Shelter In Place: Planning Resource Guide for Nursing Homes

Purpose of this Document

When faced with the difficult decision of having to evacuate or stay in the long term care center, many factors need to be considered. Sheltering in Place (SIP) is the preferred option, yet implementing this option calls for a complex chain of decisions and actions that requires these pre-event activities: Planning, Training, Preparation, Collaboration, Continual Vigilance, and Communication with Local Authorities. This guide will provide examples, references, and comparisons to what a care center has already built into its existing Emergency Management Program. Use of these materials is no guarantee that a care center is able to manage successfully an SIP event.

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The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent more than 12,000 non-profit and proprietary skilled nursing and post-acute care centers, assisted living communities, and homes for individuals with intellectual and developmental disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of individuals who receive care and services in AHCA/NCAL member facilities each day.

Document Purpose and Intent

For the purposes of this resource guide, shelter in place (SIP) is defined as: A protective action strategy taken to maintain resident care in the facility and to limit the movement of residents, staff and visitors in order to protect people and property from a hazard.

When a mandatory evacuation order is issued, the choice of the center is made. But in the absence of a mandatory order but faced with a threat such as flooding, wild fire or prolonged loss of power, to stay or go is not always clear which is the best course to take for the residents and the business. While SIP is clearly a first option, it is a complex decision and a strategy that requires these steps in preparation:

- Planning
- Training
- Preparation
- Collaboration
- Continual Vigilance
- Robust Communication with Local Authorities

The list of possible considerations and exposures includes but is not limited to:

- External/internal risks/threats/exposures for patients, staff, visitors & physical plant
- Likelihood of community and area-wide infrastructure damage
- Availability of evacuation support resources

Disclaimer:

The enclosed documents should be considered as examples, references and comparisons to what a facility has already built into their existing Emergency Management Program (EMP). Although the facility has the responsibility to make the decision to SIP it might be overridden by the local/state/federal authorities.

This document is a resource for preparation purposes only; use of these materials is no guarantee on the facilities ability to shelter-in-place.

Decision Trees: The purpose of this sampling of decision trees (matrixes) is educational in nature and is provided to assist care providers to:

- Review current SIP plans
- Review/update risk assessments
- Identify critical criteria and decision-making factors
- Develop/update SIP plans to address mitigation, preparation, response & recovery

Unless otherwise cited, the materials within are a collective work of the AHCA Emergency Preparedness Committee 2015.

Shelter in Place Planning Worksheet

SHELTER IN PLACE PLANNING TASK	STATUS (CHECK ONE)	PERSON(S) RESPONSIBLE	DEADLINE	RESOURCES
Shelter In Place Decision (page 7)				
Criteria for making shelter-in place vs. full or partial evacuation decision established	☐ not started ☐ in progress ☐ done			
Procedure established for consulting with local emergency management re: shelter-in-place decision	☐ not started ☐ in progress ☐ done			
Policy established re: whether staff families can shelter at Center	☐ not started ☐ in progress ☐ done			
Emergency Power Plan (page 13)				
Center has generator adequate to its specific power needs and its placement is not in a potentially problematic location (i.e., below sea level, in a basement in the event of a flood, etc.)	☐ not started ☐ in progress ☐ done			
If no generator, Center is "quick connect" ready	☐ not started ☐ in progress ☐ done			
Center has 4-5 day fuel supply for generator **(page 14)**	☐ not started ☐ in progress ☐ done			
Procedures established for regular checking and maintenance of generator	☐ not started ☐ in progress ☐ done			
Center has back-up, manual versions of important medical equipment	☐ not started ☐ in progress ☐ done			
Center leaders have met with local emergency management to discuss power needs of the facility **(page 16)**	☐ not started ☐ in progress ☐ done			
Center leaders have met with power company to discuss power needs of the facility	☐ not started ☐ in progress ☐ done			
Food and Water Supplies (page 18)				
Emergency Food & Water Supplies reviewed and updated	☐ not started ☐ in progress ☐ done			
Center increases to 5-7 day food stockpile for max number of patients and employees	☐ not started ☐ in progress ☐ done			
Center has adequate supply of	☐ not started			

potable water	☐ in progress ☐ done			
Emergency food supplies are inspected and rotated as needed	☐ not started ☐ in progress ☐ done			
Center has active contracts with multiple food suppliers, incl. one located out of area	☐ not started ☐ in progress ☐ done			
Medications and Supplies Stockpile (page 20)				
Center has considered increasing to 5-7 day stockpile of common medications	☐ not started ☐ in progress ☐ done			
Center has 5-7 day supply of medications for each patient	☐ not started ☐ in progress ☐ done			
Center has 5-7 stockpile of supplies needed to care for patients	☐ not started ☐ in progress ☐ done			
Center has extra supplies of IV fluids	☐ not started ☐ in progress ☐ done			
Center has reviewed pharmacy delivery with pharmacy as needed	☐ not started ☐ in progress ☐ done			
Center has reviewed deliveries from vendors of medical supplies	☐ not started ☐ in progress ☐ done			
Other Resources				
Center has access to cash in event of money supply disruption	☐ not started ☐ in progress ☐ done			
Credit and priority arrangements made with local hardware, grocer, etc.	☐ not started ☐ in progress ☐ done			
Center has on hand basic tools and materials to make emergency repairs/shore up structure	☐ not started ☐ in progress ☐ done			
Security Plan (page 21)				
Center leaders have discussed emergency security	☐ not started ☐ in progress ☐ done			
Discussions held with local law enforcement re: facility security	☐ not started ☐ in progress ☐ done			
Lockdown procedure established	☐ not started ☐ in progress ☐ done			

