



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

**Emergency Response Plan
(ERP)**

for

**PSYCHIATRIC HEALTH FACILITY
315 Camino del Remedio
Santa Barbara, CA 93110
(805) 681-5244**

Revised: June 2020

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I. Introduction

The following Emergency Response Plan (hereafter “ERP”) is provided to ensure the safety and wellbeing of the clients, staff and visitors to the Santa Barbara County Department of Behavioral Wellness Psychiatric Health Facility (hereafter “PHF”). The PHF is an acute inpatient mental health facility serving a small patient population (capacity is 16 patients) with various degrees of impairment to independent function relevant to their symptoms of mental illness. Because PHF patients experience very high-acuity disorders, it is expected that an emergency or disaster situation would be severely disruptive and destabilizing to many patients.

With sensitivity to patients’ individual impairments, all emergency responses will incorporate the protection of privacy, dignity, and physical safety. Response objectives will be directed at containment of the emergency, treatment of physical injuries and emotional trauma, and other areas requiring immediate action in order to restore treatment and continuity of unit operations.

For the purposes of this plan, an “emergency” refers to a facility-level hazard situation 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. This may result from a natural, manmade, or war-caused disaster which results in extreme peril to life, property, and resources. An emergency situation may also involve hazard conditions that are beyond the control of the resources of the affected area and require combined forces of mutual aid.

The information included in this ERP is intended as a response to the 2019 All Hazards Assessment (Attachment A). The procedures included in this ERP address specific responses to various hazards which threaten the safety and wellbeing of patients, staff, and the surrounding community.

This ERP has been updated 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. In compliance with CMS regulations, this ERP will be reviewed and updated annually by the PHF Governing Board.

The Emergency Response Plan will be:

- distributed to each new employee at the site
- reviewed with staff twice a year
- updated annually or when a new hazard is identified
- made available to all staff (accessible in a hard copy kept onsite)

II. Responsibility

Key Personnel

The following designated personnel at the PHF are responsible for identifying the type of emergency and for taking charge of the appropriate procedures. The most recent contact names and numbers can be found in the PHF Grab and Go Binder.

PHF Program Manager
PHF Nurse Supervisor
PHF Safety Officer
BWELL Chief Strategy Officer
County Safety Officer
Facilities Manager
RN Team Leader
Physical Security Coordinator

The RN Team Leader currently on duty becomes the “Incident Commander” at the time of an emergency; they assume leadership of the situation, and may assign other roles as outlined in the Emergency Patient, Staff, and Visitor Tracking policy (Attachment D).

Emergency Staffing

See the Emergency Staffing policy (Attachment E) for details on staffing procedures when the PHF requires a heightened level of staffing due to an emergency. Primarily, the PHF will draw on Behavioral Wellness personnel for staffing solutions. Secondly, the PHF will activate support from emergency services and disaster workers, using the following guidance to determine the order in which additional resources may be drawn from outside sources:

1. Departmental resources
2. Law Enforcement
3. Emergency Medical Services
4. County Office of Emergency Management
5. State resources
6. Federal resources in a manner prescribed by the National Incident Management System (NIMS)

The PHF will take guidance for cooperating with local, State, and Federal officials from the National Incident Management System (NIMS), a set of guidelines produced by The Federal Emergency Management Agency (FEMA). Communication with these and other authorities will be noted on a situation’s Unusual Occurrence Incident Report (see the Unusual Occurrence Incident Report policy, Attachment J).

III. Emergency Services Contacts

Emergency Service	Name	Emergency Telephone	Business Telephone
Fire Department	S.B Fire Dept.	9-911	(805) 681-5500
Police Department	S.B. Police	9-911	(805) 897-2300
Sheriff's Department: Jail	Shift Commander:	9-911	(805) 681-4244
EMS/Ambulance	AMR	9-911	(888) 650-2663
Hospital	Cottage Goleta Valley Cottage		(805) 682-7111 (805) 967-3411
Facility/Maintenance	Facilities Manager	(805) 252-2411	
BWELL Information Technology	Support Services	(805) 689-9294	(805) 681-4006
General Services ICT after hours Emergency Number	On Call Network & Communications Support	(805) 692-1710	
Alarm Company	Bay Alarm Co.	(805) 658-6317	(805) 658-0555
Hazardous Materials Cleanup		9-911	
Office of Emergency Management (OEM)	Duty Officer	(805) 696-1194	(805) 681-5526
Director of Public Health	Van Do-Reynoso	(805) 681-5102	
Public Health Department Security Officer (Triumph Security)	Omar Vasquez Igor Boyko Samuel Villegas-area manager	(805) 698-8627 (805) 895-4196 (805) 276-1079	
County Physical Security Coordinator	Gary Thompson	(805) 448-1734	(805) 681-5590

IV. Locations of Facility Sites and Emergency Equipment

Type	Location(s)	Instructions (e.g. Shut-off Codes, Keys)
Water/sprinkler system shut-off valve	Camino del Remedio-behind CSU- Fenced area	Call After Hours Maintenance, (805) 896-2916
Gas shut-off valve	(Below & behind the CSU)	Call After Hours Maintenance, (805) 896-2916 **To be done by General Services
Fire alarm panel	PHF Lobby	Enter: 1234 CMD/enter
Circuit breaker panel	Patient Property Room, Hallway, Building 3, right of elevators	Look for label of affected area of unit

Disaster supplies/kit	Nurse's Station Emergency Binder	Look for directions in relevant section: fire, earthquake, etc.
First aid kit	Medication room	
Automated External Defibrillators (AEDs)	Nursing Station in dedicated cabinet	Trained personnel should begin CPR/First Aid as indicated. Secure AED. Follow instructions from device.
Fire extinguishers	Extinguishers mounted to wall every 30 feet	Call 9-911. Secure extinguisher. Use extinguisher to suppress flames, if safe. Concurrently evacuate patients and staff
Fire hydrant	1.5 inch fire hose cabinets located throughout unit	If extinguisher insufficient, pull hose from hangers in cabinet, charge line with valve. Point hose at base of fire, direct "fan" of water at fire.

V. Instructions for Alarm Systems

Whistles and electronic alarms require an immediate and thorough response from all staff on duty. Patient safety, calming, and crowd control take priority over all other activities in the event of an emergency. All personnel on duty must respond to all alarms.

Overhead Paging System

1. From any phone on the PHF, dial "0#102".
2. Announce the location and type of emergency utilizing BWELL's Universal Codes. (Code cards are carried in ID Badge pouch and are required at all times while on duty.)

Electronic Alarm System

Only staff have access. Staff must push button alarms, which are located in staff offices throughout unit in the following locations:

1. Kitchen/Dining Room. Remote control device on cabinet by serving area.
2. Nurse Supervisor (front lobby)
3. Wellness Conference Room
4. Laundry Room
5. Veranda/Staff Office #1
6. Staff Office #2 Social Workers Office
7. Recreation Therapy Room
8. Hearing Room
9. Staff Office #3 Doctors' Office

Whistles

Each staff member is provided a personal whistle which is mandated to be carried at all times. Employees are trained and encouraged to blow their whistle, activate a push button alarm, and/or call loudly for help whenever the employee feels the need for immediate assistance.

VI. Uniform Emergency Alert Codes

In collaboration with the Public Health Department, a *Uniform Emergency Alert Codes* system was established to assist with quick, efficient communication of critical incidents. All Behavioral Wellness

staff, including contractors, volunteers and interns, must complete the Emergency Alert Code training through the Relias training portal, and be aware of each code's response procedure.

Emergency Alert Color Codes		
BLUE: Critical Medical Need	YELLOW: Bomb Threat	RED: Fire or Smoke Seen
PURPLE: Child Abduction	GRAY: Combative Person	
SILVER: Person w/ Weapon, Hostage, or Active Shooter	ALERT: Disaster, Internal or External	ORANGE: Hazardous Spill of unknown chemicals

VII. Evacuation Considerations

The PHF's policy is to support the safe evacuation of patients, on-duty staff, visitors, and any other person's onsite during an emergency. See the Emergency Facility Evacuation policy (Attachment B) for details on evacuation procedures, including hazard identification and criteria for the decision to evacuate; triaging of patients for priority evacuation; and precautionary measures to decrease risk to patients during an evacuation.

For handling of medical documents during an evacuation, see the Emergency Medical Documentation Management policy (Attachment H). For procedures related to tracking of persons during an evacuation, see the Emergency Patient, Staff, and Visitor Tracking policy (Attachment D). For handling of patient transfers to other facilities, see the Emergency Transfer Agreements with Other Facilities policy (Attachment G).

Two types of evacuation are possible:

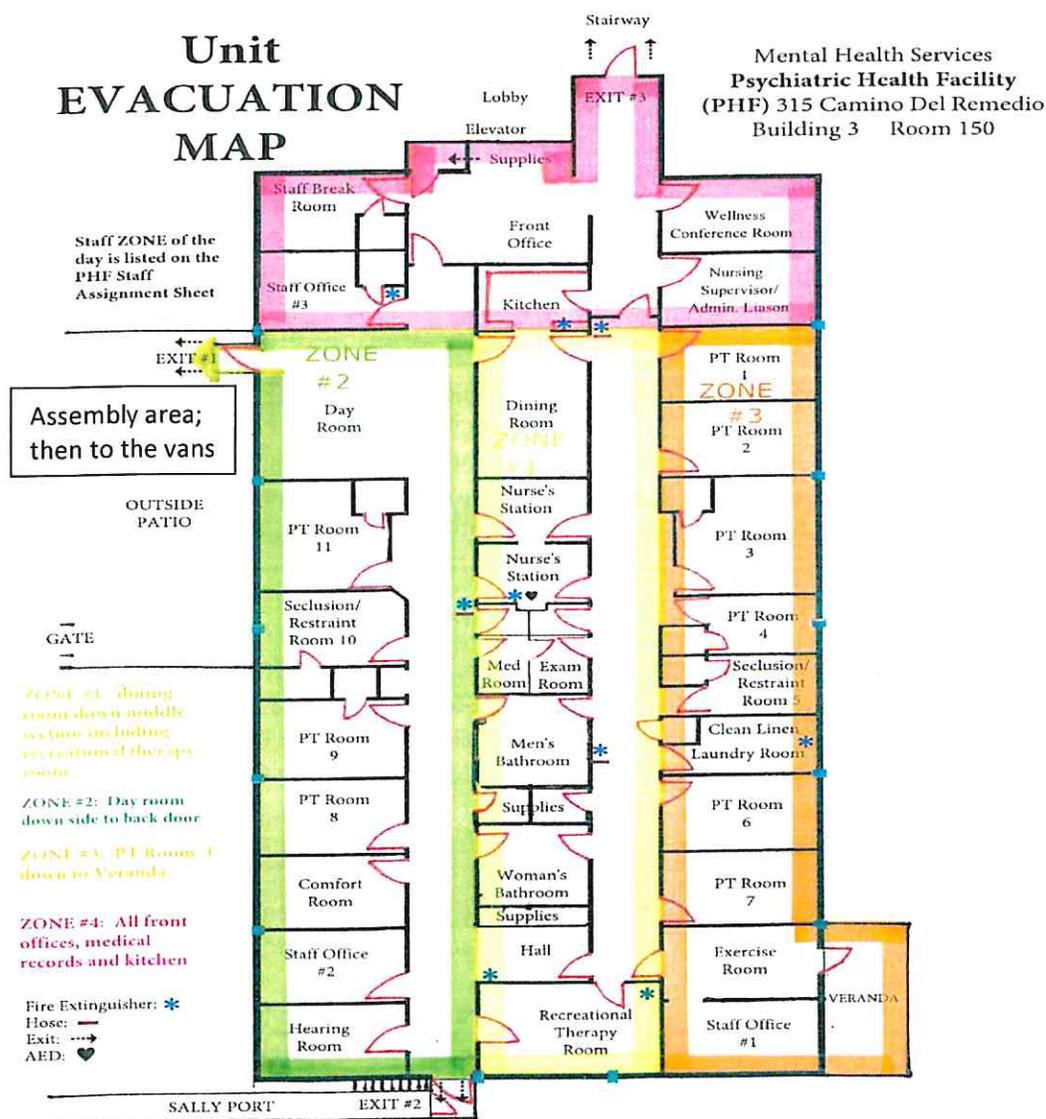
- a "standard" evacuation, in which staff have time to coordinate an evacuation, including gathering of supplies, equipment, and medical records, and triaging evacuation based on a patient's acuity and risk level
- An "immediate" evacuation, in which an immediate and potentially life-threatening danger forces an immediate evacuation of the PHF, with no time for usual documentation and tracking procedures.

