

INFLUX OF RESIDENTS / SURGE GUIDELINES FOR NURSING HOMES

[BEST PRACTICE GUIDE]

DISCLAIMER: This is not customized to Nebraska and should be used as a baseline tool to address pre-event planning for a disaster involving an influx of residents from another nursing home.

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This Initial Guide was developed by Russell Phillips & Associates, LLC as a tool for the Massachusetts Department of Public Health and the Connecticut Department of Public Health. Additionally, the project workgroup in consisted of various partners including the Massachusetts Senior Care Association, the LeadingAge Connecticut, and various long term care facilities in Connecticut and Massachusetts. This is a modified version of that initial guide.

INTRODUCTION

Natural disasters, fires, loss of utilities and other disaster related events can lead to the evacuation of healthcare facilities. Such events have led to continued focus on healthcare facility evacuation plans. Long term care facilities commonly maintain agreements to assist each other in the event of an evacuation. Some areas have even established formalized mutual aid plans to address the evacuation of residents and the allocation of resources and assets (e.g., supplies, equipment, staff and transportation).

This document is intended to provide guidance to a long term care facility on the receiving end of a healthcare facility evacuation. It is intended to serve as a best practice template. Therefore, to be properly utilized by a specific facility, the guide will require review and tailoring. In many cases, footnotes have been utilized throughout the guide to prompt locations where facility specific tailoring will be required.

Should a long term care facility plan to provide mutual aid to other health care facilities impacted by a disaster, this guide provides four (4) sections of information relative to sheltering¹ persons who are not residents of the long term care facility who have been impacted by a disaster situation:

- General activation and preparation guidelines
- Influx guidelines utilizing existing open beds within the facility's licensed bed capacity
- Guidelines for surging² to 10% beyond the facility's licensed bed capacity
- Guidelines for sheltering hospital referred special populations

Therefore, if a provider anticipates providing such a service and/or participates in a mutual aid plan arrangement, a facility should develop a strategy for establishing temporary sleeping and care areas. Included in this guide is a *Surge Planning Worksheet* to assist facilities in pre-planning designated areas and outlining the process involved in setting them up. The benefits of this tool are maximized if the facility completes the worksheet proactively rather than at the time of a disaster situation. Plans for establishment of a shelter and the surging of beds should be reviewed with the local emergency agency (LEA) and local fire department.³

¹ Shelter shall mean space designated in the licensed LTC facility in common space (e.g., dining room, activity room, etc.). In some states this may or may not include placing sheltered residents into licensed beds or expanding capacity in resident rooms.

² Surge shall mean establishment of beds located in the designated shelter space to house, beyond a 24 hour period, long term care residents evacuated from a disaster struck LTC facility who are not admitted to the receiving LTC facility.

