

**Supplement to the**  
**Emergency Action Plan**  
**for**  
**Long Term Care Facilities**

**Oklahoma State Department of Health  
Protective Health Services  
Long Term Care**

**Authored: November 7, 2005**

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## **Disaster and Evacuation Preparedness Regulation in Oklahoma's Long Term Care Facilities**

### **Nursing Facilities**

#### **State: 310:675-7-8.1. Administrative records**

- a) The administrator shall be responsible for the preparation, supervision, and filing of records.
- (d) Administrative records of the facility shall include the following information:
  - (14) Written disaster plan/emergency evacuation plan.

### **Medicaid and Medicare Certified Nursing Facilities**

#### **Federal: §483.75(m) Disaster and Emergency Preparedness**

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#### **F517**

**§483.75(m)(1) The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.**

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#### **F518**

**§483.75(m)(2) The facilities must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.**

#### **Interpretive Guidelines §483.75(m)**

The facility should tailor its disaster plan to its geographic location and the types of residents it serves. “Periodic review” is a judgment made by the facility based on its unique circumstances changes in physical plant or changes external to the facility can cause a review of the disaster review plan

The purpose of a “staff drill” is to test the efficiency, knowledge, and response of institutional personnel in the event of an emergency. Unannounced staff drills are directed at the responsiveness of staff, and care should be taken not to disturb or excite residents.

#### **K0048**

**Title 42, Code of Regulations, §483.70(a) Life safety from fire.**

**(i) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101[supreg] 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51.**

**There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 NFPA 101**

See also: NFPA 101, Life Safety Code, 2000 ed: Chapter 18 (new health care facilities) and Chapter 19 (existing health care facilities) both read the same. Copied from Chapter 19.

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### **Intermediate Care Facility for the Mentally Retarded**

**42 CFR 483.470 (h) Standard: Emergency plan and procedures.** (1) The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

(2) The facility must communicate, periodically review, make the plan available, and provide training to the staff.

(i) Standard: Evacuation drills. (1) The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to--

- (i) Ensure that all personnel on all shifts are trained to perform assigned tasks;
- (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and
- (iii) Evaluate the effectiveness of emergency and disaster plans and procedures.

(2) The facility must--

- (i) Actually evacuate clients during at least one drill each year on each shift;
- (ii) Make special provisions for the evacuation of clients with physical disabilities;
- (iii) File a report and evaluation on each evacuation drill;
- (iv) Investigate all problems with evacuation drills, including accidents, and take corrective action; and
- (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

(3) Facilities must meet the requirements of paragraphs (i)(1) and (2) of this section for any live-in and relief staff they utilize.

### **Federal Interpretive Guidelines**

Staff, and individuals who are being trained/assisted/supported to evacuate on their own, practice evacuating at different times of the day and night, from different rooms in the facility, using different escape routes and in various weather conditions.

All staff know what they are to do in an emergency. Staff know how to use fire extinguisher, alarms, and any other safety features in the facility. All individuals totally evacuate the building at least once per year per shift, regardless of the occupancy chapter under which the building falls.

All facilities, regardless of their size require actual evacuation. "Actually evacuate," as used in this standard, applies to **all** individuals. The drills are conducted not only to rehearse the individuals and staff for fire (see §483.470(i)(2)(v)), **but for other disasters such as hurricanes, tornadoes, floods, etc.** Such disasters would require the entire occupancy to be evacuated, and, therefore, the actual evacuation must be practiced, as required.

Individuals with physical disabilities can be evacuated.

What problems and corrective actions do fire drill reports identify?

When a problem is identified in evacuating, the facility takes steps which are reasonably likely to correct the problem.

### **Title 42, Code of Regulations, §483.470(i) Fire protection.**

(i) The facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the 2000 edition of the Life Safety Code of the National Fire Protection Association.

See also: NFPA 101, Life Safety Code, 2000 ed: Chapter 18 (New Health Care Occupancies) and Chapter 19 (Existing Health Care Occupancies) Chapter 32 (Existing Residential Board and Care) and Chapter 33 (New Residential Board and Care).

## Supplement to the Long Term Care Emergency Action Plan

### **Residential Care**

#### **310:680-3-6. Records and reports**

(e) An evacuation plan shall be developed and permanently displayed in the hallways and sitting room. Fire drills shall be conducted at least quarterly.

(f) Facility shall have a written plan for temporary living arrangements in case of fire, climatic conditions that warrant evacuation and/or other natural disasters that may render the home unsuitable.

#### **63 O.S Section 1-828. Fire safety inspections--Fire safety rules and regulations**

The State Fire Marshal or a designee shall conduct fire safety inspections on a regular basis at residential care homes and report any findings from the inspections to the State Department of Health. In addition, the State Fire Marshal shall develop, adopt, and promulgate rules, or specifications consistent with nationally recognized standards or practices necessary for the safeguarding of life and property of residents of residential care homes from the hazards of fire and smoke.

#### **74 O.S. § 324.7 - Rules, Regulations And Specifications**

A. Except as otherwise specified by subsection B of this section, the State Fire Marshal Commission shall have the power and duty to prescribe, adopt, and promulgate, in the manner set forth in this act, such reasonable rules, regulations, or specifications consistent with nationally recognized codes, standards, or practices on matters relating to the safeguarding of life and property from the hazards of fire and explosion arising from storage, handling, and use of flammable and combustible materials, and from conditions hazardous to life or property in the use or occupancy of buildings or premises, as are deemed just and reasonable and in accordance with nationally recognized standards, and not inconsistent with this act, and to revoke, amend, or supersede the same.

#### **OAC 265:25-1-3. Incorporated national codes and standards**

The following national codes and standards are incorporated by reference:

- (1) International Building Code, 2003 Edition
- (2) International Fire Prevention Code, 2003 Edition
- (16) NFPA #101 Life Safety Code, 2003 Edition.

See Also: International Building Code, 2003 Edition; International Fire Prevention Code, 2003 Edition; NFPA #101 Life Safety Code, 2003 Edition.

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### **Continuum of Care and Assisted Living**

Note: Nursing Facilities licensed as Continuum of Care facilities are subject to the requirements for Nursing Facilities.

#### **310:663-3-3. Description of service in assisted living center**

(a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services:

(9) provisions for evacuation of the building structure and staff to meet the evacuation needs of residents.

