

2017

FACILITY:

EMERGENCY OPERATIONS PLAN



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 Comprehensive All Hazards approach HVA (Hazard Vulnerability Assessment)	<input type="checkbox"/>		
Review your Emergency Operations Plan (EOP) with key employees and local emergency manager to identify gaps and update accordingly	<input type="checkbox"/>		
Review Emergency policies and procedures and update and document changes	<input type="checkbox"/>		
Refer to FEMA, NDLTCA, and NDDoH websites for any updates that should be included in your EOP	<input type="checkbox"/>		
Determine if there are any changes in staff assigned to NHICS. Update contact information as needed	<input type="checkbox"/>		
Have staff contact information updated with the NDDoH HAN Coordinator (in the event your facility would need to request an internal staff call down)	<input type="checkbox"/>		
Review written communication plan, update and document changes to plan	<input type="checkbox"/>		
Update emergency response contact information (see <i>Quick Reference Contact Sheet</i> , Appendix D) and other contact lists. Must document date of review	<input type="checkbox"/>		
Have staff regularly update HC Standard with resident Information for tracking purposes	<input type="checkbox"/>		
Conduct new hire training orientation and annual training seminars to familiarize staff with the EOP and Emergency Protocols, especially the Evacuation Plan, maintain copies of offerings and update staff training records	<input type="checkbox"/>		
Review written training and testing program, update and document changes to plan	<input type="checkbox"/>		
Conduct a Tabletop Exercise to familiarize staff with the EOP and Emergency Protocols, especially the Evacuation Plan	<input type="checkbox"/>		
Conduct a Full Scale Community Exercise to familiarize staff with the EOP and Emergency Protocols, especially the Evacuation Plan (Facility Based Exercise if Community partners are N/A)	<input type="checkbox"/>		
<i>EVERY TWO YEARS:</i>			
Review and update Memorandum of Agreement (MOA) with NDDoH HPP	<input type="checkbox"/>		
Review and update Financial Memorandum of Agreement (MOA) with NDLTCA	<input type="checkbox"/>		

REMARKS

Empty remarks area.

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:

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 human related 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. For ICS (or NHICS) job duties see Appendix G, and details for staff responses can be found in Appendix F.

PRE-EMERGENCY

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

Pre-Emergency Tasks/Checklists

Hazard Vulnerability Assessment Checklist

<input type="checkbox"/> TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Complete Hazard Vulnerability Assessment (HVA) , identify top risks/hazards for your facility and community	<input type="checkbox"/>	
Ensure facility leadership can explain hazards included in assessment and how risk assessment was conducted	<input type="checkbox"/>	
Ensure facility leadership can describe the facility's resident population that would be at risk during an emergency event	<input type="checkbox"/>	
Ensure facility leadership can describe the services the facility would be able to provide during an emergency	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

Emergency Operations Plan Checklist

<input type="checkbox"/> TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Review existing plans, policies, and procedures on an annual basis. Document date of review and updates made to plan based on that review	<input type="checkbox"/>	
Designate an Emergency Operations Center (EOC) in your facility as a “home base” during an emergency	<input type="checkbox"/>	
Assign staff to the Nursing Home Incident Command System (NHICS), make sure they understand their role and responsibilities. Distribute job action sheets found in Appendix G	<input type="checkbox"/>	
Re-familiarize Emergency Planning Committee with facility profile and layout. Complete Facility Profile	<input type="checkbox"/>	
Define the criteria for making shelter in place versus evacuation decision <input type="checkbox"/> Complete the Shelter in Place Planning Checklist and follow up on any incomplete tasks <input type="checkbox"/> Complete the Evacuation Planning Checklist and follow up on any incomplete tasks	<input type="checkbox"/>	
Review current policy regarding staff duties during an emergency. Complete Staffing Backup Plan . Review and edit Emergency Checklists - Department Responsibilities found in Appendix F	<input type="checkbox"/>	
Identify day-to-day essential functions and confirm there is adequate cross-training in staff. Complete Critical Resources Worksheet	<input type="checkbox"/>	
Identify and develop personnel for succession planning to fill key business leadership positions as they become available	<input type="checkbox"/>	
Include in your plan your facility’s ability to continue with daily operations (COOP)	<input type="checkbox"/>	
Ensure agreements or contracts in place to re-establish essential utility services, timeframes to initiate services, how services will be procured and delivered, and the continuity of supply of essential items throughout emergency	<input type="checkbox"/>	
Communicate plans with your local emergency manager and regional public health EPR coordinator	<input type="checkbox"/>	

Include a process for cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness officials for an integrated approach to emergency	<input type="checkbox"/>	
Assign specific staff with task of regularly updating HC Standard with current resident data	<input type="checkbox"/>	
Ensure a process to track residents, using triage tags and a tracking system	<input type="checkbox"/>	
Ensure a process to track employees, volunteers, vendors, resident families and any other person on the facility premises. Ensure staff can describe and/or demonstrate the process	<input type="checkbox"/>	
Assign specific staff to understand HAN Alert and HAN Asset Ordering system to order emergency items	<input type="checkbox"/>	
Test all emergency lighting batteries periodically, remember to document	<input type="checkbox"/>	
Post location of fire extinguishers and phone numbers of emergency contacts (Quick Reference Contact Sheet in Appendix D is useful)	<input type="checkbox"/>	
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.	<input type="checkbox"/>	
Sign an updated financial MOA with North Dakota Long Term Care Association (NDLTCA)	<input type="checkbox"/>	
House the emergency preparedness documents (including all policies and procedures) to facilitate review	<input type="checkbox"/>	

Policies and Procedures Checklist

Ensure policies and procedures address the following:

<input type="checkbox"/> TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Provision of subsistence needs including, but not limited to food, water, and pharmaceutical supplies for residents and staff	<input type="checkbox"/>	
Adequate alternate energy sources to maintain the following <ul style="list-style-type: none"> <input type="checkbox"/> temperatures to protect resident health and safety and for the safe and sanitary storage of provisions <input type="checkbox"/> emergency lighting <input type="checkbox"/> fire detection, extinguishing, and alarm systems 	<input type="checkbox"/>	
Proper disposal of sewage and waste	<input type="checkbox"/>	
Safe evacuation from the facility and includes all required elements	<input type="checkbox"/>	
Provide a means to shelter in place for residents, staff and volunteers who remain in the facility during the emergency <ul style="list-style-type: none"> <input type="checkbox"/> Are documents aligned with the facility's emergency plan and risk assessment 	<input type="checkbox"/>	
Documented resident tracking system	<input type="checkbox"/>	
Tracking of employees, resident's families, volunteers and other personnel on facility premises	<input type="checkbox"/>	
Strategy for use of volunteers and other staffing shortages during an emergency	<input type="checkbox"/>	
Describe the facility's role in providing care and treatment in alternate care sites	<input type="checkbox"/>	
Develop medical record documentation system to: <ul style="list-style-type: none"> <input type="checkbox"/> preserve resident information <input type="checkbox"/> protect confidentiality of resident information secures/maintains availability of records 	<input type="checkbox"/>	
Ensure facility leadership can explain the arrangements in place for transportation in event of an evacuation	<input type="checkbox"/>	

