Allied Healthcare Facilities Work Group

Emergency Preparedness and Planning Toolkit for Long-Term Care Providers
Disclaimer: The information contained in this toolkit binder is intended to serve as a guide and resource for the enhancement and/or development of a comprehensive emergency operations plan based on current guidelines, planning considerations and recommended best practices. Providers may use or adapt from any of the information provided in this binder.
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Emergency Information

Cell Phone Emergency Number to 9-1-1

<table>
<thead>
<tr>
<th>Location</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campbell</td>
<td>408 378-8161</td>
</tr>
<tr>
<td>Cupertino</td>
<td>408 299-3233</td>
</tr>
<tr>
<td>Gilroy</td>
<td>408 842-0191</td>
</tr>
<tr>
<td>Los Altos</td>
<td>650 947-2779</td>
</tr>
<tr>
<td>Los Altos Hills</td>
<td>408 299-3233</td>
</tr>
<tr>
<td>Los Gatos</td>
<td>408 354-8600</td>
</tr>
<tr>
<td>Milpitas</td>
<td>408 263-1212</td>
</tr>
<tr>
<td>Monte Sereno</td>
<td>408 354-8600</td>
</tr>
<tr>
<td>Morgan Hill</td>
<td>408 779-2101</td>
</tr>
<tr>
<td>Mt. View</td>
<td>650 968-1662</td>
</tr>
<tr>
<td>Palo Alto</td>
<td>650 470-1258</td>
</tr>
<tr>
<td>San Jose</td>
<td>408 277-8911</td>
</tr>
<tr>
<td>San Martin</td>
<td>408 299-3233</td>
</tr>
<tr>
<td>Santa Clara</td>
<td>408 296-2236</td>
</tr>
<tr>
<td>Saratoga</td>
<td>408 299-3233</td>
</tr>
<tr>
<td>Sunnyvale</td>
<td>408 736-6244</td>
</tr>
<tr>
<td>Unincorporated</td>
<td>408 299-3233</td>
</tr>
</tbody>
</table>

Websites & Information Services

Emergency Digital Information System:
Notifications to your email
www.edis-by-email.net/Welcome.do

National Oceanic & Atmospheric Admin:
Real time hazards information
www.noaa.gov/

Pacific Gas & Electric:
www.pge.com

Santa Clara Valley Water District:
Real time hazards information
www.valleywater.org

United States Geological Survey:
Real time hazards information
www.usgs.gov

Volunteer Center of Silicon Valley:
Disaster Staffing
www.vcsv.us

2-1-1: Information & Referral
www.211scc.org

Emergency Radio Stations

Countywide
KCBS 740 AM & 106.9 FM, KGO 810 AM, KSJO 92.3 FM, KLIV 1590 AM

City Specific
Cupertino 1670 AM
Gilroy 1610 AM
Saratoga 1610 AM
Sunnyvale 530 AM
Milpitas 1620 AM
Morgan Hill 1610 AM

12/06/08
## EMERGENCY PLANNING CHECKLIST

**RECOMMENDED TOOL FOR PERSONS IN LONG-TERM CARE FACILITIES & THEIR FAMILY MEMBERS, FRIENDS, PERSONAL CAREGIVERS, GUARDIANS & LONG-TERM CARE OMBUDSMEN**

**Part I:** For Long-Term Care Residents, Their Family Members, Friends, Personal Caregivers, & Guardians

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Date Completed</th>
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- **Emergency Plan:** Prior to any emergency, ask about and become familiar with the facility’s emergency plan, including:
  - Location of emergency exits
  - How alarm system works and modifications for individuals who are hearing and/or visually impaired
  - Plans for evacuation, including:
    - How residents/visitors requiring assistance will be evacuated, if necessary
    - How the facility will ensure each resident can be identified during evacuation (e.g., attach identification information to each resident prior to evacuation)
    - Facility’s evacuation strategy
    - Where they will go
    - How their medical charts will be transferred
    - How families will be notified of evacuation
  - Will families be able to bring their loved one home rather than evacuating, which is often less traumatic than a move to a new facility?
  - How family members can keep the facility apprised of their location and contact information (e.g., address, phone number, e-mail address), so the facility will be able to contact them, and family members will be able to check with the facility to meet their loved one following an emergency
  - How residents and the medicines and supplies they require will be prepared for the emergency, have their possessions protected and be kept informed during and following the emergency
  - How residents (if able) and family members can be helpful (for example, should family members come to the facility to assist?)
  - How residents, who are able, may be involved during the emergency, including their roles and responsibilities. **Note:** It is important for staff to know each resident personally, and whether involving him/her in the emergency plan will increase a sense of security or cause anxiety. For example, residents may have prior work or personal experience that could be of value (health care, emergency services, military, amateur ham radio operators, etc.). Provide the opportunity for residents to discuss any fears and what actions may help to relieve their anxiety (e.g., a flashlight on the bed, water beside the bed, etc.).

**Note:** Some of the recommended tasks may exceed the long-term care facility’s Federal regulatory requirements.
Helping Residents in a Relocation: Suggested principles of care for relocated residents include:

- Encourage the resident to talk about expectations, anger, and/or disappointment
- Work to develop a level of trust
- Present an optimistic, favorable attitude about the relocation
- Anticipate that anxiety will occur
- Do not argue with the resident
- Do not give orders
- Do not take the resident’s behavior personally
- Use praise liberally
- Be courteous and kind
- Include the resident in assessing problems
- Encourage family participation
- Ensure staff in the receiving facility introduce themselves to residents

Part II: For Long-Term Care Ombudsmen

- State Ombudsman Responsibilities:
  - Become generally familiar with state emergency plans pertinent to long-term care facilities, including the state or federal agency that may be established to serve as a clearinghouse for facility evacuations: know the name, telephone number and e-mail of the person to whom long-term care facility evacuations and evacuees’ names should be reported. If no clearinghouse has been established, advocate for one.
  - At least annually, ensure that all regional ombudsman coordinators and local ombudsmen and/or representatives read, are familiar with and have the opportunity to discuss resources, such as the two recommended CMS emergency preparedness checklists pertaining to long-term care facilities: the CMS Emergency Preparedness Checklist – Recommended Tool for Effective Health Care Facility Planning and this CMS Emergency Planning Checklist – Recommended Tool for Persons Living In Long-Term Care Facilities, Their Family Members, Friends, Personal Caregivers, Guardians, & Long-Term Care Ombudsmen.
  - Maintain at home and office hard copies of current regional ombudsman contact information, including cell phones.
  - Prior to an anticipated disaster, if the state ombudsman program has regional coordinators and/or other program representatives in the areas likely to be affected, call them to make sure they have assigned representatives to carry out the responsibilities listed in the section below pertaining to local ombudsman programs.
  - Immediately following a disaster, contact regional ombudsman coordinators/representatives in the affected areas to provide support and

Note: Some of the recommended tasks may exceed the long-term care facility’s Federal regulatory requirements.
### Regional Ombudsman Coordinator & Representative Responsibilities (for states with regional/local ombudsman programs and/or representatives)

#### Prior to any emergency, ombudsmen:
- Become generally familiar with the local emergency plans and the roles of local, county and state agencies in a disaster, especially as pertaining to long-term care facilities.
- Read and become familiar with emergency plans of facilities in the region for which the regional program has responsibility. If a state or regional clearing house for evacuations has been established, know the agency, phone number and e-mail where facility evacuations will be reported.
- Maintain, at home and office, hard copies of current contact information for facilities, other ombudsmen and appropriate agencies, especially the local emergency management agency.

#### Prior to an anticipated emergency and following an emergency:
- The regional ombudsman program coordinator assigns a representative to check on each facility covered by the program and reviews the responsibilities listed below with representatives assigned to facilities.
- Assigned representatives check on assigned facilities to assure that residents’ rights are protected prior to, during and after evacuation and provide information about conditions and any evacuation to the regional ombudsman coordinator; regional coordinator provides information to the state ombudsman office. **Exception:** when the ombudsman lives in an area under mandatory evacuation; however, if possible, the ombudsman should contact the facility by telephone, even if the area is under evacuation order. (Some states may have other specific procedures in place which ombudsman representatives would be required to follow.)
- Ombudsman representatives visit residents as soon as possible after the disaster, whether they have been sheltered in the facility or transferred to another location. (If they have been transferred out of the region, state ombudsman and regional coordinators coordinate visitation by ombudsman representatives in the receiving region.)
  - Discuss and record their immediate status/needs. If the state and local ombudsman coordinator decide a form is needed, use appropriate form to record information (a sample form is attached) and send a copy of the form to whomever they specify.
  - Take urgent action to help obtain the resources and assistance residents need to be safe and, if they have been evacuated, find their loved ones and relocate to an area/facility or other setting of their preference. **(Note:** the ombudsman is not responsible for providing resources but instead should be aware of available resources and work to ensure they are provided to residents.)
- Track, if possible, the impact of the disaster on the residents
- Determine whether the facility has reported the names and destination of any evacuated residents to the clearinghouse (if state or region has

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**Note:** Some of the recommended tasks may exceed the long-term care facility's Federal regulatory requirements.
established a clearinghouse), and is prepared to handle transfer trauma and support facility staff in handling resident trauma. As provided in Part I, above, suggested principles of care for the relocated residents include:

- Encourage the resident to talk about expectations, anger, and/or disappointment
- Work to develop a level of trust
- Present an optimistic, favorable attitude about the relocation
- Anticipate that anxiety will occur
- Do not argue with the resident
- Do not give orders
- Do not take the resident’s behavior personally
- Use praise liberally
- Be courteous and kind
- Include the resident in assessing problems
- Encourage staff in the receiving facility to introduce themselves to residents
- Encourage family participation

✔ Counsel residents about their rights to:
  - Be informed regarding the status of the relocation
  - Be provided information on alternative living arrangements and the options available
  - Be assessed for eligibility for funding and supports to safely return to live in their home or community
  - Visit other facilities to help them better decide where to live
  - Seek representation by an ombudsman or other representative/advocate available in the area
  - Expect to receive adequate care and treatment services during the relocation
  - Meet with the facility staff to express any concerns
  - Seek a review of any relocation changes with which they disagree
  - Expect that their rights, while a resident of any facility, will not be violated

(Note: Adapted from WI Ombudsman Program brochure for residents of facilities scheduled for closure)
### OMBUDSMAN LONG-TERM CARE FACILITY

#### RESIDENT EVACUATION ASSESSMENT CHECKLIST

<table>
<thead>
<tr>
<th>Ombudsman Name:</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Resident Evacuee Information (see reverse)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region:</td>
<td></td>
<td></td>
<td></td>
<td>Previous Facility:</td>
</tr>
<tr>
<td>Additional ombudsman follow-up is necessary</td>
<td></td>
<td></td>
<td></td>
<td>City:</td>
</tr>
<tr>
<td>Assessment Date</td>
<td></td>
<td></td>
<td></td>
<td>County:</td>
</tr>
<tr>
<td>Current Facility:</td>
<td></td>
<td></td>
<td></td>
<td>City:</td>
</tr>
<tr>
<td>County:</td>
<td></td>
<td></td>
<td></td>
<td>County:</td>
</tr>
</tbody>
</table>

**Is the facility has power? If not, do the residents have a source of light (e.g., lamps on a generator or handheld flashlights)?**

**Comment:**

**Did the facility suffer any significant structural damage? Is so please indicate.**

**Comment:**

**Are high traffic areas, such as hallways, common areas, and doorways, clear of debris so residents may move freely throughout the facility?**

**Comment:**

**Did the facility receive evacuees from other facilities? If so, how long are the displaced residents scheduled stay at the new facility?**

**Comment:**

**Have residents and their representatives been consulted regarding their wishes for return or transfer to a different facility?**

**Comment:**

**Have plans been made to return or transfer residents elsewhere, according to the wishes of the displaced residents and their representatives?**

**Comment:**

**According to displaced residents, do they have their personal belongings (e.g., clothing, toiletries, mementos, etc.)?**

**Comment:**

**According to the displaced residents, is the facility geographically accessible to their family and friends? If not, what arrangements can be made to accommodate them?**

**Comment:**

**Is there an adequate source of food, ice, and water available to meet basic needs? If not, does the facility need these items to be delivered?**

**Comment:**

**Are vital medications available and administered per residents’ medical condition? If the medication is not available, are the residents’ conditions being monitored and documented?**

**Comment:**

**According to the residents, are there sufficient staff to provide adequate care and services to meet their needs?**

**Comment:**

**Is there anything additional the Long-Term Care Ombudsman Program can do to assist in other areas besides those outlined here?**

**Comment:**

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**Ask facility for a list of evacuees and their originating or destined facilities. Please forward this information to the district coordinator for additional follow-up.**

Staff interviewed: 

Position: 

See reverse for additional information: ➤

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*Note: This form has been adapted from the Florida Ombudsman Program*
### Resident Evacuee Information
- Number of residents evacuated:
- Number of residents transferred to this facility:
- In the space provided below, please indicate the names of residents who have been transferred/evacuated

<table>
<thead>
<tr>
<th>Residents Names</th>
<th>Residents Names</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### Any Resident(s) Concerns

### Evacuee or Transferred Residents Concerns

### Additional Information

*Note: This form has been adapted from the Florida Ombudsman Program*
EMERGENCY PREPAREDNESS CHECKLIST
RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING

<table>
<thead>
<tr>
<th>Tasks</th>
</tr>
</thead>
</table>
| • Develop Emergency Plan: Gather all available relevant information when developing the emergency plan. This information includes, but is not limited to:  
  ✓ Copies of any state and local emergency planning regulations or requirements  
  ✓ Facility personnel names and contact information  
  ✓ Contact information of local and state emergency managers  
  ✓ A facility organization chart  
  ✓ Building construction and Life Safety systems information  
  ✓ Specific information about the characteristics and needs of the individuals for whom care is provided |
| • All Hazards Continuity of Operations (COOP) Plan: Develop a continuity of operations business plan using an all-hazards approach (e.g., hurricanes, floods, tornadoes, fire, bioterrorism, pandemic, etc.) that could potentially affect the facility directly and indirectly within the particular area of location. Indirect hazards could affect the community but not the facility and as a result interrupt necessary utilities, supplies or staffing. Determine all essential functions and critical personnel. |
| • Collaborate with Local Emergency Management Agency: Collaborate with local emergency management agencies to ensure the development of an effective emergency plan. |
| • Analyze Each Hazard: Analyze the specific vulnerabilities of the facility and determine the following actions for each identified hazard:  
  ✓ Specific actions to be taken for the hazard  
  ✓ Identified key staff responsible for executing plan  
  ✓ Staffing requirements and defined staff responsibilities  
  ✓ Identification and maintenance of sufficient supplies and equipment to sustain operations and deliver care and services for 7-10 days  
  ✓ Communication procedures to receive emergency warning/alerts, and for communication with staff, families, individuals receiving care, before, during and after the emergency  
  ✓ Designate critical staff, providing for other staff and volunteer coverage and meeting staff needs, including transportation and sheltering critical staff members’ family |
| • Collaborate with Suppliers/Providers: Collaborate with suppliers and/or providers who have been identified as part of a community emergency plan or agreement with the health care facility, to receive and care for individuals. A surge capability assessment should be included in the development of the emergency plan. Similarly, evidence of a surge capacity assessment should be included if the supplier or provider, as part of its emergency planning, anticipates the need to make housing and sustenance provisions for the staff and or the family of staff. |
| • Decision Criteria for Executing Plan: Include factors to consider when deciding to evacuate or shelter in place. Determine who at the facility level will be in authority to make the decision to execute the plan to evacuate or shelter in place (even if no outside evacuation order is given) and what will be the chain of command. |

Note: Some of the recommended tasks may exceed the facility’s minimum Federal regulatory requirements
* Task may not be applicable to agencies that provide services to clients in their own homes
## EMERGENCY PREPAREDNESS CHECKLIST

### RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Not Started</th>
<th>In Progress</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication Infrastructure Contingency:</strong> Establish contingencies for the facility communication infrastructure in the event of telephone failures (e.g., walkie-talkies, ham radios, text messaging systems, etc.).</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Develop Shelter-in-Place Plan:</strong> Due to the risks in transporting vulnerable patients and residents, evacuation should only be undertaken if sheltering-in-place results in greater risk. Develop an effective plan for sheltering-in-place, by ensuring provisions for the following are specified: *</td>
<td></td>
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</tr>
<tr>
<td>✓ Procedures to assess whether the facility is strong enough to withstand strong winds, flooding, etc.</td>
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<tr>
<td>✓ Measures to secure the building against damage (plywood for windows, sandbags and plastic for flooding, safest areas of the facility identified).</td>
<td></td>
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</tr>
<tr>
<td>✓ Procedures for collaborating with local emergency management agency, fire, police and EMS agencies regarding the decision to shelter-in-place.</td>
<td></td>
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<tr>
<td>✓ Sufficient resources are in supply for sheltering-in-place for at least 7 days, including:</td>
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<tr>
<td>- Ensuring emergency power, including back-up generators and accounts for maintaining a supply of fuel</td>
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<tr>
<td>- An adequate supply of potable water (recommended amounts vary by population and location)</td>
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<tr>
<td>- A description of the amounts and types of food in supply</td>
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<tr>
<td>- Maintaining extra pharmacy stocks of common medications</td>
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<tr>
<td>- Maintaining extra medical supplies and equipment (e.g., oxygen, linens, vital equipment)</td>
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<tr>
<td>✓ Identifying and assigning staff who are responsible for each task</td>
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<tr>
<td>✓ Description of hosting procedures, with details ensuring 24-hour operations for minimum of 7 days</td>
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<tr>
<td>✓ Contract established with multiple vendors for supplies and transportation</td>
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<tr>
<td>✓ Develop a plan for addressing emergency financial needs and providing security</td>
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</tr>
<tr>
<td><strong>Develop Evacuation Plan:</strong> Develop an effective plan for evacuation, by ensuring provisions for the following are specified: *</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Identification of person responsible for implementing the facility evacuation plan (even if no outside evacuation order is given)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>✓ Multiple pre-determined evacuation locations (contract or agreement) with a “like” facility have been established, with suitable space, utilities, security and sanitary facilities for individuals receiving care, staff and others using the location, with at least one facility being 50 miles away. A back-up may be necessary if the first one is unable to accept evacuees.</td>
<td></td>
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<tr>
<td>✓ Evacuation routes and alternative routes have been identified, and the proper authorities have been notified Maps are available and specified travel time has been established</td>
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<tr>
<td>✓ Adequate food supply and logistical support for transporting food is described.</td>
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<tr>
<td>✓ The amounts of water to be transported and logistical support is described.</td>
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<tr>
<td>✓ The logistics to transport medications is described, including ensuring their protection under the control of a registered nurse.</td>
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<tr>
<td>✓ Procedures for protecting and transporting resident/patient medical records.</td>
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<tr>
<td>✓ The list of items to accompany residents/patients is described.</td>
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</tbody>
</table>

**Note:** Some of the recommended tasks may exceed the facility’s minimum Federal regulatory requirements

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

**RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING**

<table>
<thead>
<tr>
<th>Not Started</th>
<th>In Progress</th>
<th>Completed</th>
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</thead>
<tbody>
<tr>
<td>✓ Identify how persons receiving care, their families, staff and others will be notified of the evacuation and communication methods that will be used during and after the evacuation.</td>
<td></td>
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</tr>
<tr>
<td>✓ Identify staff responsibilities and how individuals will be cared for during evacuation, and the back-up plan if there isn’t sufficient staff.</td>
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<td></td>
</tr>
<tr>
<td>✓ Procedures are described to ensure residents/patients dependent on wheelchairs and/or other assistive devices are transported so their equipment will be protected and their personal needs met during transit (e.g., incontinent supplies for long periods, transfer boards and other assistive devices).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ A description of how other critical supplies and equipment will be transported is included.</td>
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<td></td>
</tr>
<tr>
<td>✓ Determine a method to account for all individuals during and after the evacuation.</td>
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<td></td>
</tr>
<tr>
<td>✓ Procedures are described to ensure staff accompany evacuating residents.</td>
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<td></td>
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<tr>
<td>✓ Procedures are described if a patient/resident becomes ill or dies in route.</td>
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<td></td>
</tr>
<tr>
<td>✓ Mental health and grief counselors are available at reception points to talk with and counsel evacuees.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ It is described whether staff family can shelter at the facility and evacuate.</td>
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<td></td>
</tr>
</tbody>
</table>

- **Transportation & Other Vendors:** Establish transportation arrangements that are adequate for the type of individuals being served. Obtain assurances from transportation vendors and other suppliers/contractors identified in the facility emergency plan that they have the ability to fulfill their commitments in case of disaster affecting an entire area (e.g., their staff, vehicles and other vital equipment are not “overbooked,” and vehicles/equipment are kept in good operating condition and with ample fuel.). Ensure the right type of transportation has been obtained (e.g., ambulances, buses, helicopters, etc). *

- **Train Transportation Vendors/Volunteers:** Ensure that the vendors or volunteers who will help transport residents and those who receive them at shelters and other facilities are trained on the needs of the chronic, cognitively impaired and frail population and are knowledgeable on the methods to help minimize transfer trauma. *

- **Facility Reentry Plan:** Describe who will authorizes reentry to the facility after an evacuation, the procedures for inspecting the facility, and how it will be determined when it is safe to return to the facility after an evacuation. The plan should also describe the appropriate considerations for return travel back to the facility. *

- **Residents & Family Members:** Determine how residents and their families/guardians will be informed of the evacuation, helped to pack, have their possessions protected and be kept informed during and following the emergency, including information on where they will be/go, for how long and how they can contact each other.

- **Resident Identification:** Determine how residents will be identified in an evacuation; and ensure the following identifying information will be transferred with each resident:  
  ✓ Name  
  ✓ Social security number  
  ✓ Photograph

**Note:** Some of the recommended tasks may exceed the facility’s minimum Federal regulatory requirements

* Task may not be applicable to agencies that provide services to clients in their own homes
<table>
<thead>
<tr>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Medicaid or other health insurer number</td>
</tr>
<tr>
<td>✓ Date of birth, diagnosis</td>
</tr>
<tr>
<td>✓ Current drug/prescription and diet regimens</td>
</tr>
<tr>
<td>✓ Name and contact information for next of kin/responsible person/Power of Attorney</td>
</tr>
<tr>
<td>Determine how this information will be secured (e.g., laminated documents, water proof pouch around resident’s neck, water proof wrist tag, etc.) and how medical records and medications will be transported so they can be matched with the resident to whom they belong.</td>
</tr>
<tr>
<td>• Trained Facility Staff Members: Ensure that each facility staff member on each shift is trained to be knowledgeable and follow all details of the plan. Training also needs to address psychological and emotional aspects on caregivers, families, residents, and the community at large. Hold periodic reviews and appropriate drills and other demonstrations with sufficient frequency to ensure new members are fully trained.</td>
</tr>
<tr>
<td>• Informed Residents &amp; Patients: Ensure residents, patients and family members are aware of and knowledgeable about the facility plan, including: ✓ Families know how and when they will be notified about evacuation plans, how they can be helpful in an emergency (example, should they come to the facility to assist?) and how/where they can plan to meet their loved ones. ✓ Out-of-town family members are given a number they can call for information. Residents who are able to participate in their own evacuation are aware of their roles and responsibilities in the event of a disaster.</td>
</tr>
<tr>
<td>• Needed Provisions: Check if provisions need to be delivered to the facility/residents -- power, flashlights, food, water, ice, oxygen, medications -- and if urgent action is needed to obtain the necessary resources and assistance.</td>
</tr>
<tr>
<td>• Location of Evacuated Residents: Determine the location of evacuated residents, document and report this information to the clearing house established by the state or partnering agency.</td>
</tr>
<tr>
<td>• Helping Residents in the Relocation: Suggested principles of care for the relocated residents include: ✓ Encourage the resident to talk about expectations, anger, and/or disappointment ✓ Work to develop a level of trust ✓ Present an optimistic, favorable attitude about the relocation ✓ Anticipate that anxiety will occur ✓ Do not argue with the resident ✓ Do not give orders ✓ Do not take the resident’s behavior personally ✓ Use praise liberally ✓ Include the resident in assessing problems ✓ Encourage staff to introduce themselves to residents ✓ Encourage family participation</td>
</tr>
<tr>
<td>• Review Emergency Plan: Complete an internal review of the emergency plan</td>
</tr>
</tbody>
</table>

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

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

**RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING**

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Not Started</th>
<th>In Progress</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>on an annual basis to ensure the plan reflects the most accurate and up-to-date information. Updates may be warranted under the following conditions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Regulatory change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ New hazards are identified or existing hazards change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ After tests, drills, or exercises when problems have been identified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ After actual disasters/emergency responses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Infrastructure changes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Funding or budget-level changes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Communication with the Long-Term Care Ombudsman Program:</strong> Prior to any disaster, discuss the facility’s emergency plan with a representative of the ombudsman program serving the area where the facility is located and provide a copy of the plan to the ombudsman program. When responding to an emergency, notify the local ombudsman program of how, when and where residents will be sheltered so the program can assign representatives to visit them and provide assistance to them and their families.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Conduct Exercises &amp; Drills:</strong> Conduct exercises that are designed to test individual essential elements, interrelated elements, or the entire plan:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Exercises or drills must be conducted at least semi-annually</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Corrective actions should be taken on any deficiency identified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Loss of Resident’s Personal Effects:</strong> Establish a process for the emergency management agency representative (FEMA or other agency) to visit the facility to which residents have been evacuated, so residents can report loss of personal effects. *</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Some of the recommended tasks may exceed the facility’s minimum Federal regulatory requirements

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

This checklist can be used to help you plan what emergency supplies you’ll need and what quantities to buy for your household. It is a good idea to gradually buy items now so that you have at least a two-week supply of water and emergency supplies for each person in your home.

Two-Week Emergency Supply Checklist

<table>
<thead>
<tr>
<th>Items</th>
<th>2 people</th>
<th>4 people</th>
<th>Your quantity</th>
<th>Check off</th>
</tr>
</thead>
<tbody>
<tr>
<td>First aid kit and instructions</td>
<td>1 medium kit</td>
<td>1 large kit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency radio with batteries</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lanterns, flashlights, candles</td>
<td>2 flashlights</td>
<td>4 flashlights</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Batteries</td>
<td>2 (12-packs)</td>
<td>4 (12-packs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trash bags</td>
<td>20 bags</td>
<td>40 bags</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barbeque pits, camping stove</td>
<td>as needed</td>
<td>as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lighter fluid and matches</td>
<td>2 containers/boxes</td>
<td>4 containers/boxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire extinguisher (A-B-C type)</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual can opener and knife</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plastic food containers</td>
<td>10</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zip lock bags, one-gallon size</td>
<td>100</td>
<td>200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paper/plastic eating utensils</td>
<td>100 sets</td>
<td>200 sets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warm blankets, sleeping bags</td>
<td>2 sets</td>
<td>4 sets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extra warm clothing and shoes</td>
<td>4 full sets</td>
<td>8 full sets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal hygiene products</td>
<td>as needed</td>
<td>as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby and/or pet supplies</td>
<td>as needed</td>
<td>as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toolkit with wrench, pliers, etc.</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utility instructions, maps, etc.</td>
<td>2 copies</td>
<td>4 copies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copies of important documents</td>
<td>as needed</td>
<td>as needed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If possible:

<table>
<thead>
<tr>
<th>Items</th>
<th>2 people</th>
<th>4 people</th>
<th>Your quantity</th>
<th>Check off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell phone with battery</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency cash</td>
<td>$200</td>
<td>$400</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Two-Week Supply of Drinking Water

<table>
<thead>
<tr>
<th>Number in family/group</th>
<th>Allow 14 gallons per person</th>
<th>Total water required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>x 14 gallons</td>
<td>= total gallons</td>
</tr>
</tbody>
</table>

Public Health Department
Santa Clara Valley Health & Hospital System
## Food Supplies Checklist

This checklist can be used to help you plan what food supplies you’ll need and what quantities to buy for your household. It is a good idea to gradually buy items now so that you have at least a two-week supply of food for each person in your home.

### Foods That Will Not Spoil Easily

<table>
<thead>
<tr>
<th>Food items</th>
<th>2 people</th>
<th>4 people</th>
<th>Your quantity</th>
<th>Check off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flour</td>
<td>11 lbs</td>
<td>22 lbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bread mix</td>
<td>11 lbs</td>
<td>22 lbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sugar</td>
<td>1 lb</td>
<td>1 lb</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salt (includes medical use)</td>
<td>2.5 lbs</td>
<td>5 lbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cereal bars</td>
<td>28 bars</td>
<td>56 bars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milk powder</td>
<td>3 lbs</td>
<td>3 lbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yeast, instant dried</td>
<td>3 oz</td>
<td>6 oz</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corn meal</td>
<td>1 box</td>
<td>2 boxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oatmeal</td>
<td>1 box</td>
<td>2 boxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pasta</td>
<td>3 lbs</td>
<td>6 lbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rice</td>
<td>2 lbs</td>
<td>4 lbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beans/lentils</td>
<td>1-1.5 lbs</td>
<td>1-2 lbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breakfast cereals</td>
<td>2 boxes</td>
<td>4 boxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baking soda</td>
<td>1 box</td>
<td>1 box</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Comfort Foods

<table>
<thead>
<tr>
<th>Food items</th>
<th>2 people</th>
<th>4 people</th>
<th>Your quantity</th>
<th>Check off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chocolate and candies</td>
<td>as desired</td>
<td>as desired</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Honey</td>
<td>1 jar</td>
<td>2 jars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hot chocolate mix</td>
<td>as desired</td>
<td>as desired</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruit roll-ups and other snacks</td>
<td>as desired</td>
<td>as desired</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Packaged cookies</td>
<td>as desired</td>
<td>as desired</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Food Supplies Checklist

## Foods That Last One Year

<table>
<thead>
<tr>
<th>Food items</th>
<th>2 people</th>
<th>4 people</th>
<th>Your quantity</th>
<th>Check off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canned vegetables</td>
<td>14 (14oz) cans</td>
<td>28 (14oz) cans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canned milk</td>
<td>4 (14oz) cans</td>
<td>8 (14 oz) cans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canned casseroles/meats</td>
<td>4 cans</td>
<td>8 cans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baked beans, spaghetti</td>
<td>4 (420g) cans</td>
<td>8 (420g) cans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canned soups</td>
<td>8 (420g) cans</td>
<td>16 (420g) cans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pasta sauce</td>
<td>2 jars</td>
<td>4 jars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canned fish</td>
<td>4 (200g) cans</td>
<td>8 (200g) cans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canned fruit</td>
<td>14 (400g) cans</td>
<td>28 (400g) cans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instant meals</td>
<td>as desired</td>
<td>as desired</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instant puddings</td>
<td>as desired</td>
<td>as desired</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dried fruit</td>
<td>2 lbs</td>
<td>4 lbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dried vegetables</td>
<td>1lb</td>
<td>2 lbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soup mixes</td>
<td>6-8 packets</td>
<td>12-16 packets</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Use By Expiration Date

<table>
<thead>
<tr>
<th>Food items</th>
<th>2 people</th>
<th>4 people</th>
<th>Your quantity</th>
<th>Check off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crackers</td>
<td>7 packets</td>
<td>14 packets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Energy bars/biscuits</td>
<td>4-6 packets</td>
<td>8-12 packets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuts</td>
<td>2 lbs</td>
<td>4 lbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soy milk</td>
<td>1 box</td>
<td>2 boxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peanut butter</td>
<td>2 jars</td>
<td>4 jars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jelly</td>
<td>7 packets</td>
<td>14 packets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sports drinks</td>
<td>2 cases</td>
<td>4 cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby formula</td>
<td>as needed</td>
<td>as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby food</td>
<td>as needed</td>
<td>as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pet food (if needed)</td>
<td>2-week supply</td>
<td>2-week supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coffee (depends on usage)</td>
<td>1 medium jar</td>
<td>1-2 large jars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tea (depends on usage)</td>
<td>50-100 bags</td>
<td>100-200 bags</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Risk Assessment

<table>
<thead>
<tr>
<th>Threat</th>
<th>Applicable?</th>
<th>Probability</th>
<th>Vulnerability</th>
<th>Impact</th>
<th>Risk Factor</th>
<th>Plans Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Error: Operation</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power Outage--External</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power Outage--Internal</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power Flux</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical Spill - Internal</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical Spill - External</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Computer Equipment Failure</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water Leak/Plumbing Failure</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment Failure</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostage Taking</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bomb Threat</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HVAC Failure/Temperature Inadequacy</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death of Key Staff</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epidemic</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flooding</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire: Internal--Catastrophic</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire: Internal--Major</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire: Internal--Minor</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telecommunications Failure - Voice</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telecommunications Failure - Data</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labor Dispute/Strike</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tornado</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hurricane/Typhoon</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snowstorm/Blizzard</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ice Storm</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thunder/Electrical Storm</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Application Software Failure</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Earthquake - Major Damage</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Earthquake - Minor Damage</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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MANAGEMENT OF ENVIRONMENT HAZARD SURVEILLANCE/RISK ASSESSMENT REPORT FORM

Date: ___________________________  Building: ___________________________

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<td>Safety Management</td>
<td>1. Are grounds clean &amp; free of hazards?</td>
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<td>2. Are floors clean, dry, in good repair, &amp; free of obstruction?</td>
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<td>3. Are mechanisms for access (i.e. ramps, handrails, door opening mechanisms, etc.) operational?</td>
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<td>4. Is the parking area free of potholes or other hazards?</td>
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<td>Security Management</td>
<td>1. Are doors functioning &amp; locked as appropriate?</td>
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<td>2. Are medical records centrally located and accessible ONLY to authorized personnel?</td>
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<td>3. Are alarms functioning, tested, and maintained in accordance with manufacturer's specifications?</td>
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<td>4. Are systems/mechanisms in place to quickly notify officials or other staff quickly in the event of a security related problem?</td>
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<td>2. Have all biohazard and toxic substances present been identified?</td>
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<td>3. Are Materials Safety Data Sheets (MSDS) quickly available for all identified toxic substances?</td>
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<td>4. Are all waste contaminated with blood/body fluid considered and handled as infectious?</td>
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<td>5. Are sharps containers puncture resistant and in accordance with require safety standards?</td>
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<td>6. Are sharps and disposable syringes placed in approved sharps containers?</td>
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<td>7. Are all engineering, personal protective equipment &amp; workplace controls in effect?</td>
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<td><strong>Emergency Preparedness Management</strong></td>
<td>1. Is there an updated disaster plan in the department?</td>
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<td>2. Has a non-fire related emergency drill been performed in the past six months?</td>
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<td>3. Is staff aware of at least three different types of potential non-fire emergencies and their role in eliminating or reducing the risk of patients, staff and property?</td>
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<td>4. Is staff aware of the primary and secondary exits from the facility?</td>
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<td><strong>Life Safety Management</strong></td>
<td>1. Is the evacuation plan posted and can staff demonstrate knowledge of the plan?</td>
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<td>2. Are fire extinguishers located in accordance with NFPA standards?</td>
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<td>3. Are fire extinguishers inspected monthly and documented on/near the extinguisher?</td>
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<td>4. Are smoke/fire alarm systems functioning, tested, and maintained in accordance with manufacturers specifications?</td>
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<td>5. Are exit hallways well lit &amp; obstacle free?</td>
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<td>6. Is emergency exit lighting operational and tested in accordance with NFPA standards?</td>
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<td>7. Are fire/smoke doors operating effectively?</td>
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<td>8. Are no smoking policies in effect and signs are posted appropriately?</td>
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<td><strong>Medical Equipment Management</strong></td>
<td>1. Is there a unique inventory of all medical equipment in the facility?</td>
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<td>2. Are all equipment evaluated &amp; prioritized prior to use?</td>
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<td>3. Has all equipment been tested/maintained according to manufacturer's specifications?</td>
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<td>4. Are maintenance records complete, are they capable of tracking the maintenance history of a particular piece of equipment, and do they record the results of both electrical safety as well as calibration, as appropriate?</td>
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<td>5. Are systems/mechanisms in place to respond appropriately to a medical equipment failure?</td>
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<td>Utility Management</td>
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<td>1. Are the lights, emergency lights, and power plugs operational and in working order?</td>
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<td>2. Does the water/sewage system appear to be working properly and has the water quality been tested within the past year?</td>
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<td>3. Is the telephone system operational?</td>
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<td>4. Has the HVAC system been inspected in accordance with manufacturers specifications and have the filters been checked quarterly?</td>
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<td>5. Are fire suppression (sprinkler) systems checked at least once a year, or as appropriate by a qualified individual?</td>
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<td>6. Are shut-offs for all utility systems clearly marked, &amp; accessible for all staff in the event of an emergency?</td>
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<td>7. Are systems/mechanisms in place to respond in the event of a failure of any utility system?</td>
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<td>1. Is all staff utilizing Universal Precautions (i.e. utilizing appropriate PPE, handwashing, etc.) in the performance of their job duties?</td>
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<td>2. Are cleaning solutions secured, mixed, and utilized appropriately throughout the facility?</td>
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<td>3. Are potentially &quot;infectious patients&quot; aggressively identified and processed in a manner which would minimize the risk of infection of staff and other patients?</td>
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<td>4. Can staff intelligently describe their role in infection control within the organization?</td>
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<td>1. Are Utility Rooms locked, clean and clear of debris?</td>
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<td>2. Are Storage Rooms secure, clean, and free of flammable?</td>
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<td>3. Are Emergency Carts present, as appropriate, fully stocked, and checked per schedule?</td>
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<td>4. Are all medications, including samples, secured and accounted for by lot number?</td>
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**SCORING LEGEND:**

1 = Outstanding  
2 = Good  
3 = Satisfactory  
4 = Marginal  
5 = Unsatisfactory

Inspected Conducted By: ______________________________________________________

Reports Noted: __________________________________________ Date: ______________

Safety Officer
STRUCTURAL AND NON-STRUCTURAL HAZARD MITIGATION CHECKLIST

The following are suggested checklists (list is not all inclusive) of recommended structural and nonstructural mitigation actions:

Structural Mitigation

Structural mitigation is reinforcing, bracing, anchoring, bolting, strengthening or replacing any portion of the building that may become damaged and cause injury such as:

- exterior walls – (e.g., use a wind resistant design for tornados or windstorms)
- exterior doors – (e.g., non-combustible materials for wildfires or urban fires)
- exterior windows – (e.g., use shutters on windows for tornados or windstorms)
- foundation – (e.g., brace, anchor or bolt the facility for earthquakes)
- exterior columns/pilasters/corbels – (e.g., steel or concrete columns)
- roof – (e.g., use non-combustible materials for wildfires or urban fires)

STRUCTURAL

—— Earthquakes – anchor/brace or bolt the facility to its foundation and reinforce any portion of the exterior of the facility that may cause injury.

—— Floods and flashfloods – elevate and reinforce the facility but ultimately avoid a floodplain location.

—— Landslide and mudflow – build retaining walls on slopes. Build masonry walls to direct the mudflow around the facility. Bolt the foundation and reinforce the walls of the facility.

—— Tsunami – elevate at-risk coastal facilities. Even the strongest building can be damaged by a powerful tsunami.

—— Wildfire and urban fire – use fire resistant materials (e.g., non-combustible roofing material) on the exterior of the facility.

—— Tornado – follow local building codes to use a wind resistant design for your facility.

—— Dam failure – reinforce and flood-proof the facility.
Nonstructural Hazard Mitigation

_Nonstructural mitigation_ reduces the threat to safety posed by the effects of disasters on such nonstructural elements as building contents, internal utility systems, interior glass and decorative architectural walls and ceilings. These actions involve identifying nonstructural fixtures and equipment, which are vulnerable to a disaster and which are either essential to continued operations or a threat to public safety.

Nonstructural mitigation is:

- **Retrofit** – refers to various methods for securing nonstructural items. Retrofitting methods are bracing, securing, tying down (tethers or leashes), bolting and anchoring.
- **Replace** – replacing the item with a new one that is resistant to the hazard.
- **Relocate** – moving items from a hazardous location to a non-hazardous one.
- **Backup Plan** – if there is concern that an essential service will be disrupted, provide for backup service – _it is planning for the consequences of failure_.

Nonstructural mitigation includes all contents of the structure that do not contribute to its structural integrity such as:

- **Systems and elements** which are essential to the facility operations
- Emergency power generating equipment - plumbing, HVAC
- Fire protection system - fire sprinklers and distribution lines, emergency water tank or reservoir
- Medical equipment - respirators and life support, refrigeration units to store pharmaceuticals.
- Food storage and preparation equipment – keeping food safe to eat (i.e. refrigeration, stoves and ovens)
- Hazardous materials – restrain chemicals on shelves, containers stored on braced storage rack or tall stacks, gas tanks with flexible connections, gas tank legs anchored to a concrete footing or slab.
- **Non-essential elements** whose failure could compromise facility operations, such as:
  - suspended lights and ceilings
  - partitions
  - interior doors
  - furniture and contents - book shelves, file cabinets, etc.
NONSTRUCTURAL

______ Brace light fixtures and other items that could fall or shake loose.
______ Secure top and bottom of compressed gas cylinders with a safety chain.
______ Store containers of hazardous materials on braced storage rack or tall stacks and restrain the containers with a restraining device such as metal or wire guardrails.
______ Secure any desktop equipment such as computers, TV monitors, typewriters, printers, etc.
______ Install shatter resistant protective film or blinds on windows to prevent glass from shattering onto people or install safety glass.
______ Ensure that any equipment with piping be a flexible connection (e.g., gas pipes, water tanks, sprinkler piping, water heaters)
______ Anchor any tall, unsecured furniture to the wall and/or to each other.
______ Ensure that cabinets have positive catching latches.
______ Secure suspended ceilings with diagonal bracing wires.
______ Hang heavy objects away from workstations and beds.
______ Secure any larger equipment such as copiers or heavy machinery to the floor or use tethers and attach to the wall.
______ Cross brace tall storage racks in both directions or, for racks significantly taller than wide, secure with anchor bolts connected to the concrete slab.
______ Ensure the main breaker or fuse box and the utility meters are elevated above the anticipated flood level of your facility to prevent damage.
______ Secure one-of-a-kind equipment of high value from overturning or sliding.
Hazard Vulnerability Worksheet

The purpose of this worksheet is to provide a format for each facility to score yourself in each of 13 various areas of vulnerability. The total of these scores will provide a "vulnerability score" that can be used to allow the administrator the ability to evaluate their facility for potential mitigative actions that can reduce that vulnerability.  Please note that the Federal ASPER Grant that is providing your facility with grant funds for emergency preparedness activities REQUIRES that each facility complete this vulnerability assessment.

Step 1: Please save this document to your computer.  Step 2: Complete the assessment.  Step 3: Save the document again and attach it to an email and send it to me at deb@uthca.org.  I need to receive your completed assessment in my office by 5:00 pm on Friday, April 4th.

Please place the appropriate numeric score in the yellow shaded area marked score in the left column for each hazard. Then provide a cumulative score in the green Total Score Box at the bottom of the assessment.

Date: Enter the date this worksheet was completed.
Facility Name:
Facility Address:
Facility City and State:
Facility Zip Code:
Name of contact completing this Assessment:
Contact phone number:
Facility Type:

Scoring the Facility's Vulnerability

Facility Type: Which of the following classifications does this facility fall within? Please highlight one.
SNF – 100 plus beds
SNF/ICF-50-99 beds
SNF/ICF with 49 or less beds
ICF/MR
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<th>Subject to Temperature change:</th>
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<tr>
<td>0</td>
<td>This facility is not subject to damage from extreme temperature change.</td>
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<tr>
<td>1</td>
<td>This facility is located in area of mild temperature changes.</td>
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<tr>
<td>2</td>
<td>This facility is located in area of moderate temperature changes.</td>
</tr>
<tr>
<td>3</td>
<td>This facility is located in area of extreme temperature changes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subject to Flood, Wind or Weather Damage:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>This facility has no history of flood, wind, or weather damage.</td>
</tr>
<tr>
<td>1</td>
<td>This facility has had at least one incident of flood, wind or weather damage.</td>
</tr>
<tr>
<td>2</td>
<td>This facility has had from 2-10 incidents of flood, wind, or weather damage.</td>
</tr>
<tr>
<td>3</td>
<td>This facility has had greater than 10 incidents of flood, wind or weather damage.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subject to Earthquake:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>This facility is not located in a known seismic zone.</td>
</tr>
<tr>
<td>1</td>
<td>This facility is subject to minor damage from an earthquake.</td>
</tr>
<tr>
<td>2</td>
<td>This facility is subject to major damage from an earthquake.</td>
</tr>
<tr>
<td>3</td>
<td>This facility is subject to major damage, extensive injuries and loss of operations from an earthquake.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vulnerable to Power Outage:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>This facility has an onsite generator capable of supporting the entire facility for 72 hours.</td>
</tr>
<tr>
<td>1</td>
<td>This facility can lose power but an onsite generator will support only part of the facility. The building is configured to accept a dedicated portable generator that is readily available. A power outage at this facility will cause some minor difficulties.</td>
</tr>
<tr>
<td>2</td>
<td>This facility can lose power but an onsite generator will support only part of the facility. The building is configured to accept a portable generator if one is available. A power outage at this facility will cause some major difficulties.</td>
</tr>
<tr>
<td>3</td>
<td>This facility has no emergency power capabilities and a power outage may create major difficulties and loss of operations.</td>
</tr>
</tbody>
</table>
### Vulnerability to Lightning

This category is intended to score the facility for the effects of the electrical surge from a lightning strike.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>This facility is not particularly vulnerable to lightning due to its location, construction, profile or the fact that there are protective systems in place.</td>
</tr>
<tr>
<td>1</td>
<td>This facility is vulnerable to lightning, but equipment on site is not of a nature that disruption from a strike would create a problem or do major damage to critical systems.</td>
</tr>
<tr>
<td>2</td>
<td>This facility is vulnerable to lightning, has critical systems and/or equipment, but protective measures have been taken to lessen the likelihood of system failure from a strike.</td>
</tr>
<tr>
<td>3</td>
<td>This facility is vulnerable to lightning and a strike would create a major problem and/or critical systems will go down. No protective systems are in place.</td>
</tr>
</tbody>
</table>

### Dependent on Water Supply

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>This facility can operate without normal water supply for over 72 hours. A reserve water system is located onsite.</td>
</tr>
<tr>
<td>1</td>
<td>This facility can operate without normal water supply for between 24 and 72 hours. After that period the facility will experience difficulties.</td>
</tr>
<tr>
<td>2</td>
<td>This facility must have a normal water supply within 24 hours or the facility will not be able to function.</td>
</tr>
<tr>
<td>3</td>
<td>This facility must not lose a normal water supply.</td>
</tr>
</tbody>
</table>

### Vulnerable to Sewer System Outage

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>This facility is not vulnerable to a sewer outage.</td>
</tr>
<tr>
<td>1</td>
<td>A sewer system outage would cause minor problems for this facility.</td>
</tr>
<tr>
<td>2</td>
<td>A sewer system outage would cause moderate problems for this facility.</td>
</tr>
<tr>
<td>3</td>
<td>A sewer system outage would cause major problems for this facility.</td>
</tr>
</tbody>
</table>

### Dependent upon Communications

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>This facility is not vulnerable communications equipment failure.</td>
</tr>
<tr>
<td>1</td>
<td>This facility could lose communications capability without major problems as long as that capability is restored within 24-36 hours.</td>
</tr>
<tr>
<td>2</td>
<td>This facility will experience major problems if communications capability is not restored within the first 24 hours.</td>
</tr>
<tr>
<td>3</td>
<td>This facility must not lose communications capability.</td>
</tr>
</tbody>
</table>

---
### Hazardous Material:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Hazardous material is not a concern with this facility and is not located near a major transportation route.</td>
</tr>
<tr>
<td>1</td>
<td>The facility is not considered a hazardous material site, but periodically uses materials and processes that could create a minor hazard. This facility is not located near a major transportation route.</td>
</tr>
<tr>
<td>2</td>
<td>This facility is not considered a hazardous material site, but does contain some materials or processes that could create health and environmental problems.</td>
</tr>
<tr>
<td>3</td>
<td>This facility is not considered a hazardous material site, but there is a facility within close proximity that could create a hazardous materials problem for this facility. This facility is located near a major transportation route.</td>
</tr>
</tbody>
</table>

### Subject to a Major Fire:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>This facility does not face a high risk of major urban or wildland fire.</td>
</tr>
<tr>
<td>1</td>
<td>This facility is in a position to face the risk of major urban or wildland fire, but the treat is considered minor.</td>
</tr>
<tr>
<td>2</td>
<td>This facility is in a location that makes it moderately vulnerable to the threat of a major urban or wildland fire and/or smoke from such fire.</td>
</tr>
<tr>
<td>3</td>
<td>This facility is located in a position that makes it highly vulnerable to a major urban or wildland fire and/or smoke from such fire.</td>
</tr>
</tbody>
</table>

### Subject to Electronic Record Loss:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>This facility is not vulnerable to electronic record loss.</td>
</tr>
<tr>
<td>1</td>
<td>This facility has minor vulnerability to electronic record loss. Daily back up of electronic records to two offsite servers.</td>
</tr>
<tr>
<td>2</td>
<td>This facility has a major vulnerability for electronic record loss. Occasional back up of electronic records to an onsite server.</td>
</tr>
<tr>
<td>3</td>
<td>An electronic record loss for this facility will absolutely create a major health and safety problem.</td>
</tr>
</tbody>
</table>
### Subject to HVAC Outage:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>This facility can operate with HVAC outage for 72 hours with backup system in place.</td>
</tr>
<tr>
<td>1</td>
<td>This facility can operate with HVAC outage for 24 hours. After that period the facility will experience difficulties.</td>
</tr>
<tr>
<td>2</td>
<td>This facility must have normal HVAC within 24 hours or the facility will not be able to function.</td>
</tr>
<tr>
<td>3</td>
<td>This facility must not lose HVAC system.</td>
</tr>
</tbody>
</table>

### Subject to Influenza Outbreak:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>This facility has low risk of an influenza outbreak, PPE, immunizations and hand washing instructions are in place for staff and clients.</td>
</tr>
<tr>
<td>1</td>
<td>This facility has a moderate risk for an Influenza outbreak, moderate compliance for PPE, immunizations and hand washing.</td>
</tr>
<tr>
<td>2</td>
<td>This facility has a high risk for an influenza outbreak, poor compliance for PPE, immunizations and hand washing. Frequent turnover of staff and clients</td>
</tr>
<tr>
<td>3</td>
<td>This facility will have major health and safety problem and possible closure with an outbreak of influenza.</td>
</tr>
<tr>
<td>EVENT</td>
<td>PROBABILITY</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>Likelihood this will occur</td>
</tr>
<tr>
<td>SCORE</td>
<td>0 = N/A</td>
</tr>
<tr>
<td>Hurricane</td>
<td>0%</td>
</tr>
<tr>
<td>Tornado</td>
<td>0%</td>
</tr>
<tr>
<td>Severe Thunderstorm</td>
<td>0%</td>
</tr>
<tr>
<td>Snow Fall</td>
<td>0%</td>
</tr>
<tr>
<td>Blizzard</td>
<td>0%</td>
</tr>
<tr>
<td>Ice Storm</td>
<td>0%</td>
</tr>
<tr>
<td>Earthquake</td>
<td>0%</td>
</tr>
<tr>
<td>Tidal Wave</td>
<td>0%</td>
</tr>
<tr>
<td>Temperature</td>
<td>0%</td>
</tr>
<tr>
<td>Exhausted</td>
<td>0%</td>
</tr>
<tr>
<td>Drought</td>
<td>0%</td>
</tr>
<tr>
<td>Flood, External</td>
<td>0%</td>
</tr>
<tr>
<td>Wild Fire</td>
<td>0%</td>
</tr>
<tr>
<td>Landslide</td>
<td>0%</td>
</tr>
<tr>
<td>Dam Inundation</td>
<td>0%</td>
</tr>
<tr>
<td>Volcano</td>
<td>0%</td>
</tr>
<tr>
<td>Epidemic</td>
<td>0%</td>
</tr>
<tr>
<td>AVERAGE SCORE</td>
<td>0.00</td>
</tr>
</tbody>
</table>

*Risk = Probability * Severity

0.00 0.00 0.00

0%
Disaster Planning Guide for Home Health Care Providers
How to prepare for the emergency that could turn a home into a makeshift hospital

During a disaster, home health care professionals care for patients who do not require hospitalization or cannot be admitted into overwhelmed health care facilities. Depleted supplies, personnel shortages, and other challenges during times of crisis may strain the ability of these care providers to address their patients’ needs. Good preparedness planning is essential for ensuring that the needs of both patients, their service animals, and their caregivers are met in the most effective and professional manner possible.

When planning for contingencies, home health care providers must consider a variety of hazards and events that could impact their patients. Hurricanes, floods, tornadoes, earthquakes, tsunamis, wildfires, radiation releases, chemical exposures, seasonal and pandemic influenza, and acts of terrorism are just a few examples.

Assess Needs, Prepare Supplies, Make a Plan. These are simple measures that home health care providers can implement to increase the personal readiness of their patients and themselves. Additionally, becoming familiar with existing emergency response plans, processes, and procedures in both the workplace and community is a critical component of preparedness. Once you are armed with the necessary resources, help your patients, their family members, and other caregivers to get a kit, make a plan and be informed.

Home health care professionals play a vital role in disaster preparedness because their patients depend on them for continuity of care during a catastrophic event. Discuss resource requirements with your patients, their family members, and your organization’s staff. The following questions will help guide your planning:

Assess Needs

- Does your organization have a plan for emergencies or disasters?
- If your organization is severely impacted by an emergency or disaster, how will your patients’ health care needs be met?
- Will you be expected to stay with your patients during an emergency or disaster in either their residence or in an emergency shelter?
- Do your patients have an alternate support system (e.g., family, friends, volunteers) in the event that essential home health care services are compromised?

Prepare Supplies

- Gather enough food, water, medication, and other life-sustaining necessities for a minimum of three (3) days and up to two (2) weeks.
- If a back-up generator is available, ensure your patients are familiar with how to safely operate it and have sufficient fuel.
- Provide patients or their family members with the required knowledge, tools, and supplies to maintain, replace, or repair essential medical devices, such as wheelchairs, ventilators, oxygen tanks, etc.
- Confirm your patients have a disaster supply kit. More information on creating disaster supply kits can be obtained at www.ready.gov or through the American Red Cross chapter at www.redcross.org.

Note: An easy way to maintain an updated list of medications is to place a copy of the information that comes with each prescription in a plastic bag. Store the plastic bag in a location that is easy to access in an emergency. Replace copies each year or when there are prescription changes. Also include regularly taken over-the-counter medications such as acetaminophen, ibuprofen, antacids, etc.

Make a Plan

- If your organization is unable to ensure continuity of care, your patients should have a backup roster of home health care providers or an identified alternate means of care to ensure support during and after an emergency or disaster.
- To facilitate efficient and effective response, work with local emergency services providers (e.g., EMS, hospitals and other health care facilities, fire, law enforcement, volunteer groups, etc.) to inform them about the services your organization provides and educate them about the particular needs of your patients.
- Develop a plan for your patients and their families so you will know how you will communicate in a crisis.
- Discuss electrical needs for essential equipment (e.g., refrigeration for food and medication, air conditioning, heating, oxygen concentrators, suction machines, etc) with your patients, their family members, local emergency services providers, and local utilities companies.
Emergency Plan Review
Review emergency plans and procedures with your patients, their family, and your organization each year. Be sure to review:
- All patient health and medical needs
- Supplies to reflect evolving patient needs
- Patient, family, and emergency contact information
- Healthcare-related legal documents
- Patient, family, and organization communication plans

Online Resources
- U.S. Department of Health and Human Services, Home Health Care During an Influenza Pandemic www.pandemicflu.gov/plan/healthcare/homehealth.html
- National Association for Home Care and Hospice www.nahc.org
- The Joint Commission, Home Care Accreditation Program www.jointcommission.org/AccreditationPrograms/HomeCare

Helping patients may mean taking the show on the road in an emergency

While staying in a well-prepared home with the help of a home health provider is often the best approach to getting through a crisis, sometimes evacuation is required. Home health care providers should consider evacuation as early as possible, even if it may prove later to be unnecessary, because of the challenges faced by those with special health needs. Remember, not all shelters can support everyone and service animals and pets will also need assistance.

Basic Questions About Evacuation Shelters
- Will your patients require evacuation?
- Has your organization, patients, or their family contacted the American Red Cross for information on shelters?
- Are alternate shelter plans in place in the event that your patients are not able to reach designated shelters?

Sheltering
The criteria for staying in a special needs shelter varies by state or local government guidelines. In general, special needs shelters provide supervised care and shelter to a limited number of people requiring assistance due to pre-existing health conditions. Patients may qualify to stay at a special needs shelter if they are:
- Dependent on electricity to operate medical equipment
- In need of assistance with medication, injections, or simple dressing changes
- Receiving dialysis
- Receiving hospice services
- Demonstrating mild dementia, without abusive or wandering behavior.

Home health care providers may be required to stay with their patients in special needs shelters during their stay. When assisting patients and their family members plan to shelter, consider the following:
- Learn the health and safety resources the shelter provides.
- Determine which additional resources your patients will require if the shelter is not able to meet their needs.
- Review your organization’s plans, processes, and procedures for providing care and support for yourself and your patients while in the shelter.
- If patients are oxygen dependent, make arrangements to obtain extra supplies of oxygen canisters, refills, and other equipment as needed.
- Determine how patients will be transported to a special needs shelter and assist in making proper arrangements.
- Assist patients and their family members to prepare emergency supply kits with essential medications, equipment, and supplies that will not be provided by the shelter. Refer to www.ready.gov for a complete listing of kit supplies.
- Inform shelter managers if your patients have service animals. Pets are usually not permitted in special needs shelters.

Household Pet and Service Animal Considerations
Service animals (e.g., seeing-eye-dogs, hearing and signal dogs, assistance dogs, etc.) must be allowed in shelters as extensions of the patient under the provisions of the Americans with Disabilities Act. Therapy animals, such as dogs who visit patients in hospitals and nursing homes, are not considered service animals. Many state and local jurisdictions will shelter household pets. Coordinate with the local animal control to understand the options and inform patients and their family members so they can plan for their shelter needs. Other pet and service animal considerations:
- Assist patients in making arrangements with family members, relatives, friends, or other providers to care for pets during an evacuation or other extended emergency.
- Plan for a minimum of three (3) days and up to two (2) weeks of food and water (and possible medications) for your patients’ pets and service animals.
- Prior to relocating to a shelter, assist patients in gathering necessary food, medications, food and water bowls, cat litter, cages, collars (with tags and/or paperwork showing proof of immunizations, if possible), leashes, and muzzles.
- Contact animal control, the regional Humane Society or affiliate office, or a local veterinarian for more information. Additional information can be obtained from the Humane Society of the United States at www.hsus.org.
Emergency Reference Card for Individuals with Medical Needs Living at Home & Their Caregivers

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>Blood Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address:</td>
<td>City:</td>
<td>State:</td>
</tr>
</tbody>
</table>

Personal medical information that emergency responders need to know:

- **Allergies I have:**
- **Medications I take:**
  - **Prescription Name:**
  - **Dosage** (for example, 50 mg)
  - **Frequency** (for example, twice per day)
  - **Vaccination Type:**
  - **Dose/Units:**
  - **Date Given (month/year)**

Special needs (e.g., eye glasses, hearing aids, mobility assistive devices, language translation needs, etc.):

### Emergency Phone Numbers (if not 911)

<table>
<thead>
<tr>
<th>Local Dept.</th>
<th>Phone #</th>
<th>Emergency Contacts / Name</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td></td>
<td>Doctor</td>
<td></td>
</tr>
<tr>
<td>Fire</td>
<td></td>
<td>Doctor</td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td></td>
<td>Doctor</td>
<td></td>
</tr>
<tr>
<td>County Health</td>
<td></td>
<td>Clinic/Facility</td>
<td></td>
</tr>
<tr>
<td>Emergency Mgmt</td>
<td></td>
<td>Pharmacist</td>
<td></td>
</tr>
<tr>
<td>Local Red Cross</td>
<td></td>
<td>Dentist</td>
<td></td>
</tr>
<tr>
<td>Local Shelters</td>
<td></td>
<td>Veterinarian</td>
<td></td>
</tr>
</tbody>
</table>

### Family and Friends - Emergency Contacts

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Member</td>
<td></td>
</tr>
<tr>
<td>Family Member</td>
<td></td>
</tr>
<tr>
<td>Family Member</td>
<td></td>
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<td>Family Member</td>
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<tr>
<td>Family Member</td>
<td></td>
</tr>
<tr>
<td>Family Member</td>
<td></td>
</tr>
</tbody>
</table>
DISASTER PREPAREDNESS PLAN
Template for use in
LONG TERM CARE FACILITIES

January 18, 2007

Adopted: _____________________

1st Annual Review Date: ___________ Completed: ___________

2nd Annual Review Date: ___________ Completed: ___________

3rd Annual Review Date: ___________ Completed: ___________

4th Annual Review Date: ___________ Completed: ___________

Note: This template has been prepared as a tool to assist long term care facilities in developing a comprehensive disaster preparedness plan. Facilities may use any/all of this template in order to enhance their current emergency plan. Additionally, the Missouri Department of Health and Senior Services has prepared a video

Ready-in-3: The ABC’s of Emergency Preparedness for Adult Care Facilities” which may be ordered by calling 573/526-4768.
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<td>27</td>
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<td>Dietary/Food Services</td>
<td>29</td>
</tr>
<tr>
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<td>30</td>
</tr>
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<td>Maintenance Services</td>
<td>31</td>
</tr>
<tr>
<td>Nursing/Medical Services</td>
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<td>Resident Services</td>
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<td>Security Services</td>
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LONG TERM CARE FACILITIES

INTRODUCTION

During the past several years some of the costliest disasters of this century have occurred in the United States resulting in countless deaths and injuries. Missourians have felt the effects of floods, ice storms, grass fires, tornadoes, industrial accidents, power outages, heat/cold waves and have also been touched by the bombing and other terrorist attacks of federal buildings.

