While few would say that nursing homes are not better prepared today than when Hurricane Katrina struck the Gulf Coast in 2005, a new federal watchdog report has cast some doubt on the depth of that improvement, finding that when a crisis occurs many nursing homes still struggle to respond with incomplete plans and inadequately trained employees.

Some of these planning gaps could be closed, the report by the Department of Health and Human Services Inspector General suggests, with better federal oversight, including more detailed instruction from the Centers for Medicare and Medicaid Services on the necessary emergency plan elements and staff training.

Responding to the report, CMS agreed with the recommendations to revise the federal regulations, to improve guidance to state survey agencies and to better promote use of a voluntary checklist emergency planning checklist developed to ensure that health care facilities don’t overlook key areas of planning.

This special report summarizes the key deficiencies identified by the Inspector General. It also offers tips for getting involved in local emergency planning activities and for training both managers and frontline staff. The CMS-recommended planning checklist is included.

Inspector General Findings: Plans Incomplete, Compliance Slipping

Emergency planning took on national significance after the terrorist attacks of 2001, as the Department of Homeland Security took on the task of addressing weaknesses in national preparedness and response. But in 2005, the nation was shocked again when 34 nursing home residents drowned in floodwaters after being left behind to “shelter in place” from Hurricane Katrina in New Orleans.

Since then, many of the pitfalls in emergency planning for the elderly and disabled also have been brought to light, analyzed, and used to inform federal and state policy changes. Despite the progress, however, this aspect of emergency planning still lags behind public expectations in many states.

Now, a study of 16,000 nursing homes by the HHS Office of Inspector General (OIG) has found that nursing homes may be less prepared for emergencies than they were five years ago. As it did after Hurricane Katrina, the OIG is again urging CMS to take steps to ensure that the nation’s nursing homes are doing what they should to prepare for emergencies.¹

Same Issues in 2006

In the report, Gaps Continue to Exist in Nursing Home Emergency Preparedness and Response During Disasters: 2007-2010, the OIG said that of 16,000 nursing homes surveyed by state agencies nationwide during 2009 and 2010, 92 percent met federal regulations for planning but only 72 percent met requirements for staff training.

Overall, this represents a decline from the level of compliance the OIG found in a similar review conducted in 2006. In that study, the OIG found that 94 percent of nursing homes met federal regulations for planning and 80 percent met regulations for training.

Also In This Report

- Collaboration with Local Planners
- Incident Command System
- Approaches to Staff Training
- Conducting a Tabletop Exercise
- Fire Safety as a Building Block
- Drills as a Training Opportunity
- Planning for Residents’ Psychological Needs
- Additional Resources
- CMS Emergency Preparedness Checklist
Looking more closely, however, the OIG said it found additional red flags. Of 24 nursing homes that had experienced natural disasters — such as floods, hurricanes and wildfires — in several states between 2007 and 2010, investigators found that many of the facilities had failed to coordinate with local emergency planners or use a voluntary federal checklist for guidance on emergency planning.

Leaders at 17 of the 24 facilities said they had faced significant obstacles when implementing their plans, such as unreliable transportation contracts and residents who developed health problems — issues that might have been less troublesome had they used the voluntary planning checklist. Moreover, many of the gaps in nursing home emergency preparedness and response had already been identified in 2006, when the OIG first recommended that CMS consider beefing up federal regulations.

The report set off alarms. The New York Times noted that one facility studied by the OIG had no procedures in its emergency plan for dealing with floods, even though it was located in a flood plain, and that none of the 24 homes had participated in local emergency planning exercises.

In response, industry leaders say that the OIG study results do not represent nursing homes nationwide and that recent widespread evacuations in Florida, Georgia, Louisiana and New York City are solid evidence of progress. At the same time, they acknowledge, facilities in many states are still struggling to develop realistic and reliable plans and to train staff to carry them out.

### Vague Federal Requirements

Currently, federal regulations require Medicare and Medicaid nursing home providers to have “detailed” written plans and procedures for meeting all potential hazards — from natural disasters to missing residents — but the regulations do not specify the elements that must be covered in those plans (see sidebar, p. 3). Despite the OIG’s 2006 recommendation to make the requirements more specific, CMS failed to follow through with a rulemaking.

Instead, CMS developed a voluntary checklist for health care facilities to use in developing comprehensive emergency plans. The five-page checklist (see p. 10) includes detailed instructions for developing an emergency plan, covering areas such as:

- collaborating with local emergency management agencies;
- developing both shelter-in-place and evacuation plans;
- ensuring adequate supplies of needed provisions;
- training staff on all details of the plan, including the psychological and emotional needs of residents; and
- informing residents’ families about the plan, including whether they can come to the facility to assist in an evacuation.

But the OIG found little evidence that facilities use the checklist. Administrators from only 13 of the 24 nursing homes studied were aware of the checklist, and only seven reported using it to develop their plans. On average, the emergency plans addressed only about half of the planning tasks on the CMS checklist. Moreover, not one of the plans addressed all of the items.