Safety Drills

Drills are conducted quarterly by each of four nursing teams. In these drills, the RN Team Leader on duty assumes Incident Command, as they would in a real emergency. The RN Team Leader accounts for all staff and clients and completes a safety drill report, which is to be sent to the PHF Safety Representative for review and filing.

Evacuation Map

Evacuation maps are posted near exits throughout the unit.



VIII. Identified Hazards

Each hazard discussed in this ERP was identified by the 2020 All Hazards Assessment (Attachment A) as a potential threat to the PHF. When addressing any of the following hazards, reference the Emergency Facility Evacuation policy (Attachment B) for evacuation procedures or the Shelter in Place during Emergency policy (Attachment I) for evacuation or shelter procedures.

After any emergency, when it is safe and reasonable to do so, the PHF RN Supervisor on duty will arrange for a debriefing with all involved staff. The PHF RN Supervisor on duty or their designee must contact the current Administrator On-Call and submit an Unusual Occurrence Incident Report (see Attachment J).

When identified hazard may impact surrounding buildings notify the County Physical Security Coordinator and Public Health Department Security Officer (Triumph Security) and Director of Public Health. (See section III. Emergency Services Contacts)

In addition, consider the following guidelines for each specific hazard.

Fire

1. General considerations:
 - a) Call 9-911 to report any and all fires. Report the location plus magnitude and status of fire.
2. In the event of a moderate or large fire, keep in mind the following:
 - a) Do not panic or create panic.
 - b) Sweep and assist those in immediate need on the way out, do not back track.
 - c) Manually activate the fire alarm if it is not already activated.
 - d) Close doors, but do not lock them. On all rooms cleared, place red masking tape across the door.
 - e) Never use elevators for evacuation in the event of fire, unless directed by Police or Fire Department.
 - f) If caught in heavy smoke, direct all persons to drop to the floor, take short breaths, breathe through their noses, and then crawl to escape.
3. Small Fire, i.e., wastebasket
 - a) Do not take risks - your personal safety comes first.
 - b) Use fire extinguisher to extinguish fire.
4. If trapped by flame or heat:
 - a) Close doors separating you from the source of the heat or flame.
 - b) Remember, both smoke and heat rise, so air near the floor will be cleaner and cooler. Crouch down or crawl to exits.
 - c) Before opening a door, feel it with your hand. If it is hot, do not open it. Seek out another route.
 - d) Break windows for ventilation if necessary.

Earthquake

1. **DROP/COVER/HOLD ON!**
 - a) Everyone on the unit should take cover under a table, their desk, or another sturdy structure to avoid possible falling objects.
 - b) Keep away from file cabinets, glass windows, and heavy objects that could fall.
 - c) If in an unprotected area, get into fetal position with your hands over your head and protect your neck.
2. RN Team Leader is the "Incident Commander" who will determine and announce if work area is to be evacuated.
3. After the earthquake, be mindful of the following earthquake-specific hazards:
 - a) Stay away from damaged areas.
 - b) Be aware of falling objects or structural damage to building.
 - c) Inspect your office for damages and report damages in your space to the RN Team Leader.
 - d) Advise facilities/General Services of power outages or potential gas leaks. See the "Emergency Services Contacts" section in this ERP.

Flood

In the event of severe weather, or if flash flood warnings are in effect in the area, travel may be affected and flood hazards are possible.

1. In the event of severe weather or local flash flood warnings, the Facilities Manager or Safety Representative will consult with the Director or designee about the early release of non-essential personnel.
2. Clients and personnel scheduled to travel to the PHF will be notified of the operational plan.
3. If there are leaks in the buildings, no clients should be allowed into the area of the leakage.
4. Any buckets or basins should be emptied immediately. Wet carpets should be peeled back or removed and any standing water mopped up to avoid the breeding of mildew or bacteria.
 - a) Notify the Facilities Manager, Site Safety Representative, and Clinical Director or designee of any leakage.
5. In the event that the facility is unusable due to flood, the PHF Leadership will begin arrangements to transfer all patients to alternate facilities (see the Emergency Transfer Agreements with Other Facilities policy, Attachment G, for further information).
 - a) Evacuation protocol will be enacted at the discretion of the RN Team Leader, Incident Commander, and Leadership
 - b) In the event the site becomes flooded, the Facilities Manager or maintenance official will unplug all appliances and turn off all electrical power.

- c) In the event the site becomes flooded, only the Facilities Manager or official maintenance persons will enter the building to salvage equipment or files. The building will not be reopened until Facilities and/or emergency personnel have determined that it is habitable.

Epidemic/Pandemic

In the event of epidemic/pandemic, PHF Leadership will coordinate response according to the Santa Barbara County Public Health Department and Centers for Disease Control (CDC) orders, recommendations, or guidelines, as applicable.

Threat Involving a Weapon

1. Remove yourself from area of danger if possible.
2. Call 9-911, giving clear description of the situation and location of the threat. When law enforcement personnel arrive to the scene when weapon is involved, they assume incident command.
3. Attempt to keep others from the area of danger.

Bomb Threat

1. The staff who interacts with the person making threat should try to obtain as much information as possible from the caller, including:
 - a) Expected time of explosion
 - b) Location of bomb
 - c) Size and type of bomb
 - d) Reason bomb was placed
2. A second staff member must immediately call the Police Department at 9-911.
3. If a bomb or suspicious device is found, **DO NOT TOUCH OR DISTURB THE DEVICE.**
4. Immediately follow evacuation procedures. Evacuate away from the building.
5. Law enforcement personnel will decide what resources should be sent to assist.
6. A building search will be made by the emergency personnel. They may ask the PHF Manager or person in charge to accompany them during the search, as PHF staff will be more familiar with the facility layout.
7. PHF staff to prevent re-entry into building until emergency personnel have cleared the area and declared it to be safe.

Also note that mail bombs have been employed against individuals and organizations for purposes of revenge, extortion, and terrorism. Consider the following tips to identify mail bombs:

1. Mail bombs have been contained in letters, books, and parcels of varying sizes, shapes and colors.
 - a) Letters may feel rigid and appear uneven or lopsided, or bulkier than normal.
 - b) Oil stains may be present on the wrapper.
 - c) Excessive amounts of postage stamps may be used.

- d) The sender may be unknown.
- e) No return address may be given.
- f) The address may be prepared to ensure anonymity of sender (i.e., homemade labels, cut and paste lettering).
- g) The package may have a restricted endorsement such as "Personal" or "Private."
- h) The addressee normally does not receive personal mail at the office.
- i) The name and title of addressee may not be accurate.
- j) The mailing may emit a peculiar odor.
- k) The mailing may appear to be disassembled or re-glued.
- l) The handwriting may appear distorted or foreign.
- m) Protruding wires, tinfoil, or string may be present.
- n) Pressure or resistance may be noted when removing the contents.

If a mail bomb is suspected, follow steps 2 – 7 above to alert law enforcement and evacuate the immediate area.

Terrorism

The following applies to incidents involving shooting or hostage taking.

1. **RUN.** Escape from scene if possible. Call 9-911 at your earliest opportunity.
 - a) Take as many others with you as possible. If someone refuses to escape with you, leave them. Failure to escape when possible increases number of victims.
 - b) Keep your hands up and open. Display to responding Law Enforcement personnel that you are not the shooter.
 - c) Take direction from Law Enforcement personnel as to where to run to.
2. **HIDE.** Barricade yourself and others in safe area.
 - a) For inward-opening doors, use furniture and equipment to block entry.
 - b) Secure outward opening doors with belts, physical strength, or anything which will prevent door from being pulled open.
 - c) Try to stay away from doors as much as possible to prevent injury if shots are fired at door.
 - d) Turn lights off.
 - e) Silence cell phones. Stay silent.
3. **FIGHT.** If an intruder breaches your area and you cannot run, **FIGHT TO SURVIVE!**
 - a) Yell, throw anything you can at the shooter, and do anything you can to disrupt the shooter's concentration. Get others to follow your lead.
 - b) Attempt to disarm, distract, disable, and contain the shooter.
 - c) Engage violently to stop the shooter from killing or injuring more victims.

- d) If you are able to disarm the shooter, DO NOT CARRY THE WEAPON IN YOUR HANDS. Law Enforcement personnel may mistake you for the shooter. Put the weapon in a trash can or other receptacle to make it clear that you are not the shooter.