Preparing for disasters is not new to long term care facilities; being prepared by having a comprehensive disaster preparedness plan, practicing for disasters in your facilities and updating your plan frequently can help save lives and reduce injuries.

This template is applicable to any long term care facility including Skilled Nursing Facility, Assisted Living Facility, Residential Care Facility, Nursing Homes, Intermediate Care Facilities for the Mentally Retarded and Adult Day Care programs.

OBJECTIVE

The Missouri Department of Health and Senior Services Disaster Preparedness Task Team has developed this DISASTER PREPAREDNESS PLAN template for Long Term Care Facilities. This plan is provided as a courtesy and recipients are welcome to utilize the plan in full (by simply filling in the blanks) or alter the plan to suit the facility's individual needs.

This plan is designed as a resource tool to assist in the development and implementation of a disaster preparedness plan within your organization or agency. Specific compliance requirements addressed in this plan have been researched to the best of our ability through state and local agencies. Once in place, it is recommended that the plan be reviewed and updated on a routine basis to ensure accuracy.

If you have any questions about the plan please contact the Department of Health and Senior Services, Long Term Care Planning and Development Unit, (573) 526-8514.
I. PURPOSE

To provide guidance to ___________________________ on

(Long Term Care Facility Name)
emergency policies and procedures to protect the lives and property of residents, staff and
visitors.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. The State of Missouri is vulnerable to natural and technological disasters.

2. Residents of this facility require special emergency consideration in planning for
disasters or emergencies and in ensuring safety.

B. Assumptions

1. The possibility exists that an emergency/disaster may occur at any time.

2. In the event an emergency exceeds the facility's capability, external services and
resources may be required.

3. Local, state and federal departments and agencies may provide assistance necessary
to protect lives and property.

4. It is the responsibility of the Department of Health and Senior Services (DHSS) to
inspect the facility for compliance with published safety guidelines.

5. The local Emergency Management Agency is available to assist in writing and
reviewing the facility's emergency action plan. Contact the Missouri State Emergency
Management Agency (SEMA) at 573-526-9100 to locate your city or county
Emergency Management Director.

6. Based on authority, the DHSS is responsible for the annual review and inspection of
fire safety plans and procedures. The DHSS is responsible for the annual inspection
of the facility for compliance with all state and federal statutes and regulations. The
facility’s plan will be reviewed at these inspections.
III. CONCEPT OF OPERATIONS

Because the state is subject to the adverse effects of natural or technological disasters, the facility administrator should develop and revise, in coordination with the DHSS, the Office of the State Fire Marshal and the local Emergency Management Director or public health department, an emergency action plan capable of providing for the safety and protection of residents, staff and visitors. Procedures should be developed to insure that residents who are cognitively impaired, physically impaired, hearing impaired, speech impaired, or have English as a second language are properly informed and alerted as necessary. This plan can be effective for either internal or external emergencies.

A. Pre-Emergency

The primary focus of this phase is on the development, revision, testing and training of the emergency action plan.

1. Review, exercise and re-evaluate existing plans, policies and procedures.

2. Coordinate plans with the local emergency management agency and provide input into the county's emergency plans. A Memorandum of Understanding or Mutual Aid Agreement should be in place. Be aware that other facilities in your area may have contracts/agreements with the same companies. Ensure that the companies will be able to provide the needed supplies.

3. Review and update inventory/resource lists. (See TAB F)
   a. Ensure the availability of manpower needed to execute emergency procedures.
   b. Work with the local Emergency Management Director, in locating resources.
   c. Identify staff needing transportation and arrange for provision of this service.

4. Determine communication system. (e.g., cellular phones and fax machines may offer the best means in the event of a power loss. A supply of quarters and accessibility to a pay phone may serve as a reasonable alternative.)

5. Ensure the availability and functioning of facility emergency warning system.

6. Test reliability of emergency telephone roster for contacting emergency personnel and activating emergency procedures.

7. Develop procedure for testing generators and equipment supported by emergency generators.
   a. Recommend a 7 – 10 day supply of emergency fuel and establish an agreement for delivery with a supplier.
b. If you require delivery of a generator, make sure you allow time to hire an electrician that will assist in installing it. You will also need to determine what the generator will power.

c. If you already have a generator, ensure you know what the generator powers. Activate the generator under load according to National Fire Protection Association (NFPA) requirements and state regulations.

d. Document all testing procedures.

8. Ensure a 7 - 10 day supply of food and water for residents and staff.
   a. Arrange for a private contact to supply back-up resources.
   b. Contact the local Emergency Management Director, for assistance in establishing a private contact, as needed.

9. Schedule employee orientation training and in-service training programs on the operations of the emergency plan.

10. Enhance emergency education.
   a. Distribute personal preparedness checklists identified in TAB D (Fire Safety; Natural Disasters; Water/Electrical Outage; Bomb Threat; Missing Resident)
   b. Post display of evacuation routes, alarm and fire extinguisher locations and telephone numbers of emergency contacts.
   c. Provide demonstrations on warning systems and proper use of emergency equipment for the staff, residents and resident families.

11. Conduct, at a minimum, twelve unannounced fire drills per year. Check fire regulations in your community for local, federal and state compliance requirements.
   a. One drill is required per quarter for each shift at varied times.
   b. Document each drill, instruction or event to include date, content and participants involved. Identify and document any problems associated with the drill.

12. It is recommended that, at a minimum, annual unannounced drills exercising all aspects of the emergency action plan be conducted. Document drills with critiques and evaluations.

13. Develop and maintain Standard Operating Procedures including procedures and tasking assignments, resources, security procedures, personnel call down lists and inventories of emergency supplies. Include section designating staff, space and food provision for the facility's use as a shelter for the external population.
14. _________________ (location) Consider designating a Command Post (CP) location to serve as the focal point for coordinating operations and _________________ (location) is designated as an alternate location outside the facility for use if evacuation is necessary. If possible there should be at least two direct outside lines in the command post and multiple copies of emergency telephone numbers (home, beeper and cellular numbers of staff, community, additional key personnel; and state agency).

15. Ensure all staff are trained in the content of the disaster plan to execute the activities of the Command Post. All staff should know the location of the Disaster Preparedness Plan.

16. Plan for Evacuation and Relocation of residents

Describe the policies, role responsibilities and procedures for the evacuation of residents from the facility. (See the Supplement to Disaster Preparedness Tasks, page 14)

a. Identify the individual responsible for implementing facility evacuation procedures.

b. Identify residents who may require skilled transportation (provided by local jurisdiction resources).

c. Determine the number of ambulatory and non-ambulatory residents including residents who may need more than minimal assistance to safely evacuate (including Hospice) and assure staff are familiar with individual evacuation plans for those residents.

d. Identify transportation arrangements made through mutual aid agreements or Memorandum of Understandings that will be used to evacuate residents (Copies of the agreements should be attached as annexes).

d. Describe transportation arrangements for logistical support to include moving records, medications, food, water, and other necessities (Copies of the agreements should be attached as annexes).

f. Identify facilities and include in the plan a copy of the mutual aid agreement that has been entered into with a facility to receive residents/patients (Copies of the agreements should be attached as annexes).

g. Identify evacuation routes that will be used and secondary routes should the primary route be impassable.

h. Specify the amount of time it will take to successfully evacuate all patients/residents to the receiving facility.
i. Specify the procedures that ensure facility staff will accompany evacuating residents/patients and procedure for staff to care for residents after evacuation.

j. Identify procedures that will be used to keep track of residents once they have been evacuated to include a log system.

k. Determine what and how much should each resident take.

l. Plan for the evacuation of pets and service animals (see Tab O).

m. Recommend a minimum of a 7 – 10 day stay, with provisions to extend this period of time if the disaster is of catastrophic magnitude.

m. Establish procedures for responding to family inquiries about residents who have been evacuated.

n. Establish procedures for ensuring all residents are accounted for and are out of the facility.

o. Determine at what point to begin the pre-positioning of necessary medical supplies and provisions.

p. Specify at what point the mutual aid agreements for transportation and the notification of alternative facilities will begin.

**Mutual Aide Agreements**

Mutual-aid agreement content will vary but items to consider addressing include the following provisions:

- Definitions of key terms used in the agreement;
- Roles and responsibilities of individual parties;
- Procedures for requesting and providing assistance;
- Procedures, authorities, and rules for payment, reimbursement, and cost allocation;
- Notification procedures;
- Protocols for interoperable communications;
- Relationships with other agreements among jurisdictions;
- Workers compensation;
- Treatment of liability and immunity;
- Recognition of qualifications and certifications; and
- Sharing agreements, as required.

17. Identify community resources such as volunteers, churches, clubs and organizations, emergency medical services, law enforcement, fire departments, businesses, hospitals and local government departments/agencies.

18. Establish a plan for donations management. Delineate what is needed, where items will be received and stored and who will manage donation management operations.
B. Preparedness

Upon receipt of an internal or external warning of an emergency, the facility administrator or appropriate designee(s), should:

1. Notify staff in charge of emergency operations to initiate the disaster plan; advise personnel of efforts designed to guarantee resident safety. (See TAB A for Notification Checklist and TAB B for Emergency Call-Down Roster)

2. If potential disaster is weather related, closely monitor weather conditions and update department directors, as necessary.

3. Inform key agencies of any developing situation and protective actions contemplated.

4. Review the Disaster Preparedness Plan including evacuation routes with staff and residents.

5. Prepare the _________________ (designated area) for Command Post operations and alert staff of impending operations.

6. Receive calls from families; coordinate dissemination of messages.

7. Control facility access.

8. Confirm emergency staff availability and facilitate care of their families.

9. Pre-arrange emergency transportation of non-ambulatory residents (dialysis residents, etc.) and their records.

10. Check food and water supplies.

11. Store a supply of radios (recommend NOAA- National Oceanic and Atmospheric Administration weather radios) and flashlights. The NOAA Weather Radio broadcasts National Weather Service warnings, watches, forecasts and other hazard information 24 hours a day. The Weather Radios are equipped with a special alarm tone feature to sound an alert and give immediate information about a life threatening situation. Secure loose outdoor furniture and keep vehicles fueled (A 2 ½ tank reserve is recommended).

12. Coordinate with local authorities/agencies and private contacts to confirm availability of resources, including medical services, response personnel, etc.

13. Confirm transportation agreements with Emergency Medical Services agencies, tour bus companies or private individuals for buses or other emergency vehicles. (Check with your local and state emergency management office for examples.)
14. Have a plan in place for pharmaceuticals with ____________________________ (pharmacy name) and an alternate source to determine emergency operations in the event of halted deliveries or need for backup.

15. Warn staff and residents of the situation and expedient protective measures. Schedule extended shifts for essential staff; alert alternate personnel to be on stand-by.

16. Remain calm, reassure residents to minimize fear and panic.

C. Response

In response to an actual emergency situation, the facility administrator will coordinate the following actions:

1. Complete the actions of Pre-emergency and Preparedness outlined above.

2. Activate the Disaster Preparedness Plan and conduct Command Post operations involving communications, message control and routing of essential information.

3. Coordinate actions and requests for assistance with local jurisdiction emergency services and the community.

4. Determine requirements for additional resources and continue to update appropriate authorities and or services.

5. Ensure communication with residents' families and physicians.

6. Ensure prompt transfer of resident records.

D. Recovery

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

1. Coordinate recovery operations with the local Emergency Management Agency and other local agencies to restore normal operations, to perform search and rescue and to re-establish essential services.

2. Provide crisis counseling for residents/families as needed.

3. Provide local authorities a master list of displaced, missing, injured or dead and notify the next-of-kin.

4. Provide information on sanitary precautions for contaminated water and food to staff, volunteers, residents and appropriate personnel.

5. If necessary, arrange for alternate housing or facilities.
IV. ORGANIZATION AND RESPONSIBILITIES

The facility administrator is responsible for the overall direction and control of facility emergency operations, receiving requested assistance from the heads of each internal department, the local Emergency Management Agency, local Fire Department, private and volunteer organizations and various local and state departments and agencies. (See TAB E for Department Checklists)

Duties and activities that should be directed or assigned by the administrator:

1. Coordinate the activation and oversee the implementation of the disaster preparedness plans.

2. Direct operation of the Command Post.

3. Assign a coordinator for the delivery of resident medical needs.

4. Assign a coordinator accountable for residents and their records; and needed supplies.

5. Assign responsibility for maintaining safety of the facility grounds - securing necessary equipment and alternative power sources.

6. Review regularly the inventory of vehicles and report to administrative services.

7. Coordinate the emergency food services program.

8. Ensure availability of special resident menu requirements and assess needs for additional food stocks.

9. Assign a coordinator to ensure the cleanliness of all residents and provision of resident supplies for 7 – 10 days.

10. Coordinate the inspection of essential equipment (wet/dry vacuums) and protection of facility (lower blinds, close windows, secure loose equipment, etc.).

11. Provide security of facility/grounds and limit access to facility as necessary.

12. Coordinate provision of assistance to Maintenance and Housekeeping Departments.

13. Supervise notification of families on emergency operations.

14. Facilitate telecommunications and oversee release of information.
V. Authorities

A. Authorities

1. 42 CFR Ch IV, Part 483, Requirements for States and Long Term Care Facilities, 483.75, Administration: (m) Disaster and Emergency Preparedness.

2. 42 CFR Ch IV, Part 483, Requirements for States and Long Term Care Facilities, Subpart I Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded, Sec. 483.470, Condition of participation: Physical environment; (h) Disaster and Emergency Preparedness.

3. 19CSR Chapters 85, 86 and 90., Regulations for Skilled Nursing Facilities, Intermediate Care Facilities, Residential Care Facilities, and Adult Day Care.
Disaster Preparedness Plan Template for Long Term Care Facilities

This Supplement (Disaster Preparedness Tasks) may be used as a quick planning reference

Develop Emergency Plan: Gather all available relevant information when developing the emergency plan. This information includes, but is not limited to:

- Copies of any state and local emergency planning regulations or requirements
- Facility personnel names and contact information
- Contact information of local and state emergency managers
- A facility organization chart
- Building construction and Life Safety systems information
- Specific information about characteristics/needs of individuals for whom care is provided

All Hazards Plan: Develop a plan for all potential hazards (floods, tornadoes, fire, bioterrorism, pandemic, etc.) that could affect the facility directly and indirectly within the particular area of location. Indirect hazards could affect the community but not the facility and as a result interrupt necessary utilities, supplies or staffing.

Collaborate with Local Emergency Management Agency: Collaborate with local emergency management agencies to ensure the development of an effective emergency plan.

Collaborate with Suppliers/Providers: Collaborate with suppliers and/or providers who have been identified as part of a community emergency plan or agreement with the health care facility, to receive and care for individuals. A surge capability assessment should be included in the development of the emergency plan. Similarly, evidence of a surge capacity assessment should be included if the supplier or provider, as part of its emergency planning, anticipates the need to make housing and sustenance provisions for the staff and or the family of staff.

Analyze Each Hazard: Analyze the specific vulnerabilities of the facility and determine the following actions for each identified hazard:

- Specific actions to be taken for the hazard
- Identified key staff responsible for executing plan
- Staffing requirements and defined staff responsibilities
- Recommend identification/maintenance of sufficient supplies/equipment to sustain operations and deliver care and services for at least 7 – 10 days
- Communication procedures to receive emergency warning/alerts, and for communication with staff, families, individuals receiving care, before, during and after the emergency
- Designate critical staff, providing for other staff and volunteer coverage and meeting staff needs, including transportation and sheltering critical staff members’ family members

Decision Criteria for Executing Plan: Include factors to consider when deciding to evacuate or shelter in place. Determine who at the facility level will be in authority to make the decision to execute the plan to evacuate or shelter in place (even if no outside evacuation order is given) and what will be the chain of command.

Communication Infrastructure Contingency: Establish contingencies for facility communication infrastructure in the event of telephone failures (e.g., walkie-talkies, ham radios, text messaging systems, National Oceanic Atmospheric Administration (NOAA) weather radios, etc.).

Develop Shelter-in-Place Plan: Due to the risks in transporting vulnerable patients and residents, evacuation should only be undertaken if sheltering-in-place results in greater risk. Develop an effective plan for sheltering-in-place, by ensuring provisions for the following are specified:

- Procedures to assess whether facility is strong enough to withstand strong winds, flooding, etc.
- Measures to secure the building against damage (plywood for windows, sandbags and plastic for flooding, safest areas of the facility identified.
- Procedures for collaborating with local emergency management agency, fire, police and EMS agencies regarding the decision to shelter-in-place.
- Recommend sufficient resources are in supply for sheltering-in-place for a minimum of 7 - 10 days, including:
  - Ensuring emergency power, back-up generators and maintaining a supply of fuel
  - An adequate supply of potable water (recommended amounts may vary by location)
  - A description of the amounts and types of food in supply
  - Maintaining extra pharmacy stocks of common medications
  - Maintaining extra medical supplies and equipment (e.g., oxygen, linens, vital equipment)
Completed: This Supplement (Disaster Preparedness Tasks) may be used as a quick planning reference

- Identifying and assigning staff who are responsible for each task
- Description of hosting procedures, ensuring 24-hour operations for minimum of 7 - 10 days
- Contract established with multiple vendors for supplies and transportation
- Develop a plan for addressing emergency financial needs and providing security.

**Develop Evacuation Plan:** Develop an effective plan for evacuation, by ensuring provisions for the following are specified:
- Identification of person responsible for implementing the facility evacuation plan (even if no outside evacuation order is given)
- Multiple pre-determined evacuation locations (contract or agreement) with a “like” facility have been established, with suitable space, utilities, security and sanitary facilities for individuals receiving care, staff and others using the location, with at least one facility being 50 miles away. A back-up may be necessary if the first one is unable to accept evacuees.
- Evacuation routes and alternative routes have been identified, and the proper authorities have been notified. Maps are available and specified travel time has been established
- Adequate food supply and logistical support for transporting food is described.
- The amounts of water to be transported and logistical support is described.
- The logistics to transport medications is described, including ensuring their protection under the control of a registered nurse.
- Procedures for protecting and transporting resident/patient medical records.
- The list of items to accompany residents/patients is described.
- Identify how persons receiving care, their families, staff and others will be notified of the evacuation and communication methods that will be used during and after the evacuation
- Identify staff responsibilities and how individuals will be cared for during evacuation, and the back-up plan if there isn’t sufficient staff.
- Procedures are described to ensure residents/patients dependent on wheelchairs and/or other assistive devices are transported so their equipment will be protected and their personal needs met during transit (e.g., incontinent supplies for long periods, transfer boards and other assistive devices).
- A description of how other critical supplies and equipment will be transported is included.
- Determine a method to account for all individuals during and after the evacuation (Example: Place an arm band or name tag on each resident prior to transport for identification purposes)
- Procedures are described to ensure staff accompanies evacuating residents.
- Procedures are described if a patient/resident becomes ill or dies in route.
- Mental health and grief counselors are available at reception points to talk with and counsel evacuees. 
- It is described whether staff family can shelter at the facility and evacuate.

**Transportation & Other Vendors:** Establish transportation arrangements that are adequate for the type of individuals being served. Ensure that transportation vendors and other suppliers/contractors identified in the facility emergency plan have the ability to fulfill their commitments in case of disaster affecting an entire area (e.g., their staff, vehicles and other vital equipment are not “overbooked,” and vehicles/equipment are kept in good operating condition and with ample fuel.). Ensure the right type of transportation has been obtained (e.g., ambulances, buses, helicopters, etc).

**Train Transportation Vendors/Volunteers:** Ensure that the vendors or volunteers who will help transport residents and those who receive them at shelters and other facilities are trained on the needs of the chronic, cognitively impaired and frail population and are knowledgeable on the methods to help minimize transfer trauma.

**Facility Reentry Plan:** Describe who will authorize reentry to the facility after an evacuation, the procedures for inspecting the facility, and how it will be determined when it is safe to return to the facility after an evacuation. The plan should also describe the appropriate considerations for return travel back to the facility.

**Residents & Family Members:** Determine how residents and their families/guardians will be informed of the evacuation, helped to pack, have their possessions protected and be kept informed during and following the emergency, including information on where they will be/go, for how long and how they can contact each other.

**Resident Identification:** Determine how residents will be identified in an evacuation; and ensure the following identifying information will be transferred with each resident:
- Name
### This Supplement (Disaster Preparedness Tasks) may be used as a quick planning reference

- Social security number
- Photograph
- Medicaid or other health insurer number
- Date of birth, diagnosis
- Current drug/prescription and diet regimens
- Name and contact information for next of kin/responsible person/Power of Attorney

Determine how this information will be secured (e.g., laminated documents, water proof pouch around resident’s neck, water proof wrist tag, etc.) and how medical records and medications will be transported so they can be matched with the resident to whom they belong.

### Trained Facility Staff Members

Ensure that all facility staff members are trained to be knowledgeable and follow all details of the plan. Hold periodic reviews and appropriate drills and other demonstrations with sufficient frequency to ensure new members are fully trained.

### Informed Residents & Patients

Ensure residents, patients and family members are aware of and knowledgeable about the facility plan, including:

- Families know how and when they will be notified about evacuation plans, how they can be helpful in an emergency (example, should they come to the facility to assist?) and how/where they can plan to meet their loved ones.
- Out-of-town family members are given a number they can call for information. Residents who are able to participate in their own evacuation are aware of their roles and responsibilities in the event of a disaster.

Check for needed provisions being delivered to the facility/residents--power, flashlights, food, water, ice, oxygen, medications – and urgent action is taken to obtain the resources and assistance they need.

Determine the location of evacuated residents, document and report this information to the clearinghouse established by the state or partnering agency.

### Reviewed Emergency Plan

Complete an internal review of the emergency plan on an annual basis to ensure the plan reflects the most accurate and up-to-date information. Updates may be warranted under the following conditions:

- Regulatory change
- New hazards are identified or existing hazards change
- After tests, drills, or exercises when problems have been identified
- After actual disasters/emergency responses
- Infrastructure changes
- Funding or budget-level changes

### Conduct Exercises & Drills

Conduct exercises that are designed to test individual essential elements, interrelated elements, or the entire plan:

- Exercises or drills must be conducted at least semi-annually
- Corrective actions should be taken on any deficiency identified

### Loss of Resident’s Personal Effects

Establish a process for the emergency management agency representative (FEMA or other agency) to visit the facility to which residents have been evacuated, so residents can report loss of personal effects.
TAB A
NOTIFICATION PROCEDURES

I. Warning Systems
External Receipt of Warning
National Oceanic and Atmospheric Administration (NOAA)

Local government authorities should issue warning of a disaster by mass media (radio and television).

Internal

An internal warning of an emergency should come from the facility's Administrative Services and should be disseminated to staff, residents and visitors by ___________________________. (intercom, alarm system)

In the event of a power failure, the alternate alert/warning system shall be _____________________________.

II. Communications Procedures
All calls shall be routed through the Command Post.

Completed   Initials
________   ________   1. Alert staff, residents and visitors of emergency.
________   ________   2. Call off-duty staff from emergency call-down roster.
________   ________   3. Notify appropriate authorities. These authorities include:
               ___   a. Local Fire Department
                  # ____________________
               ___   b. Local Emergency Mgmt Agency
                  # ____________________
               ___   c. Department of Health & Senior Services
                  # 800-392-0210
               ___   d. Resident physicians and families

ATTACH LIST (PHYSICIANS, FAMILY NAMES AND NUMBERS)

________   ________   4. Keep authorities updated on emergency operations.

____________________________________________________   __________________________
Signature                                           Date
TAB B
EMERGENCY CALL-DOWN ROSTER

EMERGENCY SERVICES
(i.e. 911, Fire Department, Police Department, EMS)

Fire: # ________________________________
Police: # ________________________________
Ambulance: # ________________________________
Other: # ________________________________

FACILITY ADMINISTRATOR
# ________________________________

Administration Services Director
# ________________________________

Nurse/Medical Services Director
# ________________________________

Housekeeping Services Director
# ________________________________

Maintenance Services Director
# ________________________________

Dietary/Food Services Director
# ________________________________

Security Services Director
# ________________________________

Use additional pages as needed
NOTE: It is recommended that two types of evacuation procedures be developed. These include internal evacuation procedures (sheltering in place) and external evacuation procedures.

**DATE: __________________________ TIME: __________________________**

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<th>Initials</th>
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1. Identify and plainly designate marked exits, evacuation routes, and alternatives on master floor plan for both internal and external evacuations.

- Plan safe routes - avoid wooden stairs, open stairwells, boiler rooms, windows, etc.
- Assign handicapped, impaired or non-ambulatory residents to ground floor rooms, close to exits.
- Designate facility compartments for internal evacuation and for planning the safest external evacuation routes.

2. Inform staff/residents on exit locations and evacuation procedures.

3. **KEEP RESIDENTS CALM.**

4. Evacuate residents in orderly fashion, according to physical condition. (Use residents’ individual evacuation plans if appropriate.) Place a nametag on each resident for identification purposes.

- Ambulatory
- Wheelchair
- Bedfast residents

5. Search bathrooms, laundry room, storage closets/vacant rooms for stranded residents, visitors or staff and assist in their evacuation.

6. Clear corridors of any obstructions such as carts, wheelchairs, etc.

7. Turn off electrical appliances.

8. Recount residents to assure no missing residents.

9. Remove resident records.

_____________________________               ________________________________
Signature                          Date
If prepared, insert completed Fire Plan in this TAB

DATE: ___________________ TIME: _____________________

Completed  Initials

1. Post location of fire alarms.

2. Post location of fire extinguishers.

3. Train employees on use of alarm system and extinguishers.

4. Post directions on how to utilize emergency equipment.

5. Follow RACE procedures:

   R: Rescue - Rescue residents in immediate danger.

   A: Alarm - Sound nearest alarm if not already activated.

   C: Confine - Close doors behind you to confine fire. Crawl low if exit route is blocked by smoke.

   E: Extinguish - Utilize fire extinguisher as situation permits or;

   Evacuate - Follow evacuation procedures

________________________________________________________________________

Signature                        Date
EMERGENCY CHECKLIST
NATURAL DISASTERS

Completed  Initials

1. Severe Electrical Storms

__________ a. Relocate to inner areas of building as possible.
__________ b. Keep away from glass windows, doors, skylights and appliances.
__________ c. Refrain from using phones, taking showers.
__________ d. Stay away from computers

2. Tornado (WATCH ISSUED)

__________ a. Listen to local radio and TV stations for further updates. Check that radio batteries are available and charged
__________ b. Be alert to changing weather conditions.
__________ c. Secure equipment, outdoor furniture and articles act as projectiles.
__________ f. Alert staff to the need for possible sheltering of residents

Tornado (WARNING ISSUED)

__________ g. Seek shelter in designated area (i.e. safe room, basement, first floor interior hallways, restrooms or other enclosed small areas.
__________ h. Check restrooms or vacant rooms for visitors or stranded residents and escort to shelter area.
__________ i. Take position of greatest safety:

✓ If possible, crouch down on knees with head down and hands locked at back of neck, or:

✓ Protect head/body with pillows or mattress.

✓ Bedridden residents, if unable to be moved to central corridors, should have window blinds or curtains closed and protected as much as possible. Additional blankets may be used as shields.
3. Winter Storms

_______ _______ a. Secure facility against frozen pipes.
_______ _______ b. Check emergency and alternate utility sources.
_______ _______ c. Check emergency generator: Does it start? Is there fuel? What does it power.
_______ _______ d. Conserve utilities - maintain low temperatures, consistent with health needs.
_______ _______ e. Equip vehicles with chains and snow tires.
_______ _______ f. Keep sidewalks clear.

4. Flooding (External sources).

_______ _______ a. Shut off water main to prevent contamination.
_______ _______ b. Pack refrigerators/food lockers with dry ice.
_______ _______ c. Prepare to evacuate residents.

5. Flooding (Internal sources).

_______ _______ a. Turn off building electricity.
_______ _______ b. Move residents as required.

_____________________________             ________________________________
Signature                          Date
EMERGENCY CHECKLIST
WATER/ELECTRICAL OUTAGE

DATE: ___________________ TIME: ___________________

Completed  Initials

PREPAREDNESS:

1. Recommend a 7 – 10 day supply of food and water for residents and staff and a 7 – 10 day supply of emergency fuel.

2. Arrange for private contract to serve as an added back-up resource.

3. Work with the Local Emergency Management Agency in establishing a back-up resource.

4. Keep an accurate blueprint of all utility lines and pipes associated with the facility and grounds.

5. Develop procedures for emergency utility shutdown.

6. List all day and evening phone numbers of emergency reporting and repair services of all serving utility companies.

7. List names and numbers of maintenance personnel for day and evening notification.

RESPONSE - Electric Power Failure

1. Call #_______________ (power company).

2. Notify the maintenance staff.

3. Evacuate the building if danger of fire.

4. Keep refrigerated food and medicine storage units closed to retard spoilage.

5. Turn off power at main control point if short is suspected.

6. Follow repair procedures.
**Disaster Preparedness Plan Template for Long Term Care Facilities**

<table>
<thead>
<tr>
<th>Completed</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RESPONSE - Water Main Break**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Call #______________________________ (facility maintenance).</td>
</tr>
<tr>
<td>2.</td>
<td>Shut off valve at primary control point.</td>
</tr>
<tr>
<td>3.</td>
<td>Relocate articles which may be damaged by water.</td>
</tr>
<tr>
<td>4.</td>
<td>Call _________________________ (pre-designated assistance groups) if flooding occurs.</td>
</tr>
</tbody>
</table>

**RESPONSE - Gas Line Break**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Evacuate the building immediately. Follow evacuation procedures.</td>
</tr>
<tr>
<td>2.</td>
<td>Notify maintenance staff, Administrator, local public utility department, gas company and police and fire departments. List all numbers here.</td>
</tr>
<tr>
<td>3.</td>
<td>Shut off the main valve.</td>
</tr>
<tr>
<td>4.</td>
<td>Open windows.</td>
</tr>
<tr>
<td>5.</td>
<td>Re-enter building only at the discretion of utility officials.</td>
</tr>
</tbody>
</table>

__________________________________                  __________________________________
Signature                          Date
EMERGENCY CHECKLIST

BOMB THREAT INSTRUCTIONS

Insert your local police department’s telephone number below.* Notify your police department immediately after receiving a bomb threat. Do as the police department advises. Complete the form and give it to the Administrator, person in charge and/or police.

QUESTIONS TO ASK DURING A BOMB THREAT TELEPHONE CALL

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What kind of bomb is it?</td>
<td>Time: _____ Barometric Altitude: _____ Anti-handling: _____</td>
</tr>
<tr>
<td>2. What does the bomb look like?</td>
<td></td>
</tr>
<tr>
<td>3. Where is the bomb located right now?</td>
<td></td>
</tr>
<tr>
<td>4. When is the bomb going to explode?</td>
<td></td>
</tr>
<tr>
<td>5. What will cause the bomb to explode?</td>
<td></td>
</tr>
<tr>
<td>6. Did you place the bomb?</td>
<td></td>
</tr>
<tr>
<td>7. Why did you place the bomb?</td>
<td></td>
</tr>
<tr>
<td>8. Where are you calling from?</td>
<td></td>
</tr>
<tr>
<td>9. What is your name?</td>
<td></td>
</tr>
<tr>
<td>10. What is your address?</td>
<td></td>
</tr>
</tbody>
</table>

EXACT WORDING OF THREAT

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Sex of Caller: _____ Female _____ Male   Approximate Age of Caller: ____________
Possible Race of Caller: ______________ Is the voice familiar? Yes _____ No _____
If yes, whom did it sound like? ________________________________________________
Length of Call: ________   Number at Which Call Was Received: _________________
Date Received: ____________   Time Received: ____________
Person Receiving Call: __________________________ Police Department: ____________
## DESCRIPTION

**Circle/check all that apply.**

<table>
<thead>
<tr>
<th>VOICE</th>
<th>SPEECH</th>
<th>MANNER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loud</td>
<td>Fast</td>
<td>Calm</td>
</tr>
<tr>
<td>High Pitched</td>
<td>Distinct</td>
<td>Rational</td>
</tr>
<tr>
<td>Raspy</td>
<td>Stutter</td>
<td>Deliberate</td>
</tr>
<tr>
<td>Soft</td>
<td>Slurred</td>
<td>Angry</td>
</tr>
<tr>
<td>Deep</td>
<td>Slow</td>
<td>Crying</td>
</tr>
<tr>
<td>Pleasant</td>
<td>Lisp</td>
<td>Incoherent</td>
</tr>
<tr>
<td>Nasal</td>
<td>Breathless</td>
<td>Emotional</td>
</tr>
<tr>
<td>Disguised</td>
<td>Distorted</td>
<td>Laughing</td>
</tr>
<tr>
<td>Normal</td>
<td>Monotone</td>
<td>Intoxicated</td>
</tr>
</tbody>
</table>

**Circle/check the most appropriate answer. Use provided space for more specific information.**

<table>
<thead>
<tr>
<th>ACCENT</th>
<th>LANGUAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local</td>
<td>Articulate/Educated</td>
</tr>
<tr>
<td>Regional</td>
<td>Fair/Good</td>
</tr>
<tr>
<td>Foreign</td>
<td>Poorly Educated</td>
</tr>
<tr>
<td>Race</td>
<td>Cursing/Offensive</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>

## BACKGROUND NOISE

**Circle/check the most appropriate answer. Use provided space for more specific information.**

<table>
<thead>
<tr>
<th>Factory/Mechanical</th>
<th>Street/Traffic</th>
<th>Office Machinery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glassware/Café</td>
<td>Trains</td>
<td>Music</td>
</tr>
<tr>
<td>Airplanes</td>
<td>PA System</td>
<td>Rain/Thunder</td>
</tr>
<tr>
<td>Voices/Talking</td>
<td>Party Atmosphere</td>
<td>Quiet</td>
</tr>
<tr>
<td>Radio/TV</td>
<td>Household Appliance</td>
<td>Animals (Specify)</td>
</tr>
</tbody>
</table>

---

## FAMILIARITY:

**WITH THREATENED FACILITY**

<table>
<thead>
<tr>
<th>Much</th>
<th>Some</th>
<th>None</th>
</tr>
</thead>
</table>

**WITH GENERAL AREA/LOCATION**

<table>
<thead>
<tr>
<th>Much</th>
<th>Some</th>
<th>None</th>
</tr>
</thead>
</table>

---

## ADDITIONAL PERTINENT INFORMATION OR REMARKS

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
EMERGENCY CHECKLIST
MISSING RESIDENT

DATE: ____________________  TIME: ______________________

Completed  Initials

_______ ________ 1. Communicate internal notification of missing resident.

_______ ________ 2. Search every SPACE in facility.

_______ ________ 3. Search immediate grounds - supply flashlights.

_______ ________ 4. Call 911 or local Police Department.

_______ ________ 5. Contact DHSS Central Registry Unit 800-392-0210

_______ ________ 6. Notify responsible family member:

✔ Inform family that resident is missing.
✔ State that local Police Department has been notified.
✔ Ask family members to remain at home near phone.
✔ Discourage family members from coming to the facility until notified to do so.

_______ ________ 7. Supply resident's picture from medical records to search team members. (Current yearly photos are encouraged.)

____________________________             ______________________
Signature                                                                 Date
### EMERGENCY CHECKLISTS

#### DEPARTMENT RESPONSIBILITIES

**ADMINISTRATIVE SERVICES**

**DATE:** ______________________ | **TIME:** ______________________

<table>
<thead>
<tr>
<th>Completed</th>
<th>Initials</th>
</tr>
</thead>
</table>

1. Alert staff of emergency.
2. Determine extent/type of emergency.
3. Activate emergency plans.
4. Activate emergency staffing.
5. Provide transportation of emergency personnel, as needed.
6. Notify local jurisdiction support.
7. Contact pharmacy to determine:
   - a. Cancellation of deliveries?
   - b. Availability of backup pharmacy?
   - c. Availability of 7 - 10 days of medical supplies?
8. Authorize operation of crisis command post.
   - a. Provide checklists to staff.
   - b. Ensure communications equipment is operational.
9. Cancel special activities (i.e.: trips, activities, family visits, etc.)
10. Monitor the emergency communication station.
11. Receive briefings from Department Heads on pending operations.
12. Closely monitor weather reports for significant weather changes or warnings.
13. Determine need for evacuation and begin procedures, if necessary.
14. Arrange for emergency transportation of ambulatory residents.
15. If necessary, prepare facility for sheltering of external populations:
   - a. Designate allotted space and food.
   - b. Provide additional staffing.

_______________________________                             ___ ____________________
Signature     Date
EMERGENCY CHECKLIST
DIETARY/FOOD SERVICES

DATE: ______________________ TIME: _____________________

Completed  Initials

_________  ______  1. Check water and food for contamination.

_________  ______  2. Check refrigeration loss if refrigerator or food lockers are not on emergency power circuit.

_________  ______  3. Recommend 7 – 10 day supply of food storage for residents and staff.

_________  ______  4. Ensure availability of special resident menu requirements.

_________  ______  5. Assess needs for additional food stocks.

_________  ______  6. Secure dietary cart in sub-dining room or small, enclosed area.

_________  ______  7. Assemble required food and water rations to move to evacuation site, as necessary.

___________________________  ____________________
Signature     Date
EMERGENCY CHECKLIST

HOUSEKEEPING SERVICES

DATE: ____________________  TIME: ____________________

Completed    Initials

________  ______  1. Ensure cleanliness of residents.

________  ______  2. Ensure provision of resident supplies for five days.

________  ______  3. Clear corridors of any obstructions such as carts, wheelchairs, etc.

________  ______  4. Secure laundry cart in main bathroom.

________  ______  5. Check equipment (wet/dry vacuums, etc.)

________  ______  6. Secure facility (close windows, lower blinds, etc.)

_________________________         ___________________
Signature            Date
EMERGENCY CHECKLIST
MAINTENANCE SERVICES

DATE: ___________________________ TIME: ___________________________

Completed    Initials

_______  ______  1. Review staffing/extend shifts.

_______  ______  2. Check safety of surrounding grounds (secure loose outdoor equipment and furniture).

_______  ______  3. Secure doors.

_______  ______  4. Check/fuel emergency generator and switch to alternative power as necessary.

________  a. Alert Department Heads of equipment supported by emergency generator.

________  b. If pump or switch on emergency generator is controlled electrically, install manual pump or switch.

_______  ______  5. Check hazardous materials.

_______  ______  6. Conduct inventory of vehicles, tools and equipment and report to administrative service.

_______  ______  7. Fuel vehicles.

_______  ______  8. Identify shut off valves and switches for gas, oil, water and electricity and post charts to inform personnel.

_______  ______  9. Identify hazardous and protective areas of facility and post locations.

_______  ______  10. Close down/secure facility in event of evacuation.

__________________________________________  ______________________
Signature    Date
EMERGENCY CHECKLIST
NURSING/MEDICAL SERVICES

DATE: ______________________ TIME: _____________________

Completed  Initials

1. Ensure delivery of resident medical needs.
2. Assess special medical situations.
3. Coordinate oxygen use.
4. Relocate endangered residents.
5. Ensure availability of medical supplies.
6. Ensure safety of resident records.
7. Maintain resident accountability and control.
8. Supervise residents and their release to relatives, when approved.
9. Ensure proper control of arriving residents and their records.
10. Screen ambulatory residents to identify those eligible for release.
11. Maintain master list of all residents, including their dispositions.
   Forward this list to the local authorities.

__________________________   ______________________
Signature         Date
EMERGENCY CHECKLIST
RESIDENT SERVICES

DATE: ____________________ TIME: ____________________

Completed  Initials

1. Notify resident families.
2. Coordinate information release with senior administrator.
3. Facilitate telephone communication.
4. Act as message center.

Signature ____________________ Date ____________________
EMERGENCY CHECKLIST
SECURITY SERVICES

DATE: ___________________ TIME: ___________________

Completed  Initials

_______  ______  1. Assess building security.

_______  ______  2. Secure building as needed.

_______  ______  3. Control entry and exit.

_______  ______  4. Provide protection for residents and staff.

_________________________ ______________________
Signature            Date
Vehicle Resources Available

Locations and # of Buses ________________________________________________
______________________________________________________________________

Points of Contact _____________________________________________________

Locations and # of Vans ________________________________________________
______________________________________________________________________

Points of Contact _____________________________________________________

We recommend a minimum of five days supply for each consumable.

<table>
<thead>
<tr>
<th>Completed</th>
<th>Item</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Food Supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Water Supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ice Supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical/Medicine Supply</td>
<td></td>
</tr>
</tbody>
</table>
### TAB G
**EMERGENCY POINTS OF CONTACT DIRECTORY**

<table>
<thead>
<tr>
<th>Category</th>
<th>Name</th>
<th>Address</th>
<th>Phone EMER#</th>
<th>Bus#</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LOCAL FIRE DEPARTMENT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LOCAL POLICE DEPARTMENT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LOCAL EMERGENCY MEDICAL SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LOCAL EMERGENCY MANAGEMENT AGENCY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LOCAL AMERICAN RED CROSS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COUNTY/STATE HEALTH DEPARTMENT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**TAB H**

**WHAT TO DO AFTER A FLOOD**

- Listen for news reports to learn whether the community's water supply is safe to drink.

- Avoid floodwaters; water may be contaminated by oil, gasoline, or raw sewage. Water may also be electronically charged from underground or downed power lines.

- Be aware of areas where floodwaters have receded. Roads may have weakened and could collapse under the weight of a car.

- Stay away from downed power lines, and report them to the power company.

- Return home only when authorities indicate it is safe.

- Stay out of any building if it is surrounded by floodwaters.

- Use extreme caution when entering buildings; there may be hidden damage, particularly in foundations.

- Service damaged septic tanks, cesspools, pits, and leaching systems as soon as possible. Damaged sewage systems are serious health hazards.

- Clean and disinfect everything that got wet. Mud left from floodwater can contain sewage and chemicals.
TAB I
WHAT TO DO AFTER A HAZARDOUS MATERIALS INCIDENT

The following are guidelines for the period following a hazardous materials incident:

- Return home only when authorities say it is safe. Open windows and vents and turn on fans to provide ventilation.

- Act quickly if you have come in to contact with or have been exposed to hazardous chemicals. Do the following:
  
  o Follow decontamination instructions from local authorities. You may be advised to take a thorough shower, or you may be advised to stay away from water and follow another procedure.

  o Seek medical treatment for unusual symptoms as soon as possible.

  o Place exposed clothing and shoes in tightly sealed containers. Do not allow them to contact other materials. Call local authorities to find out about proper disposal.

  o Advise everyone who comes in to contact with you that you may have been exposed to a toxic substance.

- Find out from local authorities how to clean up your land and property.

- Report any lingering vapors or other hazards to your local emergency services office.
TAB J
WHAT TO DO AFTER A FIRE/WILDFIRE

The following are guidelines for different circumstances in the period following a fire:

- **If you are with burn victims, or are a burn victim yourself**, call 9-1-1; cool and cover burns to reduce chance of further injury or infection.

- **If you detect heat or smoke** when entering a damaged building, evacuate immediately.

- **If you are a tenant**, contact the landlord.

- **If you have a safe or strong box**, do not try to open it. It can hold intense heat for several hours. If the door is opened before the box has cooled, the contents could burst into flames.

The following are guidelines for different circumstances in the period following a wildfire:

- Check the roof immediately. Put out any roof fires, sparks or embers. Check the attic for hidden burning sparks.

- At the advice of local fire officials, maintain a "fire watch." This duty should be assigned to a specific person and the length of time of the “fire watch” shall be determined. Re-check for smoke and spark throughout the house.
TAB K
WHAT TO DO AFTER AN EARTHQUAKE

- **Expect aftershocks.** These secondary shockwaves are usually less violent than the main quake but can be strong enough to do additional damage to weakened structures and can occur in the first hours, days, weeks, or months after the quake.

- **Listen to a battery-operated radio or television** for latest emergency information.

- **Use the telephone only for emergency calls.**

- **Open cabinets cautiously.** Beware of objects that can fall off shelves.

- **Stay away from damaged areas** unless police, fire, or relief organizations have specifically requested your assistance. Return to the facility only when authorities say it is safe.

- **Help injured or trapped persons until emergency assistance arrives.** Give first aid where appropriate. Do not move seriously injured persons unless they are in immediate danger of further injury. Call for help.

- **Clean up spilled medicines, bleaches, gasoline or other flammable liquids immediately.** Leave the area if you smell gas or fumes from other chemicals.

- **Inspect the entire length of chimneys for damage.**

- **Inspect utilities.**
  - **Check for gas leaks.** If you smell gas or hear blowing or hissing noise, start evacuation procedures quickly. Turn off the gas at the outside main valve if you can.
  - **Look for electrical system damage.** If you see sparks, broken or frayed wires, or smell hot insulation, turn off the electricity at the main fuse box or circuit breaker. Begin evaluation procedures.
  - **Check for sewage and water lines damage.** If you suspect sewage lines are damaged, avoid using the toilets and call a plumber. If water pipes are damaged, contact the water company and avoid using water from the tap.
WHAT TO DO AFTER A LANDSLIDE OR DEBRIS FLOW

Guidelines for the period following a landslide:

- **Stay away from the slide area.** There may be danger of additional slides.
- **Listen to local radio or television stations** for the latest emergency information.
- **Watch for flooding,** which may occur after a landslide or debris flow. Floods sometimes follow landslides and debris flows because they may both be started by the same event.
- **Look for and report broken utility lines and damaged roadways and railways to appropriate authorities.** Reporting potential hazards will get the utilities turned off as quickly as possible, preventing further hazard and injury.
- **Check the building foundation, chimney, and surrounding land for damage.** Damage to foundations, chimneys, or surrounding land may help you assess the safety of the area.
- **Replant damaged ground as soon as possible** since erosion caused by loss of ground cover can lead to flash flooding and additional landslides in the near future.
- **Seek advice from a geotechnical expert for evaluating landslide hazards or designing corrective techniques to reduce landslide risk.** A professional will be able to advise you of the best ways to prevent or reduce landslide risk, without creating further hazard.
Disaster Preparedness Plan Template for Long Term Care Facilities

TAB M
GENERAL GUIDELINES

Disaster Events

- Everyone who sees or experiences a disaster is affected by it in some way.
- It is normal to feel anxious about your own safety and that of your family and close friends.
- Profound sadness, grief, and anger are normal reactions to an abnormal event.
- Acknowledging your feelings helps you recover.
- Focusing on your strengths and abilities helps you heal.
- Accepting help from community programs and resources is healthy.
- Everyone has different needs and different ways of coping.
- It is common to want to strike back at people who have caused great pain.
- Children and older adults are of special concern in the aftermath of disasters. Even individuals who experience a disaster “second hand” through exposure to extensive media coverage can be affected.
- Contact local faith-based organizations, voluntary agencies, or professional counselors for counseling.
- Additionally, FEMA and state and local governments of the affected area may provide crisis-counseling assistance.

Recognize Signs of Disaster Related Stress

When adults have the following signs, they might need crisis counseling or stress management assistance:

- Difficulty communicating thoughts.
- Difficulty sleeping.
- Difficulty maintaining balance in their lives.
- Low threshold of frustration.
- Increased use of drugs/alcohol.
- Limited attention span.
- Poor work performance.
- Headaches/stomach problems.
- Tunnel vision/muffled hearing.
- Colds or flu-like symptoms.
- Disorientation or confusion.
- Difficulty concentrating.
- Reluctance to leave home.
- Depression, sadness.
- Feelings of hopelessness.
- Mood-swings and easy bouts of crying.
- Overwhelming guilt and self-doubt.
- Fear of crowds, strangers, or being alone.
Easing Disaster-Related Stress

The following are ways to ease disaster-related stress:

- Talk with someone about your feelings - anger, sorrow, and other emotions - even though it may be difficult.
- Seek help from professional counselors who deal with post-disaster stress.
- Do not hold yourself responsible for the disastrous event or be frustrated because you feel you cannot help directly in the rescue work.
- Take steps to promote your own physical and emotional healing by healthy eating, rest, exercise, relaxation, and meditation.
- Maintain a normal family and daily routine, limiting demanding responsibilities on yourself and your family.
- Spend time with family and friends.
- Participate in memorials.
- Use existing support groups of family, friends, and religious institutions.
- Ensure you are ready for future events by restocking your disaster supplies kits and updating your family disaster plan. Doing these positive actions can be comforting.
TAB N

RETURNING TO FACILITY

Web-links for additional resources on disaster recovery:

- [General Tips](http://www.fema.gov/rebuild/recover/0)
- [Before You Enter Your Home](http://www.fema.gov/rebuild/recover/1)
- [Going Inside Your Home](http://www.fema.gov/rebuild/recover/2)

General Tips

Returning to your facility can be both physically and mentally challenging. Above all, use caution. Check for injuries. Do not attempt to move seriously injured persons unless they are in immediate danger of death or further injury. If you must move an unconscious person, first stabilize the neck and back, then call for help immediately.

- Keep a battery-powered radio with you so you can listen for emergency updates and news reports.

- Use a battery-powered flashlight to inspect a damaged home. Note: The flashlight should be turned on outside before entering - the battery may produce a spark that could ignite leaking gas, if present.

- Watch out for animals, especially poisonous snakes. Use a stick to poke through debris.

- [Be wary of wildlife and other animals](http://www.fema.gov/rebuild/recover/wildlife.shtm)

- Use the phone only to report life-threatening emergencies.

- Stay off the streets. If you must go out, watch for fallen objects; downed electrical wires; and weakened walls, bridges, roads, and sidewalks.

Before You Enter Your Facility

Walk carefully around the outside and check for loose power lines, gas leaks, and structural damage. If you have any doubts about safety, have your residence inspected by a qualified building inspector or structural engineer before entering.

DO NOT ENTER IF:

- You smell gas.
- Floodwaters remain around the building.
- Your home was damaged by fire and the authorities have not declared it safe.
Going Inside Your Facility

When you go inside your facility, there are certain things you should do. Enter the facility carefully and check for damage. Be aware of loose boards and slippery floors. The following items are other things to check inside your facility:

- **Natural gas.** If you smell gas or hear a hissing or blowing sound, open a window and leave immediately. Turn off the main gas valve from the outside, if you can. Call the gas company from a neighbor’s residence. If you shut off the gas supply at the main valve, you will need a professional to turn it back on. Do not smoke or use oil, gas lanterns, candles, or torches for lighting inside a damaged home until you are sure there is no leaking gas or other flammable materials present.

- **Sparks, broken or frayed wires.** Check the electrical system unless you are wet, standing in water, or unsure of your safety. If possible, turn off the electricity at the main fuse box or circuit breaker. If the situation is unsafe, leave the building and call for help. Do not turn on the lights until you are sure they’re safe to use. You may want to have an electrician inspect your wiring.

- **Roof, foundation, and chimney cracks.** If it looks like the building may collapse, leave immediately.

- **Appliances.** If appliances are wet, turn off the electricity at the main fuse box or circuit breaker. Then, unplug appliances and let them dry out. Have appliances checked by a professional before using them again. Also, have the electrical system checked by an electrician before turning the power back on.

- **Water and sewage systems.** If pipes are damaged, turn off the main water valve. Check with local authorities before using any water; the water could be contaminated. Pump out wells and have the water tested by authorities before drinking. Do not flush toilets until you know that sewage lines are intact.

- **Food and other supplies.** Throw out all food and other supplies that you suspect may have become contaminated or come in to contact with floodwater. If your basement has flooded, pump it out gradually (about one third of the water per day) to avoid damage. The walls may collapse and the floor may buckle if the basement is pumped out while the surrounding ground is still waterlogged.

- **Open cabinets.** Be alert for objects that may fall.

- **Clean up household chemical spills.** Disinfect items that may have been contaminated by raw sewage, bacteria, or chemicals. Also clean salvageable items.

- **Call your insurance agent.** Take pictures of damages. Keep good records of repair and cleaning costs.
Aiding the Injured

Check for injuries. Do not attempt to move seriously injured persons unless they are in immediate danger of death or further injury. If you must move an unconscious person, first stabilize the neck and back, then call for help immediately.

- If the victim is not breathing, carefully position the victim for artificial respiration, clear the airway, and commence mouth-to-mouth resuscitation.
- Maintain body temperature with blankets. Be sure the victim does not become overheated.
- Never try to feed liquids to an unconscious person.

Health

- Be aware of exhaustion. Don’t try to do too much at once. Set priorities and pace yourself. Get enough rest.
- Drink plenty of clean water.. Eat well.. Wear sturdy work boots and gloves.
- Wash your hands thoroughly with soap and clean water often when working in debris.

Safety Issues

- Be aware of new safety issues created by the disaster. Watch for washed out roads, contaminated buildings, contaminated water, gas leaks, broken glass, damaged electrical wiring, and slippery floors.
- Inform local authorities about health and safety issues, including chemical spills, downed power lines, washed out roads, smoldering insulation, and dead animals.

Seeking Disaster Assistance

Throughout the recovery period, it is important to monitor local radio or television reports and other media sources for information about where to get emergency housing, food, first aid, clothing, and financial assistance. Check with you local emergency planning director for assistance. The following section provides general information about the kinds of assistance that may be available.

Direct Assistance

Direct assistance to individuals and families may come from any number of organizations which provide food, shelter, supplies and assist in clean-up efforts, including:

- American Red Cross
- Salvation Army
- Other volunteer organizations
The Federal Role

In the most severe disasters, the federal government is also called in to help individuals and families with temporary housing, counseling (for post-disaster trauma), low-interest loans and grants, and other assistance. The federal government also has programs that help small businesses and farmers.

Most federal assistance becomes available when the President of the United States declares a “Major Disaster” for the affected area at the request of a state governor. FEMA will provide information through the media and community outreach about federal assistance and how to apply, or contact your local Emergency Management Director.
TAB 0
PLANNING FOR PETS AND SERVICE ANIMALS
IN AN EMERGENCY

For many people, pets and service animals are more than just animals – they are part of the family. As members of a family, they should be included in the emergency planning process. A few simple steps to ensure the pet’s safety can go a long way when disaster strikes.

Long term care facilities should identify those residents that have a pet or service animal and how those animals will be cared for in an emergency. The long term care facility itself must also plan for any pets that they keep on the premises (i.e., birds). Consider placing stickers on the main entrances of the facility to alert rescue workers to the number and types of pets inside and update the information on the stickers every six months or more.

EVACUATING WITH A PET OR SERVICE ANIMAL
Think about where the resident will go with the pet or service animal and how they will get there if they have to leave the facility during an emergency. Keep in mind that the place the resident will relocate to may not take pets or be able to care for them (such as a hospital, nursing home, or public shelter). As a reminder, service animals are always allowed. In planning for an emergency evacuation:

- Arrange for the resident’s family or friends to shelter the pet. Check with local veterinarians, boarding kennels, or grooming facilities to see if they can offer to shelter pets during an emergency. These arrangements should be made prior to an emergency (see Emergency Contacts below).

- Know where the pet/service animal’s collar/harness, leash, muzzle, etc., are kept so they can be easily found. Consider other essential items to take along if available and time permits such as:

  - Current color photograph of the resident and pet/service animal together (in case the resident is separated)
  - Copies of medical records that indicate dates of vaccinations and a list of medications the pet/service animal takes and why
  - Physical description of the pet/service animal, including species, breed, age, sex, color, distinguishing traits, and any other vital information about characteristics and behavior
  - Proof of identification and ownership
  - Collapsible cage or carrier
  - Comforting toys or treats

- When conducting evacuation drills, practice evacuating the pets/service animals. This will familiarize the animal with the process and increase their comfort level.
Identify staff that will assist the resident with their pet/service animal if needed or will be responsible for any pets the facility keeps on the premises.

- Identify which rooms the pets/service animals are located in (know the animals hiding places) so they can be easily found during an emergency.

- Keep in mind a stressed pet/service animal may behave differently than normal and their aggression level may increase. Use a muzzle to prevent bites. Also be advised that panicked animals may try to flee.

- Small animals can be transported using a covered carrier, cage, or secure box. To minimize stress, keep the carrier covered and attempt to minimize severe changes in temperature and noise. Animals too large for carriers should be controlled on a sturdy leash and may need to be muzzled.

**PROPER IDENTIFICATION**

- Pets and service animals must have proper identification. Dogs and cats should wear a collar or harness, rabies tag, and identification tag at all times. Identification tags should include a name, address, and phone number to contact.

- Talk to a veterinarian about microchipping the pet/service animal. A properly registered microchip enables positive identification if the resident and pet/service animal are separated.

**EMERGENCY CONTACTS**

Create a list of contacts for those residents with a pet or service animal as appropriate. This should be done before an emergency occurs. Consider local and out-of-area resources. Keep a copy of this list in a readily accessible location (near the phone). Contact information includes:

**Name and Telephone Number**

Local Veterinarian: ______________________________________________________

Alternate Veterinarian: ___________________________________________________

Emergency Pet Contact: _________________________________________________
(Family or Friend)

Local Boarding Facility: _________________________________________________

Local Animal Shelter: _________________________________________________

Missouri Humane Society: _______________________________________________
Disaster Preparedness Plan Template for Long Term Care Facilities

**TAB P
PANDEMIC INFLUENZA PLANNING CHECKLIST**

Planning for pandemic influenza is critical for ensuring a sustainable healthcare response. The Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) have developed this checklist to help long-term care and other residential facilities assess and improve their preparedness for responding to pandemic influenza. Based on differences among facilities (e.g., patient/resident characteristics, facility size, scope of services, hospital affiliation), each facility will need to adapt this checklist to meet its unique needs and circumstances. This checklist should be used as one tool in developing a comprehensive pandemic influenza plan. Additional information can be found at [www.pandemicflu.gov](http://www.pandemicflu.gov). Information from state, regional, and local health departments, emergency management agencies/authorities, and trade organizations should be incorporated into the facility's pandemic influenza plan. Comprehensive pandemic influenza planning can also help facilities plan for other emergency situations.

This checklist identifies key areas for pandemic influenza planning. Long-term care and other residential facilities can use this tool to self-assess the strengths and weaknesses of current planning efforts. Links to websites with helpful information are provided throughout this document. However, it will be necessary to actively obtain information from state and local resources to ensure that the facility's plan complements other community and regional planning efforts.