The CMS regulations also do not specify the in-service training on emergency preparedness that must be provided for nursing home staff. The State Operations Manual, the primary guidance to state survey agencies seeking to certify facilities’ compliance with federal regulations, provides only a few general questions for survey teams to ask to verify training of facility staff, such as “If a fire alarm goes off, what do you do?” Surveyors are told to construct their own questions to determine how well staff are trained on local disaster scenarios.

See OIG Findings, p. 3


<table>
<thead>
<tr>
<th>Deficiencies</th>
<th>Facilities</th>
<th>Percentage</th>
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<tbody>
<tr>
<td><strong>Planning Deficiencies</strong></td>
<td></td>
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<tr>
<td>Standard survey (F517)</td>
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<td>3</td>
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<tr>
<td>Life Safety Code (K46)</td>
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<tr>
<td>Total*</td>
<td>1,214</td>
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<tr>
<td><strong>Training Deficiencies</strong></td>
<td></td>
<td></td>
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<tr>
<td>Standard survey (F518)</td>
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<tr>
<td>Life Safety Code (K50)</td>
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<td>25</td>
</tr>
<tr>
<td>Total*</td>
<td>4,486</td>
<td>28</td>
</tr>
</tbody>
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*The totals for planning and training deficiencies are not the sums of the standard survey and LSC deficiencies because some facilities had one of each type of deficiency, resulting in some overlap in the categories.
But the OIG found that surveyors themselves have often not been trained in emergency planning, and suggested that if surveyors were better trained, even more facilities would be cited for deficiencies.

The OIG report also highlights other failures related to management of staff, finding for example that 22 of the 24 homes studied did not have a backup plan for ensuring enough staff to care for residents in an emergency. Most plans also failed to address whether staff family members could shelter with them at the facility during the disaster or evacuate with the facility, even though the CMS planning checklist includes those tasks.

State Regulations Uneven
The OIG report does not address state efforts to mandate or provide resources for emergency preparedness. It is important to note, however, that most, if not all, states have stepped in to some degree with their own laws and regulations intended to protect the elderly and/or disabled living in long-term care.

All states, including the District of Columbia, have relevant disaster preparedness requirements for nursing homes beyond the federal regulations, according to the University of Minnesota’s Long Term Care Resource Center, which maintains a database of federal and state regulations online (see Additional Resources, p. 9). The most common additions are specific requirements for preparedness plans and in-service training for staff.

States seem particularly likely to enumerate the hazards for which nursing facilities must prepare. For example, Washington requires emergency plans to address 11 types of emergency disasters, including fire, severe weather, loss of power, earthquake, resident elopement, armed individual and bomb threats. Other states require planning for a long list of natural and man-made disasters, such as gas explosions and nuclear power plant leaks. It’s not clear how states determine their list of hazards. Some states in hurricane-prone areas, such as Alabama and Mississippi, do not specify the need for hurricane preparedness in their rules, according to the Resource Center.

States such as Florida, Georgia and Louisiana appear to have made the greatest strides both in mandating emergency preparedness and in providing state resources. But even industry leaders acknowledge that the patchwork of state regulations combined with inconsistent federal oversight is leaving many facilities without the direction and guidance they need to protect their residents if disaster strikes.

OIG Findings (continued from p. 2)

42 C.F.R. §483.75(m) – CMS Requirements for Disaster and Emergency Preparedness

(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.

(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
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.

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

Probes: Ask two staff persons separately (e.g., nurse aide, housekeeper or maintenance person) and the charge nurse:

- If the fire alarm goes off, what do you do?
- If you discover that a resident 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?

Note: Also, construct probes relevant to a geographically specific natural emergencies (e.g., for areas prone to hurricanes, tornadoes, earthquakes, or floods, each of which may require a different response).

Life Safety Code Requirements for Emergency Plan and Fire Drills
There is a written plan for the protection of all patients and for their evacuation in the event of an emergency.

Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.
Action Steps: Community Planning, Staff Training

In its study of nursing homes that had activated their emergency plans in recent years, the OIG found that the 17 homes that experienced the most problems had not had them reviewed by local emergency planners. Although at least one state, Florida, requires facilities to submit their plans to local agencies, there is no corresponding federal requirement.

Collaboration With Local Planners

Lee Ann Griffin, an emergency planning expert with the Florida Health Care Association, insists that many nursing homes across the country are very involved with emergency planning agencies. On a national level, however, she admits that “we’re still not there yet.” While hospitals must be included in community plans because they are needed to treat the injured, many regional and local emergency management agencies are just beginning to recognize the importance of including nursing homes, she said.

In many states, this puts the burden on the nursing home to reach out, something some administrators may be reluctant to do. Griffin speculates that the unfamiliarity of many health care professionals with emergency planning terminology may be an obstacle. “They don’t speak the same language,” she said.

