Facility Safety Inspection Report
(All Hazards Risk Assessment)
Injury & Illness Prevention Program

Department/Division/Site: Department of Behavioral Wellness
Psychiatric Health Facility (PHF)

Inspection Date: March 16, 2017

Inspection Conducted by: Greg Milligan
County Safety Officer
Risk Management, County Executive Office
105 E. Anapamu St., Suite 102
Santa Barbara, CA 93101
(805)884-6864
gmilligan@countyofsb.org

SUMMARY

On March 16, 2017, I conducted an on-site safety inspection of the Psychiatric Health Facility (PHF) located at 315 Camino del Remedio, Santa Barbara, CA 93110. I was accompanied by Gerardo Puga, Veronica Heinzelmann, Ernest Thomas, Mark Lawler and Xiomara Abayari. The purpose of this visit was to help the Department of Behavioral Wellness identify and correct any unsafe work practices, physical conditions of the facility and ensure all necessary Emergency Action Plans are in place and deemed effective using an all-hazards approach in an effort to prevent or minimize loss.

The following is a list of potential hazards identified by the site as most likely to occur in the area:

- *Wildfires*
- *Fire*
- *Earthquake*
- *Tsunami*
- *Flooding/Mudslide/Landslide*
- *Hazardous Materials Release*
- *Utility Failure*
- *Violent Threat/Active Shooter*
- *Bomb Threat*

Additionally, we inspected the following:

- *Dept. Emergency Action Plan*
- *General Work Environment*
- *Employer Postings*
- *Medical and First Aid*
- *Fire Protection*
- *Walkways and Stairs*
- *Ingress and Egress (Exiting)*
- *Hazard Communication*
- *Pressure Vessels*
- *Confined Spaces*
- *Environmental Controls*
- *Proper Labeling*
- *Electrical*
- *Record Keeping & Training*

NEXT STEPS: This report will serve as a starting point and will evaluated and added to by a PHF Emergency Preparedness Committee in compliance with CMS guidelines and the most recent audit. The response to the final Risk Assessment report should describe completed and planned corrective actions including any applicable timelines.

FACILITY DESCRIPTION

The Psychiatric Health Facility (PHF) is a 16-bed facility that provides 24-hour inpatient care to individuals requiring psychiatric hospitalization. It is a Lanterman-Petris-Short-designated facility and the only Acute Psychiatric Inpatient Hospital that accepts Medi-Cal within Santa Barbara County. The PHF is licensed both as a Psychiatric Health Facility by the California Department of Health Care Services and as an Acute Hospital by the Centers for Medicare and Medicaid Services (CMS). The PHF is one of only two such free-standing psychiatric hospitals in the State of California, also known as "Super-PHFs," distinguished from other Psychiatric Health Facilities by their ability to receive Medicare reimbursement.

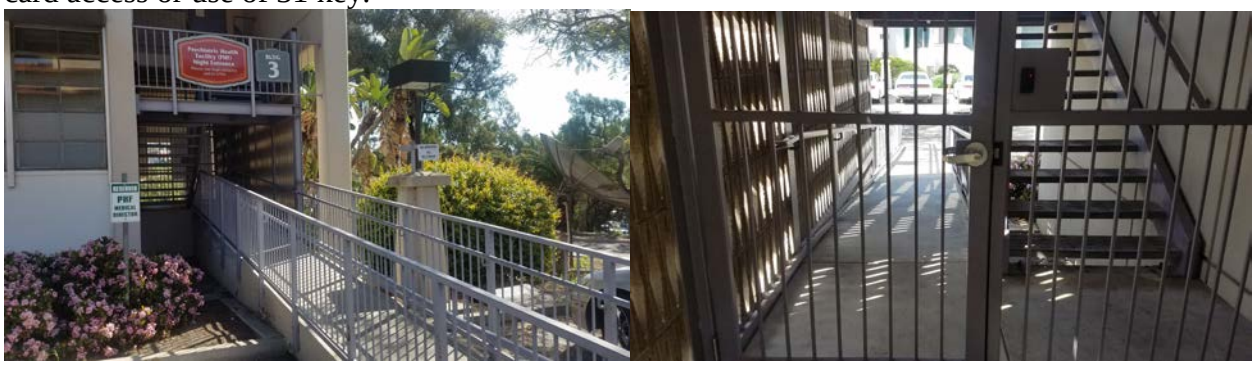
WALK THROUGH OBSERVATIONS

Knox boxes are located at the main entrance to the building and next to the bay door entrance (2nd entrance/access to the building).

The facility has a generator located around the corner of the bay door on the southeast facing side of the building. The generator is tested monthly by General Services and has no known issues.

Pressure Vessel fenced in along the southeast side of building.

The night entrance (3rd access to building) is only to be used after 5 pm and is secured with key card access or use of 31 key.



The Yard is secured with key only access. 31 key opens this access door as well. All staff have 31 key.

4th and 5th entrances/access to building at southwest corner of building.

6th entrance/access to building located on northwest side of building.

Electrical Panel for PHF floor located outside of secured area of floor.

Electrical panels located inside PHF unit

Only two means of ingress/egress to the PHF unit is through the night entrance (noted on previous page) and the following main entrance to the unit; both secured with key card access.

Panic alert system are push button devices located inside the offices of management staff. The buttons are located near the doors of each office. There is also an overhead paging system in place that is utilized during emergency response or to alert staff when assistance is needed.

Sliding kitchen door is potentially a way for individuals to access the reception area from secured patient care area or patient area from lobby/reception.

Surveillance – 13 cameras view both interior and exterior. Monitoring station set up at nurses station but did not appear to be manned and footage is not recorded from what I understand.

FOLLOW-UP RECOMMENDATIONS

WILDFIRES

Risk Factors Identified: Geographic location of facility presents significant risk to operations and occupants if wildfire occurs in the area. No official protocol or procedure established to relocate all facility occupants.

Corrective Action Needed: Relocation protocol and procedures need to be established, communicated and trained on in the event evacuation is called by local emergency response agencies.

Additional Comments/Recommendations: Continue to provide awareness and preparedness throughout wildfire season. Communicate importance of OEM alerts (Aware & Prepare) and any other resources related to this hazard. Maintain the relocation protocol and procedures in the facility's Emergency Action Plan (EAP).

FIRE EMERGENCY

Risk Factors Identified: None

Corrective Actions Needed: None

Additional Comments/Recommendations: Continue to ensure staff are trained on proper use of fire extinguishers on an annual basis.

EARTHQUAKES

Risk Factors Identified: None

Corrective Actions Needed: None

Additional Comments/Recommendations: Drills occur on an annual basis. Proper procedures and response can be found in section six of the Department's and County's Emergency Action Plan. Identify and communicate updates to roll call lists for accountability as well as establish primary and alternate evacuation coordinators. Consider implementing evacuation as part of your earthquake drills.

TSUNAMI

Risk Factors Identified: None

Corrective Actions Needed: None

Additional Comments/Recommendations: Due to the geographic location and elevation of the PHF unit, the risk of Tsunami affecting the unit's operations is very low. However, consider providing awareness to employees in the event they find themselves in areas designated as at risk.
http://cosb.countyofsb.org/uploadedFiles/emergencies/Tsunami_Inundation_Goleta_Quad_SantaBarbara.pdf
http://cosb.countyofsb.org/central.aspx?id=19852
http://www.countyofsb.org/asset.c/2780
http://www.conservation.ca.gov/cgs/geologic_hazards/Tsunami/Pages/Index.aspx

FLOODING/MUDSLIDE/LANDSLIDE

Risk Factors Identified: Geographic location of facility presents moderate risk to operations and occupants if significant rain events occur in the area such as the recent winter storms. Although the facility and unit itself did not sustain damage nor was it in danger at any time during the storms, passage to and from the facility could be affected and has been affected in past.

Corrective Actions Needed: Establish and communicate official protocol or procedure to specifically address staffing accommodations in the event of road closures and staff are not able to get home or get to work from home.

Additional Comments/Recommendations: Provide awareness of local alerts and differences between Advisories, Watches and Warnings related to weather emergencies. Designate a primary and alternate staff member responsible for monitoring conditions and communicating to all staff. Resource to consider using: https://www.ready.gov/floods

HAZARDOUS MATERIALS INCIDENTS

Risk Factors Identified: Internal – none; External release – low.

