

Forging A Plan For Disasters

While major disasters are hardly an everyday occurrence, all facilities should have detailed plans in place and be prepared for the worst.

WHILE THERE IS NO GUARANTEE that a disaster will occur, preparation for such an event is a necessary part of managing risk. It is plausible that every facility administrator and every facility, at some time, will be required to respond to a disaster. This is what happened in Florida in 2004, when a series of vicious hurricanes forced nearly every nursing facility in the state to respond to disaster conditions. The devastating impact of Hurricanes Katrina and Rita on the Gulf Coast in 2005, and the tragic results that followed, further substantiate the need for preplanned disaster management.

Getting Started

Although it can be overwhelming to prepare for every possible contingency, facility disaster management can be broken down into seven distinct planning areas:

- 1.) Patient-resident population and their clinical care needs;
- 2.) Staffing estimations and preparations;
- 3.) Supply requirements (medical and otherwise);
- 4.) Pharmaceuticals;
- 5.) Medical records;
- 6.) Physical plant considerations; and
- 7.) Operation logistics.

Whether the facility is a veteran of previous disasters or new to disaster planning, reviewing these seven plan-

ning areas will assist in facility preparations for impending disaster scenarios.

Meeting Patient Needs

In the initial planning phase, facilities must compile—and keep up to date—information about patients' conditions

30). Needs may include dialysis; ventilator dependency; receiving other outside treatments; bed-bound patients; and patients in a secured unit, who ideally should be evacuated to another secured unit or kept under direct observation.



When facilities are prepared, they can effect positive outcomes following disasters.

and needs. These needs must always be met, even during a disaster. Furthermore, disaster conditions or stress brought on by a disaster may exacerbate many patient health conditions.

In a skilled nursing facility (SNF), Form 672 and 802 reports are supposed to reflect the patient case mix for ready reference. In states like Florida—or any area subject to frequent hurricane strikes—such reports should be updated weekly during the hurricane season (June 1 through Nov.

Knowing the needs of each patient will be especially critical if a facility is working with outside services (local police or fire departments, for example) during a mass evacuation. Facilities should have emergency identification protocols in place for transmitting such critical information, as well as resident identifier information. Such protocols should identify patients in terms of who is responsible for their medications; any potential allergies; positive diabetes status; required use of thickener product for dietary reasons; patient's physician and family member contact; and any other critical diagnostic information, including risk of elopement.

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Develop A Staffing Plan

Because each disaster is unique and may be unexpected, staffing plans should be developed in advance to meet a range of contingencies. This requires participation of staff from all departments, especially nursing, during the planning process. Administrators and department managers must know beforehand who can be counted on when a disaster strikes.

At the same time, providers must recognize that staff members have homes, families, pets, and a host of other personal disaster-response needs of their own. Recognition of these needs is likely to encourage staff participation in helping to meet the disaster needs of the facility and its patients. Providers should consider using staff family members as part of the disaster-response team.

When developing a disaster staff model, split disaster teams work best. Four staff teams should be planned to take action during different phases of the disaster: Team 1, before, during, and after; Team 2, before and during; Team 3, before and immediately after; and Team 4, during and immediately after. Ideally, department managers, administrative nursing staff, and other key facility staff should be available for Team 1 duty. It is the job of the facility administrator to consider staff needs, patient needs, and staffing requirements before making facility rules and deciding on team placement.

A perception of fairness is critical, since the No. 1 role of the administrator in developing a disaster staffing plan is to make sure staff “buy in” to the plan.

Minimum necessary staffing levels should be determined, planned for, and recorded in writing—electronic time clocks may become inoperable—unless otherwise waived by a state agency. Staff records will show compliance in the event that a state agency performs follow-up surveys after the disaster has passed. The amount of staffing time worked and compensated may also be

needed for post-disaster insurance and interim cost reporting. One goal in disaster recovery is ensuring that the facility is properly reimbursed for disaster-related expenses.

Plan To Be Self-Sufficient

Every facility should plan to be self-sufficient for up to two weeks, because it may well take that long for the next delivery of supplies. Each department should plan comprehensively according to this two-week schedule.

This means planning for the needs of specific patients, which can be extremely complex. For example, diabetic patients will need glucose monitoring units (plus batteries, tests strips, and lancets), various types of insulin, and syringes, a sharps container to safely dispose of sharps, alcohol for cleansing the pre-injection or blood-sugar testing site, instant glucose (tablets) in case of hypoglycemia, and any oral medications that the patient is taking for the disease. Diabetic physician orders and medication administration records must be followed and properly documented to ensure that errors do not occur.

This planning process must be repeated for all patients with specialized needs. Each and every aspect of needed care must be planned to ensure an adequate two-week supply. To ease the burden and assist with disaster provisioning, a disaster order of necessary supplies should be prewritten and preplanned with vendors in a manner that is easily updated based on current patient needs.

In situations where the facility will evacuate to a specified location, it may be possible to arrange for delivery of the disaster supply order directly to the receiving location, thus saving staff time in packing and transporting.

Pharmacy, Medical Chart Needs

Pharmacy is critical during disaster operations and must be treated as a separate function.