Physical Threat to Staff

1. When a threat is made, there are four primary considerations:
 - a) Does the mental condition of the individual making the threat warrant considering the threat to be serious?
 - b) Can the intended victim(s) be warned?
 - c) Are there others, in addition to the intended victim(s), who are directly or indirectly endangered by the threat?
 - d) What steps can be taken to safeguard the welfare of potential victims, the patient, and/or the individual making the threat?
2. Assess the individual making the threat:
 - a) To determine the seriousness of the threat, staff who are familiar with the individual making the threat should be involved whenever possible.
 - b) The RN Team Leader will be responsible for assessment of the individual and direction of staff on site, as with all immediate emergencies. If a weapon is involved, or if serious injury has been done, staff should call 9-911.
 - c) In all communication with the individual making the threat, staff will make every possible attempt to defuse the threat.
 - d) When the assessment of the individual making the threat is complete, to the extent possible under the circumstances, the staff conducting the assessment will communicate all relevant information to the program supervisor or designee.
 - e) The staff conducting the assessment will complete a written Unusual Occurrence Incident Report (Attachment J), which will be forwarded to the PHF Leadership.
 - f) The PHF Leadership will contact the Behavioral Wellness Medical Director, Quality Care Manager, and Assistant Director by telephone as soon as possible.
3. The PHF Leadership is responsible for determining and implementing appropriate security precautions in order to minimize the risk of harm to staff, patients, and the public.
 - a) The PHF Leadership should also determine and implement appropriate steps to minimize potential psychological and emotional harm to patients, staff, potential victims, and others who may be affected by the threat or actual violence.

Physical Violence

1. In the event of physical assault, the goal of any act of self-defense will be to de-escalate the individual while avoiding physical harm to the individual and injury to the self. Staff shall implement non-violent physical intervention techniques taught in the Crisis Prevention Institute's Non-violent Physical Crisis Intervention course.
2. Staff should escape the scene until sufficient numbers of trained personnel are assembled to physically or mechanically restrain the assaultive individual.

3. Tactics taught in Restraint/Seclusion training will be employed to safely control the patient in the least restrictive manner possible to effect safety for all.
4. Documentation after the event will be consistent with the PHF's policy "Seclusion and Restraint".
5. In the event that the physical violence exceeds the containment potential of staff, staff will call 9-911 immediately to obtain assistance from law enforcement.

Physical Threats to Others

Assess the situation quickly but thoroughly:

1. Is the scene physically safe to enter or be near?
2. Is anyone in immediate proximity injured?
3. Is the perpetrator speaking? Coherent? Hallucinating?
4. Is the perpetrator responsive to dialogue?
5. Does the perpetrator have significant requests/demands?
6. Deescalate/decelerate if possible.
7. Call 9-911 if you have exhausted resources.

Threats to Self (Client)

Any patient who has made a suicide attempt or presents an imminent threat of self-injurious/suicidal behavior will immediately be engaged by staff in the least restrictive manner possible which protects the patient.

If an individual verbalizes, or otherwise demonstrates that they are an imminent threat to themselves, the person identifying the self-destructive threat will maintain visual contact with patient while notifying the RN Team Leader to request formal assessment of risk. A whistle will be used if immediate assistance is required to keep the patient safe. A psychiatrist will provide direction and Doctor's Orders declaring level of observation required to ensure patient safety.

Verbal Abuse to Staff

1. Remain calm.
2. Assess the situation in terms of demand from the client and degree of dangerousness.
3. Attempt to deescalate/decelerate the situation using CPI techniques and clinical expertise.
4. Request additional staff if needed.
5. Request law enforcement assistance if needed.

IX. Miscellaneous Hazards

VIP (Very Important Person)

A VIP might enter the facility as a patient or the visitor of a patient. In concert with VIP's request or direction:

1. Protect the VIP from the media. Do not respond to questions from the press, as answers might compromise HIPAA.
2. Refer media requests to the Department's Public Information Officer (PIO). The PIO will oversee media response, notification and messaging as appropriate to ensure patient and visitor privacy.
3. Provide for privacy. Enable the individual to participate in treatment, without regard to their celebrity status, and receive care in the same manner as any other patient admitted to the PHF.
4. Refer to department Policy #10.009- Restricted access to Consumer Information for additional information.

Civil Disturbance

1. Summon law enforcement if the building is threatened or compromised.
2. Maintain perimeter security by keeping doors locked.
3. Ensure safe staff ingress/egress using escorts.
4. Calm and reassure patients, visitors, and staff.

Labor Action

If normal PHF staffing methods are disrupted by a labor action, reference the Emergency Staffing policy (Attachment E).

1. Deny access to disruptive/antagonistic County personnel.
2. Call 9-911 as required to protect integrity of building or to report damage or breach of building.
3. Remove patients from visual/auditory access to disruptive personnel.

Forensic Admission:

Persons admitted under Penal Code 1370 (hereafter "1370 patients") will be cared for under the same policies and rules as non-penal code inpatient admissions; they are subject to the same PHF rules of therapeutic engagement, visiting, contraband, and Patient Rights Advocate services.

1. No Sheriff Department's custodial staff are required; however, PHF staff may request law enforcement presence on a case-by-case basis.
2. Designated Behavioral Wellness staff may escort the patient to Court and medical appointments.
3. Patients committed under P.C. 1370 are released or transferred exclusively by Superior Court order.
4. Physical or mechanical restraints of 1370 patients are no different than for civil commitment patients.

Persons admitted under Penal Code 4011.6 (hereafter "4011.6 admissions") remain under the custodial care of the Sheriff.

1. Deputized custodial personnel are required to be in attendance of all 4011.6 patients.
2. Custodial staff are to transport 4011.6 patients whenever they are off the unit.

3. 4011.6 patients are obligated to follow PHF rules of therapeutic engagement, visiting, contraband, and Patient Rights Advocates.
4. Physical control and containment of 4011.6 patients is the responsibility of custodial personnel.

Hostage Situation

1. Internal Hostage Taken:
 - a) CALL 9-911. Identify the situation as an “internal” hostage situation.
 - b) Attempt third party engagement to deescalate the perpetrator. Encourage perpetrator to come out and talk.
 - c) Do not permit perpetrator to exit with hostage. The hostage is at greater risk once escape has occurred; the hostage becomes a liability to perpetrator once outside security.
2. External Hostage Taken:
 - a) Maintain visual contact with perpetrator and victim for as long as possible.
 - b) Secure license plate number of perpetrator’s vehicle.
 - c) CALL 9-911. Identify the situation as an “external” hostage situation.
 - d) Take and write description of perpetrator, including sex, age, height, weight, clothing, and facial hair.
 - e) Describe victim, including sex, age, height, weight, clothing, and facial hair.

Shelter in Place

See the Emergency Subsistence Management policy (Attachment F) and the Shelter in Place during Emergency Policy (Exhibit I) for information on water supplies and restricted use/rationing of water. If water supply is operational, but running out:

1. Restrict shower use to 5 minutes per person per day.
2. Encourage judicious use of toilet flushing.

Electrical Supply Failure

For information on the PHF's generator, and on critical systems which remain functioning during a power outage, see the Emergency Subsistence Management policy (Attachment F).

1. In the case of a power outage, emergency flood lights will activate immediately.
2. The back-up generator will automatically start within 15 seconds. Red outlets are powered by the generator and found throughout the unit.
3. Fire detection systems and most plumbing will remain functioning.
4. If it is daytime, move patients to naturally lighted areas.
5. Notify General Services’ maintenance personnel.

Water Supply Failure

1. If announced as a pre-planned outage, take direction from Facilities Manager and/or General Services.
2. If unplanned, contact emergency maintenance personnel: (805) 896-2916.
3. Distribute portable water provision to patients as needed, and as outlined in the Emergency Subsistence Management policy (Attachment F).
4. Prevent patients from drinking potentially contaminated water.

Sewer Failure

1. Evacuate patients and staff from contaminated areas of the unit.
2. Dam/divert drainage of sewage overflow away from areas of patient access.
3. Notify Emergency Maintenance: (805) 896-2916.
4. See the Emergency Subsistence Management policy (Attachment F) for alternate sewage disposal procedures.

Fire Alarm Failure

1. Notify Team Lead and Facilities Manager immediately of any sudden failure.
2. The PHF Manager will contact the Facilities Manager and, if necessary, the fire alarm contractor to make repairs.
3. Staff will begin 30 minute rounds of all areas of unit to watch for fire until the system is repaired.

X. General Precautions

Security Responses

The RN Team Leader/PHF Leader is responsible for determining and implementing appropriate security precautions in order to minimize the risk of harm to staff, patients, and the public. Depending on the specific situation, security precautions may include, but are not limited to, such steps as:

1. Locking all outside doors and stationing a staff member at one or more entrance to screen individuals who wish to enter the building.
2. Locking inside doors.
4. Contacting law enforcement for advice and assistance, providing law enforcement with all available information regarding the individual making the threat, the threats received, and information regarding potential victims.
5. When an identified hazard may impact surrounding buildings, notify the County Physical Security Coordinator and Public Health Department Security Officer (Triumph Security) and Director of Public Health. (See section III. Emergency Services Contacts)
6. Clearing and closing the building if necessary.

7. Maintaining close communication with staff in the program as well as Behavioral Wellness Administration.
8. The PHF Leadership should also determine and implement appropriate steps to minimize potential psychological and emotional harm to patients, staff, potential victims, and others who may be affected by the threat or actual violence.

Personal and Office Safety

1. Furnish/arrange office with safety in mind.
 - a) Avoid having objects on desk that can be used to harm personnel, e.g., heavy objects, sharp objects, etc.
 - b) Place desk and chair to allow for easy exit for staff as well as for the client.
 - c) Leave office doors open when unsure of client's potential for violence or see client in a visible interviewing space with other staff nearby and aware of the situation.

XI. General Safety (Employee's Responsibilities)

1. Stay alert.
2. Walk, do not run.
3. Horseplay, roughhousing, or practical jokes are **not acceptable**.
4. Report all accidents, no matter how small, to the RN Team Leader.
5. Report all hazardous conditions to the RN Team Leader, including, but not limited to:
 - a) Spills on floors and/or carpets
 - b) Torn or loose carpeting or linoleum
 - c) Broken or loose handrails, doorknobs, guardrails, drawer handles, light fixtures, switch plates, or fixtures of any kind
 - d) Leaky faucets, valves or pipes
 - e) Inoperable or malfunctioning equipment of any kind
 - f) Obstructions in the corridors or on the floors of the facility, on the grounds, or in the parking lot, which might cause slipping, falling, tripping or a collision
 - g) Any improperly placed equipment, medications or supplies
 - h) Any client, visitor, or staff member who is involved in an unsafe activity of any kind
 - i) Any unusual occurrence that you feel might lead to an accident, incident or an otherwise harmful result
6. Wear proper clothing.
7. Know the proper and safe lifting method: in lifting any heavy object, you should get as close to the object as possible and plant your feet firmly and slightly apart. Keeping spine straight, bend at the knees and bring weight up against the body; using the thigh muscles, lift the object, making sure weight is evenly distributed between your two hands.