Corrective Actions Needed: Establish procedures or awareness of what teo do before, during and after a Haz Mat incident.

Additional Comments/Recommendations: Resources to consider using: https://www.ready.gov/hazardous-materials-incidents

UTILITY FAILURE

Risk Factors Identified: Moderate **-** Utility (i.e., water, sewer, electrical and gas) outages occur from time to time.

Corrective Actions Needed: None – protocol/procedures in place to respond to these type of events. Generator functions as backup power source.

Additional Comments/Recommendations: Provide annual awareness and reminders using County and Department specific Emergency Action Plan. Ensure an alternate has been identified to take Ernest's place to serve as person most knowledgeable about building facilities; includes basic understanding and function of generator and what it powers, gas and water shut-offs, etc. Resources to consider providing employees: https://m.sce.com/outage/OutageMap_new.html & https://www.ready.gov/hazardous-materials-incidents

VIOLENT THREAT/ACTIVE SHOOTER

Risk Factors Identified: Workplace Violence Prevention training and awareness needed.

Corrective Actions Needed: Update or establish site specific Workplace Violence Prevention Plan. Refer to County of Department Emergency Action Plan. Communicate best safe rooms throughout the unit in the event running not an option during active shooter event.

Additional Comments/Recommendations: Work with County Safety Officer on establishing official Workplace Violence Prevention Plan for PHF unit. Continue to provide training and awareness of what to do in Type 1/Type 2/Type 3 workplace violent acts. Refer to Mainstream Unlimited Site Security Survey and their recommendation relating to personal panic alert system as well as metal detection protocol at both entrances to the unit.

BOMB THREAT

Risk Factors Identified: Protocol/procedure is established on how to handle bomb threats when received by unit staff however, communication among other departments and facilities throughout Calle Real is lacking.

Corrective Actions Needed: Ensure procedures on what to do if bomb threat is received is readily available and staff are aware. Additionally, establish communication throughout Calle Real Campus to ensure all other departments and facilities are aware of an incident when it occurs and your unit is made aware when an incident occurs somewhere else on the campus. Identify someone (as well as an alternate) who is responsible for communicating these incidents to all staff for awareness.

Additional Comments/Recommendations: Contact County Safety Officer if assistance is needed in facilitating this communication of incidents.

ADDITIONAL HEALTH & SAFETY RECOMMENDATIONS

ELECTRICAL

Regulatory Reference/Resource: http://www.dir.ca.gov/dosh/dosh_publications/Electrical_Safety.pdf

Corrective Action Needed:

- Panels located outside PHF unit (refer to page 4 for picture) appear to be mislabeled. Also concerns from staff that breakers not labeled correctly or clearly.
- Areas around panels located inside PHF (refer to page 4/5 for picture) unit (refer to page 4/5 for picture) need to remain clear for ease of access.

Recommendations:

- Enter work order to have electrician address concerns for panels external of unit and ensure 36" clearance around all panels inside unit.

HAZARD COMMUNICATION

Regulatory Reference: https://www.dir.ca.gov/title8/5194.html

Corrective Action Needed:

- All departments shall implement and maintain at each workplace, either the County written Hazard Communication Program or develop a program suitable to their specific needs and in the manner they choose to accomplish it, except that in no case will the requirements of the County program be diminished. All programs will address labeling and other forms of warning, Safety Data Sheets (SDS), communication, initial training and additional training whenever a new hazardous substance is introduced into the workplace. The program shall be kept in a "Hazard Communication Binder."
- All Safety Data Sheets (SDSs) must be maintained on site in a common area. This is required to ensure information such as health hazards, special chemical and physical characteristics, protective measures, precautions for safe handling, use and storage of each chemical and first aid measures are readily available if needed. This must then be communicated to all staff on site.
    - Regulatory Reference: (T8 CCR 5194[g])

Recommendations:

- Keep attached County Hazard Communication Plan on site

    - Consider tailoring County plan to meet specific needs of workplace to maximize benefits of the workplace safety
- Account for all chemicals and hazardous substances onsite and collect all corresponding SDSs. Once completed, place the SDS binder/folder/file or Hazard Communication Binder in a common area to ensure all staff can access if needed. If assistance is needed in tracking down SDSs, please contact Greg Milligan, County Safety Officer.

BLOODBORNE PATHOGENS PROGRAM (BBP)/EXPOSURE CONTROL PLAN
Regulatory reference: https://www.dir.ca.gov/title8/5193.html

Corrective Action Needed: Keep copy of County BBP/Exposure Control Plan (attached) onsite readily accessible to all staff.

Recommendations: None

PRESSURE VESSELS
Regulatory Reference: Title 8 regulations, sections 450-560 and sections 750-797

Corrective Action Needed:
- Ensure pressure vessel (refer to top of page 3 for picture) is inspected annually and permitted.

Recommendations: None

RECORDKEEPING

Corrective Action Needed:
- Maintain periodic safety inspection records onsite as follows:
    - County Safety Officer annual safety inspections: 3 years
    - Department quarterly safety inspections: 3 years

Recommendations: None

Please feel free to contact me with any questions or concern regarding the content of this report.

Thank you,

Greg Milligan
County Safety Officer
Risk Management, County Executive Office
(805)884-6864 (desk)
(805)884-6861 (fax)
(858)335-4148 (cell)
gmilligan@countyofsb.org

SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Programmatic Policy and Procedure

Section	Psychiatric Health Facility (PHF)	**Effective:**	11/29/2017
Sub-section	Crisis and Emergency Response	**Version:**	1.0
Policy	Emergency Facility Evacuation	**Last Revised:**	New policy
Director's Approval	Alice Gleghorn, PhD	**Date**	12/4/17
Medical Director's Approval	Ole Behrendtsen, MD	**Date**	12-13-17
Supersedes:	New policy	**Audit Date:**	11/29/2018

1. PURPOSE/SCOPE

1.1. To ensure compliance with the Centers of Medicare & Medicaid Services (CMS) Emergency Preparedness Final Rule (42 CFR 482.15), emergency preparedness and response health care industry standards set forth by the California Hospital Association, and all other applicable federal, state and local laws.

2. DEFINITIONS

The following terms are limited to the purposes of this policy:

2.1. **Emergency** – a hazard or other critical incident that causes adverse physical, social, psychological, economic or political effects that challenges the facility's ability to respond rapidly and effectively to an interruption in normal facility functioning. Emergencies can affect the facility internally as well as the overall target population, the community at large or a geographic area.

1. For purposes of this policy, "Emergency" refers to a facility-level hazard situation, not an individual patient medical emergency. For patient-related medical emergencies, please refer to the "Emergency Medical Condition" policy.

2.2. **PHF Leadership** – managerial and executive-level personnel responsible for high-level decision-making, including those involving evacuations. This includes the PHF Chief Executive Officer (CEO), Medical Director, Director of Nursing, Manager, and Nursing Supervisor.

3. POLICY

3.1. The Santa Barbara County Psychiatric Health Facility (hereafter "PHF") shall support the safe evacuation of patients, on-duty staff, visitors, and any other persons onsite during an emergency. Safe evacuation shall include (1) consideration of care and treatment needs of evacuees, (2) staff responsibilities, (3) transportation, (4) identification of evacuation locations, and (5) the primary and alternate means of communication with external sources of assistance.

4. TYPES OF EVACUATION

4.1. **Standard Evacuation.** In a standard evacuation, staff have time to coordinate an evacuation, including gathering of supplies, equipment, and medical records, and triaging evacuation based on a patient's acuity and risk level.

4.2. **Immediate Evacuation.** If an incident or hazard (e.g. fire) poses an immediate and potentially life-threatening danger, an immediate evacuation of the PHF is required. PHF staff will direct patients, visitors and other personnel to exit the building at the nearest emergency exit and to convene at the designated assembly point (e.g. PHF Recreation Yard, Rear Parking Lot, or off-site, as specified). The PHF Team Leader and designated staff will check every room for occupancy and conduct an emergency census following evacuation of the premises.