Communication Plan Checklist

<input type="checkbox"/> TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Review written communication plan on an annual basis and update as necessary. Must document date and changes	<input type="checkbox"/>	
Review and update contact lists and resource lists annually. Must document date of review	<input type="checkbox"/>	
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 <i>Emergency Communications Planning Checklist</i>	<input type="checkbox"/>	
Ensure communication plan includes a method for sharing information and medical documentation for residents under facility’s care with other health providers to maintain continuity of care	<input type="checkbox"/>	
Ensure the plan includes policies and procedures to address the method the facility will use to release resident information (for example, general condition and location of residents)	<input type="checkbox"/>	
Ensure the availability and functioning of facility emergency warning system, remember to document	<input type="checkbox"/>	
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 call down (see Appendix B)	<input type="checkbox"/>	
Ensure the communication plan includes a method for sharing appropriate information from the emergency plan with residents and their families or representatives. <ul style="list-style-type: none"> <input type="checkbox"/> Staff should be able to demonstrate the knowledge of this method. <input type="checkbox"/> Residents and their families should be able to demonstrate their knowledge of this method 	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

Training and Testing Checklist

<input type="checkbox"/> TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Review written training and testing program annually, document date and updates made	<input type="checkbox"/>	
Annually conduct a Tabletop Exercise based on your All Hazards Assessment and compare to Emergency Operations Plan. <ul style="list-style-type: none"> <input type="checkbox"/> Maintain documentation of the Tabletop exercise: Scenarios <input type="checkbox"/> Complete AAR/IP (After Action Report and Improvement Plan) 	<input type="checkbox"/>	
Annually participate in one Community-based Emergency exercise or Facility-based exercise if cooperation with community partners is not possible. <ul style="list-style-type: none"> <input type="checkbox"/> Document what community resources were contacted, date and reason why could not participate <input type="checkbox"/> Complete AAR/IP (After Action Report and Improvement Plan) <input type="checkbox"/> Maintain documentation of full scale exercise: Emergency Exercise Plan, AAR/IP 	<input type="checkbox"/>	
Ensure facility leadership can describe the services the facility would be able to provide during an emergency	<input type="checkbox"/>	
Schedule new employee orientation training and annual in-service training on the EOP, remember to document <ul style="list-style-type: none"> <input type="checkbox"/> Maintain copies of initial and annual training offerings <input type="checkbox"/> Staff must demonstrate knowledge gained at these trainings <input type="checkbox"/> Staff training files must contain documentation of training received 	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

Emergency and Standby Power Systems Checklist

☐ TASKS	COMPLETED ☑	INITIALS
Ensure an emergency standby power system is in place	☐	
Ensure generator is located and installed in accordance with NFPA 110 and NFPA 99	☐	
Ensure if there is an onsite fuel source, that it is maintained in accordance with NFPA 110 and there is a plan for how to keep the generator operational during an emergency	☐	
	☐	
	☐	
	☐	

Multi-facility Corporation Unified and Integrated Emergency Preparedness Checklist

☐ TASKS	COMPLETED ☑	INITIALS
Ensure documentation of whether your facility has opted to be part of its healthcare system's unified and integrated program	☐	
Ensure documentation verifying your facility was actively involved in development of the program	☐	
Ensure documentation verifying your facility was actively involved in the annual reviews and updates of the program	☐	
Keep copy of the entire unified program and all required components	☐	
Ensure facility leadership can describe how the program is updated based on changes within the healthcare system	☐	
	☐	

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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, residents requiring ventilators, dialysis, 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: _____

Average number of ambulatory residents: _____

Average number of non-ambulatory residents: _____

Any ventilator or life support residents: _____

Do you have an isolation room or HEPA machine? Yes No

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:

Admin	Nursing	Dietary	Housekeeping	Maintenance	Recreation	Soc. Services	HR

Location of power shutoff: _____

Generator:

1. 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

2. Do you have an Automatic Transfer Switch installed next to the generator? Yes No

3. 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):

Name _____ Name _____

Phone _____ Phone _____

Address _____ Address _____

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

Name _____ Name _____

Phone _____ Phone _____

Address _____ Address _____

Facility's Oxygen Contractor(s):

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

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
- Facility has offered training on NHICS (Nursing Home Incident Command System)
- 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 comprehensive 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. An “All Hazard Approach” is an integrated approach that focuses on identifying hazards and developing emergency preparedness capacities and capabilities, with an emphasis on:

- Care-related emergencies
- Equipment and power failures
- Interruptions in communication
- Loss of a portion or all of a facility
- Interruptions in the normal supply of essentials

The All Hazards Approach is specific to the location of the facility, considering the types of hazards most likely to occur in the area. It does not specifically address every possible threat or risk but ensures the facility will have the capacity to address a broad range of related emergencies.

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, Florida is prone to hurricanes but not to winter storms. North Dakota is prone to winter storms, but not to hurricanes.

ACTION

Complete the following *Hazards Vulnerability Assessment* or supplement with another all-hazards version. The Kaiser Permanente Model Template is available for download on the NDLTCA website.

HAZARD AND VULNERABILITY ASSESSMENT TOOL NATURALLY OCCURRING EVENTS



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

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY		
0.00	0.00	0.00

HAZARD AND VULNERABILITY ASSESSMENT TOOL TECHNOLOGIC EVENTS



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

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY		
0.00	0.00	0.00

**HAZARD AND VULNERABILITY ASSESSMENT TOOL
HUMAN RELATED EVENTS**



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

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY
0.00 0.00 0.00

**HAZARD AND VULNERABILITY ASSESSMENT TOOL
EVENTS INVOLVING HAZARDOUS MATERIALS**



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

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY		
0.00	0.00	0.00

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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*”; however, given the health status of residents in long term care facilities, many of your essential services may have a lower threshold. 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. A few portable, battery operated oxygen concentrators
10. Kitty litter to use in red bags for alternative toileting.
11. Large water bladder to store water delivered by National Guard (especially if no well)
12. Permanent oxygen storage tank
13. Increased generator capacity which can handle HVAC.
14. 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)
15. Raise generators on concrete slabs.
16. Alternate heat source (e.g., electrical wall heaters) as backup to boiler heat.
17. One or two larger capacity vans for moving wheelchair patients
18. Duct work which would allow for hooking in alternate heating or cooling equipment outside the building with building-wide distribution of conditioned air.
19. External valves usable for pressurization of water distribution system from external source
20. Add a second story room of sufficient size to hold all the residents in a vertical evacuation.
21. Improvements to sprinkler system.
22. Addition of some carbon monoxide detectors hard wired to emergency circuits.
23. Waterproofing for electrical room (if it can't be moved).
24. New windows in residents' rooms with shatterproof glass and greater energy efficiency.
25. Large underground emergency holding tank for sewage.
26. Larger tank for storing diesel.

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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 must 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
- other local health care facilities
- regulatory agencies
- 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. These roles should be assigned within the Incident Command Structure (*see Nursing Home Incident Command Chart Appendix G*).