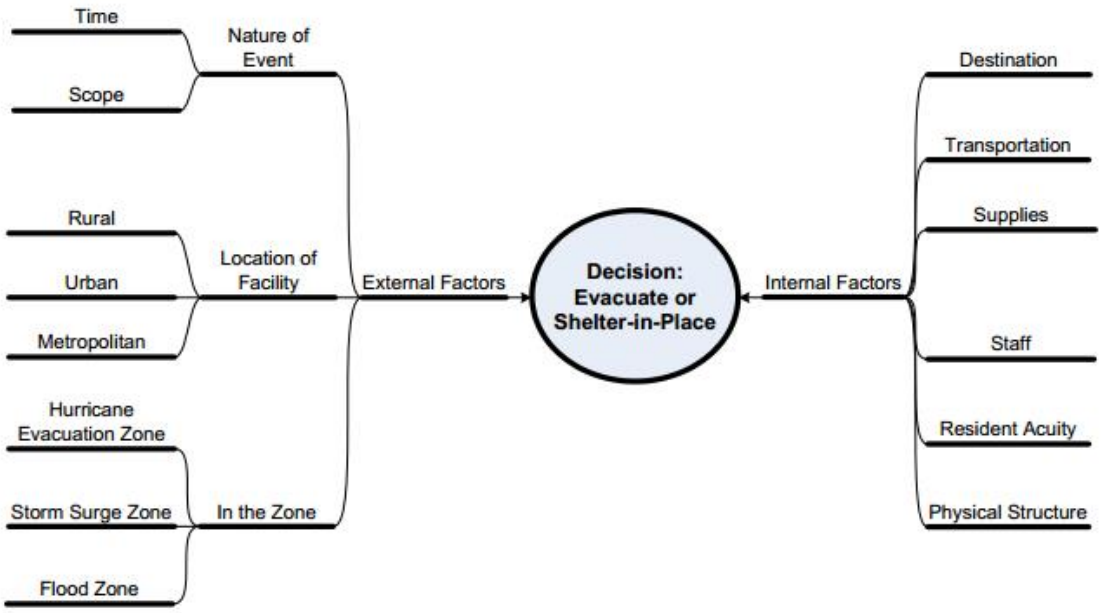
Source: As adapted from Emergency Preparedness Planning for Nursing Homes & Residential Care Setting in Vermont

SIP Decision Trees

Below are several different decision trees for your review. The intention of these flow charts is to inform your thinking about the critical decision to SIP or evacuate. There are multiple factors that need to be included in your decision-making. It is also important to remember that when a decision is made to SIP – this decision needs to be continually reviewed to ascertain if the threat increases, resources no longer meet t he needs, or other circumstances change.