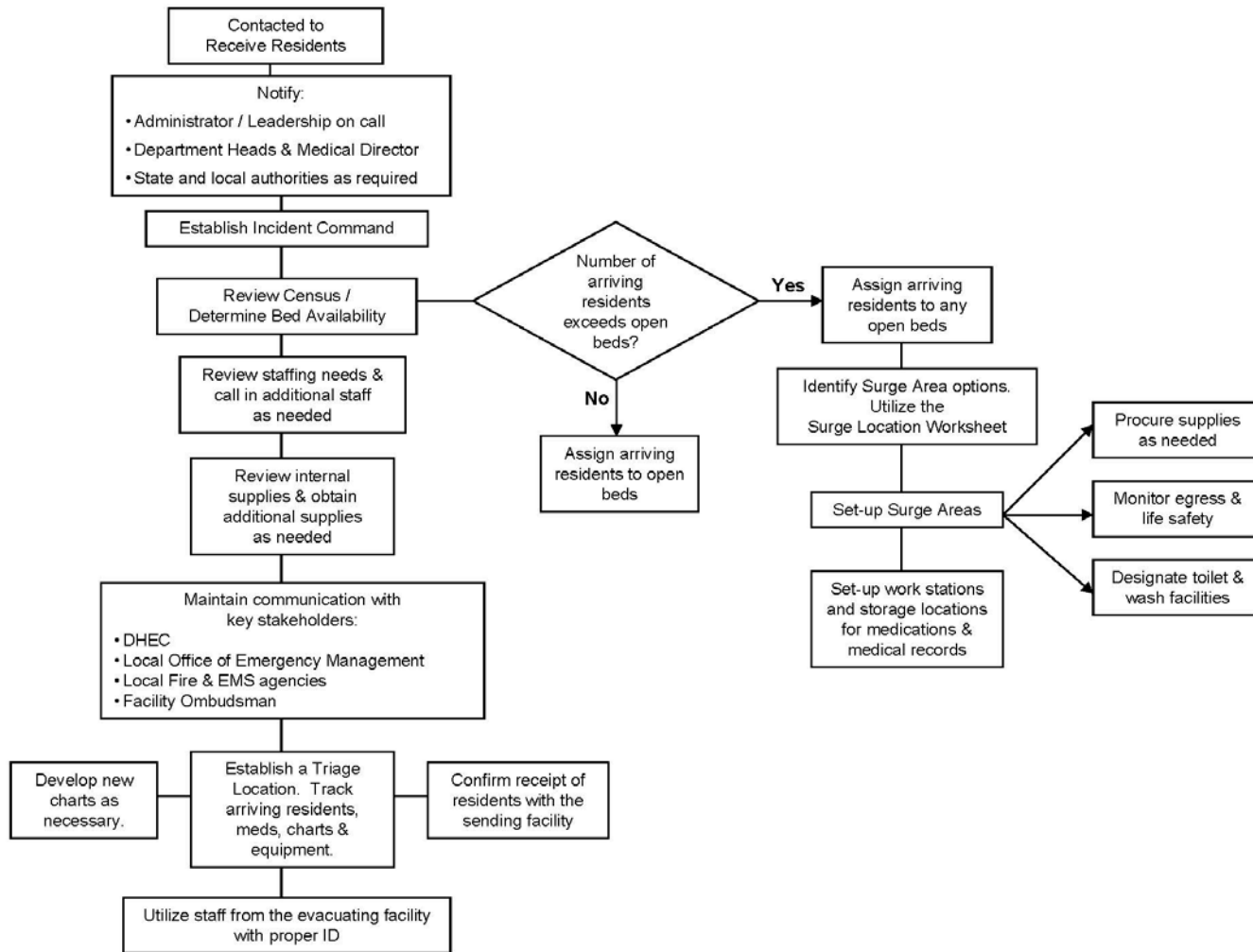
³Facilities licensed by the state licensing agency need sign a Waiver with DHEC for the LTC regulations to obtain permission to establish a shelter or to surge beds in a LTCF. Communication should be made as soon as possible prior to the pending disaster in order to secure this Agreement. In an Emergent Situation

The information in this guide addresses short-term influx / surge situations. For the purposes of this document, short-term is intended to reference 72 hours (3 days) or less. Immediately, after an initial evacuation occurs, a longer term resident care and housing plan should be developed and implemented if return to the evacuating facility is not a viable option and received persons require care and services beyond a 24 hour period, and additional open licensed beds at other LTCF(s) are not able to be located. The suggested actions in this guide are intended as short-term options and are not proposed as practical resident care and sheltering solutions beyond 72 hours.

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[defined at Section III Emergent Situations definition item (a)], a LTCF may establish a holding area to host evacuated residents/persons not to exceed a 24-72 hour period if implemented in accordance with these guidelines. The receiving facility must immediately notify the appropriate agency to do so.

