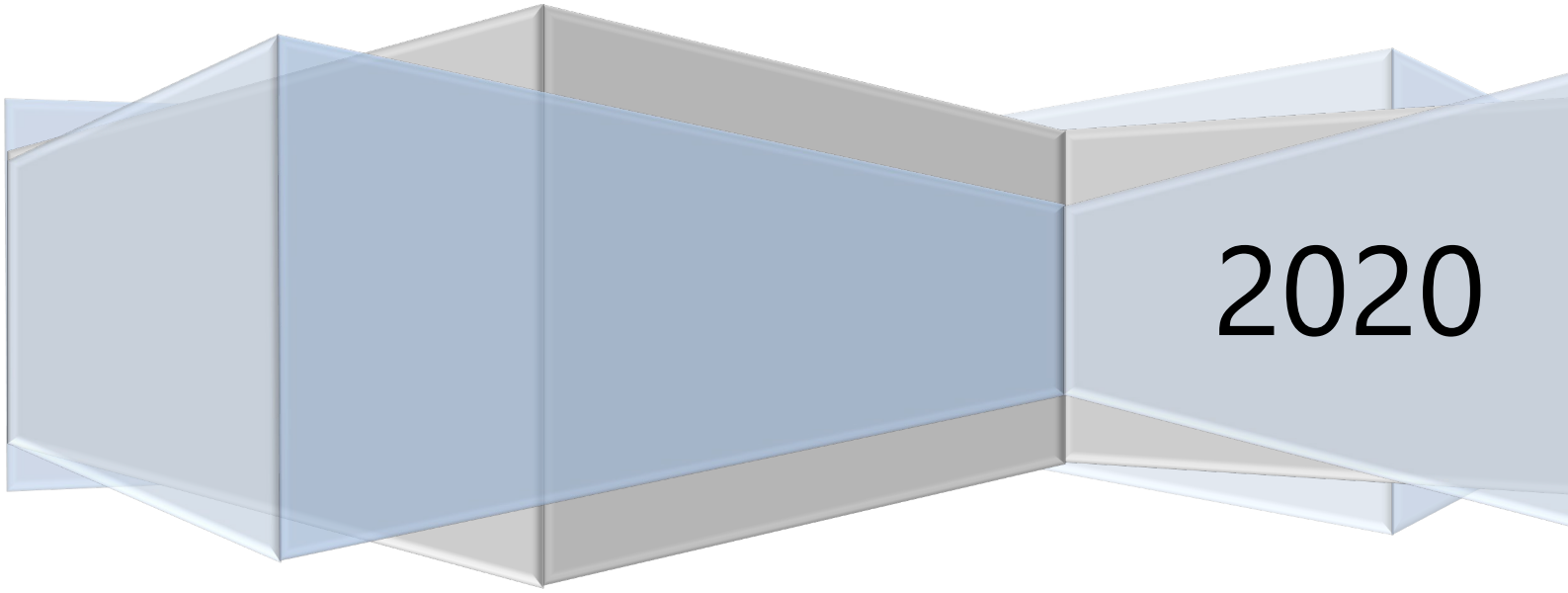
COTS

An affiliate of the Columbus Medical Association

SEOHC Coalition

LONG-TERM CARE
LEVEL 1 SURGE TEMPLATE



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Background

Community emergency response involves the coordinated efforts of many different individuals and organizations. Traditionally emergency management, police, fire, EMS, public health, and acute care hospitals have collaborated to plan for all hazards disaster response, including incidents resulting in a surge of victims requiring care. The Assistant Secretary for Preparedness and Response (ASPR) continues to encourage preparedness at the hospital and first responder level but recognizes that response by acute care providers to a large-scale incident cannot be successful without engaging other critical community partners. Collaboration in the form of Regional Coalitions involving healthcare providers other than acute care hospitals is encouraged. Long-term care facilities, though historically not involved in planning for incidents originating outside of their facilities, are encouraged to participate in local healthcare coalitions (HCC), as they will be important community partners in handling a large scale influx of patients requiring care.

During a healthcare disaster, long-term care facilities may face many issues. They may have limited ability to transfer residents to acute care hospitals because hospitals are overwhelmed with sick and/or injured. They may become receiving facilities for other long-term care organizations that are unable to remain open or need to evacuate. They may need to expand their role in the greater healthcare system to care for members of the community seeking shelter. More importantly, LTC facilities, may be asked to admit patients that are off-loaded from hospitals during an emergency in order to open up in-patient beds in the hospitals to allow for hospitals to admit acutely ill or injured patients. Whatever the presenting scenario; long-term care facilities serve particularly vulnerable populations and will face unique challenges.