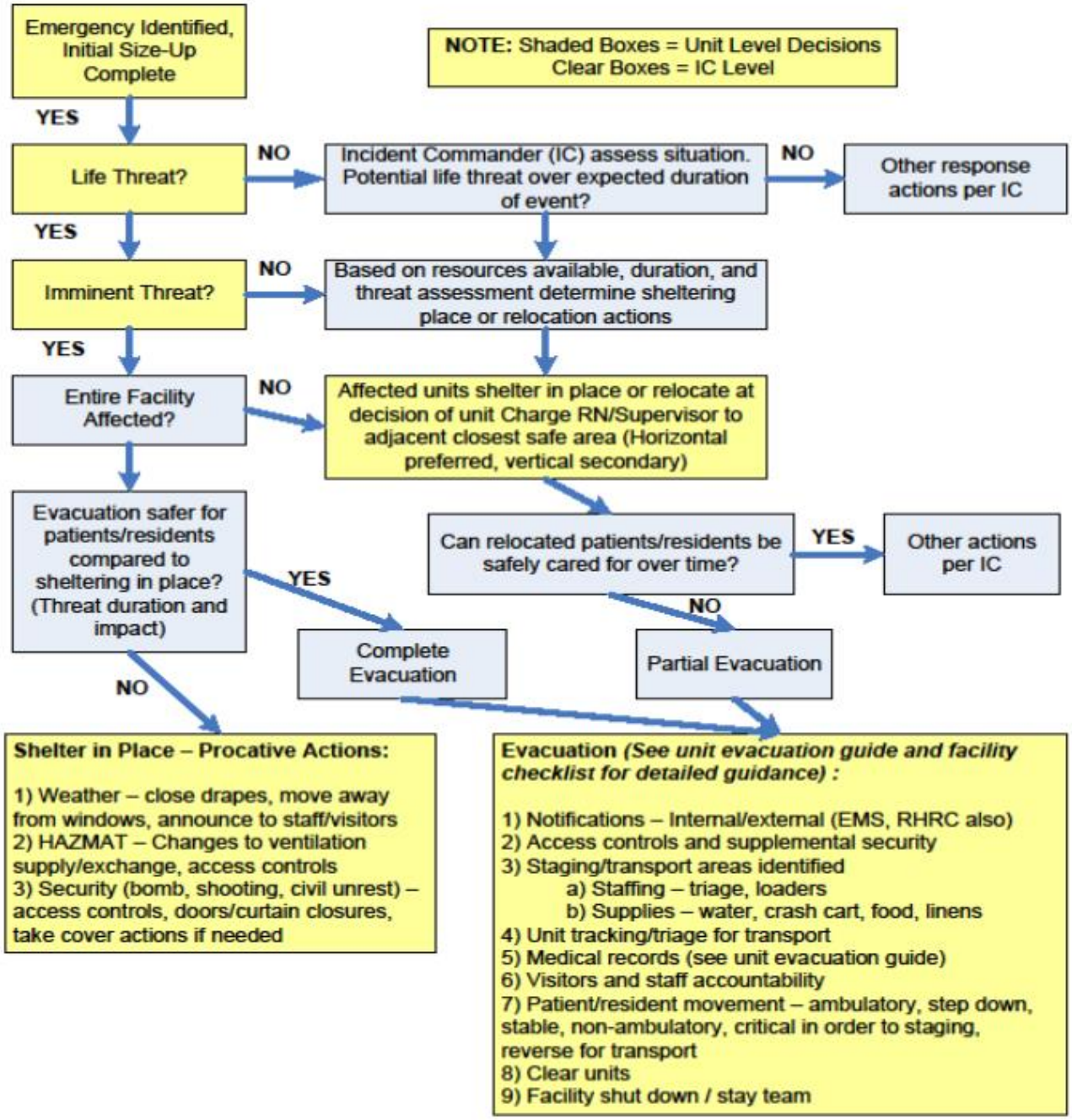
Criteria for Evacuation

The process for evacuation decision-making for nursing homes must be framed as a flexible and responsive cause and effect diagram:



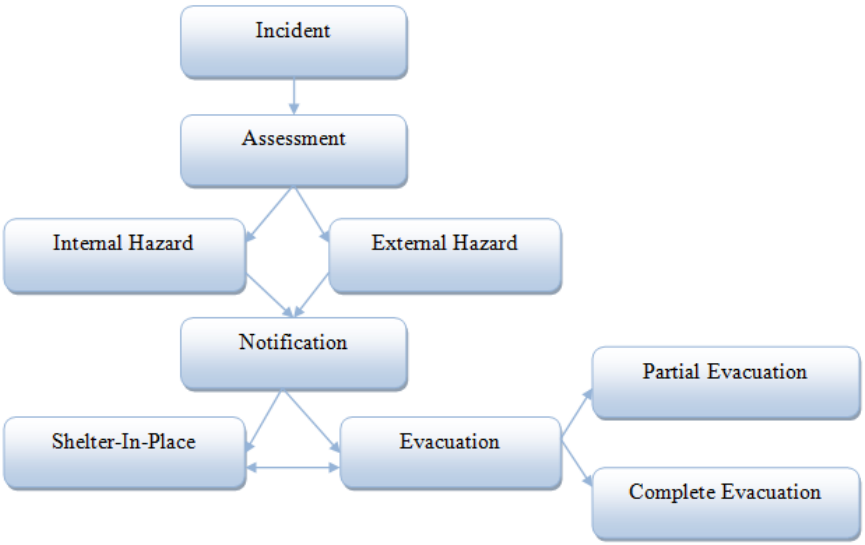
Citation: Florida Health Care Education and Development Foundation, 2008, National Criteria for Evacuation Decision-Making in Nursing Homes, developed through a project funded by the John A. Hartford Foundation. For further information, please visit www.fhca.org.

Sheltering, Relocation, and Evacuation Decision Tree



Citation: Healthcare Facility Training Matrix for Sheltering, Relocation, and Evacuation
www.health.state.mn.us/oep/**healthcare**/sip**matrix**.ppt

"Make the decision to SIP or evacuate in consultation with the response agency Incident Commander (IC) or Unified Command (e.g. EM Dir., FD, Law Enforcement., PH, EMS, HS, etc.). Lacking response from agency IC, facility IC is to do all that is necessary to protect the life and safety of residents, staff, and visitors. The facility IC is to notify 911 of its decision."



Citation: https://www.michigan.gov/.../Evacuation_and_**Shelter_in_Place**

Planning Protective Action Decision-Making: Evacuate or SIP?

4.2 CHECKLISTS

Table 2 illustrates a checklist approach to the evacuation/sheltering decision. The first column lists various decision attributes. The second and third columns list the attribute values that favor either shelter or evacuation.