ALGORITHM



SECTION I: ACTIVATION & PREPARATION

WHEN CONTACTED TO RECEIVE RESIDENTS

- Phone contact with the facility may be through an automatic messaging communication system or via a direct phone call. When an automatic message is received, the individual taking the call should immediately document the entire message. If receiving a direct phone call, the call should be forwarded to the on-site individual in charge of the facility at the time. When receiving a direct phone call, attempt to obtain the following information:
 - Total number of arriving residents
 - Estimated time of arrival
 - Sending facility contact phone number(s) and contact name
 - Gender breakdown
 - Number of arriving residents requiring wandering precautions
 - Resident medical equipment needs (do not accept residents on life support if you do not have an emergency generator)
 - Arriving residents requiring specialized medical needs (isolation, dietary, infection control)
 - Quantity and type of medical equipment arriving with residents
 - Quantity and type (clinical or not) of staff arriving with residents
 - Will medications accompany residents
 - Will charts accompany residents
 - Need for the receiving facility to provide transportation (identify what type of transportation is available and any specialized capacity)
- Relay all information to the on-site individual in-charge of the facility at the time.
- If you receive an automated message and you are not on-site, contact the on-site individual in charge of the facility at the time.

INTERNAL NOTIFICATIONS

- Notify the Administrator and/or the leadership individual on-call.
- **Administration** – Contact Department Heads and Medical Director.

EXTERNAL COMMUNICATIONS

- Notify State and local authorities, as required, to obtain any necessary permission to implement the facility's influx/shelter plan including the Local Office of Emergency Management, Local Fire & EMS, DHEC and the facility Ombudsmen.
- Initially contact and continually update resident responsible parties and attending physicians
- Provide ongoing periodic updates as necessary.

INCIDENT COMMAND

- Consider utilizing the Incident Command System and establishing an internal Command Center. The Command Center is located _____⁴.
The phone number to the Command Center is _____⁵.

CENSUS / RESIDENT CAPACITY

- Determine the up-to-date facility census and identify the number of open conventional beds and types of beds (sub-acute, dementia, psych, isolation, etc.).
- If the total number of arriving residents can be addressed through open beds within the licensed bed capacity of the facility, review *Section II – Influx Utilizing Existing Licensed Beds*.
- If the total number of arriving residents exceeds the open beds available within the licensed bed capacity, review *Section III – Surging beyond Licensed Bed Capacity*.

STAFFING

- Determine the need to call-in additional staffing.
- Attempt to identify the quantity and type (RN, LPN, CNA, other) of staff that may be provided by the sending facility. They may work in tandem with your staff or may provide all clinical care without assistance. However, additional ancillary staff such as food service, housekeeping and maintenance will probably be required throughout the situation.
- Maintain staff to resident ratios necessary to meet resident needs throughout the duration of the situation.

SUPPLIES

- Conduct a baseline inventory of all supplies with specific focus on the following departments:
 - Food Service – types and quantity of food and beverage
 - Nursing – types and quantity of medical equipment (pumps, oxygen cylinders/concentrators, oxygen tubing/cannulas/masks, etc.) and medications
 - Housekeeping / Laundry – quantity of linens
 - Maintenance – types and quantities of beds, mattresses, privacy dividers, etc.

Reference *Attachment B Surge – Equipment*

- Assess the type and quantity of equipment / supplies that will be arriving from the evacuating facility if possible.
- Contact vendors to request additional supplies as necessary. Reference *Attachment C – Vendors / Agreements*.

⁴ Insert the pre-determined location of the facility Command Center. Consider a location that provides privacy for leadership staff, is outfitted with phones and computers, and provided with emergency power.

⁵ Identify a phone number that can be provided both internally and externally to those needing to communicate with the Command Center. This may be more than one phone number. It is optimal to have a dedicated line for receiving calls that is separate from one or more lines dedicated for outgoing calls.