(b) The assisted living center's description of its services shall be included in the assisted living center's application for license and the resident service contract.

#### **310:663-7-1. General requirements**

(a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21.

#### **74 O.S. § 324.7 - Rules, Regulations And Specifications**

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### **Quality Assurance Probes**

Review the disaster and emergency preparedness plan, including plans for natural or man made disasters.

- Does responsible staff know where the plans are located?
- Are the phone numbers up-to-date?
- Are all Memorandums of Understanding or Mutual Aid Agreements current?
- Are drills being done on all shifts at least quarterly?
- Is an annual review completed on all aspects of the plan?

Ask two staff persons separately (e.g., nurse aide, housekeeper, maintenance person and the person in charge), on each shift:

- If the fire alarm goes off, what do you do?
- If you discover that a resident is missing, what do you do?
- What would you do if you discovered a fire in a resident's room?
- Where are fire alarms and fire extinguisher(s) located on this unit?
- How do you use the fire extinguisher?
- What do you do in the event of a Tornado?

**NOTE:** Also, ask your staff about plans relevant to your geographically specific natural emergencies (e.g., for areas prone to hurricanes, tornadoes, earthquakes, or floods, each of which may require a different response).

Are the answers to these questions correct (staff answers predict competency in assuring resident safety)?

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**NFPA 101, Life Safety Code, 2000 ed: Chapter 18 (New health care facilities)**

**NFPA 101, Life Safety Code, 2000 ed: Chapter 19 (Existing health care facilities)**

Copied from Chapter 19.19.7.1 Evacuation and Relocation Plan and Fire Drills

Note: This section applies to Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded

### 19.7.1 Evacuation and Relocation Plan and Fire Drills.

#### 19.7.1.1

The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, **for their evacuation to areas of refuge, and for their evacuation from the building when necessary.** *All employees shall be periodically instructed and kept informed with respect to their duties under the plan.* A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center.

The provisions of 19.7.1.2 through 19.7.2.3 shall apply.

#### 19.7.1.2\*

Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.

#### 19.7.1.3

Employees of health care occupancies shall be instructed in life safety procedures and devices.

### 19.7.2 Procedure in Case of Fire.

#### 19.7.2.1\*

For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy's fire safety plan.

#### 19.7.2.2

A written health care occupancy fire safety plan shall provide for the following:

- (1) Use of alarms
- (2) Transmission of alarm to fire department
- (3) Response to alarms
- (4) Isolation of fire
- (5) Evacuation of immediate area

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- (6) Evacuation of smoke compartment
- (7) Preparation of floors and building for evacuation
- 8) Extinguishment of fire

### 19.7.2.3

All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions:

- (1) When the individual who discovers a fire must immediately go to the aid of an endangered person
- (2) During a malfunction of the building fire alarm system personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan.

### 19.7.3 Maintenance of Exits.

Proper maintenance shall be provided to ensure the dependability of the method of evacuation selected. Health care occupancies that find it necessary to lock exits shall, at all times, maintain an adequate staff qualified to release locks and direct occupants from the immediate danger area to a place of safety in case of fire or other emergency.

**NFPA 101, Life Safety Code, 2000 ed: Chapter 32 New Residential Board And Care Occupancies**

**NFPA 101, Life Safety Code, 2000 ed: Chapter 33 Existing Residential Board And Care Occupancies (Copied from Chapter 32. )**

**32.7.1 Emergency Plan. (33.7.1 Emergency Plan)**

The administration of every residential board and care facility shall have, in effect and available to all supervisory personnel, written copies of a plan for protecting all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan shall include special staff response, including the fire protection procedures needed to ensure the safety of any resident, and shall be amended or revised whenever any resident with unusual needs is admitted to the home. All employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff not less than every 2 months. A copy of the plan shall be readily available at all times within the facility.

**32.7.2 Resident Training.**

All residents participating in the emergency plan shall be trained in the proper actions to be taken in the event of fire. This training shall include actions to be taken if the primary escape route is blocked. If the resident is given rehabilitation or habilitation training, training in fire prevention and the actions to be taken in the event of a fire shall be a part of the training program. Residents shall be trained to assist each other in case of fire to the extent that their physical and mental abilities permit them to do so without additional personal risk.

**32.7.3 Emergency Egress and Relocation Drills.**

Emergency egress and relocation drills shall be conducted not less than six times per year on a bimonthly basis, with not less than two drills conducted during the night when residents are sleeping. The drills shall be permitted to be announced in advance to the residents. The drills shall involve the actual evacuation of all residents to an assembly point as specified in the emergency plan and shall provide residents with experience in egressing through all exits and means of escape required by the Code. Exits and means of escape not used in any drill shall not be credited in meeting the requirements of this Code for board and care facilities.

*Exception No. 1:* Actual exiting from windows shall not be required to comply with 32.7.3; opening the window and signaling for help shall be an acceptable alternative.

*Exception No. 2:* If the board and care facility has an evacuation capability classification of impractical, those residents who cannot meaningfully assist in their own evacuation or who have special health problems shall not be required to actively participate in the drill. Section 18.7 shall apply in such instances.

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### **International Fire Prevention Code, 2003 Edition**

**404.3.1 Fire evacuation plans.** Fire evacuation plans shall include the following:

1. Emergency egress or escape routes and whether evacuation of the building is to be complete or, where approved, by selected floors or areas only.
2. Procedures for employees who must remain to operate critical equipment before evacuation.
3. Procedures for accounting for employees and occupants after evacuation has been completed.
4. Identification and assignment of personnel responsible for rescue or emergency medical aid.
5. The preferred and any alternative means of notifying occupants of a fire or emergency.
6. The preferred and any alternative means of reporting fires and other emergencies to the fire department or designated emergency response organization.
7. Identification and assignment of personnel who can be contacted for further information or explanation of duties under the plan.
8. A description of the emergency voice/alarm communication system alert tone and preprogrammed voice messages, where provided.