5. EVACUATION CRITERIA

5.1. An all-hazards and vulnerability assessment was conducted in 2017 by the County's Risk Management division to identify key events and triggers that would require an evacuation response at the PHF. While the following criteria reflects key assessment findings, it is in no way intended to represent all possible evacuation response triggers:

1. Internal hazards that pose a threat to health and safety (e.g. fire, smoke, explosions, hazardous material spill).
2. External hazards that pose a threat to health and safety to persons in the hazard's vicinity (e.g. wildfires, floods).
3. Post-emergency conditions that pose an ongoing threat to health and safety (e.g. shortage of food and potable water supply).
4. Failure and prolonged outage of critical systems, such as water and power generators, with no foreseeable ability to restore these systems or obtain backup subsistence in the immediate future. This inability to restore or obtain backup subsistence would likely occur following severe disaster scenarios such as a high magnitude earthquake.
5. Major structural damage to the PHF unit and/or building that poses an immediate hazard.
6. Bomb threats.

6. HAZARD IDENTIFICATION AND MANDATORY EVACUATION ORDERS

6.1. **Hazard Identified During Business Hours.** During business hours, if a hazard is identified that may require an evacuation response, the PHF Team Leader or a designee shall notify PHF Leadership immediately. The decision to evacuate is made in consultation with local and County emergency response agencies, including but not limited to law enforcement, fire department, 911/emergency dispatch center, Incident Response/Unified Command, Department of Public Health, and the Emergency Operations Center (EOC).

1. If appropriate to the type of emergency and immediacy of the hazard, PHF Leadership may elect to conduct a partial evacuation for patients requiring additional support and resources due to level of acuity and risk factors. Example: In the case of a nearby wildfire (a likely occurrence in Santa Barbara County), transferring high acuity patients following an evacuation warning can minimize disruption to operations and allow for a faster and safer evacuation of the entire unit if a mandatory evacuation is given shortly after.
2. **If the hazard poses an immediate and potentially life-threatening danger**, the PHF Team Leader or a designee will call 911 and commence evacuation procedures (see Section 7 below).

6.2. **Hazard Identified Outside Business Hours.** After business hours, if a hazard is identified that may require an evacuation response, the PHF Team Leader or a designee shall notify the On-call Administrator. The decision to evacuate is made in consultation with PHF Leadership and local and County emergency response agencies as indicated in Section 6.1 of this policy.

6.3. **Mandatory Evacuation Order.** If an evacuation order is given by authorities (e.g. State or local law enforcement, fire personnel, or other emergency response personnel), the PHF Team Leader shall notify PHF Leadership and/or the On-call Administrator immediately and begin evacuation procedures.

7. STANDARD EVACUATION PROCEDURES

7.1. Evacuation of the PHF should generally be considered as a last resort. Evacuation is the most appropriate response for situations in which sheltering-in-place, hazard mitigation, or other emergency response efforts are not expected to maintain a safe environment. PHF Leadership and local emergency officials must evaluate the nature of the hazard, consider available resources, and continuously reassess the situation as it progresses to determine the best course of action. Consideration should be given to bolstering PHF capabilities and resources if an evacuation could cause greater harm to patients by putting them into a setting that cannot provide an appropriate environment of care.

7.2. When the circumstances, proximity, and severity of the hazard require an evacuation response, the PHF Team Leader will hold a briefing with all unit staff to announce the evacuation and assign responsibilities to each staff, including, but not limited to:

1. Packing and transfer of medications, medical supplies and equipment, documentation, and other materials as necessary.
2. Coordination with receiving facilities for patient transfers.
3. Coordination of transportation services and vehicle retrieval.
4. Communication with the pharmaceutical vendor for emergency medication orders.
5. Notification of off-duty staff and patient family members of plans to evacuate as well as coordination of additional or backup staffing.
6. Identification of patients that may be safely discharged and expedite the discharge process (NOTE: Expedited discharge should occur only when appropriate to the patient's disposition and risk level. Patients who are likely to destabilize rapidly because they are unprepared to manage external emergency conditions post-discharge will not be discharged).

7.3. The PHF Team Leader will assign one staff member the position of Tracking Coordinator. This individual maintains an emergency roster and a tracking log of the locations and movement of all persons in the unit during and after the evacuation.[1]

1. The emergency roster and tracking log will be maintained and updated whenever possible, feasible, and safe to do so. In extreme or life-threatening situations, the Tracking Coordinator's priority is to directly assist patients and staff and provide life-saving and life-sustaining care. The immediate health and safety of patients and staff takes precedence over documentation.

7.4. When the patients are informed of the evacuation, PHF staff will remain aware that an emergency/evacuation event may compromise the psychiatric stability of the patients, especially those with trauma histories, anxiety, or other high acuity concerns. Patients may be triggered and experience a destabilization. The PHF will strive to minimize the emotional and psychiatric impacts of evacuation on patients.

7.5. The PHF Team Leader will identify evacuation challenges and risks for each patient. This includes, but is not limited to, mobility difficulties, medical status, elopement history, trauma history, and seclusion and restraint history. High acuity patients or persons experiencing a medical emergency will be prioritized for evacuation.

7.6. If vehicle transportation is necessary, PHF-designated vehicles will be used first. Caged vehicles will be prioritized for high acuity patients and those with a history of elopement. Behavioral Wellness and County motorpool vehicles may also be used. Duplicates of multiple Behavioral Wellness vehicles are retained onsite at the PHF for immediate or afterhours emergency needs. In cases where patients are medically or psychiatrically unstable or high-risk, transportation may be coordinated with law enforcement and American Medical Response (AMR) ambulance services.

7.7. PHF staff will instruct evacuees to use stairs, not elevators, to evacuate whenever possible.

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[1] Please refer to the PHF's "Emergency Patient, Staff, and Visitor Tracking" policy for further details.

7.8. During evacuation, patients will be closely monitored by PHF staff qualified to meet their psychiatric and medical needs, providing appropriate treatment and care enroute to the evacuation site as needed.

7.9. Once all persons have evacuated, PHF staff will ensure all doors are fully closed (doors lock automatically) to mitigate unauthorized re-entry.

7.10. Evacuation destination sites will be identified based on the proximity of the incident or hazard and its expected duration. For example, local wildfires may require evacuation to out-of-county sites due to unpredictable threats to area structures and air quality. The PHF will ensure arrangements with local and out-of-county facilities to receive patients during an evacuation to ensure safety and continuity of care.[2]

8. ELOPEMENT RISK

8.1. In the event a patient elopes during evacuation, the assigned PHF staff will attempt to redirect the patient to return and, if possible, will pursue the patient at a distance. At no time will PHF staff attempt to physically detain the eloping patient. If the patient moves beyond the boundaries of the Calle Real campus, the staff member will end their pursuit and notify the PHF Team Leader and law enforcement immediately of the patient's elopement.

1. The Tracking Coordinator will document the elopement on the patient tracking log.

9. HANDLING OF CONFIDENTIAL DOCUMENTS

9.1. When feasible, PHF staff will secure and transport hard copies of patient medical records during an evacuation. These patient medical records must be readily available and shareable for staff, emergency response personnel, and the intaking facility in the event of a transfer.

9.2. Staff will remain aware that HIPAA protections still apply during an evacuation situation.

10. RETURN AFTER EVACUATION

10.1. The PHF Team Leader will await clearance from the Behavioral Wellness Facilities Manager, County General Services, and/or law enforcement and safety personnel as to whether it is safe to return to the PHF following a facility evacuation. Individuals will only return to the PHF once any mandatory evacuation order is lifted, and once PHF Leadership have advised that it is safe and appropriate to return.

10.2. Once it is safe to do so, the PHF Team Leader will complete an Unusual Occurrence Incident Report.[3]

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[2] Please refer to the PHF's "Emergency Transfer Agreements with Other Facilities" for further details.
[3] Please refer to the PHF's "Unusual Incident Reporting" policy for further details.

11. COMMUNICATION

11.1. Prior to and during evacuation, analogue telephones and cell phones (if operable) will serve as the preferred methods of contact with PHF Leadership, authorities, and other facilities. Within the PHF, walkie-talkies may be used as a backup form of communication.[4]

ASSISTANCE

Mark Lawler, LPT, PHF Team Supervisor

Ernest Thomas, Behavioral Wellness Facilities Manager

REFERENCE

Code of Federal Regulations – Condition of Participation: Emergency Preparedness
Title 42 Section 482.15(b)(3)

Centers for Medicare & Medicaid Services (CMS)
Emergency Preparedness Final Rule Interpretive Guidelines and Survey Procedures
Ref: S&C 17-29-ALL, 6/2/2017

California Hospital Association
Evacuation and Shelter-in-Place Guidelines for Healthcare Entities. Retrieved from: https://www.calhospitalprepare.org/post/evacuation-and-shelter-place-guidelines-healthcare-entities

RELATED POLICIES/DOCUMENTS

PHF Emergency Response Plan

PHF Emergency Communication Plan

Disaster and Emergency Supplies for Dietary Services

Emergency Patient, Staff, and Visitor Tracking

Emergency Transfer Agreements with Other Facilities

Shelter-in-Place During Emergency

Emergency Subsistence Management

Unusual Incident Reporting

[4] Please refer to the PHF Emergency Communication Plan for more information on internal and external communication in an emergency situation.