RESIDENT TRIAGE

- Establish a triage area located at _____⁶.
- **Administration** – Designate an individual to oversee the set-up and operations of the triage area. Ensure adequate staffing and supplies at the triage location. Consider the following:
 - Staffing
 - Nursing / Resident Care (triage, managing care)
 - Social Work
 - Food Service (food and beverage)
 - Administrative (tracking and documentation)
 - Supplies
 - Chairs / wheelchairs
 - Pens, paper, nametags, charting materials
 - Food and beverage
 - Medications
 - Portable oxygen (cylinders, tubing, cannulas, etc.)
 - Blood pressure cuffs and stethoscopes
 - Waterless hand washing solution
 - Infection Control Universal precautions
- Document the arrival of all residents as they enter the triage area. Utilize the *Attachment A - Influx of Residents Log*.
- Triage each arriving resident. If arriving residents do not arrive with a completed *Resident Emergency Evacuation Form*⁷, attempt to minimally collect and document the following information on each resident:
 - Name
 - Age
 - Responsible party
 - Medical diagnosis
 - Medication allergies
 - Other known allergies
 - Diet restrictions / last meal
 - Medications / last administered
 - Mental status
 - Mobility
 - Hearing impairments
 - Dialysis needs
 - Special precautions, procedures or equipment

⁶ Consider a triage location that is proximal to the facility main entrance, spacious enough to accommodate a number of residents, secure enough to limit elopement opportunities and accessible to nearby toileting facilities.

⁷ The facility may participate in formal LTC Mutual Aid Plans where a Resident Emergency Evacuation Form is utilized. These forms will arrive with a resident and provide key resident information.

- Valuables with the resident
- Complete an initial nursing assessment of each arriving resident. Review available medical records that accompanied the resident. Include as part of the assessment of arriving residents a determination of any medical needs and/or history of unsafe behaviors that will require an increased level of care and supervision. Establish an interim plan of care and supervision for each resident as appropriate. Establish a new chart, if necessary⁸

FOOD AND NUTRITION

- Modify planned menus as necessary to accommodate the additional residents.
- Maintain food supplies and provide meals for residents, additional staff, and possibly families.

MEDIA AND FAMILIES

- Designate an individual to prepare and provide statements to the media and to families. Coordinate statements with the evacuating facility and emergency agencies⁹.
- Consider separate staging locations (internal or external) for media and family members.
- Attempt to unify families / responsible parties with residents as quickly as possible.

RESIDENT TRACKING

- Communicate with the sending facility the total number of residents received along with the specific name of each resident received.
- If the sending facility has designated a fax line or email address, fax or email a completed copy of the *Attachment A - Influx of Residents Log* to the sending facility.

ARRIVING STAFF & STAFF CREDENTIALING / PRIVILEGING

- Review and confirm arriving staff have ID badges provided by the facility where they are employed.
- Log in staff as they arrive.
- Provide temporary facility ID.
- Identify where and to whom arriving staff are to report.
- Disaster privileges may be granted upon presentation of a valid government issued photo ID (e.g., driver's license or passport) and any of the following:
 - A current picture ID or other ID card from a Hospital or Nursing Home.
 - A current license certification or registration to practice and a valid picture ID issued by a state, federal or regulatory agency. A primary source of verification must be given where applicable.
 - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or Medical Reserve Corps (MRC).

⁸ In most cases, it will be appropriate to establish a new chart on the resident.

⁹ If part of a formal LTC Mutual Aid Plan, include the plan's Long Term Care Coordinating Center as another group to coordinate statements with.

- Identification indicating that the individual has been granted authority to render resident care in emergency circumstances. Such authority having been granted by a federal, state or municipal entity.
- Presentation by current organizational staff member(s) with personal knowledge of the practitioner's identity.

FINANCE

- Monitor all costs and resources utilized throughout the duration of the situation, especially delineating those which are disaster related cost exceeding normal operating costs. Maintain receipts for purchases directly related to the situation.