Table 2. Protective action checklist

Attribute	Shelter	Evacuation
Infiltration	Tight housing	Leaky housing
Plume duration	Short	Long
Time of day	Night	Day
Population density	High	Low
Road Geometry	Closed	Open
Road conditions	Poor	Good
Population mobility	Immobile	Mobile
Traffic flow	Constrained	Unconstrained
Public perception of shelter effectiveness	High	Low
Toxic load	High	Low

Decision Trees will differ depending on the goals and objectives of protective action plans, which may have different, but not necessarily mutually exclusive, goals:

1. Avoid fatalities vs. minimize fatalities
2. Minimize:
    a. Number of people exposed
    b. Total population exposure
    c. Expected population risk
3. Reduce exposure:
    a. Below a threshold level (i.e. no deaths exposure)
    b. To "As Low As Reasonably Achievable" (ALARA)

Citation: National Technical Information Service --Environmental Sciences Division; **Date Published: June 2002 (ORNL/TM-2002/144); Prepared for FEMA;** http://www.ntis.gov/support/ordernowabout.htm

Regarding Levels and Depth of Training

- **Awareness** (*ALL Staff*)
    - A basic level of "competency mastery", able to identify the concept or skill, but relatively limited ability to perform skills without direction & guidance
- **Knowledge** (*Charge nurses, supervisors, manager ED*)
    - Intermediate level of mastery of competency, able to apply and describe the skills
- **Proficiency** (*Command staff*)
    - Advanced level of mastery of the competencies, in which individuals are able to synthesize, critiques or teach skill

Citation: Healthcare Facility Training Matrix for Sheltering, Relocation, and Evacuation
www.health.state.mn.us/oep/**healthcare**/sip**matrix**.ppt

Hospital SIP Planning Checklist

Plan Component		
Overview	**Reference/Location**	**Status**
1. Mitigation	**Reference/Location**	**Status**
2. Preparedness	**Reference/Location**	**Status**
A. Response plans incorporate SIP option, as appropriate		
B. Communication Plans		
C. SIP Training records (such as, new employee orientation, SIP codes, SIP plans)		
D. Drills/Exercises Incorporate SIP Decision-Making and Plans		
3. Response (SIP)	**Reference/Location**	**Status**
A. Initiation and Termination of Shelter In Place activities/plan		
B. Issuance of Alert for Hospital Emergency Code for SIP Activation(s)		
C. Activation of the Hospital Command Center (HCC) for SIP		
D. Initiate/Maintain communication and coordination		
E. Identify relevant HICS Forms and Documentation		
F. Initiate and Maintain Internal Communication (all facilities on grounds)		
G. Event-Specific Planning Guides and Response Plans [2]		
H. Identification of SIP Patient Care and Non-Patient Care Locations		
I. Document operational response procedures (what, who, where, how)		
J. Assess Available Resources and Assets (Capabilities)		
K. Management of Resources and Assets		
L. Monitor, conservation and alternatives for utilities, fuel, gases, water, etc.		
M. Management of Safety and Security		
N. Management of Clinical and Support Activities		
4. Recovery	**Reference/Location**	**Status**
A. Initiation of recovery activities initiated during Response Phase		
B. Secure and initiate clean-up and decontamination of contaminated facilities and grounds in coordination with Fire and Safety		
C. Return to normal operations (phased, approvals, priorities, checklists)		
D. Event Evaluation (Debriefing, Evaluation/Reports, Corrective Action)		

Citation: California Hospital Association, http://www.calhospitalprepare.org/cha-tools

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Hospital Evacuation and SIP Decision Tree

Event

- Event requiring facility to consider whether evacuation or Shelter in Place (SIP) plans should be activated
- External and internal intelligence regarding event

Must Shelter-In-Place

- The external environment would pose a greater danger to patients, staff and visitors than evacuation (e.g., chemical/ biological agent release, nuclear incident plume)
- Adequate and timely facility and/or mutual aid resources are not available or accessible (e.g., earthquake)

Must Evacuate

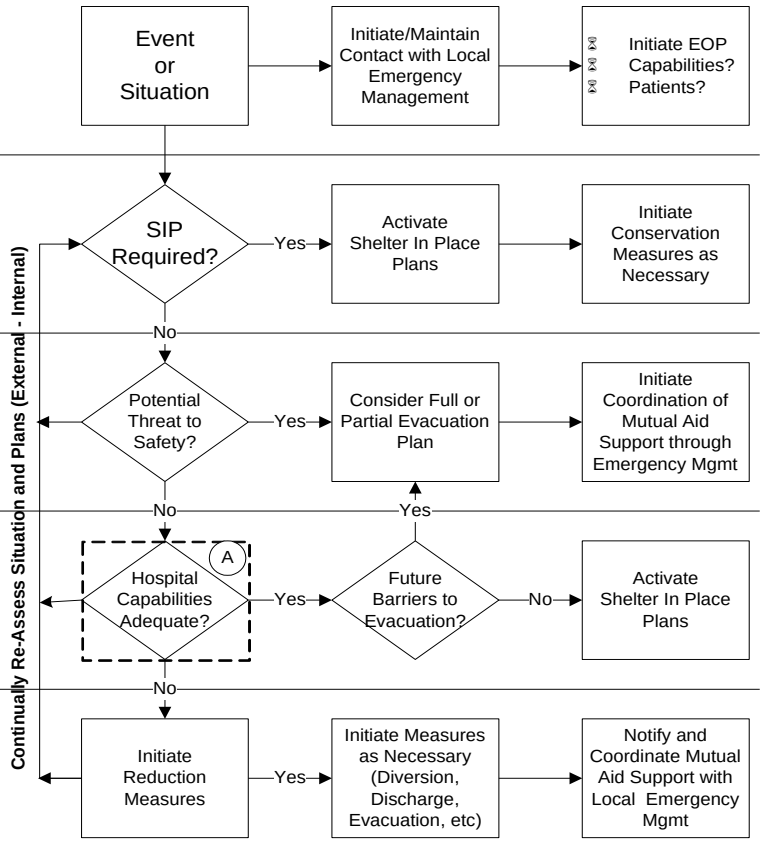
- The proximity, scope and/or expected duration of event poses an immediate threat to patient and staff safety
- Adequate and timely facility and/or mutual aid resources are available and accessible to support Full or Partial evacuation