Some emergencies escalate unexpectedly but are relatively short-lived. Some continue to evolve over time and strain not only one or two organizations but involve entire communities or regions including regional infrastructure and supply chains. In order to respond effectively to either contingency, long-term care facilities must prepare by planning to care for and shelter their own patients while expanding their role within the greater healthcare coalition.

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Hospitals in the Southeast/Southeast Central Ohio Region have Level 1 and Level 2 Surge Plans in place. Expedited transfers **to** long-term care facilities and restricted acceptance of transfers **from** long term care facilities are part of these hospital plans. It is important that long-term care facilities have plans in place to efficiently and safely respond to these challenges originating outside of their organization. Surge Planning for long-term care will include procedures for receiving a surge of residents over a short period of time without changes in standards of care or alteration of caregiver to resident ratios.

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Definition of Level 1 Surge Response:

The facility initiates procedures necessary to increase capacity and capability to accept and adequately care for residents received due to a sudden incident of short duration (hours to days) or prolonged, evolving incident (weeks to months) with minimal or no change in Standard of Care or caregiver/resident ratios.

General Assumptions:

- The region's acute care hospitals are already at or near capacity for inpatient care and will be quickly overwhelmed in a large-scale disaster incident.

- Hospitals may need to expedite transfers of all patients capable of moving to a lower acuity of care in order to accept critically ill and injured victims.

- Hospitals may be unable to accept transfers from other healthcare facilities until the disaster is over, forcing sending facilities to provide more acute care than is normally available.

- In sudden, short incidents relief from regulatory demands will likely not be available.

- The "Just in Time" theory of supply chain resource management is not conducive to generating surge capacity or sustaining capability.

- Long-term care health facilities serve particularly vulnerable populations who will face unique challenges during a disastrous event. Alteration in routine and environment increases the potential for injury and psychological distress in this.

- Incoming residents should only be accepted if Nursing Home Level of Care is pre-determined.

- Staff and volunteers will experience physical and emotional fatigue that may require behavioral health oversight and intervention.

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PROCEDURE #1: INITIATE INTERNAL AND EXTERNAL INCIDENT NOTIFICATIONS

GUIDING PRINCIPLES:

Communication is one of the most critical elements in disaster response. In the case of a planned response to an influx of residents, receiving the initial information from the requesting facility and alerting the necessary internal responders and external partners is key.

Notification procedures and responsible individuals will vary from one facility to another. However, these procedures should be planned in advance and communicated to all supervisory staff and those most likely to receive incoming notification or requests for assistance.

For the purposes of this document the facility requesting to send residents is referred to as the "Requesting Facility"; and the facility responding or accepting residents is referred to as the "Receiving Facility".

RESPONSIBLE POSITION: _____ is responsible for the functions of this procedure. (The person holding this position in the organization would make the decision to implement this procedure.)

REQUIRED ACTIVITIES:

- Initial notification of a receiving facility may originate from another long-term care facility or acute care hospital via direct phone call. When the call is received it should be directed to _____ (the facility Administrator, Director of Nursing or designee), or a detailed message should be taken and communicated to_____.

- When receiving the initial call, the following information should be gathered from the requesting facility:
    - Incident information
    - Requesting facility name, contact person and contact phone number

- Total number of residents needing beds
- Resident details
  - Number and gender of residents
  - Special needs
  - Level of care
  - Transportation method
  - Equipment and/or staff arriving with residents (if needed)
  - Medications arriving with residents and method of storage
  - Charts accompanying residents

- Other agencies/facilities involved in the incident and/or response.
- Notification of families/responsible persons by Requesting Facility.

- Notify _____ (facility Department Heads and Medical Director).

- Notify the following emergency response partners:

  - Notify the **COTS Healthcare Incident Liaison (COTS HIL)**

Contact the COTS HIL by dialing 855-266-7243, entering ID 26874451 and entering your return contact number
Or
Email 26874451@onpage.com and provide your callback number

- Contact residents' responsible parties as soon as possible and provide periodic updates as necessary.