Yet from a health care facility’s perspective, Griffin said, there are many benefits to collaborating with local agencies and responders, such as better integration of the facility’s plan with existing emergency management systems. A nursing home administrator who is versed in ICS will have an advantage when communicating with emergency responders, for example, in the event of a fire. Faster communication and response in an emergency can save lives as well as mitigate damage to buildings, she emphasized.

Incident Command System

The FHCA recommends that nursing homes incorporate the national Incident Command System (ICS) into their emergency plans, and that both managers and frontline staff be trained in the concepts.

In a broad sense, the ICS focuses on assignment of staff to key emergency management duties and designation of the equipment and supplies that staff will use to carry out their assigned duties. Training in ICS is available online and free of charge from the Federal Emergency Management Agency’s National Emergency Training Center. The FHCA recommends two FEMA courses in particular:

- Introduction to the Incident Command System for Healthcare/Hospitals, IS-100.HCB, and
- Applying ICS to Healthcare Organizations, IS-200.HCA.

Some preliminary online training in ICS may give an administrator more confidence about getting involved in local or regional planning, Griffin added.

“‘The whole ICS training experience is really a team learning experience. By default, it has to be.”

—Lee Ann Griffin, Florida Health Care Association

The hospital ICS, known as HICS, has become a cornerstone of emergency planning in acute care, Griffin notes. Inspired by the success of HICS and funded by a private grant, the FHCA worked with several partners to develop a similar system for nursing homes called NH-ICS, she said. Job action sheets and similar tools for implementing NH-ICS are available for download free of charge from the FHCA website (see Additional Resources, p.9).

Approaches to Staff Training

Employee training is another area in which federal requirements for nursing homes are sparse. The Occupational Safety and Health Administration specifies certain training requirements for workplace emergency action plans, but these are aimed at safe evacuation of employees. Generally, requirements for nurse aide training don’t include emergency planning; neither do professional level certifications and degrees.

Again, some states have gone beyond the federal requirements, but the substance of their requirements varies widely. Oregon, for example, includes disaster and emergency preparedness among the topics to be addressed in mandatory in-service quarterly training, according to the Long Term Care Resource Center. Iowa, Nevada, New York and Kansas all require initial training in emergency procedures followed by periodic reviews. Some states may require training in specific elements of emergency response, such as triage methods or how to safely move residents in response to a tornado warning. Others focus only on fire/disaster drills and evacuation procedures.

One of the benefits of the ICS system for the nursing home industry, Griffin pointed out, is that once staff
members are trained in the concepts, they can take that knowledge with them and apply it wherever they go. The next facility that employs them will reap the benefit. In an industry known for high staff turnover, standardizing the approach to emergency planning might improve preparedness as well as reduce training costs, she said.

In terms of how to implement ICS training, Griffin said that key people who can serve as “early adopters” would include facility administrators, directors of nursing, regional managers, physical plant supervisors and human resources directors. Ultimately, though, the training need not and should not be limited to management staff. “The whole ICS training experience is really a team learning experience. By default, it has to be,” she said. But frontline staff will absorb any training better, she advised, when they see that leaders are familiar with the concepts and committed to applying them.

Often, she said, staff training on emergency planning takes place within a facility and is led by in-house managers. Professional conferences also frequently offer educational sessions on topics such as how to conduct a tabletop training exercise. These professional-level training sessions are designed to educate a variety of staff members on the basics of emergency planning and response. However, for those looking to standardize the approach to emergency planning, Griffin suggests focusing on a single element, such as evacuation versus shelter in place, and asking participants to think about questions such as “What do we need to know to inform that decision?”

The Western Reserve Geriatric Education Center also has produced a template specifically for long-term care facilities. The template uses a six-step process from start to finish, as follows:

**Step 1: Review Current Policies, Procedures**
First, facilities should review their current policies and procedures addressing emergency preparedness by answering the following questions:

- When were the emergency preparedness policies last updated?
- Are the policies relevant to modern day threats?
- Do the policies designate lines of decisionmaking authority?
- Do the policies define roles and responsibilities of staff from all departments?
- What are the safety/ risk considerations for staff and their families?
- Are the policies relevant to current levels of skilled care and characteristics of the residents?
- Do the policies specify parameters for internal communication with the medical director, employees, corporate office, residents and families?
- Do the policies provide guidelines for external communication with public health, safety and law enforcement authorities?
- What are the guidelines for communicating with the media?

Facilities then should select one of their current policies to be the focus of the tabletop exercise. For example, they could apply their disaster preparedness policies to a hypothetical extended power outage.

