

2018

FACILITY:

Emergency Operations Plan for Assisted Living & Basic Care Facilities



ADDRESS:



PHONE:

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RECORD OF CHANGES AND UPDATES

TASKS	COMPLETED <input checked="" type="checkbox"/>	DATE	INITIALS
<i>EVERY YEAR:</i>			
Review and update your facility's HVA	<input type="checkbox"/>		
Review your Emergency Operations Plan (EOP)	<input type="checkbox"/>		
Refer to FEMA, NDLTCA, and NDDoH websites for any updates that should be included in your EOP	<input type="checkbox"/>		
.....All staff receive annual training on Fire and Accident Preventionand Safety (AL & BC)	<input type="checkbox"/>		
..... Review smoke detection devices or alarms, exit lighting, andsprinkler systems (AL)	<input type="checkbox"/>		
....Update and Post Evacuation Route (AL & BC)	<input type="checkbox"/>		
....Maintain documentation of monthly fire drills (BC)	<input type="checkbox"/>		
Have staff contact information updated with the NDDoH HAN Coordinator)	<input type="checkbox"/>		
Conduct training seminars and drills at least annually to familiarize staff with the EOP and Emergency Protocols, especially the Evacuation Plan	<input type="checkbox"/>		
Update emergency response contact information (see <i>Quick Reference Contact Sheet</i> , Appendix D)	<input type="checkbox"/>		
Have staff regularly update HC Standard with resident information	<input type="checkbox"/>		
<i>EVERY TWO YEARS:</i>			
Review and update Memorandums of Agreement (MOA) with NDDoH and NDLTCA	<input type="checkbox"/>		

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FACILITY PLAN DEVELOPMENT

This document will help discover the facility's strengths and weaknesses through the use of worksheets and questions. When taken as a whole, these tools are the basis of an Emergency Operations Plan (EOP). The facility-specific policy portion of the EOP should be a cumulative sum of the information discovered with your team, giving direction in the event of an incident so the needs of residents and staff can be met.

Throughout this document, you will notice orange worksheets and *ACTION* boxes, which will help identify your current situation and steps to take for better preparedness. *Notes* areas have been provided to aid your team in brainstorming, and can be used in the process of putting together the aggregate portion of your EOP. This portion should describe at minimum: who is in charge of the various aspects of emergency response, how internal and external communications will be handled, how the facility is equipped to shelter in place if necessary, and specific procedures for evacuation and relocation. The plan, as it is developed and revised, should be shared with all staff and training on the plan should be incorporated into regularly scheduled trainings.

The most effective plans are those that are developed collaboratively with input from all key units in the facility, as well as consultation with local and state level emergency management professionals.

ACTION

Identify the **Emergency Planning Committee** within your facility. Members should be staff that understands various components of the operation of your facility.

The Emergency Planning Committee:

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PURPOSE STATEMENT AND GOAL

Emergency Operations Plan Purpose

The purpose of this Emergency Operations Plan (EOP) is to improve the capacity to detect, respond to, recover from, and mitigate (ease) the negative outcomes of threats and emergencies. This EOP establishes a basic emergency plan to provide timely, integrated, and coordinated response to the wide range of natural and manmade events that may disrupt normal operations and require pre-planned response to internal and external incidents.

Goal

The overall goal of this EOP is to develop an emergency program that can be implemented immediately and effectively.

The objectives of this Emergency Operations Plan:

- To provide maximum safety and protection from injury to residents, visitors, and staff.
- To attend promptly and efficiently to all individuals requiring medical attention in an emergency situation.
- To provide a logical and flexible chain of command to enable the maximum use of resources.
- To maintain and restore essential services as quickly as possible following an incident.
- To protect facility property and equipment.
- To satisfy all applicable regulatory and accreditation requirements.

Scope

- Within the context of this plan, an incident is any event which overwhelms or threatens to overwhelm the routine capabilities of the facility.
- This all-hazards EOP describes an emergency management plan designed to respond to natural and manmade incidents, including natural disasters as well as technological, hazardous material, and terrorist events.
- This base plan describes the policies and procedures this facility will follow to mitigate, prepare for, respond to, and recover from the effects of emergencies.
- Emergency Protocols are the blueprint for how this facility will respond to certain hazards, and details for staff responses can be found in Appendix F.

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PRE-EMERGENCY

The primary focus of this phase is on the development, revision, testing, and training of the Emergency Operations Plan (EOP). Tasks are listed below; subsequent pages will address steps in greater detail.

Pre-Emergency Tasks

- Review existing plans, policies, and procedures. Annually participate in a mock disaster drill & tabletop exercise.
- Re-familiarize Emergency Planning Committee with facility profile and layout. Complete *Facility Profile*
- Complete *Hazard Vulnerability Assessment (HVA)*
- Identify day-to-day essential functions and confirm there is adequate cross-training in staff. Complete *Critical Resources Worksheet*
- Review and update contact lists and resource lists
- Determine the redundant communication system you will use in an emergency. Test this equipment regularly, remember to document. Create a Media Plan and complete the *Emergency Communications Planning Checklist*
- Designate an Emergency Operations Center (EOC) in your facility as a “home base” during an emergency
- Ensure the availability and functioning of facility emergency warning system, remember to document
- Test all emergency lighting batteries periodically, remember to document
- Assign specific staff with task of regularly updating HC Standard with current resident data
- Supply the HAN Coordinator at the NDDoH with your staff’s current contact information, and ensure your staff is trained on HAN Alert Request procedures for an internal calldown (see Appendix B)
- Review current policy regarding staff duties during an emergency. Complete *Staffing Backup Plan*. Review and edit *Emergency Checklists - Department Responsibilities* found in Appendix F
- Schedule employee orientation training and in-service training on the EOP, remember to document
- Define the criteria for making shelter in place versus evacuation decision
- Complete the *Shelter in Place Planning Checklist* and follow up on any incomplete tasks
- Complete the *Evacuation Planning Checklist* and follow up on any incomplete tasks
- Post location of fire extinguishers and phone numbers of emergency contacts (*Quick Reference Contact Sheet* in Appendix D is useful)
- Sign an updated *Memorandum of Agreement (MOA)* with the North Dakota Department of Health (NDDoH) for care of vulnerable adults/transportation in the case of an emergency.
- Include in your plan your facility’s ability to continue with daily operations (COOP)

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FACILITY

Your building is not the same as your institution, but it is the shell on your institution controlling the internal environment, protecting the contents from the outside environment, bringing in what you need, getting rid of your waste. Your building may have certain vulnerabilities (e.g., risk for flooding), but like any good shell it can be hardened to make it resistant to damage. Hardening it requires planning ahead since many of the actions to harden it have to be taken before a disaster and may require substantial resource investments.

Managing your building for disaster response will require two things. First, disaster responders need to understand it – understand how it works, where it is weak, how to protect it, and how to leave it in a hurry. Second, the institution needs to make strategic investments over time, setting aside resources to strengthen the building against disaster. This section and the section on sheltering in place will help you know how to prepare to manage your building in a disaster and where to make investments to improve it.

In addition to managing the building, one must manage the utilities that sustain it. Losing control over these resource lifelines can cause you to evacuate an otherwise intact building. For example, sustained loss of heat on a cold day will force an evacuation. You also must have a secure means of maintaining the consumable goods that flow in. For example, having a contract to supply water in a utility crisis does little good if the supplier has been flooded out or the building is surrounded by water and inaccessible. Likewise if you can't reliably access food, pharmaceuticals, or medical supplies, you must leave.

ACTION

Complete the *Facility Profile*. Following the profile, include a **blueprint of your facility and an evacuation map** in Appendix E.

FACILITY PROFILE

Facility Name: _____

Facility Type: _____

Mailing Address: _____

E911 Address (if different): _____

Phone: _____ Fax: _____

Primary contact person able to discuss emergency plans:

Name _____ Phone _____

Email _____

Backup contact person able to discuss emergency plans:

Name _____ Phone _____

Email _____

Does the facility care for, or have the ability to care for, special populations? For example, residents with dementia, or have mobility impairments, etc? If YES, please list the special populations.

Yes No

Special populations this facility has capacity to care for: _____

Average number of residents in the facility at any one time: _____

Capacity: The capacity of your facility based upon licensing _____

Surge Capacity: If an emergency, the maximum number of residents can accommodate _____

Average number of staff per shift: Days _____ Evenings _____ Overnights _____

Average number of staff in each department:

<i>Admin</i>	<i>Nursing</i>	<i>Dietary</i>	<i>Housekeeping</i>	<i>Maintenance</i>	<i>Recreation</i>	<i>Soc. Services</i>	<i>HR</i>

Location of power shutoff: _____

Generator:

- Does your facility have a backup generator? Yes No
 If YES, where is the generator located? _____
 If NO, is your facility wired to receive a backup generator? Yes No
- Do you have an Automatic Transfer Switch installed next to the generator? Yes No
- Do you have documentation of regular generator testing? Yes No

Does your facility have oxygen tanks on the premises? Yes No
 If YES, what type, how many, and where are they stored? _____

Facility's Food Supplies Vendor/Contractor(s):

<i>Name</i> _____	<i>Name</i> _____
<i>Phone</i> _____	<i>Phone</i> _____
<i>Address</i> _____	<i>Address</i> _____
_____	_____

Facility's Pharmacy/Medical Supplies Vendor/Contractor(s):

<i>Name</i> _____	<i>Name</i> _____
<i>Phone</i> _____	<i>Phone</i> _____
<i>Address</i> _____	<i>Address</i> _____
_____	_____

Facility's Oxygen Contractor(s):

<i>Name</i> _____	<i>Name</i> _____
<i>Phone</i> _____	<i>Phone</i> _____
<i>Address</i> _____	<i>Address</i> _____
_____	_____

Facility's Fuel Contractor(s):

Name _____ Name _____
Phone _____ Phone _____
Address _____ Address _____

Facility's Transportation Contractor(s):

Name _____ Name _____
Phone _____ Phone _____
Address _____ Address _____

Brief description of vehicles owned by the facility: Indicate which vehicles are equipped to transport residents.

Water Source: _____ **Sewer and Septic:** _____

Location of sprinkler system control panel: _____

Indicate the types of emergency planning your facility has completed (check all that apply):

- Criteria established for making shelter in place vs. evacuation decision
- Staff on all shifts have been trained on the current Emergency Operations Plan
- Facility has participated in local and/or regional exercises

FACILITY BLUEPRINT and EVACUATION MAP

ACTION

In **Appendix E** include a copy of your **facility's blueprint** and an **evacuation map**.

Completed	<input checked="" type="checkbox"/>	On the blueprint and evacuation map identify the locations of:
	<input type="checkbox"/>	Electrical panels
	<input type="checkbox"/>	Fire and smoke alarms
	<input type="checkbox"/>	Fire extinguishers
	<input type="checkbox"/>	Infrastructure equipment
	<input type="checkbox"/>	Gas
	<input type="checkbox"/>	Water and electrical shutoffs
	<input type="checkbox"/>	Distribution panels
	<input type="checkbox"/>	Oil and gas tanks and burners
	<input type="checkbox"/>	Sewer manholes

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HAZARD VULNERABILITY ASSESSMENT

Hazard Vulnerability Assessment (HVA) is a simple tool designed to assist in gaining a realistic understanding of the vulnerabilities your facility may face and to assist you in focusing the resources and planning efforts required.

All disasters are different, but for purposes of planning activation, it is helpful to divide them into emergent, requiring emergency actions to save life, health or property, and urgent in which a threat can be recognized in advance of the event and pre-planned actions taken to ensure optimal response. Examples of emergent events would be earthquake or flash flood. Examples of urgent events would be seasonal floods or pandemics. Determine what events could impact your facility. For example, Southern California is prone to earthquakes but not to winter storms. North Dakota is prone to winter storms, but not to earthquakes.

ACTION

Complete the following *Hazards and Vulnerability Assessment* or supplement with another all-hazards version.

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HAZARD VULNERABILITY ASSESSMENT

EVENTS	PROBABILITY	RISK			PREPAREDNESS	SCORE
	LIKELIHOOD THIS WILL OCCUR 0=N/A, 1=Low, 2=Moderate, 3=High	HUMAN IMPACT 0=N/A, 1=Low, 2=Moderate, 3=High	PROPERTY IMPACT 0=N/A, 1=Low, 2=Moderate, 3=High	BUSINESS IMPACT 0=N/A, 1=Low, 2=Moderate, 3=High	FACILITY PREPAREDNESS LEVEL 1=Good, 2=Fair, 3=Poor	
NATURAL						
Blizzard						
Drought						
Earthquake						
Epidemic						
Food, External						
Hurricane						
Ice Storm						
Landslide						
Severe Thunderstorm						
Snow Fall						
Temperature Extremes						
Tornado						
Wild Fire						
HUMAN						
Bomb Threat						
Civil Disturbance						
Forensic Admission						
Hazmat Exposure, External						
Hostage Situation						
Mass Casualty (Medical)						
Mass Casualty (Trauma)						
Missing Resident						
Terrorism, Biological						
TECHNOLOGICAL						
Communications Failure						
Electrical Failure						
Fire Alarm Failure						
Fire, Internal						
Flood, Internal						
Fuel Shortage						
Generator Failure						
Hazmat Exposure, Internal						
HVAC Failure						
Information Systems Failure						
Medical Gas Failure						
Medical Vacuum Failure						
Natural Gas Failure						
Sewer Failure						
Steam Failure						
Structural Damage						
Transportation Failure						
Unavailability of Supplies						
Water Failure						

PROBABILITY + RISK + PREPAREDNESS = SCORE

Those events which score the highest should be what your facility focuses on first when developing emergency procedures

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ESSENTIAL FUNCTIONS

Essential functions are those organizational functions and activities that must be continued under any and all circumstances. The Federal Emergency Management Agency defines essential functions as “*those functions that cannot be interrupted for more than 12 hours/must be resumed within 30 days*”; In considering your most essential and time sensitive functions take into account what is required to care for your residents and to run your facility. The essential functions you list should encompass the key activities which your organization fulfills on a day-to-day basis. These essential functions may include, for example, medical care of residents, psychosocial care of residents, feeding of residents, bathing and hygienic care of residents, purchasing essential supplies, assuring adequate staffing, maintaining the physical plant, and the various functions necessary to fulfill legal, regulatory and financial obligations.

In addition to these day-to-day essential functions, you should also identify the additional activities you may need to fulfill during an emergency (emergency essential functions).