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SECTION II: INFLUX UTILIZING EXISTING LICENSED BEDS

RESIDENT PLACEMENT

- Verify the quantity and location of open beds throughout the facility.
 - Do not consider beds that are being held for a confirmed admission.
- Ensure available rooms / beds are prepped for use.
- When feasible, utilize open beds that are proximal to each other to avoid scattering residents throughout the facility.

CONTINUING CARE

- Monitor received resident for medical, nursing, behavioral and psychological needs. Monitor the impact of the influx on existing residents.
- Provide additional nursing and medically related social services support as necessary.
- Incorporate into resident activities as appropriate.
- Communicate with attending physicians as necessary.
- Coordinate transportation needs for clinical services such as dialysis, medical appointments, etc.
- Provide consistent services and support to residents facility wide.

SECTION III: SURGING BEYOND LICENSED BED CAPACITY TO SHELTER EVACUATED LONG TERM CARE RESIDENTS

RESIDENT PLACEMENT

- Verify the quantity and location of open licensed beds throughout the facility. Utilize open licensed beds as the first phase of resident placement. When feasible, utilize open beds that are proximal to each other to avoid scattering residents throughout the facility.
- Do not consider beds that are being held for a confirmed admission.
- The establishment of a shelter area with surge beds will address the third phase of resident placement.

OPTIONS FOR INCREASING CAPACITY¹⁰

- Identify vacant licensed beds.
- Identify space in existing resident rooms where the room can be converted to accommodate additional beds.
- Identify options to transform non-sleeping areas into temporary shelter areas where surge beds may be established to provide temporary sleeping and resident care.¹¹ Areas should be at or above grade.¹² Consider the following areas:
 - Activity Rooms
 - Lounges
 - Dining Rooms
 - Auditoriums
 - Meeting Rooms
 - Rehab / Therapy Rooms¹³

Reference Attachment D - Command Center / Surge Capacity Tool

- Identify areas served with emergency power to support residents requiring critical electric medical equipment.

SURGE AREA SET-UP

- Based on the *Attachment D - Command Center / Surge Capacity Tool*, set-up surge locations based on priority.
- Utilize internal available supplies first. Consider the following options to obtain additional supplies:
 - Vendors
 - Supplies from the resident sending facility
 - Local Office of Emergency Management

¹⁰ The total occupancy of the facility (including arriving evacuated residents) should not exceed the maximum occupancy permitted by the facility's local building permit unless temporarily waived by the local Authority Having Jurisdiction.

¹¹ In Nebraska, this may include the requirement that a LTCF obtain authorization via a Waiver request to DHHS, using the Attachment ___ request form.

¹² Surge areas at or above grade are preferred. If the use of other areas becomes necessary, communicate with your state Authority having Jurisdiction.

¹³ Attempt to first utilize surge areas that will not affect normal daily operations such as rehab and therapy.

