HealthCap
RISK MANAGEMENT & INSURANCE

2024 Emergency Preparedness Manual

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EMERGENCY PREPAREDNESS MANUAL

TABLE OF CONTENTS

HealthCap
RISK MANAGEMENT SERVICES

ACTIVE SHOOTER EVENT

Policy and Procedure

Policy:

It is the policy of this community to attempt to mitigate risk of death and injury for residents, visitors and staff members related to an Active Shooter Event. This center has adopted an Active Shooter Event Preparedness Program to meet the goal of mitigating risk for death and injury.

An Active Shooter is defined as: An individual actively engaged in killing or attempting to kill people in a confined and populated area, typically using firearms.

Procedure:

In accordance with the Active Shooter Event Preparedness Program this center will:

1. Prepare for and reduce risk of an active shooter event through implementation of a Threat Assessment Team with duties described in the Active Shooter Event Preparedness Program.

2. Train and educate staff members and residents on actual or suspected Active Shooter Response.

3. Train and educate team members and residents to cooperate with First Responders and law enforcement.

4. The new employee orientation process will include education on the Active Shooter Event Policy.

5. Develop and implement a Response After Active Shooter Event including components of infection control and psychological first aid.

Date of Policy: _____

Administrator Signature: _____

Medical Director Signature: _____

Date of Review and/or Revision: _____ _____ _____ _____

Released 6/11/2024

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ADMISSION ELOPEMENT RISK ASSESSMENT

Policy and Procedure

Policy:
It is the responsibility of the interdisciplinary team to provide an environment that meets each resident's individual needs. The following guidelines will be followed for residents upon admission.

Procedure:

1. Upon admission, residents will be assessed for elopement risk using the ***Wander Elopement Risk Assessment form***. The assessment should include information provided by the resident, family or resident representative including:
    a. diagnoses,
    b. medications that may affect cognition or safety awareness,
    c. behaviors,
    d. wandering activity,
    e. mobility with or without assistive devices, and
    f. acceptance of admission to the facility.
    g. History of elopement
2. The ***Wander Elopement Risk Assessment Form*** will be completed as soon as practicable after admission. The algorithm will be used to support risk assessment decisions.
3. Residents identified at risk will be added to the elopement risk system, at the receptionist area and other locations identified by the facility.
4. A resident photo will be obtained and added to the resident record. The photo will be placed in an easily retrievable/printable location. At a minimum, photographs will be maintained in the resident's medical record and on the Medication Administration Record.
5. Photographs will be updated as required to reflect changes in resident appearance as needed post admission.
6. Residents identified as high risk for elopement will have preventive interventions initiated on the resident care plan. Interventions will reflect resident related behaviors and needs as well as specific facility layout and environmental circumstances that should be considered.
7. Direct care staff will be informed of the resident's risk and the appropriate interventions to address the risk of elopement.
8. Residents actively exhibiting exit seeking behaviors will be placed on 15-minute checks or other measures based on interdisciplinary review until appropriate placement on a secure wing or more appropriate facility is located.
9. Residents who are at risk of elopement but not actively exhibiting exit seeking behaviors may be appropriate for the ***Wander Management Program.***

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ELOPEMENT RESPONSE GUIDELINES

Policy:
It is the responsibility of all staff to provide a comfortable environment for each of our residents. The following guidelines will be followed if a resident is identified as missing. For the purposes of this policy, elopement is defined as leaving the facility premises without following the facility's policies and procedures for leave of absence.

Procedure:

1. Upon admission, each resident shall receive a name band with their name and facility name identified on it. It is the responsibility of each nursing assistant to ensure that each of their assigned residents is wearing an identification bracelet and that it is legible. Replacement bands are available from the charge nurse.

2. During medication pass, nurses shall check that a name band is present, particularly for residents at risk for wandering or who are cognitively impaired.

3. After receiving permission to photograph two photographs of newly admitted residents will be taken. The photographs will be used for identification purposes only, one will be maintained in the resident's medical record, the other in the Medication Administration Record. Photographs will be updated as required to reflect changes in resident appearance.

4. Resident and/or responsible party will receive instruction on the facility's leave of absence policy.

Responding to a suspected elopement:

1. It is the responsibility of all staff within the center to respond to activated door alarms and to return residents to their unit if leaving the facility premises without following the facility's leave of absence policy.

