reassurance and provide comfort measures.
5. Make sure fire exits are clear.

Maintenance Personnel:

1. Go directly to scene of fire, taking extra fire extinguishers.
2. Check to be sure that all ventilating or blower equipment is shut off.
3. Once fire is over, care for all fire extinguishers.

Administrator:

1. Call the fire department if not already done.
2. Coordinate staff movement for highest efficiency.
3. Assist with resident movement in coordination with charge nurse.
4. Delegate responsibility for the movement of records as deemed necessary.

Check with department heads in the event of evacuation to determine that all staff and residents are out of the building.

Annex K: Heat and Humidity Policy and Procedure

Purpose: The purpose of this policy is to provide precautionary and preventative measures for our residents during the hot and humid summer months. Elderly people are extremely vulnerable to heat related disorders.

Definitions:

Heat Exhaustion: A disorder resulting from overexposure to heat or to the sun. Early symptoms are headache and a feeling of weakness and dizziness, usually accompanied by nausea and vomiting.

There may also be cramps in the muscles of the arms, legs, or abdomen. The person turns pale and perspires profusely, skin is cool and moist, pulse and breathing are rapid.

Body temperature remains at a normal level or slightly below or above. The person may seem confused and may find it difficult to coordinate body movements.

Heat Stroke: A profound disturbance of the body's heat-regulating mechanism, caused by prolonged exposure to excessive heat, particularly when there is little or no circulation of air.

The first symptoms may be headache, dizziness and weakness. Later symptoms are an extremely high fever and absence of perspiration. Heat stroke may cause convulsions and sudden loss of consciousness. In extreme cases it may be fatal.

Precautionary Procedures:

1. Keep the air circulating.
2. Draw all shades, blinds and curtains in rooms when exposed to direct sunlight.
3. Remove residents from areas that are exposed to direct sunlight.
4. Keep outdoor activities to a minimum.
5. Check to see that residents are appropriately dressed.
6. Provide ample fluids, and provide as many fluids as the resident will take.
7. Increase the number of baths given.

Annex L: Loss of Telephone Service Policy and Procedure

Purpose: In the event that there is a power outage, or other circumstances in which the facility is out of telephone service, it is important that staff know how to respond in such a situation. The facility's operation depends on the use of telephone a great deal.

It is important that the nursing personnel are able to communicate with physicians regarding resident care. It is also important that we be able to make emergency contacts if need be. The following procedures should provide clear guidelines for staff to follow if this situation occurs.

Procedures:

1. In the event that telephone service is lost due to outside causes, the telephone company must be notified immediately.
2. Unplug the fax machine, and plug in the Emergency Phone.
3. If the Emergency Phone does not work, the Maintenance Director, or other designated person, shall be directed to go to the nearest operating telephone available in order to report the loss, and as much information concerning the outage as possible.
4. If the telephone service is anticipated to be out for an indefinite period of time, the shift charge nurse shall contact the local radio station to inform them of the phone outage so that weather and other major announcements can be relayed to the facility during the telephone outage.
5. A designated person and vehicle must be ready at all times to depart in an emergency in order to report any disaster requiring emergency services from the police, fire department, or ambulance.

Appendix M: Regional Contacts and Important Resources

Public Health and Health Care Regions and Teams

Health Care Preparedness Program Contact Information: The links below will provide the most recent information regarding Regional Health Care Coalitions and Regional Public Health Preparedness Consultants. This site also contains a map that helps you easily identify, based on your county, who to contact for your location.

Health Care Coalitions

Public Health Preparedness Consultants

Important Contact Information and Resources

Homeland Security and Emergency Management County Emergency Manager Listing: This link will provide county by county listings of emergency management based on your location.

HSEM Regional Program Coordinators

Interactive Incident Command System for Nursing Homes:

Hospital Incident Command System

Centers for Medicare and Medicaid Services Emergency Preparedness Requirements

Federal Register CMS Emergency Preparedness Requirements

TRACIE CMS Rule Resources