- a) Use a stepladder to reach objects above you. Never use a box, crate, piece of furniture, or fixture in place of a stepladder, and never step on the top three steps of a stepladder.
 - b) Obtain help to lift, move or reach heavy objects, carts or supplies.
 - c) All movement of dietary Cambro's/utensils, requires two staff members
 - d) Give some kind of warning to staff members and clients when moving objects carts or supplies.
8. Attend safety meetings/trainings.
 9. Know basic first aid methods and how to employ them.
 10. Pull electrical cords out by the plug; never yank them out from the outlet.
 11. Close any drawers or cupboards you see that are open and unattended.
 12. Place any equipment you use out of the line of traffic.

Use common sense in any task you do. Safety procedures must be used constantly and continually to be effective. Failure to follow safety procedures and policies or to report an unsafe condition could result in disciplinary action.

XII. Emergency Medical Protocol

If a medical emergency is reported, follow the Emergency Medical Condition policy (Attachment C).

1. Dial 9-9-1-1 and request an ambulance. Provide the following information:
 - Number and location of victim(s)
 - Nature of injury or illness
 - Hazards involved
 - Nearest entrance (emergency access point)
 - Alert trained employees to respond to the victim's location and bring a first aid kit or AED.

All Licensed Nursing Personnel and Recovery Assistants are trained to administer first aid, CPR, or use Automated External Defibrillator (AED).

Locations of First Aid Kits and Automated External Defibrillator(s)

Locations of First Aid Kits and "Standard Precautions" kit (used to prevent exposure to body fluids)	Emergency Food Storage Shed. Medication Room
Locations of Automated External Defibrillator(s) (AEDs)	Nursing Station

- Responders should provide first aid assistance as indicated per level of experience and training.
- Do not move the victim unless the victim's location is unsafe.
- Control access to the scene.
- Follow "standard precautions" to prevent contact with body fluids and exposure to blood borne pathogens.
- Meet the ambulance at the nearest entrance or emergency access point; direct them to victim(s).

XIII. Employee or Public Accident or Incident Procedures

Should a client or visitor be involved in an accident or harmful incident or otherwise require emergency care, the following procedures apply:

1. The first staff member to discover that the person needs help should do the following:
 - a) Go to the person and give any immediate aid that is needed. Practice safety precautions.
 - b) Summon assistance from medical personnel on site.
 - c) Without moving person, try to make them as comfortable as possible and cover them with a blanket.
 - d) Remove all objects near the person that may cause further harm.
 - e) Call ambulance or 9-911 as needed.
2. When medical personnel arrive:
 - a) If there is blood contamination, follow the PHF's Standard Precautions Policy.
 - b) DO NOT TOUCH ANYTHING CONTAMINATED WITH BLOOD WITHOUT SAFETY GLOVES!
3. Complete Unusual Occurrence Incident Report procedures (Attachment J).

XIV. Attachments

- A. 2020 All Hazards Assessment
 1. Events Involving Hazardous Material
 2. Human Related Events
 3. Naturally Occurring Events
 4. Technologic Events
- B. Emergency Facility Evacuation policy
- C. Emergency Medical Condition policy
- D. Emergency Patient, Staff, and Visitor Tracking policy
- E. Emergency Staffing policy
- F. Emergency Subsistence Management policy

- G. Emergency Transfer Agreements with Other Facilities policy
- H. Emergency Medical Documentation Management policy
- I. Shelter in Place During Emergency policy
- J. Unusual Occurrence Incident Report policy
- K. Seclusion & Restraint Policy
- L. Standard Precautions Policy

HAZARD AND VULNERABILITY ASSESSMENT TOOL EVENTS INVOLVING HAZARDOUS MATERIALS

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE – MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPAREDNESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	<i>Likelihood this will occur</i>	<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interruption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resources</i>	<i>Community/ Mutual Aid staff and supplies</i>	Relative Threat*
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0-100%
Mass Casualty Hazmat Incident (From historic events at your MC with ≥ 5)	0	0	0	0	0	0	0	0%
Small Casualty Hazmat Incident (From historic events at your MC with ≤ 5)	0	0	0	0	0	0	0	0%
Chemical Exposure, External	0	0	0	0	0	0	0	0%
Small-Medium Sized Internal Spill	1	1	1	0	1	1	1	9%
Large Internal Spill	0	0	0	0	0	0	0	0%
Terrorism, Chemical	0	0	0	0	0	0	0	0%
Radiologic Exposure, Internal	1	0	0	0	0	0	0	0%
Terrorism, Radiologic	0	0	0	0	0	0	0	0%
AVERAGE	0.22	0.11	0.11	0.00	0.11	0.11	0.11	0%

* Threat increases with percentage.

RISK = PROBABILITY * SEVERITY		
0.00	0.07	0.03

**HAZARD AND VULNERABILITY ASSESSMENT TOOL
HUMAN RELATED EVENTS**



EVENT	PROBABILITY	SEVERITY = (MAGNITUDE – MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPAREDNESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	Relative Threat*
	<i>Likelihood this will occur</i>	<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interruption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resources</i>	<i>Community/Mutual Aid staff and supplies</i>	
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0-100%
Mass Casualty Incident (trauma)	0	0	0	0	0	0	0	0%
Mass Casualty Incident (medical/infectious)	2	1	1	2	1	1	1	26%
Terrorism Biological	0	0	0	0	0	0	0	0%
VIP Situation	2	1	1	1	1	1	1	22%
Infant Abduction	0	0	0	0	0	0	0	0%
Hostage Situation	1	1	1	1	1	1	1	11%
Civil Disturbance	1	1	1	2	1	1	1	13%
Labor Action	1	1	1	1	1	1	1	11%
Forensic Admission	3	1	1	1	1	1	1	33%
Bomb Threat	1	1	1	1	1	1	1	11%
AVERAGE	1.10	0.70	0.70	0.90	0.70	0.70	0.70	

* Threat increases with percentage.

RISK = PROBABILITY * SEVERITY		
0.10	0.37	0.27

Updated 6.2020

HAZARD AND VULNERABILITY ASSESSMENT TOOL NATURALLY OCCURRING EVENTS



EVENT	PROBABILITY	SEVERITY = (MAGNITUDE – MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPAREDNESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	Relative Threat*
	<i>Likelihood this will occur</i>	<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interruption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resources</i>	<i>Community/Mutual Aid staff and supplies</i>	
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0-100%
Hurricane	0	0	0	0	0	0	0	0%
Tornado	0	0	0	0	0	0	0	0%
Severe Thunderstorm	1	1	1	1	2	2	2	17%
Snow Fall	0	0	0	0	0	0	0	0%
Blizzard	0	0	0	0	0	0	0	0%
Ice Storm	0	0	0	0	0	0	0	0%
Earthquake	2	1	1	1	1	1	1	22%
Tidal Wave	0	0	0	0	0	0	0	0%
Temperature Extremes	1	1	0	0	2	2	0	9%
Drought	2	0	0	0	1	1	1	11%
Flood, External	1	0	0	3	1	1	1	11%
Wild Fire	3	1	1	1	1	1	1	33%
Landslide	1	0	0	3	1	1	1	11%
Dam Inundation	0	0	0	0	0	0	0	0%
Volcano	0	0	0	0	0	0	0	0%
Epidemic	2	2	1	2	1	1	1	30%
AVERAGE	0.81	0.38	0.25	0.69	0.63	0.63	0.50	

* Threat increases with percentage.

RISK = PROBABILITY * SEVERITY		
0.05	0.27	0.17

Updated 6.2020

HAZARD AND VULNERABILITY ASSESSMENT TOOL TECHNOLOGIC EVENTS



EVENT	PROBABILITY	SEVERITY = (MAGNITUDE – MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPAREDNESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	<i>Likelihood this will occur</i>	<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interruption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resources</i>	<i>Community/Mutual Aid staff and supplies</i>	Relative Threat*
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0-100%
Electrical Shortage	1	1	1	1	1	1	1	11%
Generator Failure	1	1	1	1	1	1	1	11%
Transportation Failure	1	0	0	0	0	3	3	11%
Fuel Shortage	0	0	0	0	0	0	0	0%
Natural Gas Failure	0	0	0	0	0	0	0	0%
Water Failure	1	1	1	1	1	1	1	11%
Sewer Failure	1	1	1	1	1	1	1	11%
Steam Failure	0	0	0	0	0	0	0	0%
Fire Alarm Failure	1	1	1	1	1	1	1	11%
Communications Failure	2	1	1	1	1	1	1	22%
Medical Gas Failure	0	0	0	0	0	0	0	0%
Medical Vacuum Failure	0	0	0	0	0	0	0	0%
HVAC Failure	1	1	1	1	1	1	1	11%
Information System Failure	1	1	1	2	1	1	1	13%
Fire, Internal	1	1	1	1	1	1	1	11%
Flood, Internal	1	1	1	1	1	1	1	11%
Hazmat Exposure, Internal	0	0	0	0	0	0	0	0%
Supply Shortage	1	1	1	1	1	1	1	11%
Structural Damage	1	1	1	1	1	1	1	11%
AVERAGE	0.74	0.63	0.63	0.68	0.63	0.79	0.79	

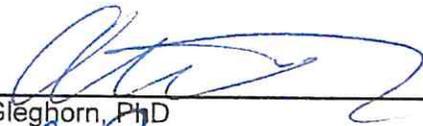
* Threat increases with percentage.

RISK = PROBABILITY * SEVERITY		
0.06	0.25	0.23



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	<u>12/4/17</u>
Medical Director's Approval	 _____ Ole Behrendtsen, MD	Date	<u>12-13-17</u>
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.

Attachment B

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.

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

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 (*contact PHF Safety Officer for most recent version*)

PHF Emergency Communication Plan (*contact PHF Safety Officer for most recent version*)

[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:	2/28/2018
Sub-section	Crisis and Emergency Response	Version:	1.0
Policy	Emergency Medical Documentation Management	Last Revised:	New policy
Director's Approval	 _____ Alice Gleghorn, PhD	Date	3/8/18
Medical Director's Approval	 _____ Ole Behrendtsen, MD	Date	3.9.18
Supersedes:	New policy	Audit Date:	2/28/2019

1. PURPOSE/SCOPE

- 1.1. To ensure compliance with the Centers of Medicare & Medicaid Services (CMS) Emergency Preparedness Final Rule (42 CFR 482.15) and all other applicable federal, state and local laws.
- 1.2. To ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), Privacy and Security Rules (45 CFR Parts 160 and 164), Welfare and Institutions Code Section 5328, and all other laws and regulations that protect the privacy and security of a patient's Protected Health Information (PHI).