<table>
<thead>
<tr>
<th>Completed</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Structure for planning and decision-making.</td>
</tr>
<tr>
<td></td>
<td>❑ Pandemic influenza has been incorporated into emergency management planning and exercises for the facility.</td>
</tr>
<tr>
<td></td>
<td>❑ A multidisciplinary planning committee or team has been created to specifically address pandemic influenza preparedness planning. (List committee or team's name.) ____________________________</td>
</tr>
<tr>
<td></td>
<td>❑ A person has been assigned responsibility for coordinating preparedness planning, hereafter referred to as the pandemic influenza response coordinator. (Insert name, title and contact information.) ____________________________</td>
</tr>
<tr>
<td></td>
<td>❑ Members of the planning committee include (as applicable to each setting) the following: (Develop a list of committee members with the name, title, and contact information for each personnel category checked below and attach to this checklist.)</td>
</tr>
</tbody>
</table>
- Facility administration
- Medical director
- Nursing administration
- Infection control
- Occupational health
- Staff training and orientation
- Engineering/maintenance services
- Environmental (housekeeping) services
- Dietary (food) services
- Pharmacy services
- Occupational/rehabilitation/physical therapy services
- Transportation services
- Purchasing agent
- Facility staff representative
- Other member(s) as appropriate (e.g., clergy, community representatives, department heads, resident and family representatives, risk managers, quality improvement, direct care staff, collective bargaining agreement union representatives)

- Local and state health departments and provider/trade association points of contact have been identified for information on pandemic influenza planning resources. (Insert name, title and contact information for each.)

Local health department contact: ________________________________

________________________________________________________

State health department contact: ________________________________

________________________________________________________

- Local, regional, or state emergency preparedness groups, including bioterrorism/communicable disease coordinators points of contact have been identified. (Insert name, title and contact information for each.)

City: ______________________________________________________

County: __________________________________________________

Other regional: ____________________________________________

- Area hospitals points of contact have been identified in the event that facility residents require hospitalization or facility beds are needed for hospital patients being discharged in order to free up needed hospital beds. (Attach a list with the name, title, and contact information for each hospital.)

- The pandemic influenza response coordinator has contacted local or regional pandemic influenza planning groups to obtain information on coordinating the facility's plan with other influenza plans.

- Copies have been obtained of relevant sections of the HHS Pandemic Influenza Plan (available at [www.hhs.gov/pandemicflu/plan/](http://www.hhs.gov/pandemicflu/plan/)) and available state, regional, or local plans are reviewed for incorporation into the facility's plan.

- The facility plan includes the elements listed in #3 below.

- The plan identifies the person(s) authorized to implement the plan and the organizational structure that will be used.

3. Elements of an influenza pandemic plan

- A plan is in place for surveillance and detection of the presence of pandemic influenza in residents and staff.

  - A person has been assigned responsibility for monitoring public health advisories (federal and state), and updating the pandemic response coordinator and members of the pandemic influenza planning committee when pandemic influenza has been reported in the United States and is nearing the geographic area. For more information, see [www.cdc.gov/flu/weekly/fluactivity.htm](http://www.cdc.gov/flu/weekly/fluactivity.htm). (Insert name, title and contact information of person responsible.)

  - A written protocol has been developed for weekly or daily monitoring of seasonal influenza-like illness in residents and staff. For more information, see [www.cdc.gov/flu/professionals/diagnosis/](http://www.cdc.gov/flu/professionals/diagnosis/). (Having a system for tracking illness trends during seasonal influenza will ensure that the facility can detect stressors that may affect operating capacity, including staffing and supply needs, during a pandemic.)

  - A protocol has been developed for the evaluation and diagnosis of residents and/or staff with symptoms of pandemic influenza.

  - Assessment for seasonal influenza is included in the evaluation of incoming residents. There is an admission policy or protocol to determine the appropriate placement and isolation of patients with an influenza-like illness. (The process used during periods of seasonal influenza can be applied during pandemic influenza.)

  - A system is in place to monitor for, and internally review transmission of, influenza among patients and staff in the facility. Information from this monitoring system is used to implement prevention interventions (e.g., isolation, cohorting). (This system will
be necessary for assessing pandemic influenza transmission.)

- A facility communication plan has been developed. For more information, see www.hhs.gov/pandemicflu/plan/sup10.html.

- Key public health points of contact during an influenza pandemic have been identified. (Insert name, title and contact information for each.)

  - Local health department contact: ________________________
  - State health department contact: ________________________

- A person has been assigned responsibility for communications with public health authorities during a pandemic. (Insert name, title and contact information.) ________________________

- A person has been assigned responsibility for communications with staff, residents, and their families regarding the status and impact of pandemic influenza in the facility. (Having one voice that speaks for the facility during a pandemic will help ensure the delivery of timely and accurate information.)

- Contact information for family members or guardians of facility residents is up-to-date.

- Communication plans include how signs, phone trees, and other methods of communication will be used to inform staff, family members, visitors, and other persons coming into the facility (e.g., sales and delivery people) about the status of pandemic influenza in the facility.

- A list has been created of other healthcare entities and their points of contact (e.g., other long-term care and residential facilities, local hospitals' emergency medical services, relevant community organizations [including those involved with disaster preparedness]) with whom it will be necessary to maintain communication during a pandemic. (Insert location of contact list and attach a copy to the pandemic plan.) ________________________

- A facility representative(s) has been involved in the discussion of local plans for inter-facility communication during a pandemic.

- A plan is in place to provide education and training to ensure that all personnel, residents, and family members of residents understand the implications of, and basic prevention and control measures for, pandemic influenza.

  - A person has been designated with responsibility for coordinating education and training on pandemic influenza (e.g., identifies and facilitates access to available programs, maintains a record of...
personnel attendance). (Insert name, title, and contact information.)

- Current and potential opportunities for long-distance (e.g., web-based) and local (e.g., health department or hospital-sponsored) programs have been identified. See www.cdc.gov/flu/professionals/training/.

- Language and reading-level appropriate materials have been identified to supplement and support education and training programs (e.g., available through state and federal public health agencies such as www.cdc.gov/flu/groups.htm and through professional organizations), and a plan is in place for obtaining these materials.

- Education and training includes information on infection control measures to prevent the spread of pandemic influenza.

- The facility has a plan for expediting the credentialing and training of non-facility staff brought in from other locations to provide patient care when the facility reaches a staffing crisis.

Informational materials (e.g., brochures, posters) on pandemic influenza and relevant policies (e.g., suspension of visitation, where to obtain facility or family member information) have been developed or identified for residents and their families. These materials are language and reading-level appropriate, and a plan is in place to disseminate these materials in advance of the actual pandemic. For more information, see www.cdc.gov/flu/professionals/infectioncontrol/index.htm and www.cdc.gov/flu/groups.htm.

- An infection control plan is in place for managing residents and visitors with pandemic influenza that includes the following: (For information on infection control recommendations for pandemic influenza, see www.hhs.gov/pandemicflu/plan/sup4.html.)

  - An infection control policy that requires direct care staff to use Standard (www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html) and Droplet Precautions (i.e., mask for close contact) (www.cdc.gov/ncidod/dhqp/gl_isolation_droplet.html) with symptomatic residents.

  - A plan for implementing Respiratory Hygiene/Cough Etiquette throughout the facility. (See www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm.)

  - A plan for cohorting symptomatic residents or groups using one or more of the following strategies: 1) confining symptomatic residents...
and their exposed roommates to their room, 2) placing symptomatic residents together in one area of the facility, or 3) closing units where symptomatic and asymptomatic residents reside (i.e., restricting all residents to an affected unit, regardless of symptoms). The plan includes a stipulation that, where possible, staff who are assigned to work on affected units will not work on other units.

- Criteria and protocols for closing units or the entire facility to new admissions when pandemic influenza is in the facility have been developed.

- Criteria and protocols for enforcing visitor limitations have been developed.

- An occupational health plan for addressing staff absences and other related occupational issues has been developed that includes the following:
  - A liberal/non-punitive sick leave policy that addresses the needs of symptomatic personnel and facility staffing needs. The policy considers:
    - The handling of personnel who develop symptoms while at work.
    - When personnel may return to work after having pandemic influenza.
    - When personnel who are symptomatic, but well enough to work, will be permitted to continue working.
    - Personnel who need to care for family members who become ill.
  - A plan to educate staff to self-assess and report symptoms of pandemic influenza before reporting for duty.
  - A list of mental health and faith-based resources that will be available to provide counseling to personnel during a pandemic.
  - A system to monitor influenza vaccination of personnel.
  - A plan for managing personnel who are at increased risk for influenza complications (e.g., pregnant women, immunocompromised workers) by placing them on administrative leave or altering their work location.

- A vaccine and antiviral use plan has been developed.
  - CDC and state health department websites have been identified for obtaining the most current recommendations and guidance for the use, availability, access, and distribution of vaccines and antiviral medications during a pandemic. For more information, see
HHS guidance has been used to estimate the number of personnel and residents who would be targeted as first and second priority for receipt of pandemic influenza vaccine or antiviral prophylaxis. For more information, see www.hhs.gov/pandemicflu/plan/sup6.html and www.hhs.gov/pandemicflu/plan/sup7.html.

- A plan is in place for expediting delivery of influenza vaccine or antiviral prophylaxis to residents and staff as recommended by the state health department.

- Issues related to surge capacity during a pandemic have been addressed.
  - A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations.
  - A person has been assigned responsibility for conducting a daily assessment of staffing status and needs during an influenza pandemic. (Insert name, title and contact information.)

- Legal counsel and state health department contacts have been consulted to determine the applicability of declaring a facility "staffing crisis" and appropriate emergency staffing alternatives, consistent with state law.

- The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis.

- Estimates have been made of the quantities of essential materials and equipment (e.g., masks, gloves, hand hygiene products, intravenous pumps) that would be needed during a six-week pandemic.

- A plan has been developed to address likely supply shortages, including strategies for using normal and alternative channels for procuring needed resources.

- Alternative care plans have been developed for facility residents who need acute care services when hospital beds become unavailable.

- Surge capacity plans include strategies to help increase hospital bed
Disaster Preparedness Plan Template for Long Term Care Facilities

<table>
<thead>
<tr>
<th>capacity in the community.</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Signed agreements have been established with area hospitals for admission to the long-term care facility of non-influenza patients to facilitate utilization of acute care resources for more seriously ill patients.</td>
</tr>
<tr>
<td>o Facility space has been identified that could be adapted for use as expanded inpatient beds and information provided to local and regional planning contacts.</td>
</tr>
<tr>
<td>▪ A contingency plan has been developed for managing an increased need for post mortem care and disposition of deceased residents.</td>
</tr>
<tr>
<td>▪ An area in the facility that could be used as a temporary morgue has been identified.</td>
</tr>
<tr>
<td>▪ Local plans for expanding morgue capacity have been discussed with local and regional planning contacts.</td>
</tr>
</tbody>
</table>
## RESOURCES

<table>
<thead>
<tr>
<th>NAME OF RESOURCE</th>
<th>E-MAIL ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Red Cross; Disaster Services</td>
<td><a href="http://www.redcross.org/services/disaster/0,1082,0_501_.00.html">http://www.redcross.org/services/disaster/0,1082,0_501_.00.html</a></td>
</tr>
<tr>
<td>Department of Health and Human Services Administration on Aging</td>
<td><a href="http://www.aoa.gov/eldfam/Disaster_Assistance/Disaster_Assistance.asp">http://www.aoa.gov/eldfam/Disaster_Assistance/Disaster_Assistance.asp</a></td>
</tr>
<tr>
<td>Local Public Health Agency (LPHA) Listing</td>
<td><a href="http://www.dhss.mo.gov/LPHA/LPHAs.html">http://www.dhss.mo.gov/LPHA/LPHAs.html</a></td>
</tr>
<tr>
<td>Long Term Care Regional Map</td>
<td><a href="http://www.dhss.mo.gov/NursingHomes/ProviderInfo.html">http://www.dhss.mo.gov/NursingHomes/ProviderInfo.html</a></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.dhss.mo.gov/SeniorServices/index.html">http://www.dhss.mo.gov/SeniorServices/index.html</a></td>
</tr>
<tr>
<td>Missouri Assisted Living Association</td>
<td><a href="http://www.malarcf.org">http://www.malarcf.org</a></td>
</tr>
<tr>
<td>Missouri Association of Homes for the Aging</td>
<td><a href="http://www.moaha.org/">http://www.moaha.org/</a></td>
</tr>
<tr>
<td>Missouri Department of Health and Senior Services</td>
<td><a href="http://www.dhss.mo.gov/BT_Response/Nat_Disaster/index.htm">http://www.dhss.mo.gov/BT_Response/Nat_Disaster/index.htm</a></td>
</tr>
<tr>
<td>Emergency Response and Terrorism</td>
<td></td>
</tr>
<tr>
<td>Missouri Health Care Association</td>
<td><a href="http://www.mohealthcare.com/">http://www.mohealthcare.com/</a></td>
</tr>
<tr>
<td>Missouri State Emergency Management Agency</td>
<td><a href="http://www.sema.dps.mo.gov">http://www.sema.dps.mo.gov</a></td>
</tr>
<tr>
<td>Jefferson City, Mo.</td>
<td></td>
</tr>
<tr>
<td>PHONE: (573) 526-9100</td>
<td></td>
</tr>
<tr>
<td>MO Department of Health and Senior Services Section for Long Term Care</td>
<td><a href="http://www.dhss.mo.gov/">http://www.dhss.mo.gov/</a></td>
</tr>
<tr>
<td>Jefferson City, MO  65109</td>
<td></td>
</tr>
<tr>
<td>PHONE:  573/526-8570</td>
<td></td>
</tr>
<tr>
<td>One-stop access to U.S. Government avian/pandemic flu information. Long Term Care; Managed by the Dept of Health and Human Services</td>
<td><a href="http://www.pandemicflu.gov/plan/LongTermCareChecklist.html">http://www.pandemicflu.gov/plan/LongTermCareChecklist.html</a></td>
</tr>
</tbody>
</table>

Last Modified Date: ________________________________________
Writing Guide for a Memorandum of Understanding (MOU)
Communications Interoperability Continuum

Figure 1
Writing Guide for a Memorandum of Understanding (MOU)

Overview and Background

With its Federal partners, SAFECOM provides research, development, testing and evaluation, guidance, tools, and templates on communications-related issues to local, tribal, state, and Federal emergency response agencies. A communications program of the Department of Homeland Security’s Office for Interoperability and Compatibility, SAFECOM is managed by the Science and Technology Directorate.

SAFECOM helps the public safety community and local, tribal, state, and Federal policy makers address critical elements for success as they plan and implement interoperability solutions. The program is working with the public safety community to encourage a shift from a technology-centric approach to a comprehensive focus on improving interoperability. Although technology is critical for improving interoperability, other elements, including governance, standard operating procedures, training and exercises, and usage of interoperable communications, play a vital role.

To assist this shift to a comprehensive focus on interoperability, SAFECOM worked with public safety practitioners and local communities to develop a comprehensive framework called the Interoperability Continuum (see Figure 1).

SAFECOM developed the Interoperability Continuum in accordance with its locally driven philosophy and its practical experience in working with communities across the Nation. The Continuum visually depicts the core facets of interoperability according to the stated needs and challenges of the public safety community and aids the efforts of public safety practitioners and policy makers to improve interoperability.

One of SAFECOM’s goals is to provide the public safety community with tools to progress along all elements of the Continuum. This tool focuses on the Governance element of the Continuum and is specifically aimed to help communities interested in establishing formal agreements, such as Memorandums of Understanding (MOU), to address multi-organization coordination and communications.
Purpose

This tool provides guidance for developing an MOU. It includes:

• Recommendations for structuring the MOU
• Questions to consider when generating content for each section
• Sample language to illustrate how a community could write each MOU section

How To Use This Tool

This tool is intended to be your guide for writing an MOU. The document is laid out in a recommended MOU structure with suggested headings for each section. Each section poses questions to consider to help guide you when writing content for it. Sample paragraphs are included for your reference; however, it is important to note that the sample paragraphs are geared for illustration purposes toward a specific MOU example. The sample used in this document is for a city that is setting up an MOU among disciplines for the use of an intra-jurisdictional interoperability channel. Further, each community’s MOU language will need to be modified according to the purpose of the agreement. The sample paragraphs provide examples and guidance only and should not be taken literally.

This document does not address every issue that jurisdictions may face when seeking to establish an MOU. An MOU should be customized to the capability or resource for which it is established and should consider any unique characteristics of the specific community and participating jurisdictions.
MOU Section 1: Introduction

The introduction section of the MOU helps the reader to understand the agreement content. It describes the need, the agencies involved, why it is necessary to work together, etc. This section should be a simple explanation of the agreement and why it is necessary. It does not need to include details about past efforts or discuss how the agencies reached this level of agreement.

1. For what capability or resource is this MOU being created?
2. What agencies are participating in the MOU? Include public safety agencies, other governmental bodies, and any private services.
3. Why is this MOU necessary?
4. What agreements are set forth by this MOU?

[Insert name of city here] public safety agencies recognize the need for interagency communication, interoperability, and cooperation. [Insert name of city here] police, fire response, and Emergency Medical Services (EMS) have well-established interoperability capabilities and mutual aid agreements in place. While these plans and agreements formally extend beyond jurisdictions, they tend to remain intra-discipline in practice. Today’s public safety realities have highlighted the need for agencies to work together to establish communications interoperability and mutual aid plans—not only across traditional jurisdictional boundaries—but across disciplines as well.

To remedy the intra-discipline communication problem, the [insert name of city here] public safety agencies, [insert agency names here], as well as the public service agencies [insert agency names], have worked cooperatively to develop an intra-jurisdictional interoperability solution. This solution establishes dedicated radio channels with procedures that are accessible on communication equipment used by key public service officials, public safety officials, and public and private service executives.
MOU Section 2: **PURPOSE**

The purpose section should be a concise statement discussing the intention of the new or proposed capability that makes the MOU necessary. It explains how the agencies involved will use the new capability and under what circumstances.

1. To what capability does the MOU apply? When answering this question, consider the questions that follow.
   a. What is the intended level of command?
   b. When will it be used?
   c. How will it be used?

The purpose of the intra-jurisdictional interoperability channel is to provide a command-level communications structure for [insert name of city here] and other key support agencies when managing any incident that affects public safety in [insert name of city here]. This network transcends traditional or mutual intra-discipline aid in terms of purpose. The intra-jurisdictional interoperability channel ensures an organized method of coordinating [insert name of city here] resources to expedite efficient deployment of those resources and serves primarily as a logistics and unified command network.

MOU Section 3: **SCOPE**

The scope section lists the agencies and jurisdictions to be included in the agreement and describes their relationship. This section can also discuss end users, level of command, level of government, voice and/or data, etc.

1. Who are the public safety, public service, and other governmental and non-governmental agencies that will use the capability/resource?
2. What is the authorized user command level for the capability/resource?

The scope of the intra-jurisdictional interoperability channel includes [insert name of city here] public safety agencies including [insert name of city here] police, fire, and EMS, as well as [insert name of city here] public service agencies including [insert public service agency names here]. Each agency has its own interoperability capabilities beyond the intra-jurisdictional interoperability channel.
**MOU Section 4: Definitions**

The definition section describes the operational and technical terms associated with the capability or resource for which the agreement is written. Providing definitions will help avoid confusion and uncertainty.

Questions to consider:

1. What are the technical and operational aspects of the capability/resource? Consider including definitions for each.
2. Are there any community-specific terms or acronyms? Consider including these acronyms and definitions.

The interoperability channels are referred to as [insert name of capability], whether transmitting on the [insert name of city] public safety communication system or the city’s 800 Megahertz (MHz) trunked communication system. The [insert name of capability] is composed of one dedicated Ultra High Frequency (UHF) channel and a dedicated talk group on the city’s trunked system that are “cross-patched.”

**MOU Section 5: Policy**

The policy section of the MOU briefly describes circumstances under which the capability can be used. This section can also mention authorized use, activation, timing, and other circumstances.

Questions to consider:

1. When can the capability/resource be used?
2. When should the capability/resource be considered for use?
3. Who has the ability to authorize use of the capability/resource?
4. Are there operating procedures associated with this capability/resource? Can specific procedures be referenced?

The intra-jurisdictional interoperability channel is available for use on an as-needed basis any time multidiscipline operations dictate or at the discretion of the mayor’s office. At a minimum, use of the channel should be considered during the planning phase for all large preplanned events and incorporated into any written operations plans. In the case of unplanned events, use of the channel will be in accordance with procedures outlined in the [insert name of capability/resource here] Standard Operating Procedures (SOP).
MOU Section 6: User Procedure Requirements

This section outlines the obligations of this agreement. For an agreement on sharing an enhanced capability, obligations may include training, exercises, user requirements, responsible parties for ensuring training, and awareness.

1. What are the training, exercise, and equipment requirements associated with participating in this MOU?
2. Are there additional requirements?
3. Are there any financial obligations that must be considered?

By signing this agreement, each agency using the intra-jurisdictional interoperability channel agrees to participate in city-wide drills to the greatest possible extent. The purpose of these procedure requirements is to ensure awareness of the channel and to prepare city personnel for its activation. Agencies with a signed MOU will be permitted to operate on the frequency but are required to provide and maintain their own equipment.

MOU Section 7: Maintenance

The maintenance section designates a responsible party or parties for maintaining equipment, systems, and licenses. The maintenance section can name a jurisdiction, agency, or individual.

1. What are the maintenance requirements associated with participating in this MOU?
2. Who will own the licenses?
3. Who will maintain the equipment?

The [insert name of city here] fire department will be responsible for licensing and maintaining the UHF and 800 MHz trunked systems that make up the intra-jurisdictional interoperability channel.
MOU Section 8: OVERSIGHT

The oversight section describes how agencies or jurisdictions will deploy the new capability. It can also describe how the agencies can provide recommendations that affect policy and whether other agencies accept or reject these recommendations. A description of internal agency policy regarding usage of the capability can also be provided.

1. What governance structure oversees the use of this capability/resource and enforces all requirements of this MOU?
2. Who is the chair of this governance structure and how is he/she appointed?
3. What are the participation requirements in this governance structure of agencies entering this MOU?
4. How are issues affecting policy, recommendations, and/or subsequent change implemented by the governance structure?
5. What is the voting method within the governance structure?
6. How do individual agencies establish oversight authority for the capability/resource?

Questions to consider:

Oversight of the intra-jurisdictional interoperability channel is administered through the [insert city name here] Interoperability Committee core members. The committee will be chaired by an appointee of the Mayor. Each agency participating in the use of the channel is required to provide a representative to the Interoperability Committee after entering into this MOU.

Any issues affecting policy, recommendation, and/or subsequent change that alter the purpose of the intra-jurisdictional interoperability channel will be implemented only after a consensus is reached by the Interoperability Committee.

Accordingly, each agency must establish oversight authority and the level of delegation in reference to use of the intra-jurisdictional interoperability channel.
MOU Section 9: Responsibility for SOP Compliance

This section assigns responsibility to agencies to ensure Standard Operating Procedures (SOP) for the capability are followed.

Questions to consider:

① Who is responsible for ensuring the SOPs associated with this capability/resource are followed and that individual agency personnel are trained appropriately?

② How will compliance be carried out?

It is the responsibility of agency heads to ensure that the intra-jurisdictional interoperability channel SOPs are followed when necessary and to ensure that agency personnel are trained appropriately.

MOU Section 10: Updates to the MOU

This section describes how updates can be made to the MOU. It includes information such as who has the authority to update the MOU, how updates will be made, how participating agencies will be notified of updates, and the types of updates that will require signatures of all participating agencies.

Questions to consider:

① Who has the authority to update/modify this MOU?

② How will this MOU be updated/modified?

③ Will updates/modifications require this MOU to have a new signature page verifying the understanding of changes by each participating agency?

Updates will take place after the Interoperability Committee meets and gains consensus on proposed changes. It is then the responsibility of the committee to decide the best possible method of dissemination to all affected agencies. In the event that a proposed change or technical upgrade to the intra-jurisdictional interoperability channel degrades the capability or changes the purpose of the channel, a new signature page verifying the understanding of changes may be required.
Conclusion

For any area or region to improve communications interoperability, collaboration and participation of pertinent public safety stakeholders in a governing body are essential. A formal governance structure provides a unified front across multiple jurisdictions and disciplines within a particular political constituency. Such unity aids the funding, effectiveness, and overall support for communications interoperability. An MOU is important because it defines the responsibilities of each party in an agreement, provides the scope and authority of the agreement, clarifies terms and outlines compliance issues. It is SAFECOM’s hope that this writing guide for an MOU helps practitioners establish the partnerships and authority necessary to achieve an effective governance structure for interoperable communications.
Sample Application

The following can be used to add agencies, jurisdictions, or individuals to the agreement.

This application is submitted by the requesting agency to the chair of the [governance body] for participation in the [name of capability/resource]. [Name of capability/resource] participation is governed by the [governance body]. Submission and acceptance of this application grants the authority for the use of the [name of capability/resource] as outlined in this MOU and in accord with the [capability/resource SOP]. Each agency will need to update its own contact information with the [governance body].

APPROVED BY:

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This MOU must be signed by the agency’s head or his/her designee and submitted to the appropriate governing body for consideration.
The Department of Homeland Security (DHS) established the Office for Interoperability and Compatibility (OIC) in 2004 to strengthen and integrate interoperability and compatibility efforts in order to improve local, tribal, state, and Federal emergency response and preparedness. Managed by the Science and Technology Directorate, OIC is assisting in the coordination of interoperability efforts across DHS. OIC programs and initiatives address critical interoperability and compatibility issues. Priority areas include communications, equipment, and training. A communications program of OIC, SAFECOM, with its Federal partners, provides research, development, testing and evaluation, guidance, tools, and templates on communications-related issues to local, tribal, state, and Federal emergency response agencies.
TRANSPORTATION AND EMERGENCY PREPAREDNESS CHECKLIST

From the events of September 11, 2001 to the devastation wrought by recent hurricanes in Florida and all along the Gulf Coast, the manner in which plans, procedures, and responses to emergency events are implemented, clearly, can save lives and rebuild communities. The need to safely and efficiently transport people, particularly those for whom community and public transportation is their primary means of mobility, before, during, and after emergency situations, is a crucial consideration.

This Transportation and Emergency Preparedness Checklist was developed by a gathering of public and community transportation professionals who convened in April 2006 at the behest of the National Consortium on the Coordination of Human Service Transportation. It is intended to provide practical guidance to transportation providers and their partner organizations in planning for the transport of persons requiring mobility assistance in the event of an emergency. The Checklist was designed to be used as a tool during the planning process—prior to an emergency situation—to ensure safe and appropriate transportation for transportation-dependent populations, including older adults, persons living in group situations, persons with disabilities (including persons with physical, visual, hearing, intellectual, psychiatric, learning, and cognitive disabilities), and individuals without access to personal transportation.

Planning and Coordination Before Emergency Situations

- Establish and maintain working relationships with partner organizations including a variety of community-based organizations—including advocacy organizations, agencies that serve the transportation-dependent populations, employment and training providers, health and human service agencies, faith and community-based organizations, departments of Workforce Development and One-Stop Career Center, and emergency response organizations and personnel. Maintain up-to-date contact list and network of communication.
Organize and conduct regular, periodic drills that include the procedures for evacuating transportation-dependent populations.

Clarify rules, regulations, and chains of responsibility at the local, state, and federal levels.

**Identify Those Needing Transportation Assistance**

Collaborate with partner organizations in identifying individuals who may require transportation assistance in the event of an emergency.

In accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations, explore the development of voluntary registries for individuals requiring transportation assistance. For those individuals agreeing to be on voluntary registries, seek to have a signed authorization. Further information on signed authorizations is available through [http://www.hhs.gov/ocr/hipaa/decisiontool/tool/auths.html](http://www.hhs.gov/ocr/hipaa/decisiontool/tool/auths.html)

*Identify and determine the appropriate transportation response for persons unable to reach a pick up/drop off location or staging area on their own, what entity will handle such needs, and what types of vehicles/equipment will be required.

Determine strategies for tracking individuals who are evacuated. Information should include the passenger’s name, point of origin, departure time, final destination, and arrival time. Ensure that enough transportation capacity exists with transportation providers, partner agencies, and suppliers to effectively meet the demand in an emergency.

**Public Involvement and Community Outreach**

Conduct outreach and education that ensures public awareness of the transportation plan, particularly as it relates to those populations requiring transportation assistance in the event of an emergency.
Include members of the public and private sector (including local businesses) in the planning and outreach process, ensuring participation of potentially transportation-dependent populations including older adults, persons with disabilities (including physical, visual, hearing, intellectual, psychiatric, learning, and cognitive disabilities), people living in group situations, and those without access to personal transportation.

Using a variety of media and accessible formats such as Braille, large-type, audio, and appropriate languages, broadly publicize information related to staging areas and pickup/drop-off locations. Determine a point-of-contact person who will address questions from the public.

Provide information in a variety of formats to accommodate non-English speakers and persons with visual or auditory disabilities or difficulties reading printed text due to visual impairments, color blindness, illiteracy, learning disabilities, or mobility limitations that may interfere with holding or turning the pages of printed materials.

Equipment and Personnel Support

Establish a reliable communications system utilizing available technologies. Ensure the availability of an alternative system in the event that normal dispatching networks and telephones are not functional and when electrical power may be out.

Maintain a transportation resources list by type and availability, including vehicle accessibility and capacity information. Develop procedures for the acquisition of additional accessible transportation equipment, securement devices, supplies, and resources.

Secure agreements with fuel suppliers and other local agencies (such as police and fire departments) that require a reliable fuel source. Distribute and maintain list of these fueling sites.

Compile and distribute evacuation route information to be used
during emergency operations, including alternative evacuation route information should the primary route be inaccessible due to damage or danger.

☐ Provide staff training regarding the emergency plan, including a review of procedures for transporting persons with a variety of assistance needs, as well as the transport of service animals.

☐ Identify staff with foreign language and sign language skills; provide staff training to ensure basic communication skills in sign language and relevant foreign languages.

☐ Maintain a master list of drivers by status and availability.

☐ Prior to activation, provide staff the opportunity to ensure the safety and security of their loved ones and personal property.

**When an Emergency is Imminent**

☐ Local officials notify partner agencies and organizations of threat.

☐ Following agreed-upon plans, coordination begins among emergency departments, public safety agencies, hospitals, transportation providers, etc.

☐ Designated transportation staging areas and pick up/drop off locations are activated.

☐ Staff, key partner agencies, and other vital personnel as designated in the emergency plan are placed on stand-by.

☐ All drivers and operations personnel are notified of potential
deployment of emergency plan, and are instructed to follow their
pre-determined emergency preparation roles.

☐ Following established protocols, persons with assistance needs
who require direct personal contact are notified of the impending
evacuation and where they will be transported.

☐ All passengers are transported to their destinations on the
planned evacuation routes or alternative routes as necessary.

During Emergency Situations

☐ Evacuation notifications are communicated to partner
organizations, and following established protocols, to pre-determined
transportation-dependent groups such as older adults, persons living in
group situations, persons with disabilities (including persons with
physical, visual, hearing, intellectual, psychiatric, learning, and
cognitive disabilities), and individuals without access to personal
transportation.

☐ In accordance with the local plan, participating agencies and
organizations are involved-with necessary personnel-to affect
evacuation, sheltering, response, and initial recovery.

☐ Emergency transportation officials report to Emergency
Operations Center (EOC).

☐ Transportation service is activated upon request of EOC
officials, or as stipulated in the plan.

☐ All transportation activities and operations are coordinated
from the EOC.

☐ Transportation operations are directed over normal dispatching
networks (if available), telephones (landlines), and cell phones, or previously tested and agreed-upon alternative communications systems as necessary.

☐ Personnel and equipment are deployed to pre-assigned locations or staging areas, including designated supervisors, mechanics, and drivers.

☐ Vehicles are fueled prior to evacuation, refueled as necessary during the evacuation process, fueled after the final trip to the sheltering location, and then taken to the pre-determined location where they will be housed safely until the response effort begins.

☐ When a vehicle reaches full capacity, the driver departs to the designated evacuation location.

☐ Door-to-door service is provided as designated in the emergency plan, based upon medical necessity or the specific transportation needs of the passenger.

☐ A roster is prepared and maintained by the operator, containing at a minimum the following information:

- Name of driver
- Driver's telephone number
- Time departed staging area
- Time arrived at sheltering location
- Vehicle number
- Sheltering location
- Trip mileage

This roster is vital as it provides a record of service that can be used after the emergency for billing purposes.

As has been highlighted in the emergency response training,
the operator reports to transportation supervisors at the agreed-upon location to receive further instructions. Operators shall continue transporting until released by the EOC.

In the event the EOC must be evacuated, transportation officials will provide vehicles to transport EOC personnel and essential equipment to pre-designated alternative EOC locations.

**Reentry and Recovery Preparations**

- Initiate recovery operations as designated in the emergency plan.

- Following the plan, operator and vehicle remain at the sheltering location to return evacuees to their home communities. Generally, passengers will return with the same operator and via the same vehicle used during the evacuation. Alternative plans for return should be in place, in the event that the evacuation lasts for days or weeks, or possibly longer.

- *Operators and passengers have picture identification to get back to their home area.*

- All operators will remain on duty in accordance with the emergency plan.

- Transportation officials, in coordination with the EOC, will assign other tasks relating to the transportation component of reentry and recovery as the situation dictates.

- Vehicles will return to established drop-off points near passengers' residences or directly to the residence, based upon necessity.

**Assessment**
☐ Evaluate emergency response effort, identifying successes and gaps in service.

☐ Make appropriate changes to the emergency plan and communicate such changes to partner organizations and the public.
### LEVEL I
**Description:** Patients/residents are usually transferred from inpatient medical treatment facilities and require a level of care only available in hospital or Skilled Nursing or Subacute Care Facilities.

**Examples:**
- Bedridden, totally dependent, difficulty swallowing
- Requires dialysis
- Ventilator-dependent
- Requires electrical equipment to sustain life
- Critical medications requiring daily or QOD lab monitoring
- Requires continuous IV therapy
- Terminally ill

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<tr>
<th>FACILITY TYPE</th>
<th>TRANSPORT TYPE</th>
<th>NUMBER OF RESIDENTS</th>
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<tr>
<td>Like Facility</td>
<td>ALS</td>
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<td>Hospital</td>
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<td>Subacute</td>
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### LEVEL II
**Description:** Patients/residents have no acute medical conditions but require medical monitoring, treatment or personal care beyond what is available in home setting or public shelters.

**Examples:**
- Bedridden, stable, able to swallow
- Wheelchair-bound requiring complete assistance
- Insulin-dependent diabetic unable to monitor own blood sugar or to self-inject
- Requires assistance with tube feedings
- Draining wounds requiring frequent sterile dressing changes
- Oxygen dependent; requires respiratory therapy or assistance with oxygen
- Incontinent; requires regular catheterization or bowel care

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<th>FACILITY TYPE</th>
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<tr>
<td>Like Facility</td>
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<td>Medical Care</td>
<td>Wheelchair Van</td>
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<td>Shelter</td>
<td>Car/Van/Bus</td>
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**NOTE:** It is unlikely that licensed health facilities such as SNFs will have residents that fall below Level II care needs. Evacuation planning must take this into consideration. Also, consider cognitive/behavioral issues in evaluating residents’ transport and receiving location needs.

### LEVEL III
**Description:** Residents able to meet own needs or has reliable caretakers to assist with personal and/or medical care.

**Examples:**
- Independent; self-ambulating or with walker
- Wheelchair dependent; has own caretaker if needed
- Medically stable requiring minimal monitoring (i.e., blood pressure monitoring)
- Oxygen dependent; has own supplies (i.e. O2 concentrator)
- Medical conditions controlled by self-administered medications (caution: refrigeration may not be available at public shelters)
- Is able to manage for 72 hours without treatment or replacement of medications/supplies/special equipment

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<th>FACILITY TYPE</th>
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<td>Like Facility</td>
<td>Car/Van/Bus</td>
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<td>Home Setting</td>
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<tr>
<td>Public Shelter</td>
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### Suggested Emergency Operations Plan Components for Evacuation

*Use common sense. No planning advice can be a substitution for good judgment on the ground as a disaster is unfolding.*

<table>
<thead>
<tr>
<th>Provision</th>
<th>Description of Provision</th>
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<tr>
<td><strong>General Provisions</strong></td>
<td>these should be part of your overall disaster plan. It is difficult to adequately plan for evacuation until you have your overall disaster plan (Emergency Operations Plan) in order.</td>
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<tr>
<td><strong>Hazard &amp; Vulnerability Analysis</strong></td>
<td>Know your risk for different types of disasters. Conduct a Hazard and Vulnerability Analysis (HVA). A sample ready-to-use HVA can be found on our website, <a href="http://www.cahf.org/public/dpp/dpp_hva.php">www.cahf.org/public/dpp/dpp_hva.php</a>. If you need help with this, your local Office of Emergency Services may be able to provide guidance, or your insurance company can help.</td>
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<td><strong>Mitigation Strategies</strong></td>
<td>After completing your HVA, take what steps are practical and necessary to reduce the severity/impact of a potential disaster. The steps you take will depend on the types of vulnerabilities you have identified. Examples include: creating a fire break around your facility; bolting large furniture to the walls in earthquake prone areas, etc.</td>
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| **Command and Control** | Define your management for emergency operations. Determine who has the authority to order a voluntary evacuation of the facility. At least one person (and a back up) with the authority to order an evacuation should be in the facility 24/7. This means multiple people need to have this authority.  
*Best Practice*: Use a modified Hospital Incident Command System (HICS) organization chart and Job Action Sheets. A sample, modified for long term care, can be found in the Pandemic Influenza Workbook for Long Term Care, found at [www.cahf.org/public/dpp/piwb082207FINAL.pdf](http://www.cahf.org/public/dpp/piwb082207FINAL.pdf). For the full hospital version, go to [www.emsa.ca.gov/hics/hics.asp](http://www.emsa.ca.gov/hics/hics.asp).  
Local responders have the authority to order a mandatory evacuation if they see a clear threat to your population or facility.  
*Best Practice*: Using the "Unified Command" principle, have the employee in charge of decision-making at your facility (your Incident Commander), work with the first responder in charge of decision-making onsite at your facility (their Incident Commander) to ensure a smooth evacuation. Share your transportation and relocation plans with the first responder Incident Commander. |
| **Decision-Making Criteria** | Include factors to consider in deciding to evacuate or shelter in place. What triggers will you use in determining whether or not to evacuate? |
| **Expense Tracking** | Create a strategy for tracking any expenses (including supplies, transportation, staff overtime, clean-up, etc.), and clearly documenting your actions during a disaster. This will help you with reimbursement later. Consider what type of payment arrangement you will use with the receiving facilities (see information below on "like facilities for more details"). |
| **Facility Supplies** | Facilities should stockpile supplies to meet the needs of both sheltering in place (staying put during a disaster) and evacuating. Supplies include food, water, durable and disposable medical equipment & supplies, medication, etc.  
*Best Practice*: designate at least one person to be responsible for ensuring that your facility has adequate supplies for both sheltering in place and evacuating. This key person should regularly review the supplies with the people designated as having the authority to order a facility evacuation. |
| **Community Coordination** | Talk to planning partners in advance of any disaster. Partners to consider include:  
- Like facilities—create MOUs (Memoranda of Understanding) with a few “like” facilities both inside and outside your risk area (as identified in your Hazard & Vulnerability Analysis). It is better to have residents go to an alternate space (cots/mattresses in common areas) in a like facility (their needs can more easily be met, in most cases) than to go to a general facility. |
| **Communications** | Specify clear communication protocols and backup plans for communicating (internally & externally) during a disaster. Also, develop your pre-disaster risk communications strategy.  

*Best Practice*: upon admission of a resident, give the family/responsible party a fact sheet with relevant information about your disaster plan, including what a family can expect if the facility has to evacuate and steps a family member or responsible party can take in helping ensure the safety of their loved one. This could also be accomplished in presentations at regular “family sessions.”  

*Best Practice*: implement a voicemail system capable of receiving external calls on which a message can be recorded about evacuation details for residents’ families, information for staff calling in, expected evacuation sites for residents, etc. |
| **Staff Personal Preparedness** | Encourage staff to develop disaster plans for themselves and their families. Staff are less likely to come to work or stay at work if they are unsure of their family’s safety. Visit www.cahf.org/public/dpp/dpp_pfp.php for more information on personal preparedness and excellent web resources that can help staff with their own planning and stockpiling. |
| **Staff Family Members** | Indicate whether staff family can shelter at your facility and/or evacuate with your facility if necessary. |
| **Specific Resident Needs** | Include lists of any special/specific resident medical and personal needs. |
| **Contact List of Required Notifications** | Create a list of any entities (such as your District L&C office, and your parent company) that will need to be notified of any change in status, such as an evacuation or admission of evacuated residents. If you cannot get through to your local district licensing office during a disaster, call the state OES Warning Center at 916-845-8911.  

*Best Practice*: Call your county (Operational Area) Emergency Operations Center (EOC) if you are evacuating. They need to know this information, and can help you with any resource requests that you may have. They may also be able to find space for your residents if necessary, or refer you to someone who can help. |
| **Other Contact Lists** | Prepare and keep up-to-date contact lists for your key evacuation partners and your staff.  

- Several different “like” facilities that you have MOUs with and their contact information (address, key staff, at least two different phone numbers, email). You don’t know what form of communication will be available to you in a disaster.  

- Staff contact list, with addresses, phone numbers, and email addresses.  

*Best Practice*: map out where your staff live, this way you will know if they are in an area affected by a disaster. |
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<th>Physical Plant Considerations</th>
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<td><strong>Emergency Supplies</strong></td>
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<th>Provisions for Evacuation</th>
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<td><strong>Evacuation Checklist</strong></td>
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<td><strong>Evacuation Procedures</strong></td>
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<td><strong>Resident Assessment</strong></td>
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<td><strong>“Like” Facility MOUs</strong></td>
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<td><strong>Securing the Facility</strong></td>
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<td><strong>Transportation</strong></td>
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<td><strong>Equipment &amp; Supplies</strong></td>
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<td><strong>Food &amp; Water Supply</strong></td>
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<td><strong>Medications</strong></td>
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<td><strong>Transfer of Medical Records</strong></td>
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<td><strong>Staffing</strong></td>
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that staffing ratios can be flexed in an emergency, at the time of the emergency.

| Resident Personal Belongings | Include in your plan a list of any other items to accompany residents. This might include a change of clothes, toothbrush, toiletries, and possibly a small personal memento such as a picture to help the resident feel at home in their new surroundings. |
| Evacuation Route | Identify evacuation routes and secondary (alternate) routes, includes maps and specifies anticipated travel time. Expect delays.  
* Best Practice †: if you have internet access, check for road closures.  
* Best Practice ‡: an inexpensive portable GPS system can help you navigate around road closures and sometimes also high volumes of traffic. It may also help you locate gas stations, rest areas, etc. If you choose to use GPS, always carry a map as a back-up, 1 per vehicle.  

| Resident Evacuation & Tracking | Identify how you will track your residents, and how you will ensure that they end up at their destination. Consider how you will identify your residents (example: using an ID bracelet)  
* Best Practice †: Print out your current resident census, and have one staff person stand at the exit and check off as each resident is evacuated. Include the location to which they are being evacuated. Also include the bus/ambulance number next to the person’s name to facilitate your ability to track the supplies accompanying each resident.  
* Best Practice ‡: Mark each resident’s door with masking tape, door open, indicating that the resident has been evacuated with staff initials of who prepared the resident to ensure that all meds and other critical items were properly bagged and evacuated with the resident.  

| Communications—Equipment and Methods | Consider the types of communications equipment you will need, and your methods of communicating:  
- Pre-evacuation: How will information be disseminated pre-evacuation (i.e. accurate information and instructions to staff, residents, families)?  
- During an evacuation: How will communications take place en route to your relocation site (consider that you will likely have multiple vehicles, and could potentially be evacuating to multiple sites—how will you coordinate logistics and provide updates)?  
- Post-evacuation: How will communications take place post-evacuation, including notifications and status reports (internal, agencies, families, media, other)?  

| Assessment for Transfer Trauma | Ensure that each resident is medically evaluated by an appropriately licensed clinician as soon as possible during and after an evacuation.  

| Notifications | In addition to communicating with your licensing body, ensure that you have a strategy for notifying the family members/responsible parties of your residents that you have evacuated and to where their loved one has been relocated.  

| Re-entry Considerations |  
| Reentry Preparation | Identify who on your staff can authorize reentry, procedures for inspecting facility, and detail transportation from the host facility. Also include any vendors (names and contact information) that may need to be involved in cleaning, repairing or restocking the facility.  
| Repatriation Guidance | Identify who must be contacted prior to repopulating your facility (i.e. your licensing body).  
* Best Practice †: Prior to a disaster, establish the specific requirements that your district L&C or CCL surveyors will be looking for before they allow reentry. This may be different depending on the type of disaster.  

| Other Thoughts on Wide-Spread Evacuation | Regional groups of LTC facilities should consider developing an "Officer of the Day" response program. This person (may be a rotating position, and should have several back-ups) would act in an assistive capacity in a wide-spread emergency. This person could help facilities evacuate, provide information to various partners, and help with any components of the response that were not clearly assigned to another entity.  
In addition, on a monthly or quarterly basis, all facilities in a specific geographic or community area should hold regular and routine meetings or conference calls to update and review the status of individual facility emergency preparations. These regular and routine discussions should include updates relative to regional transportation issues, staffing, supplies, key contact resources, and; in general serve as constant and current information sharing sessions.  

| Regional LTC Coordination |  

| disaster preparedness program dpp |  

EMERGENCY PLANNING CHECKLIST
RECOMMENDED TOOL FOR PERSONS IN LONG-TERM CARE FACILITIES & THEIR FAMILY MEMBERS, FRIENDS, PERSONAL CAREGivers, GUARDIANS & LONG-TERM CARE OMBUDSMEN

Part I: For Long-Term Care Residents, Their Family Members, Friends, Personal Caregivers, & Guardians

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<thead>
<tr>
<th>Target Date</th>
<th>Date Completed</th>
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<td></td>
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</tr>
</tbody>
</table>

- **Emergency Plan:** Prior to any emergency, ask about and become familiar with the facility’s emergency plan, including:
  - ✓ Location of emergency exits
  - ✓ How alarm system works and modifications for individuals who are hearing and/or visually impaired
  - ✓ Plans for evacuation, including:
    - How residents/visitors requiring assistance will be evacuated, if necessary
    - How the facility will ensure each resident can be identified during evacuation (e.g., attach identification information to each resident prior to evacuation)
    - Facility’s evacuation strategy
    - Where they will go
    - How their medical charts will be transferred
    - How families will be notified of evacuation
  - ✓ Will families be able to bring their loved one home rather than evacuating, which is often less traumatic than a move to a new facility?
  - ✓ How family members can keep the facility apprised of their location and contact information (e.g., address, phone number, e-mail address), so the facility will be able to contact them, and family members will be able to check with the facility to meet their loved one following an emergency
  - ✓ How residents and the medicines and supplies they require will be prepared for the emergency, have their possessions protected and be kept informed during and following the emergency
  - ✓ How residents (if able) and family members can be helpful (for example, should family members come to the facility to assist?)
  - ✓ How residents, who are able, may be involved during the emergency, including their roles and responsibilities. **Note:** It is important for staff to know each resident personally, and whether involving him/her in the emergency plan will increase a sense of security or cause anxiety. For example, residents may have prior work or personal experience that could be of value (health care, emergency services, military, amateur ham radio operators, etc.) Provide the opportunity for residents to discuss any fears and what actions may help to relieve their anxiety (e.g., a flashlight on the bed, water beside the bed, etc.).

**Note:** Some of the recommended tasks may exceed the long-term care facility’s Federal regulatory requirements.
### Helping Residents in a Relocation:

Suggested principles of care for relocated residents include:

- Encourage the resident to talk about expectations, anger, and/or disappointment
- Work to develop a level of trust
- Present an optimistic, favorable attitude about the relocation
- Anticipate that anxiety will occur
- Do not argue with the resident
- Do not give orders
- Do not take the resident’s behavior personally
- Use praise liberally
- Be courteous and kind
- Include the resident in assessing problems
- Encourage family participation
- Ensure staff in the receiving facility introduce themselves to residents

### Part II: For Long-Term Care Ombudsmen

#### State Ombudsman Responsibilities:

- Become generally familiar with state emergency plans pertinent to long-term care facilities, including the state or federal agency that may be established to serve as a clearinghouse for facility evacuations: know the name, telephone number and e-mail of the person to whom long-term care facility evacuations and evacuees’ names should be reported. If no clearinghouse has been established, advocate for one.
- At least annually, ensure that all regional ombudsman coordinators and local ombudsmen and/or representatives read, are familiar with and have the opportunity to discuss resources, such as the two recommended CMS emergency preparedness checklists pertaining to long-term care facilities: the **CMS Emergency Preparedness Checklist – Recommended Tool for Effective Health Care Facility Planning** and this **CMS Emergency Planning Checklist – Recommended Tool for Persons Living In Long-Term Care Facilities, Their Family Members, Friends, Personal Caregivers, Guardians, & Long-Term Care Ombudsmen**.
- Maintain at home and office hard copies of current regional ombudsman contact information, including cell phones.
- Prior to an anticipated disaster, if the state ombudsman program has regional coordinators and/or other program representatives in the areas likely to be affected, call them to make sure they have assigned representatives to carry out the responsibilities listed in the section below pertaining to local ombudsman programs.
- Immediately following a disaster, contact regional ombudsman coordinators/representatives in the affected areas to provide support and assistance.

**Note:** Some of the recommended tasks may exceed the long-term care facility’s Federal regulatory requirements.
resources, as needed and feasible.

<table>
<thead>
<tr>
<th>• Regional Ombudsman Coordinator &amp; Representative Responsibilities (for states with regional/local ombudsman programs and/or representatives)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior to any emergency, ombudsmen:</strong></td>
</tr>
<tr>
<td>✓ Become generally familiar with the local emergency plans and the roles of local, county and state agencies in a disaster, especially as pertaining to long-term care facilities.</td>
</tr>
<tr>
<td>✓ Read and become familiar with emergency plans of facilities in the region for which the regional program has responsibility. If a state or regional clearing house for evacuations has been established, know the agency, phone number and e-mail where facility evacuations will be reported.</td>
</tr>
<tr>
<td>✓ Maintain, at home and office, hard copies of current contact information for facilities, other ombudsmen and appropriate agencies, especially the local emergency management agency.</td>
</tr>
<tr>
<td><strong>Prior to an anticipated emergency and following an emergency:</strong></td>
</tr>
<tr>
<td>✓ The regional ombudsman program coordinator assigns a representative to check on each facility covered by the program and reviews the responsibilities listed below with representatives assigned to facilities.</td>
</tr>
<tr>
<td>✓ Assigned representatives check on assigned facilities to assure that residents’ rights are protected prior to, during and after evacuation and provide information about conditions and any evacuation to the regional ombudsman coordinator; regional coordinator provides information to the state ombudsman office. <strong>Exception: when the ombudsman lives in an area under mandatory evacuation; however, if possible, the ombudsman should contact the facility by telephone, even if the area is under evacuation order. (Some states may have other specific procedures in place which ombudsman representatives would be required to follow.)</strong></td>
</tr>
<tr>
<td>✓ Ombudsman representatives visit residents as soon as possible after the disaster, whether they have been sheltered in the facility or transferred to another location. (If they have been transferred out of the region, state ombudsman and regional coordinators coordinate visitation by ombudsman representatives in the receiving region.)</td>
</tr>
<tr>
<td>▪ Discuss and record their immediate status/needs. If the state and local ombudsman coordinator decide a form is needed, use appropriate form to record information (a sample form is attached) and send a copy of the form to whomever they specify.</td>
</tr>
<tr>
<td>▪ Take urgent action to help obtain the resources and assistance residents need to be safe and, if they have been evacuated, find their loved ones and relocate to an area/facility or other setting of their preference. <strong>(Note: the ombudsman is not responsible for providing resources but instead should be aware of available resources and work to ensure they are provided to residents.)</strong></td>
</tr>
<tr>
<td>✓ Track, if possible, the impact of the disaster on the residents</td>
</tr>
<tr>
<td>✓ Determine whether the facility has reported the names and destination of any evacuated residents to the clearinghouse (if state or region has</td>
</tr>
</tbody>
</table>

**Note:** Some of the recommended tasks may exceed the long-term care facility’s Federal regulatory requirements.
established a clearinghouse), and is prepared to handle transfer trauma and support facility staff in handling resident trauma. As provided in Part I, above, suggested principles of care for the relocated residents include:

- Encourage the resident to talk about expectations, anger, and/or disappointment
- Work to develop a level of trust
- Present an optimistic, favorable attitude about the relocation
- Anticipate that anxiety will occur
- Do not argue with the resident
- Do not give orders
- Do not take the resident’s behavior personally
- Use praise liberally
- Be courteous and kind
- Include the resident in assessing problems
- Encourage staff in the receiving facility to introduce themselves to residents
- Encourage family participation

✓ Counsel residents about their rights to:
  - Be informed regarding the status of the relocation
  - Be provided information on alternative living arrangements and the options available
  - Be assessed for eligibility for funding and supports to safely return to live in their home or community
  - Visit other facilities to help them better decide where to live
  - Seek representation by an ombudsman or other representative/advocate available in the area
  - Expect to receive adequate care and treatment services during the relocation
  - Meet with the facility staff to express any concerns
  - Seek a review of any relocation changes with which they disagree
  - Expect that their rights, while a resident of any facility, will not be violated

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

**Note:** Some of the recommended tasks may exceed the long-term care facility’s Federal regulatory requirements.
## OMBUDSMAN LONG-TERM CARE FACILITY
### RESIDENT EVACUATION ASSESSMENT CHECKLIST

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>City</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Does the facility have power? If not, do the residents have a source of light (e.g., lamps on a generator or handheld flashlights)?
  Comment:

- Did the facility suffer any significant structural damage? Is so please indicate.
  Comment:

- Are high traffic areas, such as hallways, common areas, and doorways, clear of debris so residents may move freely throughout the facility?
  Comment:

- Did the facility receive evacuees from other facilities? If so, how long are the displaced residents scheduled to stay at the new facility?
  Comment:

- Have residents and their representatives been consulted regarding their wishes for return or transfer to a different facility?
  Comment:

- Have plans been made to return or transfer residents elsewhere, according to the wishes of the displaced residents and their representatives?
  Comment:

- According to displaced residents, do they have their personal belongings (e.g., clothing, toiletries, mementos, etc.)?
  Comment:

- According to the displaced residents, is the facility geographically accessible to their family and friends? If not, what arrangements can be made to accommodate them?
  Comment:

- Is there an adequate source of food, ice, and water available to meet basic needs? If not, does the facility need these items to be delivered?
  Comment:

- Are vital medications available and administered per residents’ medical condition? If the medication is not available, are the residents’ conditions being monitored and documented?
  Comment:

- According to the residents, are there sufficient staff to provide adequate care and services to meet their needs?
  Comment:

- Is there anything additional the Long-Term Care Ombudsman Program can do to assist in other areas besides those outlined here?
  Comment:

---

**Ask facility for a list of evacuees and their originating or destined facilities. Please forward this information to the district coordinator for additional follow-up.**

Staff interviewed:  
Position:  
See reverse for additional information:  

---

*Note: This form has been adapted from the Florida Ombudsman Program*  
*September 2007*
<table>
<thead>
<tr>
<th>Resident Evacuee Information</th>
<th>Any Resident(s) Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Number of residents evacuated:</td>
<td></td>
</tr>
<tr>
<td>• Number of residents transferred to this facility:</td>
<td></td>
</tr>
<tr>
<td>• In the space provided below, please indicate the names of residents who have been transferred/evacuated</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residents Names</th>
<th></th>
<th>Residents Names</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Evacuee or Transferred Residents Concerns</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Preface

This national guide for evacuation decision-making in nursing homes is one of several tools developed through a two-year grant funded by the John A. Hartford Foundation to the Florida Health Care Association Education and Development Foundation. The project’s overall goal is to ensure the safety and quality of care of frail elders living in nursing homes during a natural disaster. Partners in the project include the University of South Florida, the Florida Department of Health Office of Emergency Operations and the Florida Health Care Association Disaster Preparedness Committee. Many national experts and advisors in long-term care, emergency management, ethics, and transportation have also contributed greatly to this work. The Hartford-funded project will produce several additional products, which will be available in the fall of 2008, including an emergency management software application specifically for nursing homes and a long-term care facility translation of the national Incident Command System. Additional information about this project is provided at the end of this guide.

Readers of this document are encouraged to use and disseminate this information widely, with proper acknowledgement and citation of the source. In addition, we request that you complete and return the Reader Feedback and Utilization Survey on the following page. The information you provide will be used to develop and disseminate future updates to the guide.

Citation: Florida Health Care Education and Development Foundation, 2008, National Criteria for Evacuation Decision-Making in Nursing Homes, developed through a project funded by the John A. Hartford Foundation. For further information, please visit www.fhca.org.

Project Partners

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Florida Department of Health
Ray Runo, ESF 8 Emergency Coordinating Officer

The Milbank Memorial Fund
Monsignor Charles J. Fahey, Ethics Consultant
Evacuation Decision-Making
Reader Feedback and Utilization Survey

Thank you for using the National Criteria for Evacuation Decision-making in Nursing Homes. To gather valuable feedback and learn more about how and where the criteria are being used, we need you to complete the following brief survey. Those who complete the survey will automatically receive updates about the Hurricane and Disaster Preparedness for Long-Term Care project funded by the John A. Hartford Foundation.

Please email, mail or fax your completed survey to:
Hurricane and Disaster Preparedness for Long Term Care
Florida Health Care Association
PO Box 1459, Tallahassee, FL 32302
Telephone (850) 224-3907
Email: ahenkel@fhca.org Fax (850) 224-9155

Name: ____________________ Title: ____________________
Organization: ____________________
Address: ____________________
City/State/Zip: ____________________
Tele.: ____________________ Email: ____________________

How did you obtain a copy of the National Criteria for Evacuation Decision-Making in Nursing Homes?

<table>
<thead>
<tr>
<th>On a scale of 1 to 4, where 1 represents “Extremely useful” &amp; 4 represents “Not useful at all”, circle the response to indicate the usefulness of this guide. If no opinion, please circle “don’t know.”</th>
<th>Extremely useful</th>
<th>Very useful</th>
<th>Somewhat useful</th>
<th>Not useful at all</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. As a decision-making tool for evacuation of Nursing Homes?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>Don’t know</td>
</tr>
<tr>
<td>2. For training long-term care staff?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>Don’t know</td>
</tr>
<tr>
<td>3. For training staff in other LTC organizations?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>Don’t know</td>
</tr>
<tr>
<td>4. To help the resident family members understand evacuation decision-making?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>Don’t know</td>
</tr>
<tr>
<td>5. To share with others outside of LTC to improve understanding of evacuation decision-making? Please describe: ____________________</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>Don’t know</td>
</tr>
</tbody>
</table>

Please describe other ways you have used or intend to use this guide:

__________________________________________________________________________________________________________________________

Please provide any comments you may have about the guide in the space below and/or on an additional page.

__________________________________________________________________________________________________________________________

Thank you.
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Overview

The evacuation of a nursing home is an extremely serious undertaking with inherent risks to the residents the facility seeks to protect. The mass movement of persons during an emergency event who are often extremely frail, bed-ridden, comatose, cognitively impaired, and/or dependent upon ventilators or intravenous feeding or hydration equipment has considerable health implications. Nursing home residents have higher disaster-associated risks than other populations. Moving them out of harm’s way may well become a community imperative. As practitioners providing care for the frail elderly and persons with disabilities, nursing homes have a moral, legal, and professional responsibility to plan and prepare for emergency operations, including the decision to evacuate or shelter-in-place.

In addition to moving residents to safety, the evacuation of a nursing home also includes moving medical records, medications, medical equipment, disposable products, and food and water. Further, staff must also be available to move with the residents to the destination location. Evacuation of a nursing home is time-consuming, complex, and expensive and must be thoughtfully addressed in the facility’s emergency management plan.

Because of the unexpected nature of emergencies, there is no single evacuation formula on which nursing home leaders may rely. Evacuation decision-making is rarely a straightforward, linear process; but rather, simultaneously involves a myriad of factors. This first national criteria for evacuation decision-making in nursing homes assists administrators and health care professionals to determine whether to evacuate or shelter-in-place during disasters, with guidance on the evacuation process.
Key Considerations

The decision to evacuate or to shelter-in-place is a part of any facility’s comprehensive emergency management plan and will be a major focus when the plan is activated. The *National Criteria for Evacuation Decision-making in Nursing Homes* identifies key decision-making markers which may be used in any emergency event, with a special focus on tropical cyclones (i.e., hurricanes, tropical storms or tropical depressions).