2. Any resident who is at imminent risk for elopement should be approached according to accepted guidelines as follows:
    a. Approach the resident in a calm and reassuring manner.
    b. Approach the resident one on one. Discourage large numbers of staff around the resident.
    c. Avoid arguing with the resident. DO NOT say, "You can't," or "You have to."
    d. Avoid touching the resident, if possible, use redirection as the first choice.
    e. Restraints are not to be used as the primary solution; rather, diversionary activities should be encouraged to prevent recurrences.

3. When a suspected elopement has occurred:
    a. Note the time the resident is first identified as unaccounted for and the time that the resident was last seen.
    b. Staff members assigned to the unit where the resident resides will verify that the resident has not followed the facility's leave of absence policy.
    c. Staff members will do a thorough, simultaneous search inside and outside of the center to locate the resident. If the resident is not located, proceed with the following:
        i. Notify the nursing supervisor and staff via overhead page (using facility selected code, i.e., Dr. Wander to room _).
        ii. The charge nurse shall immediately check sign out books to determine if the resident has left with family/friends per the facility's leave of absence policy.

iii. The charge nurse shall assign one employee to physically check each alarmed exit to determine if all alarms are in working order (this may identify the exit the resident used to elope).
iv. The charge nurse shall initiate a search of the facility and grounds by assigning staff to specific areas of the facility.
v. If department heads are on duty, they shall be responsible for the search in their respective areas. If department heads are not on duty, the charge nurse shall oversee the search of all areas of the facility and grounds where it is believed the resident might be found.
vi. Once the resident is located, the charge nurse shall page facility all clear code overhead three times (i.e., "Dr. Wander all clear").
vii. A thorough, physical assessment shall be performed by the charge nurse to identify if the resident is injured.
viii. If a thorough search of the facility and grounds does not locate the resident, the charge nurse shall ***immediately notify the Administrator and Director of Nursing Services.***

_____ _____
Administrator Signature Date

_____ _____
Medical Director Signature Date

Review Dates: _____ _____ _____

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Elopement

Policy and Procedure

Policy:
It is the policy of this facility to provide a comfortable environment for our residents while preventing elopements from occurring. For the purposes of this policy, elopement is defined as leaving the facility premises without following the facility's policies and procedures for leave of absence.

Procedure:
When an elopement is suspected the following steps will be initiated:

1. Notify the nursing supervisor and staff via overhead page (using facility selected code, i.e., Dr. Wander to room _____).
2. The charge nurse shall immediately check sign out books to determine if the resident has been taken out of the building by the responsible party.
3. The charge nurse shall assign one employee to physically check each alarmed exit to determine if all alarms are in working order (this may identify the exit the resident used to elope).
4. The charge nurse shall initiate a search of the facility and grounds by assigning staff to specific areas of the facility.
5. If department heads are on duty, they shall be responsible for the search in their respective areas. If department heads are not on duty, the charge nurse shall oversee the search of all areas of the facility and grounds where it is believed the resident might be found.
6. When/if the resident is located, the charge nurse shall page facility all clear code overhead three times (i.e., "Dr. Wander all clear").
7. If the resident is not located after a thorough search of the facility and grounds, the charge nurse shall ***immediately notify the Administrator and Director of Nursing Services.***

When a resident cannot be located after a thorough search of the facility and grounds, the following steps shall be taken:

1. A written description of the resident and a recent photograph of the resident shall be obtained by the charge nurse.
2. Notify law enforcement officials.
3. Notify the resident's legal representative and/or family.
4. Notify the resident's attending physician.
5. Maintain a documented timeline in the medical record as the situation progresses. Such documentation shall include the date and time resident was last seen, steps taken to locate the resident and the parties notified of situation. ***NO BLOCK CHARTING!***
6. If a resident cannot be located for greater than two (2) hours or other conditions exist that place the resident in harm's way (inclement weather, etc.), the state licensing and regulatory agency shall be notified using the designated 800 hot line telephone number***. (Please refer to regulations specific to your state).***

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BLOOD SPILL CLEAN UP
Policy & Procedure

Policy:
It is the policy of this facility to respond promptly to biohazard conditions that may increase the risk of the spread of infection.