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.
- 2.2. **Business associate** – a person who provides services to a health care provider or health plan for health care operations purposes but who is not considered a member of that entity's workforce. Further definition can be found in 45 CFR 160.103.

Attachment C

3. **POLICY**

- 3.1. In an emergency that threatens or restricts the usual functions of the facility, the PHF shall maintain a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.
- 3.2. The PHF shall maintain a method for sharing information and medical documentation for patients under the facility's care with emergency response personnel and other health care providers to maintain continuity of care.

4. **PATIENT INFORMATION**

- 4.1. HIPAA and state law requirements are not suspended during a community-wide, public health or national emergency. PHF staff shall uphold all laws and Department policies pertaining to the handling of PHI.
- 4.2. Pertinent patient information must be readily available and accurate. To support continuity of care during an emergency, this information must be shareable to providers of emergency medical care and to officials considered business associates. Critical information will be immediately accessible via the [Patient Critical Information form \(see Attachment A\)](#) and the patient's Medication Administration Record (MAR). This information includes, but is not limited to:
 1. Patient name, age, and date of birth.
 2. Current medications and allergies.
 3. Current diagnosis(es).
 4. Reason for admission to the PHF.
 5. Acuity status and precautions (i.e. trauma, elopement).
 6. Family, legal representative, or next-of-kin emergency contact information.

5. **TRANSPORT AND TRANSFER OF PATIENT MEDICAL RECORDS**

- 5.1. In case of evacuation, the PHF Team Leader will assign staff to gather and secure paper-based medical record charts for transport. All charts will be transported in containers or a carrying case that conceals information (i.e. name, date of birth not visible), restricts access to unauthorized individuals, and safeguards the record from damage (e.g. water damage due to flooding conditions).
- 5.2. In case of transfer to another facility or location, critical patient information will be compiled into a transfer packet. If the emergency situation allows no time to create a full transfer packet, the patient MAR and [Patient Critical Information form \(see Attachment A\)](#) or other brief summary of critical information will accompany the patient to the receiving facility or location.

1. Patient transfers and transfer of medical records will be documented on the Patient Emergency Tracking Log.¹

6. EMERGENCY ACCESS TO ELECTRONIC MEDICAL RECORDS

- 6.1. Santa Barbara County has established a primary data center located at the Emergency Operations Center (EOC) that houses data backups of PHF electronic health records. A secondary data center is located in Santa Maria. The PHF is identified as a priority system within the county to allow prompt efforts to restore electronic medical record systems in as timely a manner as possible.
- 6.2. The Department's Information Technology (IT) division is responsible for the maintenance, security, and retrieval of electronic medical record information in the event of an emergency, including extracting information from data backups located at the EOC.

ATTACHMENTS

[Attachment A – Patient Critical Information form](#)

REFERENCE

Code of Federal Regulations – Condition of Participation: Emergency Preparedness
Section 482.15(b)(5), Section 482.15(c)(4)

Code of Federal Regulations – Health Insurance Portability and Accountability Act (HIPAA)
Title 42, Parts 160, 164

California Welfare & Institutions Code
Section 5328(a)(24)-(25)

RELATED DOCUMENTS AND POLICIES

PHF Emergency Response Plan (*contact PHF Safety Officer for most recent version*)

PHF Emergency Communication Plan (*contact PHF Safety Officer for most recent version*)

[Emergency Medical Condition](#)

[Emergency Patient, Staff, and Visitor Tracking](#)

[Emergency Facility Evacuation](#)

[Shelter-in-Place During Emergency](#)

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

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION

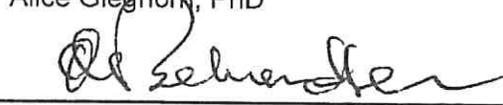
Culturally and Linguistically Competent Policies

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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	1/16/18
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.

Attachment D

- 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 (*contact PHF Safety Officer for most recent version*)

PHF Emergency Communication Plan (*contact PHF Safety Officer for most recent version*)

[Emergency Facility Evacuation](#)

[Shelter-in-Place During Emergency](#)

[Emergency Transfer Agreements with Other Facilities](#)

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION

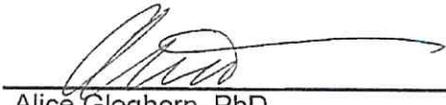
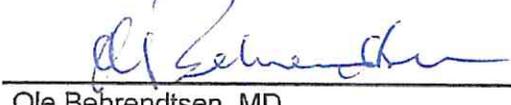
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SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

**Programmatic
Policy and Procedure**

Section	Psychiatric Health Facility (PHF)	Effective:	2/28/2018
Sub-section	Crisis and Emergency Response	Version:	1.0
Policy	Emergency Staffing	Last Revised:	New policy
Director's Approval	 _____ Alice Gleghorn, PhD	Date	<u>3/8/18</u>
Medical Director's Approval	 _____ Ole Behrendtsen, MD	Date	<u>3.7.18</u>
Supersedes:	New policy	Audit Date:	2/28/2019

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 industry standards, and all other applicable federal, state and local laws.
- 1.2. To ensure that, in the event of an emergency affecting the Santa Barbara County Psychiatric Health Facility (hereafter "PHF"), adequate staff will be present to provide appropriate care for patients.

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.
- 2.2. **Disaster** – the effects of natural, manmade, or war-caused emergency which results in extreme peril to life, property, and resources, or conditions that are beyond the control of the resources of the affected area and require combined forces of mutual aid. [California Government Code, Section 8558]

Attachment E

3. POLICY

- 3.1. In the event of an emergency or disaster, a heightened level of staffing may be required at the PHF to respond to unsafe conditions, to conduct evacuations and/or patient transfers to other facilities, and to provide additional support and care to patients. Due to the scope of an emergency or disaster, some members of PHF staff may be directly impacted by disaster or emergency conditions, or their ability to travel may be impacted. In any situation where a heightened level of staffing is needed to respond to an emergency situation, the PHF shall follow established systems described below to obtain emergency staffing.

4. STAFFING LEVEL MANAGEMENT

- 4.1. If a heightened level of staffing is required at the PHF to respond to an emergency or disaster, the PHF Team Leader will take the necessary steps to address staffing levels. The Team Leader will consult the Staffing Decision Tree (see Attachment A) and follow the procedural steps to attain the required staffing. The Staffing Decision Tree identifies the pool of possible emergency staff as follows:
 1. Extra-help (EXH) staff of the PHF and Behavioral Wellness Crisis Stabilization Unit (CSU)
 2. Civil service staff of the PHF, regardless of full-time or part-time status
 3. Civil service staff within Behavioral Wellness, regardless of job role
 4. Staff from contracted vendors such as Maxim

5. USE OF DISASTER RELIEF PERSONNEL

- 5.1. In the event that an emergency exceeds the capacity of existing personnel, the PHF will use the following guidance to determine the order in which additional resources may be drawn from outside sources:
 1. Departmental resources
 2. Law Enforcement
 3. Emergency Medical Services
 4. County Office of Emergency Management
 5. State resources
 6. Federal resources in a manner prescribed by the National Incident Management System (NIMS)
- 5.2. By State law, in the event of a disaster, all public employees (all persons employed by any county, city, state agency or public district) have a responsibility to serve as disaster service workers. This includes all PHF staff and all Department employees. Public employees must assist with any disaster service activities assigned by their supervisors or by law. This means that, should the PHF be affected by a disaster, all PHF staff and

all employees of the Department can be called upon to provide assistance beyond the usual scope of their employment. [California Government Code, Sections 3100 and 3101]

- 5.3. In the event of a catastrophic disaster, the PHF may require the assistance of volunteers from disaster relief organizations. The PHF will coordinate with the co-located Public Health Department to obtain services or staff volunteers from affiliated local, state, and federal health care organizations (e.g. the Santa Barbara County Red Cross or the Medical Reserve Corps).

6. **VOLUNTEERS**

- 6.1. As part of usual operations, volunteers from recovery-focused and other relevant organizations (e.g. Alcoholics Anonymous) may provide ancillary services at the PHF. These volunteers are not considered part of core staffing. In an emergency or disaster situation, these volunteers may continue to act in their ancillary roles, but will not act as core staff.
- 6.2. Due to the nature of PHF services and operations, the PHF will not utilize community volunteers to fill core staffing needs. The PHF is an acute mental health facility serving a small patient population to which an emergency or disaster situation may be severely disruptive and destabilizing. Because of this, the PHF has determined that it is most practical and appropriate to draw on internal staffing processes and on arrangements with contracted providers to fill core staffing needs.

ATTACHMENTS

[Attachment A – Staffing Decision Tree](#)

REFERENCE

California Government Code
Sections 3100, 3101, 8558

Code of Federal Regulations – Condition of Participation: Emergency Preparedness
Section 482.15(b)(6)

Federal Emergency Management Agency – National Incident Management System
Retrieved from: <https://www.fema.gov/national-incident-management-system>

RELATED POLICIES/DOCUMENTS

PHF Emergency Response Plan (*contact PHF Safety Officer for most recent version*)

PHF Emergency Communication Plan (*contact PHF Safety Officer for most recent version*)

[Acuity Staffing](#)

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION

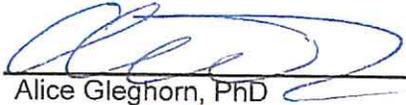
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SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

**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	<u>12/4/17</u>
Medical Director's Approval	 _____ Ole Behrendtsen, MD	Date	<u>12-03-17</u>
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.

Attachment F

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 dietitians.

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 (*contact PHF Safety Officer for most recent version*)

PHF Emergency Communication Plan (*contact PHF Safety Officer for most recent version*)

[Disaster and Emergency Supplies for Dietary Services](#)

[Fire Watch Program](#)

[Emergency Patient, Staff, and Visitor Tracking](#)

[Emergency Transfer Agreements with Other Facilities](#)

[Emergency Transfer Agreements with Other Facilities](#)

REVISION RECORD

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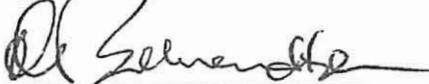
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SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

**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.

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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.

Attachment G

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 (*contact PHF Safety Officer for most recent version*)

PHF Emergency Communication Plan (*contact PHF Safety Officer for most recent version*)

[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
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	<ul style="list-style-type: none"> • 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.