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)
 - The incident commander was not kept informed
 - Chain of command was not followed and the incident commander was overwhelmed
- 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		
Incident Command positions assigned and job tasks handed out	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		

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INCIDENT COMMAND SYSTEM

The Incident Command System (ICS) is structured to support five major functional areas: command, finance, logistics, operations, and planning. Staff assigned to the Incident Command System is encouraged to complete online ICS training. Courses ICS 100, ICS 200, and ICS 700 cover the basics and can be accessed from the U.S. Department of Homeland Security FEMA website <http://training.fema.gov/IS/NIMS.aspx>. In addition to this training, your facility's Incident Commanders are also encouraged to enroll in classroom training, specifically ICS 300 and ICS 400.

The Nursing Home Incident Command System (NHICS) is very similar to incident command for any other institution. Each responder must have at least a basic understanding of incident command principles. Principles which apply to any NHICS system include:

- A single person is in charge of the incident response (incident commander) at any one time. This person must be fully invested with authority to deal with the disaster. This does not mean that the Incident Commander operates the institution, but it does mean that he or she has full authority to make decisions regarding disaster response without consulting the NF/AL/BC Administrator or corporate office or any other entity. This is one of two core principles.
- All decisions follow chain of command. This is the second core principle. Lines of authority are laid out in the incident command chart (see Appendix G). The NHICS chart must include all response position titles. The incident command chart should be revised as the number or type of responder positions change.
- The incident commander is the only required position for any particular event, but any response role for that event not delegated by the incident commander to someone else remains the incident commander's direct responsibility.
- Incident command is flexible. The number of responders can be expanded or contracted to fit the situation. The number of response units (e.g., section, group, task force) is flexible and can be expanded or contracted to fit the situation.
- All incident responders are assigned one and only one supervisor within the incident command system. (This does not imply that all staff in the facility are necessarily responders to any particular incident.)
- Each responder must follow the instructions of their assigned NHICS supervisor.
- The responder's NHICS supervisor may or may not be their usual supervisor. Unless the usual supervisor is also the responder's incident command supervisor, the usual supervisor will have no authority over the actions of that responder until released from the response and re-assigned to the usual supervisor.
- No one supervises a large number of people. The usual maximum is seven.
- The only position which can over-rule any other position, including the incident commander, is the safety officer, but only when the action is taken to prevent injury to responders or other persons.
- At a minimum, persons who may be responsible for a command staff role (i.e., incident commander, operations chief, logistics chief, planning chief, finance and administration chief, PIO, safety officer) are designated and documented pre-incident. This must include sufficient personnel to staff command staff roles 24 hours per day, perhaps for weeks. (It is not assumed that all command staff roles must be staffed throughout an event, only that sufficient trained people are available to staff the positions if needed.)

- At a minimum, persons responsible for command staff positions, including all back up persons for these positions, are thoroughly trained and exercised pre-incident. It is not assumed that any single person can only ever fill one command staff role.
- Persons critical to incident response staff must be available at all times or have known substitutes available.

ICS / Long Term Care Cross Reference Chart



ICS Position

Incident Commander

Medical Director/Specialist
Public Information Officer
Liaison Officer
Safety Officer

Operations Section Chief

Resident Services Branch Director
Nursing Unit Leader
Psychosocial Unit Leader
Admit/Transfer & Discharge Unit Leader
Infrastructure Branch Director
Dietary Unit Leader
Environmental Unit
Physical Plant/Security Unit Leader

Planning Section Chief

Situation Unit Leader
Documentation Unit Leader

Logistics Section Chief

Service Branch Director
Communication Hardware Unit Leader
IT/IS Unit Leader
Support Branch Director
Supply Unit Leader
Staffing/Scheduling Unit Leader
Transportation Unit Leader

Finance/Admin Section Chief

Time Unit Leader
Procurement/Costs/Claims Unit Leader

Long Term Care Position

Administrator

Medical Director/Nurse Consultant
Media Relations/Administrator
Assistant Administrator
Maintenance

Director of Nursing

Director of Staff Development
Charge Nurse
Activities Director
Charge Nurse or Rehab Director
Housekeeping supervisor
Cook
Housekeeper
Maintenance

Assistant/Associate Administrator

Director of Admitting
Medical Records Staff

Assistant/Associate Administrator

Director of Dietary Services

Accounts Manager
Maintenance Staff/Rehab Director
Business Office Staff
Director of Social Services
Housekeeping or Central Supply
Lead CNA
Maintenance or Activity Staff

Business/Finance Director

Payroll/Biller
Risk Manager/Quality Management

Incident Commander: Leads the response, appoints section leaders, approves plans and key actions

Operations Section: Handles key actions including first aid, search and rescue, fire suppression, securing the site

Planning Section: Gathers information, thinks ahead, makes and revises action plans and keeps all team members informed and communicating

Logistics Section: Finds, distributes and stores all necessary resources

Finance Section: Tracks all expenses, claims, activities and personnel time and is the record keeper for the incident

Public Information Officer: Provide reliable information to staff, visitors and families, the news media and concerned others as approved by the Incident Commander

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

Liaison Officer: Serves as the primary point of contact for supporting agencies assisting the facility

NHICS Forms 203 and 207 in Appendix G provide a sample structure for designating personnel to nursing home incident command positions and forming them into a chain of command structure covering all necessary response activity. The structure gives you an excellent idea of the sort of roles each person will play. However, the vast majority of institutions will never need more than command staff and perhaps one or two operational branches. Although each disaster is different, the usual order in which typical disaster response staff are expanded would commonly occur as follows:

1. Incident commander
2. Operations/Logistics Chief and Liaison
3. Planning Chief
4. PIO
5. Separate Logistics Chief and Safety Officer
6. Expansion of Operations Section into branches

Emergency actions and activation of incident command ensure that immediate actions are taken to protect life, health and property, and to ensure that incident command is activated so that one person (the incident commander) is responsible for the subsequent response and delegates authority and tasks to others.

Is a facility required to utilize incident command? No, the facility can adopt any set of principles it chooses; however, **incident command is the standard with emergency personnel** (fire, police, EMT) and there will be efficiency, compatibility and potentially financial costs of using another system.

ACTION

Assign personnel to specific roles. Each critical position should have at least two other people who can step in and fill it.

NHICS Activation

The problem faced with an emergent event is the immediate response period when all response decisions need to be made through a temporary incident command structure, and a permanent incident command structure needs to be activated. Actions must incorporate loss priorities, while ensuring that many things occur as quickly as possible. Necessary actions will potentially include responder safety, situational awareness, situational mitigation, accounting for persons, triage, treatment and notification.

A different problem is faced in urgent events. The problem is typically making the transition from business as usual to incident command management. Urgent events can be insidious in onset (e.g., rising flood waters, pandemics) and the conversion to incident command and redirection of the appropriate level of resources needs to happen early rather than late. A process for triggering incident command must be in place.

Now you will need to determine how the incident command team will be activated in a disaster. This may be accomplished with a manual or digital call down system. One common approach to activate persons assigned to incident command is for the incident commander to take charge and decide who will be assigned the current shift and who will be assigned to subsequent shifts. An alternative is for the lead incident commander (or whoever is available in his or her stead) to be notified to contact the rest of the incident command team. He or she contacts a liaison who is assigned to contact specific individuals and have them report.

