Moving from Paper to Readiness

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Chief Nursing Officer

This Can Be One of the Toughest Moments

Crisis Standards of Care, Defined

A substantial change in usual health care operations and the level of care it is possible to deliver, which is made necessary by a pervasive (for example, pandemic influenza) or catastrophic (for example, earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government, which recognizes that crisis operations will be in effect for a sustained period. The formal declaration that crisis standards of care are in operation enables specific legal/regulatory powers and protections for health care providers in the necessary tasks of allocating and using scarce medical resources and implementing alternate care facility operations.

The Disaster Life Cycle

The four phases of the disaster life cycle are Mitigation, Preparedness, Response, and Recovery.

Event: If an event occurs, it enters the Recovery phase.

Emergency Preparedness Plan

Organizations with events in the last 5 years that required implementation of the emergency preparedness plan:

- Winter Storm: 52%
- Power Outages and Other System Failures: 48%
- Tornado: 20%
- Flood: 17%
- Hurricane: 17%
- Hazardous Spill/Hazardous Material Incident: 15%
- Mass Casualty Incident: 13%
- Fire: 12%
- Emerging Infectious Diseases (exclude H1N1): 12%
- Bomb Threat: 8%
- Earthquake: 6%
- Evacuation: 5%
- Active Shooter Incident: 4%
- Mass Transit Strike or Disruption: 2%
- No Threats or Events: 13%

Source: HFM/AHE/AHE/AMM 2014 Emergency Management Survey
My Own Disasters

- Winter Storms
- Boiler Explosion
- Power Disruption
- Unbomber
- Active Shooter (x2)
- Police Line • Police Line
- Murder-Suicide
- Airplane Crash
- Flood
- Mass Casualty Incidents
- Epidemic Levels Infectious Diseases (too many to count)
- Microburst
- Surge 300 people in 30 minutes
- Fire (x4)
- Murder of pregnant woman presented as woman who delivered
- Plane Crash
- Mass Casualty Incidents
- Winter Storms
- Power Disruption

The Disaster Life Cycle

- Mitigation
- Preparedness
- Response
- Recovery
- Pre-impact
- Post-impact
- Emergency
- Restoration
- Rebuilding
- Capacity Building

EVENT
Train Yourself

- Winter Storms
- Active Shooter (x2)
- Boiler Explosion
- Power Disruption
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- Murder of pregnant woman presented as woman who delivered
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Training and Exercises

- National Incident Management System
  - NIMS 100 – All employees; part of orientation
  - NIMS 100, 200 and 700 – Administrators, Department Heads, Supervisory Employees
  - NIMS 800 – One supervisory level per facility
- Employee and volunteer training
- Exercises and drills
- Action plans, de-briefing and revisions

Incident Management Team

The Disaster Life Cycle
Moving Requirements to Tangible Understanding for Team Members and Leaders

Part 1
Readiness Planning
Anticipatory and Experiential

Part 2
Putting Planning into Organizational Memory and Action
Emergency Operations Plan (EOP)

Part 3
Memory Muscle
Drills, Training, Communication
Continuity of Operations Plan (COOP)

Not if...but when...

Readiness Planning

Emergency Preparedness Checklist
**First Requirement – Plan Must Be Reviewed and Updated at Least Annually**

Any time you activate and use the plan – you update it from the learnings gained through the debrief and the “what worked well?” “what can we do better?”

That is why you drill to have a viable plan that guides EVERYONE.