- Safety assessment of residents, staff, and structure
- Communication with emergency responders, families, and media
- Stepped-up infection control and surveillance.

Listing your facility’s essential functions highlights clearly and specifically just what operations and activities your facility must try to maintain under emergency/disaster conditions. This in turn helps you to identify the critical resources you need to carry out these functions. Together these lists, which you can record on the next two worksheets, form the basis and framework for your emergency preparedness plan.

ACTION

Complete the *Critical Resources Worksheet* and *Vital Records and Storage Worksheet*

CRITICAL RESOURCES WORKSHEET

ESSENTIAL FUNCTIONS	HUMAN RESOURCES		VITAL RECORDS	EQUIPMENT	SUPPLIES
	<i># of staff who can perform function</i>	<i>Cross-training of staff needed?</i>	<i>Vital records necessary for this function. Circle those that would not be accessible in an emergency.</i>	<i>Equipment necessary for this function. Circle those that would not be usable and/or that you need and don't have.</i>	<i>Equipment necessary for this function. Circle those that are most difficult to obtain in an emergency.</i>
CLIENT CARE Example: Preparing resident meals					
FACILITY OPERATIONS					

CRITICAL RESOURCES WORKSHEET

ESSENTIAL FUNCTIONS	HUMAN RESOURCES		VITAL RECORDS	EQUIPMENT	SUPPLIES
	<i># of staff who can perform function</i>	<i>Cross-training of staff needed?</i>	<i>Vital records necessary for this function. Circle those that would not be accessible in an emergency.</i>	<i>Equipment necessary for this function. Circle those that would not be usable and/or that you need and don't have.</i>	<i>Equipment necessary for this function. Circle those that are most difficult to obtain in an emergency.</i>
ADMINISTRATIVE OPERATIONS					
EMERGENCY RESPONSE					

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VITAL RECORDS AND STORAGE

RECORDS & DATABASES	CATEGORY, TYPE	STORAGE LOCATION	STAFF RESPONSIBLE	SUPPORTING NETWORK/SERVER	BACKUP/ ALTERNATE STORAGE
<i>EXAMPLE: EOP</i>	<i>Emergency, Paper</i>	<i>Paper copy in Preparedness Coordinator's office</i>	<i>Administrator</i>	<i>Digital version saved on H drive</i>	<i>Offsite cloud storage and a backup copy on flash drive</i>
Accounts receivable					
Contracts					
Official personnel files					
Social Security files					
Payroll files					
Retirement files					
Insurance records					
Property management and inventory records					

Facility Wish List

Develop your wish list of facility changes, supplies, and equipment for the disaster scenarios that are most likely for your facility. (You will not be able to do this until you understand your building and its vulnerabilities.) Below is a sample list in no particular order. Some items on the list may be unobtainable due to cost, but they should be added to the list.

1. Rubber hip boots for staff for evacuation of patients through flood waters.
2. Evacuation equipment for carrying people down stairs when elevators don't work.
3. Temporary shoes for staff and residents sufficient to protect against glass.
4. Move electrical room out of basement where it is subject to flooding.
5. Add electronic locks to main doors for rapid lockdown.
6. Dig well on property for alternate source of water.
7. Raise levee around property to keep out flood water.
8. Water barriers to keep water out of building if it floods around it.
9. Kitty litter to use in red bags for alternative toileting.
10. Large water bladder to store water delivered by National Guard (especially if no well)
11. Increased generator capacity which can handle HVAC.
12. Add switches to move electrical power from one circuit to another so that some things can be powered intermittently such as sewage pump (especially if no increase in generator capacity)
13. Raise generators on concrete slabs.
14. Alternate heat source (e.g., electrical wall heaters) as backup to boiler heat.
15. One or two larger capacity vans for moving wheelchair patients
16. Duct work which would allow for hooking in alternate heating or cooling equipment outside the building with building-wide distribution of conditioned air.
17. External valves usable for pressurization of water distribution system from external source
18. Improvements to sprinkler system.
19. Addition of some carbon monoxide detectors hard wired to emergency circuits.
20. Waterproofing for electrical room (if it can't be moved).
21. New windows in residents' rooms with shatterproof glass and greater energy efficiency.

OUR FACILITY WISH LIST	PRIORITY	DEADLINE

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COMMUNICATION, EMERGENCY NOTIFICATIONS

Use the *Quick Reference Contact Sheet* in Appendix D for your basic emergency contacts. Fill out this form or develop your own list of contacts that you might need to make in the case of an emergency. It is encouraged that your planning committee find at least two different phone numbers, one landline and one cell, for each person on the contact list. You don't need a list of lots of external resources outside your network—leave that to the emergency managers who you call to get assistance (i.e. NDDoH Case Manager, local emergency manager).

Some questions to consider:

- Do you have a list of contacts that must be made immediately such as to community emergency responders such as police? Do you know how to reach every person you may need day or night?
- Do you have a list of contacts that need to be made very soon such as administration, emergency management, or NDDoH? Do you have clinical care employees' contact information?
- Where else will you keep copies of these contact lists?
- Who will be responsible for making sure phone numbers are kept up to date? How often will that person(s) update the list?
- Utilize the HAN internal calldown system. The state has the Health Alert Network which allows facilities to call down employees in an emergency. This system can keep different lists of contacts and can be set to make contacts over and over until a response is received. Have designated staff update the contact lists regularly with the NDDoH HAN Coordinator.

Notes:

REDUNDANT COMMUNICATION

A strong communications system is the backbone of emergency response and disaster management. The ability to send and receive vital information and to coordinate actions with partners and emergency responders is critical during an emergency.

Long term care facilities' emergency plans should include strategies for communicating with:

- staff
- emergency management authorities, on both the local and state levels
- local emergency responders (police, fire, EMTs)
- residents' families, staff's families
- media
- suppliers

Key planning components for emergency communications:

1. Understand your facility's communications equipment/technology

Inventory all the methods your facility has available to communicate both internally and with the outside world, including: telephone system, email, voicemail, computer networks and internet connection, fax, HAN internal calldown, cell phones, wireless messaging, pagers, internal two-way radios, and more. Work with your IT team or vendor to understand the strengths and limitations of each technology for communicating under emergency conditions. AM/FM radios and TVs are also critical for receiving emergency alerts, evacuation orders and news. Make sure your internet router is hooked up to backup power so if you lose power and need to use your generator, your facility would still be able to communicate online/use web-based programs.

2. Build relationships and partnerships

It is important to think ahead of time about who will be contacting you, and who you will need information and assistance from during an emergency (see the list above). Before a disaster strikes, you should know who, specifically, to call and different ways to reach them. By building relationships with your local emergency management and other partners ahead of time, these partners will better understand your facility's needs as well as how and when to contact you with emergency information.

3. Establish clear roles and methods for systematically receiving, fielding and sending information.

Facility leaders should decide ahead of time who will be the primary and secondary voice of the facility to the outside world (families, media), who will be in charge of communications with staff, and who will be the point person for communicating with emergency management authorities

4. Develop a Media Plan.

In order to effectively deal with an emergency, a facility must also prepare and update a Media Plan as part of their Communications Plan. As a rule of thumb, an organization's leadership should release a statement in an hour or so of being contacted by the media regarding an emergency.

- To prepare, an organization needs to pre-draft emergency statements that incorporate relevant language or concepts from the organization's mission statement (i.e. "importance of resident safety"). Make these templates modifiable; just leave space to fill in specific details related to the emergency. Use these statements for any type or level of emergency or activity that generates media interest.

- Make a comprehensive list of the radio, television, newspapers, and websites covering the profession in the area. Add the names and titles of key contacts and include web addresses, group e-mail lists, text messages, and social media as a way to distribute statements and updates.
 - *Social Media* - Consider your facility's web page as a first step in the communications process. In an emergency, the media and the public will flock to a web site for news and basic information about the organization. Make sure the mission statement is readily available, along with a brief history and current facts (total beds, staff, etc.) about the organization. Be sure the designated staff member(s) regularly use and update all social media accounts, and remind staff not to speculate but rather report facts and quotes from the spokesperson(s).

5. Devise back-up plans for communications.

A communications system with back-up communications channels built into it is known as a “redundant communications system”. In a widespread disaster, cell phone and landline circuits may be overloaded. Phones, fax, and Internet may go down. Think about your fallback options for these situations.

Failure in communication is the most commonly cited deficiency in After Action Evaluation of event responses. Examples of poor communication during a disaster:

- Failure to notify or share information with partners;
 - Somebody wasn't notified in a timely manner of the event or a change in the event
 - Technical information was not shared
 - Needs were not shared or external communications coming in were misdirected or lost
- Failure to notify or share information within the operations center;
 - Team members didn't talk and consult with each other (actions taken, needs identified, information discovered)
- Failure to notify or share information within the facility
 - Someone was blindsided
 - Information wasn't disseminated to all who needed to know
 - Role or authority confusion
- IT problems

Identify and document communication pathways. One of the easiest ways to do this is with tabletop scenarios. Two or three brief scenarios done in a 30 minute training session with team members can focus on communications by identifying all persons who need to be notified about an event or new development in an event, the relative urgency of notification of each one, the methods that would be used and the person on the team to whom the communication would be assigned. Training helps to make communication second nature. Personnel changes in the team or long periods without practice tend to make problems once solved reappear. To ease IT issues in the case of an emergency, it is advised that your facility have a shared network drive with archiving so important information can be stored and easily accessed from any location in the facility. Your Emergency Planning Committee may also want to look at offsite backups as well as manual backups on Flash drives for data storage/recovery.

The other big issue for tactical communication is redundancy. When traditional methods fail, some optional methods to have available in the facility include P25 radios, 800 MHz radios, HAM radios, satellite phones and BGAN units. If a facility can get a message to emergency responders outside the

facility, the responders can assist in reestablishing communications with supplemental equipment. It is important to treat communications like any other task in the planning process, with specific assignments for ensuring it happens.

ACTION

Complete the *Emergency Communications Planning Checklist*.

EMERGENCY COMMUNICATIONS PLANNING CHECKLIST

COMMUNICATIONS PLANNING TASK	STATUS	PERSON(S) RESPONSIBLE	DEADLINE
<i>Establish and maintain contact lists</i>			
Contact list established for all staff and volunteers	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Contact list and/or <i>Staff Disaster Contact Form</i> filled out for all staff (see Appendix F)	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Contact list established for local emergency responders and other sources of assistance (see <i>Quick Reference Contact Sheet</i> , Appendix D)	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Contact list established for other LTC facilities, residents' physicians, critical vendors, and suppliers	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Staff trained on HAN Alert system and HAN internal calldown requests. Staff delegated for responsibility of regularly updating contacts on NDDoH list	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
<i>Plan for Situational Awareness</i>			
Plan established for how residents, their families, staff, and volunteers will be notified of an emergency	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Prepare a <i>Media Plan</i> including: template materials that can be modified to fit the situation at hand (e.g., memos, press statements), a list of radio/TV/newspaper contacts, two facility spokespeople identified for interviews, staff designated to update facility website and social media	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Facility has battery powered radio(s) or TV(s) and batteries on hand	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Plan established for sharing resident information and medical information with other health care providers	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
<i>Plan for Backup Communications and Managing Communications</i>			
Facility's backup communications methods have been tested	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Tabletop exercises held to test emergency communications	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		

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EMERGENCY OPERATIONS CENTER

The term Emergency Operations Center (EOC) refers to both a physical location and the events that take place there during a disaster response. It is important to establish a fully functional location to use during a disaster response and to develop procedures to help make operation of the EOC smoother.

Setup for an EOC should optimally include the following equipment and connectivity:

1. Multiple “stations”
2. A computer with internet access at each station
3. A landline phone with a dedicated line/number for each station.
4. Access to a fax machine
5. Backup power to the EOC in case power is lost during a disaster

Procedures for opening up an EOC during an event

At the beginning of the event

1. Assign someone to follow-up on information that needs to be gathered about the event.
2. Ensure all notifications have gone out. These notifications would be the Administrator, facility staff, and the contacts listed on the *Quick Reference Contact Sheet* (see Appendix D)

For each day during the event

1. Ensure all equipment is functional (e.g., phones are taken off call forward if left that way overnight).
2. Discuss how cell phones will be used.
3. Meetings should occur first thing and then at the beginning of each shift.
4. A task list is created starting with a review of tasks from the previous day and a report is made on the progress of each. The list is updated. New tasks are suggested by any person on the team, and like the old tasks, each must have an assigned person responsible for completing it.

ACTION

Select a location which can be rapidly converted into operations center space. Most facilities use a conference room which is used for other things during non-disaster periods. Others designate the space as the EOC permanently, but allow other activity to occur there during non-disaster periods. Select your space with the expectation that it will have to be fully wired for communications in a way that can be set up rapidly.

The Emergency Planning Committee has chosen the following location *and* backup location for the **EMERGENCY OPERATIONS CENTER**:

Location and Relocation

Disaster location planning requires considering the facility as a whole, including likely area availability during a disaster, infrastructure, space, privacy, external access, internal access, fire suppression, noise level and any other factor which may impact the efficiency and safety of the site.

Not every activity necessarily needs a separately designated area; that is, more than one disaster activity may occur in the same general area if the area can accommodate the entire expected level of activity. Not every disaster will require designation of space for all possible disaster-related activities; however, any activity that could be required in any likely disaster event must have a pre-designated primary and secondary area (in case the primary area is unavailable). In order for an area to function as a designated disaster location, the site must have the infrastructure, supplies and equipment present in the area at all times or else the supplies and equipment must be quickly obtainable (within minutes).

Activities: Based on the types of disasters that your facility is likely to experience, discuss the types of disaster-related activities that will need space and equipment. Consider the following potential activities:

- Emergency Operation Center
- Triage and treatment area – Most likely needed in a disaster with potential injuries such as a tornado strike. All persons potentially needing medical attention are brought to temporary treatment area where triaged care can be provided and persons needing more advanced care shipped out.
- Internal staging area – In the event that part of the facility needs to be evacuated, where in the remainder of the building can residents be gathered and cared for?
- Surge area – In the event of a large patient surge such as a pandemic, the facility may find itself caring for a larger than expected number of patients. Where would the patients be placed in the facility?
- Fatality management – In some disaster scenarios, especially serious pandemics, facilities may need to care for several bodies before they can be removed by the community.

Equipment: You will likely need to consider having equipment in more than one location both to ensure rapid access and in case part of the building is inaccessible. If you don't have all the equipment you need, create a prioritized list for purchases.

