**Estimated Number and Types of Vehicles Needed to Evacuate**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Ambulances | Supplied By | Date of Contact | MOU Signed  Date / Initials | Next Review Date |
|  |  |  |  |  |
|  |  |  |  |  |
| Buses | Supplied By | Date of Contact | MOU Signed  Date / Initials | Next Review Date |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Medi-van / Care Cabs | Supplied By | Date of Contact | MOU Signed  Date / Initials | Next Review Date |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Other Transportation  (Describe) | Supplied By | Date of Contact | MOU Signed  Date / Initials | Next Review Date |
|  |  |  |  |  |
|  |  |  |  |  |

## Transportation Agreement/Contract Contacts

(Include copies of agreement in the plan)

|  |  |
| --- | --- |
| **Company Name** |  |
| **Contact Person** |  |
| **Office** |  |
| **Cell** |  |
| **Pager** |  |
| **Type and # of vehicles** |  |
|  |  |
|  |  |

(Include copies of agreement in the plan)

|  |  |
| --- | --- |
| **Company Name** |  |
| **Contact Person** |  |
| **Office** |  |
| **Cell** |  |
| **Pager** |  |
| **Type and # of vehicles** |  |
|  |  |
|  |  |

**Evacuation Logistics**

Based on your residents’ needs, levels of mobility, cognitive abilities, and health status, your LTC community should develop evacuation logistics as part of your Disaster Plan. The following table is an example of such a logistics plan.

**Evacuation Plan**

**Transportation**

* **Residents who are independent in ambulation**: will be accompanied by a designated staff member to the designated mode of transportation.
* **Residents who require assistance with ambulation:** will be accompanied by designated staff member to the designated mode of transportation.
* **Residents who are non-ambulatory:** will be transferred by designated staff members via the designated mode of transportation.
* **Residents with cognitive impairments:** will be accompanied by an assigned staff member via the designated mode of transportation.
* **Residents with equipment/prosthetics:** equipment/prosthetics should accompany residents and should be securely stored in the designated mode of transportation.

**Medical Records**

At a minimum, each resident will be evacuated with the Critical Resident Information.

**Medications**

Each resident will be evacuated with a minimum of a 3-day supply of medications. If medications require refrigeration, indicate plan to keep medications cool.

**Estimated Evacuation Time**

Calculate basedon the number of residents andestimated time for each based on assistance required.

**Resident Tracking**

Indicate who is responsible for keeping the log of residents’ locations post-evacuation (some situations may require residents going to numerous locations).

**Resident Justification**

Indicate who is responsible for making a final check and head count of residents to ensure all residents have been evacuated.