Part of the process of response is ensuring that the most experienced response personnel are mobilized to management incident command. Other persons/structures also need to be contacted. It is necessary to have a contact list with multiple modes of contact for each person. Your facility's list should be readily assessable from multiple places in the building on paper and electronically.

Some questions to consider:

When people are used "in place" for disaster response rather than moving them to the operations center, does this create a problem for separating regular duties from emergency response duties? What is the procedure for ensuring that an emergency incident command system is immediately established from persons present in the building? One person must be in charge and delegating responsibility to others (e.g., alerting, calling in staff, determining who cannot be accounted for). Who should become commander? What if that person is injured? What if the building is large and parts of it isolated from other parts by the disaster? How will the commander be able to allocate roles and tasks among available staff?

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. Activate the NHICS team and replacement staff
2. Brief the NHICS staff as soon as they arrive
3. Assign someone to follow-up on additional information that needs to be gathered about the event.
4. 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 by the NHICS Planning Chief. 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 patients 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 patients in the evacuation staging area of your building? What would be your trigger for placing the patients 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. What happens to oxygen concentrators or ventilators or HVAC? 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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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 patients 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. high acuity, 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 be needed to protect patients, 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.

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	<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	<input type="checkbox"/> not started <input type="checkbox"/> in progress <input type="checkbox"/> done		
Facility has extra supplies of IV fluids	<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	<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	<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 and stretchers does the facility have? Do most patients 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 patient mix. An assisted living facility which has mostly ambulatory and a few wheelchair patients is going to be easier to move than residents of a skilled nursing facility which has many total care patients. The options for moving stretcher patients are typically ambulances, ambulance buses or buses converted for carrying stretcher 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 patients each, but moving dozens of patients 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 patient 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 patients move up or down the ramp.

Consider the situation where you may be unloading multiple patients 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, patient tracking and patient placement. In the case of an emergency, family members may arrive, sometimes at the last minute, to take residents home. How will that impact patient 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) and NDLTCA (financial)	<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 patient 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 patient 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., stretchers, 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			
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 patients 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, patient to patient 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.

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 patients for patient 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 patient 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 patients 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 patient 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)
- Initiate Incident Command operations and 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
FEDERAL REGULATORY REQUIREMENTS
PROPOSED FEDERAL REGULATORY REQUIREMENTS

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AUTHORITIES AND LEGAL REFERENCES

STATE REGULATIONS PERTAINING TO EMERGENCY PREPAREDNESS

Nursing Facility Regulatory Requirements

(ND Administrative Code Chapter 33-07-03.2)

33-07-03.2-09. Emergency plan

The facility shall have a written procedure to be followed in case of emergencies. The emergency plan must specify persons to be notified, locations of alarm signals and fire extinguishers, evacuation routes, procedures for evacuating residents, and assignment of specific tasks, and responsibilities to the personnel of each shift.

History: Effective July 1, 1996.

General Authority: NDCC 23-01-03, 28-32-02

Law Implemented: NDCC 23-16-01, 28-32-02

Basic Care Facilities Regulatory Requirements

(ND Administrative Code Chapter 33-03-24.1)

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.

General Authority: NDCC 23-09.3-19

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 lodgishouses 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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CODE OF FEDERAL REGULATIONS

Title 42 - Public Health

Volume: 5 Date: 2013-10-01 Original Date: 2013-10-01

Title: Section 483.70 - Physical environment.

Context: Title 42 - Public Health.

*Chapter IV - Centers For Medicare & Medicaid Services, Department of Health and Human Services
Subchapter G - Standards and Certification.*

Part 483 - Requirements for States and Long Term Care Facilities.

Subpart B - Requirements for Long Term Care Facilities.

§ 483.70 Physical environment.

The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

(a) *Life safety from fire.*

(1) Except as otherwise provided in this section—

(i) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101[®] 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to long-term care facilities.

(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.

(3) The provisions of the Life safety Code do not apply in a State where CMS finds, in accordance with applicable provisions of sections 1819(d)(2)(B)(ii) and 1919(d)(2)(B)(ii) of the Act, that a fire and safety code imposed by State law adequately protects patients, residents and personnel in long term care facilities.

(4) Beginning March 13, 2006, a long-term care facility must be in compliance with Chapter 19.2.9, Emergency Lighting.

(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to long-term care facilities.

(6) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a long-term care facility may install alcohol-based hand rub dispensers in its facility if—

(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;

(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

(iii) The dispensers are installed in a manner that adequately protects against inappropriate access;

(iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00-1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00-1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269; and

(v) The dispensers are maintained in accordance with dispenser manufacturer guidelines.

(7) A long term care facility must:

(i) Install, at least, battery-operated single station smoke alarms in accordance with the manufacturer's recommendations in resident sleeping rooms and common areas.

(ii) Have a program for inspection, testing, maintenance, and battery replacement that conforms to the manufacturer's recommendations and that verifies correct operation of the smoke alarms.

(iii) Exception:

(A) The facility has system-based smoke detectors in patient rooms and common areas that are installed, tested, and maintained in accordance with NFPA 72, *National Fire Alarm Code*, for system-based smoke detectors; or

(B) The facility is fully sprinklered in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems*.

(8) A long term care facility must:

(i) Install an approved, supervised automatic sprinkler system in accordance with the 1999 edition of NFPA 13, *Standard for the Installation of Sprinkler Systems*, as incorporated by reference, throughout the building by August 13, 2013. The Director of the Office of the Federal Register has approved the NFPA 13 1999 edition of the *Standard for the Installation of Sprinkler Systems*, issued July 22, 1999 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:

http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.

(ii) Test, inspect, and maintain an approved, supervised automatic sprinkler system in accordance with the 1998 edition of NFPA 25, *Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems*, as incorporated by reference. The Director of the Office of the Federal Register has approved the NFPA 25, *Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems*, 1998 edition, issued January 16, 1998 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:

http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.

(b) *Emergency power.*

(1) An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted.

(2) When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, *Health Care Facilities*) that is located on the premises.

(c) *Space and equipment.* The facility must—

(1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and

(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

(d) *Resident rooms.* Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents.

(1) Bedrooms must—

(i) Accommodate no more than four residents;

(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms;

(iii) Have direct access to an exit corridor;

(iv) Be designed or equipped to assure full visual privacy for each resident;

(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains;

(vi) Have at least one window to the outside; and

(vii) Have a floor at or above grade level.

(2) The facility must provide each resident with—

(i) A separate bed of proper size and height for the convenience of the resident;

(ii) A clean, comfortable mattress;

(iii) Bedding appropriate to the weather and climate; and

(iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations—

(i) Are in accordance with the special needs of the residents; and

(ii) Will not adversely affect residents' health and safety.

(e) *Toilet facilities.* Each resident room must be equipped with or located near toilet and bathing facilities.

(f) *Resident call system.* The nurse's station must be equipped to receive resident calls through a communication system from—

- (1) Resident rooms; and
- (2) Toilet and bathing facilities.