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**Risk Assessment**

<table>
<thead>
<tr>
<th>Look to the Past</th>
<th>Assess the Present</th>
<th>Design for the Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Events</td>
<td>Coordination, Collaboration</td>
<td>Readiness Planning</td>
</tr>
<tr>
<td>Records, Newspapers, Shared Stories</td>
<td>Partnerships</td>
<td>Emergency Supplies Ready</td>
</tr>
</tbody>
</table>

*Source: Medicare and Medicaid Programs Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; 10/9/2016*
Risk Assessment or Hazard Vulnerability (HVA)

Develops numeric value to quote relative threat

Probability
Human Impact
Response
Property and Business Impact

It is not a static document – It evolves to guide Emergency Preparedness Plan

Source: AHCA/NCAL

Risk Assessment

<table>
<thead>
<tr>
<th>Events</th>
<th>Vulnerabilities</th>
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</thead>
<tbody>
<tr>
<td>Naturally Occurring</td>
<td>Human Impact</td>
</tr>
<tr>
<td>Human Influenced</td>
<td>Risk of injury/death to employees or residents</td>
</tr>
<tr>
<td>Technological</td>
<td>Property Impact</td>
</tr>
<tr>
<td></td>
<td>- Damage risks</td>
</tr>
<tr>
<td></td>
<td>- Cost to replace, for temp replacements, repairs, etc.</td>
</tr>
<tr>
<td></td>
<td>- Time to recover</td>
</tr>
<tr>
<td></td>
<td>Business Impact</td>
</tr>
<tr>
<td></td>
<td>- Will business be disrupted</td>
</tr>
<tr>
<td></td>
<td>- Employees ability to report or access work environment</td>
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<tr>
<td></td>
<td>- Customers/families access to facility</td>
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<tr>
<td></td>
<td>- Contractual agreements that will result in fines, penalties, legal costs</td>
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<tr>
<td></td>
<td>- Interruption of critical supplies</td>
</tr>
<tr>
<td></td>
<td>- Financial impact/burden</td>
</tr>
<tr>
<td></td>
<td>- Public image</td>
</tr>
</tbody>
</table>

Source: AHCA/NCAL
Risk Assessment Can Not be Done in an Office on a Friday Afternoon

**Identify and Rank Hazards**
List the natural and man-made hazards that occurred in the community including earthquake, flooding, wind, man-made issues

- Data: State and local agencies
- NFIP/FEMA Maps
- Local residents and nonprofit organizations
- Topographic and soil maps
- Newspaper archives/libraries

**Considerations**
- Add maps to plan for visual cueing
- Conduct partner meetings with residents living around facility
- Have routes planned out on paper show blocks or barriers and contingency planning

Emergency Preparedness and Planning

- Identify and meet community partners
  - Emergency management, fire, police, utilities
  - Long term care and aging service providers
  - Hospital preparedness coalition members
  - Media, transport services, funeral homes
  - Special medical services i.e. dialysis care
- Invite partners to your facility
- Get contact information
- Discuss roles in an emergency
- Share facility plans with community partners

Source: http://www.uky.edu/publichealth/sites/www.uky.edu.publichealth/files/2VAV/32M5S3C1DOPowerPointHandouts.pdf
Establish Memorandums of Agreement

At a minimum, mutual-aid agreements should include the following:

- Definitions of key terms
- Roles and responsibilities
- Procedures for requesting and providing assistance
- Payment, reimbursement, and allocation of costs
- Notification procedures
- Protocols for interoperable communications
- Agreements among jurisdictions
- Workers compensation
- Liability and immunity
- Qualifications and certifications
- Sharing of agreements


Other Partners: Service Agreements and Back-up Plans

- Food, Food Service, Water
- Dialysis/Specialist Care
- Security
- Medications and Pharmaceutical Supplies
- Laundry Service
- Transportation
- Oxygen and Supplies
- Fuel
- Evacuation Locations

Disaster, Terrorism & Mass Casualties

Top 10 Features Incorporated into Facilities to Address DISASTERS, TERRORISM and MASS CASUALTIES

- Additional Fuel and Emergency Supply Storage: 45%
- Flexible Incident-Command Locations: 42%
- Additional Generator Capacity: 38%
- Advanced Security/Lockdown Systems: 37%
- Expanded Emergency Communications Systems: 32%
- Extra Space for Decontamination/Mass Casualties: 29%
- Remote Data Center: 27%
- Prevent Access to Outdoor Air Intakes: 23%
- Additional Uninterruptible Power Supply Capacity: 22%
- Enhanced Air Pressure Control and Isolation Capabilities: 19%

Source: HFM/ASHE/AHE/AHRMM 2014 Emergency Management Survey

Emergency Operations Plan
Must Haves in Emergency Operations Plan (EOP)

1. System to track the location of on-duty employees and sheltered residents in the facility’s care during and after an emergency.
   If on-duty employees and sheltered residents are located during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location.