Some questions to consider:

Discuss how a safe area in a fire would be different than a safe in a flood or a safe area in a tornado. How long might you keep residents in the evacuation staging area of your building? What would be your trigger for placing the residents in another non-impacted facility? Surge capacity doesn't require emergency equipment as much as additional patient care space. How many patients could the facility care for reasonably? Discuss how a partial evacuation might unfold. When patients arrived in the safe area, where would they stay? Would they have to sit in wheelchairs? What about those that cannot sit?

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STAFFING

The previous steps help prepare the building for disaster, but you also need to be prepared to manage your building during a disaster. Emergency Checklists for each department can be found in Appendix F, feel free to review and edit these according to your facility.

An important step in emergency planning is to have sufficient numbers of people trained who know how to take certain steps to prevent damage to the facility, and detailed protocols providing guidance if persons usually responsible are not available. For instance, if live electrical wires are hanging down in the cafeteria where the roof collapsed during a disaster, then power may have to be shut off to the entire building in order to safely care for the injured in the area. But one also needs to consider the consequences of any such action. Water may need to be shut off if pipes freeze. Who knows how to use the automatic lockdown equipment or where emergency equipment is stored?

During a disaster, your facility may face staffing shortages for a variety of reasons—staff may not be able to get in to work, may be ill, or may need to take care of their own families during the emergency. In planning to have adequate staffing during an emergency, the first step is to have a mechanism for notifying staff about the emergency and for calling in off-duty staff. Familiarize yourself with the HAN internal calldown procedure (see Appendix B)

Another important step is to have a policy in place regarding families of staff. Your facility needs to decide whether, in a community wide emergency, family members of staff can shelter in place at your facility, or even evacuate with your facility. Provision for family members may be a key factor in keeping staff on the job during a widespread emergency. To be most prepared for an emergency, staff should be cross-trained to fulfill different roles in case the primary person responsible for a given function is not available. This requires a significant investment of time and resources on the part of the facility, but can be built in as part of ongoing in-service training and professional education. The facility must hold training exercises/emergency response drills to prepare staff for a real disaster, and to expose the “gaps” in the facility’s emergency plans.

During any disaster, the work of the facility does not entirely center on disaster response activity. Disaster “independent” administrative tasks must continue. However, some disasters may impact the ability to manage the facility administratively such as meeting payroll, regulatory requirements, or family communications. These concepts are part of a facility’s Continuity of Operations Plan (COOP).

Your facility’s staffing task is to have enough people with the right skills in the right place, at the right time. You may want to consider whether volunteers would be able to fulfill some staff functions in the event of a severe staffing shortage, and develop guidelines specifying which tasks volunteers can and cannot do.

ACTION

Your facility’s staffing task is to have enough people with the right skills, in the right place, at the right time. Complete the **Staffing Backup Plan** to identify any gaps you may have in staffing. Also update **Staff Contact Information** (see Appendix D).

STAFFING BACKUP PLAN

ESSENTIAL FUNCTION	LEAD STAFF PERSON	BACKUP STAFF #1	BACKUP STAFF #2	TRAINING SCHEDULE
CLINICAL CARE				
FOOD SERVICES				
BUILDING OPERATIONS				

HOUSEKEEPING				
ADMINISTRATIVE OPERATIONS				

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MASS PROPHYLAXIS PLAN

Has your Emergency Planning Committee discussed a citywide plan for large-scale antibiotic or vaccine dispensing in the rare event of an infectious disease emergency? The NDDoH and your local public health unit are responsible for creating and maintaining this plan. Emergencies of this magnitude would include bioterrorism attacks through things like anthrax or smallpox and naturally occurring disease epidemics like pandemic influenza or meningococcal disease.

Point of Dispensing (POD) Sites

During a health emergency, PODs are places where large populations can receive medications or shots very quickly. PODs will be open to the public and all antibiotics and vaccines that are offered in response to the emergency will be free.

ACTION

Develop a plan for your facility with your local emergency manager and public health unit. How will your residents be cared for during such an emergency? How will you transport residents to the designated Point of Dispensing (POD) sites in the community? Will you be able to continue with daily operations if much of your staff is called to help administer medications?

Notes:

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SHELTERING IN PLACE (SIP)

Although sometimes necessary, evacuation is risky for at least some of the residents, upsetting for families, and very expensive. For most environmental events occurring outside the facility (flood, utility loss, toxic plume), if sheltering in place is an option, it is preferable. In some disasters it may be the only safe option (toxic plume), or sheltering in place may be needed to keep residents and staff safe until they can be safely evacuated. Certainly sheltering in place is not always a viable option. For example, during a time of rising flood waters, public health officials must balance the risk of a pre-emptive evacuation of facilities at risk, which could prove to have been unnecessary, with the risk of delaying evacuation and having to evacuate residents from a flooded facility through flood waters. In a facility that will be unable to keep its residents safe if the facility floods, public health officials must seek an evacuation order early, without waiting to see if water will continue to rise.

Once an evacuation order is issued, you must go. However, before an evacuation order is issued, if sheltering in place is an option that a facility wants to opt for, it will need to convince response authorities that it can shelter safely. Response authorities may not have the capacity or the willingness to care for a sheltering facility that cannot meet its own needs. Too often facilities think they can rely on contractors to care for their facility without realizing that contractors frequently fail in a disaster due to over commitment or general disaster conditions or sustaining disaster-related damage themselves. Response authorities do know this and are not likely to be convinced by sheltering plans that depend on contractors to support the facility. Planning for sheltering in place means planning to be self-sufficient.

The goals of planning for sheltering in place are to assess the ability of the building to keep residents and staff safe during different disasters, assess the adequacy of resources if external supplies are cut off (including utilities), identify action steps needed to ensure the facility can shelter if that is the best option, and identify procedures needed to implement sheltering in place. How a facility should invest in sheltering capacity and how much it should invest depends on its vulnerability assessment and the value it places on not having to evacuate the building and place its residents in other facilities.

According to your Hazard Vulnerability Assessment, what events could pose a risk to your facility? Are you near an interstate or railroad? The most common response to a toxic plume (e.g., from a transportation accident) is sealing the facility and waiting until the external air clears. Are you at risk for flooding? If you want the ability to shelter in place, you must have many systems in place to ensure utility backup, food, water, medication supplies, staff, evacuation resources, etc. At risk for tornado? Damage from a tornado means you need to have the ability to care for injured residents and staff and continue to care for the uninjured until the facility can be evacuated, which in a community hard hit by a tornado may be struggling to help many people such as those in your facility.

In an emergency your facility may be cut off from the outside world for a period of several days. It may be unsafe for anyone to leave the facility, and emergency responders, power companies and suppliers may be unable to reach you. External communications may or may not be disrupted. To prepare for such a situation, you must build your facility's capacity to function self-sufficiently for several days—to "shelter in place" providing your own power, food and water, medications and supplies.

Emergency Power

Your facility likely has some plans in place for dealing with short-term loss of electricity. It is important to assess whether your current plans are sufficient should power be out for multiple days.

If your facility has a generator, it is essential to:

1) check it regularly, 2) have more than one person trained to operate and maintain it, 3) have a fuel supply always in place, and 4) periodically assess whether the generator's capacity remains sufficient to cover your current power needs (for example, beds, space or equipment may have been added to your facility recently, increasing your needs for power).

If your facility does not have a generator, you can take steps to become "quick connect" ready whereby your power company brings in and starts a portable generator for you in the event of an extended power outage. Becoming "quick connect" ready requires permits, an installation portal and agreements with your power company, so it is not something that can be arranged at the last minute—it must be planned ahead for. Another important aspect of emergency planning for loss of power is to meet with and educate your local emergency management authorities and your power company about the needs of your residents. Make it understood that your residents are similar to hospital patients (i.e. vulnerable, equipment dependent)—this may push your power company to place your facility on a priority list for power restoration.

Food and Water

Facilities should have an emergency stockpile of food and water adequate to cover everyone in the facility for at least 72 hours and ideally, up to a week. When planning quantities, remember to count staff who will be sheltering in place as well as residents. Stockpile food that requires no refrigeration and little or no cooking, and remember to account for special dietary needs when assembling emergency food supplies. As for water supplies, discuss quantities needed and storage of water with your local emergency planning council, or health department.

Medication and Medical Supplies

Facilities should have an emergency stockpile of medications and medical supplies adequate to cover all residents in the facility for at least 72 hours and ideally, up to a week. In the case of both food and medications/supplies, facility leaders should give some thought to supply chains during an emergency, and have purchasing agreements with more than one vendor. Be aware that in a widespread emergency however, all vendors will be serving multiple facilities, delivery may be difficult or impossible, and supplies may be scarce—this is another reason to have adequate stockpiles.

Security

In a disaster, residential care facilities like nursing or group homes may be some of the few local buildings with power, food, water and medicine. Security measures may needed to protect residents, staff, supplies and property. As a first step, facility leaders should talk with local law enforcement officials about ways to meet security needs during an emergency. Facility leaders should also consider providing all staff with basic security training.

Some questions to consider:

Under what conditions might you want to shelter in place? Under what conditions might you not want to? How would the facility be managed if cut off from replacement staff? Are you engaged with your local and/or state emergency management planners on a regular basis? Do you know who your partners are during a disaster and what you can and cannot count on? Do you participate in community or state exercises?

Notes:

ACTION

Assess your ability to shelter in place by completing the ***Shelter In Place Planning Checklist***. For all tasks identified as “not started” or “in progress” assign responsibility and specify a deadline for completion of the task.

SHELTER IN PLACE PLANNING CHECKLIST

SHELTER IN PLACE PLANNING TASK	STATUS	PERSON(S) RESPONSIBLE	DEADLINE
<i>Shelter In Place Decision</i>			
Criteria for making shelter in place vs. evacuation decision established	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Procedures established for assessing the facility's ability to withstand strong winds, flooding, etc. and adequate supplies on hand to secure the building against damage (e.g., plywood for windows, sandbags and plastic for flooding)	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Policy established regarding whether staff families can shelter at facility	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Procedure established for consulting with local emergency management regarding shelter in place decision	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
<i>Emergency Power Plan</i>			
Facility has generator adequate to its specific power needs	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
If do not have a backup generator, facility is "quick connect" ready	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Facility has 4-5 day fuel supply for generator	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Procedures established for regular checking and maintenance of generator (testing for minimum of 4 hrs. every 12 months at 100% of the power load)	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Facility has backup manual versions of important medical equipment	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Facility leaders have met with local emergency management to discuss power needs of facility	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Facility leaders have met with power company to discuss power needs of the facility	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
<i>Emergency Food & Water Supplies</i>			
Facility has 1 week food stockpile for max number of residents and staff and has planned for special diet requirements	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		

Facility has 72 hours of potable water stored and available to residents and staff	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Emergency food supplies are inspected and rotated as needed	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Facility has active contracts with multiple food suppliers, including one located out of area	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Medications and Medical Supplies Stockpile			
Facility has 1 week stockpile of common medications and a plan is in place for temperature control and security requirements	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Facility has 1 week supply of medications for each resident dependent on level of care	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Facility has 1 week stockpile of PPE and medical supplies needed to care for residents dependent on level of care	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Facility has active contracts with multiple pharmacy suppliers, including one located out of area dependent on level of care	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Facility has active contracts with multiple vendors of medical supplies, including one located out of area dependent on level of care	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Security Plan			
Facility leaders have discussed emergency security with local law enforcement	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Have reviewed facility security measures for any gaps (controlled access, lockdown, ID badges, video surveillance, HVAC security)	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Lockdown procedure established	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Facility has access to cash in event of money supply disruption	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Facility has on hand basic tools and materials to make emergency repairs	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		

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EVACUATION

Evacuation and relocation of the residents of a facility for elderly or disabled persons, many of whom are ill or frail, have special needs, mobility limitations or cognitive deficits, is an arduous process to manage, and potentially unsafe for high acuity residents. Long term care administrators who have experienced facility evacuations and many emergency management experts agree that it is highly preferable to shelter in place if at all possible. However, in the case of some disasters, for example a flood, evacuation may be the best or only option. The question is always “How do we minimize the risk to the residents?” Erring on the side of caution is always necessary, but how much caution? Evacuation is complicated and requires detailed planning and exercising. Your facility must understand how much help it can expect from state and local disaster responders and even how reliable that help is. However, ultimately the safety of the residents is the responsibility of the institution.

Factors to consider in making the decision to stay or go include:

- Recommendations or orders of local and state emergency management authorities
- Location of facility in a storm surge or flood zone
- Resident medical needs
- Availability of a “like” facility to relocate to
- Evacuation transport time

Look at your Hazard and Vulnerability Assessment that was completed earlier. Of the events most likely to affect your facility, which ones may require evacuation? Consider whether the evacuation scenario will be the same every time.

DISASTER	TIME TO EVACUATE	EVACUATION PATIENT RISK	PARTIAL OR COMPLETE EVACUATION	STAFF AVAILABILITY PROBLEMS	# OF STAGING AREAS REQUIRED
<i>EXAMPLE: FLOOD, EMERGENCY</i>	<i>6 TO 12 HOURS</i>	<i>HIGH</i>	<i>COMPLETE</i>	<i>LIKELY</i>	<i>1 OR 2</i>
<i>EXAMPLE: FIRE</i>	<i>.2 TO .5 HOURS</i>	<i>HIGH</i>	<i>PARTIAL OR COMPLETE</i>	<i>UNLIKELY</i>	<i>2</i>
<i>EXAMPLE: TORNADO</i>	<i>1 TO 2 DAYS</i>	<i>MEDIUM</i>	<i>COMPLETE</i>	<i>LIKELY</i>	<i>0 OR 1</i>

Some evacuations may require up to two staging areas. The first destination may be to move patients to part of the building unaffected by the disaster or a nearby location outside the building, then to a building which can accommodate their care until they can return to the building or be placed in other facilities. Consider possible locations nearby that could accommodate residents until they could be moved to a medical shelter. Consider options for medical sheltering. Work with community response officials to determine what location would be used for medical sheltering.

Rapid evacuations and complete evacuations are likely to require more resources (people and equipment) than slower or only partial evacuations. How many wheelchairs does the facility have? Do most residents requiring wheelchair have one? How many do not? Remember, the resident may have to stay in the wheelchair for a prolonged period because there is no place for at least some of them to sit in the staging location (that is, you may not be able to free up the wheelchair when you get the resident to the staging area). Some residents who do not normally require a wheelchair, may require one for evacuation (e.g., slow gait, movement over non-level surfaces like gravel or grass). Where is that extra equipment and can it be accessed quickly from anywhere in the building?