(g) *Dining and resident activities.* The facility must provide one or more rooms designated for resident dining and activities. These rooms must—

- (1) Be well lighted;
- (2) Be well ventilated, with nonsmoking areas identified;
- (3) Be adequately furnished; and
- (4) Have sufficient space to accommodate all activities.

(h) *Other environmental conditions.* The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must—

- (1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;
- (2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;
- (3) Equip corridors with firmly secured handrails on each side; and
- (4) Maintain an effective pest control program so that the facility is free of pests and rodents.

[56 FR 48876, Sept. 26, 1991, as amended at 57 FR 43925, Sept. 23, 1992; 68 FR 1386, Jan. 10, 2003; 69 FR 49268, Aug. 11, 2004; 70 FR 15238, Mar. 25, 2005; 71 FR 55340, Sept. 22, 2006; 73 FR 47091, Aug. 13, 2008]

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THIS PAGE TO BE SUBSTITUTED WITH PROPOSED REGULATIONS

APPENDIX B

HEALTH ALERT NETWORK (HAN)

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HAN Assets: Ordering for Drills and Exercises

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)

RETURNING USER:

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 HAN ASSETS ORDER:

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

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

In the event of an emergency, use these steps to order needed supplies and equipment. Instead of ordering the 'Test Product', the user would login and order the item(s) needed by adding all items to the cart before checking out and submitting the order.

If placing a real event order, you will receive a call from the Emergency Preparedness and Response staff within 30 minutes of order placement. If you do not receive this confirmation call, please contact the Emergency Preparedness and Response Case Manager at 701.328.2270. If the 'Test Product' is ordered for a drill or exercise, no phone call will be received.

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HAN INTERNAL CALLOWDOWN

INSTRUCTIONS FOR REQUESTING FREE STAFF CALLOWDOWN

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. Do not list cell phone numbers with a ring back tone/holding music, as this will cause the HAN message to play before the recipient actually answers the phone.

REQUESTING A CALLOWDOWN

The process for requesting a HAN message for your facility is the same for both exercises and real events.

1. Call **701-328-2270** and ask for the Case Manager, if it is after hours or the weekend Press "2" when you hear the recording. Pressing "2" will transfer your call and you'll ask for the Department of Health Case Manager to be paged.
2. The Case Manager will return your call.
 - a. Inform them that you are requesting a HAN internal alert.
 - b. **Remember to specify whether this is an exercise or real event.**




STAFF RECEIVING INTERNAL ALERT

1. There may or may not be an opening message before the alert
2. The recipient will be required to Press "1", which will notify the facility of staff who confirmed the message

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HC Standard: Reporting Bed Availability

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.

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APPENDIX C

MEMORANDUM OF AGREEMENT (MOA)

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Memorandum of Agreement
North Dakota Nursing Facilities
Payment Guidelines for Resident Care Following Evacuation

Purpose

This Memorandum of Agreement (MOA) is a voluntary agreement among North Dakota Nursing Facilities accepting the payment/billing methodologies to be used as either a Sending facility or a Receiving facility when evacuation of residents is caused by a disaster or other critical situation as set forth in this agreement. The North Dakota Long Term Care Association (NDLTCA) will advise each facility executing this Agreement of the identity of other facilities that have executed this Agreement.

Not a Legally Binding Contract

This Agreement is not a legal binding contract. Nothing in this Agreement is intended to create any legal relationship among the organization other than that of independent entities agreeing with each other solely for the purpose of assisting each other during a disaster or other critical situation.

Intent of MOA

By signing this Agreement, a nursing facility is indicating its intent to abide by the recommended payment methodology outlined in this Agreement in the event of evacuations of residents due to a disaster or other critical situation. This Agreement will cover Medicare, Medicaid and private pay billing during a disaster or other critical situation.

Payment of Resident Care and Services After Short-Term Evacuation

- A Sending facility will continue to receive Medicare, Medicaid or private pay income on behalf of resident originally residing in its facility prior to evacuation, during an evacuation period of 30 days or less.
- A Sending facility will continue to bill Medicare, Medicaid or private pay during the evacuation period.
- A Receiving facility will bill the Sending facility for the care of resident provided during the evacuation period.
- A Receiving facility will bill per day according to the following methodology:
 - Receiving facility's Direct Care rate at the resident's classification for Medicaid or private pay resident OR the adjusted Labor portion of the Medicare classification rate for a resident who was in a Medicare benefit period prior to evacuation; plus
 - Receiving facility's Other Direct Care rate; plus
 - 50% of Receiving facility's Indirect Care rate
- A Receiving facility will be paid on a per day basis by a Sending facility. Day is defined as a 24-hour period, or any part thereof beginning at 12:00 a.m. and ending at 11:59 p.m. Receiving facility will be paid for both admission and discharge to Sending facility days for a visiting resident.
- A Sending facility will provide reimbursement within 30 days following receipt of an invoice from a Receiving facility. Payment to the Receiving facility may not be contingent upon collection of monies owed to the Sending facility by Medicare, Medicaid (including recipient liability) or private pay.
- Cost of staff or supplies provided by a Sending facility are the responsibility of the Sending facility and may not be billed to the Receiving facility.
- Receiving and Sending facilities may negotiate additional amounts for extraordinary circumstances related to a specific resident.

- Receiving and Sending facilities may negotiate payment when Sending facility rents and staffs space at Receiving facility.

Payment for Resident Care and Services After a Long Term Evacuation:

If it is determined the Sending facility will not re-open within 30 days from date first resident was evacuated and the Medicaid agency has not obtained a waiver allowing for payment to be made to both Sending and Receiving facility, resident will be discharged from the Sending facility and admitted as a resident in the Receiving facility and regular payment processes will apply (they will be treated as any other admission).

Payment for Residents transferred to Swing Bed Facilities during a Short Term Evacuation

- Sending facility will pay the Medicaid swing bed rate in effect on the date of service to the swing bed for any resident who is transferred to a swing bed facility.
- Sending facility will continue to bill Medicare, Medicaid and private pay during the disaster.
- Swing bed and Sending facility may negotiate additional amounts for extraordinary circumstances related to a specific resident.

Effective Date

The term of this Agreement shall exist for an indefinite period of time for any disaster declared or other critical situation occurring in North Dakota. Any party may terminate its participation in this Agreement by providing written notice to the President of NDLTCA.