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION

Culturally and Linguistically Competent Policies

The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).

SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Programmatic Policy and Procedure

Section	Psychiatric Health Facility (PHF)	**Effective:**	4/6/2011
Sub-section	Nursing	**Version:**	1.2
Policy	Emergency Medical Condition	**Last Revised:**	10/31/2017
Director's Approval	Alice Gleghorn, PhD	**Date**	11/1/17
PHF Medical Director's Approval	Ole Behrendtsen, MD	**Date**	11.1.17
Supersedes:	NG-4.2 Emergency Medical Condition rev. 3/29/2011	**Audit Date:**	10/31/2018

1. PURPOSE/SCOPE

1.1. To ensure patients admitted to the Santa Barbara County Psychiatric Health Facility (hereafter "PHF") receive appropriate and timely care in the event of a medical emergency.

1.2. To ensure compliance with the Centers of Medicare & Medicaid Services (CMS) Conditions of Participation (42 CFR 482.62(c)) regarding the availability of medical care and personnel, and all other applicable federal, state and local laws.

2. POLICY

2.1. A patient who develops or presents to the Santa Barbara County Psychiatric Health Facility (hereafter "PHF") with an emergency medical condition will receive stabilizing treatment within the capabilities and capacity of the PHF unit prior to transfer to an appropriate facility.

3. DEFINITIONS

3.1. **Emergency medical condition** – a medical condition manifesting with acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably result in:

a. Placing the health of the individual in serious jeopardy

b. Serious impairment of bodily function

c. Serious dysfunction to any bodily organ or part

3.2. **Stabilizing treatment** – stabilization will include a physical health assessment by nursing staff, a mental status exam, and whatever first aid, within the capability of the unit to provide, is needed to stabilize the emergency medical condition prior to transfer to an appropriate facility.

3.3. **Capability** – the PHF is a free-standing psychiatric inpatient unit and operates within the regulatory limits established through applicable regulations, the California Health and Safety code, the California Welfare and Institutions code, and the Code of Federal Regulations. Within limits established in these regulations and codes, it is not within the capability of the PHF unit to manage medically unstable patients.

4. PROCEDURE

4.1. All individuals presenting to the PHF unit shall be prescreened and a medical clearance shall be obtained.

4.2. Medical clearance will include: CBC; other laboratory work as determined by the on-call physician; vital signs; screening for recent drug use; current mental status; brief medical history, including current acute medical issues; history of head injury; history of developmental disability; ambulatory status; and, as needed, nutritional status.

4.3. All patients shall be assessed for medical and psychiatric needs and conditions by licensed nursing staff (LNS) at admission. This assessment shall include a review of medical histories and any supporting documentation available at admission. Any findings will be fully documented on the nursing assessment. PHF patients shall be reassessed during each shift by assigned LNS for ongoing or emergent medical and psychiatric conditions for the duration of their stay.

4.4. All patients will be seen by an internist within 24 hours of admission and as needed. The internist will make recommendations for any further medical assessment and specialty care to be provided through specialty clinics.

4.5. The PHF conducts at a minimum 15 minute rounds of the unit and documents the location and activity of each patient. Rounds are conducted by qualified, training staff prepared to identify and respond to an emerging medical or psychiatric condition.

4.6. In the event of an emergency medical condition or other immediate threat to life, staff will commence the following code blue procedures:

1. Provide first aid treatment using available supplies.
2. Call out "Code Blue, Code Blue" and announce it over the intercom system.
3. Call 9-911 and request immediate assistance from Emergency medical services.
4. If the individual is unresponsive, retrieve the Automated Electronic Defibrillator (AED) and CPR mask.
5. Follow the American Heart Association guidelines for Basic Life Support for Healthcare Providers.

6. Provide rescue breathing and/or CPR as indicated.
7. When the AED arrives, additional staff will turn on the AED and follow prompts.
8. Continue Basic Life Support until EMS arrives and is ready to take over.

4.7. Emergency medical conditions not treated may lead to severe consequences, e.g. shortness of breath, chest pain, swollen joints.

4.8. When a physician is on site, s/he will assess the patient. If there is no physician on site, the covering physician will respond either by coming in to assess the patient, or by choosing, after phone consultation with the Team Leader, to treat the patient at the PHF or transfer to a local hospital emergency room via American Medical Response ambulance services.

4.9. If the physician decides the transfer is necessary:

1. The patient's emergency medical condition will be stabilized within the capability of the PHF prior to transfer.
2. The Team Lead will call the local hospital emergency room to provide information about the patient's condition.

4.10. If the physician decides the patient may safely be treated at PHF, the physician will order the necessary medications and treatment, which will at the minimum include:

1. Vital signs and frequency.
2. Directions for what to do if vital signs exceed parameters.
3. When to re-contact the physician.
4. When to discontinue frequent monitoring.

4.11. An RN will remain with the patient while the patient is stabilized.

4.12. The Team Lead will ensure documentation of all the specific steps that were taken by staff during the emergency including but not limited to: arrival time of EMS, observed interventions of EMS, first aid and emergency interventions by PHF staff, patient response to all.

ASSISTANCE

Marianne Barrinuevo, RN, MSN, PHF Director of Nursing

REFERENCE

California Code of Regulations – Social Security
Title 22, Sections 77061(d)

Code of Federal Regulations – CMS Conditions of Participation
Title 42, Section 482.12(f)(2)

RELATED POLICIES

Medical Care for Patients

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION
10/31/2017	1.2	• Section 4.3 - clarified medical and psychiatric assessment process and requirements for patients admitted to the PHF. • Section 4.4 - all patients will be seen by an internist within 24 hours of admission and as needed. The internist will make recommendations for any further medical assessment and specialty care. • Section 5 - described 15 minute rounding practices.

Culturally and Linguistically Competent Policies
The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).

SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Programmatic Policy and Procedure

Section	Psychiatric Health Facility (PHF)	**Effective:**	1/3/2018
Sub-section		**Version:**	1.0
Policy	Emergency Patient, Staff, and Visitor Tracking	**Last Revised:**	New policy
Director's Approval	Alice Gleghorn, PhD	**Date**	1/11/18
Medical Director's Approval	Ole Behrendtsen, MD	**Date**	1-16-18
Supersedes:	New policy	**Audit Date:**	1/3/2019

1. PURPOSE/SCOPE

1.1. To establish standardized procedures for tracking the location and movements of patients, on-duty staff, visitors, and other persons onsite during an emergency at the Santa Barbara County Psychiatric Health Facility (hereafter "PHF").

1.2. To ensure compliance with the Centers of Medicare & Medicaid Services (CMS) Emergency Preparedness Final Rule (42 CFR 482.15), emergency preparedness and response health care industry standards set forth by the California Hospital Association, and all other applicable federal, state and local laws.

2. DEFINITIONS

2.1. **Emergency** – a hazard or other critical incident that causes adverse physical, social, psychological, economic or political effects that challenges the facility's ability to respond rapidly and effectively to an interruption in normal facility functioning. Emergencies can affect the facility internally as well as the overall target population, the community at large or a geographic area.

1. For purposes of this policy, "Emergency" refers to a facility-level hazard situation, not an individual patient medical emergency. For patient-related medical emergencies, please refer to the "Emergency Medical Condition" policy.

3. POLICY

3.1. The PHF shall track the location of patients, on-duty staff, visitors, and other persons onsite during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the PHF shall document the specific name and location of the receiving facility or other location.

3.2. Tracking logs and all other pertinent information regarding patients must be readily available, accurate, and shareable among officials within and across the emergency response system as needed in the interest of the patient.