**404.3.2 Fire safety plans.** Fire safety plans shall include the following:

1. The procedure for reporting a fire or other emergency.
2. The life safety strategy and procedures for notifying, relocation, or evacuating occupants.
3. Site plans indicating the following:
  - 3.1. The occupancy assembly point.
  - 3.2. The locations of fire hydrants.
  - 3.3. The normal routes of fire department vehicle access.
4. Floor plans identifying the locations of the following:
  - 4.1. Exits.
  - 4.2. Primary evacuation routes.
  - 4.3. Secondary evacuation routes.
  - 4.4. Accessible egress routes.
  - 4.5. Areas of refuge.
  - 4.6. Manual fire alarm boxes.
  - 4.7. Portable fire extinguishers.
  - 4.8. Occupant-use hose stations.
  - 4.9. Fire alarm annunciators and controls.
5. A list of major fire hazards associated with the normal use and occupancy of the premises, including maintenance and housekeeping procedures.

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6. Identification and assignment of personnel responsible for maintenance of systems and equipment installed to prevent or control fires.

7. Identification and assignment of personnel responsible for maintenance, housekeeping and controlling fuel hazard sources.

**404.4 Maintenance.** Fire safety and evacuation plans shall be reviewed or updated annually or as necessitated by changes in staff assignments, occupancy, or the physical arrangement of the building.

**404.5 Availability.** Fire safety and evacuation plans shall be available in the workplace for reference and review by employees, and copies shall be furnished to the fire code official for review upon request.

**408.5.1 Fire safety and evacuation plan.** The fire safety and evacuation plan required by Section 404 shall include special staff actions including fire protection procedures necessary for residents and shall be amended or revised upon admission of any resident with unusual needs.

**408.5.2 Staff training.** Employees shall be periodically instructed and kept informed of their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff at least every two months. A copy of the plan shall be readily available at all times within the facility.

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## **NFPA 99 Standard for Health Care Facilities 1999 Edition**

### **Chapter 16 Nursing Home Requirements**

16-3 General Requirements.

16-3.11

Nursing homes shall comply with the provisions of Chapter 11 for emergency preparedness planning, as appropriate.

### **Chapter 11 Health Care Emergency Preparedness**

11-1\* Scope.

This chapter establishes minimum criteria for health care facility emergency preparedness management in the development of a program for effective disaster preparedness, mitigation, response, and recovery.

11-2 Purpose.

The purpose of this chapter is to provide those with the responsibility for disaster management planning in health care facilities with a framework to assess, mitigate, prepare for, respond to, and recover from disasters. This chapter is intended to aid in meeting requirements for having an emergency preparedness management plan.

11-3\* Applicability.

This chapter is applicable to any health care facility that is intended to provide medical treatment to the victims of a disaster.

11-4 Responsibilities.

11-4.1\* Authority Having Jurisdiction (AHJ).

The AHJ shall be cognizant of the requirements of a health care facility with respect to its uniqueness for continued operation of the facility in an emergency.

11-4.2 Senior Management.

It shall be the responsibility of the senior management to provide its staff with plans necessary to respond to a disaster or an emergency. Senior management shall appoint an emergency preparedness committee, as appropriate, with the authority for writing, implementing, exercising, and evaluating the emergency preparedness plan.

11-4.3\* Emergency Preparedness Committee.

The emergency preparedness committee shall have the responsibility for the overall disaster planning and emergency preparedness within the facility, under the supervision of designated leadership.

The emergency preparedness committee shall model the emergency preparedness plan on the incident command system (ICS) in coordination with local emergency response agencies.

11-5 General Requirements.

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### 11-5.1\*

When a facility declares itself in a disaster mode, or when the authority having jurisdiction (AHJ) declares a state of disaster exists, the disaster plan shall be activated. Planning shall be based on realistic conceptual events and operating capacity thresholds that necessitate activation of the plan.

### 11-5.2\*

The decision to activate the emergency preparedness plan shall be made by the authority designated within the plan, in accordance with the facility's activation criteria. The decision to terminate shall be made by the designated authority in coordination with the authority having jurisdiction and other civil or military authorities involved.

### 11-5.3

The emergency preparedness plan, as a minimum, shall include the following.

#### 11-5.3.1\* Identification of Emergency Response Personnel.

All personnel designated or involved in the emergency preparedness plan of the health care facility shall be supplied with a means of identification, which shall be worn at all times in a visible location. Specific means of identification for incident command system (ICS) personnel shall be provided, such as vests, baseball caps or hard hats.

#### 11-5.3.2\* Continuity of Essential Building Systems.

When designated by the emergency preparedness management plan to provide continuous service in a disaster or emergency, health care facilities shall establish contingency plans for the continuity of essential building systems, as applicable:

- (a) \* Electricity
- (b) Water
- (c) Ventilation
- (d) Fire protection systems
- (e) Fuel sources
- (f) Medical gas and vacuum systems (if applicable)
- (g) \* Communication systems

#### 11-5.3.3\* Staff Management.

Planning shall include the alerting and managing of all staff and employees in a disaster, as well as consideration of (1) housing, (2) transportation of staff and staff family, and (3) critical incident staff stress debriefing.

#### 11-5.3.4\* Patient Management.

Plans shall include provisions for management of patients, particularly with respect to clinical and administrative issues.

#### 11-5.3.5\* Logistics.

Contingency planning for disasters shall include as a minimum stockpiling or ensuring immediate or at least uninterrupted access to critical materials such as the following:

- (a) Pharmaceuticals
- (b) Medical supplies
- (c) Food supplies

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- (d) Linen supplies
- (e) Industrial and potable (drinking) waters

### 11-5.3.6\* Security.

Security plans shall be developed that address facility access, crowd control, security staff needs, and traffic control.

### 11-5.3.7\* Public Affairs.

#### 11-5.3.7.1

Health care facilities shall have a designated media spokesperson to facilitate news releases.

#### 11-5.3.7.2

An area shall be designated where media representatives can be assembled, where they will not interfere with the operations of the health care facility.

### 11-5.3.8 Staff Education.

Each health care facility shall implement an educational program. This program shall include an overview of the components of the emergency preparedness plan and concepts of the Incident Command System. Education concerning the staff's specific duties and responsibilities shall be conducted upon reporting to their assigned departments or position.

General overview education of the Emergency Preparedness Plan and the Incident Command System shall be conducted at the time of hire. Department/staff specific education shall be conducted upon reporting to their assignments or position and annually thereafter.

### 11-5.3.9\* Drills.

Each organizational entity shall implement one or more specific responses of the emergency preparedness plan at least semi-annually. At least one semi-annual drill shall rehearse mass casualty response for health care facilities with emergency services, disaster receiving stations, or both.