Name of Nursing Facility _____ Date _____

Signature _____ Title _____

Printed Name _____



MEMORANDUM OF AGREEMENT
NORTH DAKOTA DEPARTMENT OF HEALTH
DEPARTMENT OPERATIONS CENTER
DECLARED EMERGENCY
 SFN 60139 (3/2012)

North Dakota Department of Health
 Emergency Preparedness & Response Section
 1720 Burlington Drive
 Bismarck, ND 58504-7707

Type: Vulnerable Population/Transportation - LTC			Term of Agreement: July 1, 2017 through June 30, 2019		
Facility Name:			NDDoH Contact Name: Tim Wiedrich, Section Chief		
Address:			Address: 1720 Burlington Drive		
City:	State: ND	Zip Code:	City: Bismarck	State: ND	Zip Code: 58504-7707
Contact Name:		Telephone Number:	Telephone Number: 701.326.2270		
<p>Purpose: Please initial beside each provision willing to participate in:</p> <p>Facility, upon receiving an emergency response activation notice from the North Dakota Department of Health, Department Operations Center (NDDoH-DOC), agrees to provide care to vulnerable citizens without a third party payment source who are displaced or injured due to the emergency event as facility resources allow. All services must be pre-approved by the NDDoH-DOC to be covered by this agreement. Facility will provide care at rates per Attachment A.</p> <p>Facility, upon receiving an emergency response activation notice from the 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 the NDDoH-DOC at the time of deployment and remain under the direction of the NDDoH-DOC or designee until completion of the authorized transportation trips/missions. Facility will provide available vehicle information as requested on Attachment A. Facility will be reimbursed at rates per Attachment A.</p> <p>Facility shall participate in the NDDoH-DOC patient tracking system and maintain records regarding eligibility criteria on NDDoH-DOC provided forms and agrees to seek third party reimbursement for patient/resident care provided.</p>					
<p>Special Conditions: Pursuant to issued emergency declaration and agreement between 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 actual delivery of services. Requests for reimbursement will be submitted on the appropriate Department of Health forms which will be provided at the time that the service is provided. 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.</p>					
<p>Terms and Conditions:</p> <ul style="list-style-type: none"> • Term of Agreement: This agreement shall be effective beginning with the date a declaration of emergency is made by the Governor of North Dakota or with approval of the NDDoH-SEOC and terminating at the conclusion of the emergency. Multiple declarations or activations may occur within the agreement period. • Applicable Law: The laws of the State of North Dakota shall govern this agreement. • 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. • Sovereignty: 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. • 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. • 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. • Renewal: This agreement will not automatically renew. <p>The State assumes no liability for the other party's actions except where liability is based on following an express direction from the State.</p>					
<p>This memorandum of agreement is not effective and expenditures related to this agreement should not be incurred until all parties have signed this document, an emergency declaration has been issued and the NDDoH-DOC has activated the Facility.</p>					
Evidence of Facility Acceptance			Evidence of NDDoH-DOC Acceptance		
Signature		Date	Signature		Date
Typed Name and Title of Authorized Representative			Typed Name and Title of Authorized Representative Tim Wiedrich, Section Chief, EPR Section Department Operations Center Incident Commander		
Signature		Date	Signature		Date
Typed Name and Title of Authorized Representative			Typed Name and Title of Authorized Representative Amy Smith, Deputy State Health Officer Department Operations Center Incident Commander		

Attachment A:

Fee Schedule for Provision of Care

Swing bed/sub-acute care, critical access hospital, acute care hospital/ PPS and nursing facilities will be reimbursed at the statewide average Medicaid skilled nursing facility rate at \$260 per day. Assisted living facilities and basic care will be reimbursed at \$185 per day.

Multi-Facility or Multi-Community

Organizations that are operated or have the same management can sign one Memorandum of Agreement to cover all of the organization locations. List all the facilities managed under this signed Memorandum of Agreement.

Facility Name	Address

Fee Schedule

Rates are intended to cover hours on duty, meals, and lodging. No additional reimbursement for expenses will be covered in this agreement. Vehicle information must be cumulative and inclusive of all facilities listed above.

Driver	\$20.00 per hour
Certified Nurse Assistant Attendant	\$19.00 per hour
LPN Attendant	\$28.50 per hour
RN Attendant	\$40.50 per hour

Vehicle Information

Vehicle mileage will be reimbursed at \$.81/mile.

Vehicle Type	Number of Vehicles	Seats per Vehicle	Wheel Chair Capacity per Vehicle	Stretcher Capacity per Vehicle
Shuttle Bus with Wheel Chair Lift				
Shuttle Bus without Wheel Chair Lift				
Van with Wheel Chair Lift				
Full Size Passenger Van				
Passenger Mini Van				
Passenger Car/SUV				

NOTE: Attachment A must be completed and returned with the signed Memorandum of Agreement.

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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 *Exercise Record*

Annually LTC facilities will need to:

- Participate in a community-based or facility-based emergency exercise
- Conduct a paper-based, tabletop exercise
- All exercises must be documented

EXERCISE RECORD

EMERGENCY PROTOCOL: _____

DATE: _____ DATE OF LAST INCIDENT/EXERCISE: _____

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

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 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

Administrator signature: _____

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THIS PAGE TO BE SUBSTITUTED WITH FACILITY BLUEPRINT

THIS PAGE TO BE SUBSTITUTED WITH EVACUATION ROUTE

THIS PAGE TO BE SUBSTITUTED WITH EVACUATION BAG LIST

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 and NHICS job action sheets 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 NHICS 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"/>	
Secure non-patient records	<input type="checkbox"/>	
Ensure appropriate staff are available to provide bedside treatments	<input type="checkbox"/>	
	<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 patient 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

NURSING HOME INCIDENT COMMAND SYSTEM (NHICS)

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NHICS FORM 203 ORGANIZATION ASSIGNMENT LIST

1. INCIDENT NAME:		2. FACILITY NAME:			
3. DATE PREPARED:		4. TIME PREPARED:		5. OPERATIONAL PERIOD:	
6. POSITION	NAME / AGENCY				
INCIDENT COMMANDER AND STAFF:					
INCIDENT COMMANDER					
PUBLIC INFORMATION OFFICER					
LIAISON OFFICER					
SAFETY OFFICER					
MEDICAL DIRECTOR/SPECIALIST					
MEDICAL/TECHNICAL SPECIALIST					
OPERATIONS SECTION:					
CHIEF					
RESIDENT SERVICES BRANCH					
NURSING UNIT					
PSYCHOSOCIAL UNIT					
ADMIT/TRANSFER & DISCHARGE UNIT					
INFRASTRUCTURE BRANCH					
DIETARY UNIT					
ENVIRONMENTAL UNIT					
PHYSICAL PLANT/SECURITY UNIT					

POSITION	NAME / AGENCY
PLANNING SECTION:	
CHIEF	
SITUATION BRANCH	
DOCUMENTATION BRANCH	
LOGISTICS SECTION:	
CHIEF	
SERVICE BRANCH	
COMMUNICATION/HARDWARE UNIT	
IT/IS UNIT	
SUPPORT BRANCH	
SUPPLY UNIT	
STAFFING/SCHEDULING UNIT	
TRANSPORTATION UNIT	
7. AGENCY REPRESENTATIVE (IN NURSING HOME COMMAND CENTER)	
AGENCY:	NAME:
8. AGENCY REPRESENTATIVE (IN NURSING HOME COMMAND CENTER)	
EXTERNAL LOCATION:	NAME:
9. PREPARED BY (DOCUMENTATION UNIT LEADER):	