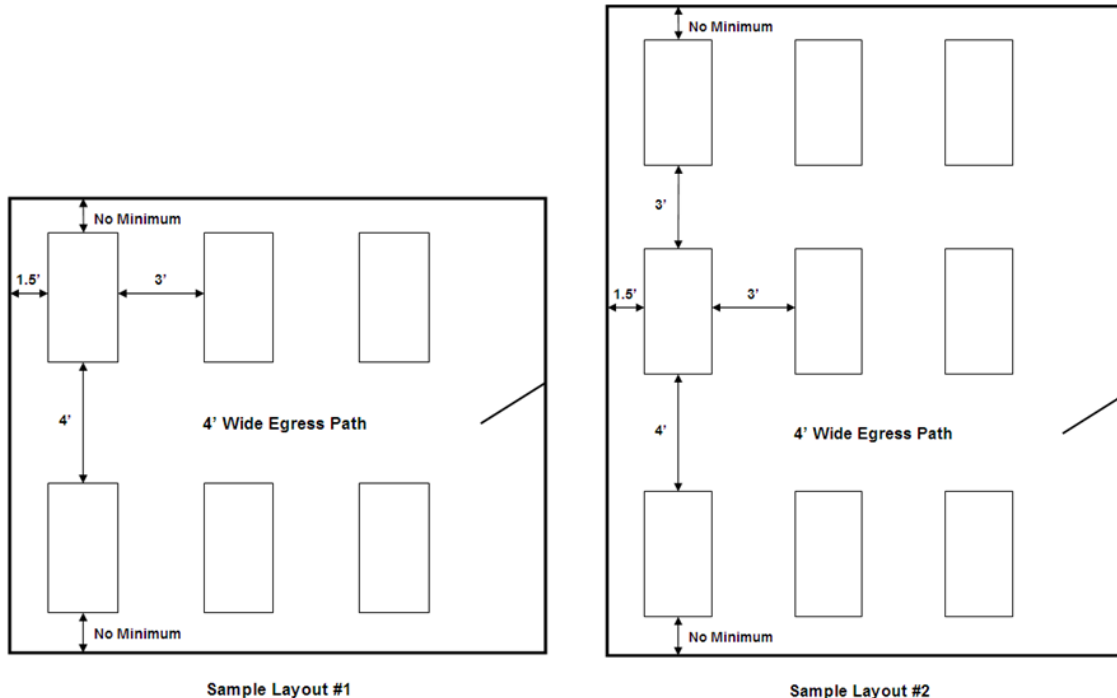
- Other healthcare facilities¹⁴
- Establish groupings of beds. Medical cots are a second option. Utilize beds whenever possible and, based on the nursing assessment of the resident, a medical cot may be used. As a last alternative, in an Emergent Situation, use mattresses only for a short period of time until beds or cots can be obtained. Always consider resident needs based on the nursing assessment (particularly as it relates to pressure sore concerns).
- ***Emergent Situations include:***
 - a) Situations where immediate hosting of persons is needed. This may include an isolated single facility evacuation.
 - b) Situations where there is a regional event resulting in multiple facility evacuations.
 - c) Situations affecting infrastructure and transportation routes. This may include situations where extended travel is unsafe due to road conditions and/or weather conditions.
 - d) Situations that limit transportation resources. This may include scenarios where transportation resources (including EMS) are overwhelmed and transport over extended distances is impractical.
- Place privacy dividers between beds, cots or mattresses.
 - Use dividers in all situations, or at minimum, when providing care.
- Provide night lighting in each surge area.
- Provide call devices for¹⁵ each resident
- Designate toilet and wash sink locations for each established surge area.
- Provide storage areas for resident belongings and personal needs equipment. Key personal belongings such as eye glasses, hearing aids, prosthesis, dentures, etc. should be located proximal to the resident. Other items such as clothing, shoes, etc. may be stored in a separate location.¹⁶
- Establish one or more provisional work station(s) located within or near surge areas.
- Provide constant (24/7) clinical staffing in surge areas located outside of normal resident care areas.
- Provide increased supervision for those residents identified in need.
- Ensure all surge bed arrangements do not impede egress or reduce life safety. Consider the following guidelines:
 - Maintain three (3) feet between beds. Adjust as necessary if using cots.
 - Maintain four (4) foot egress paths to the exit access corridor.

¹⁴ Some facilities are members of a formal LTC Mutual Aid Evacuation and Resource/Asset Support. Consider specifically referencing this in the plan if you are part of such an agreement.

¹⁵ A call device should be provided for each resident. Tap bells are commonly utilized for this purpose. Wireless call devices are another effective option. Tailor this sentence to specifically identify what type of wireless call devices is another effective option. Tailor this sentence to specifically identify what type of call devices the facility plans to utilize.

¹⁶ Consider plastic bins that can be stored under beds or cots.