Notes:

Alternate Facility

The most important aspect of planning for evacuation is to have an alternate facility to relocate to. Very few emergency shelters can accommodate people with chronic medical problems or special needs. It is best for your facility to have a specific, written agreement with a “like” facility, another health care or residential facility that provides the same level of care or higher. Depending on the number of residents you have and potential host sites’ capacities, you may need to make agreements with more than one alternate facility. It is recommended that one of your alternate facilities be located at least 50 miles away.

We have made agreements with the following facility(s):

Transportation

Few long term care facilities have the transportation resources to quickly evacuate their own residents to a different location, even if the location is only a few blocks away; the option of purchasing those resources is neither affordable nor reasonable. Working with emergency management officials from the state and local area is usually the first option. The facility will need to assist with identification, tracking, loading and securing patients on transport vehicles, and sometimes providing staffing.

Transportation needs for your facility are largely determined by your resident mix. An assisted living facility which has mostly ambulatory and a few wheelchair residents is going to be easier to move than residents of a skilled nursing facility which has many total care patients. Furthermore, if wheelchair residents are going more than a short distance, these residents too will need specialized transportation. Facility wheelchair buses, your own bus or those sent from another facility to lend a hand, can carry a few residents each, but moving dozens of residents quickly can be problematic.

As long as there are two to four hours to get ambulances to the facility, likely from other communities, you can consider the transportation to be *urgent*. That is, qualified personnel should be on hand to assist you with transportation. If you don't have that two to four hour window, then it is considered an *emergent* disaster and you need to think about options for emergency transportation sufficient to get you away from the threatened area to a stable environment.

Urgent Transportation

Most evacuation transport will be urgent. This is typical of most floods, building damage (e.g., tornado) or utility loss. If the event is a declared emergency, the North Dakota Department of Health (NDDoH) will have lead responsibility for getting your residents out and moved to a place of safety. Educate your staff on what role the NDDoH has and what they will expect from you. Examples of tasks that may be assigned to your facility: ensuring each resident has a triage tag entered into the resident tracking system *HC Standard*, bringing residents to the loading area, or providing safety spotters on either side of a bus ramp as residents move up or down the ramp.

Consider the situation where you may be unloading multiple residents to your facility from another facility which had to evacuate. Consider how your unloading plan will be similar or different than your loading plan. The residents unloaded at your facility may be just a few who are coming to stay with you for a while or may be entire bus load of evacuated long term care residents who need to be toileted before moving on to their placement site, then reloaded.

ACTION

Develop a plan for where resident loading (or unloading) will occur. Determine what staff will be assigned to the loading process. How will residents be queued? What if it is very cold or hot outside? What safety procedures are needed? Learn who has been assigned as safety officer on-site. If no one has been designated as this, make sure someone is assigned and understands what is expected of them.

Resident Specific Information

It is essential that identifying information and critical medical information accompany each resident being evacuated. This vital information must be somehow secured so that it stays with the resident. Facility Evacuation Tags are available through HAN Assets (<http://hanassets.nd.gov>) and should be used in the event of an emergency. These tags include an identification bracelet for the resident and stickers for their personal belongings. A waterproof envelope should also accompany the resident with information including: resident name, date of birth, social security number, diagnoses, primary care provider, current drug regimen, health insurance provider, family contact information, and a photograph.

In North Dakota, during a declared emergency the state health agency assumes responsibility for transportation, resident tracking and resident placement. In the case of an emergency, family members may arrive, sometimes at the last minute, to take residents home. How will that impact resident tracking? It is very important to have staff designated to routinely update HC Standard so resident information is current (see Appendix B).

The position/person(s) responsible for keeping HC Standard updated with resident information and location before and after an evacuation:

Family Members

It is important that residents' family members stay informed during an evacuation, and are aware of ways they can be helpful. It is recommended that your facility's EOP evacuation section be made available to family members, and that it lists specific details including: how families will be notified during an evacuation, how they can help (e.g., should they come to the facility to assist), and where can they plan to meet their loved one.

Training and Practice

Evacuation of residents and staff is a complex and difficult process. Facilities will be much better prepared in the event of a real emergency if staff has been given opportunities to practice evacuation procedures. Evacuation drills also help to expose weaknesses and gaps in the facility's evacuation plans. Basic Care facilities are required to perform a fire drill evacuation of all residents and staff annually.

ACTION

Assess your level of emergency readiness to evacuate by completing the ***Evacuation Planning Checklist***. For all tasks identified as "*not started*" or "*in progress*" assign responsibility and specify a deadline for completion of the task.

EVACUATION PLANNING CHECKLIST

EVACUATION PLANNING TASK	STATUS	PERSON(S) RESPONSIBLE	DEADLINE
<i>Evacuation Decision</i>			
Criteria for making shelter in place vs. evacuation decision established	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Procedure established for consulting with local emergency management regarding evacuation decision	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Identification of person responsible for implementing the facility evacuation plan	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Reliable channels established for receipt of evacuation orders	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Plan specifies whether and how staff families can evacuate with facility	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
<i>Alternate Facility</i>			
An alternate “like” facility to which residents can relocate has been identified	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Memorandum of Agreement signed with NDDoH (transportation)	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Procedures established for discharging some (lower acuity) residents to their families if feasible	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
<i>Transportation</i>			
Multiple transportation resources have been identified, considered and listed with contact information	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Arrangements made for logistical support to include moving records, medications, food, water, and other necessities.	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Fallback transportation plans made (e.g., staff vehicles, church vans, etc.)	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Evacuation route (and secondary route) to alternate facility has been identified and shared with staff and local emergency authorities	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		

Evacuation Procedures			
Procedures established for readying residents for journey—informing, attaching ID info, packing	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Staging and loading areas identified, and procedures established for orderly, systematic loading of residents onto vehicles	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Residents identified who will need most assistance, or are most complicated to move	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Procedures identified to ensure staff accompany evacuating residents	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Procedures established to account for all residents and staff (no one left behind)	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Ensure that volunteers and staff will be available to help counsel residents who may be distressed both during transit and upon arrival at destination facility	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Procedures described if resident turns up missing during evacuation or becomes ill or dies in route	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Procedures established for informing and communicating with residents’ families regarding the evacuation (e.g., making evacuation plan and procedures accessible on facility’s website)	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Resident Specific Information			
Method for transferring identifying info and essential health info with each resident is specified. Bracelet with identifying info, or HC Standard triage tag linking to digital info, should include resident name, DOB, diagnosis, SSN, Medicaid or other health insurer number, and current prescriptions. Also include with resident their bag of belongings, medications, medical records, clothing, and necessities. (see Checklist in Appendix E)	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Plan describes procedures for transporting/transferring resident medical records	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Evacuation Supplies			
Plan describes types and amount of food to take for the journey, and procedures for packing and distributing the food among vehicles	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		

Plan describes amount of drinking water to bring on journey (1 gal/person is recommended), and describes logistics for carrying water and distributing it among vehicles	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Plan describes amounts and types of medications to bring, along with procedures for transporting them (such as ensuring meds are protected under the control of a RN)	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Plan describes other critical supplies (e.g., oxygen, incontinent supplies) and equipment to bring along for the journey and to have at alternate facility	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Facility has adequate equipment to move residents (e.g., portable ramps)	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Recovery			
Plan describes re-entry to the facility: contacts to be made for having facility inspected, procedures to follow, and a plan for residents' return travel (the NDDoH can assist with transportation)	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Training and Practice			
Drills/exercises have been held with volunteers and staff on all shifts to practice evacuation procedures, and training has taken place during staff new hire orientation	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		

SAFETY

Creating strong security systems is about ensuring you remain in control of your facility. Protecting residents and staff is first priority, followed by protecting your assets. Threats may include people who want pharmaceuticals (narcotics, vaccine, antibiotics), people who carry infection into the building, violence, and looters or vandals. Security at any particular time must be balanced with the facility's role in serving the public and being a resource to the community.

You may have been in the long term care business for 30 years and never had a serious security problem. If so, that is how it should be. Although security problems can arise any time, a disaster is one of the times when security issues are most likely to arise.

- You possess something that is very valuable such as a lifesaving vaccine;
- Your facility is viewed as a shelter;
- Security is the disaster, such as a shooter or other violent person in the building; or,
- You need to keep an external threat out of your building.

As you create your all-hazards plan, remember the management issues and priorities that need to be addressed during various events. For instance, an active shooter scenario is one circumstance in which all central command may be lost; therefore, planning will need to encompass employee level response.

Are there certain actions that you can reasonably expect staff to take and other actions which would put them at undue risk and they should not take? What triggers will be set for when to contact the police? Some disasters are due to infectious disease. What procedures do you have in place to ensure your staff can implement the level of personal protection indicated by the disaster? Have all staff who need fit testing been kept up to date on fit testing? In addition to personal protective equipment, additional steps can be taken to minimize transmission employee to employee, resident to resident and auto-inoculation from environmental surfaces. Develop approaches into our plan.

Is there a reason to allow shortcuts in infection control for non-emergent events such as an evacuation due to a rising river? Document when cutting infection control practices may be acceptable and when unacceptable. Document how infection control will be maintained during a disaster response.

Notes:

POLICY

As part of preparedness process, each institution will need to consider its internal policies, and, as part of the preparedness process, have developed draft disaster policies that can be quickly implemented when needed.

Institutions must also be prepared to respond to policies and policy changes from outside the institution. This may arise from licensure (e.g., what must happen before a building can be re-occupied after evacuation), incident command (expectations for preparing residents for resident tracking during evacuation), or executive order (e.g., order to evacuate).

Whenever you develop plans and make operational decisions about how things are to operate (e.g., we will go to the community high school as our first stage shelter if evacuation is necessary), you are in a sense developing policy since the plan provides guidance on what is to be done. But this is just part of the planning process. Some issues will require more formalized policy statements either about disaster preparedness or disaster management which are typically more rigid than planning actions identified in the response plan. Of course disaster response policy can be set during a disaster, but many policies should already be in place in case they are needed.

Identify specific policy actions that may be needed and what those policies should be. Here are some domains in which you may want to have disaster policy:

- Disaster preparedness
 - Expectations of staff related to disaster preparedness and training
 - Participation in community disaster planning meetings
 - Regular checking of response equipment for functional status
 - Budgeting for improved disaster preparedness (e.g., carrying over funds from year to year for bigger budget items)

- Personnel management during a disaster
 - Expectations for resident care during a disaster
 - Expectations of staff availability during a disaster
 - Staff reimbursement policy for extended disaster response
 - Staff retention policy during periods of prolonged evacuation
 - Delegation of authority to implement incident command
 - Authority of incident command to manage the disaster
 - Assignment of personnel to specific response teams
 - Backfill of resident care roles
 - Participation in statewide health care system management of disaster
 - Family care during a disaster

- Resource allocation during a disaster
 - Process of purchasing emergency items exceeding \$_____ during a disaster
 - Prioritization of vaccine when limited supply
 - Accepting residents from other impacted facilities

- Responder safety

- Use of personal protective equipment
- Expectations for preserving personal safety during a disaster
- Authority of safety officer
- Infection control during periods of limited water availability

- Crisis communication
 - Designated agency spokesperson
 - Employee communications outside the facility with family and friends
 - Employee response expectations if approached by media during a disaster
 - Responsibility for communications with partners

- Security
 - Actions to preserve integrity of security
 - Wearing of identification during a disaster
 - Designated primary access route from outside during a disaster

- Facility and equipment use during disaster
 - Relaxation of rules for required training to drive resident van during a disaster
 - Space prioritization
 - Movement of resident equipment to an safe area
 - Access to disaster response equipment during non-disaster periods
 - Space for employees responding to disaster to stay overnight

Some questions to consider:

Should proposed policies be discussed with staff or is that an issue for senior management and disaster response planners? Do all routine policies remain in effect during a disaster (e.g., no food in vaccine refrigerator)? If not, how will employees know which are and which aren't?

ACTION

Identify a process for drafting disaster policy, the person(s) responsible, deadlines, and the process for getting policy approved.

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PLANNING

Our facility is most vulnerable to the hazards listed below. See the following Emergency Operations Plan, and the *Emergency Protocols* (Appendix E) for this facility's hazard response procedures.

-
-
-
-
-
-
-

Local Emergency Management

This facility has established and maintains an ongoing relationship with the local or county emergency manager and maintains a presence on appropriate emergency preparedness coalitions for their area. The facility has shared a copy of this Emergency Operations Plan with those individuals/agencies.

Local Emergency Manager

(name and phone number):

Regional Public Health Emergency Preparedness Coordinator

(name and phone number):

This facility has invited appropriate personnel from throughout the emergency services area to visit, access and assist in identification of appropriate and better ways to prepare for emergencies. The facility also has documented their participation in local, regional, and state emergency preparedness meetings, drills, and exercises.

Government agencies, such as the Department of Health, are valuable tools during an emergency. This facility has assigned staff to maintain training and knowhow of the North Dakota Health Alert Network (ND HAN): updating resident data on HC Standard, requesting an internal ND HAN calldown, and ordering supplies through HAN Assets (guides found in Appendix B)

Planning Assumptions

This plan was created with the following assumptions being treated as fact in all disaster situations:

- Disasters can occur in all sizes and durations and will require the coordinated response of the facility's personnel to protect residents and employees alike.
- All disasters will merit one of two responses by the facility: *to evacuate or to shelter in place*. Sheltering in place is the preferable response to most disasters.
- The facility will require outside assistance from emergency medical services, firefighters, law enforcement, the healthcare community, and the community at large to evacuate.
- This facility will be as self-sustaining as possible for 72 hours, or until community help can arrive.

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PLAN AUTHORIZATION

This Emergency Operations Plan (EOP) has been developed for use by the following facility:

The Board of Directors has delegated the authority to develop, implement, and maintain the activities described herein to the Administrator.

The Administrator, using the guidance and resources supplied by the Board of Directors, has appointed the following person/position to direct and implement the Emergency Operations Plan (EOP):

By affixing the signature indicated below, this EOP is hereby approved for implementation and intended to supersede all previous versions. This all-hazard EOP was established to promote a system to: save lives; protect the health and ensure the safety of the long term care or assisted living facility environment; alleviate damage and hardship; and reduce future vulnerability within the long term care and assisted living facilities and resident care areas. Further, this document indicates the commitment to annual planning, training, and exercise activities in order to ensure the level of preparedness necessary to respond to emergencies or incidents within the long term care facility.