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ICS JOB ACTION SHEET
CUSTOMIZE AS NEEDED TO YOUR FACILITY

INCIDENT COMMANDER

Position Assigned To: _____

Reporting To: _____

Emergency Operations Center in Facility: _____

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

IMMEDIATE TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Assume role of Incident Commander and activate the Nursing Home Incident Command System (NHICS). Notify your usual supervisor of the incident activation of NHICS.	<input type="checkbox"/>	
Determine 1. Nature of the problem (incident type, injury/illness type, etc.) 2. Safety of staff, residents and visitors 3. Risks to personnel and need for protective equipment 4. Risks to the facility 5. Need for decontamination 6. Estimated duration of incident 7. Need for modifying daily operations 8. NHICS team required to manage the incident 9. Need to open up the facility's Emergency Operations Center 10. Overall community response actions being taken 11. Need to communicate with state licensing agency	<input type="checkbox"/>	
Determine need for and appropriately appoint Command Staff and Section Chiefs, or Branch/Unit/Team leaders as needed; distribute corresponding Job Action Sheets and position identification.	<input type="checkbox"/>	
Brief all appointed staff of the nature of the problem, immediate critical issues and initial plan of action. Designate time for next briefing.	<input type="checkbox"/>	
Communicate to Command Staff and Section Chiefs how personnel time is to be recorded. Determine if Finance/Administration has any special preferences for submission at this time.	<input type="checkbox"/>	
Define and document specific existing or potential safety risks and hazards, which Section or Branch may be affected, and steps to mitigate the threat. This is the first step in an ongoing process continued by the Safety Officer and included in the subsequent briefing meetings.	<input type="checkbox"/>	
Receive status reports from and develop an Incident Action Plan with Section Chiefs and Command Staff to determine appropriate response and recovery levels. During initial briefing/status reports, the following information may be needed: • Initial facility damage survey report across sections. • Evaluate the need for evacuation. As appropriate to the incident, verify	<input type="checkbox"/> <input type="checkbox"/>	

ICS JOB ACTION SHEET
CUSTOMIZE AS NEEDED TO YOUR FACILITY

LIAISON OFFICER

Position Assigned To: _____

Reporting To: _____

Emergency Operations Center in Facility: _____

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

IMMEDIATE TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Receive appointment from Incident Commander. Obtain Job Action Sheet	<input type="checkbox"/>	
Notify your usual supervisor of your NHICS assignment	<input type="checkbox"/>	
Obtain briefing and note time for next meeting	<input type="checkbox"/>	
Establish contact with local, county and/or state emergency organization agencies to share information on current status, appropriate contacts, and message routing	<input type="checkbox"/>	
Communicate information obtained and coordinate with Public Information Officer	<input type="checkbox"/>	
Obtain initial status and information from the Planning Section Chief to provide as appropriate to external stakeholders and local and/or county Emergency Operations Center (EOC), upon request: <ul style="list-style-type: none"> • Resident Care Capacity – The number of residents that can be received and current census. • Nursing Home’s Overall Status – Current condition of facility structure, security, and utilities. • Any current or anticipated shortage of critical resources including personnel, equipment, supplies, medications, etc. • Number of residents and mode of transportation for residents requiring transfer to hospitals or receiving facilities, if applicable. • Any resources that are requested by other facilities (e.g., personnel, equipment, supplies). • Media relations efforts being initiated, in conjunction with the PIO. 	<input type="checkbox"/>	
Establish communication with other nursing homes as appropriate, the local EOC, and/or local response agencies (e.g., public health department). Report current facility status.	<input type="checkbox"/>	
Keep local EOC liaison officer updated as to critical issues and unmet resource needs	<input type="checkbox"/>	
Document all key activities, actions, and decisions on a continual basis	<input type="checkbox"/>	

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ICS JOB ACTION SHEET
CUSTOMIZE AS NEEDED TO YOUR FACILITY

PUBLIC INFORMATION OFFICER

Position Assigned To: _____

Reporting To: _____

Emergency Operations Center in Facility: _____

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

IMMEDIATE TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Receive appointment from Incident Commander. Obtain Job Action Sheet	<input type="checkbox"/>	
Notify your usual supervisor of your NHICS assignment	<input type="checkbox"/>	
Obtain briefing and note time for next meeting	<input type="checkbox"/>	
Decide where a media briefing area might be located if needed. Coordinate designation of such areas with Safety Officer	<input type="checkbox"/>	
Contact external Public Information Officers from community and governmental agencies and/or their designated websites to determine public information and media messages developed by those entities to ensure consistent messages from all entities	<input type="checkbox"/>	
Develop public information and media messages to be reviewed and approved by the Incident Commander before release to families, news media, and the public. Identify appropriate spokespersons to contact families or to deliver press briefings as needed	<input type="checkbox"/>	
Assess the need to activate a staff and/or family member "hotline" for recorded information concerning the incident and facility status and establish the "hotline" if needed	<input type="checkbox"/>	
Attend all command briefings and incident action planning meetings to gather and share incident and nursing home information	<input type="checkbox"/>	
Monitor incident/response information though the internet, radio, and television	<input type="checkbox"/>	
Establish communication with other nursing homes appropriate, local Emergency Operations Center, and /or local response agencies (e.g., public health department). Report current facility status	<input type="checkbox"/>	
Document all key activities, actions, and decisions on a continual basis	<input type="checkbox"/>	

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ICS JOB ACTION SHEET
CUSTOMIZE AS NEEDED TO YOUR FACILITY

SAFETY OFFICER

Position Assigned To: _____

Reporting To: _____

Emergency Operations Center in Facility: _____

Mission: Ensure safety of staff, residents, and visitors, monitor and correct hazardous conditions. Have authority to halt any operation that poses immediate threat to life and health.

IMMEDIATE TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Receive appointment from Incident Commander. Obtain Job Action Sheet	<input type="checkbox"/>	
Notify your usual supervisor of your NHICS assignment	<input type="checkbox"/>	
Obtain briefing and note time for next meeting	<input type="checkbox"/>	
Determine safety risks of the incident to personnel, the physical plant, and the environment. Advise the Incident Commander and Section Chiefs of any unsafe condition and corrective recommendations	<input type="checkbox"/>	
Communicate with the Logistics Chief to procure and post non-entry signs around unsafe areas	<input type="checkbox"/>	
Ensure the following activities are initiated as indicated by the incident/situation: <ul style="list-style-type: none"> • Evaluate building or incident hazards and identify vulnerabilities • Specify type and level of PPE to be utilized by staff to ensure their protection, based upon the incident or hazardous condition • Monitor operational safety of decontamination operations if needed • Contact and coordinate safety efforts with Operations, identify and report all hazards and unsafe conditions to the Operations Section Chief 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Work with ICS staff in designating restricted access areas and providing signage	<input type="checkbox"/>	
Assess nursing home operations and practices to staff, and terminate and report any unsafe operation or practice, recommending corrective actions to ensure safe service delivery	<input type="checkbox"/>	
Ensure implementation of all safety practices and procedures in the facility	<input type="checkbox"/>	
Initiate environmental monitoring as indicated by the incident or hazardous condition	<input type="checkbox"/>	
Attend all command briefings and Incident Action Planning meetings to gather and share incident and facility safety requirements	<input type="checkbox"/>	
Document all key activities, actions, and decisions on a continual basis		