Shelter In Place or Evacuation Decision

- Duration and scope of threat to hospital clear but may evolve
- Hospital capabilities adequate to care for patients and staff with available support for estimated event duration
- May or may not be barriers mutual aid resources should evacuation become necessary

Need to Implement Reduction Measures

- Hospital capabilities not adequate to maintain full operations for estimated duration of event
- Determination made that reduction measures necessary (for example, conservation of resources, curtailment of services and/or partial hospital evacuation)
- No identified barriers to mutual aid resources



(A) Hospital Capabilities may include communication, resources (medical/non-medical supplies and equipment), utilities, staff, food, water, safety and security (including safety of facilities).

Citation: California Hospital Association, http://www.calhospitalprepare.org/evacuation

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Emergency Power Plan

Does the Center have a generator adequate to its specific power needs?

Status: □ not started □ in progress □ done

Current generator: _____

Provides power to: _____

Updated review

How to determine the proper size of generator needed

1. Generators are rated by their kilowatt (kW) output.
2. Review your state regulatory requirements for the capacity of generators (i.e. must be able to power essential lighting and life support functions vs. all heating and cooling systems).
3. Determine if your location has decided to have additional generator power beyond state requirements.
4. To estimate the kilowatts desired in an emergency, make a list of the appliances needed during a power outage, and add up the amount of electricity required to start the motors. (Ex. a typical refrigerator, such as found in a medication room for the storage of medications, uses 700 watts when it is running but needs 2,800 watts to start up.) Most generator manufacturers' websites provide an online calculator to estimate the wattage needed.
5. However, it is highly recommended that a licensed electrician do an on-site inspection to properly "size" the generator.

Also, review the location of your generator or proposed generator. If you are in a flood prone area, alternative placement from a basement should be considered.

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If no generator, is the care center's "quick connect" ready?

Status:* □ *not started* □ *in progress* □ *done

If your care center does not have a permanent generator, a quick connect for generators is a proactive way to be prepared for a power outage. A quick connect set-up allows a fast and simple hook-up of a generator.

1. Contact electricians/and or generator suppliers to do an on-site visit to your Center under normal/non-emergency circumstances to determine what your needs are.
2. Review bids and determine what system will best work for your Center.
3. Installation of a quick connect system will provide you with a permanent connection for emergency power, not a temporary connection.
4. Establish an agreement to be a preferred customer for generators in emergencies with the vendor/company.
5. Being proactive, the quick connect can be installed under normal circumstances, not during a power outage or when labor/parts may be scarce and higher priced due to the emergency.
6. The quick connect can be tested as part of the installation and any facility- specific steps documented so that in the event of an emergency everyone is prepared.
7. The quick connect will eliminate the safety hazard of generator cables running thru the halls, doorways and stairwell. Building doors and/or windows can remained closed for security and safety reasons.

Does the care center have a 4 to 5 day fuel supply for the generator?

Status: □ not started □ in progress □ done

Calculate fuel use for continuation of basic and essential power per 24 hours for 4 to 5 days.

Current fuel delivery system/storage capacity: _____

Current fuel type: _____

Need additional storage: _____

Review current contract for the fuel supplier. Are you on their priority list for service and fuel replacement if an emergency occurs? What are the procedures for notification to the supplier during an emergency? Do you have cell phone numbers in case the supplier's phone lines are also disabled? Have you provided the fuel supplier with cell phone numbers for key personnel at the facility?

Also, review the location of your fuel tank. If you are in a flood prone area, alternative placement/access to the fuel source should be reviewed.

Does the care center have a fuel contract?

□ yes □ no

Are there procedures to regularly check the generator and to perform maintenance?

Status: □ not started □ in progress □ done

Always refer to the manufacturer guidelines for your generator and the testing requirements specific for your location.

Sample: Generator Monthly Inspection/Test Procedures

The state will inspect the facility at least annually. Provide them with all necessary information on the generator, repair, service visits, and test.