## Evacuation Checklists

**PREPAREDNESS: Items potentially needed for evacuation**

|  |  |
| --- | --- |
| **Check off** | **Item** |
|  | Appropriate ramp to load residents on buses or other vehicles |
|  | First aid kit(s) |
|  | Medical record of some type for residents |
|  | Special legal forms, such as signed treatment authorization forms, do not resuscitate orders, and advance directives |
|  | Clothing with each resident’s name on their bag |
|  | Water supply for trip- staff and residents (one gallon/resident/day) |
|  | Emergency drug kit |
|  | Non-prescription medications |
|  | Prescription medications and dosages labeled), to include physician order sheet |
|  | Communications devices: cell phones, walkie-talkies (to communicate among vehicles), 2 way radios, pager, Blackberry, satellite phone, laptop computer for instant messaging, CB radio (bring all you have) |
|  | Air mattresses or other bedding (blankets, sheets, pillows) |
|  | Facility checkbook, credit cards, pre-paid phone cards |
|  | Cash, including quarters for vending machines, laundry machines, etc |
|  | Copies of important papers: insurance policies, titles to land and vehicles, etc. |
|  | List of important phone numbers |
|  | Emergency prep box: trash bags, baggies, yarn, batteries, flashlights, duct tape, string, wire, knife, hammer and nails, pliers, screwdrivers, fix-a-flat, jumper cables, portable tire inflator, tarps, batteries, etc. |
|  | Non perishable food items- staff and residents |
|  | Disposable plates, utensils, cups, straws |
|  | Diet cards |
|  | Rain ponchos |
|  | Battery operated weather radio and extra batteries, to include hearing aid batteries and diabetic pump batteries |
|  | Hand sanitizer |
|  | Incontinence products |
|  | Personal wipes |
|  | Toiletry items (comb, brush, shampoo, soap, toothpaste, toothbrush, lotion, mouthwash, deodorant, shaving cream, razors, tissues) |
|  | Denture holders/cleansers |
|  | Toilet Paper |
|  | Towels |
|  | Latex Gloves |
|  | Plastic Bags |
|  | Bleach sterilizing cleaner |
|  | Coolers |
|  | Lighters |
|  | Office supplies, such as markers, pens, pencils, tape, scissors, stapler, note pads, etc. |
|  | Laptop computer with charger; Flash drives or CDs with medical records |
|  | Maps – County and State |
|  | Insect Repellant |
|  | Vehicle Emergency Kit (Safety Triangles, road flares, engine oil, transmission fluid, funnels, jumper cables, tow rope or chain, tool kit, etc.) |
|  |  |

**RESPONSE: PRIOR TO EVACUATION**

|  |  |  |
| --- | --- | --- |
| **Date/Time Completed** | **Initials** | **Item** |
|  |  | Determination made of number of residents that must be transported by ambulance, van, car, bus or other method |
|  |  | Transport services contacted and necessary transportation  arranged. |
|  |  | Receiving facilities contacted and arrangements made for receipt  of residents. |
|  |  | Contact made with facility’s medical director and/or the patient’s  physician |
|  |  | Necessary staff contacted for assistance in transporting residents  and caring for residents at the receiving facility. |
|  |  | County Emergency Management Agency contacted and informed  of the status of the evacuation. |
|  |  | Roster made of where each patient will be transferred and notify  next of kin when possible. |
|  |  | Residents readied for transfer, with the most critical residents to be  transferred first. Include: |
|  |  | a. change of clothes |
|  |  | b. 3 day supply of medications |
|  |  | c. 3 day supply of medical supplies |
|  |  | d. patient’s medical chart to include next of kin |
|  |  | e. patient identification, such as a picture, wrist band,  identification tag, or other identifying document to ensure residents are not misidentified |
|  |  | Adequate planning considerations given to needs of residents, such as dialysis patients. |
|  |  | Adequate planning considerations given to residents on oxygen. |
|  |  | Adequate planning considerations given to residents using durable medical equipment such as masks, nasal cannulas, colostomy equipment, g-tube, etc. |

## Sample Resident Profile

Resident Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AKA\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M/F\_\_\_\_\_

Resident

Current Photo

***Assistive Devices Used*** *(Circle all that apply)*

*Dentures Partial or Full*

*Cane*

*Walker*

*Wheelchair*

*Eyeglasses*

*Hearing Aid*

*Oxygen Indicate Concentration\_\_\_\_\_\_\_*

Emergency Contact Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pertinent Medical Information**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Devices:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pet\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Sheltering Facility Agreement/Contract Contacts

(Include copies of agreement in the plan)

|  |  |
| --- | --- |
| **Company Name** |  |
| **Contact Person** |  |
| **Office** |  |
| **Cell** |  |
| **Pager** |  |
| **Will Accept # and Type of Residents** |  |

|  |  |
| --- | --- |
| **Company Name** |  |
| **Contact Person** |  |
| **Office** |  |
| **Cell** |  |
| **Pager** |  |
| **Will Accept # and Type of Residents** |  |

|  |  |
| --- | --- |
| **Company Name** |  |
| **Contact Person** |  |
| **Office** |  |
| **Cell** |  |
| **Pager** |  |
| **Will Accept # and Type of Residents** |  |