**Step 2: Develop, Conduct Tabletop Exercise**
The next step is to create three to five objectives for the tabletop exercise. Objectives should be clear, narrow in scope, specifically related to desired outcomes and attainable. When writing the objectives, facilities also should consider their needs, availability of resources — additional personnel, medical supplies and waste disposal, nutritional supplies, emergency

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**Conducting a Tabletop Exercise**

The tabletop exercise is a training activity that creates mock scenarios of various disasters and emergencies in a classroom-like environment. Similar to a fire drill, a tabletop exercise gives employees a chance to practice their roles and test their knowledge of the facility’s plan, but it does not require any disruption of residents. It also provides an opportunity for small-group discussion of possible emergency scenarios, empowering staff at all levels to find solutions to problems and to acknowledge their ability to do so.

FHCA’s Griffin says her group encourages use of the tabletop emergency planning exercise and has developed some support materials for members. She advises those using the tabletop method, “You don’t have to exercise the entire plan in one session.” Rather, she suggests, focus on a single element, such as evacuation versus shelter in place, and ask participants to think about questions such as “What do we need to know to inform that decision?”

The Western Reserve Geriatric Education Center also has produced a template specifically for long-term care facilities. The template uses a six-step process from start to finish, as follows:

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**See Tabletop Exercise, p. 7**
equipment and back-up power supplies — employees’ training needs, the flow of information and communication, as well as regulatory compliance.

One sample objective for disaster preparedness for an extended power failure could include ensuring that all staff members, including nursing, dietary, housekeeping, maintenance, administration and social services can access essential resources.

Based on their objectives, facilities should write the tabletop exercise to involve a critical incident. The incident should be tailored to the facility’s resident population, staff composition and local hazards and community resources.

Then, facilities should identify employees to participate in the exercise. The quality of the tabletop exercise depends largely on the participants; therefore, recruiting enthusiastic staff members is important. Staff members should be approached in a positive manner, with acknowledgment of their skills and leadership abilities. Participation should be viewed as a “perk” without penalty of additional work.

The participants should include:

- one facilitator who guides the team members through the tabletop exercise by conveying processes and ground rules to the team members; facilitating discussion and participation; and keeping the discussion on track with objectives. The facilitator should have good interpersonal skills and experience in small group interaction;

- one recorder who records the discussion in an unbiased manner and prepares a summary that serves as the basis of the after-action report; and

- five to eight team members who actively engage in the tabletop exercise. Members should be selected based on discipline or specialty area, level of responsibility and varying roles within the facility.

Step 3: Discuss, Document Exercise Outcomes
The third step in the tabletop exercise is to review the problems and successes regarding the specific policy’s effectiveness when applied to the hypothetical incident. For example, the members should identify and document lessons learned, including strengths and weaknesses that were identified in the policies and procedures. They also should identify needed revisions or improvements to the policy.

Step 4: Revise Policies, Procedures
Next, facilities should develop a written action plan for implementing improvements in policy and/or procedures, which could include:

- acquiring necessary approvals;

- identifying internal and external resources that are needed to implement improvements;

- identifying additional “key players” to implement improvements;

- assigning responsibilities for implementing revisions; and

- establishing a timeline for completion.

Step 5: Conduct In-service Training for Staff
An important component of preparedness in facilities is ensuring that employees are prepared for an emergency by communicating any changes or updates to its emergency policies and procedures. Therefore, facilities should conduct staff training that includes written materials, reinforces the importance of teamwork and involves tabletop exercise team members. Also, the training should briefly explain the six-step process that was used to change the policy and/or procedures and the rationale for change.

Step 6: Communicate With Stakeholders
Lastly, facilities must communicate any changes to key stakeholders. Internal stakeholders could include residents and families, the medical director, attending physicians, board of trustees or corporate administration as well as contract service providers and suppliers. External stakeholders could include community responders such as public health officials, emergency services and safety forces; vendors, medical equipment and pharmaceutical suppliers, and other health care facilities; ambulance and other transport companies; local hospitals; and sister facilities.
sessions can give administrators and other managers a “head start,” she said. Later, they can engage others in training at their facility using the same tools.

Some facilities prefer to use outside vendors to train managers and frontline staff. Online training provider Silverchair Learning Systems offers a course that teaches the basics of emergency preparedness to line staff, covering topics such as direction, control and communication; evacuation; elopement; utility outages and emergency services; and bomb and terrorist threats.

“Emergency preparedness varies from one region to the other,” says Silverchair’s Debi Damas, senior director of regulatory compliance and content. “For instance, Florida needs to be prepared for hurricanes, while Montana does not.” Silverchair courses can be customized to cover whatever hazards or components an employer prefers or is required to cover by state law, she said.

Fire Safety as a Building Block

Fire safety in nursing homes is regulated by numerous federal, state and local agencies. The overlapping, and sometimes conflicting, requirements can make compliance difficult but most requirements are based on the National Fire Protection Association’s Life Safety Code (LSC).

OSHA regulations require all employers to comply with basic requirements for emergency exit from the workplace, covering design and construction; well-lit, clearly marked and unblocked exit routes; unlocked exit doors; and alarm systems. While exit route requirements may be deemed met if the employer demonstrates compliance with the LSC, an employer that uses or stores hazardous materials covered under another OSHA standard, such as the flammable chemical ethylene oxide, also may be required to have a written emergency action or fire prevention plan.