Procedure: The following procedures are intended to assist in cleaning up small spills of blood, blood products and other body fluids. (For larger spills that go beyond your ability to clean with the supplies on hand, contact OSHA Haz Mat by dialing 911).

1. ***Required personal protective equipment (PPE)*** – prior to beginning the cleanup, put on a pair of rubber, latex, PVC, or similar type gloves. In addition to gown and or plastic apron if applicable, and face mask with either goggles or face shield (if splash risk)

2. For small blood spills no other PPE should be required.

3. For larger spills where there is a possibility of contaminating your face or other parts of your body, call HazMat to perform the clean-up.

4. Obtain a spill kit containing:
    a. 10% bleach solution (or Lysol, Virex or other EPA reg. Tuberculocidal)
    b. Gloves
    c. Clear plastic bags
    d. Biohazard labels (available from OSHA HazMat)
    e. Leak-proof sharps containers
    f. Brush and dustpan or tongs or forceps for picking up sharps
    g. Disinfectant wipes

5. Spill decontamination procedures:
    a. Cover the spill area with a paper towel and then pour freshly mixed 10% bleach and water solution on the towel.
    b. Allow solution to soak into the contaminated material.
    c. Work from the outside edges of the spill inward when applying the bleach solution.
    d. Any glass, needles or other sharp objects that may puncture the skin will not be picked up by hand.
    e. Only mechanical means such as a brush and dustpan, tongs, or forceps are to be used to pick up sharps.

f. Wipe up bleached material with paper towels or absorbent pads. It may be necessary to use a scrub brush to remove the material if it impacted a hard, porous surface such as concrete.
g. If porous surfaces such as a carpet have been contaminated, an outside vendor may be needed to clean the area.
h. Mark off spill area to prevent contact, as well as accidental slips and falls.

6. Disposal:
    a. Place bleached material, gloves and other disposable materials into a labeled biohazard bag and place into either another labeled biohazard bag or container.
    b. Ensure lids are firmly sealed on all waste containers when spill clean-up is complete, keep biohazard waste container in a secured area until received by the approved medical waste professional.

7. Decontaminate re-useable equipment:
    a. Decontaminate with the bleach solution all potentially contaminated re-useable tools or protective equipment used in the cleanup.
    b. This includes dustpans, brooms, forceps, buckets, cleaning cloths, mops, etc.
    c. Anything that cannot be effectively cleaned (bleach solution must be able to contact all surfaces) must be placed in a biohazard waste container in a secured area until received by the approved medical waste professional.
    d. After the contaminated area has been cleaned, use fresh water to remove bleach residue from all surfaces.

8. If handwashing facilities are not available at the job site use disinfectant wipes and then wash hands as soon as possible.

9. If you believe you were exposed (skin puncture or splash to eyes or mucous membranes) to biohazard material that had not been decontaminated with the bleach solution:
    a. Vigorously wash affected skin with plenty of soap and water while removing contaminated clothing and shoes.
    b. Wash your eyes for at least 10 minutes with copious amounts of water, lifting the upper and lower eyelids occasionally.
    c. Seek follow-up medical attention by contacting your supervisor for referral to the Occupational Health Clinic.

DEFINITIONS:

Small Spill A volume that is easily managed with a minimal amount of decontamination equipment and materials.

Large Spill A volume that would require more than one-person, large amounts of decontamination equipment material, and/or contamination of objects that would prove difficult to decontaminate (i.e., rugs, mattresses, furniture, electronic gear).

Major Spill Large amounts of blood and/or tissue (usually because of a homicide or suicide).

Micro-encapsulation Absorbent
A dry material that rapidly converts a liquid into a solid. This material greatly simplifies blood spill clean-up and can be obtained through any lab safety vendor.

I have read, understand and agree to adhere to the requirements outlined in this policy and procedure.

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Review Dates: _____ _____ _____ _____ _____

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RISK MANAGEMENT SERVICES

STAFFING DURING AN EMERGENCY

Policy

During normal operations, the facility complies with the laws and regulations for staffing. During an emergency, including a pandemic, the facility may experience staffing shortages (potentially severe) and, under specific emergency conditions, will implement staffing strategies with minimal resident risk.

Staffing Guidelines

The facility has a plan for expediting the credentialing and training of non-facility staff from other locations to provide resident care when a staffing crisis is realized.

A contingency staffing plan has been developed that identifies the minimum staffing needs based on acuity and census and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations.