### 11-5.3.10\* Operational Recovery.

Plans shall reflect measures needed to restore operational capability to pre-disaster levels. Fiscal aspects shall be considered because of restoral costs and possible cash flow losses associated with the disruption.

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### **NFPA 99 Standard for Health Care Facilities 1999 Edition**

#### **Appendix A Explanatory Material**

##### A-11-1

Since no single model of a disaster plan is feasible for every health care facility, this chapter is intended to provide criteria in the preparation and implementation of an individual plan. The principles involved are universally applicable; the implementation needs to be tailored to the specific facility.

##### A-11-3

Such facilities include, but are not limited to, hospitals, clinics, convalescent or nursing homes, and first-aid stations (disaster receiving stations). Such facilities could be formally designated by a government authority as disaster treatment centers. Such facilities would not normally include doctors' or dentists' offices, medical laboratories, or school nurseries, unless such facilities are used for treatment of disaster victims.

##### A-11-4.1

In time of disaster all persons are subject to certain constraints or authorities not present during normal circumstances. All disaster plans written by a health care facility should be reviewed and coordinated with such authorities so as to prevent confusion. Such authorities include, but are not limited to, civil authorities (such as a fire department, police department, public health department, or emergency medical service councils), and civil defense or military authorities.

Further, an authority having jurisdiction can impose upon the senior management of the facility the responsibility for participating in a community disaster plan.

##### A-11-4.3

Emergency Preparedness Planning Committee. The incident command system (ICS) is a system having an identified chain of command that adapts to any emergency event. ICS establishes common terminology and training for incident management. This allows emergency responders from hospitals and all involved organizations to respond to an incident and be familiar with the management concepts and terminology of other responders. It also facilitates the request and processing of mutual aid requests.

A policy group consists of senior managers constituted to provide decisions related to items or incident decisions not in the disaster plan.

The command staff consists of the incident commander and support staff. This support staff consists of the public information officer, liaison officer, and safety officer.

In addition to the command staff, there are four sections, each with a section chief responding directly to the incident commander: plans section, logistics section, operations section, and finance section.

Due to the nature of a health care facility, one deviation from the traditional ICS is made to show a line of medical control. Note the advisory position of the "medical staff officer."

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### A-11-5.1

Hazard identification and risk assessment should determine whether the following types of hazards are applicable:

- (a) Natural disasters
- (b) Technological/industrial disasters
- (c) Civil/political disasters.

For further information on disaster management, see NFPA 1600, Recommended Practice for Disaster Management.

### A-11-5.2

Planning. By basing the planning of health care emergency preparedness on realistic conceptual events, the plan reflects those issues or events that are predictable for the environment the organization operates in. Thus, such conceptual planning should focus on issues, such as severe weather typical in that locale; situations that may occur due to close proximity of industrial or transportation complexes; or earthquake possibilities due to local seismic activity. Planning for these events should also focus on the capacity of the health care organization to provide services in such an emergency. Capacity thresholds are different for all facilities, but have to do with issues such as the availability of emergency departments, operating suites and operating beds, as well as logistical response and facility utilities. There is no way to plan for all possible emergencies, but by focusing on logical conceptual events and operating capacity thresholds, the health care organization can develop realistic plans as well as guidelines for staff to activate those plans.

### A-11-5.3.1

Where feasible, photo identifications or other means to assure positive identification should be used.

Visitor and crowd control create the problem of distinguishing staff from visitors. Such identification should be issued to all facility personnel, including volunteer personnel who might be utilized in disaster functions.

NOTE: Care should be taken to assure that identification cards are recalled whenever personnel terminate association with the health care facility.

Members of the news media should be asked to wear some means of identification, such as the press card, on their outside garments so that they are readily identifiable by security guards controlling access to the facility or certain areas therein. Clergy also will frequently accompany casualties or arrive later for visitations and require some means of identification.

### A-11-5.3.2

For essential building systems, consideration should be given to the installation of exterior building connectors to allow for the attachment of portable emergency utility modules.

Water storage systems should be inventoried and protected to the greatest extent possible.

### A-11-5.3.2(a)

See Sections 3-4, 3-5, and 3-6 for types of essential electrical systems for health care facilities.

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### A-11-5.3.2(g)

Telecommunication Systems. Emergency internal and external communication systems should be established to facilitate communication with security forces and other authorities having jurisdiction as well as internal patient care and service units in the event normal communication methods are rendered inoperative.

The basic form of communication in a disaster is the telephone system. As part of the contingency plan to maintain communication, a plan for restoring telephone systems or using alternate systems is necessary. Typically, the first line of internal defense for a system outage is strategically placed power-failure telephones that are designed to continue to function in the event of system failure. Plans for external outages and load control should include the use of pay phones that have first priority status in external system restoration.

Contingency plans should also contain strategies for the use of radio-frequency communications to supplement land-line usage. The plan should include a means to distribute and use two-way radio communication throughout the facility. A plan for the incorporation and use of amateur radio operators should also be considered.

It should be recognized that single-channel radio communication is less desirable than telephone system restoration due to the limited number of messages that can be managed. Cellular telephones, although useful in some disaster situations, should not be considered a contingency having high reliability due to their vulnerability to load control schemes of telephone companies.

### A-11-5.3.3

Management of staff and employees allows for the best and most effective use of the entity's human resources during disaster operations. Consideration should be given to both personnel on-hand and those that can be alerted. Specifically, staff management includes the following:

- (a) Assignment of roles and responsibilities
- (b) Method for identifying human resource needs to include status of families
- (c) Method for recalling personnel and augmenting staff
- (d) Management of space (housing, day care, etc.)
- (e) Management of staff transportation
- (f) Critical incident stress debriefing (Many case histories show that not only victims but also rescuers and treatment/handler staff bear serious emotional or even mental scars from their traumatic experiences. Emergency room and ambulance staff can also benefit from such help when stress has been acute.)

### A-11-5.3.4

The plans should focus also on modification or discontinuation of nonessential patient services, control of patient information, and admission/discharge and transfer of patients. Emergency transfer plans need to consider the proper handling of patient personal property and medical records that will accompany the patient as well as assurance of continuity of quality care. Evaluation of space, patient transport resources, and a process to ensure patient location information should be included.