If the facility has more than 10 employees, the emergency action or fire prevention plan must be in writing and address minimum elements specified in the rule, such as escape routes and procedures for determining whether all employees have safely evacuated.

Employees must be trained in the employer’s emergency action and fire prevention plans, and facilities should ensure those records are kept up to date and accessible to OSHA inspectors.

CMS requirements state that facilities must, after training staff on their emergency plans and procedures, carry out unannounced drills using those procedures. States also have requirements for drills, although the overwhelming majority are for fire drills. Several states require tornado drills. Usually, states require quarterly drills, and they may require a quarterly drill for each shift.

Drills as a Training Opportunity

Although drills can be viewed as burdensome, they are an important training tool, providing employees with an opportunity to test their knowledge of what they are supposed to do in a fire, tornado or other emergency. Drills also provide managers with an opportunity to identify problems in the plan and employees who need further training.

According to the NFPA, the goal of a fire drill is to practice an orderly, rather than speedy, evacuation. The timing of drills should vary so that all shifts have an opportunity to practice their skills. In a nursing home, residents need not be disturbed or moved for staff to practice a drill. Employees may be assigned to specific roles during the drill, such as the following:

- Drill/evacuation coordinator — plans and directs the drill or evacuation and acts as a liaison with local firefighters.
- Wardens — coordinate emergency evacuation of a particular ward or floor.
- Monitors — carry out varying assignments, such as monitoring use of a particular stairway during evacuation, directing people away from an elevator, making sure no one is left behind in a bathroom or other enclosed area, or taking attendance as occupants arrive at areas designated for assembly during or after evacuation.
- Drill evaluator — records and evaluates actions of others during the drill to identify problem areas and training effectiveness.

Because a fire can occur at any time regardless of who is present that day, it may be advisable to rotate employees among various roles and to allow several employees the opportunity to practice the coordinator role. A roster of employees or job titles assigned to particular roles can be posted in an accessible area as a reminder of who is supposed to do what in an emergency.

OSHA Non-mandatory Guidance

OSHA has provided non-mandatory guidance on how to structure an emergency action plan. In the guidance, OSHA advises employers to:

- address emergencies reasonably expected in the workplace, such as fire, toxic chemical releases, hurricanes, tornadoes, blizzards and others;
Planning for Residents’ Psychological Needs
The OIG found that some nursing homes lacked procedures for helping residents cope with the emotional trauma of an emergency. In some cases, plans were skewed heavily toward sheltering in place and failed to fully anticipate the emotional and physical hardships of evacuation.

For example, most of the facilities’ emergency plans did not include procedures for resident illness or death en route to an evacuation site, or to provide mental health or grief counseling for survivors at the evacuation site, the OIG found. Yet half of the 24 nursing homes that had activated their emergency plans reported later that residents had experienced deteriorating health conditions, skin issues or falls that resulted in injury or death. About a third said some residents had experienced emotional trauma, such as confusion and anxiety, which in at least one case required sedation.

It is estimated that about half of nursing home residents, and more than 40 percent of those in assisted living, have some form of dementia. Such individuals may find it very difficult to cope with the change and disruption of any emergency, and particularly an evacuation.

Training Non-clinical Staff, Volunteers
A consortium of industry groups, including the American Association of Homes and Services for the Aging, has compiled a three-page guide to caring for people with dementia during an emergency, “Planning for a Pandemic/Epidemic or Disaster: Caring for Persons with Cognitive Impairment.”

Intended as a training tool for non-clinical staff and lay-person volunteers, the guide explains the limitations of people with dementia and offers suggestions for care that may be adapted for a facility’s emergency plan. For example, the guide recommends:

- Filling out a personalized information form for each resident that includes, for example, the name the resident prefers to be called, cultural background, names of family and friends, past hobbies and interests, and what triggers have in the past upset them or calmed them down. Temporary or substitute caregivers can access the form to provide more consistent, personalized care.
- Including procedures for prompting residents to eat or drink throughout the day in order to avoid dehydration and maintain physical and emotional stability. Having a volunteer sit and talk with the resident during meals may improve intake. Residents with a choking risk or difficulty swallowing should be identified in advance and assisted by and monitored by trained personnel.
- Implementing interventions to prevent wandering, such as securing areas with personnel or security systems, providing a safe place to wander, providing structured activities during the day, and ensuring that residents get regular exercise.
- Providing a fact sheet to families in advance explaining facility policies during a disaster or emergency, and arranging ways to help residents communicate with families over the duration, such as with scheduled telephone calls.

Preventing a Catastrophic Reaction
A “catastrophic reaction” can occur when a situation overloads the mental ability of residents with dementia to act appropriately, the guide explains. An exaggerated response to a disaster or emergency may include: striking out, screaming, making unreasonable accusations, or becoming very agitated or very emotional.