In the event of a pandemic or other emergency that may impact staffing, the administrator or designee shall conduct a daily assessment of staffing status and needs.

Legal counsel and state health department contacts will be consulted to determine the applicability of declaring a facility "staffing crisis" and appropriate emergency staffing alternatives, consistent with state law and state and federal regulations.

The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis.

During a disaster, staff may not be able to report to work, may be ill, or may need to take care of family members. Staff are notified by the staffing liaison that there is an emergency and off-duty staff are called in as needed/available. A detailed staff emergency contact list is in the emergency preparedness plan.

Daily meetings are conducted to include a review of staffing for the current and following shift. The designated staffing liaison will communicate with absentee staff daily for updates on their situations. Documentation of all attempts to obtain staffing resources will be maintained as well as the reporting status to appropriate oversight agencies and local health department.

Surge Strategies:

1. Rely on existing staff
    a. Increase number of work hours per week
    b. Call in off duty or PRN staff
    c. Reassign licensed administrative staff to resident care duties
    d. Reassign existing personnel to provide essential services outside their current job description
        i. May need to involve collaboration with labor unions if applicable.

   e. All approved Paid Time Off (PTO) days during an event may be cancelled.
   f. Employees who do not provide direct patient care and whose departmental functions can be placed on hold until the emergency is over will be designated to a labor pool.
2. Call on external sources for temporary staff
   a. Nursing agency staffing
      i. Agreements are reviewed annually and are included in the emergency preparedness plans to assist the facility in preparing for possible staffing challenges
   b. Retired healthcare professionals may be recruited to assist with non-patient care duties
3. Request additional staffing resources through the Emergency Management System
   a. Waivers or flexibility for regulatory requirements for hiring staff may be available
4. Identify essential functions that can be performed by
   a. Trained unlicensed/uncertified personnel
   b. Private contractors
   c. Volunteers
   d. Family members
   e. Community – based organizations

   ** Supervision of volunteers and temporary healthcare personnel will be accomplished through initially pairing them with experienced staff to determine their competency and reliability and oversee their work. Restriction of visitors in the event of a pandemic may prevent use of volunteers/family members until visiting restrictions are lifted.

Staff preservation:

Providing essential care to residents cannot be done without able-bodied staff. The infectiousness of a pandemic-causing viruses could result in a loss of 20-50% of staff during an outbreak. Anxiety and concern may result in increased absenteeism. In addition, local public health departments may choose to close schools, which could further exacerbate absenteeism of employees with children.

The facility will be prepared to preserve staff with policies to protect them and strategies to provide essential care with fewer available staff.

- Education and information will be provided to staff to provide support and decrease anxiety/fear.
- Staff, families, and residents will be educated on how the emergency/pandemic planning addresses their needs and how essential services will continue to be provided.
- The facility will be transparent and honest about what the facility plans to do in an effort to ensure that all participants in your facility's daily function (staff,

residents and families) have the information they need to protect themselves and maintain their roles.

Minimizing absenteeism and its consequences during an emergency:

Review attendance/leave policies.

- Suspend requirement for a doctor's note
- Encourage ill workers to stay home
- Isolate/send home symptomatic employees
- Reassign employees at higher risk for complications (i.e. Immunocompromised, pregnancy)
- Provide cross-training/universal caregivers
- Increase inter-facility communication
- Consider hardship of unpaid time off that could discourage ill workers from staying home.
    - Allow to exhaust PTO and go into negative balances
    - Advance sick time
    - Provide special time off allotment
    - Allow employees to donate time off to others
    - Provide information on FMLA

Cross Training/Universal Caregivers:

Staff are cross trained to perform essential functions to enable the facility to operate if key staff are not able to report to work. These critical functions include:

- Essential resident care
- Food service
- Housekeeping (especially environmental disinfection)
- Laundry
- Essential administrative functions including billing and payroll

*Training can be in advance or with brief checklists.

http://www.cahf.org/Portals/29/DisasterPreparedness/pandemic/Pandemic_Workbook_2010.pdf

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Review Dates: _____ _____ _____ _____ _____

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Surveyor Request for Access to Electronic Health Records

Date: _____

Surveyor Name: _____ **Credentials:** _____

Username: _____

Access:

_____ **ON-SITE**

On-site access will be active during the hours you are in the facility. Access will be terminated upon exiting the facility.