Assuming little to no assistance from

the institutional pharmacy vendor (some may be more helpful), providers should develop a plan that includes: 1.) a breakdown of medications into routine, PRN, narcotics (routine and PRN), and intravenous; 2.) a breakdown within each of these categories into oral, injectable, nasal, optic, otic, liquid, and medications that require refrigeration; 3.) a determination of pharmaceutical inventory levels for each category and subcategory, to ensure availability of a minimum two-week supply of all medications; 4.) a complete and detailed listing of all medications and supplies that are requisitioned from the pharmacy vendor (enteral, syringes, and plastics, for example); and 5.) designation of one lead nurse to complete the facility's disaster pharmacy order and another nurse to double check the order.

Complete active medical records must be available and maintained during a disaster or an evacuation—not just certified nurse assistant flow sheets. Active records may be taped closed (use clear packing tape as opposed to duct tape because it can be easily cut open or retaped as necessary) to prevent lost or misplaced records.

Other active patient medical records that are maintained at the nurses' station should be taken out of their special books or binders and placed in the patients' separate active medical charts. Facilities using electronic files should refer to policies and procedures relating to the specific electronic system and plan accordingly.

Secure The Physical Plant

Administrators should evaluate the facility's physical plant and determine potential weaknesses and possible adaptations that may be made. Frequently, buildings can be hardened so that potential disasters will not have as detrimental an effect on the building and its functionality. Hardening a facility in such a way that allows the facility to operate and serve patients through disaster conditions must be considered

due to the likelihood that evacuation plans may fail or that limited time may be available to evacuate patients.

Hardening projects may include hurricane shuttering of exterior openings such as windows, doors, and through-wall air conditioning (AC) units; roof tie-downs and roof sealing; central AC

protections; removal of possible projectiles from patios, balconies, and all surrounding areas; reinforcement of building structural supports; and the creation of safe areas within the building core.

In addition to hardening, the physical plant should be evaluated and

adapted so that operations can be maintained. For example, facilities must frequently rely on generators to maintain electricity during and after a disaster such as a hurricane. But many facility generators are not wired to include AC systems or laundry facilities. This is not sufficient. In hot, storm-prone areas like south Florida, generators must have sufficient power to cool the patient living areas. And this is true for most parts of the country in summer.

Additionally, no facility can operate very long under sanitary conditions without clean laundry. Thus, they should have the capacity to conduct laundry operations with a generator in the event that the facility must operate without utility power for more than a few days.

Because generator electricity is so critical to continued disaster operations, the facility also should plan to have additional fuel available and identify methods to access fuel in the event that the facility is without electricity during an extended recovery period.

Plan The Logistics

Disaster-operation logistics fall into three main categories based on whether the facility will evacuate patients: operations through an evacuation, the evacuation plan, and operations when sheltering in place.

First, the administrator should create an operational plan to maintain operations before, during, and through an evacuation.

Patients' needs must be continually met throughout all phases. This means that necessary equipment, supplies, and resources must be prepared, relocated, and made available to patients and staff throughout the evacuation process. The administrator should plan and coordinate the movement of all resources with facility managers and outside parties (local fire department) and, as the final authority on disaster logistics, be prepared to make informed decisions based on resource

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availability, patient needs, and disaster variables.

While the director of nursing will be responsible for maintaining patient services during the disaster and through the evacuation process, the administrator is responsible for all operational aspects and requirements necessary to support the maintenance of patient services.

A plan should also be developed that includes defined roles for all managers and personnel. If the decision is made to evacuate, staff should be prepared to perform their pre-designed roles within the necessary time frame, while also meeting all patient needs (timing of meals, proper hydration and toileting, and medication pass requirements, for example). If possible, the evacuation should also be accomplished at opportune times that minimize potential negative effects on the patients. For example, completing the evacuation at night reduces patient exposure to dehydration and heat concerns.

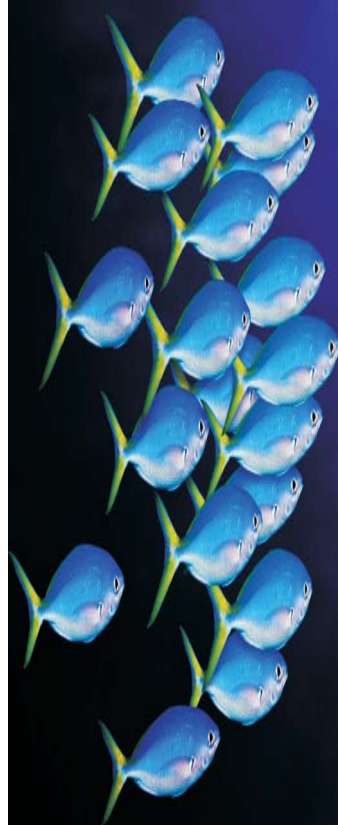
Finally, given that evacuation may not be plausible in certain cases, a disaster plan should include the ability to maintain operations while sheltering in place before, during, and after the disaster. Such a plan also may include the movement of patients to a predesignated safe area during the height of disaster conditions. Or, the plan may include rationing of resources and changes in operations considering that post-disaster recovery may last longer

than a week. Sheltering-in-place plans may also include provisions for staff and their families, which then creates the need for additional resources such as food and water.

Operation logistics are comprehensive, unique to each facility, and must be flexible enough to meet changing

disaster variables. Communications, resource acquisition and movement, and decision making are critical. Each facility's disaster plan should include the unique aspects of operations logistics necessary to continually meet its patients' needs through every phase of the disaster. ■

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■ The FHCA "Disaster Planning Guide," which includes sample protocols, is available through the American Health Care Association's Web site at www.ahca.org, click on "Bookstore," and then click on "Disaster and Emergency Preparedness."