One of the first steps in preventing and responding to a catastrophic reaction is to identify circumstances that may trigger potentially catastrophic behavior, according to the guide. Regular verbal and written cueing to the new environment may help to prevent the reaction.

Caregivers should identify the root cause of the behavior, which may include over-stimulation, inadequate attention, pain, hunger, fear, depression, an inability to understand, misinterpretation of the environment, panic reaction to an apparently new situation, or the inability to express thoughts or feelings.

Staff and volunteers should be trained to respond to catastrophic reactions and other challenging behaviors by:

- not physically forcing the resident to do something;
- speaking in a calm, low-pitched voice;
**Action Steps** (continued from p. 8)

- trying to reduce excess stimulation;
- eliminating pain as a source of agitation;
- validating the individual’s emotions by focusing on the feelings, not necessarily the content of what the resident is saying;
- understanding that the resident may be expressing thoughts and feelings relative to his or her own reality, which may differ from generally acknowledged reality;
- trying to determine what helps reduce that resident’s exaggerated reactions and including this information in the resident’s individualized plan of care;
- moving the resident to a quiet area;
- providing music or a rocking chair; and
- teaching the resident relaxed breathing.

**Endnotes**


5. EMI’s online courses can be accessed at http://training.fema.gov/IS/crslist.asp.


**Additional Resources**

More information on the topics and resources addressed in this special report is available from the following sources free of charge:

- Information on NH-ICS is available online from FHCA at http://www.fhca.org/emerprep/ics.php or from the American Health Care Association/National Center for Assisted Living’s website at http://www.ahcancal.org/facility_operations/disaster_planning/Pages/default.aspx.

- Information on state emergency planning and fire safety requirements is available from the University of Minnesota’s Long Term Care Resource Center at http://www.hpm.umn.edu/ltcresourcecenter/research/regulating_ltc.htm.

- FEMA’s National Emergency Training Center is accessible online at http://training.fema.gov. FEMA maintains a list of state emergency planning agencies at http://www.fema.gov/about/contact/statedr.shtm.

- OSHA offers an eTool to help employers determine whether they are required to have an emergency action plan at http://www.osha.gov/SLTC/etools evacuation.
## EMERGENCY PREPAREDNESS CHECKLIST
### RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING

<table>
<thead>
<tr>
<th>Tasks</th>
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<tbody>
<tr>
<td><strong>Develop Emergency Plan:</strong> Gather all available relevant information when developing the emergency plan. This information includes, but is not limited to:</td>
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<tr>
<td>- Copies of any state and local emergency planning regulations or requirements</td>
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<tr>
<td>- Facility personnel names and contact information</td>
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<tr>
<td>- Contact information of local and state emergency managers</td>
</tr>
<tr>
<td>- A facility organization chart</td>
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<tr>
<td>- Building construction and Life Safety systems information</td>
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<tr>
<td>- Specific information about the characteristics and needs of the individuals for whom care is provided</td>
</tr>
<tr>
<td><strong>All Hazards Continuity of Operations (COOP) Plan:</strong> Develop a continuity of operations business plan using an all-hazards approach (e.g., hurricanes, floods, tornadoes, fire, bioterrorism, pandemic, etc.) that could potentially affect the facility directly and indirectly within the particular area of location. Indirect hazards could affect the community but not the facility and as a result interrupt necessary utilities, supplies or staffing. Determine all essential functions and critical personnel.</td>
</tr>
<tr>
<td><strong>Collaborate with Local Emergency Management Agency:</strong> Collaborate with local emergency management agencies to ensure the development of an effective emergency plan.</td>
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<tr>
<td><strong>Analyze Each Hazard:</strong> Analyze the specific vulnerabilities of the facility and determine the following actions for each identified hazard:</td>
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<tr>
<td>- Specific actions to be taken for the hazard</td>
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<tr>
<td>- Identified key staff responsible for executing plan</td>
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<tr>
<td>- Staffing requirements and defined staff responsibilities</td>
</tr>
<tr>
<td>- Identification and maintenance of sufficient supplies and equipment to sustain operations and deliver care and services for 3-10 days, based on each facility’s assessment of their hazard vulnerabilities. (Following experiences from Hurricane Katrina, it is generally felt that previous recommendations of 72 hours may no longer be sufficient during some wide-scale disasters. However, this recommendation can be achieved by maintaining 72-hours of supplies on hand, and holding agreements with suppliers for the remaining days.).</td>
</tr>
<tr>
<td>- Communication procedures to receive emergency warning/alerts, and for communication with staff, families, individuals receiving care, before, during and after the emergency</td>
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<tr>
<td>- Designate critical staff, providing for other staff and volunteer coverage and meeting staff needs, including transportation and sheltering critical staff members’ family</td>
</tr>
<tr>
<td><strong>Collaborate with Suppliers/Providers:</strong> Collaborate with suppliers and/or providers who have been identified as part of a community emergency plan or agreement with the health care facility, to receive and care for individuals. A surge capability assessment should be included in the development of the emergency plan. Similarly, evidence of a surge capacity assessment should be included if the supplier or provider, as part of its emergency planning, anticipates the need to make housing and sustenance provisions for the staff and or the family of staff.</td>
</tr>
</tbody>
</table>