END PROCEDURE #1

PROCEDURE #2: ESTABLISH THE INCIDENT COMMAND CENTER (ICC) AND ASSIGN ESSENTIAL RESPONSIBILITIES

GUIDING PRINCIPLES:

The concept of the Incident Command System (ICS) is based on the need to respond quickly to an emergency situation by initiating a temporary hierarchy of leadership positions and management by objectives. Hospitals have used the Hospital Incident Command System (HICS) since 2004 when it became a requirement in order to qualify for federal grants related to disaster preparedness and response.

RESPONSIBLE POSITION: _____ is responsible for the functions of this procedure.

REQUIRED ACTIVITIES:

- The **Incident Command Center (ICC)** will be located in the _____. (This location should have telephones and computers available as well as desk space for several individuals to work comfortably and space for Incident Briefings). A backup location should be designated in case the primary location is damaged or unusable for any reason.

- The most appropriate senior staff member present at the time of notification of the incident will assume the role of **Incident Commander (Person in Charge)**. This role should always be filled, and all those assisting with the incident response should be aware of the identity of the **Incident Commander (Person in Charge)**. This role can be transferred to another more qualified individual if they become available.

- In the case of a **Surge** incident, appropriate **Command Staff** and **General Staff** positions should be assigned.

If the facility does not implement a formal **ICS,** critical responsibilities should be assigned as follows:

- **Safety and Security Officer** to establish a traffic pattern and provide security to those entering the facility and staff caring for them in the **Intake Area**. (This may be a staff member from any area if there is no **Safety and Security Officer** available)

- If possible, a **Recorder** should be assigned to document all aspects of the response. If there is not enough staff on duty to dedicate one person to this task, each person assisting with the response should document in as much detail as possible the events in their respective areas. The **Incident Commander** can also maintain a timeline of the response.

- Designate an individual to prepare and provide statements to the media and to families. Coordinate statements with the **Requesting Facility** and **Local Emergency Agencies**. The **Incident Commander** or **Liaison Officer** may do this. All other staff members should be instructed to direct media or family questions to the designated individual.

- **Intake Staff** to set up and implement a designated reception area for incoming residents. Include a qualified staff member to review pre-admission screens **(PAS)** and/or **Level of Care (LOC).**

- **Transportation** staff to escort incoming residents to assigned rooms.

- **Logistics** staff to obtain all necessary equipment and supplies.

- **Liaison Officer** (may be the **Incident Commander**) to communicate with all external agencies as needed.

- After initial assignments are made, assignments/goals are discussed and the **Incident Briefing** is given, a time should be established for the next meeting to discuss the status of the response. This time period is referred to as the **First Operational Period** in **ICS.**

END PROCEDURE #2

PROCEDURE #3: ASSESS THE CURRENT BED STATUS AND THE NUMBER OF ADDITIONAL RESIDENTS THAT CAN BE ACCEPTED

GUIDING PRINCIPLES:
Level 1 Surge must be accomplished without alteration of Standard of Care and/or caregiver to resident ratios. Regulatory requirements do not usually change in a Level 1 Surge incident. The number of licensed beds available will determine the number of residents that can be accepted.

Operations may change significantly and some non-essential care/documentation may be delayed until the Recovery Phase of the incident.

RESPONSIBLE POSITION: _____ is responsible for the functions of this procedure.

REQUIRED ACTIVITIES:

- _____ will refer to the (current census system or form) and round on resident units to assess the ability to covert any private rooms to semi-private.

- Open any closed rooms on resident units and prepare them for admissions.

- Request all **Charge Nurses** to designate any potential discharges on each unit and expedite necessary discharge planning.

    - Notify _____ for assistance with discharge planning.
    - Notify any facilities sending elective admissions to hold them until the incident is over.

- Report the immediate bed and level of care availability to the **Incident Commander**.

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- Communicate to staff on the resident units the need to be ready to receive an influx of residents to all open beds.

- Access the **Coalition Healthcare Disaster Information Management System (COHDIMS)** website at cotshil.org click on the correct incident tile and enter a situation report for a **Non-Hospital Healthcare Partner.**

- Communicate the number and type of residents your facility is able to receive to the:
    - **Requesting Facility**
    - **Receiving Facility Administrator**
    - **Receiving Facility Medical Director**
    - **COTS Healthcare Incident Liaison (HIL)**

Contact the COTS HIL by dialing 855-266-7243, entering ID 26874451 and entering your return contact number
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END PROCEDURE #3

PROCEDURE #4: ASSESS CURRENT RESOURCES ON HAND AND STAFFING AVAILABLE

GUIDING PRINCIPLES:

Level 1 Surge response must maintain Standard of Care and caregiver to resident ratios similar to normal operations. However, utilization of supplies may be curtailed in order to provide time for additional procurement from vendors.