The process for evacuation decision-making for nursing homes must be framed as a flexible and responsive cause and effect diagram:
Decision-makers

A nursing home’s emergency management plan must include a primary and alternate individual who has the authority to call for an evacuation. Such persons may be, for example:

- Nursing Home Administrator or Designee
- Facility Owner
- Facility Corporate Representative
- Local or State Emergency Operations Center Representative
- Governor of the State

While the final decision to evacuate or to shelter-in-place is the responsibility of one person and their alternate, he/she will be part of a decision-making team which includes internal and external partners, and the county emergency operations center utilizing real-time event data and the clinical profiles of the facility’s residents.

Incident Command System

Homeland Security Presidential Directive (HSPD) 5 called for a single, comprehensive system to enhance the ability of the United States to manage domestic incidents. The National Incident Management System (NIMS) was rolled out in 2004 by the Department of Homeland Security, providing a template enabling all levels of government, the private sector, and nongovernmental organizations to work together during an incident.

A cornerstone of NIMS is the Incident Command System (ICS). Developed in the 70’s, the ICS is a standardized, all-hazard incident management concept, allowing its users to adopt an integrated organizational structure. This common structure can be used by an organization of any size, providing greater efficiency, better coordination, and more effective communication. The framework of the Incident Command System supports critical decision-making by defining well-established lines of communication and responsibilities.

The Incident Command System is structured to support five major functional areas: command, finance, logistics, operations, and planning. These five areas comprise “Incident Command.”
Internal Factors

Internal factors influencing the decision to evacuate or shelter-in-place are unique to a specific nursing home. Two nursing homes in the same geographic location facing the same emergency event may make different evacuation decisions based on their internal factors, and both decisions may be valid.

Resident Acuity

Resident acuity is an internal, facility-specific condition influencing the decision to evacuate all or some of the residents in the facility. Clinical decisions occur in conjunction with the Administrator, Director of Nursing, Medical Director and related medical professionals.

Consideration of an acuity-based, partial evacuation may occur prior to any mandatory evacuation orders being issued. Partial evacuation may come into play when there is the potential for a planned evacuation related to an anticipated emergency event such as a hurricane. Partial evacuations are considered when there are residents whose conditions are complex and could become compromised if transport from the facility is jeopardized during or after the storm.

Residents with complex and potentially unstable conditions who are receiving special care may need to be evacuated to a hospital:

- Radiation therapy
- Chemotherapy
- Dialysis
- Intravenous therapy, newly acquired parenteral or enteral nutrition, and/or blood transfusion
- Vents or unstable tracheotomies
- Unstable respiratory or cardiac conditions
- Unstable Infectious Conditions not responding to current aggressive treatment
Residents with special care needs will be individually assessed to ensure stability of their condition(s). Residents with the following special care needs may be managed safely in the nursing home if their conditions are stable:

- Hospice care
- Respiratory treatment
- Receiving intermittent suctioning
- Pressure ulcer(s)
- Resolving Infections
- Stable IVs, parenteral or enteral nutrition

The nursing home will make the decision to evacuate based on these acuities as well as other internal and external factors.

**Physical Structure**
The facility’s structural ability to withstand the impending event influences the decision to evacuate or to shelter-in-place. The ability of the structure to withstand wind, debris impact, and shaking determines the shelter-in-place capabilities of the structure during the event and the ability to remain a safe and viable shelter after the disaster. Evacuation is necessary if it is anticipated that a structure will be unable to withstand the event or provide protection in the aftermath.

**Physical Structure Factors**

- Hardening the Facility
  - Structures are built to national, state, and, local codes which often take significant regional hazards into consideration. Additional modifications may be necessary to further ensure the integrity of the structure during and after a disaster.
  - Building hardening is the process of retrofitting or remodeling existing structures and upgrading components within so they will be stronger and more resilient in adverse conditions. This hardening can include the use of the state’s building code standard rated hurricane windows, shutters, and doors to protect openings (in Florida, use the Florida Building Code High Velocity Hurricane Zone). Roof structures can be secured to the walls using hurricane brackets and the walls can be secured to the foundation. Other locations may require structural reinforcement to counter the impact of shaking due to earthquakes.
• The Lay-down Factor
  o Hazards immediately around the facility, specifically trees which can fall onto the structure, can cause catastrophic failure of the structure. If the property has a high “lay down” factor (e.g. a number of trees that can fall onto the structure), trim them to mitigate the danger. If there is a cell tower next to the facility, it will have been constructed to withstand certain winds. Obtain the performance standards for the tower and include this factor in your plan.

• Emergency Power Capacity
  o An evaluation must be made regarding the facility’s emergency power capacity. The generator should support critical care functions and maintain lights and air temperature in at least a safe zone where residents can be congregated. The anticipated longevity of the facility’s emergency power system will influence the evacuation decision. Further, a local power outage usually results in a quicker restoration time while a community-wide power outage may result in longer restoration times and may put more strain on the facility’s emergency power.

• Security
  o Security must be sufficient to protect residents, staff, and facility resources and property. In a community-wide emergency event, nursing homes with food, water, and emergency power, become conspicuous beacons of normalcy in a sea of chaos. Desperate individuals may try to forcefully take provisions. A loss of facility resources or threats to residents and/or staff may necessitate an evacuation.
Transportation

Even when a decision to evacuate has been made, it cannot occur without a means of transport. Some emergency events such as tornadoes and earthquakes may require post-event evacuations and other impending emergency events may necessitate a planned evacuation. Regardless, the lack of transportation can abort the evacuation attempt. Nursing homes are advised to identify three transportation providers.

There are many reasons why an evacuation may not occur due to a lack of ground transportation:

- Poor planning by the facility
- Incorrect assumptions regarding vehicle sources and availability
  - Too great a demand for too few vehicles
- Vehicles are destroyed in the disaster
- Vehicles cannot respond into the region
  - Distance too great
  - Impassable roads
- Vehicle size or type
  - An insufficient number of vehicles may require several trips, causing an evacuation to take more time to complete than is available, forcing some residents to shelter-in-place
  - Vehicles that are difficult to load and unload will require more time for evacuations
    - Loading and travel times must be less than the time available to travel safely in deteriorating conditions, such as the onset of tropical storm-force winds (39-73 mph)
- Fuel source and availability

If a nursing home has exhausted their organizational resources, their transportation vendors cannot meet their obligations for whatever reason, and the facility cannot obtain transportation after a decision to evacuate has been made, the local emergency operations center should be contacted and made aware of the urgent situation. The local emergency operations center may be able to help secure transportation.
**Destination**

Even when a decision to evacuate has been made, it cannot occur without a place to go. Destination locations will be identified in the facility’s emergency management plan and should include three destination location types.

**Destination Location Types**

- Close Proximity – serves an unplanned, immediate evacuation
- Within Area – serves an unplanned or planned evacuation
- Outside of Area – serves a planned evacuation

The availability and structural integrity of the destination location will impact the nursing home’s ability to carry out its evacuation decision. Nursing homes are advised to plan “three-deep”: that is, identifying three destination locations per proximity. At least one destination should be at least 50 miles away.

The impact of the emergency event on the “home” facility may necessitate a long term stay at the destination facility or a transfer to another more permanent care location. The public shelter is a choice of last resort; conditions may be poor and the health of residents may be threatened.

**Staff**

The availability of staff to be contacted and to return to work is an important factor influencing the decision to evacuate or shelter-in-place.

There are many reasons which may affect staff’s ability to respond when called back to work:

- Impassable roads
- Injured, ill, or deceased family members
- Availability and role of non-nursing staff to support direct care, hands-on nursing staff in the evacuation process
- Concerns about dependent family members
- Concerns about pet safety
- Family members of staff
- Inability to communicate – cell towers/phone lines down.
Supplies
A decision to shelter-in-place requires the ability of a facility to be self-sufficient. Sheltering-in-place requires a significant quantity of supplies: alternate energy sources, food, potable water, medications, hygiene supplies, and other necessities. If sufficient quantities cannot be acquired prior to an event, evacuation may be warranted. Requirements vary from state to state. Florida’s state requirements are noted below, along with recommendations.

Florida Requirements and Recommendations

<table>
<thead>
<tr>
<th>Supply Type</th>
<th>2008 Florida Requirements Florida Administrative Code (FAC)</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietary: Non-perishable food &amp; supplies</td>
<td>One-week, s. 59A-4.110(4), FAC</td>
<td>7-10 days</td>
</tr>
<tr>
<td>Drinkable water supply</td>
<td>3 gallons per resident per day during and after a disaster which is defined as 72 hours, 59A-4.133 (18), FAC</td>
<td>7-10 days</td>
</tr>
<tr>
<td></td>
<td>1 gallon per staff member per day during and after a disaster which is defined as 72 hours, 59A-4.133 (18), FAC</td>
<td></td>
</tr>
<tr>
<td>Essential supplies</td>
<td>72 hours, s. 59A-4.126 (2)(b), FAC and AHCA Form 3110-6006, March, 1994</td>
<td>7-10 days</td>
</tr>
</tbody>
</table>

It may also be that supplies are sufficient to shelter-in-place during and immediately after the event, but because of disrupted supply chains, re-supply after the event may not be possible. In this situation, an evacuation, after the event is over and the threat has passed, may be required.

Projected event scope might also predict the availability of supplies post disaster (see Scope section). A wide-spread emergency might significantly disrupt transportation and communications to such degree that remaining in the facility is not feasible.

In considering quantities of supplies, the nursing home must assess the potential for an increase in facility population, such as an influx of staff dependents, incoming residents, and other staff seeking shelter.
External Factors

External factors influencing the decision to evacuate or shelter-in-place are beyond the facility’s control and tend to pose the same threat across a geographical area. External factors are described in terms of the nature of the event, time and scope, and the facility’s location and geographic vulnerability.

Nature of Emergency Event

Emergency events are unpredictable and may occur in many forms. From the impending hurricane which gives hours or even days of preparation time and impacts multiple counties, to the fire outbreak which gives only minutes and impacts only a single nursing home, varying emergency types demand different facility responses.

As a first step, the facility’s Incident Command will make a hazard assessment, determining the immediacy of the threat to the residents and staff and the likely scope of the emergency. The hazard assessment will weigh the risks of not evacuating with the possible harm the act of evacuating may cause residents.

The nature of emergency events influences the decision to evacuate in two general ways:

1. Time – Immediate threat vs. Impending threat
2. Scope – Facility-specific vs. Community-wide

Time: Emergency events may be immediate or impending.

Immediate emergency incidents (fire, gas leak):

• Occur with little or no warning
• Allow for very little planning time for Incident Command
• Response relies more heavily on training rather than immediate direction from supervisors
• Allow for no time to conduct an off-site external evacuation, though the facility population may evacuate from one portion of the building to another or from the building to outside
• Force a temporary shelter-in-place decision
**Impending disasters** (hurricane, winter storm, wildfires)

- Are tracked for some period of time prior to impact
- Allow communication beforehand with outside stakeholders, especially local emergency operations centers
- Allow some time for Incident Command to meet, formally activate disaster plans, weigh options and prepare
- Allow some consideration to pinpoint a time by which a decision to evacuate must be made in order to allow for safe evacuation by considering the following:
  - Estimated time of arrival of tropical storm winds of sustained 39 mph or at the onset of storm surge inundations, whichever occurs first
  - Time required to mobilize residents, transport them, and move them into the evacuation destination location

**Scope:** The scope of the emergency event refers to the geographic impact of the incident and may be facility-specific, local, or widespread. The decision to evacuate or to shelter-in-place will be influenced by the scope of the emergency.

**Facility-specific**

Emergency events may be facility-specific or relevant to only a local neighborhood.

Characteristics of facility-specific emergencies include:

- immediacy
- evacuation decision made by the facility’s Incident Commander rather than outside direction
- short distance to the evacuation destination, often within the community
- municipal utility services will likely continue uninterrupted
- an evacuation made within the facility, a partial evacuation of residents, or complete abandonment of the structure, depending on the damage to the structure
- an evacuation duration which is very short (hours to days) unless damage is significant
Local
Localized events will impact limited areas, including multiple city blocks or specific counties.

Characteristics of local emergencies include:
- evacuation direction will come from local officials (either voluntary or mandatory)
- immediate or impending
- evacuation destination to occur over shorter distances
  - distances within 50 miles (60 miles under extenuating circumstances)
  - travel duration between 45 minutes and 2 hours (not including load/unload time)
- evacuation may be partial or complete
- evacuation duration will generally be of shorter duration (days to weeks), although some specific circumstances could be longer
  - after the event, repairs to local infrastructure should occur relatively quickly and supply chains will experience minimal disruption

Widespread
Generally a widespread event impacts broad geographic regions, for example, multiple counties or states. Widespread events will be powerful and highly disruptive. These events will often be impending events, occurring with advance warning.

Characteristics of these widespread emergencies include:
- mandatory evacuations ordered by government authorities
- long distance travel will be required
  - distances greater than 50 miles
  - travel duration over 2 hours (not including load/unload time)
- complete evacuation of residents and staff
- evacuations which may be of an extended duration, possibly measured in months
  - after the event, supply systems and infrastructure will be significantly damaged or destroyed and services will not be restored quickly
  - facility damage is likely to be significant
**Location of Facility**

The location of the facility is a factor in deciding to shelter-in-place or evacuate.

- Rural
- Urban
- Metropolitan

A facility that is isolated in a rural area may have a buffer of distance from certain industrial or commercial accidents, civil unrest, or negative impacts of destroyed infrastructure. However, the same distance could be a liability as restoration of utility services and arrival of relief and supplies could take a considerably longer time.

Likewise, a facility in an urban or metropolitan area would likely experience greater attention on the restoration of utilities and supply chains during the post event recovery phase. However, these areas may be more vulnerable to uncontrolled fire, civil unrest, and other threats associated with the breakdown of municipal services. The ability to evacuate may be made much more difficult or even impossible in certain municipalities.
In the Zone
A facility’s hurricane evacuation zone, storm surge zone, and flood zone will contribute to the decision to evacuate or to shelter-in-place. Determined in advance by local emergency operations centers, these zone designations will influence when and where to evacuate. While knowing whether your facility is in a designated zone is essential, real-time monitoring of the emergency event is required for evacuation decision-making.

Hurricane Evacuation Zone
Hurricane evacuation zones are usually determined as part of a state's Hurricane Evacuation Study, a federal program which develops tools and information that assist State and County Emergency Management Offices decide who should evacuate during a hurricane threat and when the evacuation order should be given to insure all evacuees have enough time to get to safety.

The Hurricane Evacuation Zone is determined by considering an area’s:

- Geologic, bathymetric, and topographic features
- Transportation and Population
- Specific hazards analyses, including the likelihood of surge

Hurricane Evacuation Zone Definitions:

- Evacuation Zone A – Highest risk of flooding from a hurricane's storm surge. Zone A includes all low-lying coastal areas and other areas that could experience storm surge from ANY hurricane making landfall close to a hurricane evacuation zone county.
- Evacuation Zone B – may experience storm surge flooding from a MODERATE (Category 2 and higher) hurricane.
- No Evacuation Zone areas lie outside a hurricane evacuation zone and are not expected to face a risk of storm surge flooding from a hurricane.
Storm Surge Zone
The greatest potential for loss of life related to a hurricane is from storm surge. A Surge Zone (also referred to as a Storm Surge Zone) is a geographic area that will be inundated by the storm surge of a hurricane or tsunami. The surge zone is different for each category of storm, growing in size as the intensity of the storm increases. The storm surge will consist of salt water unless occurring along a large freshwater lake. A hurricane's predicted landfall is crucial to determining which areas will be affected by storm surge. When not associated with a tropical system, the storm surge may also be referred to as coastal flooding. Coastal flooding can occur from the combination of high tides and strong on-shore winds.

The Storm Surge information informs the assignment of hurricane evacuation zones and is impacted by incident-specific considerations such as:

• Central barometric pressure at 6-hour intervals
• Latitude and longitude of storm positions at 6-hour intervals for a 72-hour tract
• Storm size measured from the center (eye) to the region of maximum winds, commonly referred to as the radius of maximum winds.
• Height of the water surface well before the storm directly affects the area of interest

Flood Zone
A Flood Zone is an area that will be inundated by water. This excess water can come from torrential rain, snow melt, dam breaches, water ponding in low lying areas, and failure of flood control devices. Flooding can occur from sources hundreds of miles away; the facility does not need to be experiencing adverse weather to experience flooding. Flood water will likely be fresh water, will carry debris and contaminants, and might not quickly drain, thereby becoming stagnant. Flood zones are determined by emergency management and insurance professionals (Flood Insurance Rate Maps) and should be ascertained before a threat is imminent.
Conclusion
Nursing homes and assisted living facilities caring for vulnerable elders and persons with disabilities are responsible for comprehensive plans for their care and protection and, when conditions warrant, facilities must take quick, decisive action to follow through on those plans. Emergencies can be relatively localized events like tornados, or may encompass large geographic regions as in the case of earthquakes, hurricanes, and wildfires. The speed at which events unfold can vary greatly. Hurricane Katrina was tracked as a monster storm for two to three days prior to landfall, while other storms intensified explosively, catching many off-guard.

While planning for every scenario is impossible, the disaster mitigation and response plans developed and maintained by nursing homes and assisted living facilities are comprehensive by design, incorporating extensive protocols and agreements to facilitate sheltering-in-place, or if necessary, complete evacuation. Laws and regulations require comprehensive planning to ensure the protection of long term care facility residents; their proper nutrition and hydration; adequate staffing before, during, and after an event; and maintenance of essential communications with both families and government officials. There are also requirements for the safe transportation of our most frail, least ambulatory residents in the event conditions warrant swift relocation.

Redundancy in disaster planning is strongly encouraged as it is certain that resources will be stretched thin by constantly changing conditions. Facilities are encouraged to implement a three-deep philosophy, entering into contracts with multiple vendors for the provision of food, water, emergency power, transportation, and emergency destinations.

Most importantly, a facility’s Incident Command must be prepared to consider and act on a facility’s evacuation decision-making criteria.
Hurricane and Disaster Preparedness Project Summary

In February 2006, The John A. Hartford Foundation (JAHF) funded a Nursing Home “Hurricane Summit,” sponsored by Florida Health Care Association, of representatives from the six Gulf Coast States affected by hurricane damage during 2005 (Louisiana, Mississippi, Alabama, Texas and Florida), including Georgia, a receiving state for hurricane evacuees. The Summit evaluated disaster-preparedness, response and recovery of nursing homes and identified gaps that impeded safe resident evacuation and disaster response. The meeting identified emergency response system issues that require improved coordination between nursing homes and State and local emergency responders. The Hurricane and Disaster Preparedness for Long-Term Care Facilities project builds on the knowledge gained at the Nursing Home Hurricane Summit, the experience of emergency management staff during the four 2004 Florida hurricanes and the 2005 Hurricanes (Katrina and Rita), as well as the Federal Government's interest in improving disaster preparedness.

Primary Objective: This project's primary objective is to ensure the safety and quality of care of frail elders living in nursing homes during a natural disaster by helping nursing homes and state and local emergency responders improve disaster preparedness, response, and recovery.

Goals: To achieve this objective, the project will:

I. Develop a new nursing home Disaster Planning Guide and software for national use,
II. Develop and test nursing home disaster training materials, and
III. Disseminate these materials regionally at the 2007 gulf coast state Hurricane Summit, and nationally in 2008 in partnership with American Health Care Association at their annual meeting and other national meetings.

For more information, please contact:
LuMarie Polivka-West, Principal Investigator
Telephone (850) 224-3907 (ext. 33); Email: lpwest@fhca.org
Planning for pandemic influenza is critical. The Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention have developed the following checklist to help public and private organizations that provide home health care services assess and improve their preparedness for responding to pandemic influenza. Home health agencies will likely be called upon to provide care for patients who do not require hospitalization for pandemic influenza, or for whom hospitalization is not an option because hospitals have reached their capacity to admit patients. These agencies may become overburdened very quickly and shortages of personnel and supplies for providing home health care may occur. This checklist is modeled after the one included in the HHS Pandemic Influenza Plan (www.hhs.gov/pandemicflu/plan/sup3.html#app2). The list is comprehensive but not complete; each home care agency will have unique and unanticipated issues that will need to be addressed as part of a pandemic planning exercise. Also, some items on the checklist may not be applicable to a given agency. Collaboration with hospitals, local pandemic planning committees and public health agencies will be essential to ensure that the affected population receives needed health care services. Further information can be found at www.pandemicflu.gov.

This checklist identifies key areas for pandemic influenza planning. Home health care organizations can use this tool to identify the strengths and weaknesses of current planning efforts. Links to websites with information are provided throughout the document. However, actively seeking information that is available locally or at the state level will be necessary to complete the development of the plan. Also, for some elements of the plan (e.g., education and training programs), information may not be immediately available and it will be necessary to monitor selected websites for new and updated information.

1. **Structure for planning and decision making.**

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Pandemic influenza has been incorporated into emergency management planning for the organization.

A planning committee has been created to specifically address pandemic influenza preparedness.

A person has been assigned responsibility for coordinating preparedness planning (hereafter referred to as the pandemic response coordinator) for the practice or organization. (Insert name, title and contact information)

Members of the planning committee1 include the following: (Insert name, title and contact information for each)

- Administration: ____________________________________________________________
- Nursing: ________________________________
- Clerical: ________________________________
- Other: ________________________________

A point of contact has been identified for questions/consultation on infection control (e.g., hospital- or state health department-based infection control professional, healthcare epidemiologist). (Insert name, title, and contact information)

2. **Development of a written pandemic influenza plan.**

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Copies of relevant sections of the Department of Health and Human Services Pandemic Influenza Plan have been obtained. (www.hhs.gov/pandemicflu/plan/)

Copies of available state and/or local pandemic influenza plans have been obtained.

A written plan has been completed or is in progress that includes the elements listed in #3 below.

The plan describes the organizational structure (i.e., lines of authority, function and assignment of responsibility) that will be used to operationalize the plan.

The plan complements2 local response plans in communities served by the home health care agency.

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1. The committee could be very small (e.g., two or three staff members) or very large, depending on the size and needs of the organization. Members of the “group of professional personnel” required by CMS as one of the Home Health Agency Conditions of Participation should be included on the planning committee.

2. As communities develop their pandemic response plans, the provision of home health care will be a pivotal concern. Home health care agencies should have input into these plans to ensure there are no conflicts between what the agency can provide and what the community expects.
3. Elements of an influenza pandemic plan.

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**A plan is in place for monitoring for pandemic influenza in the population served.**
- Responsibility has been assigned for monitoring national and state public health advisories (e.g., [www.cdc.gov/flu/weekly/fluactivity.htm](http://www.cdc.gov/flu/weekly/fluactivity.htm)) and updating members of the pandemic influenza planning committee when cases of pandemic influenza have been reported in United States and in the geographic area. (Insert name, title, and contact information)

- A system has been created to monitor influenza-like illness in patients cared for in the home (i.e., weekly or daily number of patients with influenza-like illness). [www.cdc.gov/flu/professionals/diagnosis/](http://www.cdc.gov/flu/professionals/diagnosis/) (Having a system for tracking illness trends during seasonal influenza will ensure that organizations can detect stressors that may affect operating capacity, including staffing and supply needs, during a pandemic.)

- A system is in place to report unusual cases of influenza-like illness and influenza-related deaths to local health authorities.

**A communication plan has been developed and includes the following information:**
- Key public health points of contact for pandemic influenza have been identified. (Insert name, title, and contact information for each)
  - Local health department
  - State health department
  - Local emergency management
  - The organization’s point person for external communication (e.g., with hospitals, nursing homes, health departments, social services agencies) has been assigned. (Insert name, title and contact information)
  - A list has been created of healthcare entities and their points of contact (e.g., other home care services providers, local hospitals, residential care facilities, social service agencies, emergency medical services providers, health centers and rural health facilities, relevant community organizations including those involved with disaster preparedness) with whom the home care agency anticipates that it will be necessary to maintain communication and coordination of care during a pandemic. (Insert location of contact list):

- The pandemic response coordinator has contacted local or regional pandemic influenza planning groups to obtain information on communication and coordination of plans.

- The pandemic response coordinator has contacted other home care services providers in the area regarding their pandemic influenza planning efforts. (Whenever possible, home care agencies should consider joint planning and coordination opportunities.)

**An education and training program has been developed to ensure that all personnel understand the implications of, and control measures for, pandemic influenza and the current community response plan.** (For more information on the scope of recommended education and training, see [www.hhs.gov/pandemicflu/plan/sup3.html#edutrain](http://www.hhs.gov/pandemicflu/plan/sup3.html#edutrain))

- A person has been designated to coordinate education and training (e.g., identify and facilitate access to education and training programs, ensure that home care personnel attend, and maintain a record of attendance). (Insert name, title, and contact information):

- Current and potential sites have been identified for long-distance (e.g., web-based programs offered by professional associations or federal agencies) and local (e.g., health department or hospital sponsored programs) education of home care personnel. ([www.cdc.gov/flu/professionals/training/](http://www.cdc.gov/flu/professionals/training/))

- Language and reading-level appropriate materials have been identified on pandemic influenza (e.g., available through state and federal public health agencies and professional organizations) and a plan is in place for obtaining these materials.

- The education and training program includes information on infection control measures to prevent the spread of pandemic influenza, including information on measures home health care personnel should apply during home care of patients. (For further information on infection control recommendations for home care, see [www.hhs.gov/pandemicflu/plan/sup4.html#care](http://www.hhs.gov/pandemicflu/plan/sup4.html#care))

3. Most home health agencies will already have a list of healthcare organizations and points of contact that can be used for this purpose.
3. Elements of an influenza pandemic plan. *(continued)*

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Informational materials on pandemic influenza for patients and their families have been identified that are language and reading-level appropriate for the population being served and a plan is in place to obtain and disseminate these materials.

- Materials have been identified or developed to guide family members on infection control and care of patients with pandemic influenza in the home. [www.pandemicflu.gov/plan/tab3.html](http://www.pandemicflu.gov/plan/tab3.html)
- Patients and families are encouraged to maintain a 30-day supply of medications and medical supplies as well as a two-week supply of non-perishable food and water.

**A plan has been developed for the management of patients during a pandemic, which covers the following issues:**

- Plans have been developed to manage patient care during the height of a pandemic to accommodate the increased number of patients who will need home care services.
- The scope of services that the agency will provide and those that will be denied or referred to other providers has been clearly defined.
- The role and responsibility of the agency regarding distribution of infection control supplies (e.g., masks, hand hygiene materials), food, medications, and other necessities in the home to patients and their families has been discussed with a local or regional pandemic influenza planning group.
- Plans include decision tools for determining which patients can have altered service schedules based on their health conditions, needs, and available resources.
- Local plans and criteria for the disposition of patients have been discussed with area hospitals and other home care agencies. (Hospitals may discharge patients to home and home health care agencies early to free-up bed space for critically ill patients.)
- The plan considers how social service agencies (e.g., Red Cross, Salvation Army) will help meet the needs of families in the community (e.g., by providing child- or elder-care meals, shopping services) in homes where there are patients with pandemic influenza, particularly where the primary adult support person living in the home is ill.

**An infection control plan is in place and includes the following:**

- An infection control policy for the care of pandemic influenza patients in the home. ([www.hhs.gov/pandemicflu/plan/sup4.html](http://www.hhs.gov/pandemicflu/plan/sup4.html) and [www.cdc.gov/flu/professionals/infectioncontrol/](http://www.cdc.gov/flu/professionals/infectioncontrol/))
- The policy requires healthcare personnel to use Standard ([www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html](http://www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html)) and Droplet Precautions (i.e., mask for close contact) ([www.cdc.gov/ncidod/dhqp/gl_isolation_droplet.html](http://www.cdc.gov/ncidod/dhqp/gl_isolation_droplet.html)) with symptomatic patients.
- A list has been developed of supplies (e.g., surgical masks, gloves, alcohol-based hand hygiene products) that will be used during home care of patients with pandemic influenza.

**An occupational health plan has been developed that includes the following:**

- A liberal/non-punitive sick leave policy for managing home care personnel who have symptoms of, or documented illness with, pandemic influenza. The policy considers:
  - The handling of staff who become ill at work
  - When personnel may return to work after recovering from pandemic influenza
  - When personnel who are symptomatic, but well enough to work, will be permitted to continue working

- A system for evaluating symptomatic personnel before they report for duty has been developed and tested during a non-pandemic (e.g., seasonal) influenza period.

- Mental health and faith-based resources have been identified that are available to provide counseling to personnel during a pandemic.

- The management of personnel who are at increased risk for influenza complications (e.g., pregnant women, immunocompromised healthcare workers) has been addressed by placing them on administrative leave or altering their work location.

- Staff have been encouraged to develop their own family care plans for the care of dependent minors and seniors in the event community containment measures (e.g., “snow days,” school closures) are implemented and for possible illness in adult family members.

- The agency has the ability to monitor influenza vaccination of healthcare personnel.

- Influenza vaccine is offered or made available on an annual basis to healthcare personnel.
A vaccine and antiviral use plan has been developed.

- Websites containing current federal and state health department recommendations for the use and availability of vaccines and antiviral medications have been identified. ([www.cdc.gov/flu/professionals/vaccination/](http://www.cdc.gov/flu/professionals/vaccination/))
- An estimate has been developed of the number of personnel who would be targeted as first and second priority for receipt of pandemic influenza vaccine and antiviral prophylaxis, based on HHS guidance for use. ([www.hhs.gov/pandemicflu/plan/appendixd.html](http://www.hhs.gov/pandemicflu/plan/appendixd.html))
- The potential role of the home health care organization in the distribution of vaccine and antivirals in the community has been discussed with the local health department and/or regional pandemic planning committee.

Issues related to surge capacity during a pandemic have been addressed.

- A plan is in place for managing a staffing shortage within the organization due to illness in personnel or their family members.
- The minimum number and categories of nursing staff and other professional personnel necessary to sustain home care services for a given number of patients or on a day-to-day basis have been determined. Cross-training (where applicable) has been implemented.
- Priorities for providing care have been established.
- Contingency staffing plans have been developed for either limiting home care access or recruiting temporary personnel during a staffing crisis.
- Hospitals and other appropriate healthcare service providers have been consulted regarding contingency staffing resources.
- Anticipated consumable resource needs (e.g., masks, gloves, hand hygiene products) have been estimated.
- A primary plan and contingency plan to address supply shortages have been developed, including detailed procedures for acquisition of supplies through normal channels as well as requesting resources for replenishing supplies when normal channels have been exhausted.
- Plans include stockpiling at least a week’s supply of resources when there is evidence that the potential for pandemic influenza has reached the United States.
- There is an understanding of the process for requesting and obtaining assets (e.g., personal protective equipment, medical supplies) made available through the community’s response plan.
- Information has been obtained on local and regional plans and resources for dealing with mass fatalities including removal of the deceased from the home.
LONG-TERM CARE AND OTHER RESIDENTIAL FACILITIES
PANDEMIC INFLUENZA PLANNING CHECKLIST

Planning for pandemic influenza is critical for ensuring a sustainable healthcare response. The Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) have developed this checklist to help long-term care and other residential facilities assess and improve their preparedness for responding to pandemic influenza. Based on differences among facilities (e.g., patient/resident characteristics, facility size, scope of services, hospital affiliation), each facility will need to adapt this checklist to meet its unique needs and circumstances. This checklist should be used as one tool in developing a comprehensive pandemic influenza plan. Additional information can be found at www.pandemicflu.gov. Information from state, regional, and local health departments, emergency management agencies/authorities, and trade organizations should be incorporated into the facility’s pandemic influenza plan. Comprehensive pandemic influenza planning can also help facilities plan for other emergency situations.

This checklist identifies key areas for pandemic influenza planning. Long-term care and other residential facilities can use this tool to self-assess the strengths and weaknesses of current planning efforts. Links to websites with helpful information are provided throughout this document. However, it will be necessary to actively obtain information from state and local resources to ensure that the facility’s plan complements other community and regional planning efforts.

1. Structure for planning and decision making.

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- Pandemic influenza has been incorporated into emergency management planning and exercises for the facility.
- A multidisciplinary planning committee or team\(^1\) has been created to specifically address pandemic influenza preparedness planning.
  
  (List committee’s or team’s name.)

- A person has been assigned responsibility for coordinating preparedness planning, hereafter referred to as the pandemic influenza response coordinator. (Insert name, title and contact information.)

- Members of the planning committee include (as applicable to each setting) the following: (Develop a list of committee members with the name, title, and contact information for each personnel category checked below and attach to this checklist.)
  - Facility administration
  - Medical director
  - Nursing administration
  - Infection control
  - Occupational health
  - Staff training and orientation
  - Engineering/maintenance services
  - Environmental (housekeeping) services
  - Dietary (food) services
  - Pharmacy services
  - Occupational/rehabilitation/physical therapy services
  - Transportation services
  - Purchasing agent
  - Facility staff representative
  - Other member(s) as appropriate (e.g., clergy, community representatives, department heads, resident and family representatives, risk managers, quality improvement, direct care staff, collective bargaining agreement union representatives)

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\(^1\) An existing emergency or disaster preparedness team may be assigned this responsibility.
A plan is in place for surveillance and detection of the presence of pandemic influenza in residents and staff.

- A person has been assigned responsibility for monitoring public health advisories (federal and state), and updating the pandemic response coordinator and members of the pandemic influenza planning committee when pandemic influenza has been reported in the United States and is nearing the geographic area. For more information, see [www.cdc.gov/flu/weekly/fluactivity.htm](http://www.cdc.gov/flu/weekly/fluactivity.htm).

- A written protocol has been developed for weekly or daily monitoring of seasonal influenza-like illness in residents and staff. For more information, see [www.cdc.gov/flu/professionals/diagnosis/](http://www.cdc.gov/flu/professionals/diagnosis/). (Having a system for tracking illness trends during seasonal influenza will ensure that the facility can detect stressors that may affect operating capacity, including staffing and supply needs, during a pandemic.)

- A protocol has been developed for the evaluation and diagnosis of residents and/or staff with symptoms of pandemic influenza.

- Assessment for seasonal influenza is included in the evaluation of incoming residents and/or staff with an influenza-like illness. (The process used during periods of seasonal influenza can be applied during pandemic influenza.)

### 1. Structure for planning and decision making (continued).

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Local and state health departments and provider/trade association points of contact have been identified for information on pandemic influenza planning resources. (Insert name, title and contact information for each.)

- Local health department contact: ____________________________
- State health department contact: ____________________________
- State long-term care professional/trade association: ____________________________

Local, regional, or state emergency preparedness groups, including bioterrorism/communicable disease coordinators points of contact have been identified. (Insert name, title and contact information for each.)

- City: ____________________________
- County: ____________________________
- Other regional: ____________________________

### 2. Development of a written pandemic influenza plan.

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Copies have been obtained of relevant sections of the HHS Pandemic Influenza Plan (available at [www.hhs.gov/pandemicflu/plan/](http://www.hhs.gov/pandemicflu/plan/)) and available state, regional, or local plans are reviewed for incorporation into the facility’s plan.

- The facility plan includes the elements listed in #3 below.

### 3. Elements of an influenza pandemic plan.

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A plan is in place for surveillance and detection of the presence of pandemic influenza in residents and staff.

- A person has been assigned responsibility for monitoring public health advisories (federal and state), and updating the pandemic response coordinator and members of the pandemic influenza planning committee when pandemic influenza has been reported in the United States and is nearing the geographic area. For more information, see [www.cdc.gov/flu/weekly/fluactivity.htm](http://www.cdc.gov/flu/weekly/fluactivity.htm). (Insert name, title and contact information of person responsible.)

- A written protocol has been developed for weekly or daily monitoring of seasonal influenza-like illness in residents and staff. For more information, see [www.cdc.gov/flu/professionals/diagnosis/](http://www.cdc.gov/flu/professionals/diagnosis/). (Having a system for tracking illness trends during seasonal influenza will ensure that the facility can detect stressors that may affect operating capacity, including staffing and supply needs, during a pandemic.)

- A protocol has been developed for the evaluation and diagnosis of residents and/or staff with symptoms of pandemic influenza.

- Assessment for seasonal influenza is included in the evaluation of incoming residents and/or staff with an influenza-like illness. (The process used during periods of seasonal influenza can be applied during pandemic influenza.)
3. Elements of an influenza pandemic plan (continued).

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- A system is in place to monitor for, and internally review transmission of, influenza among patients and staff in the facility. Information from this monitoring system is used to implement prevention interventions (e.g., isolation, cohorting). (This system will be necessary for assessing pandemic influenza transmission.)

**A facility communication plan has been developed.**
For more information, see [www.hhs.gov/pandemicflu/plan/sup10.htm](http://www.hhs.gov/pandemicflu/plan/sup10.htm).

- Key public health points of contact during an influenza pandemic have been identified.
  (Insert name, title and contact information for each.)

- Local health department contact: ____________________________________________

- State health department contact: ____________________________________________

- A person has been assigned responsibility for communications with public health authorities during a pandemic. (Insert name, title and contact information.)

- A person has been assigned responsibility for communications with staff, residents, and their families regarding the status and impact of pandemic influenza in the facility. (Having one voice that speaks for the facility during a pandemic will help ensure the delivery of timely and accurate information.)

- Contact information for family members or guardians of facility residents is up-to-date.

- Communication plans include how signs, phone trees, and other methods of communication will be used to inform staff, family members, visitors, and other persons coming into the facility (e.g., sales and delivery people) about the status of pandemic influenza in the facility.

- A list has been created of other healthcare entities and their points of contact (e.g., other long-term care and residential facilities, local hospitals’ emergency medical services, relevant community organizations [including those involved with disaster preparedness]) with whom it will be necessary to maintain communication during a pandemic. (Insert location of contact list and attach a copy to the pandemic plan.)

- A facility representative(s) has been involved in the discussion of local plans for inter-facility communication during a pandemic.

**A plan is in place to provide education and training to ensure that all personnel, residents, and family members of residents understand the implications of, and basic prevention and control measures for, pandemic influenza.**

- A person has been designated with responsibility for coordinating education and training on pandemic influenza (e.g., identifies and facilitates access to available programs, maintains a record of personnel attendance). (Insert name, title, and contact information.)

- Current and potential opportunities for long-distance (e.g., web-based) and local (e.g., health department or hospital-sponsored) programs have been identified. See [www.cdc.gov/flu/professionals/training/](http://www.cdc.gov/flu/professionals/training/).

- Language and reading-level appropriate materials have been identified to supplement and support education and training programs (e.g., available through state and federal public health agencies such as [www.cdc.gov/flu/groups.htm](http://www.cdc.gov/flu/groups.htm) and through professional organizations), and a plan is in place for obtaining these materials.

- Education and training includes information on infection control measures to prevent the spread of pandemic influenza.

- The facility has a plan for expediting the credentialing and training of non-facility staff brought in from other locations to provide patient care when the facility reaches a staffing crisis.

- Informational materials (e.g., brochures, posters) on pandemic influenza and relevant policies (e.g., suspension of visitation, where to obtain facility or family member information) have been developed or identified for residents and their families. These materials are language and reading-level appropriate, and a plan is in place to disseminate these materials in advance of the actual pandemic. For more information, see [www.cdc.gov/flu/professionals/infectioncontrol/index.htm](http://www.cdc.gov/flu/professionals/infectioncontrol/index.htm) and [www.cdc.gov/flu/groups.htm](http://www.cdc.gov/flu/groups.htm).
3. Elements of an influenza pandemic plan (continued).

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An infection control plan is in place for managing residents and visitors with pandemic influenza that includes the following: (For information on infection control recommendations for pandemic influenza, see [www.hhs.gov/pandemicflu/plan/sup4.html](http://www.hhs.gov/pandemicflu/plan/sup4.html)).

An infection control policy that requires direct care staff to use Standard ([www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html](http://www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html)) and Droplet Precautions (i.e., mask for close contact) ([www.cdc.gov/ncidod/dhqp/gl_isolation_droplet.html](http://www.cdc.gov/ncidod/dhqp/gl_isolation_droplet.html)) with symptomatic residents.

A plan for implementing Respiratory Hygiene/Cough Etiquette throughout the facility. (See [www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm](http://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm)).

A plan for cohorting symptomatic residents or groups using one or more of the following strategies:
1. confining symptomatic residents and their exposed roommates to their room,
2. placing symptomatic residents together in one area of the facility, or
3. closing units where symptomatic and asymptomatic residents reside (i.e., restricting all residents to an affected unit, regardless of symptoms). The plan includes a stipulation that, where possible, staff who are assigned to work on affected units will not work on other units.

Criteria and protocols for closing units or the entire facility to new admissions when pandemic influenza is in the facility have been developed.

Criteria and protocols for enforcing visitor limitations have been developed.

**An occupational health plan for addressing staff absences and other related occupational issues has been developed that includes the following:**

- A liberal/non-punitive sick leave policy that addresses the needs of symptomatic personnel and facility staffing needs. The policy considers:
  - The handling of personnel who develop symptoms while at work.
  - When personnel may return to work after having pandemic influenza.
  - When personnel who are symptomatic, but well enough to work, will be permitted to continue working.
  - Personnel who need to care for family members who become ill.

- A plan to educate staff to self-assess and report symptoms of pandemic influenza before reporting for duty.

- A list of mental health and faith-based resources that will be available to provide counseling to personnel during a pandemic.

- A system to monitor influenza vaccination of personnel.

- A plan for managing personnel who are at increased risk for influenza complications (e.g., pregnant women, immunocompromised workers) by placing them on administrative leave or altering their work location.

**A vaccine and antiviral use plan has been developed.**

- CDC and state health department websites have been identified for obtaining the most current recommendations and guidance for the use, availability, access, and distribution of vaccines and antiviral medications during a pandemic. For more information, see [www.hhs.gov/pandemicflu/plan/sup6.html](http://www.hhs.gov/pandemicflu/plan/sup6.html) and [www.hhs.gov/pandemicflu/plan/sup7.html](http://www.hhs.gov/pandemicflu/plan/sup7.html).

- HHS guidance has been used to estimate the number of personnel and residents who would be targeted as first and second priority for receipt of pandemic influenza vaccine or antiviral prophylaxis. For more information, see [www.hhs.gov/pandemicflu/plan/sup6.html](http://www.hhs.gov/pandemicflu/plan/sup6.html) and [www.hhs.gov/pandemicflu/plan/sup7.html](http://www.hhs.gov/pandemicflu/plan/sup7.html).

- A plan is in place for expediting delivery of influenza vaccine or antiviral prophylaxis to residents and staff as recommended by the state health department.

---

2. CDC guidance on preventing and controlling influenza transmission in long-term care facilities will be a useful resource during pandemic influenza. (See [www.cdc.gov/flu/professionals/infectioncontrol/longtermcare.htm](http://www.cdc.gov/flu/professionals/infectioncontrol/longtermcare.htm)).
### 3. Elements of an influenza pandemic plan (continued).

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**Issues related to surge capacity during a pandemic have been addressed.**

- A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents’ health status, functional limitations, disabilities, and essential facility operations.
- A person has been assigned responsibility for conducting a daily assessment of staffing status and needs during an influenza pandemic. (Insert name, title and contact information.)
- Legal counsel and state health department contacts have been consulted to determine the applicability of declaring a facility “staffing crisis” and appropriate emergency staffing alternatives, consistent with state law.
- The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis.
- Estimates have been made of the quantities of essential materials and equipment (e.g., masks, gloves, hand hygiene products, intravenous pumps) that would be needed during a six-week pandemic.
- A plan has been developed to address likely supply shortages, including strategies for using normal and alternative channels for procuring needed resources.
- Alternative care plans have been developed for facility residents who need acute care services when hospital beds become unavailable.
- Surge capacity plans include strategies to help increase hospital bed capacity in the community.
  - Signed agreements have been established with area hospitals for admission to the long-term care facility of non-influenza patients to facilitate utilization of acute care resources for more seriously ill patients.
  - Facility space has been identified that could be adapted for use as expanded inpatient beds and information provided to local and regional planning contacts.
- A contingency plan has been developed for managing an increased need for post mortem care and disposition of deceased residents.
- An area in the facility that could be used as a temporary morgue has been identified.
- Local plans for expanding morgue capacity have been discussed with local and regional planning contacts.
Planning for pandemic influenza is critical for ensuring a sustainable healthcare response. The Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) have developed this checklist to help long-term care and other residential facilities assess and improve their preparedness for responding to pandemic influenza. Based on differences among facilities (e.g., patient/resident characteristics, facility size, scope of services, hospital affiliation), each facility will need to adapt this checklist to meet its unique needs and circumstances. This checklist should be used as one tool in developing a comprehensive pandemic influenza plan. Additional information can be found at www.pandemicflu.gov. Information from state, regional, and local health departments, emergency management agencies/authorities, and trade organizations should be incorporated into the facility’s pandemic influenza plan. Comprehensive pandemic influenza planning can also help facilities plan for other emergency situations.

This checklist identifies key areas for pandemic influenza planning. Long-term care and other residential facilities can use this tool to self-assess the strengths and weaknesses of current planning efforts. Links to websites with helpful information are provided throughout this document. However, it will be necessary to actively obtain information from state and local resources to ensure that the facility’s plan complements other community and regional planning efforts.

1. Structure for planning and decision making.

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Pandemic influenza has been incorporated into emergency management planning and exercises for the facility.

A multidisciplinary planning committee or team has been created to specifically address pandemic influenza preparedness planning.

(List committee’s or team’s name.)

A person has been assigned responsibility for coordinating preparedness planning, hereafter referred to as the pandemic influenza response coordinator. (Insert name, title and contact information.)

Members of the planning committee include (as applicable to each setting) the following: (Develop a list of committee members with the name, title, and contact information for each personnel category checked below and attach to this checklist.)

- Facility administration
- Medical director
- Nursing administration
- Infection control
- Occupational health
- Staff training and orientation
- Engineering/maintenance services
- Environmental (housekeeping) services
- Dietary (food) services
- Pharmacy services
- Occupational/rehabilitation/physical therapy services
- Transportation services
- Purchasing agent
- Facility staff representative
- Other member(s) as appropriate (e.g., clergy, community representatives, department heads, resident and family representatives, risk managers, quality improvement, direct care staff, collective bargaining agreement union representatives)

1. An existing emergency or disaster preparedness team may be assigned this responsibility.

May 1, 2006  Version 1
1. Structure for planning and decision making (continued).

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Local and state health departments and provider/trade association points of contact have been identified for information on pandemic influenza planning resources. (Insert name, title and contact information for each.)

- Local health department contact: ________________________________
- State health department contact: ________________________________
- State long-term care professional/trade association: ________________________________

Local, regional, or state emergency preparedness groups, including bioterrorism/communicable disease coordinators points of contact have been identified. (Insert name, title and contact information for each.)

- City: ________________________________
- County: ________________________________
- Other regional: ________________________________

Area hospitals points of contact have been identified in the event that facility residents require hospitalization or facility beds are needed for hospital patients being discharged in order to free up needed hospital beds. (Attach a list with the name, title, and contact information for each hospital.)

The pandemic influenza response coordinator has contacted local or regional pandemic influenza planning groups to obtain information on coordinating the facility’s plan with other influenza plans.


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Copies have been obtained of relevant sections of the HHS Pandemic Influenza Plan (available at [www.hhs.gov/pandemicflu/plan/](http://www.hhs.gov/pandemicflu/plan/)) and available state, regional, or local plans are reviewed for incorporation into the facility’s plan.

The facility plan includes the elements listed in #3 below.

The plan identifies the person(s) authorized to implement the plan and the organizational structure that will be used.

3. Elements of an influenza pandemic plan.

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A plan is in place for surveillance and detection of the presence of pandemic influenza in residents and staff.

- A person has been assigned responsibility for monitoring public health advisories (federal and state), and updating the pandemic response coordinator and members of the pandemic influenza planning committee when pandemic influenza has been reported in the United States and is nearing the geographic area. For more information, see [www.cdc.gov/flu/weekly/fluactivity.htm](http://www.cdc.gov/flu/weekly/fluactivity.htm). (Insert name, title and contact information of person responsible.)

- A written protocol has been developed for weekly or daily monitoring of seasonal influenza-like illness in residents and staff. For more information, see [www.cdc.gov/flu/professionals/diagnosis/](http://www.cdc.gov/flu/professionals/diagnosis/). (Having a system for tracking illness trends during seasonal influenza will ensure that the facility can detect stressors that may affect operating capacity, including staffing and supply needs, during a pandemic.)

- A protocol has been developed for the evaluation and diagnosis of residents and/or staff with symptoms of pandemic influenza.

- Assessment for seasonal influenza is included in the evaluation of incoming residents and/or staff with an influenza-like illness. (The process used during periods of seasonal influenza can be applied during pandemic influenza.)
A system is in place to monitor for, and internally review transmission of, influenza among patients and staff in the facility. Information from this monitoring system is used to implement prevention interventions (e.g., isolation, cohorting). (This system will be necessary for assessing pandemic influenza transmission.)

A facility communication plan has been developed. For more information, see www.hhs.gov/pandemicflu/plan/sup10.htm.

Key public health points of contact during an influenza pandemic influenza have been identified. (Insert name, title and contact information for each.)

Local health department contact: ________________________________

State health department contact: ________________________________

A person has been assigned responsibility for communications with public health authorities during a pandemic. (Insert name, title and contact information.)

A person has been assigned responsibility for communications with staff, residents, and their families regarding the status and impact of pandemic influenza in the facility. (Having one voice that speaks for the facility during a pandemic will help ensure the delivery of timely and accurate information.)

Contact information for family members or guardians of facility residents is up-to-date.

Communication plans include how signs, phone trees, and other methods of communication will be used to inform staff, family members, visitors, and other persons coming into the facility (e.g., sales and delivery people) about the status of pandemic influenza in the facility.

A list has been created of other healthcare entities and their points of contact (e.g., other long-term care and residential facilities, local hospitals’ emergency medical services, relevant community organizations [including those involved with disaster preparedness]) with whom it will be necessary to maintain communication during a pandemic. (Insert location of contact list and attach a copy to the pandemic plan.)

A facility representative(s) has been involved in the discussion of local plans for inter-facility communication during a pandemic.

A plan is in place to provide education and training to ensure that all personnel, residents, and family members of residents understand the implications of, and basic prevention and control measures for, pandemic influenza.

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The facility has a plan for expediting the credentialing and training of non-facility staff brought in from other locations to provide patient care when the facility reaches a staffing crisis.

Informational materials (e.g., brochures, posters) on pandemic influenza and relevant policies (e.g., suspension of visitation, where to obtain facility or family member information) have been developed or identified for residents and their families. These materials are language and reading-level appropriate, and a plan is in place to disseminate these materials in advance of the actual pandemic. For more information, see www.cdc.gov/flu/professionals/infectioncontrol/index.htm and www.cdc.gov/flu/groups.htm.
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- HHS guidance has been used to estimate the number of personnel and residents who would be targeted as first and second priority for receipt of pandemic influenza vaccine or antiviral prophylaxis. For more information, see [www.hhs.gov/pandemicflu/plan/sup6.html](http://www.hhs.gov/pandemicflu/plan/sup6.html) and [www.hhs.gov/pandemicflu/plan/sup7.html](http://www.hhs.gov/pandemicflu/plan/sup7.html).

- A plan is in place for expediting delivery of influenza vaccine or antiviral prophylaxis to residents and staff as recommended by the state health department.

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2. CDC guidance on preventing and controlling influenza transmission in long-term care facilities will be a useful resource during pandemic influenza. (See [www.cdc.gov/flu/professionals/infectioncontrol/longtermcare.htm](http://www.cdc.gov/flu/professionals/infectioncontrol/longtermcare.htm).)
3. Elements of an influenza pandemic plan (continued).

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**Issues related to surge capacity during a pandemic have been addressed.**

- A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents’ health status, functional limitations, disabilities, and essential facility operations.

- A person has been assigned responsibility for conducting a daily assessment of staffing status and needs during an influenza pandemic. (Insert name, title and contact information.)

- Legal counsel and state health department contacts have been consulted to determine the applicability of declaring a facility “staffing crisis” and appropriate emergency staffing alternatives, consistent with state law.

- The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis.

- Estimates have been made of the quantities of essential materials and equipment (e.g., masks, gloves, hand hygiene products, intravenous pumps) that would be needed during a six-week pandemic.

- A plan has been developed to address likely supply shortages, including strategies for using normal and alternative channels for procuring needed resources.

- Alternative care plans have been developed for facility residents who need acute care services when hospital beds become unavailable.

- Surge capacity plans include strategies to help increase hospital bed capacity in the community.
  - Signed agreements have been established with area hospitals for admission to the long-term care facility of non-influenza patients to facilitate utilization of acute care resources for more seriously ill patients.
  - Facility space has been identified that could be adapted for use as expanded inpatient beds and information provided to local and regional planning contacts.

- A contingency plan has been developed for managing an increased need for post mortem care and disposition of deceased residents.

- An area in the facility that could be used as a temporary morgue has been identified.

- Local plans for expanding morgue capacity have been discussed with local and regional planning contacts.
Pandemic Flu Supplies Checklist

In addition to your regular emergency supplies, additional items should be added for Pandemic Flu Preparedness so that you are able to care for sick family members at home. This checklist can help you plan on what types of home care supplies you'll need in case of pandemic flu and what amounts to buy for your household. It is a good idea to gradually buy items now so that you have at least a two-week supply of home care supplies for each person in your home.

Two-Week Pandemic Flu Supply Checklist

<table>
<thead>
<tr>
<th>Items</th>
<th>2 people</th>
<th>4 people</th>
<th>Your quantity</th>
<th>Check off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thermometer</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye dropper</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical or procedural masks</td>
<td>50 masks</td>
<td>100 masks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleach</td>
<td>1/2 gallon</td>
<td>1 gallon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry detergent</td>
<td>1 lb</td>
<td>2 lbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dishwashing detergent</td>
<td>1 bottle (250 ml)</td>
<td>2 bottles (500 ml)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soap</td>
<td>2 bars / 3 dispensers</td>
<td>4 bars / 6 dispensers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet paper</td>
<td>6 rolls</td>
<td>12 rolls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paper towels</td>
<td>4 rolls</td>
<td>8 rolls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tissues</td>
<td>3 boxes</td>
<td>6 boxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-based hand sanitizer</td>
<td>2 (8 fl. oz) containers</td>
<td>4 (8 fl. oz) containers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drinks with electrolytes</td>
<td>48 (8 fl. oz) bottles</td>
<td>96 (8 fl. oz) bottles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription medicines</td>
<td>as needed</td>
<td>as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain and fever medicines</td>
<td>1 large bottle</td>
<td>2 large bottles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough medicines</td>
<td>2 bottles</td>
<td>4 bottles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liquid medicine for children</td>
<td>2 cups per child</td>
<td>2 cups per child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubber gloves</td>
<td>1 pair</td>
<td>2 pairs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposable gloves</td>
<td>100 pairs</td>
<td>200 pairs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibacterial wipes/gel</td>
<td>1 box</td>
<td>2 boxes</td>
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Pandemic Influenza

Workbook
for Long Term Care Providers

California Association of Health Facilities
August 2007

Joel Adelson, MD, PhD, MPH
Ellie Anderson, BS
Jocelyn Montgomery, RN, PHN
Ashby Wolfe, MD
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DISCLAIMERS

This Pandemic Influenza Workbook for Long Term Care Providers from the California Association of Health Facilities (CAHF) is exclusively intended to provide guidance. It does not contain or constitute legal advice in any form and does not make any assurance or representation that the guidance contained herein will be determined to constitute compliance with any state or federal law or regulation.

In addition, CAHF, the University of California, the Centers for Medicare & Medicaid Services, the California Department of Public Health and the individual authors are not responsible for any errors or omissions contained in the Workbook and assume no responsibility for the misuse or erroneous interpretation of its contents.

Furthermore, Dr. Wolfe's work as an author of this document was performed outside the scope of her employment as a U.S. government employee. This work represents her personal and professional views, and not necessarily those of the U.S. government.

ACKNOWLEDGMENTS

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Finally, we thank the Emergency Preparedness Office, California Department of Public Health, for its generous grant support of this project through the California Association of Health Facilities’ Disaster Preparedness Program.
1.0 INTRODUCTION

People who operate long term care facilities have a great deal to worry about. Issues related to staffing, reimbursement and regulations take much of their time and present constant challenges that require their immediate attention. Disaster planning often gets put off in the interest of handling routine, everyday responsibilities. No one likes to think about disasters — particularly one like a pandemic that could strike millions of people around the world. But the problem with failing to think about disasters is that they do happen, and when they happen, it is the people who are least prepared who suffer the most. While there is no mechanism to predict when the next pandemic will hit or how severe it will be, the consensus is that it will occur. When it does, it will impact every aspect of our daily lives, and those who did not prepare will be hit the hardest.

A pandemic is an outbreak of an infectious disease that affects people or animals over an extensive geographical area. It is anticipated that an influenza pandemic will occur in the future and spread across the populations in the world. In a pandemic, hospitals and other healthcare facilities and providers may be overwhelmed with the massive numbers of acutely ill persons. Long term care facilities will be impacted as they may not be able to transfer their residents to hospitals and may need to expand current facility capacity to accommodate additional patients. Widespread absenteeism will affect their ability to staff their facilities and may also cause shortages in services and supplies. For these reasons, long term care providers must develop proactive plans to prepare for the challenges that an influenza pandemic will bring.

A pandemic is not like an earthquake or a fire where the impact is localized and help can be shifted from one area to another. A pandemic could hit everywhere at once, and every individual and community will need to maximize its own resources. While all levels of government have done a great deal to prepare for such an event, the prudent long term care provider will do all she or he can to become as informed and as self-reliant as possible. The California Association of Health Facilities presents this Pandemic Influenza Workbook for Long Term Care Providers as a guide for those who want to know what actions they can take to protect the health and safety of the people who live and work in their facilities in the event of a pandemic influenza outbreak.

The intent of this Workbook is to explain to long term care providers
- **Why** they need to prepare for a pandemic
- **What** they need to do to be prepared and
- **How** they can go about making preparations

The recommendations within are based on the currently available guidance, research and, to a certain extent, the authors’ common sense and best judgment about what is practical and realistic in this type of care setting. It is a tool designed to be used in conjunction with official guidance on pandemic influenza that is constantly being developed and refined by the state of California, the federal government and the World Health Organization.

1.1 INTENDED AUDIENCE

This Workbook is primarily intended for licensed long term care (LTC) facilities — those small and large residential institutions that care for the elderly, people with developmental disabilities or chronic mental illness and/or other medically fragile individuals who require 24-hour care and supervision. These settings include nursing facilities, intermediate care facilities, intermediate care facilities for the mentally retarded, adult residential and assisted living facilities. While these facility types are the target audience, information and the basic planning principles in this Workbook can be adapted as needed according to facility type and based on size and available resources. Small facilities may need to have
one staff person who manages all aspects of pandemic planning, with help from external resources during the response, while larger facilities can divide this work among many staff members.

1.2 HOW TO USE THIS DOCUMENT

The *Pandemic Influenza Workbook for Long Term Care Providers* is a tool to assist long term care providers and facilities in planning for and responding to an influenza pandemic. It is broken into chapters that address the following broad topic areas:

1.0 Introduction — p. 2
2.0 Clinical Overview — p. 11
3.0 Containment Strategies — p. 19
4.0 Sustainment Strategies — p. 37
5.0 Communication — p. 67

Each chapter consists of detailed information and related worksheets on that topic. Readers are encouraged to review the *Workbook* in its entirety. Also included are several addresses for Web sites where more detailed information on pandemic and other disaster-related issues is available. This *Workbook* and a review of the referenced Web sites will give long term care providers the basic information they need to develop a pandemic influenza section or “annex” to their existing disaster response plan. There is a great deal of information contained in this document, and most of it will require significant review and internal discussion with the facility staff.

1.3 SUGGESTED STEPS FOR LONG TERM CARE PANDEMIC PLANNING

- Convene a multidisciplinary Pandemic Influenza (PI) Planning Committee for the facility. (Hereafter this committee will be referred to as the “Internal PI Committee.”)
  - Convene a new committee or expand an already-existing committee (such as the quality improvement, infection control or resident rights committee) to include physicians and clinical, administrative, purchasing, engineering or maintenance personnel and others as needed and as available at your facility.