### A-11-5.3.5

Logistics. It will be essential to assess these kinds of resources currently available within the health care facility itself, and within the local community as a whole. Community sources identification can be

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effectively performed by the local disaster council, through the cooperation of local hospitals individually or collectively through local hospital associations, nursing homes, clinics, and other outpatient facilities, retail pharmacies, wholesale drug suppliers, ambulance services, and local medical/surgical suppliers and their warehouses.

Knowing the location and amount of in-house and locally available medical and other supply sources, a given health care facility could then desire to stockpile such additional critical material and supplies as could be needed to effectively cope with the disaster situation. Stockpiling of emergency preparedness supplies in carts should be considered as they facilitate stock rotation of outdated supplies, provide a locally secured environment, and are easily relocated to alternate site locations both within and outside the facility.

### A-11-5.3.6

**Security and Traffic Control.** Facilities should formally coordinate their security needs during a disaster with local law enforcement agencies. This action could be necessary as a means to supplement the facility security capabilities, or to provide all security needs when the facility lacks its own internal security forces.

The health care institution will find it necessary to share its disaster plans with local law enforcement agencies, or better still involve them in the process of planning for security support during disasters. The information should at least include availability of parking for staff, patients, and visitors, and normal vehicular, emergency vehicular, and pedestrian traffic flow patterns in and around the facility. The extent of the security and traffic control problems for any given health care facility will depend upon its geographical location, physical arrangement, availability of visitor parking areas, number of entrances, and so forth.

(a) **Crowd Control.** Visitors can be expected to increase in number with the severity of the disaster. They should not be allowed to disrupt the disaster functioning of the facility. Ideally, a visitor's reception center should be established away from the main facility itself, particularly in major disasters. Volunteer personnel such as Red Cross, Explorer Scouts, or other helpers can be utilized as liaisons between the visitors and the health care facility itself. Normal visiting hours on nursing units should be suspended where possible.

(b) **Vehicular Traffic Control.** Arrangement for vehicular traffic control into and on the facility premises should be made in the disaster planning period. It will be necessary to direct ambulances and other emergency vehicles carrying casualties to triage areas or the emergency room entrance, and to direct incoming and outgoing vehicles carrying people, supplies, and equipment. Charts showing traffic flow and indicating entrances to be used, evacuation routes to be followed, and so forth, should be prepared and included in the Health Care Disaster Plan. Parking arrangements should not be overlooked.

(c) **Internal Security and Traffic Control.** Internal security and traffic control are best conducted by facility trained personnel, that is, regular health care facility security forces, with reinforcements as necessary. Additional assistance from the local law enforcement agencies should be coordinated in the disaster planning phase. Upon activation of the Health Care Disaster Plan, security guards should be stationed at all unlocked entrances and exits, as necessary. Entrance to the facility should be restricted to personnel bearing staff identification cards and to casualties. In the case of major access corridors between key areas of the facility, pedestrian traffic should be restricted to one side of the corridor,

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keeping one side of the corridor free for movement of casualties. Traffic flow charts for internal traffic should also be prepared in the planning phase, as is the case with external traffic control.

### A-11-5.3.7

News Media. Because of the intense public interest in disaster casualties, news media representatives should be given as much consideration as the situation will permit. Ideally, news media personnel should be provided with a reception area, with access to telephone communication and, if possible, an expeditor who, though not permitted to act as spokesman for news releases, could provide other assistance to these individuals. News media personnel should not be allowed into the health care facility without proper identification. To alert off-duty health care staff and for reassuring the public, use of broadcast media should be planned. Media representatives should have access to telephone communications. Media representatives should be requested to wear some means of identification for security purposes.

### A-11-5.3.9

Experiences show the importance of drills to rehearse the implementation of all elements of a specific response including the entity's role in the community, space management, staff management, and patient management activities.

To consider an exercise a drill, the following aspects are typically incorporated and documented: a general overview of the scenario, activation of the disaster plan, evaluation of all involved participants/departments, a critique session following the drill, and any identified follow-up training to correct or improve any deficiencies.

### A-11-5.3.10

Recovery measures could involve a simple repositioning of staff, equipment, supplies, and information services; or recovery could demand extensive cleanup and repair. It can, under certain circumstances, present an opportunity to evaluate long-range ideas concerning modifications to the facility. Filing of loss claims might require special approaches.

Finance. Health care facilities should have access to cash or negotiable instruments to procure immediately needed supplies.

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### **Appendix B Referenced and Informatory Publications**

#### **B-4 Addresses of Organizations and Agencies that Provide Health Care Emergency Preparedness Educational Material (Written or Audio-Visual) (Ref.: Chapter 11.)**

##### Publications

National Fire Protection Association, 1 Batterymarch Park, P.O. Box 9101, Quincy, MA 02269-9101.  
American Health Care Association, 1200 Fifteenth Street NW, Washington, DC 20005.  
American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611.  
American Medical Association, 535 North Dearborn Street, Chicago, IL 60610.  
American National Red Cross, National Headquarters, 17th & D Streets, NW, Washington, DC 20006.  
American Nurses' Association, 10 Columbus Circle, New York, NY 10019.  
Association of American Railroads, 1920 L Street NW, Washington, DC 20036.  
Charles C. Thomas Publisher, 301-327 East Lawrence Avenue, Springfield, IL 60611.  
Dun-Donnelley Publishing Corp., 666 Fifth Avenue, New York, NY 10019.  
Federal Emergency Management Agency, Washington, DC 20472.  
Florida Health Care Association, P.O. Box 1459, Tallahassee, FL 32302.  
Helicopter Association International, 1635 Prince Street, Alexandria, VA 22314-2818.  
International Association of Fire Chiefs, 4025 Fair Ridge Drive, Fairfax, VA 22033-2868.  
Joint Commission on Accreditation of Healthcare Organizations (JCAHO), One Renaissance Blvd., Oakbrook Terrace, IL 60181.  
Pan American Health Organization, 525 23rd Street NW, Washington, DC 20036 (Attn.: Editor, Disaster Preparedness in the Americas).  
University of Delaware, Disaster Research Center (Publications), Newark, DE 19716.  
U.S. Department of Transportation (available from Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402).