2. Safe evacuation from the facility, which includes consideration of care and treatment needs of evacuees; employee responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

Source: Medicare and Medicaid Programs Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; 10/9/2016
Must Haves in EOP

3. A means to shelter in place for residents, employees and volunteers who remain in the facility

Source: Medicare and Medicaid Programs Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; 10/9/2016

Must Haves in EOP

4. A system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records.

Source: Medicare and Medicaid Programs Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; 10/9/2016
The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of state or federally designated health care professionals to address surge needs during an emergency.

The development of arrangements with other facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to residents.
Facility Go-Box

- May use for shelter-in-place or evacuation
- Vital information for facility
- Emergency equipment, phones, radios
- Keys, floor plans, badges, security vests
- Personnel lists, payroll information
- Personal preparedness equipment
- Badges for visitors, labels, markers
- Cash, credit cards
- Incident Command Job Action Cards


Shelter-in-Place Decision Criteria

- Determine the type of emergency
- Determine the extent and severity of the emergency
- Activate Incident Commander and Management Team
- Get input from National/State/Local Officials, Emergency Management, Fire, Police, etc.
- Determine the greatest safety for residents – Stay or Go
- Determine the immediate ability to meet needs
- Determine opportunities to make alternate decisions as conditions change

Shelter-in-Place: Decision to Stay

- Activate Incident Command System, if not activated
- Notify owners, regulation offices, Emergency Management, LTC Ombudsman, medical directors, etc.
- Notify employees, residents, family members/responsible parties
- Activate department call lists – confirm availability, family
- Instruct all visitors, volunteers to stay
- Enable communication with persons off-site
- Close/lock windows, exterior doors, other openings
- Create water supply (3 gal/person/day/7days)
- Turn off/on fans, heat as needed to fit emergency
- Access supplies as needed

Shelter-in-Place: Surge Capacity

Assess Surge Hosting/Capacity

- Conventional Capacity in a regular emergency – Employees, family, volunteers, visitors
- Contingency Capacity – Surge in neighborhood, county, other facilities
- Crisis Capacity – Major surge from across the state, other states, hospitals, other facilities, community

Sheltering Non-Residents

- Determine what your facility is able to do for families of residents, employees and the community
- Establish time lines and risk waivers
- Establish rules for facility use
- Plan for pets and children
- Secure additional food and supplies
- Advise employees, residents and community partners of the plan and the limitations

Evacuation Order

- The Administrator/Incident Commander of the Facility determines the order of resident evacuation. Type/level of disaster, patients’ conditions and transportation may change order for evacuation.
  - Phase I: Transport the highest acuity residents traveling via ambulance; these residents will be transferred first, if possible
  - Phase II: Transport all other residents who can travel via buses and cars.
- Triple the usual estimated time for a full-scale facility evacuation and travel to sheltering facility
- Triple the estimated food, water, blankets, medication, fuel, personal hygiene items, etc.
- Consider means of transportation
  - School buses
  - Vans
  - Motorcycles – Pick up medications and supplies, ferry people out and in
Death Surge

- Community planning for worst case
- Agreements in place with funeral homes, public health and emergency management
- Assessment of facility capacity for holding deceased residents
- Plans for notifying others
  - Officials
  - Families
  - Responsible parties
  - Media


Must Haves for EOP

Communication Plan – Plan must be reviewed and updated at least annually

1. Plan must include: Names and contact information

Entities Providing Services Under Arrangements

Other Long Term Care Facilities

Residents’ Physicians

Volunteers

Employees

Source: Medicare and Medicaid Programs Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; 10/9/2015
Must Haves for EOP