- Assign one person in your facility to be a pandemic influenza coordinator (PI coordinator).
  - It is important to assign one person to oversee the development and implementation of your facility’s Pandemic Annex.
  - The PI coordinator ideally will have clinical and infection control experience. Give this person the authority, resources *and* dedicated time to develop your facility Pandemic Annex.
  - The PI coordinator will work with the Internal PI Committee to develop your Annex and oversee the implementation of pandemic preparedness in your facility.
  - PI coordinator duties may include:
    1. Using this *Workbook* as a guidance document for planning. Using the resources identified in the *Workbook* to research pandemic influenza and current recommendations.
    2. Adapting the guidance and recommendations to the specific size of the facility, the type of people you serve and the availability of resources.
    3. Developing a timeline and outline for pandemic planning in the facility.
    4. Coordinating the Internal PI Committee meetings.
    5. Participating in the local community pandemic influenza planning meetings and committees. Contacting your local health department and/or your local hospital for types of community planning meetings to attend.

*Pandemic Influenza Workbook for Long Term Care Providers*
6. Overseeing the completion of the planning tasks, purchasing, training and exercises.
7. Informing facility administration of pandemic influenza developments and progress of the Internal PI Committee and pandemic preparedness progress.
8. Advising management on status of pandemic activity as events develop.

- Develop the facility pandemic plan as an “annex” to the existing facility disaster plan.
  - Build on work that you have already done. Several of the recommendations in this Workbook will be applicable to any large scale emergency and will help you in your general disaster preparedness efforts.
  - If your facility does not already have a complete and current all-hazards disaster plan, visit the California Association of Health Facilities Disaster Preparedness Program Web site at www.cahf.org/public/dpp for helpful information, resources, templates and tools.

- Interface with existing local, community, city or county pandemic influenza planning committees
  - Every county and some cities have disaster planning committees some of which are convened specifically to deal with pandemic planning. Call your local public health department¹ to find out how you can communicate with and possibly send a representative to the local PI planning committee in your area. (Hereafter this local PI committee will be referred to as the “External PI Committee.”)

1.4 HOW TO USE THE WORKSHEETS PROVIDED IN THE WORKBOOK

Many of the pandemic planning elements in this Workbook have been summarized and converted to worksheets to be used for response during a pandemic and for training of staff, families, residents and volunteers. The worksheets are intended as quick reference pages that can be reproduced as needed to provide guidance for specific pandemic preparedness and response activities.

1.5 OVERVIEW OF PANDEMIC INFLUENZA AND THE CHALLENGE TO LONG TERM CARE FACILITIES

The World Health Organization (WHO) criteria for an influenza pandemic are that 1) a novel strain of influenza has emerged to which humans have limited or no immunity; 2) the virus has the ability to cause severe disease in humans; 3) the virus is efficiently transmitted person to person.²

Phases of a Pandemic
The WHO has developed a system of six phases based on the three criteria above.³ Each phase represents a particular stage of influenza infection in the population, and facilities should respond as appropriate to the current phase. Changes from phase to phase are triggered by the behavior of the virus. The designation of phases, including decisions on when to move from one phase to another, is made by the director general of WHO. The world is currently in Phase 3, the pandemic alert period, where limited human-to-human transmission is taking place because the virus is unable to sustain human-to-human infection in the population.

¹ In California, there are 58 counties and 58 public health departments. In addition, three California cities have local public health departments — Berkeley, Long Beach and Pasadena. Many tribal governments also have a health department function. For information on how to contact your local public health department, visit the National Association of County and City Health Officials Web site: http://lhadirectory.naccho.org/phdir/search.asp?State=California&Abbr=CA. When you contact your local public health department, ask for the person in charge of pandemic planning.
Pandemic Severity Index
The world has faced many pandemics throughout history, and some of them have been more severe than others in terms of the number of deaths they caused. During the Hong Kong flu (1968-69), for example, only 34,000 people in the U.S. died as compared to the Spanish influenza (1918-19) which resulted in 675,000\(^4\) deaths in the U.S. No one knows how severe the next pandemic will be, so the U.S. Centers for Disease Control and Prevention (CDC) has recently developed a Pandemic Severity Index (PSI), based upon the percentage of likely deaths. The PSI is similar to the categories used to designate the severity of hurricanes and will be used to help guide the response activities that should be taken. A Category 4 or 5 designates the greatest severity and indicates that extreme measures will be required. Depending on the severity of the pandemic, or PSI, government will recommend specific activities to slow or contain the spread of the pandemic, such as closing schools or isolating the ill.

See Worksheet II: Pandemic Influenza Severity Index and Recommended Community Interventions (p. 10)

Impact of the Pandemic
It is anticipated that an influenza pandemic may last more than 18 months to two years, with three waves of illness sweeping through the general community followed by periods with less influenza activity.

At the beginning of a pandemic, there may be a prolonged period during which antiviral medications and vaccines are either completely unavailable or in limited supply. The federal government, state of California and local health departments have been stockpiling antiviral medications to cover a percentage of the population, but it is not clear how effective these antiviral medications will be in the event of a new strain of influenza. These antiviral medications will be controlled and distributed carefully by governmental agencies according to specific criteria during the pandemic. The pandemic influenza vaccine, while in initial development, cannot be fully developed and stockpiled until the pandemic viral strain is identified, and it may be up to six months before vaccines are widely available.

The societal impact of a pandemic will be experienced in all sectors of life. People may be unable to go to work or school due to illness, and many will have to stay at home to care for their loved ones, friends and neighbors. The local or state health departments may recommend school closures or maintaining a social distance (usually at least three feet) at work sites and social gatherings. These issues may directly impact staffing and staff availability at facilities, as well as normal supply chains for getting medications, food, supplies and utilities.

1.6 PLANNING FOR INFLUENZA

In this very difficult situation, there are very few certainties. As with any potential disaster, preparations can be time-consuming and expensive, and if the disaster does not occur for a prolonged period, there is a tendency to feel such preparation is wasted and unnecessary. However, adequate preparation and planning are essential to survive a major event like a pandemic.

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Hurricane Katrina resulted in tremendous loss of life, displacements of populations and severe financial losses. In the aftermath of Katrina, it was demonstrated that gaps in planning and insufficient follow-through on existing emergency plans resulted in a disaster which was, on some levels, preventable. Similarly, an influenza pandemic is expected to occur and its impact could be huge. Preparations are underway at all levels, international, federal, state and local and as soon as possible, careful and methodical planning needs to begin in each individual facility. Pandemic planning won’t be a waste of time or resources because the steps you must take to be ready for a pandemic will help you to be better prepared for all emergencies. Planning needs to be undertaken proactively, not reactively (after there is an acute crisis), because at that point options may become very limited.

Part of planning for any disaster includes a facility self-assessment of its own capacities, technical skills and flexibility to respond. By preparing now, you increase the likelihood of your facility surviving the pandemic and minimizing the impact to staff, residents and your business. You may also be able to assist your community during the pandemic.

In our interconnected communities, it will be critical to help one another. There are a few ways in which you can do this:

**Self Sufficiency**
The first thing that LTC facilities need to do is to prepare themselves for the impact of pandemic influenza — this will not be “business as usual.” Once the infection hits your community, you will likely experience:

- Disruptions to the supply chain for goods and services
- Decrease in staffing
- Difficulty in transferring residents to acute care facilities because these facilities will likely be operating well over capacity
- Higher levels of acuity within your resident population (both pandemic-infected residents and residents with illness/injury who normally would have been transferred to a hospital)

For these reasons, facilities need to plan on being far more self-sufficient than they currently are. How you will do this is covered in this Workbook under 3.0 Containment Strategies (p.19) and 4.0 Sustainment Strategies (p. 37). Through effective infection control, you will prevent the inoculation of your population with the pandemic virus as long as possible. Through careful planning and implementation of your sustainment strategies, you will be able to manage most of your facility’s needs during a period of outbreak. Your ability to be self-sufficient will not only help your residents and staff, it will also help your community.

**Care of Sick Residents**
During the pandemic, it is likely that the healthcare system will become saturated and that hospitals will be overwhelmed during the peak of the outbreak. There may come a point where you are told that you cannot transfer your sick residents to the hospital. Should this occur, you will need to be ready to manage the care of those residents whose clinical care needs may be greater than that which you typically provide. Plan with your Internal and External PI Committees on how you will manage the treatment of residents who may be suffering from respiratory complications, dehydration and other complications of pandemic influenza. Skilled nursing facilities will probably be able to accommodate IV therapy, oxygen treatments and other special needs of these patients, but long term care facilities that have no medical or nursing personnel on a regular basis will be extremely challenged by this situation.6

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6 See 4.7 Altered Standards of Care in this Workbook (p. 52) for more information.
There also may be non-influenza-related care issues (like injuries) that in a normal situation would typically require a trip to the emergency room but during a pandemic event may need to be dealt with elsewhere. It is important to consider how you will manage these conditions if this situation arises. Discuss this potential situation with your attending physicians. Talk to your medical consultants about what supplies you should keep in house to be ready to manage acute illness and injury.

In addition to following the advice of the medical and nursing consultants who serve these facilities, we recommend that all long term care facilities review Good Home Treatment of Influenza by Dr. Grattan Woodson, MD, for advice on managing pandemic patients in a non-medical setting, which may be helpful for all types of facilities and settings.

Surge Capacity
“Surge capacity” refers to the ability of the healthcare system to rapidly expand beyond its normal services to meet the increased demand for qualified personnel, medical care and public health in the event of a large scale disaster. “Surge capacity encompasses potential patient beds; available space in which patients may be triaged, managed, vaccinated, decontaminated or simply located; available personnel of all types; necessary medications, supplies and equipment; and even the legal capacity to deliver healthcare under situations which exceed authorized capacity.”

Certain types of facilities, such as skilled nursing facilities (SNFs) that are licensed as a “distinct part” of a hospital, may be able to participate in a community-wide surge capacity plan once they have adequately planned for their own self-sufficiency. If you operate such a facility, consider participating in your community surge response during a moderate or severe pandemic.

Participating in a surge response may not be possible or appropriate for everyone — that is a decision which must be made at the individual facility level. Discuss with your city or county External PI Committee about what stockpiled supplies may be available to those facilities that are willing to take on a broader role within the community in a pandemic situation. This broader role may include:

- Taking hospital patients before the pandemic arrives in your community by accepting admissions of non-infectious patients whom hospitals are transferring out to make room for the predicted wave of pandemic patients. These would be the hospital’s less acute patients, but they may have a higher acuity than you are used to admitting.
- Participating as a “step-down” facility (from an acute care facility or a triage site) after the pandemic has arrived in your community. This could involve either providing care for recovering individuals before they are ready to go home or end-of-life care. In either scenario, unless the facility is adequately equipped and staff is trained on how to handle infectious persons, the patients you accept should be past the contagious stage.

It is important to note that accepting patients who are beyond your licensed capacity or are of a higher acuity than you are currently licensed to care for could only be done under emergency permissions from the state and possibly federal governments.

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9 The California Department of Public Health is currently involved in a project to develop standards and guidelines for healthcare surge capacity during large scale emergencies. The deliverables for this project will include a “Standards and Guidelines” manual with recommendations that will guide government decision-making for emergency orders, waivers and regulatory flexes that can be implemented in the event of a pandemic. This guidance is planned to be released by the fall of 2007 and will be posted on the CAHF Web site once it is available. For more information on this project go to: Pandemic Influenza Workbook for Long Term Care Providers
## World Health Organization Phases and US Federal Government Response Stages

We are currently (July 2007) in WHO Pandemic Phase 3, which is the Pandemic Alert Period with “no or limited human-to-human transmission.” This chart compares the WHO phases with the federal government phases and includes helpful actions for LTC providers to take in each phase.

<table>
<thead>
<tr>
<th>WHO Phases</th>
<th>Federal Gov’t Response Stages</th>
<th>Recommended Actions for LTC Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTER-PANDEMIC PERIOD</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>No new influenza virus subtype in humans, though one may be present in animals with a low risk to humans</td>
<td>New domestic animal outbreak in at-risk country</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Conduct emergency preparedness planning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Conduct pandemic &amp; general infection control training and education (for staff, families, and residents)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Conduct facility surveillance for influenza</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Post signs for respiratory hygiene/cough etiquette</td>
</tr>
<tr>
<td>2</td>
<td>No new influenza virus subtype in humans, but a circulating animal strain poses a substantial risk of human disease</td>
<td></td>
</tr>
<tr>
<td><strong>PANDEMIC ALERT PERIOD</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Human infection(s) with a new subtype, but no or limited human-to-human spread</td>
<td>New domestic animal outbreak in at-risk country</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Refine facility EOP and Pandemic Annex (including establishing/updating contact with key public health, healthcare, OES, and community partners)</td>
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<tr>
<td></td>
<td></td>
<td>• Conduct facility surveillance activities</td>
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<tr>
<td></td>
<td></td>
<td>• Vaccinate residents and staff for seasonal influenza and pneumonia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stockpile recommended supplies (see Worksheet IV: Suggested Pandemic Supply List)</td>
</tr>
<tr>
<td>4</td>
<td>Small cluster(s) with limited human-to-human transmission—spread is highly localized suggesting virus is not well adapted to humans</td>
<td>Confirmed human outbreak overseas</td>
</tr>
<tr>
<td>5</td>
<td>Large cluster(s) but human-to-human spread is still localized, suggesting virus is becoming increasingly well adapted to humans, but may not yet be fully transmissible (substantial pandemic risk)</td>
<td></td>
</tr>
<tr>
<td><strong>PANDEMIC PERIOD</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Pandemic phase: increased and sustained transmission in the general population</td>
<td>Widespread human outbreaks in multiple locations overseas</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Implement facility surveillance for new influenza strain (all incoming and previously admitted residents)</td>
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<tr>
<td></td>
<td></td>
<td>• Implement a system for early detection and treatment of healthcare personnel who might be infected</td>
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<td></td>
<td></td>
<td>• Reinforce infection control procedures</td>
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<tr>
<td></td>
<td></td>
<td>• Accelerate staff training/cross training in accordance with the facility’s Pandemic Annex</td>
</tr>
<tr>
<td>3</td>
<td>First human case in North America</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Implement activities to increase capacity, supplement staff and obtain supplies and equipment (if you have planned to be involved with the county surge capacity, contact them for supply distribution)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Maintain close contact with healthcare facilities and with local health department</td>
</tr>
</tbody>
</table>

**WORKSHEET 1: PHASES OF PANDEMIC INFLUENZA (CONT.)**

### World Health Organization Phases and US Federal Government Response Stages

<table>
<thead>
<tr>
<th>WHO Phases</th>
<th>Federal Gov’t Response Stages</th>
<th>Recommended Actions for LTC Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PANDEMIC PERIOD (continued from previous page)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Continued from previous page</td>
<td>Maintain high index of suspicion that residents/staff presenting with influenza-like illness could be infected with pandemic strain</td>
</tr>
<tr>
<td></td>
<td>First human case in North America</td>
<td>Ensure that infection control signs and measures (such as hand sanitizer) are refreshed and highly visible</td>
</tr>
<tr>
<td>5</td>
<td>Spread throughout United States</td>
<td>If the pandemic strain is detected within your facility (resident, staff, family member, etc.), implement the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If in a resident—implement droplet precautions for the resident and roommate(s) pending confirmation of pandemic strain infection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Residents and roommates should not be separated or moved out of their rooms unless medically necessary—by the time a person is symptomatic, they have already been infectious for some time.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Once a resident has been diagnosed with the pandemic strain, roommates should be treated as exposed cohorts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cohort residents and staff on units with known or suspected cases</td>
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<tr>
<td></td>
<td></td>
<td>• Limit movement within the facility (e.g., temporarily close the dining room and serve meals on nursing units, cancel social and recreational activities)</td>
</tr>
<tr>
<td>6</td>
<td>Recovery and preparation for subsequent waves</td>
<td></td>
</tr>
</tbody>
</table>

### ADDITIONAL CONSIDERATIONS

<table>
<thead>
<tr>
<th>Precautions to take in the event of pandemic infection locally</th>
<th>Limit/Control Access</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Limit number of visitors to those essential for resident support</td>
</tr>
<tr>
<td></td>
<td>Screen all visitors at point of entry to facility for clinical signs and symptoms of influenza</td>
</tr>
<tr>
<td></td>
<td>Limit points of entry to facility; assign clinical staff to provide entry screening</td>
</tr>
<tr>
<td></td>
<td><strong>Staffing practices</strong></td>
</tr>
<tr>
<td></td>
<td>• Consider furlough or reassignment of pregnant staff and other staff at high risk for complications of influenza</td>
</tr>
<tr>
<td></td>
<td>• Consider re-assigning non-essential staff to support critical services or placing them on administrative leave</td>
</tr>
<tr>
<td></td>
<td>• Consider assigning staff recovering from the pandemic strain to care for your influenza patients</td>
</tr>
<tr>
<td></td>
<td>• As possible, provide staff with antiviral prophylaxis or vaccine following local distribution recommendations (participation in local surge may help you obtain limited supplies)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nosocomial Transmission</th>
<th>Infection in your facility:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Consider closing units where there has been nosocomial transmission</td>
</tr>
<tr>
<td></td>
<td>• Restrict new admissions (except other pandemic patients) to affected units</td>
</tr>
<tr>
<td></td>
<td>• Restrict visitors to the affected units to those essential for resident care and support</td>
</tr>
</tbody>
</table>

CASE FATALITY RATIO

PROJECTED NUMBER OF DEATHS*
US POPULATION, 2006

≥2.0% CATEGORY 5 ≥1,800,000

1.0 to <2.0% CATEGORY 4 900,000 to <1,800,000

0.5 to <1.0% CATEGORY 3 450,000 to <900,000

0.1 to <0.5% CATEGORY 2 90,000 to <450,000

<0.1% CATEGORY 1 <90,000

*Assumes 30% illness Rate

Interventions by Setting

<table>
<thead>
<tr>
<th>Setting</th>
<th>Pandemic Severity Index</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Category 1</td>
</tr>
<tr>
<td>HOME</td>
<td></td>
</tr>
<tr>
<td>Voluntary Isolation of the ill at home</td>
<td>Generally not recommended</td>
</tr>
<tr>
<td>Voluntary quarantine of household members in homes with ill persons</td>
<td>Generally not recommended</td>
</tr>
<tr>
<td>SCHOOL</td>
<td></td>
</tr>
<tr>
<td>Child social distancing</td>
<td>Generally not rec.</td>
</tr>
<tr>
<td>Dismissal of students from schools, school based activities; childcare closure</td>
<td>Generally not rec.</td>
</tr>
<tr>
<td>Reduce out of school contacts and community mixing</td>
<td>Generally not rec.</td>
</tr>
<tr>
<td>WORKPLACE/COMMUNITY</td>
<td></td>
</tr>
<tr>
<td>Adult Social Distancing</td>
<td>Generally not rec.</td>
</tr>
<tr>
<td>Decrease # of social contacts (e.g. encourage teleconferencing, non-face-to-face interaction</td>
<td>Generally not rec.</td>
</tr>
<tr>
<td>Increase distance between people</td>
<td>Generally not rec.</td>
</tr>
<tr>
<td>Postpone/cancel selected public gatherings</td>
<td>Generally not rec.</td>
</tr>
<tr>
<td>Modify workplace schedules and practices (staggered shifts, telecommute)</td>
<td>Generally not rec.</td>
</tr>
</tbody>
</table>
2.0 CLINICAL OVERVIEW

Planning Assumptions
We do not currently know how infection with pandemic influenza disease will affect the human population, primarily because we do not yet know what specific virus will cause a pandemic. However, health professionals are concerned that the current continued spread of a particular avian influenza virus (H5N1) may represent a pandemic threat. As a result, the best we can do is make assumptions based on the history of past pandemics and current threats. All Pandemic Annexes (from the level of your individual organization through the county to the state and federal levels) must start with educated assumptions or our “best guess.” To give you some guidance on how to prepare for the disease, we have used historical information as well as information about the H5N1 virus now circulating among birds and some people in Asia, Africa and Europe. While the H5N1 strain does not, at this point, have the ability to spread from person to person, health officials are concerned because H5N1 is especially virulent, is being spread by migratory birds, can be transmitted from birds to humans and continues to evolve. The following advice is based on these accepted planning assumptions.

2.1 PANDEMIC INFLUENZA VS. SEASONAL INFLUENZA

Influenza is a highly contagious disease, with a very brief incubation period lasting only a few days. Unfortunately, it is contagious even before any symptoms develop and continues to be contagious well into the period of clinical illness. Despite the contagiousness, not everyone gets very sick, and many cases are mild or even asymptomatic (without symptoms, despite infection).

It is not possible to predict with certainty the clinical differences between pandemic and seasonal flu. Both seasonal influenza and pandemic influenza are caused by an influenza virus. The newer a virus, the more impact it may have on a population. In the case of pandemic influenza, the human population has no previous exposure to this particular virus and therefore has no immunity to protect from infection. Because of this, healthy people are at risk for serious complications from infection with pandemic influenza virus.

If an influenza pandemic occurs, current estimates suggest that approximately 30 percent of the entire human population will contract the disease; many of these people will become very sick. However, pandemics occur in waves over a period of months, so one-third of the population will not be sick all at once, and those who have recovered after the first wave will have developed immunity against that influenza strain. A person with immunity to a particular influenza strain cannot get sick from that strain again.


Figure 1 shows the key differences between seasonal and pandemic flu.

**Figure 1:**

<table>
<thead>
<tr>
<th>Key Differences Between Seasonal Flu and Pandemic Flu&lt;sup&gt;12&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Seasonal Flu</strong></td>
</tr>
<tr>
<td>Occurs every year, mostly during the winter months.</td>
</tr>
<tr>
<td>Affects 5-20 percent of the U.S. population.</td>
</tr>
<tr>
<td>Kills 500,000 to 1 million people each year worldwide; 36,000-40,000 die from flu in the U.S. annually.</td>
</tr>
<tr>
<td>Most people recover in a week or two.</td>
</tr>
<tr>
<td>Deaths generally confined to at-risk groups, such as the elderly (over 65 years of age), the very young (children aged 6-23 months), those with existing medical conditions such as lung diseases, diabetes, cancer, kidney or heart problems, and people with compromised immune systems.</td>
</tr>
<tr>
<td>Vaccination is effective because the viral strain in circulation each year can be fairly reliably predicted and vaccine manufacturers have time to prepare for each year’s flu season.</td>
</tr>
</tbody>
</table>

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<sup>13</sup> Elderly and immunocompromised persons are unlikely to be protected from the virus through vaccination and therefore have been excluded from the vaccine priority list. U.S. Department of Health and Human Services (May 15, 2007). HHS Pandemic Influenza Plan, Appendix D. Retrieved July 2, 2007, from [www.hhs.gov/pandemicflu/plan/appendixd.html](http://www.hhs.gov/pandemicflu/plan/appendixd.html).
Antiviral drugs are generally available for those at greatest risk of serious illness.

Antiviral drugs may be in limited supply, and their effectiveness will only be known definitively once an actual pandemic is underway. Decisions may have to be made on how to prioritize antiviral medications within each facility, with reference to local, state and federal guidance. HHS has ranked the residents of long term care facilities sixth out of 11 priority groups to receive stockpiled antiviral medication for post-exposure prophylaxis and treatment (i.e. in response to an outbreak in a facility, antivirals may be given to treat influenza as well as distributed to asymptomatic residents to slow or halt the spread of the virus).  

2.2 DISEASE PROFILE

Signs and Symptoms
The signs and symptoms of influenza may vary, depending on the actual strain of the virus that causes the pandemic. Common symptoms include:

- High fever
- Shaking chills
- Severe body aches and muscle pain
- Headache
- Pain when eye movement occurs
- Fatigue
- Malaise (slowing down, lack of energy)
- Loss of appetite
- Dry and wet cough
- Runny nose
- Dry or sore throat

In children, the symptoms may also include:

- Otis media (ear infection/inflammation)
- Nausea
- Vomiting

It is important to note that symptoms have been reported in the recent outbreak of avian influenza H5N1 which differ from the common ones listed above. These are:

- Watery diarrhea
- Profound shortness of breath
- Patchy areas revealed in the lung by X-rays

In the avian influenza H7 outbreaks (H7N3 in Canada in 2004 and H7N7 in The Netherlands in 2003), one of the primary human symptoms was conjunctivitis (infection/inflammation of the outer layer of the eye and eyelids).

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17 The reason it is important to review the common symptoms of seasonal influenza, as well as the more unusual symptoms that have been caused by avian influenza strains H5 and H7, to give us a starting point for our planning and preparedness efforts. If there is potential that a pandemic strain could cause extreme lung damage, we need to be ready for this. If a pandemic influenza strain turns out to cause watery diarrhea, it will be important to have a stockpile of incontinence supplies. Check the supply list worksheet for our recommendations on stockpiling for pandemic influenza.

Pandemic Influenza Workbook for Long Term Care Providers
Once the pandemic strain is identified, there will be widely available information about the particular symptoms that it causes. Check with your local public health department, the California Department of Public Health (formerly the California Department of Health Services) and the federal Centers for Disease Control and Prevention (CDC). The Web sites\textsuperscript{18} of each of these organizations should have strain-specific information. See Appendix C for a list of Web sites referred to in this document.

\textbf{Clinical Course and Disease Incidence}

The clinical course and disease incidence of pandemic influenza are largely unknown at this point and will be unknown until the pandemic strain is identified. You should review your local public health department pandemic plan (often available on the county and/or public health department Web site) and the California Department of Health Services Pandemic Influenza Preparedness and Response Plan (http://www.dhs.ca.gov/ps/dcdd/DCDCIndex.htm) in order to understand local and state-level planning for an influenza pandemic. There is also free modeling software called “FluSurge” available at www.hhs.gov/nvpo/pandemics. This software can help you predict the impact of a moderate or severe pandemic on your particular locale as you input specific variables.

Figure 2 shows the comparative impact of a moderate and a severe pandemic in the United States.

\textbf{Figure 2:}

\begin{center}
\textbf{Potential Burden of a Pandemic in the US}
\end{center}

\begin{tabular}{|l|c|c|}
\hline
 & Moderate (1957-like) & Severe (1918-like) \\
\hline
Illness & 90 Million (30\%) & 90 Million (30\%) \\
\hline
Outpatient Medical Care & 45 Million (50\%) & 45 Million (50\%) \\
\hline
Hospitalization & 865,000 & 9,900,00 \\
\hline
ICU Care & 128,750 & 1,485,000 \\
\hline
Mechanical Ventilation & 64,875 & 745,500 \\
\hline
Deaths & 209,000 & 1,903,000 \\
\hline
\end{tabular}


\textbf{Complications}

By far, the most likely complication of a flu pandemic is pneumonia, followed by respiratory compromise and failure. In the U.S. Department of Health and Human Services Pandemic Influenza Plan, health planners predict that 10 percent of those contracting influenza during the pandemic will develop post-influenza bacterial pneumonia. The exact clinical course, disease incidence and common complications cannot be predicted until the specific organism is known. However, as you can see in Figure 2, in a severe pandemic, the rates of hospitalization, ICU care and ventilation are all greatly increased compared with a moderate pandemic; in other words, the more severe the pandemic, the greater the risk of complications. Current hospital resources are inadequate to accommodate the projected increase in demand for inpatient services during a severe pandemic while continuing to provide care to severely ill non-influenza patients. This is why LTC facilities must prepare to treat

\textsuperscript{18} See Appendix C: Useful Web Sites in this Workbook (p. 79).
critically ill residents within their facilities who would under normal circumstances be admitted to the hospital.

**Diagnostic Testing and Reporting**

There are diagnostic (laboratory) tests that can be performed to identify influenza. When a pandemic influenza occurs, the local and state health departments will provide healthcare organizations with advice and decision-making on diagnostic testing for residents. Diagnostic testing will occur in the early phases of the pandemic, but once the pandemic is widespread, testing will be less frequent. Currently, healthcare providers are not testing for “pandemic flu” because the strain does not yet exist; however, once a pandemic virus evolves, laboratories will be able to test for it immediately using available technology.

In LTC facilities, it is important to be alert to the signs and symptoms of influenza, whether during the regular flu season or a pandemic, and to report those symptoms to the resident’s physician as soon as possible. Early detection can reduce the spread of any type of influenza throughout your facility. It is also important to be on the lookout for flu-like symptoms in staff or visitors who have recently returned from an area with human cases of avian influenza H5N1.\(^{19}\)

The CDC has developed recommendations for inpatient facilities with regards to seasonal influenza. These recommendations include developing a plan for collecting respiratory specimens and performing influenza screening using rapid diagnostic testing or immunofluorescence and viral cultures (although the viral culture is to measure changes in the virus and will not be helpful in clinical decision-making due to the prolonged wait for results) when there are clusters of respiratory illness or any suspected influenza in a patient or provider.\(^{20}\)

If you suspect a novel influenza virus (one that is different from the currently circulating seasonal strains) in your facility, contact your local public health department — *Novel Influenza A is now on the national list of Reportable Diseases and Conditions.*\(^{21} 22\)

**Transmissibility**

Generally, influenza spreads mainly through the air (in droplet form) and is transmitted from person to person by sneezing, coughing, talking or by just breathing the same air in a room, bus, subway or other enclosed space. It is also spread by physical contact, touching any surface that may have live flu virus on it, including hands, recently-touched objects, door handles and so on. No one knows whether a new pandemic strain of virus will also have what is technically called “airborne spread,” which means small amounts of virus that can float through the air (independent of droplets) and make someone sick even if they were across a large room from a contagious person. The best idea is to plan for the worst-case scenario (a virus that has airborne, droplet and contact transmission) and hope for the best (a virus that does not have airborne transmission).

### 2.3 PREVENTION AND TREATMENT

\(^{19}\) See [www.pandemicflu.gov](http://www.pandemicflu.gov) or [www.who.int/en](http://www.who.int/en) for the current disease incidence and case definition.


\(^{21}\) Visit [www.cdc.gov/epo/dphsi/phs/infdis2007r.htm](http://www.cdc.gov/epo/dphsi/phs/infdis2007r.htm) for the complete national list of Notifiable Infectious Diseases. *Note: Avian influenza H5N1 is a novel influenza A virus, and so it, and any mutation of it, would need to be reported to your local public health department.* Check with your local public health department to understand all national, state and local reportable conditions.

\(^{22}\) See *Appendix A: Communicable Disease Reporting* in this Workbook (p. 77) for additional important information you should know about reporting certain diseases and conditions to your local public health authority.

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**Pandemic Influenza Workbook for Long Term Care Providers**
The best prevention of any type of influenza, either seasonal or pandemic, is by preventing exposure to persons sick with influenza — unexposed persons will not contract the disease. Strong attempts should be made to avoid exposure to people suspected of having influenza, whether residents, staff or visitors. Non-pharmaceutical methods of reducing exposure are discussed extensively below. Also discussed is information about vaccination and antivirals, two of the best ways of preventing or lessening the spread and severity of seasonal influenza but which have serious limitations in a pandemic situation.

Since post-influenza bacterial pneumonia will be a common complication of pandemic flu, now is the time to ensure that all residents and staff of LTC facilities are vaccinated against Pneumococcal pneumonia with Pneumovax®.

See Appendix D: Preventing Pneumonia during Pandemic for more information.

The CDC recommends revaccination after five years for immunocompromised individuals, including the elderly whose immune function becomes impaired. It remains imperative for all residents and staff to continue to receive vaccination for seasonal influenza during the pandemic. While the seasonal influenza vaccine will not prevent pandemic flu, it will reduce the risk of having a concurrent outbreak of seasonal and pandemic flu within an LTC facility.

Persons with pandemic influenza should be isolated within the facility to the extent possible. They should be treated and cared for by staff, family members or friends who have as little contact as possible with other well residents or staff. Fever should be treated with antipyretics such as acetaminophen (Tylenol®) or other fever medications. Hydration should be maintained with liquids by mouth if possible or IV if necessary.

See Worksheet III: Oral Rehydration (p. 17)

Pain may also be controlled to a great extent with acetaminophen or aspirin or other “anti-cold” medications. Consider stockpiling enough for six weeks (a minimum of two weeks is necessary, and ideally facilities should prepare for three months worth of supplies, including medication) with each resident receiving 600 mg ibuprophren (i.e., Advil®) every six hours and 650 mg acetaminophen (i.e. Tylenol®) every four hours either through pills, suppository or liquid. Be sure to check with the resident’s physician before administering medication and understand the regulations (and how they might be flexed in an emergency) when attempting to stockpile medications.

See Worksheet IV: Suggested Pandemic Supply List of medications to consider stockpiling if you are able (p. 18)

Bed rest will be necessary. Respiratory distress and failure will have to be treated in a hospital setting, if available; otherwise facilities will have to do the best they can under the advice of physicians, nurses or nurse practitioners and public health officials. Antiviral medications, if available, may be helpful in treatment of those with active influenza infection, as well as persons exposed to the influenza virus. Before and during a pandemic, follow the advice of public health and governmental authorities.
Oral Rehydration Solution

PREVENTING DEHYDRATION IS CRITICAL!

If you suspect dehydration is developing, begin administering an oral electrolyte maintenance product such as Gatorade (for adults) or Pedialyte (for children), or use the simple home-made solution below:

- 1 quart clean water
- 1 level teaspoon table salt
- 3 tablespoons table sugar

This can be drunk plain or with additional flavoring added, such as powdered drink mix from the grocery store or natural flavoring such as tea, vanilla, cloves, cinnamon or mint.

Administering ORS to an Influenza Patient

When an influenza patient is very weak, whichever solution you have chosen may need to be administered using a baby bottle or teaspoon. Persist until the patient has taken in at least 1 quart of fluids. This may take several hours.

Progress has been made when the patient becomes more alert and needs to urinate. Your patient will be very tired, and you need to allow him or her to sleep—however, don’t stop pushing fluids with these very sick influenza patients.

For more detail, see Good Home Treatment of Influenza by Dr. Grattan Woodson, available at www.birdflumanual.com.
### General Infection Control Supplies
- Hand hygiene supplies (antimicrobial soap and ≥60% alcohol-based, waterless hand hygiene products)
- Facial Tissues
- Paper towels
- Heavy duty garbage bags
- Facility disinfectants (see Worksheet X)
- *Positive air purifying respirators (PAPRs) or other equivalent*

### Personal Protective Equipment
- Disposable N-95 respirators and surgical masks
- Face shields or goggles
- Gowns
- Gloves

### Respiratory Care Equipment
- Portable oxygen
- Regulators and flow meters
- Oxygen and ventilator tubing, cannulae, masks
- Suction kits
- Tracheotomy
- Vacuum gauges for suction and portable suction machines
- Ventilators
- Manual resuscitators (bag-valve mask)

### Medications (consider stockpiling a 6-week supply)

#### Over the Counter
- Nonsteroidal anti-inflammatory drugs (NSAIDS) such as ibuprofen 200mg—pill and liquid forms
- Acetaminophen (pills, suppository, liquid)
- Vasopressors such as diphenhydramine 25 mg and Robitussin DM or generic equivalent
- Loperamide 2 mg
- Meclizine 25mg

#### Prescription
- Antibiotics (consider ciprofloxacin, levofloxacin, vancomycin, peperacillin/tazobactam, ceftriaxone)
- *Antivirals (oseltamivir, zanamivir as 2nd choice)*
- Vaccines (seasonal influenza, pneumococcal, pandemic influenza strain vaccine when it becomes available)
- Benzodiazepines such as Valium, propofol
- Proton pump inhibitors
- Bronchodilators

### Food-Type Supplies
- Table salt
- Sugar
- Baking soda
- Caffeinated tea
- Bullion
- Pedialyte or similar (for children)
- Gatorade or similar (for adults)
- Clean water

### Mortuary Supplies
See Altered Std. of Care/Mass Fatality Care section
- Morgue packs
- Plastic tarps (temporary screens, floor protection)
- Heavy rubber gloves
- Heavy rubber boots
- Unscented bleach or dry bleach used for swimming pool maintenance
- Basins
- Mops
- Buckets
- Cloths
- Labels or tags (for identification of the deceased)
- 20lbs/person sufficient to embalm 15% of your expected census of common roadway salt
- 20lbs/person sufficient to embalm 15% of your expected census of quick lime

### Other Supplies
- Beds
- Stretchers/gurneys
- Syringes and needles (for vaccine administration)
- IV pumps & equipment
- Incontinence supplies (including adult diapers)
- Electronic thermometers
- An accurate scale to monitor weight loss
- Pill cutter
- Humidifier
- Automatic blood pressure cuff
- Coca butter (for suppositories and skin care)
- Petroleum jelly (lubrication of tubes, suppositories)
- 8 oz plastic baby bottles with rubber nipples
- Soda straws
*may not be possible/appropriate for all facilities*
3.0 CONTAINMENT STRATEGIES

3.1 GENERAL INFECTION CONTROL

General infection control measures are some of the most important steps your facility can take, and taking these measures is something that you can do right now. It is important to educate, post appropriate signs and remind all staff, all visitors and all residents to practice hand hygiene and respiratory etiquette. With some infectious diseases, including pandemic influenza, the use of masks and other barriers will help decrease disease transmission. Always keep the facility clean, sanitized and free of garbage.

See Worksheet V: Infection Control Overview for Pandemic Influenza (p. 26) for more details about how you can reduce the risk of infectious disease in your facility.

For the currently circulating strain of avian influenza H5N1, it is recommended that full infection control measures remain in effect for seven days after the resolution of fever for adults >12 years and for 21 days after the onset of illness in children ≤12 years and immunocompromised adults. When the pandemic begins, check with your local public health department or the CDC for current information on the route of transmission (i.e. airborne, droplet, etc.), the level of protection required and the infectious period. This will give you the specific information for implementing your infection control practices and planning for the stocking and disbursement of supplies.

Start implementing good infection control strategies now because they take a little practice. It is better for people to get used to modifying their behavior (cleaning their hands more regularly, coughing and sneezing into a tissue or into their sleeve) before there is an infectious disease outbreak, and these simple steps can greatly reduce the likelihood of having an infectious disease spread throughout your facility.

Hand Hygiene
Hand washing and sanitizing are critical to reducing the spread of any disease, and it is particularly important to practice good hand hygiene with influenza and influenza-like illnesses. Encourage staff, residents and all visitors to wash their hands frequently, especially when they are visibly soiled or have come in contact with mucous or other bodily secretions. When soap and water are not readily available, use an alcohol-based (60-percent alcohol) hand sanitizer when hands are not visibly soiled. If hands are visibly soiled, they must be washed with soap and water. Post reminder signs throughout your facility in the appropriate languages and establish and maintain hand hygiene stations throughout the facility stocked with hand sanitizer dispensers. You will be surprised how much hand hygiene improves when hand sanitizers are widely available! Remember, lots of hand washing or hand sanitizing can dry your hands, so it is important to keep them moisturized in order to prevent small cracks in the skin.

See Worksheet VI: Sample Hand Washing Poster (p. 27)—you can use this or draw from it to make your own

See Worksheet VII: Sample Hand Sanitizing Poster (p. 28)

Respiratory Etiquette
Respiratory etiquette is another good infection control strategy that all staff, visitors and residents should practice. Teach/remind all these groups about the “sleeve sneeze” and coughing into your elbow if you don’t have a tissue available. These practices reduce the amount of infectious material on your hands, which reduces the spread of the virus around the facility. Post signs in visible locations.
throughout your facility and provide tissues and wastebaskets. Make sure that signs are language-appropriate for your staff, visitors and residents.

See Worksheet VIII: Sample Respiratory Etiquette Poster (p. 29)

Keep tissues readily available throughout the facility and teach residents, staff and visitors the importance of throwing the used tissues into a trash receptacle immediately after use. If a resident is coughing, consider putting a surgical-type mask on the resident when he/she is in a group — but only if the resident can tolerate wearing the mask and it does not interfere with breathing. This will help decrease the spread of droplets to others by coughing.

**Social Distancing**
Influenza is transmitted by droplets from the respiratory system, especially when you cough or sneeze, but can even be transmitted through speaking or singing. These droplets usually do not travel more than three feet from the person coughing, sneezing, etc., and therefore, keeping a “social distance” of three feet among the residents can reduce the spread of influenza, whether seasonal or pandemic. To accomplish this, long term care facilities could consider rotating times in common areas so they are not as crowded and placing residents at least three feet apart at meal times or during therapy.

**Contaminated Surfaces**
It is critical to clean all surfaces that you suspect could be contaminated by a pandemic strain of influenza or an infectious disease. Increase the frequency of wiping down and disinfecting frequently-touched surfaces such as counters, table tops, door knobs, telephones, TV knobs, computer keyboards, etc. (see Worksheet IX, p. 30, and Worksheet X, p. 31, on environmental cleaning.) Also consider “soft,” or porous, surfaces such as linens, pillows, furniture coverings and keep these items laundered as much as possible.

See Worksheet IX: Environmental Cleaning and Disinfection (p. 30)

See Worksheet X: Environmental Cleaning and Disinfection Products (p. 31). (Note: Influenza is an enveloped virus, so review the items in that category to see which cleaning products will be most effective in a pandemic.)

**Personal Protective Equipment, Including Masks**
Personal protective equipment (PPE) plays an important role in reducing the spread of infectious diseases. PPE appropriate for healthcare worker use in long term care facilities includes gloves, gowns, masks and goggles/face shields. In the case of pandemic influenza, until the route of transmission is determined, it is recommended that healthcare providers use:

- **Standard precautions:** Practice good hand hygiene.
- **Contact precautions:** Use of gloves, gown and dedicated equipment.
- **Eye protection:** Use of goggles or face shield.
- **Airborne precautions:** A respirator (mask) rated N-95 or higher should be worn by care providers, cleaning staff and/or susceptible persons when coming within three feet of a suspected case.
- **Droplet precautions:** To further reduce the risk of transmission, a respirator should be worn by any symptomatic person within three feet of others. If a facility runs short of N-95 respirators, a surgical mask will provide some protection against influenza and should be used.

See Worksheet XI: Personal Protective Equipment for Pandemic Influenza (p. 33) for more information about N-95s and surgical masks.
Additionally, special care should be exercised when performing any aerosol-producing procedure. Discuss any types of treatments, including nebulizer use, with the ordering physician and refer to current guidance available on the CDC Web site. Upon exiting the room, always ensure the proper removal and disposal of all personal protective equipment in a receptacle for infectious wastes.

You will need to develop policies and procedures for determining who will be allowed to use the different types of personal protective equipment in a pandemic situation, particularly making sure that you plan for running short of protective supplies. Keep in mind that while PPE is inexpensive and widely available today, soon after the arrival of a pandemic, alcohol gel hand sanitizer, surgical masks, N-95 respirator masks and even latex gloves are predicted to become scarce or even impossible to obtain. Preparing to cope with shortages of essential supplies like these need to be part of all LTC facilities’ Pandemic Annexes.

It is also important to consider the fact that direct care staff are not the only ones who come in close contact with the virus; for example, housekeeping staff are an at-risk group vital to your continued operations. Consider all the different types of staff within your facility that might need access to personal protective equipment to keep your facility functioning.

3.2 SURVEILLANCE AND DETECTION

Before the pandemic: Keep alert to the news and any announcements from public health authorities regarding both avian and pandemic influenza. Report any unusual illnesses (including novel influenza A viruses) in your facility to public health and follow their guidance. See Appendix A: Communicable Disease Reporting for more details.

During the pandemic: During a pandemic, local public health will issue guidelines for reporting cases and conducting surveillance—follow this guidance.

3.3 NON-PHARMACEUTICAL CONTAINMENT

Non-pharmaceutical containment refers to the measures that you can take to contain the spread of disease within your facility without the use of pharmaceuticals such as vaccine or antivirals.

Before the pandemic: All planning must occur in the “pre-pandemic” period. Understand and use infection precautions and learn about what you might expect to occur if a pandemic arrives. Before the pandemic is the time to develop policies, procedures and training materials for containment strategies. Decide, plan and practice the items given under the following “During the Pandemic” sections pertinent to this area of planning. A key task you can perform now is to decide on the “trigger” for the implementation of non-pharmaceutical containment measures.

Triggers

23 See 4.5 Staff Preservation in this Workbook (p. 46) for more discussion and additional considerations.
During the pandemic:

1. **Reduce Social Interactions**: Reduce exposure to other persons, whether they are known to be sick or not, wherever possible. Reduce social interactions where possible; avoid crowds, public transport, crowded events, schools, emergency rooms, theaters, group picnics, etc. Anyone can give the flu to anyone else, and therefore limiting contact with others helps to minimize risk. Use common sense and avoid panic. If you are responsible for the care of others or are being cared for by others or are conducting a vital service for others, you should continue to do so whenever possible, using precautions described above. If your facility is participating in a higher level of surge capacity (see p. 7) and admitting non-infectious patients from the hospital, you still want to make a reasonable attempt to keep all residents distanced from one another within your facility.

There may be some residents of LTC facilities who, in a pandemic, will be able to go to a family home, to stay with friends or to stay in a smaller or less crowded facility where more protection from infection can be afforded. These are important considerations for facilities, residents and families that can be decided well in advance of any outbreak of pandemic flu in your locality. Reducing your census by implementing previously identified discharge plans for those individuals who can go to an alternate placement could help to make the situation more manageable from an infection control and staffing perspective.

2. **Shelter in Place**: As the name suggests, this concept refers to the fact that the preferable place for people in a difficult situation like a pandemic is usually in their normal living situation, at “home” in a long term care facility. Consider where the best care and shelter are available for your residents at the time of the outbreak and plan to stay there until the pandemic is over.

Planning carefully for disruptions in your supply chain and staffing patterns will increase your chances of being able to weather through without having to close your facility. It is important, however, to have contingency plans should the situation become unmanageable. What if you have to close due to difficulties maintaining staffing levels? Is there an alternate place to go? How will you transport your residents, staff, equipment and supplies? Individual facilities should openly discuss and plan for these contingencies with their External PI Committee and be prepared to revise plans should the fundamental situation change.

3. **Self-Isolation Concept**: Keep sick visitors and staff out of the LTC facility. This is both very important and very difficult. Signs and placards must be posted at all entrances. Families, friends, delivery people, repair people and staff must all understand and respect this goal.

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24 See 4.5 Staff Preservation in this Workbook (p. 46) for more information.
25 See 4.4 Supplies in this Workbook (p. 46) for more information.
26 See 4.3 Business Continuity Planning in this Workbook (p. 43) for more information.
27 “Sick” means sick with flu or anything that resembles flu, like acute colds, coughs, fevers, feeling quite ill. It does not mean ill with a different, clearly diagnosed noninfectious disease, such as asthma, diabetes, allergies, etc.
Persons who have been exposed to flu or who reasonably suspect that they have been exposed should also stay out of the facility.

The right message to give all visitors and staff is: “If you have the flu or if you think you might have the flu or if you have been exposed to someone who has the flu (or even if you have been exposed to someone who became ill within two days of your exposure to them), PLEASE STAY OUT. If you MUST enter, please wear a mask, wash your hands frequently and avoid breathing or coughing/sneezing near anyone else. Please leave as soon as possible.” Again, remember that any signs you post should be posted in all the languages spoken by residents, families, staff and delivery people. If you are asking people entering the facility to wear a mask, they may be expecting you to provide them with masks. Have a box of surgical masks handy at all entrances for this purpose.

All essential visitors to the facility should be required to wash their hands upon entry and don a surgical mask to prevent unintended spread of influenza or other infectious disease by an infected but asymptomatic person to the facility’s residents. If the visitor will be touching a resident, consider supplying other contact barriers as well. After pandemic outbreak, under no circumstances should children 12 years of age and younger be permitted to enter the facility.

Cancel all unnecessary travel by residents outside the facility. Ideally, residents leaving the facility after this point should wear a properly fitted N-95 respirator mask (if they can tolerate a respirator) and latex gloves the entire time they are away from the facility and should strictly limit their contact with other people during their trip. If the resident cannot tolerate a respirator, a surgical mask is a good alternative, although it will offer less protection than a fit-tested N-95.

**Handling New Admissions During “Self Isolation”**

When pandemic outbreaks occur in your area, you will need to make decisions about whether to continue to accept new admissions. Plan to screen new admits for a history of exposure and/or signs and symptoms of pandemic influenza, before accepting them into the facility. Follow guidance for the state Department of Health Care Services (DHCS), federal Centers for Disease Control and Prevention (CDC) and your local health department for laboratory testing as part of this screening. Alternately, you may also decide that while new pandemic cases are occurring in your geographical area, you will close your facility to new admissions.

As discussed earlier in this Workbook, LTC facilities, especially ones such as skilled nursing facilities with licensed medical and nursing staff, may volunteer or be asked by public health officials to participate in the “surge” response in their community by taking non-infectious hospital patients once the hospitals become full. If your facility is asked to be available during a pandemic to take in non-infectious patients, consider this request very carefully. Ensure that your facility is at a level of preparedness that enables it to sustain this additional load. This type of capability may only be applicable to certain highly prepared facilities, including those that are a distinct part of a hospital.

To safely manage any new admits during a pandemic influenza outbreak will require aggressive planning and preparation of your facility involving all of the infection control strategies that have been discussed in this Workbook. Be sure that you are included in your city and county planning for local allocations for PPE, vaccines, antivirals and other medicines, emergency personnel, other surge supplies and resources that are being collected in your local area.

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28 See Appendix C: Useful Web Sites in this Workbook (p. 79) for these links.
29 See Surge Capacity (p. 7) under 1.6 Planning for Influenza in this Workbook for the definition and additional details.
4. **Isolation and Quarantine: Limit the Access of Exposed or Sick Persons:** “Isolation” means the separation of persons with actual flu. “Quarantine” refers to the separation of those who have been exposed or are likely to have been exposed to the pandemic influenza virus. The idea of both of these concepts is to break the chain of transmission as soon as possible. If staff are sick or have been exposed, they should separate themselves from non-sick and non-exposed people — they should stay home and stay away from their own families and friends as much as possible until they have recovered from their sickness or the incubation period has passed and they have not gotten sick. They should not re-enter the facility until they are well. The same is true for anyone who is likely to visit the facility. People who enter the facility inadvertently and find they are sick after arriving or within two days of leaving should let the facility know that the exposure has occurred, and the facility should attempt to quarantine (separate) the exposed persons. This may become impossible, if the exposure was broad within the facility. Be sure to communicate this message to visitors, staff and delivery people.

5. **When Quarantine Must Occur Within a Facility:** If a definite exposure has occurred in a limited part of the facility, with, for example, just a few residents, these individuals should be kept apart from the rest of the population as effectively as possible. This may mean keeping them in their own rooms, while also quarantining roommates who would also have been exposed to the quarantined individuals. This is a cumbersome process but is essential for limiting risk of infection within the facility.

6. **Cohort the Sick in a Section of the Facility:** The placing together of patients in a care facility who have like symptoms and/or diagnosis for the purposes of infection control and efficiency of is considered by some to be an extreme measure for an LTC facility to employ. However, when used early in the course of the pandemic and applied comprehensively, it can very effectively reduce the spread of influenza and its complications within the facility. This measure is usually only used in acute care hospitals with a specific physical layout and highly trained staff but can be adapted to the LTC facility.

7. **Length of Time for Precautions:** Most of the precautions should be in place as long as the pandemic lasts, which may be many months. Public health officials will advise you. Trust their advice. Try to plan to keep up sheltering within the facility for as long as possible. Assure that food, water and utilities remain available as long as possible before breaking the isolation. Until and unless the flu gets into the facility and creates an internal outbreak, it is worth continuing to protect the residents, staff and their families from external introduction of the virus.

### 3.4 VACCINE

Influenza is often preventable if a vaccine is available, and your staff will be the most likely to benefit when vaccine is offered. A simple injection will reduce the number of persons who become infected in the first place and therefore will reduce the number of persons who are actively spreading the infection to others. Additionally, the vaccine is likely to reduce the severity of the clinical symptoms, even if it does not completely prevent infection in all cases.

**Before the pandemic:** At the start of a pandemic, no vaccine will be available. It is unlikely that an effective vaccine will be available until at least six or more months after the start of a pandemic. When a vaccine becomes available, it will be in very limited supply and not available to the whole population at once. Public health authorities have established priorities for the use of the vaccine in various segments of the population. It is expected that healthcare personnel, first responders or government authorities will have first priority to receive the vaccine when it becomes available. Your facility should develop internal protocols for the prioritization of vaccine among staff so that you will be ready once...
there is a vaccination available. Elderly and immunocompromised persons have been excluded from the list because they are unlikely to be protected by vaccination.30

While there is currently no vaccine for pandemic flu, governments have been working hard to assure that a new and effective vaccine can be developed as rapidly and efficiently as possible if and when a pandemic does start. Several “practice” vaccines have been successfully developed against the present strain of H5N1 virus which is circulating in birds in Asia, so it appears it will be possible to develop a vaccine to protect humans if a pandemic virus does eventually develop. Again, if and when a pandemic starts, no vaccine will be available for several months.

**During the pandemic:** People should be vaccinated as soon as vaccine is available, depending on the governmental/public health mandated order of priorities. From our experience with seasonal flu, we understand that flu vaccines are often less effective in aged persons. This means that, whether we are talking about seasonal flu or pandemic flu, the most important strategy is to keep the virus out of your facility.

### 3.5 ANTIVIRALS

Antiviral drugs are different from a vaccine for pandemic influenza. Used prophylactically (in anticipation of, or directly after, exposure) these drugs may prevent some or many infections with pandemic influenza, but it is presently unclear which antivirals, if any, will be effective. There is also significant concern that these drugs will be in limited supply if a pandemic starts in the near future. However, constant stockpiling is going on, leading to increased supplies of the most likely effective antiviral, oseltamivir (brand name Tamiflu®). Another antiviral, zanamivir (brand name Relenza®), is similar to Tamiflu®. This is the drug of second choice and is also being stockpiled nationally. It should be noted that in a pandemic situation it may be quite difficult to take antivirals prophylactically due to the large amount required to be ingested in order for the drug to be effective, as well as the likelihood that exposure will be constant and therefore a single prophylaxis regimen would be ineffective.

Antiviral medication may also help lessen the effect of influenza when given to patients who already have the disease, thereby lessening the severity and duration of symptoms and possibly limiting the spread.

**Before the pandemic:** Long term care providers may wish to stockpile antivirals if possible; the State of California does not discourage this practice (as some states may). Providers may obtain the discounted state pricing from the manufactures of these medications as allowed by your local public health department. It should be noted that these medications can be expensive and must be used correctly to be effective. Residents of long term care facilities are on the priority list (number six out of 11) to receive antiviral medication for treatment and prophylaxis against outbreaks occurring in LTC facilities.31 Contact your local public health department and discuss this issue with the person in charge of pandemic planning.

**During the pandemic:** The local public health department may provide you with antiviral medications should they be needed. This will depend on availability and rank on the federal antiviral priority list. Contact your local public health department for information about antivirals during the pandemic.

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Contaminated Surfaces

**Influenza can survive:**
- Up to 48 hours on non-porous surfaces (i.e. bedrails, door knobs, TV remotes, pens)
- Up to 12 hours on porous surfaces (i.e. tissues, cloth, linens)

**Disinfection**
- In general, diluted bleach or common healthcare setting cleaning products are sufficient
- Do not spray disinfectant or use aerosolizing cleaning methods
- Give close attention to cleaning frequently-touched hard surfaces
- Ensure soiled linens and laundry, and dishes and eating utensils, are washed with detergent at appropriate water temperature
See Worksheet IX: Environmental Cleaning and Disinfection for more details

Hand Hygiene

Critical to controlling the spread of infectious diseases, this is a measure that EVERYONE (all staff, patients and visitors) can take part in. Post hand hygiene (hand washing and sanitizing) signs in common areas and staff break rooms. See Worksheets IV and V for sample posters. Make antimicrobial soaps available near sinks, and make alcohol-based hand rubs available in common areas, staff areas, and all other places that hand washing is not available.

**Alcohol-based Hand Rubs**
Use only when hands are not visibly soiled. Alcohol-based hand rubs reduce time required for hand disinfection!
- Use only 60-95% alcohol content sanitizers
- Rub hands together 10-15 seconds (hands should feel wet during this time)
- Rub hands together until dry

**Hand Washing**
In healthcare settings, use antimicrobial products (such as products containing 4% chlorhexidine gluconate) and water to cleanse hands before and after patient contact. Wash hands before gloving and after removing gloves.
- Rub hands together vigorously for 15-30 seconds
- Cleanse all sides
- Pay attention to nails, rings, watches
- Ensure hands are completely dry at conclusion—disposable paper towels are best

Respiratory Hygiene

With education and reminders, staff, patients and visitors can all practice good respiratory hygiene. Hang posters (cover your cough, sleeve sneeze) in common areas and staff break rooms. See Worksheet VIII for sample poster. Keep facial tissues and wastebaskets available in patient rooms, common areas and break rooms.
- When coughing, place a tissue over nose and mouth
- Put used tissue in the trash
- If you don’t have a tissue, cough or sneeze into your sleeve, not your hands
- Follow above steps on hand hygiene
- When possible, keep your distance (3 feet) from anyone coughing or sneezing

www.cdc.gov/handhygiene/download/hand_hygiene_core.pdf
www.toronto.ca/health/sleeve_sneeze.htm#posters
www.who.int/foodsafety/micro/Al_QandA_May06_EN.pdf
Hand Washing

1. Wet hands.
2. Apply soap.
3. Lather for 15 seconds. Rub between fingers, back of hands, fingertips, under nails.
4. Rinse well under running water.
5. Dry hands well with paper towel or hot air blower.
6. Turn taps off with paper towel, if available.

Stop the Spread of Germs!

Always Wash Your Hands

<table>
<thead>
<tr>
<th>After you:</th>
<th>Before AND After you:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sneeze, cough or blow your nose</td>
<td>• Prepare or eat food</td>
</tr>
<tr>
<td>• Use the bathroom or change</td>
<td>• Touch a cut or open sore</td>
</tr>
<tr>
<td>diapers</td>
<td></td>
</tr>
<tr>
<td>• Handle garbage</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Toronto Public Health, www.toronto.ca/health
Hand Sanitizing

1. Apply sanitizer (minimum 60% alcohol-based).

2. Rub hands together.

3. Work sanitizer between fingers, back of hands, fingertips, under nails.

4. Rub hands until dry.

Stop the Spread of Germs!

Always Sanitize Your Hands

<table>
<thead>
<tr>
<th>After you:</th>
<th>Before AND After you:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sneeze, cough or blow your nose</td>
<td>• Prepare or eat food</td>
</tr>
<tr>
<td>• Use the bathroom or change diapers</td>
<td>• Touch a cut or open sore</td>
</tr>
<tr>
<td>• Handle garbage</td>
<td></td>
</tr>
</tbody>
</table>

If hands are visibly soiled, use soap and water

Adapted from Toronto Public Health, www.toronto.ca/health
Cover Your Cough or Sneeze

1. Cover your mouth and nose when you cough, sneeze or blow your nose.
2. Put used tissue in the garbage.
3. If you don’t have a tissue, cough or sneeze into your sleeve, not in your hands.
4. Wash hands with soap and water or hand sanitizer (minimum 60% alcohol-based).

Stop the Spread of Germs!

Always Cover Your Cough

- Covering your cough or sneeze can stop the spread of germs
- If you don’t have a tissue, cough or sneeze into your sleeve
- Keep your distance (more than 3 feet) from people who are coughing or sneezing
Facility Disinfection in Detail—For All Staff

The transfer of bacteria and viruses from surfaces to people occurs when people touch an object and then touch their eyes, nose or mouth. In a pandemic, it is likely that there will be a shortage of cleaning staff, and available staff may be working outside of their regular hours to lessen their exposure risk. Therefore, it may become necessary for other staff to assist with cleaning.