4. TRACKING COORDINATOR

4.1. In a shelter-in-place or evacuation situation, the PHF Team Leader will assign one staff member the position of Tracking Coordinator. This staff member is responsible for managing emergency rosters and tracking logs during and after the emergency.

4.2. The emergency roster and tracking logs will be maintained and updated whenever possible, feasible, and safe to do so. In extreme or life-threatening situations, the Tracking Coordinator's priority is to directly assist patients and staff and provide life-saving and life-sustaining care. The immediate health and safety of patients and staff takes precedence over documentation.

4.3. The Tracking Coordinator will use the *Emergency Roster* (see Attachment A) to rapidly document the names of all patients, staff and visitors onsite during the emergency. The *Emergency Roster* can be completed quickly and easily while an emergency is in-progress.

4.4. The Tracking Coordinator will use the *Patient Emergency Tracking Log* (see Attachment B) to document the location all patients during the emergency, including transfers to other locations and facilities. The *Patient Emergency Tracking Log* is completed when there is more time to coordinate an emergency response, and is not meant to be used during emergencies requiring immediate/rapid response.

1. The PHF is not required to track the location of patients who have voluntarily left on their own, or have been appropriately discharged. However, this information must be documented on the *Patient Emergency Tracking Log* and in the patient's medical record should any questions later arise as to their whereabouts.
2. Patients relocated to another location or facility that will receive ongoing care from PHF staff are not considered to be discharged and therefore will be tracked accordingly.

4.5. The Tracking Coordinator will use the *Staff and Visitor Emergency Tracking Log* (Attachment C) to document the location of on-duty staff, visitors, and any other persons onsite during the emergency. This includes the specific location of on-duty staff who are evacuated, or on-duty staff who leave the PHF during the emergency to assist with patient transfers or for other emergency response purposes.

1. The PHF is not required to track the location of staff once they are off-duty, but must document the time and date a staff member finished work.

5. PATIENT TRANSFER TRACKING

5.1. If patients are transferred to another facility during the emergency, the Tracking Coordinator will document the following on the *Patient Emergency Tracking Log* (see Attachment B):

1. Date and time the transfer was initiated
2. Evacuation triage category (i.e. "Standard" or "Immediate"; patients experiencing a medical emergency will be designated for immediate transfer)
3. Receiving facility name or location name
4. Facility or location contact name and phone number
5. Whether medical records and medication were sent with the patient
6. Whether family has been notified of the transfer
7. Date and time transfer was completed

5.2. Transfer agreements with receiving facilities are discussed in further detail in the PHF's "Transfer Agreements with Other Facilities" policy.

ASSISTANCE

Mark Lawler, LPT, PHF Team Supervisor

REFERENCE

Code of Federal Regulations – Condition of Participation: Emergency Preparedness
Section 482.15(b)(2)

Centers for Medicare & Medicaid Services (CMS)
Emergency Preparedness Final Rule Interpretive Guidelines and Survey Procedures
Ref: S&C 17-29-ALL, 6/2/2017

California Hospital Association
Hospital Evacuation Checklist. Retrieved from: https://www.calhospitalprepare.org/evacuation

ATTACHMENTS

Attachment A – *Emergency Roster*

Attachment B – *Patient Emergency Tracking Log*

Attachment C – *Staff and Visitor Emergency Tracking Log*

RELATED POLICIES/DOCUMENTS

PHF Emergency Response Plan

PHF Emergency Communication Plan

Emergency Facility Evacuation

Shelter in Place During Emergency

Emergency Transfer Agreements with Other Facilities

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION

Culturally and Linguistically Competent Policies

The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).

SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Programmatic Policy and Procedure

Section	Psychiatric Health Facility (PHF)	**Effective:**	11/29/2017
Sub-section	Crisis and Emergency Response	**Version:**	1.0
Policy	Emergency Subsistence Management	**Last Revised:**	New policy
Director's Approval	Alice Gleghorn, PhD	**Date**	12/4/17
Medical Director's Approval	Ole Behrendtsen, MD	**Date**	12.03.17
Supersedes:	New policy	**Audit Date:**	11/29/2018

1. PURPOSE/SCOPE

1.1. To ensure compliance with the Centers of Medicare & Medicaid Services (CMS) Emergency Preparedness Final Rule (42 CFR 482.15), emergency preparedness and response health care industry standards set forth by the California Hospital Association, and all other applicable federal, state and local laws.

2. DEFINITIONS

The following terms are limited to the purposes of this policy:

2.1. **Emergency** – a hazard or other critical incident that causes adverse physical, social, psychological, economic or political effects that challenges the facility's ability to respond rapidly and effectively to an interruption in normal facility functioning. Emergencies can affect the facility internally as well as the overall target population, the community at large or a geographic area.

1. For purposes of this policy, "Emergency" refers to a facility-level hazard situation, not an individual patient medical emergency. For patient-related medical emergencies, please refer to the "Emergency Medical Condition"

3. POLICY

3.1. The Santa Barbara County Psychiatric Health Facility (hereafter "PHF") shall ensure the provision of emergency subsistence supplies for patients, staff, visitors and other personnel in the event of an emergency requiring evacuation or sheltering on the unit. Subsistence measures shall include:

1. Food, water, medical, and pharmaceutical supplies; and
2. Alternate sources of energy to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions; emergency lighting; fire detection, extinguishing, and alarm systems; and sewage and waste disposal.

4. SUBSISTENCE STORAGE

4.1. Emergency food, potable water, medical and pharmaceutical supplies shall be stored at least six (6) inches off the ground to protect from environmental hazards such as flooding. The PHF is situated on the second floor of a building built on a hill, making substantial or dangerous flooding within the unit unlikely.

5. FOOD AND POTABLE WATER SUPPLIES

5.1. In the event of an emergency, the PHF shall utilize stored, nonperishable food and potable water supplies that provide up to seven (7) days of nutrition and hydration for a maximum of 50 patients, staff, visitors and other personnel on the unit. Supplies shall be provided by an emergency preparedness food vendor with menus created and approved by registered dieticians.

5.2. Each food and potable water item shall be clearly dated. Potable water items shall be rotated out on an annual basis.

5.3. Equipment and supplies for the preparation and distribution of emergency food and potable water will be stored onsite.

5.4. All emergency food and potable water supplies shall be stored onsite in an enclosed emergency supply shed located on the PHF patio.

5.5. For procedures and further details on emergency food and potable water supplies, please refer to the PHF's "Disaster and Emergency Supplies for Dietary Services" policy.

6. MEDICAL AND PHARMACEUTICAL SUPPLIES

6.1. Emergency medical supplies are stored in the PHF exam room and the emergency supply shed located on the PHF patio. Sufficient medical supplies will be available to respond to basic first aid needs of patients and staff during an emergency. An inventory checklist of medical supplies will be maintained and reviewed twice monthly.

6.2. In the event of an emergency, the PHF's pharmaceutical vendor will work collaboratively with staff to ensure the continuity of pharmacy services. The PHF will communicate inventory levels of critical medications, prioritize patients with urgent medication needs, and submit emergency orders accordingly. Any non-emergency refills will be placed on hold.

6.3. For immediate needs, or if the PHF anticipates significant delays in medication delivery due to hazardous conditions, road closures, or other disruptions to service, the PHF will utilize Geriscripts with local area pharmacies. Please refer to the pharmacy vendor's most current "Provision of Pharmacy Services During an Emergency" policy for further instructions.

6.4. For additional pharmaceutical needs, the PHF has established contingency contracts with local area retail pharmacies and pharmacies in the vicinity of transfer locations (i.e. Vista Del Mar/Hillmont).

7. ALTERNATE ENERGY SOURCES

7.1. **Emergency power systems.** The PHF maintains a diesel-powered emergency generator onsite in the event that normal electrical power sources fail. The generator is located in the immediate vicinity of the PHF in accordance with location requirements found in the National Fire Protection Association's (NFPA) Health Care Facilities Code, Life Safety Code, and Standards for Emergency and Standby Power Systems, and is accessible only to the Behavioral Wellness Facilities Manager and County General Services maintenance personnel. This generator is maintained in compliance with NFPA regulations that include weekly visual inspection, bimonthly testing under load, and annual maintenance based on the manufacturer's recommendations. All generator inspection, testing and maintenance is completed by County General Services and documented by the Behavioral Wellness Facilities Manager; logs are kept onsite at the PHF.