_____**REMOTE** (approved upon written request during Emergency situations only)

- Will be granted for 2 days only: (Dates: _____ and _____).
- Limited to normal business hours (9:00am – 5:00pm).
- Access will be activated at 9:00am and termed at 5:00pm each day.
- If access is needed for more than 2 days an extension request must be approved by the Administrator and/or Director of Nursing (DON).

In exchange for granting remote access to the facility's Electronic Health Records:

You agree to safeguard and not disclose your username or passwords to others.

You agree not to permit others to access our EHR using your username and password.

You agree not to permit any unauthorized person to access any facility resident's Electronic Health Records.

You agree not to leave your computer unattended without logging off or using your system's screen saver function before leaving your work area.

My signature acknowledges that I understand the above notice and will utilize HIPAA compliant technology and safeguards to access and review the facility's Electronic Health Records.

Signature of Surveyor: _____ Date: _____

Administrator/DON/Designee: _____ Date: _____

Verification of surveyor credentials will be requested prior to initiating on-site or remote access to our electronic health record system.

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Telemedicine
Policy and Procedure

Policy:

To improve access to medical care and increase the efficiency of medical evaluation and management, it is the policy of this facility to enable the use of telecommunication technology. Virtual care may be an option while protecting beneficiaries and assisting with infection control protocols. Residents who provide appropriate consent will be connected to a health care professional at a different location via telemedicine/electronic devices. *

Procedure

1. Telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located.

2. Providers must have an existing physician-patient relationship.

3. Consent must directly or indirectly be obtained by a health care professional utilizing telemedicine.

4. The provider will use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the resident.

5. Video conferencing platforms used for telemedicine services must have the appropriate tools to authenticate individual users and secure transmission (such as end to end encryption). The platforms must meet the privacy and security requirements of, and be compliant with, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

6. It is the policy of this facility to require use of the _____ as its telehealth platform. Use of a non-HIPAA compliant telehealth platform as detailed in the Addendum below will only be allowed with written permission from the _____ (Administrator / Executive Director) and the written consent of the resident.

7. Only in emergency situations and with prior approval may the use of non-HIPAA compliant video conferencing platforms be used.

8. These platforms must be authorized and documented by the Compliance Officer, and only under certain conditions which have been defined and permitted by the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR), which enforces the HIPAA privacy and security regulations.

9. The use of public-facing video communication applications is NEVER allowed, such as Facebook Live, Twitch, TikTok, and other similar applications.

Modified Procedure

1. Any use of non-HIPAA compliant video conferencing technology platforms must be approved by the Compliance Officer and the resident for telemedicine consultations only.

2. The use of non-HIPAA compliant video conferencing platforms should only be used if there are no other HIPAA-compliant options available for the telemedicine consultations.

3. Providers who wish to use non-HIPAA compliant video conferencing platforms under this exception must get prior authorization for such use and must document that they have made a good faith effort to use HIPAA-compliant solutions before using an alternative platform.

4. The responsible workforce members are still required to get a signed "Resident Consent to Telemedicine Consultations" form prior to initiating a telemedicine consultation with any provider.

5. If approved by the Compliance Officer, providers may use any non-public facing remote communication product that is available to communicate with patients. These may include popular applications that allow for video chats, such as:

    a. Apple FaceTime
    b. Facebook Messenger video chat
    c. Google Hangouts video
    d. Skype

6. Telemedicine consultations must be documented by the provider in the same manner as a normal telemedicine consultation.

7. The use of public-facing video communication applications is NEVER allowed, such as Facebook Live, Twitch, TikTok, and other similar applications.

Definitions

Telemedicine: Means the use of electronic information and telecommunication technologies to support or promote long-distance clinical health care, patient and professional health-related education, public health, or health administration. To be considered telemedicine, the health care professional must be able to examine the resident via a real-time, interactive audio or video, or both, telecommunication system, and the resident and/or nurse must be able to interact with the off-site health care professional at the time the services are provided.

*Medicaid reimburses for live video telemedicine for certain healthcare professionals and for residents at certain originating sites. Live video telemedicine is reimbursed and should primarily be used when travel is prohibitive for the beneficiary or there is an imminent health risk justifying immediate medical need for services.

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Review Dates: _____ _____ _____ _____ _____