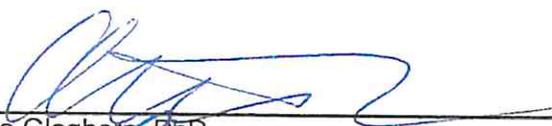
Culturally and Linguistically Competent Policies

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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	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 (*contact PHF Safety Officer for most recent version*)

PHF Emergency Communication Plan (*contact PHF Safety Officer for most recent version*)

[Emergency Facility Evacuation](#)

[Disaster and Emergency Supplies for Dietary Services](#)

[Emergency Subsistence Management](#)

[Emergency Patient, Staff, and Visitor Tracking](#)

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

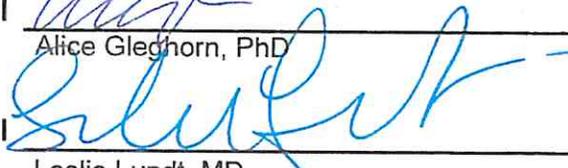
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SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

**Programmatic
Policy and Procedure**

Section	Psychiatric Health Facility	Effective:	4/6/2011
Sub-section	Administration and Management		
Policy	Unusual Occurrence Reporting	Last Revised:	1/4/2017
Policy #			
Director's Approval	 _____ Alice Gleghorn, PhD	Date	1/10/17
PHF Medical Director's Approval	 _____ Leslie Lundt, MD	Date	1/18/17
Supersedes:	NG and L – Incident Reports	Audit Date:	1/4/2020

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, Welfare and Institutions Code §15610.63, §15658 and §15630, and the Code of Federal Regulations, Title 42, §482.13(g)(1)(i-iii).
- 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 nonconsenting¹;
- 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 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.

5. PATIENT DEATH FOLLOWING SECLUSION AND RESTRAINT

- 5.1. The PHF must report the following information by fax to DHCS and the California Department of Public Health (CDPH) no later than the close of business on the next business day following knowledge of the patient's death:
 1. Each death that occurs while a patient is in restraint or seclusion.
 2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
 3. Each death known to the hospital that occurs within one (1) week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.
- 5.2. 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 DHCS and the California Department of Public Health (CDPH). CDPH will be contacted by phone within 24 hours of the patient's death at (805) 604-2926 or (800) 547-8267.
- 5.3. 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

California Code of Regulations
 Title 22, Sections 77036 and 77137

Welfare and Institutions Code
 Sections 15610.63, 15658 and 15630

Code of Federal Regulations – Conditions of Participation: Patient’s Rights
 Title 42, Section 482.13(g)(1)(i-iii)

ATTACHMENTS

- A. [Unusual Occurrence Incident Report](#)
- B. [24 Hour Unusual Occurrence Incident Report](#)

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION
12/15/16	1.2	<ul style="list-style-type: none"> • Clarified reporting requirements for patient death following seclusion and restraint

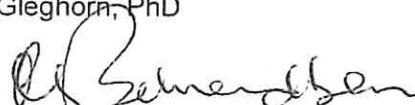
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SANTA BARBARA COUNTY
DEPARTMENT OF
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A System of Care and Recovery

**Programmatic
Policy and Procedure**

Section	Psychiatric Health Facility (PHF)	Effective:	4/7/2014
Sub-section	Crisis and Emergency Response	Version:	3.0
Policy	Seclusion and Restraint	Last Revised:	4/24/2019
Director's Approval	 _____ Alice Gleghorn, PhD	Date	<u>5/3/19</u>
PHF Medical Director's Approval	 _____ Ole Behrendtsen, MD	Date	<u>4.30.19</u>
Supersedes:	Seclusion and Restraint rev. 5/31/2017		
Approvals:	PHF Medical Practice Committee: 4/24/2019	PHF Governing Board:	4/24/2019

1. PURPOSE/SCOPE

- 1.1. To ensure the use of seclusion and restraints at the Santa Barbara County Psychiatric Health Facility (hereafter the "PHF") are in accordance with the requirements set forth in Sections 1180 *et seq.* of the California Health and Safety Code; the California Code of Regulations, Title 22, Division 5, Chapter 9; the Centers for Medicare & Medicaid (CMS) Conditions of Participation for Hospitals codified in the Code of Federal Regulations, Title 42, Part 482; and all other applicable state and federal laws and standards of professional practice.

2. DEFINITIONS

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

- 2.1. **Violent behavior** – physically aggressive or self-destructive behavior that jeopardizes the immediate safety of the patient, a staff member or others.
- 2.2. **Seclusion** – the involuntary confinement of a patient alone in a locked room or an area from which the patient is physically prevented from leaving for the purposes of modifying a behavior. Seclusion may only be used for the management of violent or self-destructive behavior. Seclusion does not include a timeout or exclusion timeout. [HSC §1180.1(e); 22 CCR §77029; 42 CFR §482.13(e)(1)(ii)]
- 2.3. **Exclusion timeout** – removing a patient from an activity to another area in the same room or vicinity for a period of time contingent on a specific maladaptive behavior. [22 CCR §77010]
1. Exclusion timeout is voluntary and may be patient-initiated or staff-directed. During exclusion timeout, the patient is not physically prevented from leaving the designated area; both the patient and staff collaboratively determine when the patient has

regained self-control and is able to return to the treatment milieu. When staff do not permit the patient to leave a room because the patient thinks he or she is calm but the staff disagree, then the exclusion timeout becomes a seclusion.

- 2.4. **Restraint (also known as “behavioral restraint”)** – any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. A restraint does not include: (1) certain devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, (2) other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm, and (3) a physical escort as defined in Section 2.7 of this policy. [HSC §1180.1(a); 42 CFR §482.13(e)(1)(i)(A) & (C)]
- 2.5. **Mechanical restraint** – the use of a mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove, and that restricts the freedom of movement of all or part of a patient's body or restricts normal access to the patient's body. Mechanical restraint is used only as an emergency psychiatric intervention when a patient exhibits violent behavior. The PHF utilizes mechanical bed restraints exclusively. [HSC §1180.1(c)]
- 2.6. **Physical restraint/hold** – any manual or physical method of holding the patient against the patient's will that restricts freedom of movement of all or part of a patient's body, or to restrict normal access to patient's body. For example, holding a patient to give a forced psychotropic medication in a manner that restricts his or her movement, even for a matter of seconds, constitutes a physical restraint. Physical restraint does not include briefly holding a patient without force in order to calm or comfort, or physical contact intended to gently assist a person in performing tasks or to guide or assist a person from one area to another. [HSC §1180.1(d)]
- 2.7. **Physical Escort** – using a “light” grasp to escort a patient to a desired location. If the patient can easily remove or escape the grasp, it is not a physical restraint. However, if the patient cannot easily remove or escape the grasp this would be a physical restraint. [CMS State Operations Manual: Appendix A Interpretive Guidelines rev. 183, 10/12/18]
- 2.8. **Chemical restraint** – the use of a medication used to restrict the patient's freedom of movement that is not a standard treatment for the patient's new or continuing medical or behavioral condition.
- 2.9. **Licensed Nursing Staff (LNS)** – an individual employed or contracted by the PHF who holds a valid California license as a: registered nurse (RN); licensed vocational nurse (LVN); or licensed psychiatric technician (LPT).
- 2.10. **Licensed Independent Practitioner (LIP)** – any practitioner permitted by law as having the authority under their license to independently order restraints, seclusion or medications for patients. This includes a doctor of medicine (MD) or osteopathy (DO), or a nurse practitioner (NP).

2.11. **Qualified Registered Nurse (QRN)** – a registered nurse who has received training and demonstrates competency in conducting the one-hour face-to-face evaluation of a patient following seclusion or restraint.

3. POLICY

- 3.1. The PHF is committed to reducing and preventing the use of seclusion and restraint through early identification and intervention of high-risk behaviors or events when possible. Nonphysical interventions are the preferred method of intervention and the use of seclusion and restraint is considered an exception and not a standard of practice.
- 3.2. All patients have the right to be free from physical or mental abuse, and corporal punishment as well as the right to be free from restraint or seclusion of any form imposed as a means of coercion, discipline, convenience, or retaliation by staff. This includes, but is not limited to, the right to be free from the use of a drug used in order to control behavior or to restrict the patient's freedom of movement (i.e., chemical restraints), if that drug is not a standard treatment for the person's medical or psychiatric condition.
[22 CCR §77103(c); HSC §1180.4(k); 42 CFR §482.13(e)]
- 3.3. Restraint or seclusion may only be imposed for behavioral emergencies when a person's behavior presents an imminent danger of serious harm to self or others as a last resort for the management of violent or self-destructive behavior and to ensure the immediate physical safety of the patient, a staff member, or others. Restraint or seclusion shall not be used as an extended procedure and must be discontinued at the earliest possible time.
[22 CCR §77103(a); HSC §1180.4(b & h); 42 CFR §482.13(e)]
- 3.4. Seclusion and restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.
[42 CFR §482.13(e)(2); HSC §1180.4(b)]
- 3.5. Behavioral restraints shall be utilized only with patients being treated pursuant to Welfare and Institutions Code (WIC) Sections 5150 et seq., or patients that have been judicially committed.
[22 CCR §77103(i)]
- 3.6. Patients will be afforded the least restrictive mechanical restraint (i.e., least number of restraint points) and the maximum freedom of movement while ensuring the physical safety of the patient and others. [HSC §1180.4(j); 42 CFR §482.13(e)(3)] Application of mechanical restraints at the PHF will include the use of one (1) of the following:
1. 4-point mechanical restraints; or
 2. 5-point mechanical restraints when necessary to maintain the patient's safety and the use of the chest restraint is not medically contraindicated.
- 3.7. With the exception of during the removal or application of mechanical restraints, or to conduct range of motion exercises, at no time will less than a 4-point mechanical restraint be applied.

- 3.8. Seclusion and restraints are initiated and applied only by trained, qualified staff in accordance with the PHF policy *Staff Orientation and Training for Seclusion and Restraint*. [42 CFR §482.13(f)]
- 3.9. Orders for seclusion and restraint can never be written as a standing order or on an as-needed (PRN) basis. [42 CFR §482.13(e)(6); 22 CCR §77103(e)]
- 3.10. The dignity and privacy of patients will be preserved to the greatest extent during the implementation and monitoring of these interventions. [42 CFR §482.13(c)]
- 3.11. The PHF does not utilize simultaneous seclusion and mechanical restraints, Geri-chair restraints, or walking restraints. Prone restraints (i.e., placing the patient facedown during a restraint) are prohibited.

