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

Programmatic Policy and Procedure

Section	Psychiatric Health Facility (PHF)	**Effective:**	DRAFT
Sub-section	Crisis and Emergency Response	**Version:**	1.0
Policy	Shelter-in-Place During Emergency	**Last Revised:**	New policy

Director's Approval _____ **Date** _____
Alice Gleghorn, PhD

Medical Director's Approval _____ **Date** _____
Ole Behrendtsen, MD

Supersedes: New policy

Audit Date: DRAFT

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.

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

3. POLICY

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

4. SHELTER-IN-PLACE CRITERIA

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

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

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

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

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

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

5. HAZARD IDENTIFICATION AND SHELTER-IN-PLACE ORDER

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

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

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

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

6. SHELTER-IN-PLACE PROCEDURES

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

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

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

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

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

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

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

7. SUBSISTENCE

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

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

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

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

8. HANDLING OF CONFIDENTIAL DOCUMENTS

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

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

9. DURATION AND LIFTING OF SHELTER-IN-PLACE

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

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

10. COMMUNICATION

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

ASSISTANCE

Mark Lawler, LPT, PHF Team Supervisor

RELATED DOCUMENTS AND POLICIES

PHF Emergency Response Plan

PHF Emergency Communication Plan

Emergency Facility Evacuation

Disaster and Emergency Supplies for Dietary Services

Emergency Subsistence Management

Emergency Patient, Staff, and Visitor Tracking

[2] Please refer to the PHF's "Unusual Incident Reporting" policy for further details.
[3] Please refer to the PHF Emergency Communication Plan for more information on internal and external communication in an emergency situation.

REFERENCES

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

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

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

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION

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