Date

Chairperson of the Board of Directors Signature

Facility NF/AL/BC Administrator Signature

Corporate Office Representative Signature

Environmental Services Manager Signature

Planning Committee Member Signature

Planning Committee Member Signature

Planning Committee Member Signature

Planning Committee Member Signature

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EMERGENCY OPERATIONS PLAN DISTRIBUTION

INDIVIDUAL / DEPARTMENT / OUTSIDE ORGANIZATION (ombudsman, local emergency manager)	DATE DISTRIBUTED

The **MASTER COPY** of the Emergency Operations Plan is located at the following physical location and is saved digitally in the following folder:

Facilities are encouraged to partner with other local resources when conducting exercises to maximize the effectiveness of the event. It is important to keep this plan current, accurate and effective in the facility's daily operating procedures. Without revision and improvement, plans quickly stagnate and lose effectiveness. The following staff position is responsible for the annual review and maintenance of this Emergency Operations Plan:

Signature of Employee

Date

Signature of Employee *(if personnel change)*

Date

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EMERGENCY PREPAREDNESS COLLABORATION EFFORTS

TYPE OF DRILL / EXERCISE / MEETING	REMARKS	DATE

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ACTION

Insert your facility-specific **Emergency Operations Plan** here.

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RESPONSE CHECKLIST

In response to an actual emergency situation, delegated personnel will coordinate the following actions:

- Activate the Emergency Operations Plan (EOP)
- Open the Emergency Operations Center (EOC)
- Alert staff of impending operations
- Follow your facility's plan and the Emergency Protocol procedures pertaining to the problem at hand (see Appendix E)
- If applies, utilize *Template for Receiving Facility* (see Appendix H)
- Coordinate actions and requests for assistance with your local emergency manager, public health unit, NDDoH, and NDLTCA
- If needed, request medical or non-medical volunteers from the NDDoH Emergency Preparedness and Response Section through the PHEVR/MRC program (see Appendix H)
- Control facility access
- Check food and water supplies
- Coordinate dissemination of messages to residents' family members
- Utilize Media Plan
- Determine requirements for additional resources and continue to update appropriate authorities and/or services
- Determine if will shelter-in-place or evacuate and follow appropriate protocol (reference the EOP, and *Emergency Protocols* in Appendix E)

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RECOVERY CHECKLIST

Immediately following the emergency situation, the facility administrator should take the provisions necessary to complete the following actions:

- If evacuated residents or received residents due to a disaster, notify NDDoH Health Facilities with displaced resident information (for reimbursement purposes)
- Coordinate recovery operations with your local emergency manager and other local agencies to restore normal operations, to perform search and rescue and to re-establish essential services
- Provide crisis counseling for residents/staff as needed
- Provide local authorities a master list of displaced, missing, injured or dead and notify the next-of-kin
- Provide information on sanitary precautions for contaminated water and food to staff, volunteers, residents and appropriate personnel
- If necessary, arrange for alternate housing or facilities
- Contact insurance agency and take an inventory of damaged goods. Arrange times for an emergency management agency rep or insurance agency reps to visit for residents' reporting of loss of personal effects
- Have a hazard evaluation performed and make sure building is declared safe for occupancy by NDDoH
- Arrange for fire marshal to assess fire-fighting services in property (i.e., sprinklers, standpipes, alarms, etc.)
- Ensure pest control/containment procedures are in effect
- Ensure HVAC system is operational
- Ensure emergency call system, business telephones, and internet access are all functioning
- Check that water supply and other system components are in place for dialysis residents
- Confirm that the facility has adequate dietary area, refrigeration, personnel, food, and supplies
- Ensure that electrical systems- main switchboard, utility transfer switches, fuses and breakers- are operational
- Ensure adequate oxygen available onsite and develop plan to replenish oxygen supply
- Confirm distribution system (ductwork, piping, valves, filtration, etc.) operational
- Confirm treatment chemicals (water treatment, boiler treatment) operational
- Infection Control- Check that procedures in place to isolate and prevent contamination from unused portions of facility, and to segregate contaminated supplies, medications, etc. prior to reopening facility
- Ensure medical records are accessible, updated, and backed up
- Confirm that waste management system is in place for trash handling
- Confirm water system is operational, with potable water for drinking, bathing, dietary service and that the sewer system is adequate

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APPENDIX A

STATE REGULATORY REQUIREMENTS

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AUTHORITIES AND LEGAL REFERENCES

STATE REGULATIONS PERTAINING TO EMERGENCY PREPAREDNESS

Basic Care Facilities Regulatory Requirements

(ND Administrative Code Chapter 33-03-24.1)

(The fire safety provisions located in section 33-03-24.2-08 apply to this chapter.)

33-03-24.1-10. Fire Safety

The facility shall comply with the national fire protection association life safety code, 1988 edition, chapter twenty-one, residential board and care occupancy, slow evacuation capability, or a greater level of fire safety.

Fire drills must be held monthly with a minimum of twelve per year, alternating with all workshifts. Residents and staff, as a group, shall either evacuate the building or relocate to an assembly point identified in the fire evacuation plan. At least once a year, a fire drill must be conducted during which all staff and residents evacuate the building.

Fire evacuation plans must be posted in a conspicuous place in the facility.

Written records of fire drills must be maintained. These records must include dates, times, duration, names of staff and residents participating and those absent and why, and a brief description of the drill including the escape path used and evidence of simulation of a call to the fire department.

Each resident shall receive an individual fire drill walk-through within five days of admission.

Any variation to compliance with the fire safety requirements must be approved in writing by the department.

Residents of facilities meeting a greater level of fire safety must meet the fire drill requirements of that occupancy classification.

History: Effective January 1, 1995; amended effective July 1, 1996; October 1, 1998; July 1, 2015.

General Authority: NDCC 23-09.3-09, 28-32-02

Law Implemented: NDCC 18-01-03.2, 23-09.3-09

Assisted Living Facilities Regulatory Requirements

(ND Century Code Chapter 23-09-02- 23-09-08)

23-09-02. State department of health to enforce provisions of chapter.

The department shall enforce the provisions of this chapter. Under no circumstances may any other state agency adopt rules that relate in any way to the provisions of this chapter.

23-09-02.1. Smoke detection devices or other approved alarm systems - Administrative procedure and judicial review.

Each lodging establishment and assisted living facility shall install smoke detection devices or other approved alarm systems of a type and in the number approved by the department, in cooperation with the state fire marshal. The department, in cooperation with the state fire

marshal, shall adopt reasonable rules governing the spacing and minimum specifications for approved smoke detection devices or other approved alarm systems. The department and state fire marshal shall provide all reasonable assistance required in complying with the provisions of this section.

23-09-03. Exiting requirements.

Every lodging establishment and assisted living facility constructed in the state shall have adequate exiting as defined by the state building code in chapter 54-21.3 with the following exceptions:

1. All lodging establishments and assisted living facilities in existence at the time of implementation of this section are required to continue with fire escapes previously provided for within this section providing that they are deemed adequate by the local fire authority having approval, or by the state fire marshal's office.
2. If the lodging establishment or assisted living facility is provided with exterior access balconies connecting the main entrance door of each unit to two stairways remote from each other.

23-09-04. Fire escapes in hotels and lodgings not more than two stories high.

Repealed by S.L. 1985, ch. 292, § 5.

23-09-05. Fire escapes to be kept clear - Notice of location and use of fire escapes required.

Access to fire escapes required under this chapter must be kept free and clear at all times of all obstructions of any nature. The proprietor of the lodging establishment or assisted living facility shall provide for adequate exit lighting and exit signs as defined in the state building code, chapter 54-21.3.

23-09-06. Chemical fire extinguishers - Standpipes.

Each lodging establishment or assisted living facility must be provided with fire extinguishers as defined by the national fire protection association standard number ten in quantities as defined by the state building code and the state fire code. Standpipe and sprinkler systems must be installed as required by the state building code and state fire code. Fire extinguishers, sprinkler systems, and standpipe systems must conform with rules adopted by the state fire marshal. A contract for sale or a sale of a fire extinguisher installation in a public building is not enforceable, if the fire extinguisher or extinguishing system is of a type not approved by the state fire marshal for such installation. No fire extinguisher of a type not approved by the state fire marshal may be sold or offered for sale within the state.

23-09-07. Lodging establishments or assisted living facilities with elevators - Protection to prevent spread of fire.

All new construction of, remodeling of, or additions to lodging establishments or assisted living facilities equipped with passenger or freight elevators must comply with state building code fire protection requirements.

23-09-08. Bolts or locks to be supplied on doors of sleeping rooms.

The doors of all rooms used for sleeping purposes in any lodging establishment within this

state must be equipped with proper bolts or locks to permit the occupants of such rooms to lock or bolt the doors securely from within the rooms. The locks or bolts must be constructed in a manner that renders it impossible to unbolt or unlock the door from the outside with a key or otherwise, or to remove the key therefrom from the outside, while the room is bolted or locked from within. Any lodging establishment proprietor who fails to comply with this section is guilty of a class B misdemeanor.

Assisted Living Facilities Regulatory Requirements

(ND Administrative Code Chapter 33-33-05, 33-33-09)

33-33-05-01. Smoke detectors required.

Every sleeping room in a lodging establishment or assisted living facility shall be equipped with a smoke detection device which has been inspected and listed by underwriters laboratories, factory mutual engineering division or equivalent. Smoke detectors shall be installed in accordance with the manufacturer's installation instructions.

History: Effective August 1, 1988; amended effective January 1, 2008.

General Authority: NDCC 23-01-03(3), 23-09-02.1

Law Implemented: NDCC 23-09-02.1

33-33-05-02. Passageway devices - General alarm.

Lodging establishments or assisted living facilities without direct access from sleeping rooms to the outside shall have hallways or exit corridors equipped with listed smoke detection devices. Hallway or exit corridor smoke detection devices shall be wired into an approved fire alarm system so as to sound an alarm when any of the smoke detection devices are activated. Audible signaling appliances shall be located so as to be clearly heard throughout the facility regardless of the maximum noise level under normal conditions of occupancy. In all cases one appliance must be installed at manufacture's recommendations or for each thirty feet [9.15 meters] of hallway or exit corridor or fraction thereof.

History: Effective August 1, 1988; amended effective January 1, 2008.

General Authority: NDCC 23-01-03(3), 23-09-02.1

Law Implemented: NDCC 23-09-02.1

33-33-05-03. Devices for the hard of hearing.

At least one sleeping room in every lodging establishment or assisted living facility shall be equipped with a listed smoke detection device capable of producing at least eighty-five decibels of sound at ten feet [3.05 meters] and capable of flashing a two hundred fifty watt bulb for a period of five minutes.

History: Effective August 1, 1988; amended effective January 1, 2008.

General Authority: NDCC 23-01-03(3), 23-09-02.1

Law Implemented: NDCC 23-09-02.1

33-33-05-04. Initial testing and certification.

After a smoke detection system has been initially installed, the lodging establishment or assisted living facility owner or manager shall certify in writing to the state department of health that the system has been tested and that each smoke detection device is working properly. Copies of written installer certifications will be accepted as owner or manager certifications.

History: Effective August 1, 1988; amended effective January 1, 2008.

General Authority: NDCC 23-01-03(3), 23-09-02.1

Law Implemented: NDCC 23-09-02.1

33-33-05-05. System inspection - Testing - Maintenance.

1. No smoke detection device shall be approved unless the device installer:
 - a. Instructs the owner or manager in the operation of the system.
 - b. Provides the owner or manager with a set of written instructions for the proper maintenance and testing of the system.
2. The owner or manager or designee of the owner or manager of a lodging establishment or assisted living facility shall test at least ten percent of the battery-operated smoke detectors weekly and at least ten percent of the hard-wired detectors monthly on a systematic basis. The owner or manager or designee of the owner or manager shall maintain written records for two years which:
 - a. Detail the date of the test, the units tested, the name of the person conducting the test, and the results of the test.
 - b. Indicate the date, results, and name of the person conducting a complete system maintenance inspection and test. Complete tests shall be conducted once each year or more often as necessary to assure proper operational condition.
3. The owner or manager of a lodging establishment or assisted living facility is responsible for, and shall cause, the necessary maintenance service or repairs to be made to ensure proper operational conditions of the smoke detection system at all times.

History: Effective August 1, 1988; amended effective January 1, 2008.

General Authority: NDCC 23-01-03(3), 23-09-02.1

Law Implemented: NDCC 23-09-02.1

33-33-09-01. Emergency lighting. Emergency lighting for means of egress shall be provided in all assisted living facilities. Emergency illumination shall be provided for not less than one and one-half hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of one footcandle [10 lux]. Where each living unit has a direct exit to the outside of the building at ground level, no emergency lighting shall be required.

History: Effective April 1, 2012.

General Authority: NDCC 23-09-02

Law Implemented: NDCC 23-09-02

33-33-09-02. Emergency plans

All assisted living facilities must have a current, written emergency disaster plan. That plan must contain a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency. The emergency disaster plan must be readily available for review by any tenant, family member, or emergency responders. An emergency evacuation route should be posted prominently in the facility.

History: Effective April 1, 2012.

General Authority: NDCC 23-09-02

Law Implemented: NDCC 23-09-02

33-33-09-03. Sprinkler systems. If sprinkled, systems should be inspected and maintained according to National Fire Protection Association 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Smoke detection systems shall be installed and maintained as specified in chapter 33-33-05.

History: Effective April 1, 2012.