##### Audio-visual material

National Fire Protection Association, 1 Batterymarch Park, P.O. Box 9101, Quincy, MA 02269-9101.  
Abbott Laboratories, Audio/Visual Services, 565 Fifth Avenue, New York, NY 10017.  
Brose Productions, Inc., 10850 Riverside Drive, N. Hollywood, CA 91602.  
Federal Emergency Management Agency, Office of Public Affairs, Washington, DC 20472.  
Fire Prevention Through Films, Inc., P.O. Box 11, Newton Highlands, MA 02161.

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General Services Administration, National Audiovisual Center, Reference Section, Washington, DC 20409.

Helicopter Association International, 1635 Prince Street, Alexandria, VA 22314-2818.

Pyramid, P.O. Box 1048, Santa Monica, CA 90406.

University of Illinois Medical Center, Circle Campus, Chicago, IL 60612.

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### **Appendix C Additional Explanatory Notes to Chapters 1-20**

#### C-11 Additional Information on Chapter 11.

Appendix C-11 consists of the following:

C-11.1 General Considerations

C-11.2 Personnel Notification and Recall

C-11.3 Special Considerations and Protocols

##### C-11.1 General Considerations.

The basic plan should be written broadly, providing general but concise coverage of disaster responsibilities and procedures for each facility department and providing detailed responsibilities and procedures for those functions not normally a part of regular routines, for example, operation of the disaster control center. Keyed to the basic plan, the departmental annexes of the plan then outline individual department responsibilities in greater detail. Finally, the disaster procedures for each function within each department are described in terms of actual instructions for individual staff members and employees. Individuals should never be mentioned by name in the plan; rather, responsibilities and procedures should be written in terms of job title. The health care occupancy chapters of NFPA 101, Life Safety Code, are relevant for review and rehearsals.

##### C-11.2 Personnel Notification and Recall.

Medical staff, key personnel, and other personnel needed will be notified and recalled as required. In order to relieve switchboard congestion, it is desirable to utilize a pyramidal system to recall individuals who are off duty or otherwise out of the facility. Under the pyramidal system, an individual who has been notified will notify two other individuals, who in turn will each notify two other individuals, and so on. A current copy of the notification and recall roster, with current home and on-call telephone numbers, will be maintained at the hospital switchboard at all times. In case the pyramidal system is to be utilized, each individual involved in the system must maintain a current copy of the roster at all times, in order that each knows whom they are to notify and the telephone numbers concerned. It is essential that key personnel rosters be kept current.

##### C-11.3 Special Considerations and Protocols.

###### C-11.3.1 Fire and Explosion.

In the event that the health care facility need not be completely evacuated immediately, the actions staff should take when they are alerted to a fire are detailed in Chapter 31 of NFPA 101, Life Safety Code.

###### C-11.3.2 Severe Storm.

The warning system operated by the National Oceanic and Atmospheric Administration will, in most cases, provide adequate time to permit the health care facility to take certain precautions, and if disaster appears inevitable, to activate the Health Care Disaster Plan in advance of the disaster event. Assuming evacuation is not feasible, some precautions include the following:

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- (a) Draw all shades and close all drapes as protection against shattering glass.
- (b) Lower all patient beds to the low position, wherever possible.
- (c) Place blankets on patients/residents.
- (d) Close all doors and windows.
- (e) Bring indoors those lawn objects that could become missiles.
- (f) Remove all articles from window ledges.
- (g) Relocate patients/residents to windowless hallways or rooms.

### C-11.3.3 Evacuation.

Evacuation can be partial or total. It might involve moving from one story to another, one lateral section or wing to another, or moving out of the structure. Even partial evacuations can involve all categories of patients; where these are people who would not routinely be moved, extraordinary measures might be required to support life. It is also necessary to ensure movement of supplies in conjunction with any evacuation. Decisions to evacuate might be made as a result of internal problems or under menace of engulfing external threats. In all cases, the following considerations govern:

- (a) Move to pre-designated areas, whether in the facility, nearby, or in remote zones. Evacuation directives will normally indicate destinations.

NOTE: It is recommended to predesign a mutual aid evacuation plan with other health care facilities in the community. (See B-1.2 for one document on the subject of health care community mutual aid and evacuation planning.)

- (b) Ensure movement of equipment, supplies, and medical records to accompany or meet patients and staff in the new location.
- (c) Execute predetermined staffing plans. Some staff will accompany patients; others will rendezvous in the new location. Maintenance of shifts is more complex than normal, especially when (1) some hard-to-move patients stay behind in the threatened location, and (2) staff might be separated from their own relocated families.
- (d) Protection of patients and staff (during and after movement) against the threatening environment must be provided.
- (e) Planning must consider transportation arrangements and patient tracking.

### C-11.3.4 High Profile.

Admission of a high profile person to a health care facility in an emergency creates two sets of problems that might require partial activation of the Health Care Emergency Preparedness Plan. These problems are as follows:

#### C-11.3.4.1 Security.

Provision of security forces in this situation will normally be a responsibility of the U.S. Secret Service or other governmental agency. However, activation of facility security forces might be required to prevent hordes of curious onlookers from entering facility work areas and interfering with routine facility functioning. Routine visiting privileges and routine visiting hours might need to be suspended in parts of the facility.

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### C-11.3.4.2 Reception of News Media.

The news media reception plans will need to be activated. In this instance, additional communications to the news reception center will be required. Additional telephones and telephone lines can be installed on an emergency basis on request to the local telephone company. Such requests for additional telephone connections in the facility should, however, first be coordinated with the senior Secret Service officer or governmental representative accompanying the dignitary.

### C-11.3.5 Other Protocols as Deemed Desirable.

In addition to the above, there should follow a number of additional protocols for internal disasters, to be determined by the geographical location of the individual health care facility, for example, natural disasters, civil disturbance protocol, bomb threat protocol, hazardous material protocol, loss of central services (power, water, and gas).

### C-11.3.6 Activation of Emergency Utility Resources.

In the planning phase, backup utility resources will have been stockpiled and arrangements made for mutual aid when required. Such utilities include electrical power, water, and fuel. Through prior coordination with the local office of emergency preparedness or fire department, mobile generators and auxiliary pumps can be obtained in the internal disaster situation. Through these same sources arrangements could be made to supply water tank trucks. Obviously, such planning is in addition to routine planning, in which all health care facilities maintain emergency electrical power plants and, in those areas requiring central heating in winter, backup supplies of oil, coal, or gas. Priorities for use of available power (e.g., air circulation but not air conditioning) must be determined. Sanitation requirements can become overriding in prolonged disasters, and even an ordinary strike by garbage collectors can cause difficulties.