BATTERY ELECTROLYTE SPECIFIC GRAVITY TEST:

1. Using a hydrometer, draw enough fluid from the battery cell to allow indicator to float freely
2. Read indicator with your eye approximately level with fluid and record your readings. NOTE: Readings taken while looking at indicator from a sharp angle are very inaccurate.
3. Test all cells of battery and record readings.
4. High to low difference shall be 0.030 points maximum at 80°F electrolyte temperature, each cell of a fully charged battery should read 1.280 maximum. A battery discharges at 80° F if it reads less than 1.120 temperature affects specific gravity. Each 10° F variation from 80° F will change specific gravity 0.004. Add .004 to readings for every 10° F above 80° F and subtract .004 for every 10° F below 80° F.

Standards

1. Have the generator professionally serviced following manufacturers and state recommendations/requirements
2. Replace fuel filters
3. Replace engine oil and filter
4. Have a sample of engine oil and diesel fuel sent to lab for analysis
5. Replace intake air filter
6. Test system safety shut down devices -- oil pressure, coolant temp, over speed, over crank, coolant level
7. Inspect radiator coolant level, coolant condition, and air flow
8. Inspect starting system- battery(s), cables, charger, and alternator
9. Inspect exhaust system-silencer, piping, manifolds, insulation, etc.

10. Inspect/adjust governor- linkage, electrical connection, pickup, stability, etc.
11. Inspect fuel system, ignition system, and interment/control panel
12. Inspect generator- stator, rotor, circuit breaker, and exciter.
13. Inspect / adjust voltage regulator
14. Inspect automatic transfer switch
15. Diesel generator sets exercised monthly at less than 30% of the nameplate KW rating require annual load bank testing Per NFPA 110 8.4.2.3 2005 edition 8.4.2.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 (less than 30% KW rating) shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25% of nameplate rating for 30 minutes, followed by 50% for 30 minutes, followed by 75% for 60 minutes, for a total of two (2) continuous hours.

After all service has been completed:

16. Alert staff that the generator will be tested
17. Run generator (see local requirements for minutes) under full load
18. Verify generator starts and transfers load within ten seconds maximum
19. Check for unusual noise or vibration
20. Verify transfer switch operation
21. Check and record gauge readings
22. Record start and stop times
23. Record hour meter start and stop readings
24. Record voltage and amperage
25. Check operation of remote annunciator panel
26. Record any unsatisfactory condition and the corrective action taken, including parts replaced

(Note: The above procedures are provided as general information, as with any equipment, follow the manufacturer's manual for the specific preventative maintenance procedures.)

Have care center leaders met with local emergency management personnel to discuss power needs of the care center?

Status: □ not started □ in progress □ done

Annually contact your local emergency management department to remind them of the location/purpose of your facility. Discuss the power needs of your facility and the current ability to SIP; record and verify both their and your contact information. If they have not toured your facility, please set up a meeting and invite them to your facility. Actions/on-site visits are always best.

Do not assume that they are aware of your facility. Personnel and documentation requirements may have changed. Likewise, any time the senior leadership of your care center changes, contact with your local emergency management department should be made again.

Have care center leaders met with the power company personnel to discuss the power needs of the facility?

Status: □ not started □ in progress □ done

Annually contact your local power company to remind them of the location/purpose of your facility. Discuss the power needs of your facility and the current ability you have to SIP, document and verify both their and your contact information

Do not assume that they are aware of your facility as personnel and documentation at the power company may have changed. Likewise, any time the senior leadership of your facility changes, the above contact to your local power company should be made again.

(Example: A local power company relied on the billing information to determine priority locations; in this case, the billing was to a corporate office not the location. The power company could not identify the SNF based on the billing name. No one discovered this oversight until an LPN called a local radio station during a disaster to let the local power official know that the SNF was still without power.)

Food and Water Supply Planning

Red Cross: Food and Water in an Emergency

Provides Information on ways to treat water, emergency water sources, preparing containers and filling water containers.
https://www.redcross.org/images/MEDIA_CustomProductCatalog/m4440181_Food_and_Water-English.revised_7-09.pdf

WHO: Food and Nutritional Needs in Emergencies

Information on food options for individuals for special dietary and nutritional needs. (Page 23).
http://www.who.int/nutrition/publications/en/nut_needs_emergencies_text.pdf

CDC: Emergency Water Supplies

Provides information regarding water containers and how to properly clean and store. A link to tips and methods for making water safe during an emergency.
http://www.cdc.gov/healthywater/emergency/

Emergency Water Supply Panning Guide for Hospitals and Health Care Facilities

Document outlines how to create a plan, items to consider, how to conduct a water audit and emergency water alternatives.
http://www.cdc.gov/healthywater/pdf/emergency/emergency-water-supply-planning-guide.pdf

Table 6.3-1. Some Typical Water Usage Functions/Services (not all inclusive; functions/services vary depending on the individual facility)

Type of Usage	Function/Service
Facility Usage	Air-conditioning Boilers Dishwashing Laundry Autoclaves Medical equipment Outdoor irrigation systems Fire suppression sprinkler system Vacuum pumps Water system flushing Water-cooled air compressors
Staff and Patient Usage	Drinking fountains Dietary Dialysis services Eye-wash stations Ice machines Laboratory Patient decontamination/hazmat Patient floors Pharmacy Surgery Radiology Toilets, washrooms, showers