Non-essential patient care activities may be postponed during a Level 1 Surge incident so that staff can be re-assigned.

Work schedules may be changed to maximize staff availability (eight hour shifts extended to 12 hours).

Staffing should be planned to support several consecutive shifts in a Level 1 Surge incident, therefore all staff should not report for duty immediately.

RESPONSIBLE POSITION: _____ is responsible for the functions of this procedure.

REQUIRED ACTIVITIES:

- _____ will assess available staff on duty at the time of the notification.
- Initiate staff call-in procedures, as needed keeping in mind the need to plan for more than the current shift.
- Document all resources used that are disaster related throughout the duration of the incident, especially those exceeding normal usage.
- Establish a **Labor Pool** in _____ and direct off-duty staff called in to report there for assignment to the most appropriate resident unit.

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- There may be times when staff from the requesting facility accompanies the residents arriving at your facility. If this occurs, confirm that arriving staff from **Requesting Facilities** are identified and tracked:

    - Log in staff as they arrive.
    - Provide **ID Badges** or request that staff wear ID from their own facility.
    - Identify where and to whom arriving staff are to report on the resident units.
    - Follow **Disaster Privilege Policy** if applicable.

- _____ will assess patient care and nutritional supplies and water on hand and contact vendors for additional supplies as needed.

- The **Incident Commander** or designee may contact the **COTS HIL** for supplies available in **Regional Supply Caches** if needed.

- Contact the local **Emergency Management Agency (EMA)** for supplies or equipment not available from other sources.

Note: All Southeast/Southeast Central **Region Hospitals** and **Southeast/Southeast Central Ohio Healthcare Coalition (SEOHC)** share supplies in **Regional Supply Caches** based on population served and urgency of need. Therefore, availability is not guaranteed and is based on the type and severity of the incident.

END PROCEDURE #4

PROCEDURE #5: ESTABLISH A RECEPTION AREA FOR INCOMING RESIDENTS

GUIDING PRINCIPLES:

All new residents must be received in a coordinated way that ensures proper identification and admission documentation. New resident arrivals may be handled per usual processes. Procedure #5 may be implemented if several residents arrive at the same time in mass transit.

Real life disasters such as Hurricane Katrina and Hurricane Sandy have shown that elderly LTC facility residents suffer more physically and emotionally from the stress of disaster response than the general public. Care should be taken to provide comfort measures and psychological support during and after transfer to a new location.

The Reception Area must be protected from the environment and offer easy access to transport vehicles.

The Reception Area must have a method of communication to the ICC and Facility Security.

Documents arriving with residents will vary according to the sending facility.

Admission documentation requirements are not waived in a Level 1 Surge incident. However, the timing of their completion may be altered to allow for the sudden influx of residents and the need to expedite their safe transport to a room.

ICS forms may be used to streamline admission documentation.

Permission to treat should be obtained in the Reception Area from the resident and/or from the responsible party as soon as possible.

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Staff arriving from the Requesting Facility to assist with resident care remain employees of the Requesting Facility for the purposes of wages and Workers Compensation. They should be paired with regular staff of the Receiving Facility for supervision.

RESPONSIBLE POSITION: _____ is responsible for the functions of this procedure.

REQUIRED ACTIVITIES:

- Request _____ to complete the physical setup of the **Reception Area**. The following equipment/supplies are suggested:

    - Tables and chairs for staff work areas

    - Vital sign monitor equipment (electronic or manual)
    - Communication devices (land line telephones, cell phones, radios)
    - Intake forms
    - Master list of incoming residents
    - Restroom facilities
    - Staff nutrition station/cart
    - Hand washing station or sanitizer
    - Personal Protective Equipment (gloves, masks)
    - Wheelchairs
    - Blankets
    - Portable oxygen (cylinders, tubing, cannulas and masks)

- _____ will assign staff to the **Reception Area.** Suggested staffing in this area includes but is not limited to:

    - Charge Nurse
    - Social Work/Case Management
    - Nursing Assistant
    - Registrar
    - Transporter(s)
    - Security

- Triage each arriving resident. If residents do not arrive with a completed **Disaster Tag** or other form of identification, attempt to minimally collect and document the following information for each resident:

    - Name/Date of Birth
    - Responsible party
    - Medical diagnosis
    - Medication allergies
    - Other allergies
    - Diet restrictions/time of last meal
    - Medications/ time of last administration
    - Mental status
    - Mobility
    - Special needs, precautions or equipment
    - Valuables with the patient (method of storing and documentation)

- Apply a **Patient Identification Band** and **Special Needs/Allergy Band** to each resident entering the facility.

- Initiate an **Interim Admission Folder** that can later be converted to a resident chart or scanned into a permanent medical record.

- Identify a method to receive and secure medications arriving with residents according to **Pharmacy** regulations.

END PROCEDURE #5

PROCEDURE #6: INITIATE THE RECOVERY PHASE OF LEVEL 1 SURGE

GUIDING PRINCIPLES:

Disaster and crisis planning is often very focused on preparing and responding. Another critical component is recovery. At this point the worst of the acute crisis has past, but often the hardest part for responding facilities is the Recovery Phase.

The Recovery Phase needs to be well coordinated with others such as local emergency management, financial personnel, public health, etc.

Level 1 Surge efforts must occur with no change in standards of care, caregiver to resident ratios or regulatory requirements. Depending on the volume and timing of incoming residents, admission documentation and assessment may be delayed, but must be completed as soon as possible. This may be an important part of the Recovery Phase.

Requesting and Receiving facilities must plan for the safe return of residents to their original facility if possible, or make alternate arrangement.

Residents and responsible persons should be kept informed of any patient transfers that are to be made.

Trigger Point for Recovery from Level 1 Surge:

When the ICC is de-activated **AND** additional resources are no longer required beyond those normally available/required for routine operations, the **Recovery Phase** may begin and return to normal operations can occur.

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RESPONSIBLE POSITION: _____ is responsible for the functions of this procedure.

REQUIRED ACTIVITIES:

- As soon as possible after resident arrives on the unit, complete a nursing assessment, review of medical records and needs assessment.
- Establish an interim plan of care and supervision. Coordinate transportation needs for special services such as dialysis, medical appointments, etc.
- Communicate with the **Requesting Facility** that the patient has arrived and give their location and condition.
- Communicate with the resident's **Attending Physician** as necessary.
- Monitor the impact of the influx on existing residents.
- Provide additional **Nursing** and medically related **Social Services** support as necessary.
- Provide staff nourishment and breaks as needed.
- Keep residents updated as much as possible on the status of the incident and any plans for their return to their original facility or alternate plans.
- Coordinate transportation back to the sending facility if that facility is operational.
- If the sending facility is not operational within 24 hours, coordinate admission or transfer with the resident and/or responsible party.
- **Coordinate discharge of patients received from hospitals that meet discharge criteria.**
- Chart, medication and **Medication Administration Record (MAR)** must accompany the resident to their destination.

- Crisis counseling should be provided for residents and staff involved in the incident.

- Staffing time and accountability for disaster response should be documented.

- Inventory should be taken of all supplies and purchase orders processed to replace supplies used during the disaster.

- Contact the sending facility's insurance company to discuss reimbursement available.

- Any equipment that was transported with arriving residents should be returned to owners.

- Dismiss staff as residents are transported out of the facility and return to normal staffing patterns.

- Meet with staff involved in the incident to debrief the response to the surge.

- Collate notes from the response into a document to identify strengths and opportunities for improvement during **Quality Assurance Meetings**.

END PROCEDURE #6

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ACRONYM KEY

Acronym	Meaning
ASPR	Assistant Secretary for Preparedness and Response
COHDIMS	Coalition Healthcare Disaster Information Management System
EMA	Emergency Management Agency
EMR	Electronic Medical Record
EMS	Emergency Medical Services
HCC	Healthcare Coalitions
HICS	Hospital Incident Command System
HIL	Healthcare Incident Liaison
ICC	Incident Command Center
ICS	Incident Command System
ID	Identification
LOC	Level of Care
LTC	Long Term Care
MAR	Medication Administration Record
NHICS	Nursing Home Incident Command System
PAS	Pre-admission Screen