7.2. **Generator fuel.** Generator fuel is stored in an outdoor fuel tank capable of generating power for up to five (5) days. During an emergency, County General Services emergency maintenance personnel will assist with refueling the generator and obtaining additional fuel to ensure emergency power systems stay operational for the duration of the emergency. Fuel may be obtained from the County-operated gas station on County Rd. (less than one mile from the PHF), local retail gas stations, or County-operated gas stations in Lompoc and Santa Maria.

7.3. **Temperature control.** The PHF is situated in the city of Santa Barbara and experiences mild climate with an average high of 77° in August and an average low of 42° in December. Extreme hot or cold temperatures that pose a risk to health and safety are unlikely, including during an outage of HVAC (heating, ventilation, and air conditioning) systems. In case of high temperatures or ventilation problems, portable fans and other cooling solutions can be run from generator-powered outlets (marked in red throughout the unit) to maintain safe temperatures for people sheltering during an emergency. Several portable fans can be obtained from Behavioral Wellness Facilities or County General Services. During colder periods, additional bedding and blankets will be provided to patients. For water temperature, controls are tested monthly by the Behavioral Wellness Facilities Manager. During a gas outage, a diesel-powered boiler is available for emergency needs. Emergency repairs for water temperature will be coordinated by Behavioral Wellness Facilities Manager with local area vendors.

7.4. **Emergency lighting.** The PHF is equipped with emergency floodlight fixtures mounted adjacent to illuminated exit signage powered by the emergency generator. Emergency floodlights automatically activate within ten seconds when power is unexpectedly lost. Exit signage is battery-operated, drawing power from the building's power grid and lighting automatically in the event of a power loss. Emergency and exit lighting will be functional for a minimum of 90 minutes following power failure. Testing of emergency

lighting is completed by County General Services with a monthly 30-second test and an annual 90-minute test. County General Services also completes preventive maintenance of exit signage. Backup battery-operated flashlights and batteries are stored onsite in offices, the nursing station, and the emergency supply shed located in the PHF patio. These are maintained in their original packaging and labeled for emergency use only.

7.5. **Fire detection, extinguishing, and alarm systems.** In the event of a power failure, PHF fire detection, extinguishing (i.e. sprinkler), and alarm systems are set to continue running with emergency generator power. If the PHF were to experience a water supply failure, handheld fire extinguishers are available onsite located every 30 feet along PHF hallways. If the PHF experiences a planned or unplanned outage of fire alarm and sprinkler systems for more than 4 hours in a 24-period, the PHF activates a fire watch tour of the facility.[1] County General Services complete quarterly testing of the sprinkler system and inspector valve and monthly testing of the fire alarm system. The Behavioral Wellness Facilities Manager documents all testing completed and keeps logs onsite at the PHF.

7.6. **Sewage and waste disposal.** In the event of failure of the mainline sewer system, alternate sewage disposal solutions will be used. The PHF Team Leader will contact General Services to arrange delivery of Porta-Potties or additional water supplies. Porta-Potties may be placed in the parking lot to serve staff and in the PHF courtyard to serve patients. Alternately or in addition, General Services will provide emergency water containers or buckets for manually forced toilet flushing. The PHF is equipped with collection and disposal bins for potentially infectious waste, including soiled linens, and manages and disposes all waste in accordance with infection control guidelines. Non-sharps medical waste collection and disposal containers are stored onsite for emergency use. Waste removal during an emergency will be coordinated with contracted local area vendors and/or General Services emergency maintenance personnel as needed. If waste cannot be removed from the premises during an emergency, waste will be stored in an isolated, restricted location on or in close proximity to the unit until proper disposal arrangements can be made.

8. EMERGENCY REPAIRS AND ASSISTANCE FROM OUTSIDE VENDORS

8.1. The PHF has agreements and contracts with local area contractors for any emergency repair needs impacting functioning of critical systems, including, but not limited to, electrical, plumbing, and HVAC systems.

9. GENERAL SERVICES CONTACT INFORMATION

9.1. County General Services can be reached after hours for emergency repair and support needs:

805-896-2916

[1] Please refer to the PHF's "Fire Watch Program" policy for further details.

ASSISTANCE

Mark Lawler, LPT, PHF Team Supervisor

Ernest Thomas, Behavioral Wellness Facilities Manager

Alesha Silva, RN, PHF Interim Nursing Supervisor

Marianne Barrinuevo, RN, MSN, PHF Director of Nursing

Heather Lengyel, RD, PHF Registered Dietician

REFERENCE

Code of Federal Regulations – Condition of Participation: Emergency Preparedness
Sections 482.15(b)(1), 482.15(e)(1-3)

National Fire Protection Association (NFPA)
NFPA 70 - National Electric Code
NFPA 99: Health Care Facilities Code
NFPA 101: Life Safety Code
NFPA 110: Standard for Emergency and Standby Power Systems

Centers for Medicare & Medicaid Services (CMS)
Emergency Preparedness Final Rule Interpretive Guidelines and Survey Procedures
Ref: S&C 17-29-ALL, 6/2/2017

California Hospital Association
Hospital Emergency Food Supply Planning Guidance and Toolkit. Retrieved from: https://www.calhospitalprepare.org/foodplanning

RELATED POLICIES/DOCUMENTS

PHF Emergency Response Plan

PHF Emergency Communication Plan

Disaster and Emergency Supplies for Dietary Services

Fire Watch Program

Provision of Pharmacy Services During an Emergency (Hometown Pharmacy policy)

Emergency Patient, Staff, and Visitor Tracking

Emergency Transfer Agreements with Other Facilities

Shelter-in-Place During Emergency

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION

Culturally and Linguistically Competent Policies

The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).

SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Programmatic Policy and Procedure

Section	Psychiatric Health Facility (PHF)	**Effective:**	1/3/2018
Sub-section		**Version:**	1.0
Policy	Emergency Transfer Agreements with Other Facilities	**Last Revised:**	New policy
Director's Approval	Alice Gleghorn, PhD	**Date**	1/11/18
Clinical Division Chief's Approval	Ole Behrendtsen, MD	**Date**	1.16.18
Supersedes:	New policy	**Audit Date:**	1/3/2019

1. PURPOSE/SCOPE

1.1. To ensure compliance with the Centers of Medicare & Medicaid Services (CMS) Emergency Preparedness Final Rule (42 CFR 482.15), emergency preparedness and response health care industry standards set forth by the California Hospital Association, and all other applicable federal, state and local laws.

2. DEFINITIONS

2.1. **Emergency** – a hazard or other critical incident that causes adverse physical, social, psychological, economic or political effects that challenges the facility's ability to respond rapidly and effectively to an interruption in normal facility functioning. Emergencies can affect the facility internally as well as the overall target population, the community at large or a geographic area.

1. For purposes of this policy, "Emergency" refers to a facility-level hazard situation, not an individual patient medical emergency. For patient-related medical emergencies, please refer to the "Emergency Medical Condition" policy.

3. POLICY

3.1. In an emergency that threatens or restricts the usual functions of the PHF, patients may be transferred to a licensed and accredited acute care facility equipped with the appropriate facilities, services and staff necessary to provide medical and psychiatric care. The PHF shall maintain Letters of Agreement and/or Memoranda of Understanding ("MOUs") with facilities able to accept PHF patients for transfer in an emergency.

4. FACILITY AGREEMENTS AND MOUS

4.1. Copies of agreements and MOUs with transfer facilities will be maintained by PHF Leadership and hard copies kept in the Nurses' Station.

5. PHARMACEUTICAL SUPPLIES

5.1. When possible, existing medications will be sent along with the patient during the transfer. Prescriptions will also be transferred to the receiving facility. In the event that existing medications cannot be sent with the patient, the PHF has established agreements with local area pharmacies in the vicinity of transfer facilities to assist with emergency prescription refills.

6. TRACKING OF TRANSFERRED PATIENTS

6.1. The PHF Tracking Coordinator will use the *Patient Emergency Tracking Log* (see Attachment A) to track the location and movement of patients during an emergency. The tracking log will be used to document patient transfers to other facilities, including date and time of transfer and the receiving facility's contact information.[1] Transfer to a new facility is considered a formal discharge; the PHF is not required to track the location of patients after they have been appropriately discharged. However, this information must be documented on the *Patient Emergency Tracking Log* and in the patient's medical record should any questions later arise as to their whereabouts.