General Authority: NDCC 23-09-02

Law Implemented: NDCC 23-09-02

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APPENDIX B

**HEALTH ALERT NETWORK (HAN)
HC STANDARD BED AVAILABILITY
HC STANDARD PATIENT TRACKING**

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HAN ASSETS

INSTRUCTIONS FOR ORDERING FROM THE CACHE

LOGGING INTO ACCOUNT FOR NEW USERS:

1. Go to: <http://hanassets.nd.gov/>
2. Click on the 'Register' link in the top right corner
3. Enter your email address, create and confirm a password, under 'Pending Membership' select 'User'
4. Click 'Create'
5. Click 'Add new address' under the 'Address book' tab
6. Complete all fields
7. Click 'Save changes'
8. Click the 'Home' tab to return to the catalog
9. Continue with steps under Placing a HAN Assets Order (below)

LOGGING INTO ACCOUNT FOR RETURNING USER:

1. 1. Go to: <http://hanassets.nd.gov/>
2. Click on 'Sign in' in the top right corner
3. Login: Enter email address and password
4. Continue with steps under Placing a HAN Assets Order (below)

PLACING A TEST HAN ASSETS ORDER FOR A DRILL/EXERCISE:

1. 1. Select 'Test Category' on left side of screen
2. Click 'Test Product'
3. Click 'Add to cart'
4. Click 'Go to checkout'
5. Enter the shipping address if different than the billing address
6. Click 'Place order: \$0.00'
7. An order confirmation will appear, print invoice and log out (upper right corner)
8. An email confirmation will also be sent

PLACING A HAN ASSETS ORDER FOR A REAL EVENT:

1. Click on ANY category
2. Find items that are needed and click "Add to Cart"
3. Click on Check out
4. Click on Submit (if you've logged in). For creating new account proceed with Steps for logging in as a new user

Additionally in a **REAL EVENT & AFTER HOURS**, PLEASE CONTACT NORTH DAKOTA DEPARTMENT OF HEALTH AT **701.328.2270**. FOLLOW THE PROMPTS TO SPEAK TO THE **CASE MANAGER AND INFORM THEM OF YOUR HAN ASSET REQUEST.**

HEALTH ALERT NETWORK (HAN) INTERNAL CALLDOWN INSTRUCTIONS FOR REQUESTING A HAN MESSAGE

Prior to making a request it is important that your facility be registered with the NDDoH. After you contact the HAN Coordinator, you will be sent a template to fill with staff contact information. Remember to update the HAN Coordinator throughout the year with any staff changes.

Your facility may want to request a HAN message for an internal drill, exercise, or real event. The procedure to request a message is as follows:

1. If requesting a HAN message during regular business hours (8:00am – 5:00pm CST), call the Emergency Preparedness and Response office at **701.328.2270**
 - a. Ask for the Case Manager
 - b. Inform the Case Manager that you are requesting a HAN message
 - c. Specify whether it is a drill, exercise, or real event

2. If requesting a HAN message after hours call the Emergency Preparedness and Response office at **701.328.2270** and follow the prompts to reach the Case Manager
 - a. The Case Manager will be paged and will return a call to you
 - b. Inform the Case Manager that you are requesting a HAN message
 - c. Specify whether it is a drill, exercise, or real event

3. Things to note:
 - a. An accurate call-down list in an excel format will need to be provided in order to contact your employees
 - b. A call-down list must include the following:
 - i. First name, last name, email, primary phone, secondary phone
 - ii. If wanting to send messages via text message the cell phone provider needs to be included in the list as well
 - iii. The list is not limited to the above elements, additional information such as individual roles or facility address may be added as well
 - c. The call-down list can be uploaded into the state system at any time
 - d. Do not list cell phone numbers with ring back tones
 - i. Ring back tones cause the message to play before the individual answers
 - ii. Ring back tones disable the automated calling mechanism as the system thinks that the phone has been answered
 - e. The Caller ID that is displayed is customizable. It can show a specific number or the default to the Department of Health Emergency Preparedness and Response Section number of 701.328.2270

HEALTH ALERT NETWORK (HAN) INSTRUCTIONS FOR RECEIVING A HAN MESSAGE

The ND Health Alert Network (HAN) is the call-back system used by the State to call health facilities during an exercise (such as Bed Availability, HAN Assets or VoIP) or in a real event. Your facility may also use ND HAN to do an internal call down drill, exercise, or in a real event.

A HAN message from the ND Department of Health will have one or more of the following formats:




1. Voice call (with a recorded message) Examples:
 - a. "This is the North Dakota Health Alert Network with an important message."
 - i. The remainder of the message will play and end without any user interaction
 - b. "This is the North Dakota Health Alert Network with an important message."
 - i. The remainder of the message will play and ask for user input, i.e. "Will you be able to respond to an event? Press 1 for yes 2 for no."
2. Email with or without attachments
3. Text messaging
4. If receiving the HAN message via phone please note the following:
 - 5. DO NOT FORWARD THE CALL OR PUT THE CALL ON HOLD**
 - a. Doing so disables the automatic response feature in the system
 6. If you receive this call and are not the person who needs the information or who completes this drill, document the information and promptly relay the information to the appropriate person
 7. If you do not understand or are unsure of the message: press 2 to repeat the message
 8. Cell phones with ring back tones disable the automatic response feature
 - a. The system interprets the music as if the phone was answered
 9. Real events require immediate response
 10. Exercises or drills are timed, it is important for your facility to respond promptly

Types of Messages:

- | | |
|-----------------------------|--|
| 11. Health Alerts: | Require immediate action or attention; highest level of importance |
| 12. Health Advisory: | Provides important information on an incident or situation |
| Health Update: | Provides updated information regarding an incident or situation |
| HAN Information: | Provides general public health information |

HC STANDARD INSTRUCTIONS FOR BED AVAILABILITY DATA ENTRY

ALWAYS CONFIRM RECEIPT OF THE HAN MESSAGE

1. Access the web link for HC Standard at <https://hc.ndhealth.gov>
2. Enter the facility username and password
3. Hold the cursor over 'Workspaces' along the top of the screen – Scroll to find facility name or Type in facility name to narrow the search
4. Under 'Matrices' click on 'Facility Bed Availability – "Your Facility Name"'
5. Click on the pencil icon  on the left to edit your data
6. Complete the bed tables as requested in the alert
 - a. If the data has not changed click on the clock icon  to automatically update the date and time for that particular data point
7. Click 'Save' in the upper right hand corner
8. Once the data has been saved, click on the  symbol in the upper right hand corner and select 'Logout'

The response goal is for data to be entered within 60 minutes of notification.

Please assure that your facility has a sufficient number of staff trained and designated to successfully enter data within the 60 minute time frame – 24/7/365.

For assistance please email: hcstandard@nd.gov or call 701.328.2270.

HC STANDARD
INSTRUCTIONS PATIENT TRACKING DATA ENTRY

The Department of Health Hospital Preparedness Program offers a mobile application to assist in Patient Tracking.

Refer to the NDLTCA website: www.ndltca.org

HC Standard:

HC Standard App Instruction Manual

HC Standard App Installation Questions & Answers

www.ndltca.org/emergencypreparedness/planning-1

For assistance please email: hcstandard@nd.gov or call 701.328.2270.

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APPENDIX C

MEMORANDUM OF AGREEMENT (MOA)

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MEMORANDUM OF AGREEMENT
NDDoH-DOC and Facility

This agreement is entered into between the North Dakota Department of Health, Department Operations Center (NDDoH-DOC) and the Unknown Health Care Facility (Facility), Location.

1. PURPOSE

Facility, upon receiving an emergency response activation notice from NDDoH-DOC, agrees to utilize facility assets to transport displaced residents from evacuated facilities to destination facilities as resources and circumstances allow. Facility agrees to respond with transportation vehicle to a location to be determined by NDDoH-DOC at the time of deployment and remain under the direction of the NDDoH-DOC or designee until completion of the authorized transportation trip.

Facility shall participate in the NDDoH-DOC patient tracking system and maintain records regarding transportation activities on NDDoH-DOC provided forms.

2. TERM OF AGREEMENT

This agreement shall be for a period beginning with a declaration of flood emergency and terminating at the conclusion of the flood emergency.

3. APPLICABLE LAW

The laws of the State of North Dakota shall govern this agreement.

4. COMPLIANCE WITH LAWS

The Facility agrees to comply with all applicable laws, rules, regulations, and policies, including those relating to public records and the confidentiality of records.

5. SEVERABILITY

The parties agree that if any term or provision of this agreement is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the agreement did not contain the particular term or provision held to be invalid.

6. WAIVER

The failure of the NDDoH-DOC to enforce any provisions of this agreement shall not constitute a waiver by the NDDoH-DOC of that or any other provision.

7. MERGER, WAIVER AND MODIFICATION

This agreement constitutes the entire agreement between the parties. No waiver, consent, modification, or change of terms of this agreement shall bind either party unless in writing and signed by both parties. Any such waiver, consent, modification, or change, if made, shall be effective only in the specific instance and for the specific purpose given. There are no understandings, agreements, or representations, oral or written, not specified in the agreement regarding this agreement. The Facility's authorized representative by his/her signature acknowledges that he/she has read this agreement, understands it, and agrees to be bound by its terms and conditions.

8. RENEWAL

This agreement will not automatically renew.

9. INDEMNITY

The NDDoH-DOC and the Facility each agrees to assume its own liability for any and all claims of any nature including all costs, expenses and attorneys’ fees which may in any manner result from or arise out of this agreement.

10. SPECIAL CONDITIONS

Pursuant to the attached agreement between North Dakota Department of Health, Department Operations Center (NDDoH-DOC) and North Dakota Department of Emergency Services, State Emergency Operations Center (NDDoH-SEOC), NDDoH-SEOC will process and provide reimbursement for services provided by the Facility through this agreement. Reimbursement will be dependent on the Facility’s delivery of services for resident transportation and attendants providing care during transport. Reimbursement requests shall be based on the attached fee schedule. Reports and request for reimbursement (invoices) must be received by the NDDoH within 30 days of the conclusion of the emergency. NDDoH-DOC will forward all invoices received from the Facility to NDDoH-SEOC for payment. NDDoH-DOC will not assume any financial liability under this agreement.

Facility

Date

North Dakota Department of Health

Arvy Smith,
Deputy State Health Officer
Department Operations Center Incident Commander

Tim Wiedrich,
Section Chief
Emergency Preparedness Section
Department Operations Center Incident Commander

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**North Dakota Department of Health
Fee Schedule for Provision of Care**

The following levels of care will be reimbursed at the Medicaid rate in effect at the time of service: Swing bed/sub-acute care; critical access hospital; acute care hospital, PPS; at the statewide average skilled nursing facility rate.

Provision of care in assisted living facilities and basic care will be reimbursed at \$185 per day.

Fee schedule for transportation

Vehicle Mileage	
Driver	
Certified Nurse Assistant Attendant	
LPN Attendant	
RN Attendant	

Rates are intended to cover hours on duty, meals, and lodging. No additional reimbursement for expenses is covered in this agreement.

Vehicle information

Total Number of Available Vehicles _____

Vehicle Type (See examples	Wheel Chair	Stretcher	Ambulatory

- Examples of Vehicle Types:
 - Wheel Chair Coach
 - Van with Wheel Chair Lift
 - Bus / drop down stairs
 - Passenger Van

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APPENDIX D

CONTACTS

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QUICK REFERENCE CONTACT SHEET

	COMPANY / CONTACT NAME	OFFICE PHONE	EMERGENCY PHONE
Medical, Fire, Police Emergencies			911
Fire Dept.			
Police Dept.			
Sheriff's Dept.			
Local Emergency Manager			
NDDoH			
Emergency Operations Center		701.328.2270	701.328.2270
ND Long Term Care Ombudsman			
NDLTCA		701.222.0660	701.354.9776
Insurance			
Legal Services			
Pharmacy			
Records Retention Services			
REPAIR			
Electrical			
General Contractor			
Glass			
Mechanical			
Plumbing			
Smoke/Fire			
UTILITIES			
Electrical Power Provider			
Gas Supplier			
Telephone Company			
Water Dept.			

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APPENDIX E

EXERCISE RECORDS
EMERGENCY PROTOCOLS
FACILITY BLUEPRINT
EVACUATION ROUTE
EVACUATION CHECKLIST FOR RESIDENT

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FIRE EXERCISE RECORD

DATE: _____

DATE OF LAST EXERCISE: _____

TASK	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Location of fire alarms AND fire extinguishers are posted	<input type="checkbox"/>	
Employees have been trained on the use of alarm system and extinguishers	<input type="checkbox"/>	
Fire evacuation procedures posted	<input type="checkbox"/>	
Fire drills must be conducted at a frequency of one per shift per quarter	<input type="checkbox"/>	
Fire drills must be conducted under varying conditions (location, time of day, type of fire, outside weather, etc.)	<input type="checkbox"/>	
Document equipment functioning, such as release of doors and alarm sounding	<input type="checkbox"/>	
Fire drill was conducted with both audible and visual alarm signal (silent alarm may be used instead of audible alarm 9:00pm – 6:00am)	<input type="checkbox"/>	

For Basic Care Facilities: *(BC facilities must conduct a fire drill evacuation of all residents and staff annually)*

List staff and residents who did not participate in the drill and why:

Briefly describe drill, duration, and the escape path used:

Exercise of procedures was *satisfactory*: YES NO

If answered "NO"- list the procedures/policies needing improvement:

1.

2.

3.

Corrective action for procedures/policies needing improvement:

1.

2.

3.

Next exercise to be completed on: _____ *(Basic Care required to hold monthly drills)*

Administrator signature: _____

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Make copies of this *Drill/Exercise Record*

Annually LTC facilities will need to:

- Participate in a community-based mock or facility-based mock disaster drill
- Conduct a paper-based, tabletop exercise
- All drills and tabletop exercises must be documented

DRILL/EXERCISE RECORD

EMERGENCY PROTOCOL: _____

DATE: _____ DATE OF LAST DRILL/EXERCISE: _____

IMPORTANT TASKS NEEDING TO BE INCLUDED IN DRILL/EXERCISE	COMPLETED <input checked="" type="checkbox"/>	INITIALS
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

Drill/Exercise of procedures was *satisfactory*: YES NO

If answered "NO" - list the procedures and policies needing improvement:

- 1.
- 2.
- 3.
- 4.

Corrective action for procedures/policies needing improvement:

- 1.
- 2.
- 3.
- 4.

Next drill/exercise to be completed on or before: _____

Administrator signature: _____

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**ASSISTED LIVING FACILITIES
SMOKE DETECTOR TESTING**

DATE: _____

DATE OF LAST EXERCISE: _____

- 10% of battery-operated smoke detectors are to be tested weekly
- 10% of hard-wired smoke detectors are to be tested monthly

UNITS TESTED	COMPLETED <input checked="" type="checkbox"/>	INITIALS
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

RESULTS OF TEST

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Administrator signature: _____

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APPENDIX F

**STAFF FORMS
DEPARTMENT CHECKLISTS**

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STAFF EMERGENCY FAMILY CARE PLAN

Staff Name: _____

Department: _____

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.