Table 6.4-1. List of Essential Functions

Functions	Water Needs Under Normal Operating Conditions (gpd)	Critical to Total Facility Operations (Yes or No)	Waterless Alternatives Possible (Yes or No)	Water Needs Under Water Restriction Situation (gpd)	Essential to Specific Operations (Yes or No)
Building					
HVAC					
Fire suppression sprinkler system					
Food service					
Sanitation					
Drinking water					
Laundry					
Laboratory					
Radiology					
Medical care					
Other					
Other					
Total minimum water needs to keep facility open and meet patients' needs					

CDC: Emergency Food Supplies
Tips for storing and planning for emergency food supplies. List of when to replace stored food items.
http://emergency.cdc.gov/preparedness/kit/food/index.asp

Hospital Emergency Food Supply Planning Guidance and Toolkit
A toolkit from the California Hospital Association for guidance in planning for and documenting emergency food supplies.
http://www.calhospitalprepare.org/foodplanning
http://www.calhospitalprepare.org/sites/main/files/file-attachments/chaemergencyfoodguidaanceandtool.pdf

Medications and Supplies Stockpile

Has the care center considered increasing its inventory of common medications from 5 to 7 day?

Status: □ not started □ in progress □ done

SIP: Medication and Supplies Stock

The care center should have an emergency stockpile of medications, [inclusive of oxygen as this is considered a medication] and supplies adequate to support patients in the Center for at least 72 hours and ideally up to one week. Plan to extend the volume of supplies based on the projected event cycle. If you are considering SIP, consider speaking with your pharmacy provider for an extended supply of medication.

Understanding the difficulty with keeping medications current, and also insurance company requirements, it is recommended to plan with your designated pharmacy and back-up pharmacy to provide needed medications upon request, with emphasis on narcotics, insulin, Coumadin, albuterol, etc. Plan in advance with back up pharmacy that physician orders will most likely not be available immediately and discuss how that pharmacy will send needed medications. In addition, discussion with the oxygen provider will need to include the same planning.

Have care center leaders reviewed pharmacy delivery with pharmacy personnel?

Discussion with your designated pharmacy rep should include identifying an off site location for medication delivery. Also discuss the types of emergencies common to your environment.

In reviewing IV supplies, consider increasing stock of IV fluids available as well as IV start supplies and IVAC pumps with back-up battery packs. When SIP, total patient care will be provided by the nursing care center including treatment of any acute conditions. This may increase the need for IV support. When reviewing supplies, consider specific patient needs. If a patient has a specific need that requires medications/supplies that may be difficult to obtain or stock during an emergency, consider a partial evacuation for that patient. As an example, you may wish to evacuate a patient receiving TPN as interruption of TPN or stockpiling of TPN may not be a desirable option.

While oxygen concentrators may be available within the care center and the plan may be to continue to provide oxygen via concentrators using generated back-up power, a back-up plan should be developed. At a minimum, the center should ensure that available oxygen cylinders are full and that there is an adequate supply of oxygen regulators. Consideration should be given to increasing the supply of oxygen cylinders, regulators, tubing, masks, and nasal cannula's in anticipation of increased patient need and in anticipation of power failure. Another consideration to keep in mind is the use of nebulizers, and having extra spacers, tubing and masks available.

In the case of both food and medications/supplies, center leaders should give some thought to supply chains during an emergency, and speak with your distributors and/or major vendors. Be aware that in a widespread emergency, however, all vendors will be serving multiple facilities. Delivery may be difficult or impossible, and supplies may be scarce-this is another reason to have adequate stockpiles. If conditions allow, consider ordering the next shipment of supplies early. This is a worthy option in cases of expected snow/ice storms or severe weather with anticipated extensive power outages may be expected.

Citation: As adapted from Emergency Preparedness Planning for Nursing Homes & Residential Care Settings in Vermont

Security Plan

Sample Lockdown Policy

Policy: The ability to lockdown the center in the event of an emergency, which threatens the safety of residents, employees, staff and visitors and/or health facility operations, is of paramount importance. While it is the policy and intent of this facility to be an aid to the community during an emergency event, our residents are our first responsibility. If the rendering of aid and/or the provision of shelter to convergent victims would degrade our ability to preserve the safety and wellbeing of our residents, we cannot provide that aid. Procedures: Locking down the care center is the process by which pedestrian and vehicular traffic is channeled to specific entry/exit points and entrance into the facility is controlled by the safety officer or his/her designee.