2. Contact information for the following:
   - Federal, State, Tribal, Regional or local emergency preparedness employees
   - The State Licensing and Certification Agency
   - The Office of the State Long Term Care Ombudsman
   - Other sources of assistance

Crisis Public Relations

- May need to identify an LTC Facility Incident Command Employee Public Relations Officer
  - Official spokesperson for the facility for the press, families, responsible parties and community
  - Should be trained regarding public relations/press
  - Needs to provide balanced release of information
    - How, Who, When and Where you will release information
    - What residents, volunteers, families, responsible others, press want to know

Source: Medicare and Medicaid Programs Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; 10/9/2016
The Disaster Life Cycle

The diagram illustrates the disaster life cycle with the following stages:
- Mitigation
- Preparedness
- Response
- Recovery
- Pre-Impact
- Capacity Building
- EVENT
- Emergency
- Restoration
- Reconstruction

Memory Muscle

Training That Sticks in Action and Function
Must Haves in EOP

Training Program

The facility must do all of the following:

1. Initial training in Emergency Preparedness policies and procedures to all new and existing employees, individuals providing services under arrangement, and volunteers consistent with their expected roles
2. Provide emergency preparedness training at least annually
3. Maintain documentation of the training
4. Demonstrate employee knowledge of emergency procedures

Source: Medicare and Medicaid Programs Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; 10/9/2016

Training Process

- Drill off hours with least resources available
- Utilize a scenario that requires full activation of plan
  - Earthquake
    Complete isolation
    Total evacuation
  - Pandemic Disease
    Cannot transfer
    Isolation for protection
- Remember to test Human Behavior reactions

Source: Medicare and Medicaid Programs Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; 10/9/2016
The Disaster Life Cycle

Further Actions
Emergency and Standby Power Systems

1. Emergency Generator Location
2. Emergency Generator Inspection and Testing
3. Emergency Generator Fuel

Post-Evacuation

- Return and Recovery
  - Responsibility of the sending facility
  - Includes return arrangements and costs
  - Return timeframes may involve multiple shifts/days depending on volume, distance and availability of transportation

- Resident Psychological Needs
  - Greatest after an evacuation, especially if fatalities
  - Stress reactions may appear up to six months post evacuation

- Employees Psychological Needs
  - Post-Traumatic stress disorder will impact your organization
Continuity of Operations and Recovery

- Operating with reduced employees
- Securing additional employees
- Maintaining essential functions
- Assuring safety of residents, employees and volunteers
- Protecting equipment, records and assets
- Minimizing disruption and losses
- Addressing financial needs (continued payroll, invoice payment, cash on hand)


Re-Entry and Post Disaster

- Re-Entry to Facility
  - When deemed safe by appropriate authorities
  - After notification of LTC Ombudsman
  - May involve gradual return to normal operations

- Post Disaster Procedures
  - Secure property
  - Damage assessment
  - Inventory (facility/residents’ property)
  - Insurance/FEMA documentation

Post Evacuation Return

- **Transportation**
  - Transportation may be scarce/need staging
  - Work with Emergency Management before, during and after the emergency
  - Collaboration with receiving facility
  - Be aware of community need to share resources in wide-spread disaster
  - Payment for transport and resident/employee care is responsibility of original sending facility

- **Behavioral/Mental Health/Psychological First Aid**
  - Community mental health services

Corrective Action Plan for Actual Disaster

- **Internal Action**
  - Have a multi-departmental de-briefing
  - Review what parts of the plan worked well
  - Identify areas that need revisions
  - Make revisions as needed
  - Record changes and dates on LTC Facility Emergency Preparedness Plan

- **External/Community Action**
  - Share lessons learned with community providers (Regional Healthcare Preparedness Program Coalition, LTC Subcommittee, Emergency Management, Utilities, Vendors, etc.)
"You think you're prepared, and then when it happens – you realize how vastly you're not."

– Hatsue Seto, Chief Nursing Officer
Tahoku yakka University Hospital