### C-11.3.7 Civil Disturbance.

Large-scale civil disturbances in recent years have shown that health care facilities and their personnel are not immune to the direct effects of human violence in such disturbances. Hospitals in large urban areas must make special provisions in their disaster plans to ensure the physical safety of their employees in transit from the hospital exit to and from a secure means of transportation to their homes. In extreme cases it might be necessary to house employees within the health care facility itself during such civil disturbances. Examples of direct attacks or sniping are extremely rare.

Another aspect of civil disturbances not to be overlooked in facility security planning is the possibility that a given health care facility might have to admit and treat large numbers of prisoners during such emergencies; however, security guards for such patients will normally be provided by the local police department.

### C-11.3.8 Bomb Threats.

The disaster potential inherent in the telephoned bomb threat warrants inclusion of this disaster contingency in the Health Care Emergency Preparedness Plan. Experience has shown that facility personnel must accompany police or military bomb demolition personnel in searching for the suspected bomb, since speed is of the essence and only individuals familiar with a given area can rapidly spot unfamiliar or suspicious objects or condition in the area. This is particularly true in health care facilities. The facility switchboard operator must be provided with a checklist to be kept available at all times, in order to obtain as much information as possible from the caller concerning location of the supposed bomb, time of detonation, and other essential data, which must be considered in deciding whether or not to evacuate all or part of the facility.

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### C-11.3.9 Radioactive Contamination.

Disaster planning must consider the possibility of radioactive materials being released from nuclear reactors or transportation accidents, as well as from internal spills. These incidents could require that health care staff and patients be sheltered. Shelter areas can be selected in existing structures and should be planned for during the design of new facilities or additions. Similarly, plans must also consider radiation dose control and decontamination of victims or staff personnel and public safety in connection with nuclear accidents or incidents such as reactor excursions.

### C-11.3.10 Hazardous Materials.

There are at least three major sources of concern with regard to non-radioactive hazardous materials. The first is the possibility of a large spill or venting of hazardous materials near the facility; this is especially likely near major rail or truck shipping routes, near pipelines, or near heavy manufacturing plants. Second, every facility contains within its boundaries varying amounts of such materials, especially in the laboratory and custodial areas. A spill of a highly volatile chemical can quickly contaminate an entire structure by way of the air ducts. Finally, contaminated patients can pose a risk to staff, though on a more localized basis. Usually removal of their clothing will reduce the risk materially. In any case, staff must be prepared to seek advice on unknown hazards. This type of advice is not usually available from poison centers, but rather from a central referral, such as CHEMTREC, and its toll-free emergency information service number (800-424-9300).

### C-11.3.11 Volcanic Eruptions.

While most of the direct effects of a volcanic eruption are covered in other protocols for disasters (fire, explosion, etc.), it is necessary to make special provisions for functioning in areas of heavy to moderate ash fall. This hazard can exist hundreds of miles downwind from the eruption.

Volcanic “ash” is actually finely pulverized rock blown out of the volcano. Outside the area of direct damage, the ash varies from a fine powder to a coarse sand. General housekeeping measures can exclude much ash. It should be noted, however, that people move about freely during and after ash fall.

Ash fall presents four problems for health care facilities.

- (1) People require cleanup (brushing, vacuuming) before entering the building.
- (2) Electromechanical and automotive equipment and air-filtering systems require special care because of the highly abrasive and fine penetration nature of the ash.
- (3) Increased flow of patients with respiratory complaints can be expected.
- (4) Eye protection is required for people who must be out in the dust. (No contact lenses should be worn; goggles are suggested.) Dust masks are available. They are approved by the National Institute for Occupational Safety and Health (NIOSH), and are marked TC-21 plus other digits.

## Sample Evacuation and Relocation Policies and Procedures

### I. Evacuation and Relocation

#### Policy

This facility will plan for partial or total evacuation and relocation of residents, staff, and visitors as required to ensure their care and safety during an emergency event.

#### Key terms used:

- **Total evacuation** – exit and relocation of all residents and staff to any one of several pre-selected relocation sites. The magnitude of the disaster will affect the choice of relocation sites.
- **Partial evacuation** – exit from one part of a facility to another area which has been determined to be safe and structurally sound. Partial evacuations may involve all categories of residents.
- **Horizontal (or lateral) evacuation** – evacuation on the same plane as the incident causing the evacuation. The evacuation should be in a direction away from the scene of the incident to an area behind smoke barriers and fire doors. This evacuation is effective for a facility that is all on one level.
- **Vertical evacuation** – evacuation necessary for any facility that is on more than one level. (Note: if facility is all on one level, horizontal evacuation is the required procedure for this facility).
- **Relocation site** – a facility (whether undamaged health care facility, school, hotel, etc.) where staff and other emergency personnel must be prepared to reestablish some degree of health care function and to accept an influx of additional residents as well.

“In planning for evacuation, a variety of relocation sites must be selected, and the rationale for choice of each option incorporated into the plan for use at the time of implementation. The magnitude of the disaster will affect the choice, as well as consideration of actual or potential damage to the facility itself.” (1990 Edition NFPA Healthcare Facilities, annex 1-3.12)

#### Procedure

1. Total evacuation to another facility
  - A. The key requirement is having current Transfer Agreements/Memoranda of Understanding (MOU) with other facilities that detail agreed upon services and capacities to be made available to the facility being evacuated by the facilities that will receive evacuees. These MOUs will be maintained in the Contracts Manual or other suitable location accessible to the person responsible for managing an evacuation event.
  - B. The following table details applicable contact information for evacuation sites with which this facility maintains Memoranda of Understanding:

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<b>Name</b>		<b>Name</b>	
<b>Address</b>		<b>Address</b>	
<b>City, State Zip</b>		<b>City, State Zip</b>	
<b>Phone Number</b>	(    )	<b>Phone Number</b>	(    )

<b>Name:</b>		<b>Name</b>	
<b>Address</b>		<b>Address</b>	
<b>City, State Zip</b>		<b>City, State Zip</b>	
<b>Phone Number</b>	(    )	<b>Phone Number</b>	(    )

2. Partial evacuation to another facility

A. Current MOUs will be maintained with facilities that can adequately support partial evacuation or short term total evacuation. Due to the expected shorter term of use, these facilities need not offer the full range of services required for total and/or longer duration evacuations, but safety and quality of care will not be compromised.