- Maintain 1.5 – 2 feet between the perimeter wall and the side of a bed. Adjust as necessary if using cots. For resident rooms, typically, depending on room configuration, a room with a depth of 13' can be a semi-private room. A room with a depth of 19' can be a triple. That model is dependent on bathroom configurations and other unique room configurations.



MEDICATIONS AND MEDICAL RECORDS

- Develop and designate specific storage locations for resident medications and medical records. Maintain normal controlled substance security standards.
- Account for all medications.

CONTINUING CARE

- Monitor resident toilet needs and provide staff to accompany residents to toilet facilities.¹⁷
- Develop a bathing schedule based on the available bathing facilities.
- Maintain infection control standards. Provide an appropriate level of isolation/containment as needed.
- Monitor resident psychological status. Provide additional social services support.
- Provide resident activities.
- Coordinate clinical services such as dialysis, medical appointments, etc. and any transportation as needed.
- Communicate with attending physicians as necessary.
- Establish a process for constant monitoring of surge areas.

¹⁷ When possible, attempt to limit the ratio of residents to toilet facilities to 10:1.

SECTION IV: SHELTERING HOSPITAL REFERRED SPECIAL POPULATIONS

In certain disasters (e.g., extended loss of power in the region), local hospitals may be overwhelmed by the influx of community persons into their facility emergency rooms. This influx may include those citizens who were able to live in the community with nursing and medical supports. This special population may, for example include those persons with special medical equipment, frail elderly living at home with home health services, persons on hospice, or those with other medical needs, where their level of care does not necessarily require an acute care facility. In order to continue to serve as the acute care facility for the area, the hospital may need to decompress these individuals to appropriate community medical shelters or other care facilities.

In these extra-ordinary disaster situations, long term care facilities may consider the possibility of providing assistance by sheltering those special populations with nursing or sheltering needs and able to be managed at their facility. It is recommended that this optional service to the community, only be considered when mutual aid to other like-facilities is determined to have been satisfactorily met.

Should a facility decide to provide this community medical sheltering support service, this guide and the criteria below provide minimum sheltering and care guidelines.

RESIDENT INTAKE AND PLACEMENT

- The Local Emergency Agency (LEA) is responsible to meet the sheltering needs of community persons including those with special medical needs. Use of a long term care facility as a medical shelter for this special population is only to be provided in collaboration with the LEA, and at their request to supplement existing community shelters when the severity of the disaster has resulted in the need for increased capacity; and, mutual aid to other long term care facilities has been determined to be satisfied.
- All components listed in Sections I-III of these guidelines shall apply here (including the requirement to notify state and local authorities as applicable¹⁸ and except as indicated below.)
- Due to the unknown needs of these potential individuals and because this special needs population referred from a hospital or other health care entity may not have a known history or medical record, the facility is not to place these individuals into existing nursing units, resident sleeping areas and in regulated licensed beds, unless the triage process dictates that a particular individual needs this level of care..

¹⁸ In Nebraska, this may include the requirement that a LTCF obtain authorization via a Waiver request to DHHS, using the Attachment ___ request form.

- Establish a shelter utilizing beds or cots as appropriate. Mattresses may be used if necessary until beds or cots become available.

SECURITY / MONITORING

- Due to the unknown nursing, medical, behavioral needs of this population, increased supervision and assessment is especially important to ensure the health and safety of these sheltered individuals, as well as the safety of the facility's existing resident population. Hence, 24/7 security and monitoring must be incorporated to ensure appropriate security for the existing resident population and to monitor for any medical emergencies of the sheltered individuals.