4. SECLUSION AND RESTRAINT ASSESSMENT AT ADMISSION

- 4.1. Upon admission, an LNS shall assess the patient for seclusion and restraint risk and identify factors that could minimize the use of seclusion/restraint including, but not limited to:
 1. Preventative strategies to mitigate seclusion and restraint;
 2. Identification of early warning signs, triggers, and precipitants that cause a person to escalate, and identification of the earliest precipitant of aggression for persons with known or suspected history of aggressiveness, or persons who are currently aggressive;
 3. Pre-existing conditions or any physical disabilities or limitations that would place the patient at greater risk during restraint or seclusion;
 4. Whether the patient has a behavioral advance directive regarding de-escalation and the use of seclusion and restraints, and ensures that the direct care staff is aware of its content;
 5. Any trauma history, including any history of sexual or physical abuse that the affected patient feels is relevant.
[HSC §1180.4(a)(1)-(5)]
- 4.2. The PHF shall not use physical or mechanical restraint on a person who has a known medical or physical condition and there is reason to believe that the use would endanger the person's life or seriously exacerbate the person's medical condition. [HSC §1180.4(d)]
- 4.3. LNS will document contact information for a family member, domestic partner, significant other, or authorized representative designated by the patient who is contacted if the patient requires use of seclusion and/or restraints. This contact person may also be reached to participate in a debriefing following a seclusion and/or restraint if the patient requests their involvement during the debriefing. [HSC §§1180.4(a) and 1180.5(b)]

5. INITIATION OF PHYSICAL ESCORTS AND PHYSICAL RESTRAINTS

- 5.1. All physical escorts and physical restraints will follow Crisis Prevention and Intervention (CPI) techniques.
- 5.2. Trained staff will apply physical escorts and physical restraints in a humane and therapeutic manner while monitoring the patient for safety and freedom from pain.
- 5.3. If physical restraint is indicated, at least two (2) staff must participate. Physical restraints must be brief and are discontinued as soon as the imminent danger of serious physical harm is mitigated or the patient can be safely transitioned into a more restrictive intervention if required. [HSC §1180.4(h); 42 CFR § 482.13(e)(9)]
- 5.4. Each episode of physical restraint shall be initiated upon the order of a psychiatrist.
 1. In an emergency, PHF staff may initiate a physical restraint as a protective measure provided that a psychiatrist's order is obtained as soon as possible (and when it is safe to do so) after the physical restraint has been applied.
 2. Telephone orders for physical restraint shall be received only by LNS, shall be recorded immediately in the patient's health record and signed by the psychiatrist within 24 hours in accordance with Departmental policy. [42 CFR §482.13(e)(5); 22 CCR §77103(b)]
- 5.5. At no time shall the PHF use a physical restraint technique that obstructs a patient's respiratory airway or impairs the patient's breathing or respiratory capacity, including techniques in which a staff member places pressure on a patient's back or places his or her body weight against the patient's torso or back. At no time shall a pillow, blanket, or other item cover the patient's face as part of a physical restraint. [HSC §1180.4(c)(1)-(2)]
 1. Prone restraints (i.e., placing the patient facedown during a restraint) are prohibited.

6. INITIATION OF SECLUSION OR MECHANICAL RESTRAINT

- 6.1. Each episode of seclusion or mechanical restraint shall be initiated upon the order of a psychiatrist.
 1. In an emergency, the PHF RN Team Leader may initiate a seclusion or mechanical restraint as a protective measure provided that a psychiatrist's order is obtained as soon as possible (and when it is safe to do so) after the seclusion or mechanical restraint has been initiated.
 2. Telephone orders for seclusion or mechanical restraint shall be received only by LNS, shall be recorded immediately in the patient's health record and signed by the psychiatrist within 24 hours in accordance with Departmental policy. [42 CFR §482.13(e)(5); 22 CCR §77103(b)]
- 6.2. Trained staff will apply seclusion or mechanical restraints in a humane and therapeutic manner while monitoring the patient for safety and freedom from pain.

- 6.3. At no time shall a pillow, blanket, or other item cover the patient's face as part of a mechanical restraint. [HSC §1180.4(c)(2)]
 1. Prone restraints (i.e., placing the patient facedown during a restraint) are prohibited.

7. REQUIREMENTS FOR SECLUSION, PHYSICAL OR MECHANICAL RESTRAINTS

- 7.1. The *Physical Restraint, Seclusion or Mechanical Restraint and/or Emergency Medication* form (also known as the *Initial Seclusion or Restraint Record*) shall be completed by LNS immediately upon initiation of the intervention.
- 7.2. As allowed by law and scope of practice, a psychiatrist or other Licensed Independent Practitioner (LIP), Qualified Registered Nurse (QRN), or physician assistant (PA) – collectively referred to as “practitioner” – conducts a face-to-face evaluation of the patient in seclusion, physical or mechanical restraints within one (1) hour of initiation and documents their findings on the *One-Hour Face-to-Face Evaluation* form.
- 7.3. The *One-Hour Face-to-Face Evaluation* form will document the following:
 1. The intervention(s) used;
 2. Justification for seclusion, physical or mechanical restraint;
 3. Alternatives or other less restrictive interventions attempted (as applicable);
 4. The patient's response to the intervention;
 5. Evaluation of the patient's immediate situation and medical and behavioral condition; and
 6. The rationale to continue or terminate the seclusion, physical or mechanical restraint. [42 CFR §482.13 (e)(12) & (16)]
- 7.4. A psychiatrist or other LIP that is onsite during a seclusion, physical or mechanical restraint will be responsible for completing and signing the *One-Hour Face-to-Face Evaluation* form. If a psychiatrist or other LIP is not immediately available onsite during the seclusion, physical or mechanical restraint, a QRN or PA will complete the evaluation and form.
 1. If a QRN or PA conducts the face-to-face evaluation, they must consult with a psychiatrist or other LIP who is responsible for the care of the patient as soon as possible after the completion of the one (1) hour face-to-face evaluation. [42 CFR §482.13(e)(14)]
 2. **Physical restraints only.** Typically, a physical restraint is brief and discontinued before a practitioner arrives to perform the one-hour face-to-face evaluation. This practitioner is still required to conduct the evaluation within one (1) hour after the initiation of the physical restraint.
- 7.5. The patient should be informed of the violent or self-destructive behavior requiring seclusion, physical or mechanical restraint, and specific behavioral criteria required for release.

- 7.6. Orders for seclusion, physical or mechanical restraints shall remain in effect until the patient's behavior or situation no longer requires seclusion, physical or mechanical restraints.
 1. **Seclusion or mechanical restraint only.** A renewal order will be obtained every four (4) hours if the patient does not meet criteria for release. Renewal documentation must be completed for each order and includes the (a) *Physical Restraint, Seclusion or Mechanical Restraint and/or Emergency Medication* form (also known as the *Initial Seclusion or Restraint Record*), and (b) *One-Hour Face-to-Face Evaluation* form. Orders for seclusion or mechanical restraint may only be renewed for up to a total of 24 hours. [42 CFR §482.13]
 2. After 24 hours, before writing a new order for the use of seclusion or mechanical restraint, a psychiatrist or other LIP must see and assess the patient. [42 CFR 482.13(e)(2)(ii)]
- 7.7. If a patient was recently released from seclusion, physical or mechanical restraint, and again exhibits behavior that can be handled only through the reapplication of seclusion, physical or mechanical restraint, a new order is required.
- 7.8. Within 24 hours, a psychiatrist will complete the *Post-Seclusion or Restraint Evaluation* form to indicate any treatment recommendations to reduce the future incidence of seclusion or restraints.
- 7.9. For each incident of seclusion, physical or mechanical restraint, licensed staff will complete the applicable sections in the *Denial of Rights* form.
 1. Licensed staff will also notify the Patients' Rights Advocate immediately following a seclusion, physical or mechanical restraint.

8. **EMERGENCY MEDICATIONS**

- 8.1. The PHF may utilize physical or mechanical restraints to administer emergency medications. An emergency exists when there is a sudden marked change in the patient's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient or others, and it is not practical to first obtain consent. If antipsychotic medication is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient. [9 CCR §853]
- 8.2. Following the administration of emergency medications, staff are to monitor the patient and complete vital signs every 15 minutes for one (1) hour, as the patient allows and it is deemed safe to do so by staff.
- 8.3. Please refer to the PHF's policy [Emergency Medications](#) for further instructions.

9. **SECLUSION: CARE AND MONITORING**

- 9.1. A designated staff who is trained and has demonstrated competency in cardiopulmonary resuscitation (CPR), CPI and the use and monitoring of seclusion will provide 1:1 direct observation of the patient every 15 minutes to monitor the physical and psychological effects of the seclusion. Direct observation will be conducted immediately outside the locked seclusion room door. If this type of observation distresses the patient, observation will occur via video monitor.
1. For information on orientation and training, please see the PHF's policy [Staff Orientation and Training for Seclusion and Restraint](#).
- 9.2. Trained staff will provide evaluation at the initiation of the seclusion and every 15 minutes thereafter while in seclusion. A written record shall be kept of these evaluations and maintained in the individual patient's health record. Evaluation will include:
1. Signs of any injury associated with seclusion; and
 2. Patient's readiness for discontinuation of seclusion.
[22 CCR §77103(g)]
- 9.3. Trained staff will notify the PHF Team Leader of any changes in the patient's physical or psychological status/comfort needs.
- 9.4. On an hourly basis, a RN who is trained and has demonstrated competency in CPR, CPI and the use and monitoring of seclusion will conduct an assessment of the patient to determine their physiological and psychological status. If needed, the RN may modify the frequency of this assessment. This assessment includes, but is not limited to:
1. Nutrition and hydration monitoring;
 2. Hygiene and elimination monitoring;
 3. Vital signs (if allowed by patient); and
 4. Justification for continued use of the seclusion.
[42 CFR §482.13(e)(10)]
- 9.5. A trained RN will evaluate the need to continue or terminate the seclusion. Discontinuation will occur if:
1. The behaviors or situations that prompted the use of seclusion are no longer evident; or
 2. It is determined that less restrictive means will be effective in protecting the patient and others.

10. **MECHANICAL RESTRAINTS: CARE AND MONITORING**

- 10.1. A designated staff who is trained and has demonstrated competency in CPR, CPI and the application and monitoring of mechanical restraint will provide continuous, 1:1 face-to-face observation of the patient to monitor the physical and psychological effects of the mechanical restraint. Direct observation will occur at the patient's (open) doorway.
[HSC §1180.4(i); 42 CFR §482.13(e)(15); 22 CCR §77103(f)]

1. For information on orientation and training, please see the PHF's policy [Staff Orientation and Training for Seclusion and Restraint](#).
- 10.2. Trained staff will provide bedside evaluation at the initiation of the mechanical restraint and every 15 minutes thereafter while in mechanical restraints. A written record shall be kept of these evaluations and maintained in the individual patient's health record. The evaluation will include:
1. Signs of any injury associated with applying mechanical restraint;
 2. Review of mechanical restraints to ensure they remain properly applied; and
 3. Justification for continued use of the mechanical restraint.
[22 CCR §77103(g)]
- 10.3. On an hourly basis, a RN who is trained and has demonstrated competency in CPR, CPI and the application and monitoring of mechanical restraint will conduct an assessment of the patient to determine their physiological and psychological status. If needed, the RN may modify the frequency of this assessment. This assessment includes, but is not limited to:
1. Signs of any injury associated with applying mechanical restraint;
 2. Evidence of any cardiopulmonary compromise;
 3. Circulation in the extremities (radial, pedal pulses) and skin integrity;
 4. Nutrition and hydration monitor;
 5. Hygiene and elimination monitor;
 6. Range of motion exercise for at least 10 minutes shall be provided to the patient (unless contraindicated and documented by a physician); and
 7. Patient's readiness for discontinuation of the mechanical restraint.
[22 CCR §77103(h); 42 CFR §482.13(e)(10)]
- 10.4. A trained RN will evaluate the need to continue or terminate the mechanical restraint. Discontinuation will occur if:
1. The behaviors or situations that prompted the use of mechanical restraint are no longer evident; or
 2. It is determined that less restrictive means will be effective in protecting the patient and others.

