



Emergency Response and Disaster Operations Information Intake Form

For

Skilled Nursing, Board and Care Facilities,

Home Support Service Programs and Home Health Agencies in Santa Clara County

Disclaimer: The information provided is completely voluntary and will not be used in any other way/ shape or form than to gather information for the EMS Agency and the Public Health Department of Santa Clara County in preparation for a large scale event or local disaster.

Name of Facility: _____

Type of Facility: (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Skilled Nursing Facility (SNF) | <input type="checkbox"/> Sub-Acute Care |
| <input type="checkbox"/> Intermediate-Care (ICF) | <input type="checkbox"/> ICF/Mental Retardation (ICF/MR) |
| <input type="checkbox"/> ICF/DD-Habilitative (ICF/DD-H) | <input type="checkbox"/> ICF/Developmental Disabled (ICF/DD) |
| <input type="checkbox"/> ICF/DD-Nursing (ICF/DD-N) | <input type="checkbox"/> Institute for Mental Health (SNF/STP) |
| <input type="checkbox"/> Social Rehabilitation Facility | <input type="checkbox"/> Residential Care For the Elderly (RCFE) |
| <input type="checkbox"/> Adult Residential Facility (ARF) | <input type="checkbox"/> Continuing Care Retirement Community (CCRC) |
| <input type="checkbox"/> Residential Care Facility for the Chronically III | |

Facility Address: _____

Facility Website: _____

Main Telephone Number: _____ Fax Number: _____

Contact Person: _____ Title: _____

Contact Person's Phone Number: _____ Email: _____

24-HOUR EMERGENCY CONTACT INFORMATION:

Name: _____ Title: _____

Phone Number: _____ Backup #: _____ Email: _____

FACILITY SPECIFICS:

Bed Capacity: Total Number of Licensed Beds: _____
Total Assisted Living Beds: _____
Specialty Beds: a) Alzheimer: _____
b) Hospice: _____
c) Acute Psychiatry: _____
Other, please specify: _____

MEDICALLY FRAGILE SERVED (approx. total number for each type):

Alzheimers _____ Bed Bound _____ Wheelchair Bound _____
Bariatric _____ Ambulatory _____ Cognitively Impaired _____
Assistive Devices (walker, crutches) _____ Hearing Impaired: _____
Medically fragile (feeding tube, IV Pump) _____ Blind: _____
Non-English Speakers, please specify language spoken: _____
Other (please specify and provide total # served) _____

STAFF SUPPORT AND CAPACITY (approx. total number for each type):

Registered Nurses (RN): _____ Licensed Vocational Nurses (LVN): _____
Certified Nurse Assistants (CNA): _____ Social Workers: _____ Physicians: _____
Other Licensed Staff: _____ Other Non-Licensed Staff: _____

PHYSICAL PLANT AND OPERATIONS SUPPORT:

Does the facility have a generator for providing emergency power? Yes No

Total number of generators: _____

How long could the facility generator(s) supply emergency power?

Total # of Hours _____

Does the facility have adequate amount of emergency fuel stored for the generator(s)?

Yes No

Does the facility generator(s) control all electrical circuits (including AC, oxygen generators)? Yes No

If NO, does the generator fail to control any of the following:

Lights Air Conditioners Computers Oxygen Kitchen

Refrigeration

Does the facility have one or multiple ventilation systems for the building?

One Multiple

Does the facility have internal capabilities for Food Preparation or does the facility rely on external food distributor? Internal External

Does the facility maintain emergency food in case food delivery cannot be made? Yes No

If YES, for how many days? 24hrs 48hrs 72hrs 96hrs

Does the facility have the ability to filter own water? Yes No

If NO, does the facility maintain bottled water in case of an emergency? Yes No

If YES, how many days of bottled water does facility have on hand? **Days** _____

Does the facility have an on-site designated emergency command center? Yes No

Does the facility have isolation or reverse ventilation rooms? Yes No

If YES, how many isolation rooms are there? **Number:** _____

EMERGENCY PLAN:

Does the facility emergency plan address....

Emergency Disaster Evacuation Plan? Yes No

In case of a local disaster or large scale event, where do you relocate to?

Does the facility maintain a vendor contract with a transportation company to provide for emergency evacuation? Yes No

If YES, with who are contracts established with? _____

If NO, does the facility have own transportation to transport residents in the event of an evacuation? Please describe: _____

Emergency Disaster Plan for residents with special needs?