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ATTACHMENT A: INFLUX OF RESIDENTS LOG

(Accounting for Incoming Residents and Equipment)

Make additional copies prior to use

1. FACILITY NAME			2. DATE/TIME PREPARED			3. INCIDENT DESCRIPTION											
4. TRIAGE AREA (for entry into the facility)																	
Arrival Time	Facility Received From	Medical Record # or Triage #	Resident Name (Last, First)	Sex	DOB/ Age	Original Chart Arrived w/ Resident		Meds & MAR Arrived w/ Resident		Equipment Received	Family Notified: Name, Date, Time, Phone # w/ Area Code			Primary Physician Notified: Name, Date, Time, Phone # w/ Area Code			Disposition (Unit, Discharge to Home, Transfer)
						(Y)	(N)	(Y)	(N)		<u>Y</u>	<u>N</u>		<u>Y</u>	<u>N</u>		
5. SUBMITTED BY					6. PHONE NUMBER			7. DATE/TIME SUBMITTED									

ATTACHMENT C: VENDORS / AGREEMENTS

Vendor / Agreements Checklist

Facility Name:			Facility Contact Person (name/title/phone #):						
<i>Does the facility have arrangements for the following:</i>	Type of agreement: Written (W) Verbal (V) None (N) (Circle One)	Vendor Name	Address	City	State	Zip Code	Phone #	Contact Person	Notes
Transportation Vendor									
EMS (list separately if more than one)	W V N								
	W V N								
	W V N								
Bus/Van Company (list separately if more than one)	W V N								
	W V N								
	W V N								
Wheelchair Vehicle (list separately if more than one)	W V N								
	W V N								
	W V N								
Other (list separately if more than one)	W V N								
	W V N								
Transfer Agreements									
Hospitals (list separately if more than one)	W V N								
	W V N								
	W V N								
Nursing Homes (list separately if more than one)	W V N								
	W V N								
	W V N								
	W V N								
	W V N								

Vendor / Agreements Checklist

<i>Does the facility have arrangements for the following:</i>	Type of agreement: Written (W) Verbal (V) None (N) (Circle One)	Vendor Name	Address	City	State	Zip Code	Phone #	Contact Person	Notes
Other (list separately if more than one)	W V N								
	W V N								
Transfer Agreement - Stop Over Points									
Stop Over Point Agreements (lower level of care or non-healthcare - list separately if more than one)	W V N								
	W V N								
Generator Vendor									
Repairs	W V N								
Rental	W V N								
Primary Food Vendor									
Food (list separately if more than one)	W V N								
	W V N								
Fuel Vendor (for generators)									
Fuel (list separately if more than one)	W V N								
	W V N								
Pharmaceuticals									
Pharmacy Vendor (bulk) - (list separately if more than one)	W V N								
	W V N								
Primary Pharmacy (list separately if more than one)	W V N								
	W V N								
Potable Water									
Bulk (tanker)	W V N								
Consumable (bottled)	W V N								

Vendor / Agreements Checklist

<i>Does the facility have arrangements for the following:</i>	Type of agreement: Written (W) Verbal (V) None (N) (Circle One)	Vendor Name	Address	City	State	Zip Code	Phone #	Contact Person	Notes
Staffing Agency									
Nursing	W V N								
	W V N								
CNA	W V N								
Other:	W V N								

ATTACHMENT D: COMMAND CENTER / SURGE CAPACITY TOOL

FACILITY NAME
COMMAND CENTER / SURGE CAPACITY TOOL

Internal Location / Surge Area	Ability to Set-up 1 = 0-2 Hours 2 = 2-4 Hours 3 = Extended	Surge Priority		Total Additional Residents	Additional Staffing Required (Licensed)	Additional Staffing Required (CIA)	Additional Beds Needed	Equipment & Supplies	Secured Area (Locked)		Set-up Instructions & Notes
		High	Low						Y	N	
		TOTAL		0	0	0	0				
					Total Additional Beds Available						
					Gap (needed)		0				

The total capacity of the facility (including arriving evacuated residents) should not exceed the maximum occupancy permitted by the facility's local building permit unless temporarily waived by the local Authority Having Jurisdiction.
Factor shelter / surge area priority based on location, set-up disruption, emergency power, nurse call availability, grade level (at or above) and access to toilet/wash facilities.