11. CLINICAL/QUALITY REVIEW AND DEBRIEFING

- 11.1. The PHF shall conduct a clinical and quality review for each episode of the use of seclusion, physical or mechanical restraints. [HSC §1180.5(a)]
- 11.2. Staff must conduct a debriefing as quickly as possible, but no later than prior to the end of the shift after the use of seclusion, physical or mechanical restraints. This debriefing shall include the patient if they wish to participate. If the patient requests it, the patient's

family member, domestic partner, significant other, or authorized representative will be asked to participate in the debriefing, if the desired third party can be present at the time of the debriefing at no cost to the PHF. [HSC §1180.5(b)]

11.3. Debriefings shall include the staff members involved in the incident, if reasonably available, and a supervisor/Team Leader to discuss how to avoid a similar incident in the future. The purposes of the debriefing shall be to do all of the following:

1. Assist the patient to identify the precipitant of the incident and suggest methods that are safer and more constructive for responding to the incident.
2. Assist the staff to understand the precipitants to the incident, and to develop alternative methods of helping the patient avoid or cope with those incidents.
3. Help treatment team staff devise treatment interventions to address the root cause of the incident and its consequences, and to modify the treatment plan.
4. Help assess whether the intervention was necessary and whether it was implemented in a manner consistent with staff training and PHF policies.
[HSC §1180.5(b)]

11.4. During the debriefing, the PHF shall provide both the patient and staff the opportunity to discuss the circumstances resulting in the use of seclusion, physical or mechanical restraints, and strategies to be used by the staff, the patient, or others that could prevent the future use of seclusion, physical or mechanical restraints. [HSC §1180.5(c)]

11.5. A follow-up debriefing will be held the following day during the patient's treatment team meeting. This follow-up debriefing shall include the patient if the patient wishes to participate.

11.6. The PHF staff shall document in the patient's record all debriefing sessions that took place and any changes to the patient's treatment plan that resulted from the debriefings.
[HSC §1180.5(d)]

12. REPORTING SECLUSION- AND RESTRAINT-RELATED DEATHS

12.1. The Centers for Medicare & Medicaid Services (CMS) require that all certified hospitals report to CMS any death associated with the use of seclusion, physical or mechanical restraint. The PHF will inform CMS whenever a patient dies:

1. While in seclusion, physical or mechanical restraints;
2. Within 24 hours after being released from a seclusion, physical or mechanical; or
3. Within one (1) week after a seclusion, physical or mechanical restraint, where it is reasonable to assume that the placement in seclusion or use of physical or mechanical restraints contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation. [42 CFR §482.13(g)(1)]

12.2. Each death must be reported to the CMS Regional Office by submitting the CMS-10455 form no later than the close of business the next business day following knowledge of the patient's death.

[CMS Survey and Certification Group Memo, 5/8/2014; 42 CFR §482.13(g)(1)]

12.3. Staff must document in the patient's medical record the date and time the death was reported to CMS. [42 CFR §482.13(g)(3)]

REFERENCE

California Health and Safety Code
Sections 1180, 1180.1-1180.6

California Code of Regulations
Title 22, Section 77029, 77103

Code of Federal Regulations
Title, Section 482.13(e)

Centers for Medicare & Medicaid Services (CMS)
State Operations Manual. Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. Revision 183, 10/12/2018. Accessed at:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

Survey and Certification Group Memo, 5/8/2014. Hospital Restraint/Seclusion Deaths to be Reported Using the Centers for Medicare and Medicaid Services (CMS) Form CMS-10455, Report of a Hospital Death Associated with Restraint or Seclusion. Accessed at:
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-27.pdf>

RELATED POLICIES

[Staff Orientation and Training for Seclusion and Restraint](#)

[Emergency Medications](#)

[Beneficiary Rights](#)

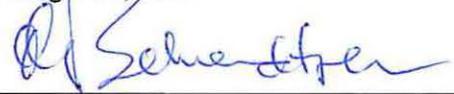
Culturally and Linguistically Competent Policies

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:	9/28/2016
Sub-section	Infection Prevention	Version:	1.1
Policy	Standard Precautions	Last Revised:	3/27/2019
Director's Approval	 _____ Alice Gleghorn, PhD	Date	<u>4/2/19</u>
PHF Medical Director's Approval	 _____ Ole Behrendtsen, MD	Date	<u>4-2-19</u>
Supersedes:	Standard Precautions eff. 9/28/2018		
Approvals:	PHF Medical Practice Committee: 3/27/2019		PHF Governing Board: 3/27/2019

1. PURPOSE/SCOPE

- 1.1. To ensure the health and safety of all patients and staff at the Santa Barbara County Psychiatric Health Facility (hereafter the "PHF") by preventing transmission of infectious agents.

2. DEFINITIONS

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

- 2.1. **Standard precautions** – a group of infection prevention practices that applies to all patients in any healthcare setting regardless of suspected or confirmed infection status. Standard precautions are followed to protect patients and healthcare workers.

3. POLICY

3.1. **Hand Hygiene**

1. Hand hygiene is the single most important practice to reduce the transmission of infectious agents in health care. The PHF utilizes the Centers for Disease Control (CDC) model for hand hygiene.
2. Refer to PHF policy [Hand Hygiene](#) for further details.

3.2. **Gloves**

1. Wear clean, non-sterile gloves when touching blood, body fluids, secretions, excretions, and contaminated items. Don clean gloves just before touching mucous membranes and non-intact skin.

Attachment L

2. Change gloves between tasks and procedures on the same patient if moving from a dirty body site to a clean body site.
3. Remove and discard gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another patient or task. Perform hand hygiene immediately to avoid transfer of microorganisms to other patients or environments.
4. Do not reuse gloves.
5. Refer to the CDC Guide for Personal Protective Equipment for more information ([Attachment A](#)).

3.3. Gowns

1. Wear a clean gown to protect skin and to prevent soiling of clothing during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions. Bring a new paper bag for discarding the used gown.
2. Remove used gowns inside the patient's room and place into the paper bag. Do not reuse gowns.
3. Wash hands to avoid transfer of microorganisms to other patients or environments.
4. Refer to the CDC Guide for Personal Protective Equipment for more information ([Attachment A](#)).

3.4. Patient-Care Equipment

1. Handle used patient-care equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and environments, wearing gloves and a gown as necessary.
2. Ensure that reusable equipment is not used for the care of another patient until it has been cleaned and reprocessed appropriately.
3. Ensure that single-use items are discarded properly.

3.5. Environmental Control

1. Refer to the PHF policy [Environmental/Janitorial Services](#) for procedures for the routine care, cleaning, and disinfection of environmental surfaces, beds, bedside equipment, and other frequently touched surfaces.
2. Decontaminate using only facility-approved cleaning and disinfecting agents in accordance with the manufacturer's instructions.

3.6. Healthcare Laundry, Linens and Articles of Clothing

1. Handle, transport, and process used healthcare laundry, linens and articles or clothing soiled with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures. Avoid contamination of clothing

and the environment, wearing gloves and a gown as necessary. Refer to the PHF policy *Healthcare Laundry Processing* for further details.

3.7. Sharps and Risk of Bloodborne Pathogens

1. To prevent injuries, staff will utilize standard precautions when using and disposing of needles and other sharp instruments or devices and when cleaning used instruments.
2. Never recap used needles, or otherwise manipulate them using both hands, or use any other technique that involves directing the point of a needle toward any part of the body; rather, use either a one-handed "scoop" technique or activate the safety feature.
3. Do not remove used needles from disposable syringes by hand, and do not bend, break, or otherwise manipulate used needles by hand.
4. Place used disposable syringes and needles and other sharp items in appropriate puncture-resistant, leak-proof and biohazard-labeled containers which are located as close as practical to the area in which the items were used.
5. Use safety devices and features whenever possible.

3.8. Safe Injection Practices

1. Used needles may not be re-injected into multi-dose vials or saline containers.
2. Use a sterile needle and syringe for each puncture of multi-dose vials.
3. If multi-dose vials are used, a sterile syringe and needle must be used every time.

3.9. Patient Placement

1. A private room is preferable for patients who may contaminate the environment or do not or cannot be expected to maintain appropriate hygiene or environmental control.

3.10. Respiratory Hygiene/ Cough Etiquette

1. Teach patients and employees to cover coughs and sneezes and wash hands immediately after.
2. Use mouthpieces, resuscitation bags, or other ventilation devices as an alternative to mouth-to-mouth resuscitation methods in areas where the need for resuscitation is predictable.
3. Employees may wear masks when a communicable respiratory disease is suspected.

ASSISTANCE

Andra Dillard, MSN, PHN, RN, CIC, Infection Preventionist

ATTACHMENTS

[Attachment A – CDC Guide to Personal Protective Equipment](#)

REFERENCE

Association for Professionals in Infection Prevention and Epidemiology (APIC)
4th edition, Section 4, 28-1 through 28-4

Centers for Disease Control and Prevention (CDC)
Standard Precautions for All Patient Care. Accessed at:
<https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html>

RELATED POLICIES

[Hand Hygiene](#)

[Environmental/Janitorial Services](#)

[Healthcare Laundry Processing](#)

[Bloodborne Pathogen Exposure Control Plan](#)

[Safe Injection Practices, Single Use Devices and Sterile Fluid Management](#)

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION
3/27/19	1.1	<ul style="list-style-type: none"> Emphasized need to use clean, non-sterile gloves, changing gloves when moving from a dirty body site to a clean body site, and requirement to discard gloves and never reuse. Added use of paper bag for discarding used gowns. Handling of healthcare laundry in accordance with the PHF's policy Healthcare Laundry Processing. Added CDC Guide on use of PPE as an attachment.

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).