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## EMERGENCY PREPAREDNESS CHECKLIST

**RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING**

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Not Started</th>
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<tbody>
<tr>
<td>• <strong>Decision Criteria for Executing Plan:</strong> Include factors to consider when deciding to evacuate or shelter in place. Determine who at the facility level will be in authority to make the decision to execute the plan to evacuate or shelter in place (even if no outside evacuation order is given) and what will be the chain of command.</td>
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<tr>
<td>• <strong>Communication Infrastructure Contingency:</strong> Establish contingencies for the facility communication infrastructure in the event of telephone failures (e.g., walkie-talkies, ham radios, text messaging systems, etc.).</td>
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<tr>
<td>• <strong>Develop Shelter-in-Place Plan:</strong> Due to the risks in transporting vulnerable patients and residents, evacuation should only be undertaken if sheltering-in-place results in greater risk. Develop an effective plan for sheltering-in-place, by ensuring provisions for the following are specified: *</td>
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<tr>
<td>- Procedures to assess whether the facility is strong enough to withstand strong winds, flooding, etc.</td>
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<tr>
<td>- Measures to secure the building against damage (plywood for windows, sandbags and plastic for flooding, safest areas of the facility identified.</td>
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<tr>
<td>- Procedures for collaborating with local emergency management agency, fire, police and EMS agencies regarding the decision to shelter-in-place.</td>
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<tr>
<td>- Sufficient resources are in supply for sheltering-in-place for at least 7 days, including:</td>
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<tr>
<td>- Ensuring emergency power, including back-up generators and accounts for maintaining a supply of fuel</td>
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<tr>
<td>- An adequate supply of potable water (recommended amounts vary by population and location)</td>
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<tr>
<td>- A description of the amounts and types of food in supply</td>
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<tr>
<td>- Maintaining extra pharmacy stocks of common medications</td>
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<tr>
<td>- Maintaining extra medical supplies and equipment (e.g., oxygen, linens, vital equipment)</td>
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<tr>
<td>- Identifying and assigning staff who are responsible for each task</td>
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<tr>
<td>- Description of hosting procedures, with details ensuring 24-hour operations for minimum of 7 days</td>
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<tr>
<td>- Contract established with multiple vendors for supplies and transportation</td>
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<tr>
<td>- Develop a plan for addressing emergency financial needs and providing security</td>
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<tr>
<td>• <strong>Develop Evacuation Plan:</strong> Develop an effective plan for evacuation, by ensuring provisions for the following are specified: *</td>
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<tr>
<td>- Identification of person responsible for implementing the facility evacuation plan (even if no outside evacuation order is given)</td>
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<tr>
<td>- Multiple pre-determined evacuation locations (contract or agreement) with a “like” facility have been established, with suitable space, utilities, security and sanitary facilities for individuals receiving care, staff and others using the location, with at least one facility being 50 miles away. A back-up may be necessary if the first one is unable to accept evacuees.</td>
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<td>- Evacuation routes and alternative routes have been identified, and the proper authorities have been notified Maps are available and specified travel time has been established</td>
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<tr>
<td>- Adequate food supply and logistical support for transporting food is described.</td>
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<td>- The amounts of water to be transported and logistical support is described.</td>
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<tr>
<td>- The logistics to transport medications is described, including ensuring their protection under the control of a registered nurse.</td>
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<tr>
<td>- Procedures for protecting and transporting resident/patient medical records.</td>
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<tr>
<td>- The list of items to accompany residents/patients is described.</td>
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<tr>
<td>- Identify how persons receiving care, their families, staff and others will be notified of the evacuation and communication methods that will be used during and after the evacuation</td>
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<tr>
<td>- Identify staff responsibilities and how individuals will be cared for during evacuation, and the back-up plan if there isn’t sufficient staff.</td>
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<tr>
<td>- Procedures are described to ensure residents/patients dependent on wheelchairs and/or other assistive devices are transported so their equipment will be protected and their personal needs met during transit (e.g., incontinent supplies for long periods, transfer boards and other assistive devices).</td>
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<tr>
<td>- A description of how other critical supplies and equipment will be transported is included.</td>
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<tr>
<td>- Determine a method to account for all individuals during and after the evacuation</td>
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<tr>
<td>- Procedures are described to ensure staff accompany evacuating residents.</td>
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<tr>
<td>- Procedures are described if a patient/resident becomes ill or dies in route.</td>
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<tr>
<td>- Mental health and grief counselors are available at reception points to talk with and counsel evacuees.</td>
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<tr>
<td>- It is described whether staff family can shelter at the facility and evacuate.</td>
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- **Transportation & Other Vendors:** Establish transportation arrangements that are adequate for the type of individuals being served. Obtain assurances from transportation vendors and other suppliers/contractors identified in the facility emergency plan that they have the ability to fulfill their commitments in case of disaster affecting an entire area (e.g., their staff, vehicles and other vital equipment are not “overbooked,” and vehicles/equipment are kept in good operating condition and with ample fuel.). Ensure the right type of transportation has been obtained (e.g., ambulances, buses, helicopters, etc). *