1. Patients relocated to another location or facility that will receive ongoing care from PHF staff are not considered to be discharged and therefore will be tracked accordingly.

REFERENCE

Code of Federal Regulations – Condition of Participation: Emergency Preparedness
Section 482.15(b)(7), 482.15(b)(2)

ATTACHMENTS

Attachment A – Patient Emergency Tracking Log

RELATED POLICIES/DOCUMENTS

PHF Emergency Response Plan

PHF Emergency Communication Plan

Emergency Patient, Staff, and Visitor Tracking

[1] Please refer to the PHF's "Emergency Patient, Staff, and Visitor Tracking" policy for further details.

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION

Culturally and Linguistically Competent Policies

The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).

SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
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Programmatic Policy and Procedure

Section	Psychiatric Health Facility (PHF)	**Effective:**	11/29/2017
Sub-section	Crisis and Emergency Response	**Version:**	1.0
Policy	Shelter-in-Place During Emergency	**Last Revised:**	New policy
Director's Approval	Alice Gleghorn, PhD	**Date**	12/4/17
Medical Director's Approval	Ole Behrendtsen, MD	**Date**	12-13-17
Supersedes:	New policy	**Audit Date:**	11/29/2018

1. PURPOSE/SCOPE

1.1. To establish standardized emergency shelter-in-place procedures at the Santa Barbara County Psychiatric Health Facility (hereafter "PHF").

1.2. To ensure compliance with the Centers of Medicare & Medicaid Services (CMS) Emergency Preparedness Final Rule (42 CFR 482.15), emergency preparedness and response health care industry standards set forth by the California Hospital Association, and all other applicable federal, state and local laws.

2. DEFINITIONS

The following terms are limited to the purposes of this policy:

2.1. **Emergency** – a hazard or other critical incident that causes adverse physical, social, psychological, economic or political effects that challenges the facility's ability to respond rapidly and effectively to an interruption in normal facility functioning. Emergencies can affect the facility internally as well as the overall target population, the community at large or a geographic area.

1. For purposes of this policy, "Emergency" refers to a facility-level hazard situation, not an individual patient medical emergency. For patient-related medical emergencies, please refer to the "Emergency Medical Condition" policy.

2.2. **PHF Leadership** – managerial and executive-level personnel responsible for high-level decision-making, including those involving sheltering. This includes the PHF Chief Executive Officer (CEO), Medical Director, Director of Nursing, Manager, and Nursing Supervisor.

2.3. **Shelter-in-place** – during and after an emergency, to seek immediate shelter on-site and remain in place until the emergency is resolved, the order to shelter is lifted by PHF Leadership and emergency officials, and/or instructed to commence other emergency procedures such as evacuation.

3. POLICY

3.1. The PHF shall support the safe sheltering of patients, on-duty staff, visitors, and any other persons onsite at the PHF in an emergency situation that makes evacuation unsafe.

4. SHELTER-IN-PLACE CRITERIA

4.1. An all-hazards and vulnerability assessment was conducted in 2017 by the County's Risk Management division to identify events, hazards and triggers that may require an emergency shelter-in-place response at the PHF. While the following criteria reflect key assessment findings, they are in no way intended to represent all possible shelter-in-place response triggers.

1. Emergency or disaster that is external to the unit/building, and poses a threat to health and safety if the unit is not locked down and/or if persons leave the premises, including, but not limited to:
   a. Individual brandishing a weapon or active shooter
   b. Civil disturbances or riots
   c. Terrorism
   d. Explosions or similar volatile conditions
   e. Severe thunderstorm or other unsafe weather conditions
   f. Chemical/biological/radiological hazard or dangerous contaminants in the air
2. Earthquakes, unless post-earthquake conditions present hazards to health and safety (e.g. structural damage, gas leak).

4.2. For all other hazards, sheltering-in-place will be ordered based on the circumstances, proximity, and severity of the hazard. PHF Leadership and local emergency officials must evaluate the nature of the hazard, consider available resources, and continuously reassess the situation as it progresses to determine the best course of action.

4.3. Once a decision to shelter-in-place is made, all persons at the PHF are to remain on-site until further notice. However, if extenuating circumstances or a medical emergency require the evacuation of a patient, staff, or visitor, the PHF Team Leader or a designee will coordinate evacuation with local emergency personnel.

4.4. Following an earthquake or other damage-causing incidents, the PHF may continue to shelter-in-place if the unit and the building have sustained little to no structural damage, and no immediate risks are apparent (NOTE: A structural assessment must be

conducted following any event that may impact structural integrity. County General Services will assist with the coordination of contracted vendors for the purpose of inspection and assessment). If significant structural damage is detected, the PHF Team Leader or a designee and local emergency personnel will commence arrangements to transfer patients to alternate settings. Please refer to the PHF's "Emergency Transfer Agreements with Other Facilities" policy for further details.

5. HAZARD IDENTIFICATION AND SHELTER-IN-PLACE ORDER

5.1. **Hazard Identified During Business Hours.** During business hours, if a hazard is identified that may require an emergency shelter-in-place response, the PHF Team Leader or a designee shall notify PHF Leadership immediately. The decision to shelter-in-place is made in consultation with local and county emergency response agencies, including but not limited to law enforcement, fire department, 911/emergency dispatch center, Incident Response/Unified Command, Department of Public Health, and the Emergency Operations Center (EOC).

1. **If the hazard poses an immediate and potentially life-threatening danger**, the PHF Team Leader or a designee will call 911 and commence immediate shelter-in-place procedures.

5.2. **Hazard Identified Outside Business Hours.** After business hours, if a hazard is identified that may require an emergency shelter-in-place response, the PHF Team Leader or a designee shall notify the On-call Administrator. The decision to shelter-in-place is made in consultation with PHF Leadership and local and county emergency response agencies as indicated in Section 5.1 of this policy.

5.3. **Mandatory Shelter-in-Place Order.** If an order to shelter-in-place is given by authorities (e.g. State or local law enforcement, fire personnel, or other emergency response personnel), the PHF Team Leader shall notify PHF Leadership and/or the On-call Administrator immediately and begin shelter-in-place procedures.

6. SHELTER-IN-PLACE PROCEDURES

6.1. When a decision is made to shelter-in-place, the PHF Team Leader will hold a briefing with all unit staff to announce the decision and assign responsibilities to each staff, including securing all entrances and windows (i.e. lockdown) and retrieving emergency subsistence supplies. The PHF Team Leader will assign one staff member the position of Tracking Coordinator. This individual maintains an emergency roster and a tracking log of the locations and movement of all persons on the unit during the emergency event.[1]

1. The emergency roster and tracking log will be maintained and updated whenever possible, feasible, and safe to do so. In extreme or life-threatening situations, the Tracking Coordinator's priority is to directly assist patients and staff and provide life-saving and life-sustaining care. The immediate health and safety of patients and staff takes precedence over documentation.

[1] Please refer to the PHF's "Emergency Patient, Staff, and Visitor Tracking" policy for further details.

6.2. The PHF Team Leader or a designee will notify all persons onsite to shelter and stay on the unit until further notice. When the patients are informed of the order to shelter-in-place, PHF staff will remain aware that an emergency event may compromise the psychiatric stability of the patients, especially those with trauma histories, anxiety, or other high acuity concerns. Patients may be triggered and experience destabilization. The PHF will strive to minimize the emotional and psychiatric impacts that sheltering may have on patients.

6.3. The PHF Team Leader will identify sheltering challenges and risks for each patient. This includes, but is not limited to, medical status, elopement history, trauma history, and seclusion and restraint history. Assistance will be prioritized for high-acuity patients.

6.4. Staff will instruct patients to shelter in their rooms and/or other designated areas of the unit. Staff may shelter alongside patients who require continued assistance.

6.5. Staff not sheltering with patients will close and lock all windows and doors if it is safe to do so, then take shelter in the nearest securable location, such as an office or nurse's station.

7. SUBSISTENCE

7.1. Because the PHF is not a large or highly publicized institution, and because it is located further from residential areas and city centers than local general-population hospitals, a significant surge of community members seeking shelter at the PHF in an emergency situation is not expected.