Name: _____

Relationship to staff member: _____

Work phone: _____ Cell phone: _____

Name: _____

Relationship to staff member: _____

Work phone: _____ Cell phone: _____

Location of children or other dependents:

Name	School/Daycare Facility	Phone

Signature

Date

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EMERGENCY CHECKLIST DEPARTMENT RESPONSIBILITIES

ADMINISTRATIVE SERVICES

TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Determine type of emergency and alert staff of emergency	<input type="checkbox"/>	
Utilize your facility EOP, reference applicable Emergency Protocol (See EOP Appendix E)	<input type="checkbox"/>	
Call Emergency Contacts, which can include your local emergency manager, public health EPR Coordinator, and the NDDoH (See EOP Appendix D)	<input type="checkbox"/>	
If needed, make a HAN request for an internal staff calldown (See EOP Appendix B)	<input type="checkbox"/>	
If EOC is activated, provide checklists to staff	<input type="checkbox"/>	
If needed, order supplies through HAN Assets	<input type="checkbox"/>	
Determine if can shelter-in-place or need to evacuate	<input type="checkbox"/>	
	<input type="checkbox"/>	

IN THE EVENT OF AN EVACUATION

TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Organize <ul style="list-style-type: none"> • Copies of important papers that you may not have access to electronically (e.g., insurance policies, titles, etc.) • Facility checkbook, credit cards, and any petty cash 	<input type="checkbox"/>	
Work with Administrator or Financial Officer to track expenses (including supplies, transportation, staff overtime, clean-up, etc.)	<input type="checkbox"/>	
Contact alternate receiving site(s)	<input type="checkbox"/>	
	<input type="checkbox"/>	

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**EMERGENCY CHECKLIST
DEPARTMENT RESPONSIBILITIES**

NURSING / MEDICAL SERVICES

TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Ensure delivery of resident medical needs and assess special medical situations	<input type="checkbox"/>	
Assign duties to CNAs and supervise resident transfer to designated safe areas in building	<input type="checkbox"/>	
Ensure availability of medical supplies and coordinate oxygen use	<input type="checkbox"/>	
Relocate endangered residents, determine which will need to be admitted to a hospital	<input type="checkbox"/>	
Ensure safety of resident records	<input type="checkbox"/>	
Coordinate staffing needs, brief supervisor as needed	<input type="checkbox"/>	
If possible, contact pharmacy to determine cancellation of deliveries or the availability of backup pharmacy while delivery service is still operating	<input type="checkbox"/>	
	<input type="checkbox"/>	

IN THE EVENT OF AN EVACUATION

TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Maintain resident accountability and control	<input type="checkbox"/>	
Supervise residents and their release to relatives, screen ambulatory residents to identify those eligible for release	<input type="checkbox"/>	
Maintain master list of all residents, including their dispositions, and update information on HC Standard	<input type="checkbox"/>	
Pack supply of incontinence products, latex gloves, plastic bags, personal wipes, and hand sanitizer to take to receiving facility(s)	<input type="checkbox"/>	

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**EMERGENCY CHECKLIST
DEPARTMENT RESPONSIBILITIES**

DIETARY / FOOD SERVICES

TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Oversee kitchen management, make sure dietary staff have been notified if need to report to duty	<input type="checkbox"/>	
Check water and food for contamination; supervise movement and separation of food stores to designated areas.	<input type="checkbox"/>	
Check refrigeration loss if refrigerator or food lockers are not on emergency power circuit	<input type="checkbox"/>	
Ensure 1 week supply of food storage for residents and staff	<input type="checkbox"/>	
Ensure 1 week supply of disposable dishes, utensils, cups, straws, and napkins	<input type="checkbox"/>	
Ensure availability of special resident menu requirements and plan alternate menus	<input type="checkbox"/>	
Update dietary records/resident needs on a Flash drive or external hard drive	<input type="checkbox"/>	
Conserve water	<input type="checkbox"/>	

IN THE EVENT OF AN EVACUATION

TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Supervise loading of food and water to be transported to receiving facility	<input type="checkbox"/>	
Supervise closing of kitchen; store kitchen equipment and secure kitchen area	<input type="checkbox"/>	
Ensure disposable dishes, utensils, cups, straws, and napkins are packed	<input type="checkbox"/>	
	<input type="checkbox"/>	

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**EMERGENCY CHECKLIST
DEPARTMENT RESPONSIBILITIES**

HOUSEKEEPING SERVICES

TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Ensure cleanliness of residents' environment	<input type="checkbox"/>	
Ensure provision of resident supplies for 3 days	<input type="checkbox"/>	
Clear corridors of any obstructions such as carts, wheelchairs, etc.	<input type="checkbox"/>	
Check equipment (wet/dry vacuums, etc.)	<input type="checkbox"/>	
Ensure adequate cleaning supplies and toilet paper are available	<input type="checkbox"/>	
Ensure adequate supplies of linens, blankets, and pillows and that emergency linens are available for soaking up spills and leaks	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

IN THE EVENT OF AN EVACUATION

TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Assist with moving residents to departure areas as needed	<input type="checkbox"/>	
Supervise loading of laundry and housekeeping supplies into transportation vehicles	<input type="checkbox"/>	
Help secure facility (close windows, lower blinds, etc.)	<input type="checkbox"/>	
	<input type="checkbox"/>	

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**EMERGENCY CHECKLIST
DEPARTMENT RESPONSIBILITIES**

MAINTENANCE SERVICES

TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Review staffing/extend shifts	<input type="checkbox"/>	
Check safety of surrounding grounds (secure loose furniture/equipment)	<input type="checkbox"/>	
Secure exterior doors and windows	<input type="checkbox"/>	
Check backup generator and switch to alternative power as necessary	<input type="checkbox"/>	
Check hazardous materials	<input type="checkbox"/>	
Conduct inventory of vehicles, tools, and equipment. Ensure communications equipment is operational and extra batteries are available	<input type="checkbox"/>	
Fuel vehicles	<input type="checkbox"/>	
Post charts on location of shut off valves/switches for gas, oil, water, and electricity	<input type="checkbox"/>	

IN THE EVENT OF AN EVACUATION

TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Close down/secure facility	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

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**EMERGENCY CHECKLIST
DEPARTMENT RESPONSIBILITIES**

RESIDENT SERVICES

TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Notify resident families	<input type="checkbox"/>	
Coordinate information release with liaison officer	<input type="checkbox"/>	
Facilitate telephone communication, answering phones and directing questions to appropriate areas	<input type="checkbox"/>	
Ensure that therapy appointments and all facility activities have been cancelled	<input type="checkbox"/>	
Monitor and document costs associated with the incident	<input type="checkbox"/>	

IN THE EVENT OF AN EVACUATION

TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Coordinate movement of residents	<input type="checkbox"/>	
Assist in transport of residents from rooms to departure areas	<input type="checkbox"/>	
Ensure adequate trained staff is available for emotional needs of resident and staff	<input type="checkbox"/>	
	<input type="checkbox"/>	

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**EMERGENCY CHECKLIST
DEPARTMENT RESPONSIBILITIES**

SECURITY SERVICES

TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

IN THE EVENT OF AN EVACUATION

TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

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APPENDIX G

DOCUMENTS TO ASSIST WITH COOP / RECOVERY

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VOLUNTEERS

During recovery, an Administrator may request for volunteers to assist with performing essential functions.

Public Health Emergency Volunteer Reserve/Medical Reserve Corps

What is PHEVR/MRC?

PHEVR/MRC stands for *Public Health Emergency Volunteer Reserve/Medical Reserve Corps*. It is a partnership between the state and local health departments and communities throughout the state of North Dakota. The PHEVR/MRC program enhances the ability of North Dakota's health and medical system to respond in a public health emergency situation.

What is the purpose of PHEVR/MRC?

PHEVR/MRC's mission is to provide medical and non-medical personnel to assist in a public health emergency. The purpose of the PHEVR program is to recruit volunteers (medical and non-medical) and train them before an event occurs to thus save time in the response phase of a public health emergency.

North Dakota a database of PHEVR/MRC volunteers will be maintained by the North Dakota Department of Health Emergency Preparedness and Response Section. It should help minimize the number of spontaneous volunteers and maximize the response capacity in the event of an emergency.

Call or email the PHEVR/MRC Program Representative with a volunteer request:

Marie Ricketts

701-328-5250

mricketts@nd.gov



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TEMPLATE FOR RECEIVING FACILITY

This document is intended to provide guidance to a long term care facility on the receiving end of a healthcare facility evacuation. It is intended to serve as a best practice template. Therefore, to be properly utilized by a specific facility, the guide will require review and tailoring.

The guide provides three (3) sections of information relative to receiving residents from another healthcare facility:

- General activation and preparation guidelines
- Influx guidelines utilizing existing open beds within the facility licensed bed capacity
- Guidelines for surging beyond the facility licensed bed capacity.

As a rule of thumb, long term care facilities should be prepared to surge to 110% of their licensed bed capacity. Therefore, a facility should develop a strategy for establishing temporary sleeping and care areas.

The information in this guide addresses short-term influx / surge situations. For the purposes of this document, short-term is intended to reference 72 hours (3 days) or less. After an initial evacuation occurs, a longer term resident care and housing plan should be developed and implemented if return to the evacuating facility is not a viable option. The suggested actions in this guide are intended as short-term options and are not proposed as practical resident care and housing solutions beyond 72 hours.

SECTION I:

ACTIVATION & PREPARATION FOR *RECEIVING* RESIDENTS FROM EVACUATING FACILITIES

When Your Facility Is Contacted To *Receive* Residents

Phone contact with the facility may be through an automatic messaging communication system or via a personal call. When an automatic message is received, the individual taking the call should immediately document the entire message. If receiving a personal call, the call should be forwarded to the on-site individual in-charge of the facility at the time. When receiving a personal call, attempt to obtain the following information:

- Total number of arriving residents
- Estimated time of arrival
- Sending facility contact phone number(s) and contact name
- Gender breakdown
- Number of arriving residents requiring wandering precautions
- Arriving residents requiring specialized medical needs (isolation, dietary, infection control)
- Resident medical equipment needs
- Quantity and type of medical equipment arriving with residents
- Quantity and type (clinical or not) of staff arriving with residents
- Will medications accompany residents
- Will charts accompany residents
- Need for the receiving facility to provide transportation (identify what type of transportation is available and any specialized capacity)
- Relay all information to the on-site individual in-charge of the facility at the time.
- If you receive an automated message and you are not on-site, contact the on-site individual in-charge of the facility at the time.

INTERNAL NOTIFICATIONS

- Notify the Administrator and/or the leadership individual on-call.
- **Administration** – Contact department heads and Medical Director.

INCIDENT COMMAND

- Consider establishing an internal Command Center.

CENSUS / RESIDENT CAPACITY

- Determine the up-to-date facility census and identify the number of open conventional beds and types of beds (dementia, psych, etc.).
- If the total number of arriving residents can be addressed through open beds within the licensed bed capacity of the facility.
- If the total number of arriving residents exceeds the open beds available within the licensed bed capacity.

STAFFING

- Determine the need to call-in additional staffing.
- Attempt to identify the quantity and type (RN, LPN, CNA, other) of staff that may be provided by the sending facility. They may work in tandem with your staff or may provide all clinical care without assistance. However, additional ancillary staff such as food service, housekeeping and maintenance will probably be required throughout the situation.
- Maintain staff to resident ratios necessary to meet resident needs throughout the duration of the situation.

SUPPLIES

- Conduct a baseline inventory of all supplies with specific focus on the following departments:
 - Food Service – types and quantity of food and beverage
 - Nursing – types and quantity of medical equipment (pumps, oxygen cylinders/concentrators, oxygen tubing/cannulas/masks, etc.) and medications
 - Housekeeping / Laundry – quantity of linens
 - Maintenance – types and quantities of beds, mattresses, privacy dividers, etc.
- Assess the type and quantity of equipment / supplies that will be arriving from the evacuating facility if possible.
- Contact vendors to request additional supplies as necessary.

EXTERNAL COMMUNICATIONS

- Initially communicate with the NDDoH
- Request permission to surge beyond licensed bed capacity if necessary. Provide on-going periodic updates as necessary.
- Notify NDLTCA

RESIDENT TRIAGE

- Establish a triage area.
- **Administration** – Designate an individual to oversee the set-up and operations of the triage area. Ensure adequate staffing and supplies at the triage location. Consider the following:
 - Staffing
 - Nursing / Resident Care (triage, managing care)

- Social Work
- Food Service (food and beverage)
- Administrative (tracking and documentation)
- Supplies
 - Chairs / wheelchairs
 - Pens, paper, nametags, charting materials
 - Food and beverage
 - Medications
 - Portable oxygen (cylinders, tubing, cannulas, etc.)
 - Blood pressure cuffs and stethoscopes
 - Standard precautions
- Document the arrival of all residents as they enter the triage area.
- Triage each arriving resident. If arriving residents do not arrive with a completed Resident Evacuation Tag (Disaster Tag), attempt to minimally collect and document the following information on each resident:
 - Name
 - Age
 - Responsible party
 - Medical diagnosis
 - Medication allergies
 - Other known allergies
 - Diet restrictions / last meal
 - Medications / last administered
 - Mental status
 - Mobility
 - Hearing impairments
 - Special precautions, procedures or equipment
 - Valuables with the resident
- Complete an initial nursing assessment of each arriving resident. Review any available medical records that accompanied the resident and establish an interim plan of care for each resident as appropriate. Establish a new chart if necessary.

FOOD AND NUTRITION

- Modify planned menus as necessary to accommodate the additional residents.
- Maintain food supplies and provide meals for residents, additional staff, and possibly families.

MEDIA AND FAMILIES

- Designate an individual to prepare and provide statements to the media and to families.
- Coordinate statements with the evacuating facility and emergency agencies.
- Consider separate staging locations (internal or external) for media and family members.
- Attempt to unify families / responsible parties with residents as quickly as possible.

RESIDENT TRACKING

- Communicate with the sending facility the total number of residents received along with the specific name of each resident received.

ARRIVING STAFF & STAFF CREDENTIALING / PRIVILEGING

- Review and confirm arriving staff have ID badges provided by the facility where they are employed.
- Log in staff as they arrive.
- Provide temporary facility ID.
- Identify where and to whom arriving staff are to report.
- Disaster privileges may be granted upon presentation of a valid government issued photo ID (i.e. driver's license or passport), and any of the following:
 - A current picture ID or other ID card from a Hospital, NH, ALR, RH.
 - A current license certification or registration to practice and a valid picture ID issued by a state, federal or regulatory agency. A primary source of verification must be given where applicable.
 - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or Medical Reserve Corps (MRC).
 - Identification indicating that the individual has been granted authority to render resident care in emergency circumstances. Such authority having been granted by a federal, state or municipal entity.
 - Presentation by current organizational staff member(s) with personal knowledge of the practitioner's identity.