Directing a lockdown

The safety officer has the authority to defer and/or deny access based upon his/her assessment of the situation. It is preferable that the determination be made with consultation of members of the executive management group. However, in the event of a true emergency that requires

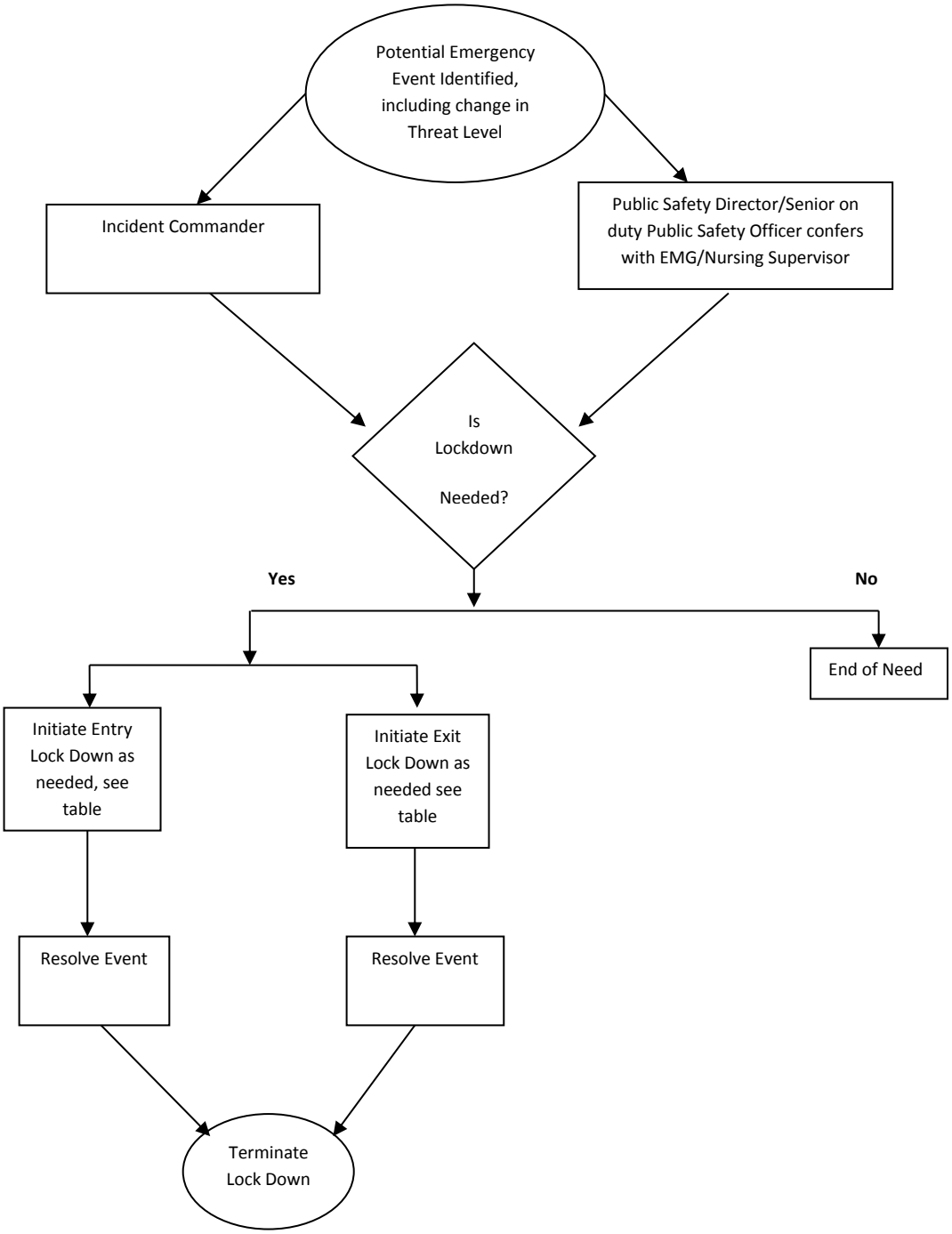
immediate intervention, such as a Code Red or active shooter, this action may be undertaken independently by the senior safety officer on duty. In this event, the public officer will review the situation and his/her assessment with a member of the executive management group. During off hours this collaboration will be with the nursing supervisor.

During a “Code Red”, the lockdown decision rests with the incident commander (IC).

Occasions for Lockdown*:*

Event	Prevent Entry	Prevent Exit
Power failure	X	
Earthquake	X	
Flooding	X	
Fire	X	
Bomb threat	X	
External Contamination	X	X
Civil disturbance	X	X
Hostage event	X	
Active Shooter	X	
Resident abduction	X	X
Convergent victims	X	

Decision Tree



Procedures

Exit lockdown is for the propose of preventing individuals from leaving due to an existing hazard outside, whether it be a civil disturbance, possible exposure to a hazardous substance, or the need to screen those leaving due to a missing resident.

Entry lockdown is for the purpose of preserving the care center's ability to operate and respond to a possible emergency event such as a fire, flood, or keeping contaminated individuals from entering. It is also used to control the flow of convergent victims, who may be seeking aid, and to stop them from entering if the facility is unable to provide assistance without degrading their ability to care for their residents.

The Safety Officer will be responsible for the closing and locking of required doors and gates. Additional staff may be required to control non-entry doors, such as fire exits.

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent more than 12,000 non-profit and proprietary skilled nursing and post-acute care centers, assisted living communities, and homes for individuals with intellectual and developmental disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of individuals who receive care and services in AHCA/NCAL member facilities each day.