7.2. At capacity, the PHF can accommodate 16 patients. Typically, staff on-duty, visitors and other personnel total approximately 12 to 20 individuals, though this number can fluctuate depending on the shift (i.e. day or overnight), day of the week, and patient census. To prepare for the rare case in which community members seek shelter at the PHF, the PHF is equipped with subsistence supplies and emergency nonperishable food and potable water to support 50 persons for seven (7) days. The PHF has acquired and planned for several other means of subsistence to support sheltering during an emergency. Subsistence measures include:

1. Emergency medical supplies and pharmaceuticals.
2. Alternative sources of energy, including temperature management, backup power generators, emergency lighting, and fire detection and suppression.
3. Sewage and waste management.

7.3. For greater detail on subsistence measures, please refer to the PHF's "Disaster and Emergency Supplies for Dietary Services" and "Emergency Subsistence Management" policies.

8. HANDLING OF CONFIDENTIAL DOCUMENTS

8.1. When feasible, PHF staff will secure hard copies of patient medical records. These patient medical records must be readily available and shareable with staff, emergency response personnel, and the intaking facility in the event of a transfer.

8.2. Staff will remain aware that HIPAA protections still apply during an emergency situation.

9. DURATION AND LIFTING OF SHELTER-IN-PLACE

9.1. The PHF Team Leader will await notification from the Behavioral Wellness Facilities Manager, County General Services, building inspectors and engineers, and/or law enforcement and safety personnel to cease sheltering and resume normal operations.

9.2. Once it is safe to do so, the PHF Team Leader will complete an Unusual Occurrence Incident Report.[2]

10. COMMUNICATION

10.1. Prior to and during the emergency situation, telephones and cell phones will serve as the preferred methods of contact with PHF Leadership, authorities, and other facilities. Within the PHF, walkie-talkies may be used as a backup form of communication.[3]

ASSISTANCE

Mark Lawler, LPT, PHF Team Supervisor

RELATED DOCUMENTS AND POLICIES

PHF Emergency Response Plan

PHF Emergency Communication Plan

Emergency Facility Evacuation

Disaster and Emergency Supplies for Dietary Services

Emergency Subsistence Management

Emergency Patient, Staff, and Visitor Tracking

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[2] Please refer to the PHF's "Unusual Incident Reporting" policy for further details.

[3] Please refer to the PHF Emergency Communication Plan for more information on internal and external communication in an emergency situation.

REFERENCES

Code of Federal Regulations – Conditions of Participation: Emergency Preparedness Final Rule
Title 42, Section 482.15(b)(4)

Centers for Medicare & Medicaid Services (CMS)
Emergency Preparedness Final Rule Interpretive Guidelines and Survey Procedures
Ref: S&C 17-29-ALL, 6/2/2017

California Hospital Association
Evacuation and Shelter-in-Place Guidelines for Healthcare Entities. Retrieved from: https://www.calhospitalprepare.org/post/evacuation-and-shelter-place-guidelines-healthcare-entities

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION

Culturally and Linguistically Competent Policies
The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).

SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Programmatic Policy and Procedure

Section	Psychiatric Health Facility	**Effective:**	4/6/2011
Sub-section			
Policy	Unusual Occurrence Reporting	**Last Revised:**	10/3/16
Policy #			
Director's Approval	Alice Gleghorn, PhD	**Date**	10/3/16
PHF Medical Director's Approval	Leslie Lundt, MD	**Date**	10/3/16
Supersedes:	NG and L – Incident Reports	**Audit Date:**	10/3/19

1. PURPOSE/SCOPE

1.1. To define unusual occurrences and establish a reporting and review process to ensure continuous focus on patient safety through effective performance improvement and quality assessment practices.

2. POLICY

2.1. Santa Barbara County Psychiatric Health Facility (PHF) shall report unusual occurrences pursuant to Title 22, California Code of Regulations §§ 77036 and 77137.

2.2. It shall be the policy of the PHF to investigate the source of any unusual occurrence, initiate any safety measures deemed necessary and comply with the requirements of any participating regulatory agency involved. Such actions may require an intense analysis to be conducted in a timely and thorough manner, relative to any identified qualifying unusual occurrence, with the intent to develop, implement, and monitor the effectiveness of a correction action initiated to prevent the risk of reoccurrence.

3. DEFINITION OF UNUSUAL OCCURRENCE

3.1 Unusual Occurrence Defined: An unusual occurrence is any condition or event which has jeopardized or could jeopardize the health, safety, security or well-being of any patient, employee or any other person while in the facility and shall include, but not be limited to:

a) An epidemic outbreak of any disease, prevalence of communicable disease, whether or not such communicable disease is required to be reported by Title 17, California Administrative Code, Section 2500, or epidemic infestation by parasites or vectors;

b) Poisonings;

c) Fires;

d) Physical injury to any person which, consistent with good medical and professional practice, would require treatment by a physician;

e) Death of a patient, employee or visitor from unnatural causes;

f) Sexual acts involving patients who are nonconsenting[1];

g) Physical assaults on patients, employees or visitors;

h) All instances of patient abuse;

i) Actual or threatened staff walkout, or other curtailment of services or interruption of essential services provided by the facility;

j) Patient escape from the facility with serious consequences (e.g., serious injuries or death);

k) Patient transfer to a hospital for serious and emergent medical situation as a result of the services, treatment, (or a lack thereof), and/or lack of supervision provided by the psychiatric facility;

l) Attempted patient suicide with serious consequences / outcomes, (e.g., fractured or broken bones, sutures, loss of major body function, surgery);

m) Seclusion/Restraint resulting in or related to death or serious injury to a patient, (e.g., fractured or broken bones, sutures, surgery).

n) Significant patient and staff exposure to human blood/body fluids. A significant exposure is defined as a contact with blood, saliva, tissue, or other body fluids that are potentially infectious to an area with percutaneous injury (e.g., needlestick or cut with a sharp object) or contact of mucous membrane or nonintact skin (e.g., exposed skin that is chapped, abraded, or with dermatitis).

4. PROCEDURE

4.1. Upon discovery by PHF staff of an unusual occurrence, that individual will immediately contact the PHF Nursing Supervisor or designee, who will in turn follow the chain of command for reporting or immediately contacting the PHF Chief Executive Officer (CEO) and/or PHF Medical Director.

4.2. It will be the responsibility of the PHF Nursing Supervisor to develop and submit the initial report to the California Department of Health Care Services (DHCS), as well as serve to as the liaison with that agency during the subsequent investigation process. In the event that the PHF Nursing Supervisor is not available, a designee will report the event to the DHCS. Disclosure of individually identifiable patient information is permitted consistent with applicable law.

[1] For patients identified as engaging in sexual contact, a psychiatric evaluation will be conducted to determine both patient's capacity to consent to sex acts and engage in consensual sex during the course of their stay at the PHF. Patients who have been deemed competent to consent to and engage in consensual sex are excluded from reporting.

4.3. Unusual occurrences shall be reported by the PHF within 24 hours, by telephone with written confirmation via email or fax, to the PHF CEO, PHF Medical Director and DHCS. An unusual occurrence report shall be retained on file by the PHF for three years. The PHF shall furnish other pertinent information related to the occurrences as the PHF CEO or the DHCS may require.

4.4. Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, as defined in Welfare Institutions Code, Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone or through a confidential Internet reporting tool, as authorized by Section 15658, immediately or as soon as practicably possible. If reported by telephone, a written report shall be sent, or an Internet report shall be made through the confidential Internet reporting tool established in Section 15658, within two working days.

4.5. Every fire or explosion which occurs in or on the premises shall be reported immediately to the local fire authority.

4.6. Whenever serious injury or death occurs in the PHF, specialized reporting is required. The PHF Nursing Supervisor, PHF Program Manager and QCM Manager will coordinate reporting with the PHF CEO and PHF Medical Director to ensure that all required reports are completed and forwarded to the DHCS and the Centers for Medicaid and Medicare Services (CMS) regulatory agencies in a timely manner.

4.7. Clinical staff will outreach to impacted family members and offer support through the resources of the department, potentially including meetings, referrals, and other supportive actions. Staff will respect the confidentiality rights of the injured or deceased individual(s) involved during this process.

ASSISTANCE

Charlotte Balzer-Gott, RN, PHF Nursing Supervisor

REFERENCES

Title 22, California Code of Regulations, Sections 77036 and 77137

Welfare Institutions Code, Sections 15610.63, 15658 and 15630

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