As mentioned on Worksheet V: Infection Control Overview for Pandemic Influenza, Influenza can survive:

- Up to 48 hours on non-porous surfaces (i.e. bedrails, door knobs, TV remotes, pens)
- Up to 12 hours on porous surfaces (i.e. tissues, cloth, linens)

Cleaning Tasks

- Routine cleaning tasks (e.g., vacuuming, floor cleaning, dusting, window cleaning) should be suspended during a pandemic and the focus should be on cleaning surfaces/items that are frequently touched by many people in those areas of the facility where staff are working (not all areas of a facility may be in use during a pandemic)
- Vacuuming and dusting should be avoided during a pandemic to reduce the spread of dust particles that could contain influenza virus
- If dusting is performed, it should be damp, not dry
- If vacuuming is performed, it should be done using vacuum cleaners with high-efficiency particulate air (HEPA) filters
- Persons performing cleaning duties should wear cleaning gloves and should clean their hands after removing gloves
- Trash from the rooms of residents known or suspected to be infected with pandemic influenza does not need to be handled as biohazardous waste unless it otherwise meets that definition*

Frequent Disinfection of Your Facility is Necessary

- Shared work areas such as desktops and tables, and frequently touched surfaces such as door handles, stair rails, faucet handles, etc. should be cleaned and disinfected by cleaning staff or other staff at least once a day, and between shifts or more often if possible

Additional Measures to Reduce the Spread of Disease

- Telephones, pens, and other equipment should not be shared. If equipment must be shared it should be cleaned and disinfected between users
- Remove non-essential items (e.g., magazines/newspapers) from common areas (such as dining and group living areas)

Cleaning Supplies (See Worksheet X: Environmental Cleaning and Disinfection Products for additional details)

- Cleaning supplies should be made available for use by staff. Specialized cleaning solutions are not needed. Routinely used cleaning products (EPA-registered disinfectants or bleach solution) may be used
- If bleach solution is used, mixing ¼ cup household bleach with 1 gallon of water makes an adequate bleach solution. This solution should be mixed fresh daily

*Under the California Health and Safety Code (section 117635), biohazardous waste is defined as waste that contains recognizable fluid blood, fluid blood products, containers or equipment containing blood that is fluid, or blood from animals known to be infected with diseases that are highly communicable to humans.
### The Antimicrobial Spectrum of Disinfectants

**Note:** Removal of organic material must ALWAYS precede the use of any disinfectant.

<table>
<thead>
<tr>
<th>Acids</th>
<th>Alcohols</th>
<th>Aldenihydes</th>
<th>Alkalis</th>
<th>Biguanides</th>
<th>Halogens</th>
<th>Oxidizing Agents</th>
<th>Phenolic Compounds</th>
<th>Quaternary Ammonium Compounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>hydrochloric acid, acetic acid, citric acid</td>
<td>ethanol, isopropyl alcohol</td>
<td>formaldehyde, paraformaldehyde, glycolaldehyde</td>
<td>sodium or ammonium hydroxide, sodium carbonate</td>
<td>chlorhexidine, hypochlorite, iodine</td>
<td>NaOCl, NaClO, ClO-, Cl-, ClO3-, ClO2-</td>
<td>hydrogen peroxide, peroxycetic acid, Trifectan, Virkon-S, OxySept 333</td>
<td>Lysol, Gym, Tecno, Phero-Tek 1</td>
<td>Roccal, Zepnatin, DIQicid, Parvosol D-256</td>
</tr>
</tbody>
</table>

**most susceptible**
- mycoplasmas
- gram-positive bacteria
- gram-negative bacteria
- pseudomonads
- rickettsiae
- enveloped viruses
  - chlamydia
  - non-enveloped viruses
- fungal spores
- picornaviruses (i.e., H1N1)
- paroviruses
- acid-fast bacteria
- bacterial spores
- coccidia
- prions

**most resistant**
- ++ highly effective
- ± limited activity
- N unknown
- + effective
- - no activity
- a—varies with composition
- b—peracetic acid, a strong oxidizing agent is sporicidal
- c—ammonium hydroxide
- d—some have activity against coccidia
## Characteristics of Selected Disinfectants

<table>
<thead>
<tr>
<th>Disinfectant Category</th>
<th>Alcohols</th>
<th>Aldehydes</th>
<th>Biguanides</th>
<th>Halogens: Hypochlorites</th>
<th>Halogens: Iodine Compounds</th>
<th>Oxidizing Agents</th>
<th>Phenols</th>
<th>Quaternary Ammonium Compounds (QAC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism of Action</td>
<td>Precipitates proteins</td>
<td>Denatures proteins</td>
<td>Denatures proteins</td>
<td>Alters membrane permeability</td>
<td>Denatures proteins</td>
<td>Denatures proteins</td>
<td>Denature proteins and lipids</td>
<td>Alters cell wall permeability</td>
</tr>
<tr>
<td>Advantages</td>
<td>Fast acting</td>
<td>Leaves no residue</td>
<td>Broad spectrum</td>
<td>Inexpensive</td>
<td>Stable in storage</td>
<td>Broad spectrum</td>
<td>Relatively safe</td>
<td>Good efficacy with organic material</td>
</tr>
<tr>
<td>Disadvantages</td>
<td>Rapid evaporation</td>
<td>Flammable</td>
<td>Carcinogenic</td>
<td>Irritation to mucous membranes and tissues</td>
<td>Only use in well ventilated areas</td>
<td>Functions in limited pH range (5-7)</td>
<td>Toxic to fish (environmental concern)</td>
<td>Inactivated by sunlight, some metals</td>
</tr>
<tr>
<td>Precautions</td>
<td>Flammable</td>
<td>Carcinogenic</td>
<td>Never mix with acids; will release toxic chlorine gas</td>
<td>Toxic to animals, especially cats</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetative Bacteria</td>
<td>Effective</td>
<td>Effective</td>
<td>Effective</td>
<td>Effective</td>
<td>Effective</td>
<td>Effective</td>
<td>Effective</td>
<td>YES—Gram Positive Limited—Gram Negative</td>
</tr>
<tr>
<td>Mycobacteria</td>
<td>Effective</td>
<td>Effective</td>
<td>Variable</td>
<td>Effective</td>
<td>Limited</td>
<td>Effective</td>
<td>Variable</td>
<td></td>
</tr>
<tr>
<td>Enveloped Viruses</td>
<td>Effective</td>
<td>Effective</td>
<td>Limited</td>
<td>Effective</td>
<td>Effective</td>
<td>Effective</td>
<td>Effective</td>
<td>Variable</td>
</tr>
<tr>
<td>Non-enveloped Viruses</td>
<td>Variable</td>
<td>Effective</td>
<td>Limited</td>
<td>Effective</td>
<td>Limited</td>
<td>Effective</td>
<td>Variable</td>
<td>Not Effective</td>
</tr>
<tr>
<td>Spores</td>
<td>Not Effective</td>
<td>Effective</td>
<td>Not Effective</td>
<td>Variable</td>
<td>Limited</td>
<td>Variable</td>
<td>Not Effective</td>
<td>Not Effective</td>
</tr>
<tr>
<td>Fungi</td>
<td>Effective</td>
<td>Effective</td>
<td>Limited</td>
<td>Effective</td>
<td>Variable</td>
<td>Variable</td>
<td>Variable</td>
<td>Variable</td>
</tr>
<tr>
<td>Efficacy with Organic Matter</td>
<td>Reduced</td>
<td>Reduced</td>
<td>?</td>
<td>Rapidly reduced</td>
<td>Rapidly reduced</td>
<td>Variable</td>
<td>Effective</td>
<td>Inactivated</td>
</tr>
<tr>
<td>Efficacy with Soap/ Detergents</td>
<td>?</td>
<td>Reduced</td>
<td>Inactivated</td>
<td>Inactivated</td>
<td>Effective</td>
<td>?</td>
<td>Effective</td>
<td>Inactivated</td>
</tr>
</tbody>
</table>

- Information not documented

**Disclaimer:** Use of trade names does not in any way signify endorsement of a particular product. For additional product names, please consult the most recent Compendium of Veterinary Products.
WORKSHEET XI: PERSONAL PROTECTIVE EQUIPMENT FOR PANDEMIC INFLUENZA

Personal Protective Equipment (PPE)
Until the route of transmission is determined, it is recommended that healthcare providers use:
- **Standard precautions**: hand hygiene
- **Contact precautions**: gloves, gown, dedicated equipment
- **Eye protection**: goggles or face shield

Respiratory Protection
- **Airborne precautions**: N-95 mask or higher on provider and/or susceptible persons when coming within three feet of a suspected case, surgical mask on patient
- Special care should be exercised when doing any aerosol-producing procedure
- Ensure proper removal of all personal protective equipment upon exiting room
- For the current avian influenza H5N1, full infection control measures should remain in effect for 7 days after the resolution of fever for adults >12 years, and for 21 days after the onset of illness in children ≤12 years

NIOSH-Approved N-95 (and above) Respirator

**Purpose**
According to its name (N-95, N-99, N-100), particulate respirators are designed to filter out 95%, 99%, or 99.97% of inhalable particles, and also are named according to their resistance to degradation from oil. It is currently advisable for all healthcare providers coming within 3 feet of a suspected case of avian influenza H5N1 OR a pandemic flu strain to wear a fit-tested, NIOSH certified N-95 or higher.

**Considerations**
- Respirator must be fit-tested and adjusted to face to be effective; wearer must be medically cleared
- Several sizes should be ordered to facilitate fit-testing
- It must fit closely to form a tight seal over nose and mouth—some people may feel claustrophobic
- Any facial hair will prohibit respirator from forming the necessary tight seal around nose and mouth
- Must be safely removed and discarded

**Supply**
You should be able to order N-95s, N-99s, or N-100s through your current medical supplier. For a list of NIOSH-certified disposable respirators, visit [www.cdc.gov/niosh/npptl/topics/respirators/disp_part](http://www.cdc.gov/niosh/npptl/topics/respirators/disp_part)

**Cost**
Approximately $1.00 each

**Reusability**
Disposable masks and respirators ideally should be disposed of once used. However, in a pandemic situation, where respirator availability will be very limited, an Institute of Medicine committee suggested that if necessary, a non-contaminated respirator could be reused by a single wearer with precautions:
- A protective covering (medical mask or plastic face shield) was worn over it to protect the respirator from contamination—if contaminated, respirator must be disposed of properly
- The respirator was carefully stored between uses
- The wearer washed his hands after touching the respirator and the device used to shield it

Surgical or Procedural Mask

**Purpose**
Prevent organisms in the nose and mouth from falling into the sterile field of a surgical site; also provides droplet protection to wearer. In a pandemic, if N-95s are still available to providers, surgical masks might best be used on the patient to lower the risk of transmission whenever someone is within three feet of the patient

**Considerations**
Does not provide protection to wearer from diseases with airborne transmission

**Supply**
Order through your current medical supplier

**Cost**
$0.10-$0.20 each

**Reusability**
No recommendations at this time

www.pandemicflu.gov/plan/healthcare/maskguidancehc.htm
General Donning Instructions for N-95 Respirators

The following instructions must be followed each time the respirator is worn. Before donning, wash your hands and inspect the respirator to ensure the integrity of the components, including the shell, straps and metal nose clip.

1. Cup the nosepiece in your hand with the nosepiece at fingertips, allowing the headbands to hang freely below hands.

2. Position the respirator under your chin. The nosepiece should be over the bridge of your nose.

3. Pull the top strap over your head so it rests high on the back of the head.

4. Pull the bottom strap over your head and position it around neck below ears.

5. Using both hands, mold the metal nosepiece (if present) to the shape of your nose by pushing inward while moving fingertips down both sides of nosepiece.

6. SEAL CHECK: The respirator seal MUST be checked before each use-to check fit, place both hands over the respirator and exhale. If air leaks out around nose, repeat step 5. If air leaks along the edges, adjust the straps at the back of your head. Check again.

If you cannot achieve proper fit, DO NOT enter the contaminated area. See your manager.
General Donning Instructions for Personal Protective Equipment

The type of PPE used will vary based on the level of precaution required (i.e., standard and contact, droplet or airborne infection). **Ensure that you correctly wash your hands before donning PPE.**

**USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION**

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

1. Remove any eyewear or jewelry that could affect the respirator fit

2. Don respirator. Prescription eye-wear can be re-donned after fit-testing. See Worksheet XII for how to correctly don an N-95.

3. Don goggles or face shield—adjust to fit

4. Don fluid resistant gown. Fasten at back of neck and waist

5. Put on gloves—extend to cover wrist of isolation gown

Adapted from CDC Sequence for Donning & Doffing PPE poster and Occupational Health & Safety Agency for Healthcare in BC
General Doffing Instructions for Personal Protective Equipment

Except for respirator, remove PPE at doorway. Remove respirator after leaving patient room and closing the door.

1. Remove gloves:
   - Outside of gloves are contaminated!
   - Grasp outside of glove with opposite gloved hand—peel off
   - Hold removed glove in gloved hand
   - Slide fingers of ungloved hand under remaining glove at wrist
   - Peel 2nd glove off over 1st glove
   - Discard gloves in waste container

2. Remove gown:
   - Gown front and sleeves are contaminated!
   - Unfasten ties
   - Pull away from neck and shoulders, touching inside of gown only
   - Turn gown inside out
   - Fold or roll into a bundle and discard

3. Remove eye protection and discard or clean with disinfectant
   - Outside is contaminated!

4. Remove eye glasses (if present) prior to doffing respirator

5. Remove respirator
   - Outside is contaminated!
   - Grasp bottom then top ties or elastics and remove

6. Remove hair cover if present
   - Outside is contaminated!

7. Wash hands

Adapted from CDC Sequence for Donning & Doffing PPE poster and Occupational Health & Safety Agency for Healthcare in BC
4.0 SUSTAINMENT STRATEGIES

4.1 HOW CALIFORNIA AND THE NATION RESPOND TO DISASTER

All disasters in California are managed locally, which means that the local government holds the primary responsibility and is the lead agency for the response. All others (the region, the state and the federal government) act in support of the local response. It is important that the response be handled at the local level, because local officials are there first and know the area. It also helps to ensure that locally available resources are used first.

The Emergency Response System: SEMS/NIMS

In California, the Standardized Emergency Management System (SEMS) dictates the way local and state governments manage disasters and provide support to local responders. SEMS was enacted by state law in 1991 as a result of the Oakland Hills Fires, during which it became clear that California needed to standardize the way that different organizations and agencies responded to disasters. The goal was to improve coordination among state and local response agencies. SEMS is used by all local, regional and state governmental agencies, as well as by many healthcare providers, to manage information and resources (supplies, equipment and personnel) and document the activities undertaken during the disaster. SEMS incorporates the Incident Command System (ICS) as the management tool for disasters.

The National Incident Management System (NIMS) was created in response to the attacks of Sept. 11, 2001, to coordinate and manage disasters at the federal level. Like SEMS, NIMS uses ICS as the management tool and mandates development of systems to manage resources and public information and provide mutual aid (support). Local, state and federal government agencies are mandated to adopt NIMS, and healthcare organizations are beginning to adopt the principles of SEMS, NIMS and ICS into their disaster plans.

There are a few differences between SEMS and NIMS, However, for the purposes of this Workbook, we will refer to the disaster response system as SEMS, although these particular statements also apply to NIMS.

SEMS helps local authorities with inter-agency coordination, priority-setting and the efficient flow of resources and information. Each of these elements is an important part of a coordinated response. Any agency wishing to receive disaster-related reimbursement (i.e., from FEMA or the state) must document its use of SEMS and NIMS.

Key Concepts in SEMS

There are four key elements of SEMS that are important for long term care organizations to understand:

1. Operational Area Concept
2. Multi-Agency Coordination System
3. Master Mutual Aid Agreement
4. Incident Command System

32 Here we provide a brief overview of SEMS. It is not designed to teach everything there is to know about this complex but effective system. There are many Web-based resources that provide a much more detailed explanation of SEMS, as well as educational courses (both online and in person) that can provide SEMS training. One place you can visit to learn more about SEMS is www.scc-ares-races.org/sems.htm. You may also check the Governor’s Office of Emergency Services Web site for additional SEMS information and training.

33 For more information and to compare and contrast SEMS and NIMS, visit www.oes.ca.gov, and review the SEMS/NIMS Crosswalk document.
Below, we discuss the first three of these concepts, and in the next section we present an overview of the Incident Command System (ICS).

**Operational Area Concept**
The Operational Area (Op Area) is an intermediate response level created by SEMS (Figure 3). The Op Area consists of the county and all its political subdivisions, including special districts. The county government is the lead agency unless otherwise specified. There are 58 Operational Areas (counties) in California. The Op Area manages and coordinates resources from its Emergency Operations Center (EOC). The purpose of the Op Area EOC is to support the response and coordinate obtaining resources and information. The Op Area does not manage the local response but supports the responders. For example, a long term care facility is located within an Op Area and during a disaster conducts its own internal response to an incident, while the Op Area EOC may assist by providing information and resources (supplies, equipment, personnel, pharmaceuticals, etc.)

**Multi-Agency Coordination System**
Because the objective of SEMS is to coordinate a disaster response, one of its important components is the creation of a Multi-Agency Coordination System. Agencies and disciplines at any SEMS level need to work together in a coordinated effort to develop joint plans, coordinate inter-agency resource use and facilitate decision-making. This is one of the reasons that CAHF stresses the importance of working on a disaster plan with your local partners — including your local health department, local OES and local Op Area Emergency Operations Center — before a disaster occurs.

In most disasters, the governor's Office of Emergency Services (OES) is the lead agency at the county level managing the response; in a pandemic, however, the California Department of Public Health (DPH) also has a key role to play. OES and DPH are now sorting through how they will manage a pandemic response in a coordinated fashion on both a county and state level. In addition to calling your local public health department, call your local fire department or local OES to determine who is in charge of emergency services coordination in your county. This is your first step in planning with other agencies, both public and private, to ensure that you are included in the organized (SEMS) response.

**Master Mutual Aid Agreement**
SEMS mandates the formation of a mutual aid system — the voluntary provision of services and facilities — when existing resources prove to be inadequate. Under this agreement, cities, counties and the state work together to voluntarily provide services, resources and facilities to jurisdictions when local resources prove to be inadequate to cope with a given situation. Plans and procedures have been developed for several discipline-specific mutual aid systems, and these function within the Master Mutual Aid Agreement. Under SEMS, if resources are needed locally, healthcare providers contact the local Op Area EOC medical and health coordinators to request those resources. These coordinators would utilize mutual aid agreements to get those needed resources and allocate them appropriately. See “Requesting Help during a Disaster” below for more information. For more information about how medical mutual aid works in your locality, contact your local OES office or public health department.

See Worksheet XV: California OES Mutual Aid Regions Map (p. 57)

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34 Contact information for the local branches of the OES may be found through the Office of Emergency Services Web site at [http://www.oes.ca.gov/Operational/OESHome.nsf/NewResourceBranches?OpenForm](http://www.oes.ca.gov/Operational/OESHome.nsf/NewResourceBranches?OpenForm).
35 Mutual aid is also something that long term care facilities may agree to provide each other in times of need. Sample Memorandums Of Understanding or MOUs for this purpose are available on the CAHF Web site, [www.cahf.org](http://www.cahf.org), under the Disaster Preparedness Program link.
**Requesting Help during a Disaster**

It is important for long term care facilities to anticipate the flow of resources in a disaster, and knowing how to request resources through your local government or operational area will be essential. Figure 3 shows the resource request and receipt concept.

**Figure 3: Flow of Requests/Resources**

As you can see in Figure 3, with long term care facilities at the local agency level, your requests for resources should go to your local government EOC. If your need cannot be met, your request will move up to the next level. If the capacity of the Op Area is exceeded, the request would go to the Mutual Aid Regional Area. If the region cannot meet the need, the request goes to the state, and if the need still cannot be met, the request finally goes to the federal government. After the resources are secured at the lowest level possible, they will then flow downward to you. During a disaster, resources must be distributed appropriately and fairly to the responders, including healthcare providers. Sometimes this means that you may only receive a limited amount of the requested resource. The Op Area EOC is responsible for assessing the needs and distributing limited resources to providers according to need.

When requesting resources, always explain what it is you want to accomplish rather than asking for a resource you think you need to have. For example, tell the Op Area EOC what you need to care for 10 critically ill residents whom you are unable to transfer to the hospital, rather than a general request for assistance or supplies. The Op Area EOC coordinators will decide how best to meet your needs with available resources.

**Depending on Mutual Aid During a Pandemic**

Despite the considerable time, effort and resources devoted to disaster planning at all levels of government, many experts and officials are concerned that they will prove inadequate during a severe 1918-like pandemic. The reason for this concern is the expectation that pandemic influenza will strike...
virtually every U.S. community at roughly the same time. This means that it is unlikely that there will be any unaffected community able to provide help to its neighbors, as all communities will have their hands full coping with their own populations. “All hazards” disaster plans address a short term event that is localized to a specific area. An influenza pandemic, however, is a long term emergency that is generalized. Plans designed for management of short term localized emergencies will prove ineffective in the management of long-term generalized ones. Given this reality, LTC providers should not assume that they will be receiving help from any outside source. While it is likely that even with a severe pandemic, some assistance may well be forthcoming, the resources or services available may not be those you require. This is why we have stressed the importance of self-sufficiency throughout this Workbook and have encouraged facilities to develop a Pandemic Annex in addition to their all-hazards disaster plan to help manage the unique nature of a pandemic.

4.2 COMMAND AND CONTROL IN YOUR ORGANIZATION: DETERMINING AUTHORITY AND USING HICS

Before the pandemic: In any emergency response, it is critical that clear lines of authority (chain of command) exist within the facility to make sure there is timely and efficient decision-making. It is important that you define this chain of command and the authority and decision-making ability of the facility’s incident commander and identify who is in charge if the incident commander is not available. This is an important aspect of your disaster plan and should be followed through in your Pandemic Annex.

Support for your pandemic planning needs to start at the top of the organization. Bring the leaders of your organization into the planning process from the very beginning to identify and agree upon the best course of action for your facility, its residents and staff. It is important to discuss the financial and clinical implications of the various proposed response strategies, such as closing to new admissions or agreeing to be a “surge” or overflow setting for the local hospital. Medical and administrative priorities need to match, and your facility’s leadership team needs to be clear about its role and authority.

Early in the pandemic planning process in your facility, your Internal PI Committee should identify which individual in your facility would act as the incident commander with authority to:

a. Authorize expenditure for additional training, stockpiling of supplies, purchasing of personal protective equipment and other pandemic preparedness-related costs

b. Activate the plan. Activating your disaster plan and Pandemic Annex may change certain facility practices, such as the assignment of staff, the screening of admits or acceleration of discharges. When these measures have clinical, administrative and financial implications, identify which individual has the authority to activate the plan.

c. Approve modifications to the plan based on current recommendations, new information and/or lessons learned during the course of the pandemic. Determine the best course of action based on changing circumstances.

Learn about and incorporate the Incident Command System (ICS) into your disaster plan — it is a useful tool that will help you manage any incident. First developed by the military, ICS was modified by fire and law enforcement agencies to manage their responses in the field and throughout their systems. The Hospital Incident Command System (HICS) was developed to implement ICS into the healthcare facilities and effectively manage emergency response and recovery. We present a sample modified HICS applicable to the long term care setting in this Workbook.

Based on the Incident Command System (ICS), HICS is a tool to manage all aspects of the emergency, including the coordination and use of resources (supplies, equipment, pharmaceuticals, personnel, etc.) and information and to ensure the support of the facility and staff during an emergency.
It helps you manage your response at an organizational level, and you will find that many other organizations, including emergency medical services, hospitals, the public health department and other healthcare providers use it too. The bottom line: Learning to use HICS will help you manage the emergency more effectively, and speaking the language of HICS and ICS used by other community responders will help you get what you need in an emergency.

HICS includes a system to assign emergency management personnel to roles that will make the facility be more effective. It includes:

- Job action sheets that provide a description of the role of a manager in the facility incident command center, with assignment of specific roles and a distinct job title.
- Definition of the lines of authority (or chain of command) in the facility, with everyone assigned to one supervisor to whom they report in the chain.
- Expandable and contractible provisions to meet the size and difficulty of the emergency. Positions are only activated if they are needed for the emergency.

HICS can be used at organizations both large and small — it can even be used by just one person! If you have a small organization, the same person may fill multiple spots on the HICS organizational chart. Just be sure through practice and exercise that one designated person is not disproportionately overburdened with her or his roles in an emergency. Also ensure that, if staff must fill more than one position, they do so only within one section.

See Worksheet XVI: Modified HICS Organizational Chart — Incident Management Team for Long Term Care (p. 58) This is a resource that you can modify and put into your disaster plan.

Basic HICS Job Action Overview

- **Incident Commander**: Leads the response, appoints team leaders, approves plans and key actions (CEO, administrator, nursing supervisor.)
- **Operations Team**: Handles key actions including first aid, search and rescue, fire suppression, securing the site (direct care staff.)
- **Planning Team**: Gathers information, thinks ahead, makes and revises action plans and keeps all team members informed and communicating (PI Committee.)
- **Logistics Team**: Finds, distributes and stores all necessary resources (maintenance supervisor.)
- **Finance Team**: Tracks all expenses, claims, activities and personnel time and is the record keeper for the incident (controller, accounts dept, payroll.)

See Worksheet XVII: Main Modified HICS Positions with Suggested Missions (p. 59) for more detail on what each position on the Incident Management Team chart does.
Figure 4 shows the main components of the Incident Command System. Please refer to the HICS organizational chart worksheet included in this Workbook for greater detail.

Figure 4:

It is recommended that LTC providers practice HICS when participating in drills and exercises with local responders (such as EMS, fire, law enforcement, local public health departments, similar facilities, acute care facilities, etc.) Practice of these exercises can range from participating in a table top exercise (where your management group would meet and discuss the issues about the emergency and how the plans and procedures would work) to conducting a full scale exercise. In this case you actually would implement the procedure or plan and move personnel, equipment, supplies and even residents. Local hospitals, emergency services agencies and county public health departments periodically have exercises and will include you if you ask. Contact your local hospital, first responders or public health department for more information and to get involved in this process. Any time you conduct an internal or external drill or exercise is a good time to practice using your facility Hospital Incident Command System.36

See Worksheet XVIII: Sample Modified HICS Job Action Sheet (Incident Commander) (p. 61) for a long term care-specific Job Action Sheet.

See Worksheet XIX: Sample Facility Liaison Officer Job Action Sheet (p. 63)

See Worksheet XX: Sample Facility Public Information Officer Job Action Sheet (p. 65)

You can modify these LTC-specific job action sheets to use in your disaster plan and develop additional job action sheets following the same format.

Training Available Online
Training on Incident Command System is available online for free through the FEMA Web site. Visit www.training.fema.gov/EMIWeb/IS.

- Click on the “ISP Course List” link on the right side of the page.
- Find the course you wish to take (you may want to print out the exam to review as you go through the course.)

36 For greater detail on HICS, you may wish to visit EMSA’s Web site at www.emsa.ca.gov/hics/hics.asp.
Scroll down to the bottom and click “Take Final Exam.” Fill it in and submit it, and you will receive a certificate of completion if you get 75 percent or more of the answers right (you may want to keep this in your files). You may be able to get CEUs for taking these courses. You don’t have to take the test unless you wish to receive the certificate.

Here are some of the courses you may wish to take, depending on your level of interest and availability of time.

- **IS100.HC** — Introduction to Incident Command System I-100 for Healthcare/Hospitals (alternately, you could take IS-100: Introduction to Incident Command System)
- **IS-197.SP** — Special Needs Planning Considerations for Services and Support Providers
- **IS-200.HC** — Applying ICS to Healthcare Organizations
- **IS-235** — Emergency Planning (includes how to develop a properly structured Emergency Operations Plan)
- **IS-700** — National Incident Management System (NIMS) and Introduction

**During the pandemic:** In a disaster such as a pandemic, you may want to activate a basic level of your disaster plan and Pandemic Annex in stages, depending on the level of the emergency. As the pandemic or other emergency gets worse and your facility, residents and staff become impacted, activate more of the plan and the Hospital Incident Command System positions. For example, depending upon your disaster plan, the Planning Section and the Logistics Section would be activated to prepare for the emergency before the illness actually hits your local area. The Operations Section and the Finance/Administration Section would be activated when the pandemic actually impacts your facility and your daily operations.

For any level of activation of your plan, your first steps will be to take out your plan and review your job action sheets. Your job action sheets will detail out each step that each position needs to take.

**4.3 BUSINESS CONTINUITY PLANNING**

"Business continuity" means ensuring that your facility’s essential business functions can survive a natural disaster, technological failure, human error or other disruption. Your facility may already have a business continuity plan (BCP). If this is the case, start by reviewing the BCP with your Internal PI Committee to ensure that it addresses the unique challenges of a pandemic. If you do not have a BCP for your facility, there are many resources available on the internet to help you develop one.²⁷

Your Pandemic Annex should address how your business will prepare to survive a “worst case scenario” of up to 50-percent absenteeism, significant delays, disruptions and increased costs of supplies and increased care needs of your residents. Begin by working with your Internal PI Committee to:

1. Identify your essential services/functions — those that, when not delivered or performed, create an impact on the health and safety of individuals and/or lead to the failure of the business.
2. Identify the number of staff needed and the necessary skills required to perform and maintain those essential services/functions.
3. Develop strategies to continue those essential services/functions during a pandemic and incorporate those strategies into the facility’s Pandemic Annex.

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²⁷ We have included some of these Internet resources in Appendix C: Useful Web Sites in this Workbook (p. 79).
4) Test the plan and modify as needed.

**Essential Service/Function of Long Term Care Facilities**
Clearly, the essential service/function of any long term care facility is to provide care for the people who reside there. The next step in preparing for your pandemic business continuity is to identify what supplies, staff and administrative support are necessary in order to deliver that essential service of care. The information in the following sections on financial planning, supplies and staff preservation will help you to identify these needed resources.

See *Worksheet IV: Suggested Pandemic Supply List (in Addition to Your General Disaster Supplies)* (p. 18)

**Financial Resources**
Business continuity includes planning to maintain critical internal facility services, such as paying your employees and ensuring that billing and reimbursement services are maintained. Identify the critical resources necessary to provide these essential business services and plan strategies to maintain basic business operations during a pandemic.

**Before the pandemic:** As previously stated, there may be delays or disruptions to various systems during a pandemic, including disruptions to financial institutions and potential delays in reimbursement for long term care. Additionally, it is possible that your facility may experience decreased revenues as a result of lower census and/or increased costs as a result of higher resident acuity, staff shortages, increased prices for goods, etc. Your Pandemic Annex should include strategies to withstand increased costs and temporary cash flow problems. These strategies could include:
- Access to corporate resources
- Lines of credit
- Savings
- Other sources of cash reserves
- Cash on hand in the event of bank closures, power failures or unsafe conditions for travel

Do this planning now so that the financial survival of your business is one less thing you have to worry about when a pandemic hits.

**During the pandemic:** Accounts receivable, billing and payroll are critical services that must continue so that you can fulfill your essential function of providing care to your residents. Consider setting up systems that enable your business office staff to perform these services from home during a pandemic. This will decrease their risk of contracting the disease. Also make sure backup staff are trained to do these services in the event that the office staff become ill.  

**4.4 SUPPLIES**

In a pandemic, residents, other individuals and communities will all be affected by widespread illness among people of all ages. High rates of absenteeism are expected in all workplaces. This could mean that suppliers, truck drivers, food and drug manufacturers and even utility companies will be forced to reduce production and deliveries for some period of time. To cover the possibility that your regular deliveries may be delayed or become unavailable, we recommend that every facility prepare for this possibility. Planning carefully for disruptions in your supply chain will increase your chances of being able to weather the pandemic successfully.

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38 See 4.5 Staff Preservation in this Workbook (p. 46) for more information on cross training of staff.
Before the pandemic:
Planning ahead is critical, and we recommend that each facility:

1) Develop a list of the essential materials and equipment needed to provide basic care to the residents.

See Worksheet IV: Suggested Pandemic Supply List (in Addition to Your General Disaster Supplies) (p. 18)

2) Estimate the quantities that will be needed for a six- to eight-week period.³⁹
3) Meet with your vendors to discuss their pandemic plans and strategies to keep you supplied during a six- to eight-week outbreak.
4) Develop a plan to stock a minimum of a two-week supply of food, medications and critical consumable supplies, such as incontinence briefs, masks and gloves in the building at all times. The more supplies that you can stockpile and store for your facility, the more self-reliant you will be. Many experts recommend that a three-month stock of essential supplies be stockpiled in the facility in anticipation of a pandemic outbreak, all though this may not be realistic for all LTC facilities because of lack of storage space and reimbursement limitations.
5) Identify alternate sources should the normal procurement channels be disrupted. Alternative sources could include:

- Emergency resources through the city or county stockpiles
- Local sources in place of regional vendors
- Re-use of materials when safe to do so
- Homemade substitutes

For examples of alternate sources see Worksheet XI: Personal Protective Equipment for Pandemic Influenza (p. 33) for strategies on N-95 use/re-use and Worksheet III: Oral Rehydration (p. 17) for home-made electrolyte solution

During the pandemic: As previously stated, it is anticipated that pandemic influenza will break out in a given community in waves, with approximately six-week intervals between. This may allow time to conduct an inventory, restock and get ready for the next wave, depending on how supply chains are faring.

Requesting Resources
If at any time during the pandemic, you are unable to acquire the critical supplies and equipment necessary to provide essential care through your usual supply channels, request resources through the local EOC according to SEMS.⁴⁰ The exact procedures on how to access the local EOC to request resources will vary from county to county and city to city. Talk to the local (External) PI Planning Committee, the county health department or the local OES to obtain contact information for those who receive requests for resources. Put that contact information in your disaster plan.

Safeguard Deliveries
During the pandemic, it is important to establish a secure and safe method of receiving deliveries of goods and supplies to the LTC facility that does not require direct contact between the delivery personnel and the facility staff. This will reduce your staff’s risk of exposure. It is also important that supplies not be left unsupervised for any length of time. Thanks to your good planning, your facility may

⁴⁰ Refer to 4.1 How California and the Nation Respond to Disasters in this Workbook (p. 37) for more details.
have supplies when others in the community do not. This may increase the likelihood of theft, so make sure you safeguard your supplies.\footnote{Refer to 4.6 Facility Security in this Workbook (p. 52) for more information.}

4.5 STAFF PRESERVATION

Providing essential care to your residents cannot be done without able-bodied staff. Depending on the infectiousness of the influenza strain, you could lose the services of 20 percent to 50 percent of your staff during the outbreak.\footnote{Centers for Disease Control and Prevention (Sept, 2006), Pandemic Planning Assumptions. Retrieved April 6, 2007, from \url{http://www.pandemicflu.gov/plan/pandplan}.} Even before the illness strikes your community, anxiety and concern may result in increased absenteeism. Be prepared to preserve the staff you have by developing policies to protect them — and strategies to get by with fewer of them.

Start with education and information as a way to fight fear. Educate your staff, families and residents about how your pandemic planning addresses their needs and how you will continue to provide essential services during the pandemic. Adapt the information in your Pandemic Annex to the language needs and cognitive level of your audience. It is essential to be transparent and honest about what you plan to do in an effort to ensure that all of your team (staff, residents and families) have the information they will need to protect themselves and carry out their roles.

**Before the pandemic:** Develop staffing policies and procedures in the following areas:

**Infection Control:** This will be a large component of these policies and procedures. All staff and volunteers should be trained and assessed for competency in implementing the facility’s infection control measures, including:\footnote{See 3.0 Containment Strategies in this Workbook (p. 19) for more detail on implementing infection control.}

- Respiratory hygiene measures
- Cohorting of residents and consistent staff assignments
- Posting of visual reminders
- Verbal reminders/in-services
- PPE, vaccine and antiviral distribution
- Restriction of visitors
- Decisions on how to handle (and perhaps decline) new admissions and/or transfers
- Evaluation and management of ill staff

**Emergency Staffing Strategies:** During normal operations, long term care facilities must comply with all the laws and regulations for staffing of the facility. However, in a pandemic, healthcare providers will probably experience severe staffing shortages and, under specific emergency conditions, may need to use volunteers, retired healthcare professionals and trained unlicensed personnel to provide care.\footnote{California Department of Health Services, Pandemic Influenza Preparedness and Response Plan (September 2006), Chap 4, Retrieved April 6, 2007, from \url{http://www.dhs.ca.gov/ps/dcdc/izgroup/pdf/pandemic.pdf}.} This may involve the use of newly-recruited volunteers and staff and the reassignment of existing personnel to provide essential services that are outside of their current job description.

You must be given permission from the authorizing state agency before you can deviate from the current regulations and laws that describe staffing standards for your facility.\footnote{These agencies may include the California Department of Public Health, the Department of Social Services Community Care and Licensing Division, the Centers for Medicare & Medicaid Services or other entities as determined by your facility type.} In a pandemic, you may be given that permission, so plan now on how you can utilize emergency staffing strategies with minimum risk to your residents.
The California Department of Public Health (CDPH) is involved in a project to develop standards and guidelines for healthcare surge during large scale emergencies. The deliverables for this project will include a standards and guidelines manual and tools that will guide decision-making for emergency orders, as well as waivers and regulatory flexes that can be implemented in the event of a pandemic. This guidance is planned for release by the fall or winter of 2007 and will be posted on the CAHF Web site once it is available.

Reassignment of Existing Personnel
One emergency strategy to consider is the reassignment of staff to provide essential services. Consider training two staff members for every one staff who will be needed to perform the critical functions of:

- Essential resident care
- Food service
- Housekeeping (especially environmental disinfection)
- Laundry
- Essential administrative procedures, such as billing and payroll

Plan how you will accomplish this training. We suggest you develop “just in time” training materials in the form of checklists and brief “how to” sheets for each critical staff position that you can use when it becomes necessary to implement your Pandemic Annex.

Direct Care
California has many regulatory requirements governing the screening and training of direct care staff in LTC facilities. As stated earlier, it is possible that these requirements will be temporarily waived or modified to allow for emergency staffing strategies during a pandemic so that you can use reassigned, volunteer and/or newly-recruited staff to provide direct care.

For the training of staff in the essential service of direct care, we recommend the use of training materials for nursing assistants that are widely available in published teaching manuals. In skilled nursing facilities, most of these materials will be on hand, as these facilities are required to provide regular in-service education on basic resident care. For other long term care facilities, we recommend calling the local certified nursing assistant (CNA) training program or American Red Cross office to ask what materials they use and where they are available. They may be willing to share some of their training materials with you or at least give you the publisher information so you can order your own.

The following is a list of core skills for basic patient care that should be covered in the “just in time” training of reassigned or newly recruited staff/volunteers who will be providing basic care.

Basic Patient Care Skills:

- Infection control, including airborne precautions and respiratory hygiene techniques (See Worksheets V, VI, VII, VIII, IX and X)
- Donning and doffing of personal protective equipment (See Worksheets XI, XII, XIII and XIV)
- Positioning a patient in bed
- Moving patients from bed to chair
- Assisting ambulation
- Making both an unoccupied and an occupied bed

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46 For more information on this project go to http://bepreparedcalifornia.ca.gov/EPO/CDHSPackages/PublicHealthPrograms/EmergencyPreparednessOffice/EPOPrograms/Surge.
47 See list of recommended core skills for patient care below.
48 Adapted from the American Red Cross of Greater Los Angeles, Nurse Assistant Review Manual, Preparation for Testing (2000).
- Brushing a patient’s teeth/dentures
- Mouth care for the unconscious patient
- Giving a patient a bed bath
- Assisting a patient with eating
- Assisting a patient with a bedpan/urinal
- Assisting a patient with using the bathroom
- Incontinence care
- Taking a patient’s temperature (oral and electronic)
- Taking a patient’s pulse
- Counting a patient’s respirations
- Post-mortem care (some counties have mass fatality workgroups, usually with the county coroner. Participating may help you to understand the plans they are developing).

Reassigning Staff
Develop policies and procedures that allow for and describe the reassignment of personnel under emergency conditions (as permitted by the regulatory oversight agency). This may involve collaboration with labor unions or employee organizations and a modification of job descriptions in your facility.

Volunteers
Plan for the use of volunteers and temporary healthcare personnel consistent with advice from the CDPH, and/or your specific regulatory oversight agency regarding how and when this can be allowed under state and federal law. Should you be given permission to use volunteers under emergency conditions, you will need policies and procedures to screen volunteers and temporary personnel before assigning them to resident care. This might include:

- Criminal record check or, at a minimum, a reference check
- Infectious disease screening
- Verification of credentials if the volunteer is to be utilized in a clinical capacity (i.e., nursing or medical license)
- Training and supervision by a “buddy-up” with experienced staff until trained
- Determination of competency through demonstration, observation and/or formal testing

You will also need to plan for the supervision of volunteers and temporary healthcare personnel. This might be best accomplished through pairing them with experienced staff, at least initially, to determine their competency and reliability and oversee their work.49

Occupational Health
The health of your staff must be preserved in order to carry out the essential service of resident care. Sound employee health policies and procedures will help to ensure their safety and also to reassure them that their employer is doing everything possible to keep them safe. The latest recommendations from the CDPH, California Occupational Safety and Health Administration (Cal-OSHA) and CDC should be followed regarding the protection and management of employees during pandemic influenza. Here are some suggested occupational health policies to consider developing now:

1. Plan for the use, availability, access and distribution of PPE, vaccines and antiviral medications. With the most current recommendations of the U.S. Department of Health and Human Services, the California Department of Public Health and the External PI Committee, develop a prioritized list of staff for the distribution of limited supplies. Include PPE, strain-specific vaccine (once it becomes available) and antiviral medications. Direct care staff are in a high priority group for vaccine.

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49 See Additional Strategies to Stretch Limited Staff Resources in this Workbook (p. 50) for more information.
2. Set up systems for employees to work from home when performing essential business functions such as billing and payroll. Test such systems by encouraging these employees to work from home for a day to see how this arrangement will work. By testing this ahead of time, the facility can make information technology or other adjustments to facilitate these employees working from home.

3. Provide education to employees on the importance of self-assessing and reporting influenza symptoms before they come to work. Figure 5 can be used by employees to screen themselves for symptoms during an outbreak before coming to work, and it can also be used to screen employees for symptoms at the beginning of each shift.

4. Develop policies for the isolation of employees who show up for work and are suspected of being infected until they can be sent home or to an appropriate level of care. This policy should include:
   - Instruct the symptomatic employee to don a surgical mask immediately to help to prevent further exposure of others.
   - Isolate him or her in a room with a door that closes.
   - Advise the employee to contact his or her healthcare provider and leave the facility immediately via private transportation if at all possible.
   - Decontaminate any areas the person was in that day. Notify the health department, and identify contacts of the sick employee if asked to do so by the health department.

Figure 5:

<table>
<thead>
<tr>
<th>Influenza-Like Illness Screening Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask the ill person if he or she has any of the following symptoms:</td>
</tr>
<tr>
<td>- Fever (feels feverish and hot)</td>
</tr>
<tr>
<td>- Headache</td>
</tr>
<tr>
<td>- Fatigue or weakness</td>
</tr>
<tr>
<td>- Sore throat, cough or difficulty breathing</td>
</tr>
<tr>
<td>- Muscle or joint aches or pains</td>
</tr>
<tr>
<td>During a pandemic, ill persons with any of the above symptoms should be suspected of having pandemic influenza.</td>
</tr>
</tbody>
</table>

5. Liberalize absentee policies for serious illness, family sickness and/or inability to work as a result of loss of caregivers for dependent family members. The Family and Medical Leave Act may apply to eligible employees who are impacted by pandemic influenza. Employers should review these pandemic absentee policies with their human resource and risk management consultants to ensure that they are consistent with fair labor standards and other legal requirements.

6. Plan for protection of personnel who are at increased risk for influenza complications (e.g., pregnant women, immunocompromised workers) by placing them on administrative leave or altering their work location.

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51 See Worksheets VII and VIII for more information on environmental disinfection.
7. Develop return-to-work standards (based on current guidance) that allow employees to return as soon as they are healthy enough to do so. These staff will be immune to pandemic strain and are a valuable labor resource once they are strong enough to work and no longer contagious.

During the pandemic: Assign a liaison to work with the city/county Emergency Operations Center to ensure that your facility’s needs are considered when staffing resources are allocated. This person can also regularly communicate with the local health department, your regulatory agency and outside contractors, such as staffing registries, to make sure that you can take advantage of all the available resources in order to keep your staffing at required levels.

See Worksheet XIX: Sample Facility Liaison Officer Job Action Sheet (p. 63)

It is also essential to document your actions in attempting to keep adequate staffing levels. You may be asked at some point to describe your efforts to find staff in order to justify your actions in utilizing emergency staffing strategies.

Implement your carefully crafted policies, and be ready to use your common sense when the unexpected occurs. When staffing ratios can no longer be met and requested resources have not arrived, it is time to be creative.

Additional Strategies to Help Stretch Limited Staff Resources

Alternate Care Sites
Many counties have developed specific plans for what they will do when the local acute care hospitals are full and it is necessary to expand beyond the existing resources to meet the community’s increased needs for medical care. These plans may include a temporary infirmary called an “alternative care site” where medical services will be available to augment the hospital system in your area. Find out from your public health office or your EOC liaison if there will be an alternative care site set up in your area where you can send your most critical or “comfort care” residents. If this resource exists, it will be coordinated through your local EOC. Your Internal PI Coordinator should find out what the plan is in your county and incorporate this information into your facility’s Pandemic Annex.

Emergency Discharges
Your Pandemic Annex should address what to do in the event that the number of sick residents in the facility, or the number of sick staff who cannot come to work, begins to seriously impair your ability to provide adequate care to your residents. As discussed earlier, one strategy that may work for some facilities is to determine which families have the ability to temporarily provide home care for their family members (currently your residents) for the duration of the emergency. While this concept will come as a surprise to many families and some providers, it is important to discuss with families that under severe pandemic conditions, taking on this hardship may become a necessity. It is important that this discussion take place soon to permit the families that can provide home care adequate time both to accept this concept and prepare for it.

By reducing the facility’s census to the lowest level possible during the emergency, you will be able to focus your limited staff and other resources on a smaller number of residents. This will extend the time your LTC facility can operate safely under the adverse conditions expected during a pandemic. In the event that family members become unable to provide home care to a resident, determine whether they would be willing to volunteer within the facility to help care for their family member and other residents in the event of staffing shortages become severe.

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53 See 4.3 Business Continuity Planning in this Workbook (p. 43), for more information.
Stretch experienced staff
Use your experienced healthcare workers to supervise newly recruited and/or reassigned staff. They can oversee the care for many residents if they are not consumed with providing care to a few. Utilize the core skills listed above and organize resident care in the most efficient manner possible. Use this strategy to pair experienced staff with new staff in dietary, laundry, payroll and housekeeping as well if at all possible.

Consistent staff assignments
Cohort sick residents, and assign consistent staff to them. Minimize the floating of staff in all departments but especially with staff who are caring for contagious residents. Ideally, the staff assigned to care for sick residents will be:
- Licensed
- The most experienced
- Vaccinated or given antiviral treatment or have recovered from the illness themselves so they are not at a high risk of infection

Staff dependants
If feasible, organize a safe space at the facility for staff to bring their dependant family members who would otherwise be left unsupervised while staff are at work as a result of school closures, etc.

Keep expectations realistic
Be realistic about what you can do. Focus on providing basic and essential care to the greatest number of people and watch for staff burnout.

Staff burnout
Recognize and prepare for caregiver burnout. Caregivers are not immune to the stress and grief of a pandemic. Facilitate access to mental health professionals, clergy and support groups and provide access at the facility if possible. Organize time for caregivers to rest, eat, relax and talk about what they are feeling if they need to. Consider providing literature on the signs and symptoms of burnout and ways to cope with it. It may not be possible to resolve caregiver burnout in a crisis situation, but it is important to recognize it, acknowledge that it exists and take steps to protect residents from it by supporting or replacing staff who have reached their limit of effectiveness.

Signs of Caregiver Burnout
- Being on the verge of tears or crying a lot
- Feeling helpless or hopeless
- Overreacting to minor nuisances
- Constant exhaustion
- Loss of interest/apathy
- Decreased productivity
- Social withdrawal
- Increased use of alcohol or stimulants
- Change in eating or sleeping habits
- Inability to relax
- Scattered thinking
- Increased feelings of resentment

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54 See 4.7 Altered Standards of Care in this Workbook (p. 52) for more information.
• Short temper
• Increasing thoughts of death

4.6 FACILITY SECURITY

In widespread disasters, law enforcement resources may be scarce. During a pandemic, when the state of emergency may continue for months, the demands on law enforcement could be overwhelming due to their internal absenteeism and increased external demands related to community containment measures and/or social unrest. Your Pandemic Annex should include security measures to increase the protection of your residents, staff and resources during a pandemic.

Some security measures that you may want to add to your plan for periods of high risk\textsuperscript{56} include:

**Before the pandemic:**
- Develop a facility security plan that can be quickly implemented to limit access to the facility, if one is not already in place. Many facilities use a code to initiate their security plan, such as “Code Silver” or “Dr. Strong” on the public address system, which means that there is a security issue in an area of the facility and that help is required.
- Make sure staff are trained and drilled regularly on the security plan.
- Develop a checklist/job action sheet for facility security specific to your building.
- Develop policies and provide training in self protection strategies for staff traveling to and from the workplace.
- Work with your vendors to ensure safe delivery of your supplies during the pandemic.

**During the pandemic:**
- Assign security personnel -. Ensure that these staff are adequately trained and equipped to do this job. If you normally have security personnel, consider increasing their numbers and/or hours of coverage during high risk times. If you contract with an outside agency for this service, talk with agency staff about their disaster plan and how they are planning to uphold your security contract during a pandemic. Ensure you have staff assigned to security on every shift if at all possible.
- Increase monitoring of the grounds - particularly outbuildings where supplies are stored.
- Direct all incoming staff, visitors and others to a single entrance and station someone to monitor and control access to the facility.
- Limit visitors to one visitor at a time per resident.

4.7 ALTERED STANDARD OF CARE

The increased demands for services during pandemic influenza will challenge the capacity of the healthcare system in California to a level not previously experienced. It is to be hoped that when the next pandemic hits, it will be at a mild to moderate severity level and the steps that we have taken to prepare as a county and as individuals will be adequate to meet the challenge. In a worst case scenario, however, a severe pandemic will make "business as usual" impossible in long term care facilities. During a severe pandemic, the number of pandemic influenza victims will far exceed the current healthcare capacity, and personnel and supplies will dwindle. While we hope that this will never happen, it could, and providers should familiarize themselves with the measures described in this section, so they can plan how they will deal with these circumstances should they arise.

\textsuperscript{56} "High risk" is defined as low availability of law enforcement and high probability of social unrest such as looting, rioting or increased incidents of theft and/or assaults in your area.
The implementation of altered standards of care means that, during an overwhelming disaster, the priority of those who provide care and allocate scarce healthcare resources will shift to “the greater good” and focus on how to save the largest number of lives vs. using the resources to save only one person. The goal in this kind of situation becomes to adjust expectations to an achievable level so that a “graceful degradation” of care occurs and the usual level of care given slowly changes and decreases in order to avoid a complete and sudden failure of the healthcare system. In order to keep the healthcare system functional in a severe pandemic and to preserve as many lives as possible, it may become necessary to:

- Focus on care delivery that is basic and essential
- Minimize the time spent on documentation
- Make difficult decisions about who gets what treatment

The ethical and legal implications involved in a discussion of altered standards of care are beyond the scope of this Workbook, but we would be remiss if we did not attempt to address some of the practical planning elements related to this issue.

Although it is extremely difficult to anticipate a facility’s inability to maintain required standards of care during a pandemic, there are some areas that have been identified as likely targets for altered standards during a severe pandemic. Some of the strategies for continuing operations in the face of dwindling resources and increased demands have already been described in 4.4 Supplies (p. 44) and 4.5 Staff Preservation (p. 46) of this Workbook. Some additional considerations are described below.

**Before the pandemic:** Work with the External PI Committee to ensure that your facility’s planning effort is compatible with the local pandemic plan. Integrate your facility planning into the operational area or county plan to help to ensure that you are not competing with other providers for the same resources and that your facility will be considered when resource allocations are made at the operational area level.

Find out what other healthcare providers (other long term care facilities, hospitals, clinics, etc.) are planning to do when critical resources in your community begin to dwindle. As much as possible, become part of the local plan by incorporating the altered standards that are being adopted by other healthcare entities in your area into your Pandemic Annex. Should you have to explain or defend the altered care decisions that you make at some later point, it could be important to show that your actions were based on community practice and were part of an integrated community response.

Decide what events will trigger the implementation of the various sections of your facility’s Pandemic Annex. When should you start to conserve resources, cut back on optional activities or stretch supplies? It is important that you do not wait until you are almost out of a critical supply to begin to conserve it (e.g., PPE, medications and staff), but it also is important that you do not change standards of care until there is a clear need to do so.

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57 Agency for Healthcare Research and Quality (April 2005), Altered Standards of Care in Mass Casualty Events, AHRQ Publication No. 05-0043.
59 For more information on the legal and ethical issues related to altered standards of care in California, please refer to California Department of Public Health Surge Standards and Guidelines project at: [http://bepreparedcalifornia.ca.gov/EPO/CDHSPublicHealthPrograms/EmergencyPreparednessOffice/EPOProgramsServices/Surge/](http://bepreparedcalifornia.ca.gov/EPO/CDHSPublicHealthPrograms/EmergencyPreparednessOffice/EPOProgramsServices/Surge/).
Possible triggers for altered standards of care include:

- Public health emergency declared by local or state health officer
- First documented case of pandemic influenza in your operational area
- Extreme increase in admissions to your facility due to other facility overload or closure
- Decrease in staff and inability to find replacement workers
- Hospital cancellation of elective procedures and/or limits on transfers due to implementation of their surge capacity response plan

Consult with Experts

Work with your medical director, the local health officer and your attorneys regarding the decision-making process and potential liability issues related to:

- Managing acutely ill residents in your facility due to an inability to transfer to acute care.
- Allocation of scarce resources (e.g., ventilators, respiratory therapy, IV therapy).
- Utilization of newly recruited, reassigned and volunteer personnel.
- Criteria for a shift from treatment to comfort care for specific residents.
- Authorization to re-use disposable equipment (under specific safety guidelines).
- Pronouncement, postmortem requirements and the issuing of death certificates in a mass fatality situation.

Medications

During a severe pandemic, a disruption in the supply of pharmaceuticals will probably occur. This will place residents who are on certain critical “must take” medications at high risk for a severe complication of their underlying disease. Drug treatment for coronary heart disease, COPD, diabetes and hypertension are a few examples of diseases that can be expected to deteriorate — resulting in severe complications or death — if the medication is stopped. On the other hand, there are many other medications prescribed by physicians to prevent complications of chronic diseases or for the comfort of the patient that may not be in the “must take” category. Since only the patient’s physician can decide what is a “must take” medication and what could be temporarily discontinued during an emergency, the choice will be theirs.

If residents’ physicians are comfortable making recommendations about identifying the “must take” medications for your residents, these are some of the medications that you should consider stockpiling first. Facilities should also think about their own particular needs and prepare a store of medications that are pertinent to their resident population. Some categories of medications to consider are analgesics, antipyretics, cholesterol medications, etc. Additionally, providers should obtain a supply of medications for the routine treatment of influenza. Consult with your medical director or attending physician regarding which types of medications to stockpile for influenza treatment. (See 2.3 Prevention and Treatment (p. 15) to review suggested medications for influenza treatment).

Although it may not be possible under the existing reimbursement and regulatory structure, it is recommended that facilities have a six- to eight-week supply of medications in the “must take” category to cover expected supply interruptions. Many experts say that a three-month stockpile of medications is ideal. At a minimum, providers should have a two-week supply of the “must take” medications in the facility at all times and a plan with their pharmaceutical providers to have an additional six- to eight-

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60 See 4.5 Staff Preservation in this Workbook (p. 46) for greater detail.
61 “Mass fatality” in this context refers to a situation in which the number of deceased residents at any one time exceeds the facility resources to manage them according to established routines and procedures.
62 Refer to Pandemic Severity Index (p. 5) under 1.5 Overview of Pandemic Influenza and the Challenge to Long Term Care Facilities and to Worksheet III in this Workbook for more information on the Pandemic Severity Index.
63 Stockpiling of medications may not be practical for all long term facilities due to storage, reimbursement and/or regulatory limitations. The authors of this Workbook suggest that you review the medication storage and drug reimbursement regulations for your facility type before actually purchasing medications for this purpose to ensure that you can do so within your regulatory and reimbursement parameters.

Pandemic Influenza Workbook for Long Term Care Providers
week supply available to their facility in an emergency. Talk to your pharmaceutical suppliers now about their ability to maintain an inventory that will allow them to supply your facility for several weeks in the event of a disruption to their supply chain.

Drug supply management of the stockpile medications involves the rotation of the stock and proper storage to ensure the integrity of the stored pharmaceuticals. See Appendix E: Stocking up on Regular Medications for more information.

See Worksheet IV: Suggested Pandemic Supply List (in Addition to Your General Disaster Supplies) (p. 18)

Mass Fatality Care
During a severe pandemic, you may be faced with a large and prolonged loss of life among your residents. Providers should consider, plan and prepare for dealing with the deaths of up to 15 percent of the LTC facility’s residents during the pandemic. While we do not expect the pandemic will have an average case fatality rate this high, it is imperative to be ready and able to deal with outlier conditions that will occur in some facilities. Your Pandemic Annex must include the possibility that routine funeral home services will not be available and that the deceased’s remains will have to be maintained at ambient temperatures on site for a prolonged period of time, possibly months, before they can be properly buried. While there is no precedent or generally accepted method for managing this situation in LTC facilities, or anywhere else for that matter, a few general guidelines can be recommended. In preparation, your Pandemic Annex should include:

- An identified area in your facility, preferably in an outbuilding, that could serve as a temporary morgue. Ideally this will be a cool area with good ventilation that is protected from high traffic and environment factors.
- Procurement of body bags and other post-mortem supplies such as:
  - Watertight zippered body bags for up to 15 percent if the facility’s expected census
  - Plastic tarps for temporary screens and floor protection
  - Protective clothing, face shields, heavy duty rubber gloves and boots
  - Cleaning materials — basins, mops, buckets, clothes, disinfectant (unscented household bleach or dry bleach used for swimming pool maintenance)
  - Heavy duty trash bags
  - Large cable ties
  - Labels or tags to identify the body
  - 20 pounds of common roadway salt sufficient to embalm 15 percent of the expected census. This is a good choice for this purpose, is inexpensive and is available in bulk.
  - 20 pounds of quick lime sufficient to embalm 15 percent of the expected census. This product can be obtained from gardening centers, is available in 40-pound bags and is inexpensive (See emergency embalming procedures described below).

Consider stockpiling these supplies now, or at least talk to your External PI committee about the availability of these supplies through the EOC if needed. We also recommend that you identify a vendor who will supply you with adequate supplies should the time come that they are needed.

Suggested Emergency Embalming Procedure for Temporary Mortuaries
In the event the deceased’s remains cannot be removed from the facility in a timely fashion, place the body in the body bag and carry it to the temporary morgue. Cover the body entirely with salt and lime and close the bag. The salt and lime will embalm the remains, kill bacteria, mold and viruses within the body, reduce bloating, lessen odors and absorb body fluids to some degree. Tag the bag including enough information to clearly identify whose remains are stored there. While this is far from an ideal, it is certainly preferable to not being prepared and confronted with this challenge.

Funeral Services for Deceased LTC Facility Residents during the Pandemic
Since traditional funeral services are unlikely to be available soon after the death of a facility resident, it will be important for the LTC facility to consider having memorial services for the deceased. Following this custom will be important to the morale of the residents and staff and be a comfort to all.

Discuss the plan for management of remains in your area with the local External PI Committee or coroner. Your city or county may have identified a place to serve as a temporary morgue. Find out if you will have to transport the body to this site and, if so, what permits may be required and how you should obtain them.

Communication during Times of Altered Standards of Care
When it comes to altered standards of care, timely communication with concerned parties is critically important. Be ready for inquiries from staff, families, regulatory oversight agencies and possibly the media should you have to implement altered standards of care. Make sure this is considered in the risk communication section of the Pandemic Annex to your disaster plan.66

During the pandemic: When the pandemic hits, your response will need to be geared to the circumstances you face. Having a solid plan with pre-identified triggers for implementation will guide you to make sound decisions.

Conduct pandemic status meetings at least once a day to ensure that you have the latest information about conditions in your facility and in the community. Follow your incident command process66 to ensure that your plan is being effectively implemented. Items to review at these meetings include:

- Pandemic status updates from the local, regional, state and national authorities
- New cases in the facility
- Status of current cases
- Deaths in last reporting period
- Staffing for the current and next shift
- Status of critical supplies
- Critical unmet needs

Furthermore, you will need to document all attempts to obtain adequate resources and report your status to the appropriate oversight agencies and the local health department as directed.

It is critical to communicate honestly with staff, families and residents. Listen to their ideas and concerns and assure them that your goal and actions are to provide the best care possible under the circumstances.