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ICS JOB ACTION SHEET
CUSTOMIZE AS NEEDED TO YOUR FACILITY

OPERATIONS

Position Assigned To: _____

Reporting To: _____

Emergency Operations Center in Facility: _____

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

IMMEDIATE TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Receive appointment from Incident Commander. Obtain Job Action Sheet	<input type="checkbox"/>	
Notify your usual supervisor of your NHICS assignment	<input type="checkbox"/>	
Obtain briefing and note time for next meeting	<input type="checkbox"/>	
Assess need to appoint Branch Directors: <ul style="list-style-type: none"> • Resident Services • Infrastructure 	<input type="checkbox"/>	
Transfer the corresponding Job Action Sheets to Branch Director. If a Branch Director is not assigned, the Planning Chief keeps the Job Action Sheet and assumes that function	<input type="checkbox"/>	
Brief Branch Directors on current situation and develop the section's initial projection/status report. Establish the Operations Section chain of command and designate time and location for next section briefing. Share resident census and condition information gained at initial Command briefing. Communicate how personnel time is to be recorded	<input type="checkbox"/>	
Establish Operations Section Center (in proximity to Incident Command area, if possible)	<input type="checkbox"/>	
Serve as primary contact with nursing home Medical Director: <ul style="list-style-type: none"> • Meet with Resident Services Branch Director and Nursing Services Unit Leader and communicate with Medical Director to plan and project resident care needs 	<input type="checkbox"/>	
Document all key activities, actions, and decisions on a continual basis	<input type="checkbox"/>	

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ICS JOB ACTION SHEET
CUSTOMIZE AS NEEDED TO YOUR FACILITY

PLANNING

Position Assigned To: _____

Reporting To: _____

Emergency Operations Center in Facility: _____

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

IMMEDIATE TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Receive appointment from Incident Commander. Obtain Job Action Sheet	<input type="checkbox"/>	
Notify your usual supervisor of your NHICS assignment	<input type="checkbox"/>	
Obtain briefing and note time for next meeting	<input type="checkbox"/>	
Assess need for the following Unit Leaders and appoint as needed: <ul style="list-style-type: none"> • Situation Status • Documentation 	<input type="checkbox"/>	
Transfer the corresponding Job Action Sheets to Unit Leader. If a unit leader is not assigned, the Planning Chief keeps the Job Action Sheet and assumes that function	<input type="checkbox"/>	
Brief all unit leaders on current situation and develop the section's initial projection/status report. Designate time and location for next section briefing. Communicate how personnel time is to be recorded	<input type="checkbox"/>	
Establish a Planning/Information Section Center	<input type="checkbox"/>	
Facilitate and conduct incident action planning meetings with Command Staff, Section Chiefs, and other key personnel as needed to plan for the next operational period	<input type="checkbox"/>	
Coordinate preparation and documentation of the Incident Action Plan and distribute copies to the Incident Commander and all Section Chiefs	<input type="checkbox"/>	
Call for status and resource projection reports from all Section Chiefs for scenarios 4, 8, 24 & 48 hours from time of incident onset. Adjust time for receiving these reports as necessary	<input type="checkbox"/>	
Direct Situation Unit Leader to document and update projection/status reports from all sections	<input type="checkbox"/>	
Document all key activities, actions, and decisions on a continual basis	<input type="checkbox"/>	

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ICS JOB ACTION SHEET
CUSTOMIZE AS NEEDED TO YOUR FACILITY

LOGISTICS

Position Assigned To: _____

Reporting To: _____

Emergency Operations Center in Facility: _____

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

IMMEDIATE TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Receive appointment from Incident Commander. Obtain Job Action Sheet	<input type="checkbox"/>	
Notify your usual supervisor of your NHICS assignment	<input type="checkbox"/>	
Obtain briefing and note time for next meeting	<input type="checkbox"/>	
Assess need to appoint Branch Directors and/or Unit Leaders and distribute corresponding Job Action Sheets. Refer to Nursing Home Incident Command System organizational chart. Transfer the corresponding Job Action Sheets to persons appointed. <ul style="list-style-type: none"> • If a function is not assigned, the Logistics Chief keeps the Job Action Sheet and assumes that function 	<input type="checkbox"/>	
Brief Branch Directors on current situation and develop the section's initial project/status report. Establish the Logistics Section chain of command and designate time and location for next section briefing. Communicate how personnel time is to be recorded.	<input type="checkbox"/>	
Establish Logistics Center	<input type="checkbox"/>	
Maintain communications with Operations Section Chief and Branch Directors to assess critical issues and resource needs	<input type="checkbox"/>	
Ensure resource ordering procedures are communicated to appropriate Sections and their requests are timely and accurately processed	<input type="checkbox"/>	
Attend damage assessment meeting with Incident Commander, Environmental Services Unit Leader, and the Safety Officer	<input type="checkbox"/>	
Document all key activities, actions, and decisions on a continual basis	<input type="checkbox"/>	

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ICS JOB ACTION SHEET
CUSTOMIZE AS NEEDED TO YOUR FACILITY

FINANCE/ADMINISTRATION

Position Assigned To: _____

Reporting To: _____

Emergency Operations Center in Facility: _____

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

IMMEDIATE TASKS	COMPLETED <input checked="" type="checkbox"/>	INITIALS
Receive appointment from Incident Commander. Obtain Job Action Sheet	<input type="checkbox"/>	
Notify your usual supervisor of your NHICS assignment	<input type="checkbox"/>	
Obtain briefing and note time for next meeting	<input type="checkbox"/>	
Assess need for the following Unit Leaders and appoint as needed: <ul style="list-style-type: none"> • Procurement • Cost • Employee Time • Compensation / Claims • Business Continuity 	<input type="checkbox"/>	
Transfer the corresponding Job Action Sheets to Unit Leaders. If a unit leader is not assigned, the Finance/Admin Chief keeps the Job Action Sheet and assumes that function	<input type="checkbox"/>	
Brief unit leaders on current situation and develop the section's initial projection/status report. Designate time for next section briefing. Communicate how personnel time to be recorded	<input type="checkbox"/>	
Discuss with Employee Time Unit Leader how to document facility-wide personnel work hours worked relevant to the emergency	<input type="checkbox"/>	
Assess the need to obtain cash reserves in the event access to cash is likely to be restricted as an outcome of the emergency incident	<input type="checkbox"/>	
Participate in Incident Action Plan preparation, briefings, and meetings as needed: <ul style="list-style-type: none"> • Provide cost implications of incident objectives • Ensure Incident Action Plan is within financial limits established by Incident Command • Determine if any special contractual arrangements/agreements are needed 	<input type="checkbox"/>	
Identify and document insurance company requirements for submitting damage/claim reports	<input type="checkbox"/>	
Document all key activities, actions, and decisions on a continual basis	<input type="checkbox"/>	

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APPENDIX H

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 utilizing the Incident Command System and 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 (sub-acute, dementia, psych, isolation, 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.
- Establish a process for constant monitoring of surge areas.

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THIS PAGE TO BE SUBSTITUTED WITH NDDoH GENERAL REQUIREMENTS...ACCEPTING

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 patients. 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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