B. The following table details applicable contact information for evacuation sites with which this facility maintains Memoranda of Understanding:

<b>Name</b>		<b>Name</b>	
<b>Address</b>		<b>Address:</b>	
<b>City, State Zip</b>		<b>City, State Zip</b>	
<b>Phone Number</b>	(    )	<b>Phone Number</b>	(    )

<b>Name</b>		<b>Name</b>	
<b>Address</b>		<b>Address:</b>	
<b>City, State Zip</b>		<b>City, State Zip</b>	
<b>Phone Number</b>	(    )	<b>Phone Number</b>	(    )

3. Partial evacuation to from one part of facility to another part of same facility

A. This alternative should be considered if:

- 1) The emergency is relatively minor in magnitude;
- 2) The emergency is localized and readily limited to a defined area; or

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- 3) The emergency is likely to be relatively short in duration.
- B. The person in charge will assess the emergency situation and determine if evacuation to another part of the facility is an appropriate remedy to maintain the care and safety of all persons within the facility. This internal evacuation/relocation must be started immediately to minimize danger and must be continuously re-evaluated relative to emergency resolution.
- C. If the emergency is not contained and/or reduced to a level that allows restoration of standard care and safety levels within a previously determined acceptable time interval, the person in charge is responsible for instituting additional actions up to and including full evacuation to alternate facilities that will allow restoration of appropriate and acceptable care and safety.
- D. The following detailed evacuation process is to be used in time of emergency as follows:
  - 1) Staff will immediately remove any person(s) that might be in a room wherein there is a hazard. The door or doors and windows to this area will then be closed. The adjoining rooms will then be evacuated.
  - 2) Evacuees will be moved away from the danger area in the direction of the nearest safe exit, on the same floor. Evacuees must be beyond the nearest smoke barrier/fire doors.
  - 3) Persons that may be in the hall or corridors will also be moved in the direction of the nearest safe exit away from the danger area.
  - 4) If conditions warrant, evacuees are to be taken out of the building to a pre-designated safety zone where the person in charge will take a census.

## **II. Transportation Planning to Enable Evacuation/Relocation**

### **Policy**

To have current Memoranda of Understanding (MOU) in place that detail source(s) of vehicles available to the facility for relocating residents and staff during an emergency event as an integral component of the evacuation preparedness planning.

### **Procedure:**

Initiate and maintain

1. Memoranda of Understanding (MOU) [see Contract Manual] with transportation provider(s) who will provide appropriate vehicles to facilitate safe and timely transportation of residents and staff to alternative sites.

<b>Name</b>		<b>Name</b>	
<b>Address</b>		<b>Address</b>	
<b>City, State, Zip</b>		<b>City, State, Zip</b>	
<b>Phone No.</b>	(     )	<b>Phone No.</b>	(     )

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<b>Name</b>		<b>Name</b>	
<b>Address</b>		<b>Address</b>	
<b>City, State, Zip</b>		<b>City, State, Zip</b>	
<b>Phone No.</b>	(     )	<b>Phone No.</b>	(     )

2. Listing of local and surrounding rescue departments with whom the facility has Memoranda of Understanding for assistance during an emergency event requiring evacuation of residents and staff.

<b>Name</b>		<b>Name</b>	
<b>Address</b>		<b>Address</b>	
<b>City, State, Zip</b>		<b>City, State, Zip</b>	
<b>Phone No.</b>	(     )	<b>Phone No.</b>	(     )

<b>Name</b>		<b>Name</b>	
<b>Address</b>		<b>Address</b>	
<b>City, State, Zip</b>		<b>City, State, Zip</b>	
<b>Phone No.</b>	(     )	<b>Phone No.</b>	(     )

### **III. Resident care during evacuation/relocation and return**

#### **Policy**

To ensure that residents receive all required care throughout the period of evacuation/relocation and return to the original facility.

#### **Procedure**

The Director of Nursing is responsible for ensuring resident care during evacuation/relocation events.

1. All resident evacuation/transfers to be appropriately documented per required transfer sheet process.
2. A 24-hour supply of medications necessary for continuity of care for each resident will be placed in a plastic bag.
  - A. The resident's transfer information sheet will be stapled to his/her medication bag and transported along with him/her to the evacuation site.
  - B. Medications that are sent will be documented in the Medication Administration Record.

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3. The Director of Nursing or designee will notify the attending physician and pharmacy of resident transfers.

### **IV. Acceptance of Residents from other Facilities**

#### **Policy**

To define and develop the process and Memorandum of Understanding (MOU) requirements for accepting residents from another facility affected by an emergency/disaster event.

#### **Procedure:**

1. Develop and maintain a facility occupancy database on a scheduled basis. Data is to include licensed capacity by bed/acuity level type, equipped capacity by type, and occupancy by type. These data will facilitate an accurate determination of number and type of additional residents that can be accommodated up to licensed levels.
2. If there is either unused space or under-utilized space, estimate the number of additional residents that could be accommodated by resident type, acuity level, other resident-specific characteristics that would define facility needs in order to meet required care levels for incoming temporary residents.
3. Estimate time and other logistics required to prepare the unused and/or under-used space to accept temporary residents, and incorporate into the facility emergency occupancy levels planning.
4. Review staffing levels and necessary logistics to increase based on expansion scenarios described above, including the time required to meet minimum required levels.
5. In coordination with the local, municipal, and/or county Office of Emergency Management, designate the facilities that may request to include your facility into their Emergency Management Plan as an evacuation site.
6. Define and develop a Memorandum of Understanding with possible sending facility(s) that details terms and conditions, activation and notification protocols, cost accounting and billing procedures, and other logistics required to accommodate the needs of both sending and receiving facilities. Be sure that a priority order is established if your facility is included as a potential evacuation site for multiple facilities whose combined volume of residents cannot be accommodated.
7. Review with OSDH any potential issues regarding staffing levels or other licensure regulations that have the potential for breach during the response and recovery phases of any emergency event that involves receiving residents from other facilities. This review should include planned-for (via MOU) and unplanned resident in-flow, and the notification protocol to OSDH by the receiving facility in the event that discussion is required during the resident receipt process.
8. At least annually, review these MOUs with sending facilities and the appropriate OEM coordinators and update as necessary.