65 See 5.0 Communications in this Workbook (p. 67) for greater detail.
66 See 4.2 Command & Control in Your Organization in this Workbook (p. 40).
1. Mutual Aid Regions III, IV, and V make up the Inland Administrative Region
2. Mutual Aid Regions I and VI make up the Southern Administrative Region
3. Mutual Aid Region II is also the Coastal Administrative Region
WORKSHEET XVI: MODIFIED HICS ORGANIZATIONAL CHART—INCIDENT MANAGEMENT TEAM FOR LTC

Facility Incident Commander
Administrator on call, Nursing Supervisor

Public Information Officer
Marketing Director, Resident Relations

Medical/Technical Specialist
(ex: infection control officer)

Safety Officer
Bldg. Engineer, Nursing Supervisor

Liaison Officer
Risk Management, Community Relations

Operations Section Chief
Administrator, DON

Medical Care Branch Director
Medical Director, DON, Nursing Consultant

Planning Section Chief
CEO, Office Manager

Security Branch Director
Nursing Supervisor, Building Engineer

Logistics Section Chief
Building Engineer, Office Manager, Administrator

Resource/Situation Unit Leader
Office Manager

Medical/Technical Specialist
(ex: infection control officer)

Document Unit Leader
Medical Records Specialist

Medical Care Branch Director
Medical Director, DON, Nursing Consultant

Service Branch Director
Office Manager, IT Specialist

Security Branch Director
Nursing Supervisor, Building Engineer

Support Branch Director
Staffing Coordinator, Director of Staff Development

Business Continuity Branch Director
Office Manager, IT Specialist

Employee/Family Health & Well-being Unit Leader
Staffing Coord., Dir. Staff Devl.

Supply Unit Leader
Bldg. Engineer, Housekeeping

Finance/Administration Section Chief
Chief Operating Officer, Office Manager

Staff & Resident Food and Water Unit Leader
Dietary Services

Staffing Coordinator, Director of Staff Development

Employee/Family Health & Well-being Unit Leader
Staffing Coord., Dir. Staff Devl.

Support Branch Director
Staffing Coordinator, Director of Staff Development

Depending on the size of your facility, one person may fill multiple positions within the section. You do NOT need to activate all the positions—only activate what you need for the incident. These are only suggestions of people who might fit the positions—use whoever is most qualified for each position at your facility.
INCIDENT MANAGEMENT TEAM POSITIONS AND THEIR MISSIONS

Incident Commander
MISSION: Organize and direct the Facility Command Center. Give overall direction for facility operations and if needed, authorize evacuation.

Public Information Officer
MISSION: Serves 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.

Medical/Technical Specialist
MISSION: Advises the Incident Commander and/or assigned Section on issues related to the response in their area of expertise (example: in a pandemic, it might be an infection control officer).

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

Liaison Officer
MISSION: Functions as incident contact person for representatives from other agencies.

Operations Section Chief
MISSION: Develops and implements strategy and tactics to carry out the objectives established by the Incident Commander. Coordinates and supervises Medical Care, Infrastructure, Security, and Business Continuity.

Medical Care Branch Director
MISSION: Organizes and manages the delivery of emergency and continued medical care for residents and any staff casualties.

Security Branch Director
MISSION: Coordinates all of the activities related to personnel and facility security such as access control, crowd and traffic control, and law enforcement interface.

Business Continuity Branch Director
MISSION: Ensures business functions are maintained, restored or augmented to meet designated recovery objectives with limited interruptions to continuity of essential business operations. Ensures access/preservation of business records, maintenance of IT business functions, maintenance of business/clerical functions, etc.

Planning Section Chief
MISSION: Organizes and directs all aspects of Planning Section operations. Ensures distribution of critical information and data. Compiles scenario/resource projections from all section chiefs. Effects long range planning. Documents and distributes facility Action Plan. Develops and coordinates an Incident Demobilization Plan that includes specific instructions for all staff and resources that will require demobilization at the conclusion of the incident.
Resource/Situation Unit Leader

**MISSION:** Maintains information on the status, location and availability of personnel, facilities, supplies and major equipment to ensure availability. Maintains master list of all resources assigned to incident operations. Collects, processes, and organizes on-going situation information; prepares situation summaries, and develops projections.

Documentation Unit Leader

**MISSION:** Maintains accurate and complete incident files, including a record of the facility’s Command Center response and recovery actions and decisions; provides duplication services to incident personnel; and maintains and stores incident files for legal, analytical and historical purposes.

Logistics Section Chief

**MISSION:** Organizes and directs those operations associated with maintenance of the physical environment and with the provision of human resources, material, and services.

Service Branch Director

**MISSION:** Organizes and manages the services required to maintain the facility’s communication systems, food and water supply for staff, residents and any others staying at the facility during the incident; and is responsible for information technology and systems.

Staff & Resident Food and Water

**MISSION:** Organizes food and water stores and prepares for rationing during periods of anticipated or actual shortage.

Support Branch Director

**MISSION:** Organizes and manages the services required to maintain the facility’s supplies, buildings, transportation and labor pool. Ensures the provision of logistical, psychological and medical support of staff and their dependants.

Employee/Family Health & Well-being Unit Leader

**MISSION:** Provides for medical screening, evaluation, care and follow-up of employees and family members. Ensures the availability of behavioral and psychological support for staff and families during and after an incident. Coordinates mass prophylaxis/vaccination/immunization of staff and family members, if required. Provides arrangements for day care and pet care, as needed.

Labor Pool and Transportation Unit Leader

**MISSION:** Organizes and coordinates the transportation of all ambulatory and non-ambulatory residents. Arranges for the transportation of human and material resources within or outside facility. Collects and inventories all available staff and volunteers at a central point for assignment. Maintains adequate numbers of personnel.

Supply Unit Leader

**MISSION:** Acquire, inventory, maintain and provide medical and non-medical care equipment, supplies and pharmaceuticals.

Facilities Unit Leader

**MISSION:** Organizes, manages and supports building systems (incl. utilities, HVAC), equipment and supplies. Ensures proper cleaning and disinfection of facility environment.

Finance/Administration Section Chief

**MISSION:** Monitors the utilization of financial assets. Oversees the acquisition of supplies and services necessary to carry out the facility’s mission. Supervises the documentation of expenditures, claims and cost reimbursement activities, including personnel time keeping activities/collection of time sheets.
Incident Commander

Assigned Position (potential): Administrator-On-Call, Nursing Supervisor, CEO

Position assigned to: ____________________________ (Your name)
You report to: ________________________________ (CEO, Board, etc.)

MISSION: Organize and direct the Facility Command Center. Give overall direction for facility operations and if needed, authorize evacuation.

INTERNAL CONTACT PHONE NUMBERS (IF ANY):

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<th>Time</th>
<th>Initial</th>
<th>Actions</th>
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<td></td>
<td></td>
<td><strong>OPEN FACILITY COMMAND CENTER</strong></td>
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<td><strong>ASSIGN FACILITY COMMAND CENTER SET-UP</strong> to Administrative Assistant</td>
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<td></td>
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<td><strong>READ THIS ENTIRE JOB ACTION SHEET</strong></td>
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<td><strong>PUT ON THE VEST</strong> that identifies your position</td>
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<td><strong>NOTIFY</strong> your usual supervisor and facility CEO, or designee, of the incident and activation of your EOP</td>
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<td><strong>DETERMINE NEED FOR AND APPOINT SECTION CHIEFS.</strong> Give them Job Action Sheets for their sections</td>
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<td><strong>APPOINT OFFICERS:</strong> Information Officer, Liaison Officer, Safety Officer, Medical/Technical Specialist as needed. Instruct them to read their Job Action Sheets</td>
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<td><strong>ANNOUNCE A MEETING</strong> to start in 20 minutes for all Chiefs and Directors</td>
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<td><strong>ASSIGN SOMEONE</strong> to be the Documentation Recorder/Aide</td>
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<td><strong>START MEETING</strong> with Section Chiefs, Officers. Request status report and action plan. Determine best level of service</td>
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<td></td>
<td><strong>UPDATE YOUR LOCAL MUNICIPAL OR COUNTY EOC</strong> regarding status of incident</td>
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<td><strong>RESIDENT CENSUS / STATUS</strong> - ask Planning Section Chief to have the Resource/Situation Unit compile. Emphasize proactive actions within Planning Section</td>
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<td><strong>ASSESS RESIDENT PRIORITY FOR EARLY DISCHARGE,</strong> if additional beds are needed</td>
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<td><strong>CONTACT APPLICABLE OUTSIDE AGENCIES/PARTNERS</strong> for mutual situation updates</td>
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<td><strong>ENSURE THAT LIAISON OFFICER</strong> gives contact and resource information to appropriate external agencies</td>
</tr>
</tbody>
</table>

### IMMEDIATE (0-2 Hours) – *Start here*

- OPEN FACILITY COMMAND CENTER
- ASSIGN FACILITY COMMAND CENTER SET-UP to Administrative Assistant
- READ THIS ENTIRE JOB ACTION SHEET
- PUT ON THE VEST that identifies your position
- NOTIFY your usual supervisor and facility CEO, or designee, of the incident and activation of your EOP
- DETERMINE NEED FOR AND APPOINT SECTION CHIEFS. Give them Job Action Sheets for their sections
- APPOINT OFFICERS: Information Officer, Liaison Officer, Safety Officer, Medical/Technical Specialist as needed. Instruct them to read their Job Action Sheets
- ANNOUNCE A MEETING to start in 20 minutes for all Chiefs and Directors
- ASSIGN SOMEONE to be the Documentation Recorder/Aide
- START MEETING with Section Chiefs, Officers. Request status report and action plan. Determine best level of service
- UPDATE YOUR LOCAL MUNICIPAL OR COUNTY EOC regarding status of incident
- RESIDENT CENSUS / STATUS - ask Planning Section Chief to have the Resource/Situation Unit compile. Emphasize proactive actions within Planning Section
- ASSESS RESIDENT PRIORITY FOR EARLY DISCHARGE, if additional beds are needed
- CONTACT APPLICABLE OUTSIDE AGENCIES/PARTNERS for mutual situation updates
- ENSURE THAT LIAISON OFFICER gives contact and resource information to appropriate external agencies

**INTERMEDIATE (2-12 Hours)**

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<tr>
<th>Time</th>
<th>Initial</th>
<th>Actions</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td><strong>RESOURCES</strong> - authorize as requested by Section Chiefs</td>
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<tr>
<td></td>
<td></td>
<td><strong>ACTION PLANS</strong> - ask Section Chiefs to create</td>
</tr>
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<td></td>
<td></td>
<td><strong>BRIEFINGS</strong> - schedule with Section Chiefs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>STATUS REPORTS</strong> - ask Section Chiefs to report</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>ACTION PLANS</strong> - ask for updated plans</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>COMMUNICATE STATUS</strong> to the Chairperson of the Board/other facility governing body</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>FULFILL NEEDS</strong> of Section Chiefs for staff, residents, volunteers, and dependents</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>FOOD AND SHELTER</strong> - ensure adequate supply for staff, residents and dependents</td>
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## EXTENDED (Beyond 12 Hours)

<table>
<thead>
<tr>
<th>Time</th>
<th>Initial</th>
<th>Actions</th>
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</thead>
<tbody>
<tr>
<td>MEDIA RELEASES</td>
<td></td>
<td>review/approve when submitted by Public Information Officer</td>
</tr>
<tr>
<td>COORDINATE WITH SECTION CHIEFS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FACILITY BOARD OR CEO</td>
<td>update as needed</td>
<td></td>
</tr>
<tr>
<td>PROVIDE FOR STAFF REST PERIODS AND RELIEF</td>
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## DEMOBILIZATION/RECOVERY

<table>
<thead>
<tr>
<th>Time</th>
<th>Initial</th>
<th>Actions</th>
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</thead>
<tbody>
<tr>
<td>ASSESS DEMOBILIZATION PLAN</td>
<td>developed by Planning Section Chief</td>
<td></td>
</tr>
<tr>
<td>RETURN STAFF TO NORMAL JOBS</td>
<td>as appropriate as incident is resolved. This may be done in a phased manner</td>
<td></td>
</tr>
<tr>
<td>BRIEF STAFF, ADMINISTRATION, BOARD OF DIRECTORS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENSURE OUTSIDE AGENCIES ARE AWARE OF STATUS CHANGE WITHIN FACILITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENSURE RESTOCKING OF SUPPLIES</td>
<td>as appropriate</td>
<td></td>
</tr>
<tr>
<td>□ Return equipment to original location</td>
<td>□ Clean/disinfect facility</td>
<td></td>
</tr>
<tr>
<td>□ Replace lost/broken items</td>
<td>□ Restock supplies</td>
<td></td>
</tr>
<tr>
<td>ENSURE AFTER-ACTION ACTIVITIES ARE COMPLETED:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Collection of documentation by Planning Section Chief</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Coordination &amp; submission of response and recovery costs, and reimbursement documentation by the Finance/ Administration and Planning Section Chiefs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Conduct staff debriefings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Identify needed revisions to Emergency Operations Plan, including Job Action Sheets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Participate in external debriefings with external (community and governmental) agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Conduct stress management activities for staff, residents</td>
<td></td>
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</tr>
</tbody>
</table>

## Your Toolbox

- □ 1 Vest for your assigned position
- □ 2 Modified HICS Job Action Sheets
- □ 3 Facility Emergency Operations Plan
- □ 4 Facility Pandemic Influenza Annex
- □ 5 Facility Organizational Chart

Adapted from Stanford Hosp & Clinics’ Comprehensive Healthcare Emergency Response Plan and HICS
Liaison Officer

Assigned Position (potential):  Risk Management, Community Relations, CEO, Administrator

Position assigned to: ____________________________________________ (Your name)

You report to: _________________________________________ (Incident Commander)

MISSION: Function as incident contact person for representatives from other agencies.

INTERNAL CONTACT PHONE NUMBERS (IF ANY):

IMMEDIATE (0-2 Hours) – Start here

<table>
<thead>
<tr>
<th>Time</th>
<th>Initial</th>
<th>Actions</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>BE APPOINTED by the Incident Commander</td>
</tr>
<tr>
<td></td>
<td></td>
<td>READ THIS JOB ACTION SHEET</td>
</tr>
<tr>
<td></td>
<td></td>
<td>REVIEW ORGANIZATION CHART (INCIDENT MANAGEMENT TEAM CHART)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PUT ON VEST that identifies your appointed position</td>
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<tr>
<td></td>
<td></td>
<td>RECEIVE BRIEFING FROM INCIDENT COMMANDER</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NOTIFY OUTSIDE AGENCIES OF EMERGENCY STATUS &amp; gather information from such agencies if applicable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Local Police Dept EOC. _ _ _ _ _ _ _ , Fax: _ _ _ _ _ _ _</td>
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<tr>
<td></td>
<td></td>
<td>□ Local Sheriff _ _ _ _ _ _ _ , Fax: _ _ _ _ _ _ _</td>
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<tr>
<td></td>
<td></td>
<td>□ Local Public Health Dept. _ _ _ _ _ _ _ , Fax: _ _ _ _ _ _ _</td>
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<tr>
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<td>□ County Office of Emergency Services _ _ _ _ _ _ _</td>
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<td></td>
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<td>□ Local Fire Dept. _ _ _ _ _ _ _ , Fax: _ _ _ _ _ _ _</td>
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<tr>
<td></td>
<td></td>
<td>□ Local Hospital _ _ _ _ _ _ _ , Fax: _ _ _ _ _ _ _</td>
</tr>
<tr>
<td></td>
<td></td>
<td>COORDINATE with the Public Information Officer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OBTAIN ASSESSMENT OF ACUITY OF YOUR RESIDENT POPULATION from your Medical Care Branch Director or Resource/Situation Unit Leader</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ # of Residents requiring immediate care ______</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ # of Residents requiring delayed care ______</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Wheelchair or stretcher patients requiring transfer to other LTC facility/hospital ______</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MEET WITH OTHER SECTION CHIEFS to ASSESS CRITICAL NEEDS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Condition of facility structure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Shortages of equipment/supplies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Resources requested by other facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RELAY STATUS OF FACILITY to relevant external partners—use phone tree in your EOP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CONTACT LIAISONS IN OTHER AGENCIES. Update government agencies and regulatory bodies. Maintain lists/call logs of contact with public health and other agencies</td>
</tr>
</tbody>
</table>

INTERMEDIATE (2-12 Hours)

<table>
<thead>
<tr>
<th>Time</th>
<th>Initial</th>
<th>Actions</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>REQUEST ASSISTANCE through existing MOUs and municipal and/or county EOC</td>
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<tr>
<td></td>
<td></td>
<td>SET UP and organize stakeholder meetings as necessary to update status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RESPOND TO REQUESTS and complaints from incident personnel regarding inter-organization problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ASSIST LABOR POOL UNIT LEADER with credentialing/observation to determine competency of volunteers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RELAY INFORMATION from other Command Section Officers as necessary</td>
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</tbody>
</table>
### EXTENDED (Beyond 12 Hours)

<table>
<thead>
<tr>
<th>Time</th>
<th>Initial</th>
<th>Actions</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>ASSIST YOUR MEDICAL CARE BRANCH DIRECTOR and your Labor Pool Unit Leader to solicit personnel to volunteer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>COMMUNICATE WITH OTHER FACILITIES ON NEEDED OR REQUESTED RESOURCES. Coordinate with your Logistics and Planning Section Chiefs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SUPPLY CASUALTY DATA. Collect the following numbers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Casualties / Types of injuries __________________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Discharged to home / Other facilities ____________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Hospitalized ____________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Dead ____________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>WATCH FOR SIGNS OF STRESS IN STAFF. Report concerns to your Employee Health &amp; Well-Being/Family Care Unit Leader</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PROVIDE REST PERIODS AND RELIEF FOR YOUR STAFF</td>
</tr>
</tbody>
</table>

### DEMOBILIZATION/RECOVERY

<table>
<thead>
<tr>
<th>Time</th>
<th>Initial</th>
<th>Actions</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DEACTIVATE ANY LIAISON STAFF used for the incident as the need subsides—return staff to their normal jobs. This may be done in a phased manner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ENSURE RETURN/RETRIEVAL OF EQUIPMENT &amp; SUPPLIES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BRIEF your Incident Commander on current problems, outstanding issues, and follow-up actions needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>COMPLETE AND SUBMIT all documentation to your Planning Section Chief</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PARTICIPATE in after-action briefings. Document observations and make recommendations for improvements. Consider:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Accomplishments and issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Review of pertinent position descriptions and checklists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Recommendations for procedural changes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PARTICIPATE in stress management and after-action debriefings and other meetings and debriefings as required</td>
</tr>
</tbody>
</table>

#### Your Toolbox

- □ Vest for your assigned position
- □ Facility Pandemic Influenza Annex
- □ 7 County Org Chart and Contact #s
- □ Modified HICS Job Action Sheet
- □ Facility Organizational Chart
- □ Municipal Org Chart and Contact #s
- □ Facility Emergency Operations Plan
- □ 6 Municipal Org Chart and Contact #s
Public Information Officer
Assigned Position (potential): Marketing Director, Resident Relations, etc.

Position assigned to: ____________________________________________ (Your name)
You report to: _________________________________________ (Incident Commander)

MISSION: Provide information to the news media.

INTERNAL CONTACT PHONE NUMBERS (IF ANY):

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**IMMEDIATE (0-2 Hours) – Start here**

<table>
<thead>
<tr>
<th>Time</th>
<th>Initial Actions</th>
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<tbody>
<tr>
<td></td>
<td>BE APPOINTED by the Incident Commander</td>
</tr>
<tr>
<td></td>
<td>READ THIS JOB ACTION SHEET</td>
</tr>
<tr>
<td></td>
<td>REVIEW ORGANIZATION CHART (INCIDENT MANAGEMENT TEAM CHART)</td>
</tr>
<tr>
<td></td>
<td>PUT ON VEST that identifies your appointed position</td>
</tr>
<tr>
<td></td>
<td>MANAGE NEWS RELEASES. Identify information that should be restricted. Ensures that risk communication principles (See Worksheet XXI) are being followed. Get approval from Incident Commander before any media releases</td>
</tr>
<tr>
<td></td>
<td>ESTABLISH MEDIA AREA away from Facility Command Center and patient/resident care activity</td>
</tr>
</tbody>
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**INTERMEDIATE (2-12 Hours)**

<table>
<thead>
<tr>
<th>Time</th>
<th>Initial Actions</th>
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<tbody>
<tr>
<td></td>
<td>ENSURE APPROVAL OF ALL NEWS RELEASES by the Incident Commander</td>
</tr>
<tr>
<td></td>
<td>CHECK MEDIA AND REPORTS to understand what messages are being given, and what questions might be asked of the facility. Relay relevant data back to Command staff (i.e. Incident Commander, Officers and Section Chiefs)</td>
</tr>
<tr>
<td></td>
<td>ENSURE ALL MATERIALS are culturally and linguistically appropriate for your population (i.e. staff, residents, families)</td>
</tr>
<tr>
<td></td>
<td>ISSUE INITIAL INCIDENT INFORMATION REPORT to news media with cooperation of your Resource/Situation-Status Unit Leader. Relay relevant data back to your Resource/Situation-Status Unit Leader</td>
</tr>
<tr>
<td></td>
<td>INFORM ON-SITE MEDIA of which physical areas are accessible and which are restricted. Coordinate with your Safety Officer and your Security Branch Director</td>
</tr>
<tr>
<td></td>
<td>COORDINATE INFORMATION. Contact other involved agencies’ PIOs to coordinate released information for consistency of message. Make sure to coordinate your Liaison Officer</td>
</tr>
<tr>
<td></td>
<td>LIST AVAILABLE PARTNERS/CONTRACTORS who can help in the effort to put together and distribute information related to the event</td>
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### EXTENDED (Beyond 12 Hours)

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<th>Time</th>
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<tr>
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<td>REQUEST PROGRESS REPORTS from Section Chiefs as appropriate</td>
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<td>CONTINUE TO INFORM MEDIA OF FACILITY STATUS as necessary</td>
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<tr>
<td></td>
<td></td>
<td>DIRECT CALLS FROM VOLUNTEERS to your Labor Pool Unit. Ask Labor Pool Unit if they have requests of the public to be broadcast through the media</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OBSERVE ALL STAFF AND VOLUNTEERS for signs of stress, fatigue, and inappropriate behavior. Report concerns to your Employee Health &amp; Well-Being/Family Care Unit Leader</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PROVIDE REST PERIODS AND RELIEF FOR YOUR STAFF</td>
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### DEMOBILIZATION/RECOVERY

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<th>Time</th>
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<th>Actions</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>DEACTIVATE ANY PUBLIC INFORMATION STAFF used for the incident as the need subsides—return staff to their normal jobs. This may be done in a phased manner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>COORDINATE release of final media briefings and reports</td>
</tr>
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<td></td>
<td>ENSURE RETURN/RETRIEVAL OF EQUIPMENT &amp; SUPPLIES</td>
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<td></td>
<td>BRIEF your Incident Commander on current problems, outstanding issues, and follow-up actions needed</td>
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<td>COMPLETE AND SUBMIT all documentation to your Planning Section Chief</td>
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<td>PARTICIPATE in after-action briefings. Document observations and make recommendations for improvements. Consider:</td>
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<td>□ Accomplishments and issues</td>
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<td></td>
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<td>PARTICIPATE in stress management and after-action debriefings and other meetings and debriefings as required</td>
</tr>
</tbody>
</table>

### Your Toolbox

- □ Vest for your assigned position
- □ Modified HICS Job Action Sheet
- □ Facility Emergency Operations Plan
- □ Facility Pandemic Influenza Annex
- □ Local PIO Contact Information (city, county, other LTC facilities, local hospital, etc.)
5.0 COMMUNICATIONS

5.1 INTRODUCTION TO DISASTER COMMUNICATIONS

In any disaster, reliable, frequent and rapid communication is one of the primary needs of all involved. It is also one of the most difficult things to get right during a disaster, because the situation is ever changing, the process for communication is sometimes confusing and the usual types of communications equipment are not always reliable or available. From the facility standpoint, there are primarily two important audiences to whom you need to communicate — internal (staff, physicians, residents and families, suppliers and contractors) and external (families and visitors, media, community leaders, regulators and officials and other healthcare providers.)

This chapter will provide some guidance and thoughts on communications with all of the above mentioned groups.

Effective communication in long term care settings, both before and during a pandemic, will be critical to mitigate the effect on your facility. Effective communication among communities and LTC facilities will require that health departments, hospitals and non-hospital providers communicate and plan together.

The following sections discuss how communication with residents, staff, government agencies and the media can ameliorate confusion and improve coordination of care during a pandemic.

5.2 CONCEPTS IN RISK COMMUNICATION

To avoid confusion early in a crisis, messages should be accurate, relevant, simple, fast, frequent and consistent. Research also stresses that successful communication, especially in a crisis, requires the following steps:

- Develop a solid communication plan before the pandemic, with pre-written messages that can be modified when the pandemic occurs as needed.
- Work with the local public health department on messages so that you are consistent with what local officials are saying. You can find information on risk communication messages from the local public health Web site or the CDC at www.pandemicflu.gov.
- Be the first source of information about the pandemic with regard to your facility for your residents, their families and your staff. People will want to know what is going on immediately, so be ready and be credible.
- Express empathy early and often (e.g., “I understand how frightening this is for you.”)
- Show competence and expertise.
- Remain honest and open.
- Use the same spokesperson(s) throughout.
- Schedule regular briefings even if there is little new information.

Five Communications Don’ts:
- Don’t release information late. When people need information, they will find it somewhere, and it may not be the correct information.


- Don’t give mixed messages. Be clear and correct and consistent with the messages from the local health department.
- Don’t tell people not to be afraid. Acknowledge their fear and use the facts to fight it.
- Don’t delay in addressing myths and rumors.
- Don’t engage in public power struggles and don’t add to the confusion — this will only make the situation worse.

Your initial message must be short and relevant, must give positive action steps and must be consistent and repeated. Do not use jargon, be judgmental, make promises that cannot be kept or include humor.

It is important not to over-reassure people during a crisis. It is much better to give them something to do. Express your wishes and ask more of people. Continue to do these things throughout the pandemic, not just at the beginning.

See Worksheet XXI: Checklist for Crisis & Emergency Communications (p. 73)

5.3 COMMUNICATION TRIGGERS

The Centers for Disease Control and Prevention (CDC) has suggested the following events as trigger points for federal, state and local public health authorities to increase their communication to the public regarding pandemic influenza. Provided that you keep your contact information with public health authorities current, your facility can expect information following these particular events, which may then trigger your own internal and external communication process:

**In Birds**
- First case of bird flu (H5N1) or other potential pandemic virus in a wild bird in the Western Hemisphere.
- First case of bird flu (H5N1) or other potential pandemic virus in a wild bird in the United States.
- First case of bird flu (H5N1) or other potential pandemic virus in any domestic animal or bird in the United States.

**In Humans**
- First human case of H5N1 or other potential pandemic virus identified in a person in the United States, acquired internationally.
- First human case of H5N1 or other potential pandemic virus identified in a person in the United States, acquired in the U.S. from a bird, without secondary transmission.
- First human case of H5N1 or other potential pandemic virus in the United States, acquired domestically, from another human.
- Sustained human-to-human transmission of H5N1 or other potential pandemic virus occurring somewhere other than the Western Hemisphere.
- First cluster of human H5N1 or other potential pandemic influenza virus transmitted person-to-person in the United States.

*Note: Any of these triggers may occur rapidly or they may skip around. They are not necessarily in order. This list is given to provide you with “triggers” to think about while developing your risk communication plan.*

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5.4 SPECIAL CONSIDERATIONS FOR THE POPULATION YOU SERVE

The people being served in a long term care facility — and by extension their families — are often considered a “special population,” and this is also true in planning communications for an emergency like pandemic influenza. A special population is any group that cannot be reached effectively during the initial phases of a public safety emergency with general public health messages delivered through mass communication channels. Residents and staff in the facility may constitute one of these populations, depending on the circumstances as outlined below. Challenges to communication include:

- Language barriers severe enough that the message could be incorrectly acted upon.
- Reaching people with cognitive impairment (if the proxy or guardian is not present to receive the messages.)
- Reaching people with physical impairment.
- Strong challenges to cultural beliefs relevant to the event.
- Environmental barriers (lack of a TV or phone, for example).
- Pre-existing group social, political or legal contexts that could interfere with honest and respectful information exchange during emergencies.

Early in a crisis, communication resources will be limited and the potential will be great for mixed messages that confuse the audience. A simple and consistent message is best unless strong evidence indicates that it won’t be effectively received by an identifiable group that should receive the message in some other, more effective, form.

5.5 WITH RESIDENTS

Before the pandemic: Communication with residents and visitors is an essential part of pandemic containment strategy. Based on your surveillance plan, determine how to look for pandemic influenza in healthcare personnel and in the population served and how this information will be communicated to the residents and their families. Develop policies and procedures for managing pandemic influenza information among residents and staff.

During the pandemic: Monitoring residents for pandemic influenza and instituting appropriate control measures are essential. Despite aggressive efforts to prevent the introduction of pandemic influenza virus, staff or visitors in the early stages of pandemic influenza could bring it into the facility. Early detection of the presence of pandemic influenza in a facility is critical for ensuring timely implementation of infection control measures and appropriate communication of this information. Follow the recommendations in 3.0 Containment Strategies (p.19) in this Workbook and consider providing a telephone number for people to call for information on measures used to prevent the introduction of pandemic influenza — check with your external PI committee to see if your health department is planning an influenza hotline.

5.6 WITH STAFF

Before the pandemic: Educate and train your staff about your containment plan before you need to implement it. Examples of containment measures that will need to be discussed include:

- The screening procedures your facility expects to implement.
- Information about cohorting residents and assigning staff.
- How residents’ movement may be limited (e.g., temporarily closing the dining room and serving meals on nursing units, canceling social and recreational activities, etc.).

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70 See 3.0 Containment Strategies in this Workbook (p. 19) for more information.
During the pandemic: As mentioned, consider posting visual alerts and having a system of communication among units in the event that certain areas of the facility are closed to visitors or additional staff. You should have staff briefings every shift, post situation updates in staff areas and develop a system for how to communicate with any absentee staff for updates on their situation.

5.7 WITH VOLUNTEERS

Before the pandemic: As with precautions taken with staff, ensure that volunteers are aware of the procedures that will be implemented during a pandemic. Be sure that volunteers know what facility number to call and/or set up a phone tree that, if necessary, can be kept current to prevent volunteers from coming in to work.

During the pandemic: At the start of the pandemic, it will be important to limit the interaction of unnecessary personnel, volunteers and families with residents of long term care facilities. As with staff, ensure that volunteers are aware of the procedures that will take place or be implemented during a pandemic. Be sure that volunteers know what hotline number to call and/or set up a phone tree that can be kept current to prevent volunteers from coming in to work if necessary.

Once the pandemic has progressed, restrictions on visitors and volunteers may be modified in certain circumstances. At this point, a system for recalling volunteers to the facility will need to be implemented. Family members or other volunteers may be an important resource to help in your facility in the later stages of a pandemic.

5.8 WITH GOVERNMENT AGENCIES

Before the pandemic: As described earlier, the federal government has adopted the NIMS/ICS structure for effective management of emergency events. This will be the organizing principle in a national influenza pandemic response.

Under NIMS and ICS, one of the duties of your facility liaison officer will be communication with government agencies. Your facility should have a pre-identified liaison officer and an alternate.

See Worksheet XIX: Sample Facility Liaison Officer Job Action Sheet (p. 63)

Determine how the facility will communicate and coordinate with healthcare partners and public health authorities during a pandemic. Make sure the facility has updated the appropriate contact information with the local public health agency.

During the pandemic: Early in the progress of a pandemic in the region, staff must maintain surveillance for influenza-like symptoms. Notify state or local health department officials if a case is suspected and maintain open lines of communication with the appropriate local, state and federal agencies, following NIMS as outlined earlier.

Stay in close communication with your regulatory agency to ensure that you have the latest information on waivers, emergency permission and other special arrangements that will allow you greater flexibility in implementing your self-sustainment strategies.

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71 See 4.5 Staff Preservation in this Workbook (p. 46) for more information.
72 See 4.5 Staff Preservation (p. 46) and 4.7 Altered Standards of Care (p. 52) in this Workbook for more discussion about possible emergency permissions.
5.9 WITH THE MEDIA

Before the pandemic: Again, in a pandemic influenza situation, all levels of government and many other types of agencies and facilities will be operating under the NIMS system described in the SEMS/HICS section.

Under NIMS and ICS, the public information officer (PIO) is in a command position, responsible for ensuring the accurate and timely release of information to the public. Your facility should have a pre-identified PIO (and an alternate), but the lead for communicating with the external community will reside with the county PIO.

See Worksheet XX: Sample Facility Public Information Officer Job Action Sheet (p. 65)

An influenza pandemic will generate immediate, intense and sustained demand for information. In this situation, some healthcare workers are likely to be involved in media relations and health communications. Whether media communication is a role that your organization intends to take on, there are advantages to doing a little planning so that you know what to do if the media come to you.

- Determine the message that will be given to the media about how the facility plans to communicate and coordinate with healthcare partners and public health authorities during a pandemic.
- Determine the message that will be given to the media about how the facility plans to communicate with residents, staff and families regarding prevention and control measures.
- Utilize the resources of your professional or trade association, such as CAHF, to help draft your message.
- Provide media training to staff who will be assigned the job of public information officer. Basic media training will be useful even without a pandemic event.

In larger organizations, it may be beneficial to have a communications team to assist your PIO.

In the event of a pandemic influenza outbreak, consider the following as you develop your plans for a response. If you were an information officer for your facility, what communication infrastructure would you want to have in place immediately? Before a pandemic, consider the following:

- Have you established a contact with the local public health department?
- Have you contacted your local Office of Emergency Services to ensure that you are included in the organized SEMS response?
- Do you know how to contact or have you established contact with, the local government Emergency Operations Center (EOC)?
- Are there clear lines of authority in your facility of which every staff member is aware (HICS)?

Try to anticipate the questions that the media will ask you in a pandemic influenza situation. Examples of these may be: How are you managing the outbreak? How many deaths have you had? Prepare your PIO ahead of time to answer these questions.  

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73 Use the tips in the “During” section to start considering your communications now.
During the pandemic: These specific tips are designed to help you consider how to organize your thoughts and conduct yourself during your interview with the media.

1. Think like a headline. Give the broad, overarching thought first and then fill in the details.

2. Have the point you want to make formulated clearly in your mind, and make that statement. Even if the reporter doesn't ask you the question that leads to that answer, make your statement anyway. This establishes you as the expert.

See Worksheet XXI: Checklist for Crisis & Emergency Communications (p. 74)

3. To the extent possible, always try to incorporate the reporter's question into your answer. That will ensure that it cannot be taken out of context.

4. Make continuous eye contact with the reporter — not the camera — even during a long interview. Although it may seem awkward, this is an important technique. If you make a key point while your eyes are cast away from the reporter's face, that portion of the interview may not be used. Even if the footage is used, you may appear less credible.

5. Monitor the pace at which you communicate information. Speak slowly and clearly — and stop when you are out of up-to-date information. If you are unable to answer further questions or provide more detail, say so. Knowing when to say "I don't know" is just as important as having a detailed answer.

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74 Hite, Betsy. Media Interview Tips. California Association of Health Facilities.
### WORKSHEET XXI: CHECKLIST FOR CRISIS & EMERGENCY COMMUNICATIONS

#### Planning, research, training, and evaluation

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<tr>
<td><strong>Does your organization have an emergency response/crisis communication operational plan for public information and media, partner, and stakeholder relations?</strong></td>
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#### Yes No

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<td><strong>If yes, does the plan have the following elements:</strong></td>
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<td><strong>Designated line and staff responsibilities for the public information team</strong></td>
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<td><strong>Information verification and clearance/approval procedures</strong></td>
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<td><strong>Agreements on information release authorities (who releases what/when/how)</strong></td>
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<td><strong>Regional and local health authorities contact list and media contacts (including after-hours news desks)</strong></td>
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<td><strong>Procedures to coordinate with the public health EOC, including after hours</strong></td>
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<td><strong>Designated spokespersons</strong></td>
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<td><strong>Contact numbers for emergency information partners (e.g., Governor’s public affairs officer, regional CMS information officer, local or regional department of health services public information officers, Red Cross and other non-government organizations)</strong></td>
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<td><strong>Identified vehicles of information dissemination (e.g., e-mail listservs, broadcast fax, press releases) during a crisis to stakeholders (including families, staff, suppliers, and other partners)</strong></td>
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<td><strong>Have you coordinated your planning with your local Public Health or Office of Emergency Services?</strong></td>
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<td><strong>Have you coordinated your planning with other response organizations or competitors?</strong></td>
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<td><strong>Have designated spokespersons received media training and risk communication training?</strong></td>
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<tr>
<td><strong>Do they understand emergency crisis/risk communication principles to build trust and credibility?</strong></td>
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#### Message and audiences

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<td><strong>Have you identified special populations within your staff, residents, and families (i.e. cultural or linguistic differences, people with specific health needs that need specific information related to their need)</strong></td>
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<td><strong>Have you identified your organization’s partners and stakeholder organizations who should receive direct information and updates from your organization? Examples may include the Public Health Department, local acute care facilities, other local long term care facilities, licensing, your parent company, etc.</strong></td>
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<td><strong>Will you be able to create messages for the media and your population under severe time constraints, including methods to clear these messages within the emergency response operations of your organization (include cross clearance)?</strong></td>
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#### Do you have topic-specific pre-crisis materials for identified emergency issues, or have you identified sources of these materials if needed? Check the CDC and California DHS websites, as well as your county public health department website, for downloadable materials at the time of the crisis and as it develops.

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<td><strong>Topic fact-sheet (e.g., description of the disease, public health threat, treatment, etc.)</strong></td>
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<td><strong>Public Q/As</strong></td>
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<td><strong>Partner Q/As</strong></td>
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<td><strong>Resource fact-sheet for media/public/partners to obtain additional information</strong></td>
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<td><strong>Web access and links to information on the topic</strong></td>
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<td><strong>Recommendations for affected populations</strong></td>
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<tr>
<td><strong>List of subject matter experts outside your organization that would be effective validators to public/media regarding your activities during a public health emergency.</strong></td>
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Public Information Team

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Note: The local Department of Public Health and local Office of Emergency Services will manage the official media communications for your area—you need only be concerned with messages as they relate directly to your facility, residents, staff, or families.

Media Spokesperson Preparation Tips

- Don’t “step on” a reporter’s question. When we are anxious to answer a question, we often begin to respond before the reporter has finished asking the question. This causes a couple of problems: first, it makes editing difficult and second, it can result in losing the best part of an interview, since the first sentence of a response is usually the most succinct and best explanation of the issue.

- To make sure you give the media good sound bites, make a conscious one-and-a-half to two-second pause between key points of arguments. However, do not pause so long that the next statement can’t follow without being edited.

- Make the points you have prepared. If a reporter tries to take you down a questioning path where you don’t want to go, it is perfectly acceptable to redirect them to the topic you want to cover. There are a number of ways to do this:
  
  A. Give a quick two or three word answer to the question and then say “However, the more interesting/critical issue is_______, and we are doing_______ or I am committed to ________.”

  B. Skip the answer to their question altogether and simply move into, “That does not concern me nearly as much as ________, which I am addressing through the following ________.”

- If they ask you something so specific that a precise answer will paint you into a comer, respond by saying, “We can come back to that in a minute if you would like, but let me address your question in the context of a larger picture. We need to examine how we deliver health care as a state…..” Then, if you have to, go back to the specific issue mentioned.

- Particularly for women: use your hands more on camera than you usually would

- Tuck the back of your jacket under you when you sit down to assure that you will not slump during seated interviews

- Develop three or four power words and one “Notable quotable” before the interview and MAKE SURE IT GETS SAID. Examples include: “landmark”, “precedent-setting”, “first of its kind”, “absolutely inexcusable”, “completely preventable”, etc.

- In order to make sure your answer is comprehensive, the following are words to avoid using at the beginning of an interview:
  “Because”
  “Sure”
  “They”
  “It depends”
  “I don’t know”
  “And”

  Instead, remember to begin using full sentences. Often, it will sound like you are repeating the reporter’s question, but that’s ok because it’s more important that you have a full sound bite.

- Use “Yes” or “No” only if you can immediately follow-up with an explanation (“Yes, the number of patients in county facilities has grown steadily.”) But it is better to say, “The number of patients in county facilities HAS grown steadily. Some factors we believe contributed to this growth are…..”

- Speak a little more slowly than usual and use a stronger vocal inflection than in normal conversation—but not to the point that it is uncomfortable.

- Assume that the camera is always on. An old, devilish trick which is still employed on occasion is for the reporter to chat “off the record” with the interviewee while the camera is “setting up.” The comments you made during that interval may be used and cause problems.
Media Spokesperson Preparation Tips (cont.)

- Remember to be sincere!
- Be aware of the needs and application of the sound bite. Does the reporter need a seven second bite (most television and radio) or does s/he need a twenty-five to thirty-second bite (public radio, live radio, investigative television.)
- Prior to the interview, make notes on your chosen key points and rehearse them out loud with someone, making eye contact just as you will during the interview. You may think you know exactly what you’re going to say and are sure that it will fit the required “sound bite” time frame, but when you first rehearse it, you may discover you’re not as articulate as you thought.
- In a crisis, don’t speculate. Reporters love the juiciest of juicy gore and destruction. Give out only information you are sure of with regard to death, destruction, costs of damage, missing persons etc. Qualify the information that you are providing as “preliminary” and assuring the press that confirmation or adjustments will be forthcoming.

CRISIS COMMUNICATION TIPS FOR YOUR FACILITY

- Within your organization, be very clear on who’s responsible for communication to whom. There should be one key communicator to the media (usually your PIO). This provides a level of stability in a difficult time.
- Your Public Information Officer is a member of your Command staff (top 4-5 HICS positions) for a reason—be honest with this person. Let them know all aspects of the situation that you are aware of, and then work out together what should be communicated and when.
- The communicator should not be the same person who is in charge of directing the crisis operations. For example, in your facility, your Incident Commander should not be your PIO.
- Set up regular briefing periods to answer all questions at once, rather than having to answer the same question over and over. Provide written updates to hand out at each briefing so everyone has the same information. This greatly reduces the incidents of errors in reporting.
- Utilize the media. They are the most effective conduit of information between you and the public and they can play a vital role in getting your message out.

Suggestions about Planning & Resources

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- Contracts and memoranda of agreement:
- Consider a contract for administrative support, or consider how staff may be cross-trained to provide administrative support

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- Suggested Equipment:
- Fax machine (number that’s pre-programmed for broadcast fax releases to media and partners)
- Computers (on LAN with e-mail listserves designated for partners and media)
- Copier (and backup)
- Visible calendars, flow charts, bulletin boards, easels
- Designated personal message board
- Paper
- TVs with cable hookup
- VHS VCR
- CD-ROM
- Paper shredder

Adapted from CDC’s Crisis Emergency Risk Communication: Pandemic Influenza and CAHF’s Media Spokesperson Preparation Tips
6.0 CONCLUSION

An influenza pandemic is widely expected to break out and spread rapidly sometime in the future. There is no predicting exactly where/when a pandemic will start or how fast it will spread. In the event of an influenza pandemic, all long term care facilities will need a great deal of guidance. This Workbook is offered as one source of that guidance. While not all recommendations are applicable to every site of care, the basic planning principles outlined in this Workbook are relevant to all long term care facilities and are offered as a basis for them to use in developing a Pandemic Annex to their existing disaster plan.

Adequate planning before a pandemic hits is essential to allow clear, careful, informed choices to be made at the appropriate time. LTC providers are encouraged to evaluate the effectiveness of their current disaster preparedness and infection control plans and to use this Workbook and the referenced materials to build a detailed Pandemic Annex to those existing plans. By doing so, you will be better prepared for disasters in general and in particular for infectious disease outbreaks such as norovirus that are already circulating in the general public.

In addition to planning within your facility, begin working with your local partners. Effective communication with your local public health department, Office of Emergency Services and the local Emergency Operations Center is essential to preparedness of facilities and communities.

Threats are also opportunities, and the pandemic threat is an opportunity to improve all-hazard planning, infection control, self-reliance and crisis communication in long term care facilities. It also is an opportunity for improved coordination among LTC facilities and the operational area response network.
Appendix A
COMMUNICABLE DISEASE REPORTING

Because the state and counties are able to add to the national list of Reportable Diseases and Conditions (but not subtract from it), it is important to periodically review your own county’s list. This way you will catch all nationally reportable diseases and conditions and all state requirements, as well as your own county’s additions. Your county list can usually be found on your local public health department Web site (check in the communicable disease section) or by calling your local public health department. Please refer to the NACCHO Web site for a list of all local public health departments in California.

According to California Code of Regulations (CCR), Title 17, Section 2500: If you are a healthcare provider or administrator of a facility where known or suspected reportable diseases are present, you are responsible for their reporting within the designated timeframe. Your county public health department will be able to give you the communicable disease reporting form that you need to fill out for any suspected/known disease on the list.

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75 See Appendix C: Useful Web Sites in this Workbook (p. 79).
Appendix B
INFLUENZA A TESTING

The following is additional information on testing for influenza A: The optimal specimen for influenza A virus detection is a nasopharyngeal aspirate obtained within three days of the onset of symptoms, although nasopharyngeal swabs and other specimens can also be used.??

Assays available for diagnosing influenza A virus infection are:?? 78 79

1. Rapid antigen detection (results in 15-30 minutes). Most of the rapid influenza tests are somewhat more than 70-percent sensitive for detecting influenza and are slightly over 90-percent specific compared with virus culture — false negative results occur more commonly than false positives.
   ▪ Near-patient tests (NPT) for influenza. Commercially available tests.
   ▪ Immunofluorescence assay (2-4 hours). Widely used, sensitive method for diagnosing influenza A and B and five other clinically important respiratory viruses.
   ▪ Enzyme immunoassay. For influenza A nucleoprotein (NP).

2. Viral culture (results in 2-10 days). Widely available in laboratories but often does not yield results in time for treatment decisions (such as the use of antivirals).

3. Polymerase chain reaction (PCR) and real-time PCR assays (results in a few hours). PCR is not widely available and results may not be available in a timely manner for clinical decisions.

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?? Ibid.

Appendix C

USEFUL WEB SITES

General Disaster Preparedness
- CAHF’s Disaster Preparedness Program has developed a Web site with useful tools, best practices and disaster planning information specific to long term care at www.cahf.org/public/dpp

Personal Preparedness
General
- CAHF’s Disaster Preparedness Program Web site also has personal preparedness information — visit www.cahf.org/public/dpp, go to the “Disaster Planning for LTC” section and find the personal/staff preparedness page.
- www.72hours.org — San Francisco’s personal and family preparedness Web site. It is extremely user-friendly and will guide you through all the components of a good personal plan in simple bite-sized steps. It is well organized and visually appealing.
- www.emergencypreparednessweek.ca — an excellent Canadian Web site that walks you through simple forms so that you end up with a plan at the end. Also click on "prepare your emergency kit" to learn how to build your own kit or where to purchase one.
- www.prepare.org — a Web site produced by the American Red Cross that provides information and planning help specifically for vulnerable populations. Large print format is available, and there is information for seniors, people with disabilities, children and pet owners.

Pandemic-Specific
- www.birdflumanual.com — will help you prepare at home for pandemic influenza. There are several guides available on this site; in particular, you may be interested in "Good Home Treatment of Influenza." Dr. Woodson, the author of these excellent planning manuals, is a reviewer for this Pandemic Influenza Workbook for Long Term Care Providers.

Public Health Officials
- Know your local public health officials: http://lhadirectory.naccho.org/phdir/search.asp?State=California&Abbr=CA
- Know your state public health contacts: www.pandemicflu.gov/state/statecontacts.html

Disaster Response Contacts
- Contact information for the local branches of the OES, the lead agency in disaster response (although in a public health emergency like a pandemic, responsibility will be shared between OES and public health) may be found through the Office of Emergency Services Web site, at http://www.oes.ca.gov/Operational/OESHome.nsf/NewResourceBranches?OpenForm.
- Know your local public health officials: http://lhadirectory.naccho.org/phdir/search.asp?State=California&Abbr=CA

Pandemic and Avian Flu Informational Resources
- Find copies of this Workbook and other important information for pandemic planning in the Pandemic Influenza section of CAHF’s Disaster Preparedness Program Web site: www.cahf.org/public/dpp/
- Find copies of Dr. Grattan Woodson’s excellent pandemic planning guides for home (useful in helping your staff and residents’ families prepare at home, as well as providing additional information that LTC providers will find useful) at www.birdflumanual.com.
- CDC and HHS have a very useful pandemic influenza Web site: www.pandemicflu.gov. Access a variety of plans (including preparedness checklists), information about the pandemic threat,

- The World Health Organization has the most up-to-date information about the current avian influenza situation: www.who.int/csr/disease/avian_influenza/en.

**Business Continuity Planning Resources**

Links to Free Business Continuity Planning Tools:
- [http://www.tampabaydisaster.org/fldisasterkit/pdfs/template.PDF](http://www.tampabaydisaster.org/fldisasterkit/pdfs/template.PDF)

**Surge Capacity Information**


**Licensing and Regulatory Agencies**

- Facilities licensed under the California Department of Public Health Licensing and Certification Division should go to [www.dhs.ca.gov/lnc](http://www.dhs.ca.gov/lnc), and also visit your local district office Web sites (a list is available at [www.dhs.ca.gov/lnc/org/default.htm](http://www.dhs.ca.gov/lnc/org/default.htm)).
- Facilities licensed/certified under the Department of Social Services Community Care Licensing Division should go to [http://ccld.ca.gov](http://ccld.ca.gov).

**Helpful Training**

- The Agency for Healthcare Research and Quality (AHRQ), part of the federal Department of Health and Human Services, released a new training DVD on April 30, 2007, to teach medical professionals who are not respiratory care professionals how to provide respiratory care and ventilator management. It covers infection control, respiratory care terms and definitions, manual ventilation, mechanical ventilation, airway maintenance and airway suctioning. It was developed as part of project XTREME (Cross-Training Respiratory Extenders for Medical Emergencies). It is available for free by calling (800) 358-9295 or by sending an e-mail to ahrqpubs@ahrq.gov.

- The California Healthcare Association with Kaiser Permanente developed an abbreviated course on SEMS and HICS in May 2007. This course will be archived on the CHA Web site at [http://www.calhospital.org/public/edu/nims.html](http://www.calhospital.org/public/edu/nims.html)

- FEMA on NIMS and ICS [www.training.fema.gov/EMIWeb/IS](http://www.training.fema.gov/EMIWeb/IS). Click on “ISP Course List” link (right side) and find the course you wish to take (you may wish to print out the exam to review as you go through the course). Consider taking:
  - IS100.HC — Introduction to Incident Command System I-100 for Healthcare/Hospitals (alternately, you could take IS-100: Introduction to Incident Command System)
  - IS-200.HC — Applying ICS to Healthcare Organizations
  - IS-700 — National Incident Management
PREVENTING PNEUMONIA DURING A PANDEMIC

By Grattan Woodson, MD, FACP

The “old man’s friend”

Pneumococcal pneumonia has a long and infamous association with mankind. The disease is probably responsible for more human deaths through history than even influenza. The doctors of old dubbed this scourge “the old man’s friend” because of the quick and certain way in which it delivered the coup de grace to the elderly and infirm.

The advent of the antibiotic era

Alexander Fleming’s discovery of the effect a mold had on the growth of staphylococcus in 1928 led eventually to the development of penicillin for clinical use in the early 1940s. The widespread availability of penicillin later that decade changed medical history. While S. pneumoniae was exquisitely sensitive to penicillin for almost 50 years, toward the end of the 20th century this began to change.

Today this bacterium is becoming increasingly resistant to penicillin and several alternative antibiotics, including erythromycin. It is thought that the practice of adding penicillin to cattle feed and its inappropriate use in humans combined to cause this unfortunate development.

The U.S. FDA Indications for Pneumovax®

After being informed of the difficulty people were having obtaining this vaccination from other doctors, I reviewed the U.S. FDA approved indications for Pneumovax® from its product circular, which include:

Immunocompetent persons:

- Routine vaccination for persons 50 years of age or older
- Persons aged ≥ 2 years with chronic cardiovascular disease (including congestive heart failure and cardiomyopathies), chronic pulmonary disease (including chronic obstructive pulmonary disease and emphysema) or diabetes mellitus.
- Persons aged ≥ 2 years with alcoholism, chronic liver disease (including cirrhosis) or cerebrospinal fluid leaks.
- Persons aged ≥ 2 years with functional or anatomic asplenia (including sickle cell disease and splenectomy).
- Persons aged ≥ 2 years living in special environments or social settings (including Alaskan Natives and certain American Indian populations).

Immunocompromised persons:

- Persons aged ≥ 2 years, including those with HIV infection, leukemia, lymphoma, Hodgkin’s disease, multiple myeloma, generalized malignancy, chronic renal failure or nephrotic syndrome; those receiving immunosuppressive chemotherapy (including corticosteroids); and those who have received an organ or bone marrow transplant.

While it is true healthy adults under age 50 and healthy children are not included on the list, this in no way precludes their being given this vaccine.

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80 Pneumovax® product circular, Merck.
The coming influenza pandemic is predicted to be severe. The CDC predicts that post-influenza bacterial pneumonias will complicate the clinical course of 10 percent of those who contract pandemic flu. This amounts to about 10 million cases of pneumonia with many of these cases caused by *S. pneumoniae*. The U.S. Department of Health and Human Services Pandemic Influenza Plan states that, during the pandemic, access to commonly used antibiotics for treatment of post-influenza pneumonia could be in short supply or unavailable. For this reason, it is recommended that Pneumovax® be given to healthy adults and children as part of a key prevention strategy. Below is an excerpt from the HHS PIP regarding this practice:

“Efforts to maximize vaccination coverage against *Streptococcus pneumoniae* is an important component of post-influenza bacterial community-acquired pneumonia prevention during the Interpandemic, Pandemic Alert, and Pandemic Periods. Current guidelines on the use of the 23-valent pneumococcal polysaccharide vaccine among adults and the 7-valent pneumococcal conjugate vaccine among children are available.”

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We may experience shortages or the temporary unavailability of many key drugs during the next influenza pandemic. This scenario is likely to coincide with the height of the pandemic when drug production and distribution could come to a temporary halt. Pharmaceutical manufacturing during the pandemic period could experience production interruptions due to shortages of basic materials and absentee staff. Getting these complex facilities up and running again will take much longer than the time they were closed because of supply, staffing, safety, regulatory and legal concerns.

Some chronic medical conditions are of sufficient severity that great harm could occur to someone unable to continue their drug treatment. Other drug treatments, while important to long term health or present comfort may be ignored in the short or intermediate term without risk of significant harm. For critical medications, a prudent course for consumers is to stockpile a six-month supply to ensure that they will be able to maintain continuous therapy should we experience a severe influenza pandemic.

Stockpile rotation, expiration dates and storage
Those who are able to establish a stockpile would still purchase their regular 30- or 90-day supply of medications for day-to-day use. To keep the drug stockpile fresh, rotate supplies — each time a new prescription is obtained, put it in the stockpile and pull out a month’s worth of the same drug with the least amount of time left before expiration. Drug expiration dates are printed on the container’s label. These dates are very conservative, meaning that almost every drug is still good for years after its expiration date, especially if the drug has been stored properly.

To keep drugs in good condition, the most important consideration is that they be stored properly. Humidity, temperature, air and sunlight are the factors that most affect drug longevity. It is usually best to keep drugs unopened in their original packaging, especially those provided by the manufacturer or the pharmacist. Store the drug stockpile in an airtight plastic container at room temperature. Keep drugs away from moisture and in the dark. Both heat and freezing temperatures can cause drugs to deteriorate and must be avoided.

Critical medications
Medications in the critical “must take” category include those for chronic medical conditions like diabetes, hypertension, emphysema, chronic bronchitis, asthma, coronary artery disease and hypothyroidism. This simple list is for illustration purposes only. There are many other conditions for which treatment must be continued during the pandemic period. Part of your planning activities should include a review of every resident’s med sheet with your medical director or the resident’s physician to determine critical medications. He or she is responsible for advising you on the need for stockpiling a particular drug. For the ones he or she recommends that you stockpile, you will need a prescription for a three-month quantity of the drug, not just a one-month supply with three refills. For instance, if you take one tablet daily, a three-month supply means obtaining a prescription for 90 tablets.

Patients with special medical problems
Patients with organ transplants, insulin-dependent diabetes, active rheumatoid arthritis, AIDS, active systemic lupus erythematositis and other connective-tissue diseases and those taking anti-coagulants

Stockpiling of medications may not be practical for all long term facilities due to storage, reimbursement and/or regulatory limitations. The authors of this Workbook suggest that you review the medication storage and drug reimbursement regulations for your facility type before actually purchasing medications for this purpose to ensure that you can do so within your regulatory and reimbursement restrictions.
will present special management difficulties during a pandemic emergency, especially if the drug supply chain is disrupted. This issue should be discussed with the doctor who may be able to help find available options even during the emergency.

A person on major tranquilizers for psychiatric problems like bipolar disorder and schizophrenia also needs to establish a three-month supply of medication. Similarly, patients on antidepressants for either depression or anxiety disorders should try to continue these medications during the crisis. Discuss this with the resident’s doctor and get his or her opinion.

Non-critical medications
Chronic medical conditions for which medical therapy is optional — meaning that it may be possible to go without treatment in the short-term without much harm — include cholesterol lowering drugs, osteoarthritis treatment and medication for GERD (indigestion and heartburn), migraine headaches, sleeping pills, osteoporosis treatments and hormones. Some patients on anti-seizure medications may find that they can cope without their medication. They may have an occasional seizure, but as long as they are not driving, they can survive. If a patient’s seizures are frequent without treatment, the patient should consider obtaining enough medication for six months.

Rely on the resident’s doctor for advice and guidance
Advice about what medications you need to stockpile for your residents ultimately needs to come from their doctors. The physician is the only person who can competently guide you in these matters. This information about pharmaceutical use is intended to notify facilities that this is an important issue which you and the doctor need to consider.
Appendix F
GLOSSARY

**Airborne spread** – A route of infection where small amounts of virus or particles can float through the air and travel through air currents. These particles can make someone sick even if they were across a large room from a contagious person.

**Alternate care site** – A temporary infirmary where medical services are made available to augment the hospital system in an area during times of healthcare surge.

**Altered standard of care** – During an overwhelming disaster, the priority of those who provide care and allocate scarce healthcare resources will shift to “the greater good” and focus on how to save the largest number of lives in contrast to the traditional focus on saving individuals.

**Amelioration** – A process of making something more tolerable.

**Annex** – The section of a facility’s disaster preparedness plan that describes the specialized actions the facility will take in response to a specific hazard, such as pandemic or other infectious disease outbreaks, extreme hot weather, prolonged power outages, etc. Annexes are designed to augment the core disaster plan which describes the general actions the facility takes during all disasters such as activating the chain of command, communication, staff call backs, plant security, etc.

**Antigen** – Any substance capable of inducing a specific immune response and of reacting with the products of that response.

**Antipyretic** – Reducing or tending to reduce a fever.

**Antiviral medications** – Drugs used to prevent or cure a disease caused by a virus, by interfering with the ability of the virus to multiply in number or spread from cell to cell. Used prophylactically (in anticipation of, or directly after, exposure) these drugs *may* prevent some or many infections with pandemic influenza, but it is presently unclear which antiviral, if any, will be effective. There is also significant concern that these drugs will be in limited supply if a pandemic starts in the near future.

**Aspirate** – Secretions obtained during suction from the nose or throat used in the testing for influenza.

**Asymptomatic** – To be without symptoms, despite infection.

**Attenuated** – A thinned or weakened infectious organism.

**Avian influenza virus (H5N1)** – A strain of influenza A viruses found chiefly in birds. H5N1 is highly contagious in birds and can be deadly. While it does not usually infect people, more than 200 human cases have been reported. Most of those cases have occurred from direct or close contact with infected poultry or contaminated surfaces; however, a few cases of human-to-human spread have occurred. If the H5N1 virus were to gain the capacity to spread easily from person to person, an influenza pandemic could occur.

**Business continuity** – Ensuring that your facility’s essential business functions can survive a natural disaster, technological failure, human error or other disruption.

**BCP** – Business Continuity Plan
CAHF – California Association of Health Facilities.

Cal/OSHA – California Occupational Safety and Health Administration, responsible for enforcing California laws and regulations pertaining to workplace safety and health and for providing assistance to employers and workers about workplace safety and health issues.

CDC – U.S. Center for Disease Control and Prevention.