FINANCE

- Monitor all costs and resources utilized throughout the duration of the situation. Maintain receipts for purchases directly related to the situation.

SECTION II:

UTILIZING EXISTING BEDS FOR RECEIVING RESIDENTS

RESIDENT PLACEMENT

- Verify the quantity and location of open beds throughout the facility.
- Do not consider beds that are being held for a confirmed admission.
- Ensure available rooms / beds are prepped for use.
- When feasible, utilize open beds that are proximal to each other to avoid scattering residents throughout the facility.

CONTINUING CARE

Monitor resident psychological status. Provide additional social services support.

- Incorporate into resident activities as appropriate.
- Communicate with attending physicians as necessary.
- Provide consistent services and support to residents facility wide.

SECTION III:

EXCEEDING YOUR FACILITY'S LICENSED CAPACITY

RESIDENT PLACEMENT

- Verify the quantity and location of open beds throughout the facility. Utilize open beds as the first phase of resident placement. The establishment of surge areas will address the second phase of resident placement.
- Do not consider beds that are being held for a confirmed admission.

- When feasible, utilize open beds that are proximal to each other to avoid scattering residents throughout the facility.

OPTIONS FOR INCREASING CAPACITY

- Contact NDDoH Health Facilities division
- Utilize the form *General Requirements When Accepting Residents Above Licensure...*
- Identify options for adding beds to existing sleeping rooms (i.e. a single room becomes a double room, a double room becomes a triple room, etc.).
- Identify options to transform non-sleeping areas into temporary sleeping / resident care areas. Areas should be at or above grade. Consider the following areas:
 - Activity Rooms
 - Lounges
 - Dining Rooms
 - Chapel
 - Meeting Rooms
 - Rehab / Therapy Rooms
 - Identify areas served with emergency power to support residents requiring critical electric medical equipment.

SURGE AREA SET-UP

- Set up surge locations based on priority. Utilize internal available supplies first. Consider the following options to obtain additional supplies:
 - Vendors
 - Supplies from the resident sending facility
 - Local Office of Emergency Management
 - Other healthcare facilities
- When establishing groupings of beds, cots or mattresses, attempt to place privacy dividers between them.
- Provide night lighting in each surge area.
- Provide call devices for each resident.
- Designate toilet and wash sink locations for each established surge area.
- Provide storage areas for resident belongings. Key personal belongings such as eye glasses, hearing aids, prosthesis, dentures, etc. should be located proximal to the resident. Other items such as clothing, shoes, etc. may be stored in a separate location.
- Consider establishing one or more provisional work station(s) located within or near surge areas.
- Provide constant clinical staffing in surge areas located outside of normal resident care areas.
- Ensure all surge arrangements do not impede egress or reduce life safety.

MEDICATIONS AND MEDICAL RECORDS

- Develop and designate specific storage locations for resident medications and medical records.

CONTINUING CARE

- Monitor resident toilet needs and provide staff to accompany residents to toilet facilities.
- Develop a bathing schedule based on the available bathing facilities.
- Maintain infection control standards.
- Monitor resident psychological status. Provide additional social services support.
- Provide resident activities.
- Communicate with attending physicians as necessary.

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PSYCHOLOGICAL FIRST AID

Information taken from SAMHSA, US Dept. HHS, field guide for the Medical Reserve Corps, National Child Traumatic Stress Network, National Center for PTSD. Info from SAMHSA can be shared with source citation, but may not be charged money to use it.

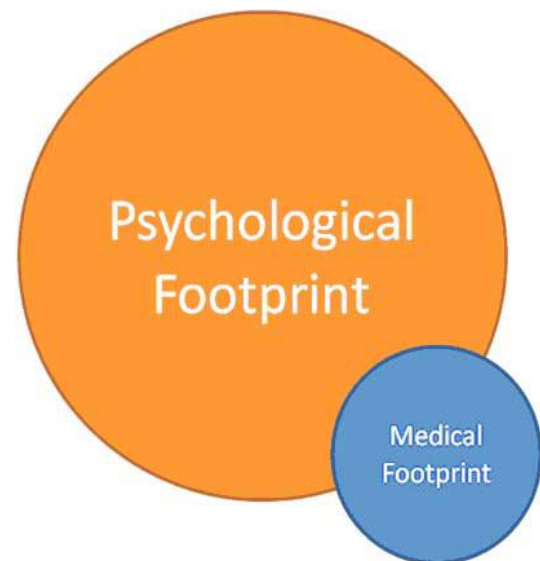
The National MRC Mental Health Work Group is recommending 'Psychological First Aid' be used as a standard model of mental health intervention in early response to disasters and other traumatic events.

What is Psychological First Aid? Definition:

Psychological First Aid is an evidence-informed modular approach to assist children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism.

Psychological First Aid is designed to reduce the initial distress caused by traumatic events, and to foster short- and long-term adaptive functioning and coping. Principles and techniques of Psychological First Aid meet four basic standards. They are: (1) consistent with research evidence on risk and resilience following trauma; (2) applicable and practical in field settings; (3) appropriate to developmental level across the lifespan; and (4) culturally informed and adaptable. Psychological First Aid does not presume all survivors will develop severe psychopathology, but instead fosters an understanding that disaster survivors, and others impacted by such events, will experience a broad range of reactions (e.g. physical, psychological, cognitive, spiritual).

Some of these reactions will cause sufficient distress for the individual and may be alleviated by support from compassionate and caring disaster responders.



In many natural disasters and terrorism events, it is likely that many more people will be mentally affected than the actual number of physically injured residents. The "Psychological Footprint" is much larger than the "Medical Footprint."

As you probably know from your own experience, the mental stress of a serious incident can linger with you for hours, days, weeks, months, or years. Pre-, during, and post-incident stress management is as important as ever. Proactively managing your stress will help you be at your best for your partner, patients, friends, and family.

When Should Psychological First Aid Be Used?

PFA is a supportive behavioral intervention for use in the immediate aftermath of disasters and other traumatic events. It is intended to blend into the general Medical Reserve Corps (MRC) response structure early in disaster stabilization and recovery efforts.

Strengths of Psychological First Aid

- Psychological First Aid includes basic information-gathering techniques to help mental health specialists make rapid assessments of survivors' immediate concerns and needs and how to implement supportive activities in a flexible manner.

- Psychological First Aid relies on field-tested, evidence-informed strategies that can be provided in a variety of disaster settings.
- Psychological First Aid emphasizes developmentally and culturally appropriate interventions for survivors of various ages and backgrounds.
- Psychological First Aid includes important elements of risk communication and education via the use of materials and handouts that provide information for youth, adults, and families for their use over the course of recovery in contending with post-disaster reactions and adversities.

Basic Objectives of Psychological First Aid

- Establish a human connection in a non-intrusive, compassionate manner.
- Enhance immediate and ongoing safety, and provide physical and emotional comfort.
- Calm and orient emotionally-overwhelmed or distraught survivors.
- Help survivors to articulate immediate needs and concerns, and gather additional information as appropriate.
- Offer practical assistance and information to help survivors address their immediate needs and concerns.
- Connect survivors as soon as possible to social support networks, including family members, friends, neighbors, and community helping resources.
- Support positive coping, acknowledge coping efforts and strengths, and empower survivors; encourage adults, children, and families to take an active role in their recovery.
- Provide information that may help survivors to cope effectively with the psychological impact of disasters.
- Facilitate continuity in disaster response efforts by clarifying how long the Psychological First Aid provider will be available, and (when appropriate) linking the survivor to another member of a disaster response team or to indigenous recovery systems, mental health services, public-sector services, and organizations.

Delivering Psychological First Aid

Professional Behavior

- Operate only within the framework of an authorized disaster response system.
- Model sound responses; be calm, courteous, organized, and helpful.
- Be visible and available.
- Maintain confidentiality as appropriate.
- Remain within the scope of your expertise and your designated role.
- Make appropriate referrals when additional expertise is needed or requested by the individual.
- Be knowledgeable and sensitive to issues of culture and diversity.
- Pay attention to your own emotional and physical reactions, and actively manage these reactions.

Guidelines for Delivering Psychological First Aid

- Politely observe first, don't intrude. Then ask simple respectful questions, so as to be able to discuss how you may be of help.
- Initiate contact only after you have observed the situation and the person or family, and have determined that contact is not likely to be an intrusion or disruptive.
- Be prepared to be either avoided or flooded with contact by affected persons, and make brief but respectful contact with each person who approaches you.
- Speak calmly. Be patient, responsive, and sensitive.

- Speak in simple, concrete terms; don't use acronyms or responder 'jargon'. If necessary, speak slowly.
- If survivors want to talk, be prepared to listen. When you listen, focus on learning what they want to tell you and how you can be of help.
- Acknowledge the positive features of what the person has done to keep safe and reach the current setting.
- Adapt the information you provide to directly address the person's immediate goals and clarify answers repeatedly as needed.
- Give information that is accurate and age-appropriate for your audience, and correct inaccurate beliefs. If you don't know, tell them this and offer to find out.
- When communicating through a translator or interpreter, look at and talk to the person you are addressing, not at the translator or interpreter.
- Remember that the goal of Psychological First Aid is to reduce distress, assist with current needs, and promote adaptive functioning, not to elicit details of traumatic experiences and losses.

Some Behaviors to Avoid

- Do not make assumptions about what the person is experiencing or what they have been through.
- Do not assume that everyone exposed to a disaster will be traumatized.
- Do not pathologize. Most acute reactions are understandable and expectable given what people exposed to the disaster have personally experienced. Do not label reactions as 'symptoms,' or speak in terms of "diagnoses," "conditions," "pathologies," or "disorders."
- Do not talk down to or patronize the survivor, or focus on their helplessness, weaknesses, mistakes, or disability. Focus instead on what the person has done that is effective or may have contributed to help others in need, both during the disaster and in the present setting.
- Do not assume that all survivors want to talk or need to talk to you. Often, being physically present in a supportive and calm way helps affected people to feel safer and more able to cope.
- Do not "debrief" by asking for details of what happened.
- Do not speculate or offer erroneous or unsubstantiated information. If you don't know something that you are asked, do your best to learn the correct facts.
- Do not suggest fad interventions or present uninformed opinion as fact.

Preparing to Deliver Psychological First Aid

In order to be of assistance to disaster-affected communities, the provider must be knowledgeable about the nature of the event, the post-event circumstances, and the type and availability of relief and support services.

Pre-planning and Preparation

Pre-planning and preparation is particularly important. PFA could pose potential communication problems unless thought about and resolved ahead of time. Facilities should discuss staff that has enough training to understand expectations and limitations, agreed upon response guidelines, organizational control, incident command structure and working guidelines of other 'partner' agencies in order to keep residents calm and functional during disasters or crises. Pre-event exercises and interagency drills to help bridge these important differences should be conducted in the community and facility to help understand psychosocial impacts on facility residents.

Flexibility, open-mindedness and cooperation will be highly regarded skills early in the response.

Talk with community resources when discussing psycho-social impact.

As you provide Psychological First Aid, you need to have accurate information about what is going to happen, what services are available, and where services can be found. This information needs to be gathered as soon as possible, given that providing such information is often critical to reducing distress and promoting adaptive coping.

Providing Services

In some settings, Psychological First Aid may be provided in designated areas. In other settings, Psychological First Aid staff may circulate around the facility to identify those residents who are distressed by disaster events. Focus your attention on how people are reacting and interacting in the setting. Individuals who may need assistance include those showing signs of acute distress.

This includes individuals who are:

- Disoriented
- Confused
- Frantic
- Panicky
- Extremely withdrawn, apathetic or “shut down”
- Extremely irritable or angry
- Individuals who are exceedingly worried

Decide who may need help.

Maintain a Calm Presence

People take their cue from how others are reacting. By demonstrating calmness and clear thinking, you can help survivors feel that they can rely on you. Others may follow your lead in remaining focused, even if they do not feel calm, safe, effective, or even hopeful. Psychological First Aid techniques often model a sense of hope that affected persons cannot always feel while they are still attempting to deal with what happened, and current pressing concerns during the disaster.

Be Sensitive to Culture and Diversity

Sensitivity to culture and ethnic, religious, racial, and language diversity is key to providing Psychological First Aid. Staff should be aware of their own values and prejudices, and how these may match or differ with those of the facility residents. Helping to maintain or reestablish customs, traditions, rituals, family structure, gender roles, and social bonds is important to helping survivors cope with the impact of a disaster. Information about the residents, including how emotions and other psychological reactions are expressed, attitudes towards governmental agencies, and whether the facility population (including staff) is open to counseling, should be available to staff. Some information could be gathered with the assistance of community cultural leaders who represent and best understand local cultural groups.

Be Aware of At-Risk Populations

Individuals that are at special risk after a disaster include:

- Staff’s children (especially children whose parents have died, were significantly injured or are missing) those who have had multiple relocations and displacements
- medically frail adults
- the elderly
- those with serious mental illness
- those with physical disabilities or illness

- adolescents who may be risk-takers
- adolescents and adults with substance abuse problems
- pregnant women
- mothers with babies and small children
- professionals or volunteers who participated in disaster response and recovery efforts
- those who have experienced significant loss of their possessions (e.g., home, pets, family memorabilia, etc.)
- those exposed first hand to grotesque scenes or extreme life threat

The prevalence of exposure to pre-disaster trauma may be higher among economically disadvantaged populations. As a consequence, minority and marginalized communities may have higher rates of pre-disaster trauma-related mental health problems, and are at greater risk for developing problems following disaster. Mistrust, stigma, fear (e.g., fear of deportation), and lack of knowledge about disaster relief services are important barriers to seeking, providing, and receiving services for these populations. Those living in disaster-prone regions are more likely to have had prior disaster experiences, although having dealt well with a disaster in the past may be helpful in the current situation.

Psychological First Aid Resources

The National Medical Corps Mental Health Work Group
www.medicalreservecorps.gov/file/mrc_resources/mrc_pfa.doc

Psychological First Aid for Nursing Homes

http://www.ahcancal.org/facility_operations/disaster_planning/documents/psychologicalfirstaid.pdf

Psychological First Aid for First Responders

<http://store.samhsa.gov/shin/content/NMH05-0210/NMH05-0210.pdf>

Mental Health and Psychosocial Support During Emergencies

http://www.who.int/mental_health/emergencies/en/index.html

Psychological First Aid Power Point Presentations

<http://www.pptsearch365.com/Psychological-Response-to-Disaster.html>

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