- **Train Transportation Vendors/Volunteers:** Ensure that the vendors or volunteers who will help transport residents and those who receive them at shelters and other facilities are trained on the needs of the chronic, cognitively impaired and frail population and are knowledgeable on the methods to help minimize transfer trauma. *

- **Facility Reentry Plan:** Describe who will authorize reentry to the facility after an evacuation, the procedures for inspecting the facility, and how it will be determined when it is safe to return to the facility after an evacuation. The plan should also describe the appropriate considerations for return travel back to the facility. *

- **Residents & Family Members:** Determine how residents and their families/guardians will be informed of the evacuation, helped to pack, have their possessions protected and be kept informed during and following the emergency, including information on where they will be/go, for how long and how they can contact each other.

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| **Resident Identification:** Determine how residents will be identified in an evacuation; and ensure the following identifying information will be transferred with each resident:  
- Name  
- Social security number  
- Photograph  
- Medicaid or other health insurer number  
- Date of birth, diagnosis  
- Current drug/prescription and diet regimens  
- Name and contact information for next of kin/responsible person/Power of Attorney  
Determine how this information will be secured (e.g., laminated documents, waterproof pouch around resident’s neck, waterproof wrist tag, etc.) and how medical records and medications will be transported so they can be matched with the resident to whom they belong. | | | |
| **Trained Facility Staff Members:** Ensure that each facility staff member on each shift is trained to be knowledgeable and follow all details of the plan. Training also needs to address psychological and emotional aspects on caregivers, families, residents, and the community at large. Hold periodic reviews and appropriate drills and other demonstrations with sufficient frequency to ensure new members are fully trained. | | | |
| **Informed Residents & Patients:** Ensure residents, patients and family members are aware of and knowledgeable about the facility plan, including:  
- Families know how and when they will be notified about evacuation plans, how they can be helpful in an emergency (example, should they come to the facility to assist?) and how/where they can plan to meet their loved ones.  
- Out-of-town family members are given a number they can call for information. Residents who are able to participate in their own evacuation are aware of their roles and responsibilities in the event of a disaster. | | | |
| **Needed Provisions:** Check if provisions need to be delivered to the facility/residents -- power, flashlights, food, water, ice, oxygen, medications -- and if urgent action is needed to obtain the necessary resources and assistance. | | | |
| **Location of Evacuated Residents:** Determine the location of evacuated residents, document and report this information to the clearing house established by the state or partnering agency. | | | |
| **Helping Residents in the Relocation:** Suggested principles of care for the relocated residents include:  
- Encourage the resident to talk about expectations, anger, and/or disappointment  
- Work to develop a level of trust  
- Present an optimistic, favorable attitude about the relocation  
- Anticipate that anxiety will occur  
- Do not argue with the resident  
- Do not give orders | | | |

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<tr>
<td>- Do not take the resident’s behavior personally</td>
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<tr>
<td>- Use praise liberally</td>
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<tr>
<td>- Include the resident in assessing problems</td>
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<tr>
<td>- Encourage staff to introduce themselves to residents</td>
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<tr>
<td>- Encourage family participation</td>
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- **Review Emergency Plan:** Complete an internal review of the emergency plan on an annual basis to ensure the plan reflects the most accurate and up-to-date information. Updates may be warranted under the following conditions:
  - Regulatory change
  - New hazards are identified or existing hazards change
  - After tests, drills, or exercises when problems have been identified
  - After actual disasters/emergency responses
  - Infrastructure changes
  - Funding or budget-level changes

- **Communication with the Long-Term Care Ombudsman Program:** Prior to any disaster, discuss the facility’s emergency plan with a representative of the ombudsman program serving the area where the facility is located and provide a copy of the plan to the ombudsman program. When responding to an emergency, notify the local ombudsman program of how, when and where residents will be sheltered so the program can assign representatives to visit them and provide assistance to them and their families.

- **Conduct Exercises & Drills:** Conduct exercises that are designed to test individual essential elements, interrelated elements, or the entire plan:
  - Exercises or drills must be conducted at least semi-annually
  - Corrective actions should be taken on any deficiency identified

- **Loss of Resident’s Personal Effects:** Establish a process for the emergency management agency representative (FEMA or other agency) to visit the facility to which residents have been evacuated, so residents can report loss of personal effects. *