CDHS – California Department of Health Services, reorganized as the California Department of Health Care Services and the California Department of Public Health as of July 1, 2007.

CDPH – California Department of Public Health. Prior to July 1, 2007, its services were part of the California Department of Health Services (CDHS).

Cohort – To place together patients in a care facility who have like symptoms and/or diagnosis for the purposes of infection control and efficiency of care.

Comfort care – End-of-life care designed to provide comfort and dignity when curative therapy is no longer available or appropriate. It includes the process of relieving pain and suffering and controlling debilitating symptoms as much as possible while not preventing the patient from dying.

Contact spread – A route of infection where a person contracts a disease through direct contact with the saliva, nasal secretions or feces of infected animals or humans.

Direct care staff – Healthcare workers whose primary responsibility is to provide care to residents that requires them to come within three feet.

Doff – To remove an article of clothing.

Don – To put on an article of clothing.

Droplet spread – A route of infection where the coughing or sneezing of an infected person expels droplets into the air that carry small amounts of the virus that can make someone sick. The droplets travel only about three feet because they are too large to stay suspended in the air for any length of time. If a droplet comes in contact with a person’s eyes, nose or mouth, it can cause infection with the illness.

EOC – Emergency Operations Center.

External PI Committee – In a county or city, a specific disaster planning committee that deals with pandemic planning for that local entity. It is usually convened by the local public health department.


Hospital Incident Command System (HICS) – Originally developed in 1980s and known as Hospital Emergency Incident Command Systems (HEICS), it is an emergency management system for hospitals that incorporates the concepts and structure of incident command, NIMS and SEMS.

Immunocompromised – Incapable of developing a normal immune response, usually the result of disease, malnutrition or immunosuppressive therapy.
Incident Command System (ICS) – A management system used to organize emergency response. It was developed in the 1970s following a series of catastrophic fires in California.

Incubation period – The time from the moment of exposure to an infectious agent until the signs and symptoms of the disease appear.

Inoculation – The placement of an organism where it will grow or reproduce.

Internal PI Committee – A multidisciplinary Pandemic Influenza (PI) Planning Committee for the facility. This can be a newly formed new committee or an expanded already-existing committee such as quality improvement, infection control or resident rights. This committee should include physicians and clinical, administrative, purchasing, engineering or maintenance personnel and others as needed and as available at the facility. This committee will oversee the development and implementation of the facility’s pandemic plan.

Isolation – Separation of ill persons with a contagious disease from people who do not have the disease.

“Just in time” training – The technique of preparing newly recruited or reassigned workers to their task at the point in time when they are needed. This kind of training requires having training materials ready and trainers and supervision available so that new workers can be quickly and safely utilized in an emergency.

Long term care (LTC) facilities – Small and large licensed residential institutions that care for the elderly, people with developmental disabilities or chronic mentally illness and/or other medically fragile individuals who require 24-hour care and supervision. They can be licensed by the California Department of Public Health or the California Department of Social Services, depending on the type of residents they serve and the services they offer.

Mass fatality event – An incident that causes more deaths than can be managed locally with available resources.

N-95 mask (or respirator) – A face mask that filters out 95 percent of the particles that are drawn to the mask by respiration. “N” means it is not resistant to oil. It is a physical barrier that fits over the mouth and nose and makes a seal so that air only passes through the filter. This air passage is what differentiates a mask, which is a physical a barrier against droplets from a respirator. N-95s should be fit-tested to make sure that the seal is tight and air is not able to leak in from the sides.

Nasopharyngeal – The nose and pharynx or the nasopharynx area.

Nebulizer – A medical device used to humidify oxygen and/or deliver medications in the form of a fine spray that is breathed through the nose or the mouth.

NIMS – National Incident Management System mandated by Homeland Security Presidential Directive 5 to provide a consistent nationwide approach for federal, state, local and tribal governments to respond to and recover from domestic incidents.

Non-pharmaceutical – Measures to prevent or limit the spread of a disease that do not include the use of drugs or vaccines. Non-pharmaceutical measures include isolation, quarantine, social distancing and infection control.
Novel strain – A microorganism that evolves or emerges to which humans have limited or no immunity.

OES – Office of Emergency Services. The Governor’s Office of Emergency Services is the state agency that coordinates the response activities of all local and state agencies. In addition, OES coordinates the integration of federal resources into state and local response and recovery operations.

Operational Area (OA or Op Area) – A county and all its political subdivisions, including special districts. The county government is the lead agency unless otherwise specified. There are 58 Operational Areas (counties) in California. The Op Area manages and coordinates resources from its Emergency Operations Center (EOC).

Pandemic – Worldwide outbreak of an infectious disease.

Personal protective equipment (PPE) – Equipment that prevents contact with potentially toxic or infectious substances. PPE refers to gloves, masks, respirators, face shields, eye protection and various protective suits.

PIO – Public information officer.

Pneumonia – A disease of the lungs resulting in inflammation and consolidation.

Pneumococcal – A bacterial (Streptococcus pneumoniae) organism that causes acute pneumonia in one or more lobes of the lung.

PPE – Personal protective equipment.

Prophylactic – Measures used in anticipation of, or directly after, exposure to an infectious disease intended to prevent or reduce the severity of infection in the exposed person. (Ex: antibiotics, antiviral).

PSI – Pandemic Severity Index, developed by the U.S. Centers for Disease Control and Prevention (CDC) to indicate the severity of a pandemic, based upon the percentage of likely deaths. The PSI is similar to the categories used to designate the severity of hurricanes and will be used to help guide the response activities that should be taken. A Category 4 or 5 designates the greatest severity and indicates that extreme measures will be required.

Quarantine – Separation or restriction of movement of select person(s) who have been exposed to a disease but are not ill.

Residents – Generic term used to identify clients, patients, members, consumers and/or people who live in and receive care in a long term care facility.

Respiratory etiquette – An infection control strategy for respiratory illness that includes visual alerts to remind people to cover their coughs and sneezes, dispose of their tissues and wash their hands.

SEMS – Standardized Emergency Management System, enacted by state law in 1991 as a result of the Oakland Hills Fires, in an effort to standardize the way that different organizations and agencies respond to disasters in California.

Social distancing – Reduction or elimination of contact among people during periods of disease outbreak. This can be done through maintaining a distance of three feet or more when around others, and avoiding crowds and public gatherings whenever possible. Social distancing could also involve the
cancellation of public events, school closures, telecommuting rather than reporting to the workplace and other measures.

**Surge capacity** – The ability of the healthcare system to rapidly expand beyond its normal services to meet the increased demand for qualified personnel, medical care and public health in the event of a large scale disaster.

**Vaccination** – A suspension of killed or attenuated microorganisms administered for the prevention, amelioration or treatment of an infectious disease. Vaccine is one of the most effective ways to minimize suffering and death from influenza. Efforts are underway to develop and manufacture a vaccine for pandemic influenza; however, experts agree that it will take several months after the emergence of a pandemic outbreak for there to be sufficient amounts of an effective vaccine available to the public.

**WHO** – World Health Organization.
## Crosswalk of Emergency Management Regulations

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<tr>
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<tbody>
<tr>
<td>Hospitals are not bound by NFPA regulations, but this program provides a good framework for Emergency Management</td>
<td>Element 1 Adopt the National Incident Management System (NIMS) at the organizational level for all appropriate departments and business units, as well as promote and encourage NIMS adoption by associations, utilities, partners and suppliers.</td>
<td>70741 (a) A written disaster and mass casualty program shall be developed and maintained in consultation with representatives of the medical staff, nursing staff, administration and fire and safety experts. The program shall be in conformity with the California Emergency Plan of October 10, 1972 developed by the State Office of Emergency Services and the California Emergency Medical Mutual Aid Plan of March 1974 developed by the Office of Emergency Services, Department of Health. The program shall be approved by the medical staff and administration. A copy of the program shall be available on the premises for review by the Department.</td>
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<tr>
<td>NFPA 1600</td>
<td>NIMS</td>
<td>The Joint Commission</td>
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<td><strong>Program Coordinator: 4.2</strong>&lt;br&gt;The program coordinator shall be appointed by the entity and authorized to administer and keep current the program.</td>
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<td><strong>Advisory Committee: 4.3</strong>&lt;br&gt;1. An advisory committee shall be established by the entity in accordance with its policy.&lt;br&gt;2. The advisory committee shall provide input to or assist in the coordination of the preparation, implementation, evaluation, and revision of the program.&lt;br&gt;3. The advisory committee shall include the program coordinator and others who have the appropriate expertise, knowledge of the entity, and the capability to identify resources from all key functional areas within the entity and shall solicit applicable external representation.</td>
<td><strong>Element EC 4.11 (1)</strong>&lt;br&gt;The organization’s leaders (HAP: including those of the medical staff)(LTC, LT2: including the administrator, the medical director, the nursing leader, and other clinical leaders) actively participate in emergency management planning.</td>
<td><strong>70741 (a)</strong>&lt;br&gt;A written disaster and mass casualty program shall be developed and maintained in consultation with representatives of the medical staff, nursing staff, administration and fire and safety experts.</td>
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<td><strong>70743 (a)</strong>&lt;br&gt;A written fire and internal disaster program, incorporating evacuation procedures, shall be developed with the assistance of fire, safety and other appropriate experts. A copy of the program shall be available on the premises for review by the Department.</td>
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<td><strong>Program Evaluation: 4.4</strong>&lt;br&gt;1. The entity shall establish performance objectives for program management addressed in Chapter 4 and program elements identified in Chapter 5&lt;br&gt;2. The entity shall conduct a periodic evaluation of the program based on the objectives.</td>
<td><strong>Element EC 4.11 (11)</strong>&lt;br&gt;The objectives, scope, performance, and effectiveness of the organization’s emergency management planning efforts are evaluated at least annually.</td>
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<tr>
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<tr>
<td><strong>General Program Elements: 5.1</strong></td>
<td></td>
<td>Rationale EC 4.11</td>
<td>70741 (b)</td>
</tr>
<tr>
<td>1. The program shall include the elements given in Section 5.2 – 5.16, the scope of which shall be determined by the impact of the hazards affecting the entity.</td>
<td></td>
<td>An emergency in a health care organization or in its community can suddenly and significantly affect demand for its services or its ability to provide those services. Therefore, it is important that organizations define a comprehensive approach to identifying risks and mobilizing an effective response within the organization as well as in collaboration and co-ordination with essential response partners in the community.</td>
<td>The program shall cover disasters occurring in the community and widespread disasters.</td>
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<td>2. The program elements shall be applicable to prevention, mitigation, preparedness, response, and recovery.</td>
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<td>Elements 4.11 (4-8)</td>
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<td>When developing its emergency operations plan (see Standard EC.4.12), the organization communicates its needs and vulnerabilities to community emergency response agencies and identifies the capabilities of its community in meeting their needs. For each emergency identified in its HVA, the organization defines (EPs 5-8):</td>
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<td></td>
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<td>• Mitigation activities designed to reduce the risk of and potential damage due to an emergency</td>
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<td>• Preparedness activities that will organize and mobilize essential resources</td>
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<td>• Response strategies and actions to be activated during the emergency</td>
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<td></td>
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<td>• Recovery strategies and actions designed to help restore the systems that are critical to resuming normal care, treatment and services</td>
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<td><strong>Laws and Authorities: 5.2</strong></td>
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<tr>
<td>1. The program shall comply with applicable legislation, policies, regulatory requirements, and directives.</td>
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<td>2. The entity shall implement a strategy for addressing need for revisions to legislation, regulations, directives, policies, and industry codes of practice.</td>
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### NFPA 1600

**Risk Assessment: 5.3**
1. The entity shall identify hazards, monitor those hazards, the likelihood of their occurrence and the vulnerability of people, property, the environment, and the entity itself to those hazards.
2. Hazards to be evaluated shall include the following:
   - Natural hazards (geological, meteorological, and biological)
   - Human-caused events (accidental and intentional)
   - Technological-caused events
3. The entity shall conduct an impact analysis to determine the potential detrimental impacts of the hazards on the following:
   - Health and safety of persons in the affected area at the time of the incident (injury and death)
   - Health and safety of personnel responding to the incident
   - Continuity of operations
   - Property, facilities, and infrastructure
   - Delivery of services
   - The environment
   - Economic and financial condition
   - Regulatory and contractual obligations
   - Reputation of or confidence in the entity
   - Regional, national, and international considerations

### NIMS

**Element EC 4.11 (2)**
The organization conducts a Hazard Vulnerability Analysis (HVA) to identify events that could affect demand for its services or its ability to provide those services, the likelihood of those events occurring, and the consequences of those events. Note: the HVA is evaluated at least annually as part of EP11.

**Element EC 4.11 (3)**
The organization (CAH, HAP: together with its community partners) prioritizes those hazards, threats and events identified in its HVA.

### The Joint Commission

### Calif. Code of Regulations

70741 (b)
The program shall cover disasters occurring in the community and widespread disasters.
<table>
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<tr>
<th>NFPA 1600</th>
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<th>Calif. Code of Regulations</th>
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<tr>
<td><strong>Incident Prevention  5.4</strong>&lt;br&gt;1. The entity shall develop a strategy to prevent an incident that threatens people, property, and the environment.&lt;br&gt;2. The prevention strategy shall be based on the information obtained from Section 5.3 and shall be kept current using the techniques of information collection and intelligence.&lt;br&gt;3. The entity shall have a system to monitor the identified hazards and adjust the level of preventative measures to be commensurate with the risk.</td>
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<td><strong>Mitigation: 5.5</strong>&lt;br&gt;1. The entity shall develop and implement a mitigation strategy that includes measures to be taken to limit or control the consequences, extent, or severity of an incident that cannot be reasonably prevented.&lt;br&gt;2. The mitigation strategy shall be based on the results of hazard identification and risk assessment, impact analysis, program constraints, operational experience, and cost-benefit analysis.&lt;br&gt;3. The mitigation strategy shall include interim and long term actions to reduce vulnerability</td>
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## Resource Management and Logistics: 5.6

1. The entity shall establish resource management objectives consistent with the overall program goals and objectives as identified in Section 4.1 for the hazards as identified in Section 5.3

2. The entity shall establish procedures to locate, acquire, store, distribute, maintain, test, and account for services, personnel, resources, materials, and facilities procured or donated to support the program

3. The resource management objectives established shall include the following:
   - Personnel, equipment, training, facilities, funding, expert knowledge, materials, technology, information, intelligence, and the time frames within which they will be needed
   - Quantity, response time, capability, limitations, cost, and liability connected with using the involved resources
   - Resources and any needed partnership arrangements essential to the program

### Element 15
Maintain an inventory of organizational response assets.

### Element 16
To the extent permissible by law, ensure that relevant national standards and guidance to achieve equipment, communication, and data interoperability are incorporated into acquisition programs.

### Elements EC 4.11 (9)
The organization keeps a documented inventory of the assets and resources it has on-site, that would be needed during an emergency (at a minimum, personal protective equipment, water, fuel, staffing, medical, (CAH, HAP: surgical,) and pharmaceuticals resources and assets).

Note: The inventory is evaluated at least annually as part of EP 11.

### Elements EC 4.11 (10)
The organization establishes methods for monitoring quantities of assets and resources during an emergency.

### Standard EC.4.14
The organization establishes strategies for managing resources and assets during emergencies. (CAH: Corresponds to COP 485.623 (c)(3) and (c)(4))

### Rationale for EC.4.14
During emergencies, health care organizations that continue to provide care, treatment and services to their patients must sustain essential resources, materials, and facilities. The emergency operation plan should identify how resources and assets will be solicited and acquired from a range of possible sources, such as vendors, neighboring health care providers, other community organizations, state affiliates, or a regional parent company. To address emergency of long duration or broad geographic scope, the organization’s plan must proactively identify, locate, acquire, distribute and account for critical resources and supplies. The plan should also recognize the risk that some assets may not be available from planned sources and that contingency plans will be necessary for critical supplies. This situation may occur when multiple organizations are vying for a limited supply from the same vendor.

The infrastructure for supplying and supporting the health care organization is complex, and the Hazard Vulnerability Analysis will help identify risks to this infrastructure that can be mitigated. Planning must address managing and maintaining the facility, but also must consider evacuation of the entire facility when the environment is no longer deemed safe.
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<tr>
<td><strong>Resource Management and Logistics, continued</strong></td>
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<td><strong>Element EC.4.14 (1-11)</strong></td>
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<td>4. Resource management shall include the following tasks:</td>
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<td>The organization plans for the following (EPs 1-11):</td>
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<td>• Establishing processes for describing, inventorizing, requesting, and tracking resources</td>
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<td>• Obtaining supplies that will be required at the onset of emergency response (medical, pharmaceutical and non-medical)</td>
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<td>• Activating these processes prior to and during an incident</td>
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<td>• Replenishing medical supplies and equipment that will be required throughout response and recovery, including personal protective equipment where required</td>
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<td>• Dispatching resources prior to and during an incident</td>
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<td>• Replenishing pharmaceutical supplies that will be required throughout response and recovery, including access to and distribution of caches (stockpiled by the organization or its affiliates, local state or federal sources) to which the organization has access.</td>
<td>(3)</td>
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<td>• Deactivating or recalling resources during or after incidents</td>
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<td>• Replenishing non-medical supplies that will be required throughout response and recovery (for example, food, linen, water, fuel for generators and transportation vehicles)</td>
<td>(4)</td>
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<td>• Contingency planning for shortfalls of resources</td>
<td></td>
<td>• Managing staff support activities (for example, housing, transportation, incident stress debriefing)</td>
<td>(5)</td>
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<tr>
<td>5. An assessment shall be conducted to identify the resource capability shortfalls and the steps necessary to overcome any shortfalls.</td>
<td></td>
<td>• Managing staff family support needs (for example, child care, elder care, communication)</td>
<td>(6)</td>
</tr>
<tr>
<td>6. A current inventory of internal and external resources shall be maintained.</td>
<td></td>
<td>• Potential sharing of resources and assets (for example, personnel, beds, transportation, linens, fuel, personal protective equipment, medical equipment and supplies) with other health care organizations within the community that could potentially be shared in an emergency response</td>
<td>(7)</td>
</tr>
<tr>
<td>Donations of goods, services, personnel, and facilities, solicited and unsolicited, and the management thereof, shall be addressed.</td>
<td></td>
<td>• Potential sharing of resources and assets with health care organizations outside of the community in the event of a regional or prolonged disaster</td>
<td>(8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Evacuating (both horizontally and, when required by circumstances, vertically) when the environment cannot support care, treatment, and services</td>
<td>(9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Transporting patients, their medications and equipment, and staff to an alternative care site or sites when the environment cannot support care, treatment, and services</td>
<td>(10)</td>
</tr>
<tr>
<td><strong>NFPA 1600</strong></td>
<td><strong>NIMS</strong></td>
<td><strong>The Joint Commission</strong></td>
<td><strong>Calif. Code of Regulations</strong></td>
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<tr>
<td><strong>Resource Management and Logistics, continued</strong></td>
<td></td>
<td>• Transporting pertinent information, including essential clinical and medication-related information, for patients to an alternative care site or sites when the environment cannot support care, treatment, and services (11)</td>
<td></td>
</tr>
</tbody>
</table>

**Standard EC.4.17**
The organization establishes strategies for managing utilities during emergencies. (CAH: Corresponds to COP 485.623 (c)(3) and (c)(4))

**Rationale EC.4.17**
Different types of emergencies can have the same detrimental impact on an organization's utility systems. For example, brush fires, ice storms, and industrial accidents can all result in a loss of utilities required for care, treatment, services, related transport and building operations. Organizations, therefore, must have alternative means of providing for essential utilities, whether through: negotiated relationships with the primary supplies; Memoranda of Understanding (MOUs) with other organizations in the community alternative equipment at the organization; or provision through a parent entity, etc. Organizations should determine how long they expect to remain open to care for patients, and plan for their utilities accordingly. Because some emergencies may be regional in scope or of long duration, organizations should not rely solely on single source providers in the community. Where possible, organizations should identify other suppliers outside of the local community in case the communities' infrastructure is severely compromised and unable to support the organization.
<table>
<thead>
<tr>
<th><strong>Resource Management and Logistics, continued</strong></th>
<th><strong>Element EC.4.17 (1-5)</strong></th>
<th><strong>Standard HR.1.25</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizations identify an alternative means of providing for the following utilities in the event that their supply is compromised or disrupted (EPs 1-5):</td>
<td></td>
<td>The organization may assign disaster responsibilities to volunteer practitioners.</td>
</tr>
<tr>
<td>• Electricity (1)</td>
<td></td>
<td><strong>HR.1.25 Element 1</strong></td>
</tr>
<tr>
<td>• Water needed for consumption and essential care activities (2)</td>
<td></td>
<td>Disaster responsibilities are assigned only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate patient needs.</td>
</tr>
<tr>
<td>• Water needed for equipment and sanitary purposes (3)</td>
<td></td>
<td><strong>HR.1.25 Element 2</strong></td>
</tr>
<tr>
<td>• Fuel required for building operations or essential transport activities (4)</td>
<td></td>
<td>The organization identifies in writing the individual(s) responsible for assigning disaster responsibilities.</td>
</tr>
<tr>
<td>• Other essential utility needs (for example, ventilation, medical gas/vacuum systems) (5)</td>
<td></td>
<td><strong>HR.1.25 Element 3</strong></td>
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<td></td>
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<td>The organization describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who are assigned disaster responsibilities.</td>
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<td></td>
<td></td>
<td><strong>HR.1.25 Element 4</strong></td>
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<td>The organization has a mechanism to identify volunteer practitioners that have been assigned disaster responsibilities.</td>
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<td>NFPA 1600</td>
<td>NIMS</td>
<td>The Joint Commission</td>
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<tr>
<td>Resource Management and Logistics, continued</td>
<td></td>
<td>HR.1.25 Element 5</td>
</tr>
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<td>Volunteer practitioners must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:</td>
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<td>• A current hospital picture identification card that clearly identifies professional designation</td>
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<td>• A current license, certification, or registration</td>
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<tr>
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<td>• Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession)</td>
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<td>• Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups</td>
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<td>• Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)</td>
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<td></td>
<td>• Identification by current organization member(s) who possesses personal knowledge regarding the volunteer practitioner's qualifications.</td>
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<td>HR.1.25 Element 6</td>
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<td></td>
<td>Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.</td>
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<td>HR.1.25 Element 7</td>
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<td>The organization oversees the professional practice of volunteer practitioners.</td>
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<td>HR.1.25 Element 8</td>
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<td></td>
<td>The organization makes a decision (based on information obtained regarding the professional practice of the volunteer practitioner) within 72 hours related to the continuation of the disaster responsibilities initially assigned.</td>
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</table>
### Resource Management and Logistics, continued

<table>
<thead>
<tr>
<th>NFPA 1600</th>
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</thead>
<tbody>
<tr>
<td><strong>Standard MS.4.110</strong>&lt;br&gt;The organization may grant disaster privileges to volunteers eligible to be licensed independent practitioners.&lt;br&gt;&lt;br&gt;<strong>MS.4.110 Element 1</strong>&lt;br&gt;Disaster privileges are granted only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet patient needs.&lt;br&gt;&lt;br&gt;<strong>MS.4.110 Element 2</strong>&lt;br&gt;As described in the bylaws, the individual(s) responsible for granting disaster privileges is identified.&lt;br&gt;&lt;br&gt;<strong>MS.4.110 Element 3</strong>&lt;br&gt;The medical staff describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who receive disaster privileges.&lt;br&gt;&lt;br&gt;<strong>MS.4.110 Element 4</strong>&lt;br&gt;The organization has a mechanism to readily identify volunteer practitioners who have been granted privileges.&lt;br&gt;&lt;br&gt;<strong>MS.4.110 Element 5</strong>&lt;br&gt;While disaster privileges are granted on a case-by-case basis, volunteers considered eligible to act as licensed independent practitioners in the organization must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport) and at least one of the following:&lt;br&gt;- A current picture hospital ID card that clearly identifies professional designation&lt;br&gt;- A current license to practice&lt;br&gt;- Primary source verification of the license&lt;br&gt;- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups</td>
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<tr>
<td>Resource Management and Logistics,</td>
<td></td>
<td>• Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)</td>
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<td>continued</td>
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<td>• Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding the volunteer’s ability to act as a licensed independent practitioner during a disaster</td>
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<td></td>
<td><strong>MS.4.110 Element 6</strong> Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.</td>
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<td><strong>MS.4.110 Element 7</strong> The medical staff oversees the professional practice of volunteer licensed independent practitioners.</td>
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<td><strong>MS.4.110 Element 8</strong> The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.</td>
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<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<td><strong>Element 5</strong> Hospitals and healthcare systems will track NIMS implementation annually as part of the organization’s emergency management program.</td>
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<td></td>
<td><strong>Standard EC.4.12</strong> The organization develops and maintains an Emergency Operations Plan.</td>
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<td><strong>Rationale for EC.4.12</strong> A successful response relies upon planning around the management of six critical areas: communications; resources and assets; safety and security; staffing; utilities; and clinical activities. It is important for</td>
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<td></td>
<td><strong>70741 (b)(4)</strong> Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care.</td>
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<td><strong>Mutual Aid/Assistance:  5.7</strong></td>
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<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<tr>
<td>1. The need for mutual aid/assistance</td>
<td></td>
<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<td>shall be determined</td>
<td></td>
<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<tr>
<td>2. If mutual aid/assistance is needed,</td>
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<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<td>agreements shall be established.</td>
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<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<td>3. Mutual aid/assistance agreements</td>
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<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<td>shall be referenced in the program</td>
<td></td>
<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<td>plan.</td>
<td></td>
<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<tr>
<td><strong>Planning:  5.8</strong></td>
<td></td>
<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
<td></td>
</tr>
<tr>
<td>1. Planning Process-</td>
<td></td>
<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<tr>
<td>• The program shall follow a planning</td>
<td></td>
<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<tr>
<td>process that develops plans for the</td>
<td></td>
<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<td>strategy, prevention, mitigation,</td>
<td></td>
<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<td>emergency operations/response,</td>
<td></td>
<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<tr>
<td>business continuity, and recovery.</td>
<td></td>
<td><strong>Element 8</strong> Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and/or non-governmental organizations.</td>
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<td>The Joint Commission</td>
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</table>
| **Planning, continued** | **Element 7** Revise and update plans [i.e. Emergency Operations Plan (EOPs)] and standard operating procedures (SOPs) to incorporate NIMS components, principles and policies, to include planning, training, response, exercises, equipment, evaluation and corrective actions. | organizations to develop a comprehensive Emergency Operations Plan (EOP) as documentation to help guide the organization in its emergency response and recovery efforts. While the EOP can be formatted in a variety of ways, it must address these six critical areas to serve as a blueprint for managing care and safety during an emergency. Some emergencies can escalate unexpectedly and strain the organization and the entire community. An organization cannot mitigate risks, plan thoroughly, and sustain an effective response and recovery without preparing its staff and collaborating with the community, suppliers and external response partners as well. Such an approach will aid the organization in developing a scalable response capability and in defining the timing and criteria for decisions that involve sheltering in place, patient transfer, facility closings, or evacuation. | **70743 (b)** The written program shall include at least the following:  
(1) Plans for the assignment of personnel to specific tasks and responsibilities.  
(2) Instructions relating to the use of alarm systems and signals.  
(3) Information concerning methods of fire containment.  
(4) Systems for notification of appropriate persons.  
(5) Information concerning the location of fire fighting equipment.  
(6) Specification of evacuation routes and procedures.  
(7) Other provisions as the local situation dictates. |
<p>| The entity shall engage in the planning process on a regularly scheduled basis or when the situation has changed to put the accuracy of the existing plan into question. | <strong>Element EC.4.12 (1)</strong> The organization develops and maintains a written Emergency Operations Plan (EOP) that describes an “all hazards” command structure for coordinating six critical areas (see EC.4.13 through EC.4.18) within the organization during an emergency. |  |  |
| Where applicable, the entity shall include key stakeholders in the planning process. | <strong>Element EC.4.12 (6)</strong> The EOP identifies the organization’s capabilities and establishes response efforts when the organization cannot be supported by the local community for at least 96 hours in the six critical areas. Note: An acceptable response effort would be to temporarily close or evacuate the facility, consistent with their designated role in their community response plan. |  |  |
| 2. Common Plan Elements- | <strong>Element EC.4.12 (7)</strong> The EOP identifies alternative sites for care, treatment or service that meet the needs of its patients during emergencies. |  |  |
| • Plans shall have clearly stated objectives. |  |  |  |
| • Plans shall identify functional roles and responsibilities of internal and external agencies, organizations, departments, and positions. |  |  |  |
| • Plans shall identify lines of authority for these agencies, organizations, departments, and positions. |  |  |  |
| • Plans shall identify logistics support and resource requirements. |  |  |  |
| • Plans shall identify the process for managing an incident. |  |  |  |
| • Plans shall identify the process for managing the communication and flow of information, both internally and externally. |  |  |  |
| 3. Plans- |  |  |  |
| • The program shall include a strategic plan, an emergency operations/ response plan, a prevention plan, a mitigation plan, a recovery plan, and a continuity plan. |  |  |  |
| • The plans developed shall be either individual or integrated into a single plan document, or a combination, of the two. |  |  |  |</p>
<table>
<thead>
<tr>
<th>NFPA 1600</th>
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<tr>
<td>Planning, continued</td>
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<tr>
<td>• The strategic plan shall define the vision, mission, goals, and objectives of the program. (See Section 4.1) The emergency operations/response plan shall assign responsibilities for carrying out specific actions in an emergency.</td>
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<tr>
<td>• The prevention plan shall establish interim and long-term actions to eliminate hazards that impact the entity.</td>
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<td>• The mitigation plan shall establish interim and long-term actions to reduce the impact of hazards that cannot be eliminated.</td>
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<td>• The recovery plan shall provide for short-term and long-term priorities for restoration of functions, services, resources, facilities, programs, and infrastructure.</td>
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<tr>
<td>• The continuity plan shall identify stakeholders that need to be notified, the critical and time-sensitive applications, alternative work sites, vital records, contact lists, processes, and functions that shall be maintained, as well as the personnel, procedures, and resources that are needed while the entity is recovering.</td>
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<td>The entity shall make appropriate sections of the plans available to those assigned specific tasks and responsibilities therein and to other stakeholders as required.</td>
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<tr>
<td>Incident Management: 5.9</td>
<td>Element 2</td>
<td>Element EC.4.12 (2)</td>
<td>Element EC.4.12 (4-5)</td>
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<tr>
<td>1. The entity shall develop an incident management system to direct, control, and coordinate response and recovery operations.</td>
<td>Manage all emergency incidents, exercises and preplanned (recurring/special) events in accordance with ICS organizational structures, doctrine, and procedures, as defined in NIMS. ICS implementation must include consistent application of Incident Action Planning and Common Communications Plans.</td>
<td>The EOP establishes an incident command structure (CAH, HAP: that is integrated into and consistent with its community’s command structure).</td>
<td>The EOP identifies to whom staff report in the organization’s incident command structure. The EOP describes processes for initiating and terminating the response and recovery phases, including the following (EPs 4 and 5):</td>
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<tr>
<td>2. The incident management system shall describe specific organizational roles, titles, and responsibilities for each incident management function.</td>
<td>Element 3</td>
<td>70741 (b)(2)</td>
<td>70741 (b)(3)</td>
</tr>
<tr>
<td>3. The entity shall establish applicable procedures and policies for coordinating response, continuity, and recovery activities with stakeholders directly involved in response, continuity, and recovery operations.</td>
<td>Coordinates and supports emergency incident and event management through the development and use of integrated multi-agency coordination systems (MACs). That is, develop and coordinate connectivity capability with Hospital Command Center (HCC) and local Incident Command Posts (ICPs), local 911 centers, local Emergency Operations Centers (EOCs), the state EOC and others as applicable.</td>
<td>An efficient system of notifying and assigning personnel.</td>
<td>Unified medical command.</td>
</tr>
<tr>
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<tr>
<td>Incident Management, continued</td>
<td></td>
<td>Element EC.4.16 (1) Staff roles and responsibilities are defined in the Emergency Operations Plan for all six critical areas (communications, resources and assets, safety and security, utilities and clinical activities).</td>
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<td>Element EC.4.16 (2) Staff are trained for their assigned roles during emergencies.</td>
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<td>Element EC.4.16 (3) The organization communicates to licensed independent practitioners their roles in emergency response and to whom they report during an emergency.</td>
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<td>Element EC.4.16 (4) The organization establishes a process for identifying care providers and other personnel (such as identification cards, wrist bands, vests, hats, badges, computer printouts) assigned to particular areas during emergencies.</td>
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<tr>
<td>Communications and Warning: 5.10</td>
<td></td>
<td>Standard EC.4.13 The organization establishes emergency communications strategies.</td>
<td></td>
</tr>
<tr>
<td>1. Communications systems shall be established and regularly tested to support the program.</td>
<td></td>
<td>Rationale for EC.4.13 The organization maintains reliable surveillance and communications capability to detect emergencies and communicate response efforts to organization response personnel, patients and their families, and external agencies. The organization plans for backup communications processes and technologies (for example, cell phones, land lines, bulleting boards, fax machines, satellite phones, ham radio, text messages) if primary communications systems fail. It is important that responders and incident managers use common terminology.</td>
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<td>2. Communication procedures shall be established by the entity and regularly exercised to support the program.</td>
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<td>3. The entity shall develop and maintain the capability to alert officials and emergency response personnel.</td>
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<td>4. Emergency communications and warning protocols, systems, processes, and procedures shall be developed, periodically tested, and used to alert people potentially impacted by an actual or impending emergency.</td>
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</table>
### Communications and Warning, continued

5. The entity shall determine communication needs, provide capabilities to execute plans, and review and address the interoperability of multiple responding organizations.

<table>
<thead>
<tr>
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<td></td>
<td>5. The entity shall determine communication needs, provide capabilities to execute plans, and review and address the interoperability of multiple responding organizations.</td>
<td><strong>Element EC.4.13 (1)</strong>&lt;br&gt;The organization plans for notifying staff when emergency response measures are initiated.</td>
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<td><strong>Element EC.4.13 (2)</strong>&lt;br&gt;The organization plans for ongoing communication of information and instructions to its staff once emergency response measures are initiated.</td>
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<td><strong>Element EC.4.13 (3)</strong>&lt;br&gt;The organization defines processes for notifying external authorities when emergency response measures are initiated.</td>
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<td><strong>Element EC.4.13 (4)</strong>&lt;br&gt;The organization plans for communicating with external authorities once emergency response measures are initiated.</td>
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<td><strong>Element EC.4.13 (5)</strong>&lt;br&gt;The organization plans for communicating with patients and their families during emergencies, including notification when patients are relocated to alternative care sites.</td>
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<td><strong>Element EC.4.13 (6)</strong>&lt;br&gt;The organization defines the circumstances and plans for communicating with the community and/or the media during emergencies.</td>
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<td><strong>Element EC.4.13 (7)</strong>&lt;br&gt;The organization plans for communicating with purveyors of essential supplies, services, and equipment once emergency measures are initiated.</td>
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<tr>
<td>Communications and Warning, continued</td>
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<td>Element EC.4.13 (12)</td>
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<td>The organization plans for communicating in a timely manner with other health care organizations that together provide services to a contiguous geographic area (for example, among health care organizations serving a town or borough) regarding the following (EPs 8-11)</td>
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<td>• Essential elements of their command structures and control centers for emergency response (8)</td>
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<td>• Names and roles of individuals in their command structures and command center telephone numbers (9)</td>
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<td>• Resource and assets that potentially could be shared in an emergency response (10)</td>
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<td>• Names of patients and deceased individuals brought to their organizations in accordance with applicable law and regulation, when requested (11)</td>
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<td>The organization defines the circumstances and plans for communicating information about patients to third parties (such as other health care organizations, the state health department, police, Federal Bureau of Investigation).</td>
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<td>Element EC.4.13 (13)</td>
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<td>The organization plans for communicating with identified alternative care sites.</td>
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<td>Element EC.4.13 (14)</td>
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<td>The organization establishes backup communication systems and technologies for the activities identified above.</td>
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### NFPA 1600 | NIMS | The Joint Commission | Calif. Code of Regulations
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**Operations and Procedures:** 5.11

1. The entity shall develop, coordinate, and implement operational procedures to support the program and execute its plans.

2. Procedures shall be established and implemented to respond to and recover from the consequences of those hazards identified in Section 5.3 and shall address health and safety, incident stabilization, operational/business continuity, property conservation, and protection of the environment under the jurisdiction of the entity.

3. Procedures, including life safety, incident stabilization, operational/business continuity, and property conservation, shall be established and implemented for response to, and recovery from, the consequences of those hazards identified in Section 5.3.

4. Procedures shall be in place to conduct a situation analysis that includes a needs assessment, damage assessment, and the identification of resources needed to support response and recovery operations.

5. Procedures shall allow for concurrent recovery and mitigation activities during emergency response.

6. Procedures shall be established for succession of management/government as required in 5.8.3.8.

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| Standard EC.4.15 | Rationale EC.4.15 | 70741 (b)(5) |
---|---|---|
The organization establishes strategies for managing safety and security during emergencies. (CAH: Corresponds to COP 485.623 (c)(3) and (c)(4)) | Controlling the movement of individuals into, throughout, and out of the organization during an emergency is essential to the safety of patients and staff, and to the security of critical supplies, equipment, and utilities. The organization determines the type of access and movement to be allowed by staff, patients, visitors, emergency volunteers, vendors, maintenance and require workers, utility suppliers, and other individuals when emergency measures are initiated. Factors influencing access and movement vary depending upon the type of emergency and local conditions (that is, the decision by the organization to shelter staff families, the allowance for or prohibition against firearms, mutual aid agreements with nearby facilities or vendors). During an emergency, the campus or immediate environment around the organization may be under the authority of the local police or sheriff serving the larger community. Access to and from the organization on local roads and interstates could be subject to local, state or even federal control. As an incident evolves, this responsibility and authority may shift from one agency to another. For this reason, it is important that the Emergency Operations Plan includes reference to any existing community command structure to provide for on-going communication and coordination with this structure. In the absence of such a command structure, the organization maintains direct contact with the agencies charged with community security. | Prompt transfer of casualties, when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care. |

| 70741 (b)(6) | 70741 (b)(7) | 70741 (b)(8) |
---|---|---|
A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved. | Procedures for the prompt discharge or transfer of patients already in the hospital at the time of the disaster who can be moved without jeopardy. | Maintaining security in order to keep relatives and curious persons out of the triage area. |
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<th><strong>NFPA 1600</strong></th>
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| **Operations and Procedures, continued** | | **Element EC.4.15 (2)**  
The organization identifies the roles of community security agencies (police, sheriff, national guard) and defines how the organization will coordinate security activities with these agencies. | **70743 (b)**  
The written program shall include at least the following:  
(1) Plans for the assignment of personnel to specific tasks and responsibilities.  
(2) Instructions relating to the use of alarm systems and signals.  
(3) Information concerning methods of fire containment.  
(4) Systems for notification of appropriate persons.  
(5) Information concerning the location of fire fighting equipment.  
(6) Specification of evacuation routes and procedures.  
(7) Other provisions as the local situation dictates. |
| | | **Element EC.4.15 (3)**  
The organization identifies process that will be required for managing hazardous materials and waste once emergency measures are initiated. | |
| | | **Element EC.4.15 (4)**  
(CAH, HAP only) The plan identifies means for radioactive, biological, and chemical isolation and decontamination. | |
| | | **Element EC.4.15 (5)**  
(LTC, LT2 only) The organization identifies residents who might be susceptible to wandering once emergency measures are initiated. | |
| | | **Element EC.4.15 (6-8)**  
The organization establishes processes for the following (EPs 6-8):  
• Controlling entrance into and out of the health care facility during emergencies  
• Controlling the movement of individuals within the health care facility during emergencies  
• Controlling traffic accessing the health care facility during emergencies | |
| | | **Standard EC.4.18**  
The organization establishes strategies for managing [patient] clinical and support activities during emergencies. (CAH: Corresponds to COP 485.623 (c)(3) and (c)(4)) | |
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<th>NFPA 1600</th>
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<tr>
<td><strong>Operations and Procedures, continued</strong></td>
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<td><strong>Rationale EC.4.18</strong>&lt;br&gt;The fundamental goal of emergency management planning is to protect life and prevent disability. The manner in which care, treatment and services are provided may vary by type of emergency. However, certain clinical activities are so fundamental to safe and effective care that the organization should determine how it will re-schedule or manage [patient] clinical needs even under the most dynamic situations or in the most austere care environments.&lt;br&gt;The emergency triage process will typically result in [patient]s being quickly treated and discharged, admitted for a longer stay, or transferred to a more appropriate source of care. It is especially important to identify and triage [patient]s whose clinical needs are outside of the usual scope of service of the organization. A catastrophic emergency may result in the decision to keep all [patient]s on the premises in the interest of safety or, conversely, in the decision to evacuate all [patient]s because the facility is no longer safe. Planning for clinical services must address these situations accordingly.</td>
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<td><strong>Element EC.4.18</strong>&lt;br&gt;The organization plans to manage the following during emergencies:&lt;br&gt;• The clinical activities required as part of [patient] scheduling, triage, assessment, treatment, admission, transfer, discharge, and evacuation (1)&lt;br&gt;• Clinical services for vulnerable populations served by the organization, including [patient]s who are pediatric, geriatric, disabled, or have serious chronic conditions or addictions (2)&lt;br&gt;• Personal hygiene and sanitation needs of its [patient]s (3)&lt;br&gt;• The mental health service needs of its [patient]s (4)&lt;br&gt;• Mortuary services (5)</td>
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<td><strong>Element EC.4.18 (6)</strong>&lt;br&gt;The organization plans for documenting and tracking [patient]s’ clinical information.</td>
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| **Facilities: 5.12** | 1. The entity shall establish a primary and an alternate emergency operations center, physical or virtual, capable of managing continuity, response, and recovery operations.  
2. Facilities capable of supporting continuity, response, and recovery operations shall be identified. | 70741 (b)(1) Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials. | |
| **Training: 5.13** | 1. The entity shall develop and implement a training/educational curriculum to support the program.  
2. The objective of the training shall be to create awareness and enhance the skills required to develop, implement, maintain, and execute the program.  
3. Frequency and scope of training shall be identified.  
4. Personnel shall be trained in the entity’s incident management system.  
5. Training records shall be maintained.  
6. The training and education curriculum shall comply with all applicable regulatory requirements. | **Element 9**  
Complete IS-700: NIMS: An Introduction.  
**Element 10**  
Complete IS-800: NRP: An Introduction.  
**Element 11**  
Complete ICS 100 and ICS 200 Training or equivalent courses. | 70741 (c) The program shall be brought up-to-date, at least annually, and all personnel shall be instructed in its requirements. There shall be evidence in the personnel files, e.g., orientation checklist or elsewhere, indicating that all new employees have been oriented to the program and procedures within a reasonable time after commencement of their employment. |
| **Exercises, Evaluations and Corrective Actions: 5.14** | 1. The entity shall evaluate program plans, procedures, and capabilities through periodic reviews, testing, and exercises.  
2. Additional reviews shall be based on post-incident analyses and reports, lesson learned, and performance evaluations.  
3. Exercises shall be designed to test individual essential elements, interrelated elements, or the entire plan(s). | **Element 12**  
Incorporate NIMS/ICS into internal and external, local, regional, and state emergency management training and exercises.  
**Element 13**  
Participate in an all-hazard exercise program based on NIMS that involves responders from multiple disciplines, multiple agencies and organizations. | **Standard EC.4.20**  
The organization regularly tests its emergency operation plan.  
**Rationale EC.4.20**  
Periodic testing of an emergency operation plan enables organizations to assess the plan’s appropriateness, adequacy, and the effectiveness of logistics, human resources, training, policies, procedures, and protocols. Exercises should stress the limits of the organization’s emergency management system. The goal of this testing is to assess the organization’s preparedness capabilities and performance when systems are stressed during an actual emergency. Exercises should be developed using plausible scenarios.  
70741 (d) The disaster plan shall be rehearsed at least twice a year. There shall be a written report and evaluation of all drills. The actual evacuation of patients to safe areas during the drill is optional. |
<table>
<thead>
<tr>
<th><strong>Exercises, Evaluations and Corrective Actions, continued</strong></th>
<th><strong>Element 14</strong></th>
<th><strong>The Joint Commission</strong></th>
<th><strong>Calif. Code of Regulations</strong></th>
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<td>4. Procedures shall be established to take corrective action on any deficiency identified.</td>
<td>Hospitals and healthcare systems will incorporate corrective actions into preparedness and response plans and procedures.</td>
<td>that are realistic and relevant to the organization. Events should be based on each organization’s Hazard Vulnerability Analysis (HVA). Exercises should also validate the effectiveness of the plan and identify opportunities to improve. This standard will assist health care organizations to test their emergency operation plan, identify deficiencies, and take corrective actions to continuously improve the effectiveness of their emergency operation plan. Only a thorough and objective evaluation of performance during an emergency management event or planned exercise will demonstrate how effective the organization’s planning efforts have been. It is important to communicate the strengths and weaknesses of the performance revealed by the exercise to all levels of the organization, including administration, clinical staff, governing body, and those responsible for managing the patient safety program.</td>
<td>70743 (c) Fire and internal disaster drills shall be held at least quarterly for each shift of hospital personnel and under varied conditions. The actual evacuation of patients to safe areas during drill is optional.</td>
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**Number and Types of Exercises:**

**Element EC.4.20 (1)**
- (CAH, HAP, LTC only) The [organization] tests its Emergency Operations Plan twice a year, either in response to an actual emergency or in a planned exercise.
  - Note 1: Staff in freestanding buildings classified as a business occupancy (as defined by the Life Safety Code ®) that does not offer emergency services nor is community-designated as a disaster-receiving station need to conduct only one emergency preparedness exercise annually.)
  - Note 2: Tabletop sessions, though useful, are not acceptable substitutes for exercises.

**Element EC.4.20 (2)**
- (CAH, LTC only) [Organizations] that offer emergency services or are community-designated disaster receiving stations conduct at least one exercise a year that includes an influx of actual or simulated [patients].
<table>
<thead>
<tr>
<th>Exercises, Evaluations and Corrective Actions, continued</th>
<th><strong>Element EC.4.20 (3)</strong></th>
<th><strong>Element EC.4.20 (4)</strong></th>
<th><strong>Scope of Exercises:</strong> <strong>Element EC.4.20 (6)</strong></th>
<th><strong>Element EC.4.20 (8)</strong></th>
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<td>(CAH, HAP, LTC only) At least one exercise a year is escalated to evaluate how effectively the organization performs when it cannot be supported by the local community. Note: Tabletop sessions are acceptable in meeting the community portion of this exercise.</td>
<td>(CAH, HAP, LTC only) [Organizations] that have a defined role in the community-wide emergency management program participate in at least one community-wide exercise a year. Note 1: “Community-wide” may range from a contiguous geographic area served by the same health care providers to a large borough, town, city, or region. Note 2: Exercises for EC.4.20, EPs 2 and 3 may be conducted separately or simultaneously. Note 3: Tabletop sessions are acceptable in meeting the community portion of this exercise.</td>
<td>(CAH, HAP, LTC only) Planned exercise scenarios are realistic and related to the priority emergencies identified in the [organization]’s Hazard Vulnerability Analysis.</td>
<td>(CAH, HAP, LTC only) During planned exercises, an individual whose sole responsibility is to monitor performance (and who is knowledgeable in the goals and expectations of the exercise) documents opportunities for improvement. (This individual may be a staff member of the organization who is not participating in the exercise.)</td>
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| Exercises, Evaluations and Corrective Actions, continued |  | Element EC.4.20 (9)  
During planned exercises, the [organization] monitors, at a minimum, the following six critical areas (EPs 9-14):  
- (CAH, HAP, LTC only) Communication, including the effectiveness of communication both within the [organization] as well as with response entities outside of the [organization], such as local governmental leadership, police, fire, public health, and other health care organizations within the community.  
|  |  | Element EC.4.20 (10)  
- (CAH, HAP, LTC only) Resource mobilization and allocation, including responders, equipment, supplies, personal protective equipment, and transportation.  
|  |  | Element EC.4.20 (11)  
- (CAH, HAP, LTC only) Safety and security  
|  |  | Element EC.4.20 (12)  
- (CAH, HAP, LTC) Staff roles and responsibilities  
|  |  | Element EC.4.20 (13)  
- (CAH, HAP, LTC) Utility systems  
|  |  | Element EC.4.20 (14)  
- (CAH, HAP, LTC) Patient clinical and support care activities  
|  |  | Element EC.4.20 (15)  
(CAH, HAP, LTC) Exercises are critiqued to identify deficiencies and opportunities for improvement based upon monitoring activities and observations during this exercise.  
|  |  | Element EC.4.20 (16)  
(CAH, HAP, LTC) Completed exercises are critiqued through a multi-disciplinary process that includes administration, clinical (CAH, HAP: (including physicians)), and support staff.  
|  |  | Element EC.4.20 (17)  
(CAH, HAP, LTC) The [organization] modifies its emergency operations plan in response to critiques of exercises.  
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<th><strong>Exercises, Evaluations and Corrective Actions, continued</strong></th>
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<td>Element EC.4.20 (18) (CAH, HAP, LTC) Planned exercises evaluate the effectiveness of improvements that were made in response to critiques of the previous exercise. Note: When improvements require substantive resources that cannot be accomplished by the next planned exercise, interim improvements must be put in place until final resolution.</td>
<td>Element EC.4.20 (19) (CAH, HAP) The strengths and weaknesses identified during exercises are communicated to the multidisciplinary improvement team responsible for monitoring environment of care issues. (See Standard EC.9.20)</td>
<td>70741 (b)(9) Establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will be made to provide organized dissemination of information.</td>
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<td><strong>Crises Communication and Public Information: 5.15</strong></td>
<td><strong>Element 4</strong> Implements processes and/or plans to communicate timely accurate information through a Joint Information System (JIS) and Joint Information Center. (JIC)</td>
<td><strong>Element 17</strong> Apply standardized and consistent terminology, including the establishment of plain English communications standards across the public safety sector.</td>
<td><strong>70743 (d)</strong> The evacuation plan shall be posted throughout the facility and shall include at least the following: (1) Evacuation routes; (2) Location of fire alarm boxes; (3) Location of fire extinguishers.</td>
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<td>1. The entity shall develop procedures to disseminate and respond to requests for pre-incident, incident, and post-incident information, as well as to provide information to internal and external audiences, including the media, and deal with their inquiries.</td>
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<td>2. The entity shall establish and maintain an emergency public information capability that includes the following:</td>
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<td>• A central contact facility for the media.</td>
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<td>• A system for gathering, monitoring, and disseminating emergency information.</td>
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<td>• Pre-scripted information bulletins</td>
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<td>• A method to coordinate and clear information for release.</td>
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<td>• The capability of communicating with special needs populations.</td>
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<td>Crisis Communication and Public Information, continued</td>
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<td>70746 (b) The administrator shall be responsible for informing the Department, via telephone, immediately upon being notified of the intent of the discontinuance or disruption of services or upon the threat of a walkout of a substantial number of employees, or earthquake, fire, power outage or other calamity that causes damage to the facility or threatens the safety or welfare of patients or clients.</td>
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<td>• Protective action guidelines/recommendations (e.g., shelter-in-place or evacuation)</td>
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<td>3. Where the public is potentially impacted by a hazard, a public awareness program shall be implemented. The entity shall develop procedures to advise the public, through authorized agencies, of threats to people, property, and the environment.</td>
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| **Finance and Administration:  5.16**  
1. The entity shall develop financial and administrative procedures to support the program before, during, and after an emergency or a disaster.  
2. Procedures shall be created and maintained for expediting fiscal decisions in accordance with established authorization levels and fiscal policy.  
3. The procedures shall include the following:  
  • Establishment and definition of responsibilities for the program finance authority, including its reporting relationships to the program coordinator.  
  • Program procurement procedures.  
  • Payroll.  
  • Accounting systems to track and document costs.  
  • Management of funding from external sources. | **Element 6**  
Develop and implement a system to coordinate appropriate hospital preparedness funding to employ NIMS across the organization. | **Element 6**  
Develop and implement a system to coordinate appropriate hospital preparedness funding to employ NIMS across the organization. | **Element 6**  
Develop and implement a system to coordinate appropriate hospital preparedness funding to employ NIMS across the organization. |
Emergency Preparedness Information, Tools, and Resources

California Association of Health Facilities (CAHF)
Disaster preparedness information and resources for members and non-members.
Link: (http://www.cahf.org/public/dpp/cahf_dpp.php)

Agency for Healthcare Research and Quality (AHRQ)
Public health emergency preparedness tools, evidence reports and articles, community planning, resources, mass prophylaxis, pandemic influenza, pediatrics, surge capacity, conferences and meetings.
Link: (http://www.ahrq.gov/prep/)

American Veterinary Medical Association (AVMA)
Disaster preparedness for animals.
Link: http://www.avma.org/about_avma/default.asp

American Red Cross
Find your local chapter.
Link: http://www.prepare.org

American Red Cross – Santa Clara Valley Chapter
Link: www.santaclaravalley.redcross.org

American Red Cross – Palo Alto Chapter
Link: www.paarc.org

California Department of Public Health
State public health emergency preparedness, response and recovery.
Link: http://bepreparedcalifornia.ca.gov/epo/
California Emergency Management Agency (formerly OES)
Link:  www.oes.ca.gov

Centers for Disease Control and Prevention (CDC)
All hazards emergency preparedness and response.
Link:  http://emergency.cdc.gov/

Citizen Corps.
Citizen Corps. is FEMA’s grassroots strategy to bring together government and community leaders to involve citizens in all-hazards emergency preparedness and resilience.
Link:  www.citizencorps.gov/

Collaborating Agencies Responding to Disasters (CARD)
Emergency preparedness, response and recovery information, tools and education for community groups.
Link:  www.firstvictims.org

Federal Emergency Management Agency (FEMA)
Link:  www.fema.gov

Interagency Coordinating Council on Emergency Preparedness and Individuals with Disabilities
Established to ensure that the federal government appropriately supports safety and security for individuals with disabilities in disaster situations.
Link:  www.disabilitypreparedness.gov

National Oceanic & Atmospheric Administration
Real time hazards information.
Link:  www.noaa.gov/

Pacific Gas & Electric
Link:  www.pge.com
Pandemic Influenza Preparedness
Links:  www.pandemicflu.gov  AND
www.sccphd.org/portal/site/phd/agencychp?path=%2Fv7%2FPublic%20Health%20Department%20%28DEP%29%2FPandemic%20Influenza%2FPandemic%20Information

Personal Preparedness
Link:  www.72hours.org

Santa Clara County Emergency Medical Services Agency
Link:  www.sccemsagency.org

Santa Clara County Office of Emergency Services
Link:  www.sccgov.org/portal/site/oes/

Santa Clara Valley Water District
Real time hazards information.
Link:  www.valleywater.org

Santa Clara County HAM Radio
Link:  www.scc-ares-races.org/aresraces.htm

US Department of Homeland Security
Link:  www.ready.gov/

US Environmental Protection Agency (EPA)
The mission of EPA is to protect human health and the environment.
Link:  www.epa.gov

US Geological Survey (USGS)
Real time hazards information.
Link:  www.usgs.gov
Emergency Preparedness Courses and Trainings

California Specialized Training Institute (CSTI)
Offers all-hazards training and exercises throughout the State of California.
Link: [www.csti.ca.gov](http://www.csti.ca.gov)

FEMA Independent Study (Free online courses)
Link: [www.training.fema.gov/IS/](http://www.training.fema.gov/IS/)

- **IS-100.HC Introduction to Incident Command System for Healthcare/Hospitals**
  - *Course Overview*
  - This course introduces the Incident Command System as it applies to the healthcare/hospital environment and provides the foundation for higher level ICS training. It describes the history, features and principles, and organizational structure of the ICS. It also explains the relationship between ICS and the National Incident Management System (NIMS).

- **IS-200.HC Applying ICS to Healthcare Organizations**
  - *Course Overview*
  - This course is designed to enable healthcare/hospital personnel to operate efficiently during an incident or event within the Incident Command System. It provides training on and resources for personnel who are likely to assume a supervisory position within the ICS.

- **IS-700.a NIMS, An Introduction**
  - *Course Overview*
  - This course introduces and overviews the National Incident Management System (NIMS). NIMS provides a consistent nationwide template to enable all government, private-sector, and nongovernmental organizations to work together during domestic incidents.

- **IS-800.b National Response Framework, An Introduction**
  - *Course Overview*
  - This course introduces participants to the concepts and principles of the National Response Framework.

Santa Clara County Office of Emergency Services
SCC OES offers an ICS/NIMS/SEMS combined course every last Tuesday of the month. The course is offered in a classroom setting, but requires interested participants to register for the course online. Please go to the following link:
Link: [http://comboclass.eventbrite.com/](http://comboclass.eventbrite.com/)

Yale New Haven Emergency Preparedness Online Education and Training
Offers online emergency preparedness training courses (The Joint Commission/CMS, NIMS Courses, OSHA, Special Populations, Radiation, Biological/Infectious Diseases, Behavioral Health, and Evacuation).
Link: [http://ynhhs.emergencyeducation.org/](http://ynhhs.emergencyeducation.org/)

*Dedicated to the health of the whole community*
*The Public Health Department is a division of Santa Clara Valley Health & Hospital System, owned and operated by the County of Santa Clara.*
### Santa Clara County City Phone Numbers and Websites

<table>
<thead>
<tr>
<th>City</th>
<th>Phone</th>
<th>Website Link</th>
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</thead>
<tbody>
<tr>
<td>City of Campbell</td>
<td>408.866.2784</td>
<td><a href="http://www.ci.campbell.ca.us/Police/EmergencyPreparedness.htm">www.ci.campbell.ca.us/Police/EmergencyPreparedness.htm</a></td>
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<tr>
<td>City of Los Altos Hills</td>
<td>650.947.2824</td>
<td><a href="http://www.losaltoshills.ca.gov/city-government/emergency">www.losaltoshills.ca.gov/city-government/emergency</a></td>
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<td>City of Milpitas</td>
<td>408.586.2810</td>
<td><a href="http://www.ci.milpitas.ca.gov/resident/emergency/default.asp">www.ci.milpitas.ca.gov/resident/emergency/default.asp</a></td>
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<tr>
<td>City of Monte Sereno</td>
<td>408.354.7635</td>
<td><a href="http://www.montesereno.org/">www.montesereno.org</a></td>
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<tr>
<td>City of Morgan Hill</td>
<td>408.776.7318</td>
<td><a href="http://www.morgan-hill.ca.gov/">www.morgan-hill.ca.gov</a></td>
</tr>
<tr>
<td>City of Mountain View</td>
<td>650.903.6825</td>
<td><a href="http://www.ci.mtnview.ca.us/city_hall/fire/programs_n_services/disaster_preparedness.asp">www.ci.mtnview.ca.us/city_hall/fire/programs_n_services/disaster_preparedness.asp</a></td>
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<tr>
<td>City of Palo Alto</td>
<td>650.617.3164</td>
<td><a href="http://www.cityofpaloalto.org/info/default.asp">www.cityofpaloalto.org/info/default.asp</a></td>
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<tr>
<td>City of San Jose</td>
<td>408.277.4595</td>
<td><a href="http://www.sanjoseca.gov/emergencyServices/SanJosePrepared/">www.sanjoseca.gov/emergencyServices/SanJosePrepared/</a></td>
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<tr>
<td>City of San Martin</td>
<td>408.808.7800</td>
<td></td>
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<td>City of Santa Clara</td>
<td>408.615.4954</td>
<td><a href="http://www.ci.santa-clara.ca.us">www.ci.santa-clara.ca.us</a></td>
</tr>
<tr>
<td>City of Saratoga</td>
<td>408.868.1213</td>
<td><a href="http://www.saratoga.ca.us/emergencypreparedness.html">http://www.saratoga.ca.us/emergencypreparedness.html</a></td>
</tr>
<tr>
<td>City of Sunnyvale</td>
<td>408.730.7198</td>
<td><a href="http://sunnyvale.ca.gov/homeindex.htm">http://sunnyvale.ca.gov/homeindex.htm</a></td>
</tr>
<tr>
<td>Santa Clara County (Unincorporated)</td>
<td>408.808.7800</td>
<td><a href="http://www.sccgov.org/portal/site/oes/">www.sccgov.org/portal/site/oes/</a></td>
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