Yes No

Isolation of infected patients/residents? Yes No

Triage of casualties? Yes No

Quarantine? Yes No

Decontamination? Yes No

Reconfiguration of facility space for quarantine of communicable diseases and treatment of infectious disease epidemics? Yes No

Transfer of multiple or mass casualties? Yes No

Credentialing, orientation and supervision of clinicians not normally working in facility responding to a disaster or emergency event? Yes No

Mechanisms to manage unsolicited clinical help and donated items? Yes No

Patient registration process for disaster victims? Yes No

Coordination with Local or Regional Hospitals? Yes No

Coordination with Local or State Emergency Planning Agencies? Yes No

Coordination with Red Cross/Local Relief Agencies? Yes No

Has your facility emergency operations plan been reviewed by state or local officials?
 Yes No

EXTERNAL EMERGENCY RESPONSE COORDINATION AND COMMUNICATION:

Does your facility have access to any of the following communication methods:

Radio 2-Way Radio NOAA Radio Power-safe Emergency Telephone

Multiple Phone Lines Internet Satellite Video Conferencing Email

Other, please specify: _____

Do you know who and how to contact local agencies in case of a local disaster or large scale event? Yes No

If YES, who are your contacts? _____

How does the facility get informed when a local disaster or large scale event is anticipated or has happened? _____

How does the facility receive external communication alerts in regards to a disaster/ event? _____

Is your facility registered or connected to a county-wide or local community alerting system? Yes No

If YES, please describe: _____

COOPERATIVE ASSISTANCE/PARTNERSHIP AGREEMENTS:

Do you perceive your facility as having a formal role in a community/state/federal response to an emergency situation? Yes No Not Sure

Does your facility have a contingency plan (or procedure) for giving or receiving mutual aid or cooperative assistance (support to/from): Check all that apply

- A local or state emergency planning agency
- A neighboring hospital or hospital system
- Another nursing home or nursing home consortium
- Other community health providers (home health, physicians' offices)
- Do not have such an agreement

Does the facility have any Memorandums of Understanding (MOU's) with "like-facilities" or other agencies/organizations/partners within the community?

Yes No

If YES, are any MOU's established with outside facilities/agencies/organizations?

Yes No

PHARMACEUTICAL STOCKPILE:

Does your facility keep stocks of antibiotics on site for emergency use? Yes No

Does your facility keep Intravenous (IV) fluids on site for emergency use? Yes No

Does your facility maintain oxygen on site for emergency use? Yes No

Does your facility maintain respiratory bronchodilators (albuterol nebulizers) on site for emergency use? Yes No

LOGISTICS, FACILITIES, AND SECURITY:

Does your facility require all staff to wear ID badges? Yes No

Are the facility's security staff.....(check all that apply)

Facility employed Contracted Facility does not have security Staff

Is the facility staffed with security 24/7? Yes No

Does the facility have a procedure in place to lock down all exterior doors within 30 minutes, without requiring "outside" personnel? Yes No

Does the lock down procedure include notification of ...(check all that apply):

- Personnel in building Fire Police EMS
 Area Hospitals Medical Director/Administration Other_____

TRAINING, EXERCISES AND DRILLS:

Does the facility provide staff with annual emergency preparedness and response education? Yes No

Have facility personnel received any Emergency Disaster training? Yes No

If YES, please specify: SEMS NIMS ICS Other: _____

Does the facility practice internal emergency response exercises or drills? Yes No

If YES, what type exercises and/or drills (i.e., fire, earthquake, etc.): _____

How often are exercises/drills conducted? _____

Who participates in the emergency exercises/drills? _____

Has the facility conducted drills/exercises during the following times or under the following circumstances? (check all that apply)

- Day Shift (7AM-3PM) Night Shift (11PM-7AM)
 Evening Shift (3PM-11PM) Weekend (Saturday, Sunday)

FORMATION OF GROUPS/ COMMITTEES/ MEETINGS:

Would your facility be interested in participating in disaster preparedness committees/ meetings with other Long-term care facilities for information sharing and collaboration?

- Yes No

Would a facility staff member be interested in taking on a "facilitator" role for a Long-Term Care Facilities Preparedness Committees/Meetings? Yes No

TRAINING OPPORTUNITIES:

Would the facility staff be interested in learning more about disaster preparedness?

- Yes No

Would the facility staff be interested in attending seminars/workshops related to disaster preparedness? Yes No

Would the facility be interested in receiving "topic specific" education and/or training?

Yes No Please specify the topic(s) of interest: _____

Have any of your facility staff completed any of the following trainings (check all that apply)?

Standardized Emergency Management System (SEMS)

National Incident Management System (NIMS)

Incident Command System (ICS)

Other, please specify: _____

OTHER TRAINING: ALERT & NOTIFICATION

Would your facility be interested in receiving alert and notification training? Yes No

MEDICAL VOLUNTEER NETWORK OPPORTUNITY:

In the event of a County-Wide disaster, would your staff be willing and interested in volunteering as Disaster Workers? Yes No

We would like to thank you for your participation in assuring the wellbeing and continuous preparation of our community.

Emergency Preparedness and Response:

[Information for Medical Volunteers](#)

MVDR Coordinator

Medical Volunteers for Disaster Response

Email: mvdr@hhs.sccgov.org

[Information for Disaster Preparedness](#)

FEMA Disaster information

www.fema.gov/hazard/index.shtm

Information for Disaster Training (SEMS/NIMS/ICS)

www.fema.gov/emergency/nims/nims_training.shtm#0

Contact Information Local EMS Agency

Santa Clara County Emergency Medical Services Agency
976 Lenzen Avenue, San Jose, CA 95128
Phone: 408-885-4250
Fax: 408-885-3538

Email: emsagency@hhs.co.scl.ca.us

Website: www.sccemsagency.org