Disaster Preparedness:

A Guide for Chronic Dialysis Facilities

Second Edition

Supplemental Appendix of Customizable Forms

Note: This manual is intended as a guide and does not represent a comprehensive disaster preparedness program for your facility. As your specific needs may exceed the scope of the information presented here, you should also seek professional guidance from qualified risk managers, engineers, and technicians to create the best plan for your center. The Kidney Community Emergency Response Coalition (KCER) also provides resources for the development of facility-specific disaster plans.

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Appendix A - Emergency Management Contact Form

The purpose of the Emergency Management Contact Form is to document the facility's annual contact with the local emergency management agency. Communication with the local emergency management agency can ensure that local disaster aid agencies are aware of the dialysis facility's patients' needs in the event of an emergency and ensure that the agency is aware of the dialysis facility's needs in the event of an emergency. This pre-emptive contact could facilitate the meeting of dialysis patient needs during a disaster. Dialysis facilities should provide education and data about their facility (location, number of patients, emergency contact information). Remember, using this form is only a recommended practice and just a "first step." The facility will need to build and maintain a relationship with the local emergency management agency and develop and practice your disaster plans in order to provide the highest quality patient care and safe working environment for staff.

Contact with Local Emergency Management: **Date:** _____

Facility Name: _____

CMS Certification Number: _____

Name Of Person Completing This Form: _____

List of resources and information sent to the local emergency management office:

☐ _____

☐ _____

☐ _____

Date the information was sent: _____

Information was sent to:

Name/Title: _____

Agency: _____

Address: _____

Phone/Fax: _____

E-Mail: _____

Other contact with the emergency management agency or emergency operations center (EOC) (e.g., phone calls/emails, including dates and who was involved):

_____

Follow-up indicating information was received (e.g., returned fax verification, email responses, etc):

_____

Facility's plan for annual communication:

_____

Attach copies of letters, faxes, emails, or other documentation to this form.

Appendix B - County Emergency Management Support Form

The purpose of the County Emergency Management Support Form is to communicate your facility's status to the county Emergency Operations Center (EOC) serving your area. This information will enable emergency management to determine available resources and services that might be needed in the event of a disaster affecting the facility. It is recommended that facility's forward this information to the county EOC on at least an annual basis and any time there is a change in the information.

Form Instructions:

If you are responsible for multiple clinics, you must complete a separate form for each clinic.

1. Complete the facility demographic information. Indicate whether the facility is deemed a "hub" or "critical facility" for emergencies.
2. Provide the name and contact information for the administrator, corporate contact, and Medical Director. Provide a minimum of two (main and alternate) contacts for each. Be sure to include **all** available emergency phone numbers and e-mail addresses.
3. List power utility providers and the number of the facility's electric meter. This number can be found on the utility bill and will expedite the diagnostic process if the facility loses power.
4. Provide information regarding alternate power sources/generators available at the facility, including the type of fuel used to power the generator. If the facility does not have a permanent generator, indicate whether a transfer switch is installed for use of a temporary generator.
5. Complete information regarding water storage and hookup capabilities in the facility.
6. Provide the number of stations and total number of patients served in your facility.
7. Describe any other emergency protection the facility has (e.g., hurricane shutters).
8. Indicate all special instructions that may be helpful to the county EOC in facilitating services.
9. Indicate person completing the form and the date completed.
10. Include educational information regarding the needs of dialysis patients, such as the *Save a Life* brochure, which is available on www.kcercoalition.com.
11. Forward to the county EOC.
12. Retain a copy of this form and document any follow-up actions or responses.

Dialysis Facility Name: _____

This Facility is a: ☐ Critical Facility ☐ Hub

Facility Address: _____

Facility Phone/Fax: Phone ( ) _____ Fax ( ) _____

Alternate Emergency Numbers: _____

Administrator Name/Contact Number: _____

Corporate Contact Name/Number: _____

Medical Director Name/Contact Number: _____

Name of Power Company: _____

Meter Number: _____

Permanent Generator? ☐Y ☐N **If NO, is Transfer Switch Installed/Available?** ☐Y ☐N

Type of Fuel: _____ **Water Storage?** ☐Y ☐N

Gallons: _____ **Water Hookup?** ☐Y ☐N

Number of Dialysis Stations: _____ **Number of Isolation Stations:** _____

Total Patients Served: _____ **Any Special Disaster Protections:** _____ _____ _____ _____

Comments/Special Instructions:

_____

_____

Form Completed By: _____ **Date:** _____

Appendix C - Emergency Contact Information Forms

Update these forms annually and with any changes.

Community – Emergency Contact Information

Organization	Contact Name	Phone Number
Ambulance		
Fire Department		
Fire Department: Non-Emergency		
Police Department		
Police Department: Non-Emergency		
County Emergency Operations Center		
State Emergency Management Agency		
Hazardous Materials Handling/Information		
Local Electric Company		
Local Gas Company		
Local Water Department		
Nearest Hospital		
Nearest Trauma Center		
Poison Control		
Public Health Department		
Telephone Repair		
Transportation Company		

Date of Last Form Update: _____

Facility – Emergency Contact Information

Department/Individual	Contact Name	Phone Number
Management/After Hours		
Facility Administrator (Home)		
Facility Administrator (Cell)		
Charge Nurse (Home)		
Charge Nurse (Cell)		
Alternative Dialysis Center		
Building Inspector		
Chief Technician (Home)		
Chief Technician (Cell)		
Medical Director (Home)		
Medical Director (Cell)		
Water Treatment Contractor		

Date of Last Form Update: _____

Appendix D - Hazard Vulnerability Analysis Tool

A hazard vulnerability analysis is usually the first step in disaster planning for an organization. The Hazard Vulnerability Analysis Tool is designed so organizations can evaluate their level of risk and preparedness for a variety of hazardous events. The following tool lists possible hazards that would require disaster planning and can be individually tailored to suit the needs of the organization.

List potential hazardous events for your organization. Evaluate and rate each event for probability, vulnerability, and preparedness using the following scales:

Ranking probability and vulnerability	Ranking preparedness
High = 3 Moderate = 2 Low = 1	High = 1 Moderate = 2 Low = 3

To calculate, multiply the ratings for each event: probability x vulnerability x preparedness = total score

Example

Probability	X	Vulnerability	X	Preparedness	= Total Score
(3) 2 1 High Low		3 (2) 1 High Low		1 (2) 3 High Low	12

The higher scores will represent the events most in need of planning. Using this method, 1 is the lowest possible score, while 27 is the highest possible score. *Remember the scale for preparedness is in reverse order from probability and vulnerability.*

- When evaluating probability, consider the frequency and likelihood an event may occur.
- When evaluating vulnerability, consider the degree with which the organization will be impacted, such as infrastructure damage, loss of life, service disruption, etc.
- When evaluating preparedness consider elements such as the strength of your preparedness plan and the organization's previous experience with the hazardous event.

Based on the results, determine which values represent an acceptable risk level and which events require additional planning and preparation.

Event	Probability			Vulnerability Level/Disruption Degree			Preparedness			Score
	High (3)	Moderate (2)	Low (1)	High (3)	Moderate (2)	Low (1)	High (1)	Moderate (2)	Low (3)	
Ice/Snow										
Flooding										
Earthquake										
Hurricane										
Hazardous Material Accident										
Fire										
Tornado										
Volcano										
Civil Disturbance										
Mass Casualty Event										
Terrorist Attack										
Pandemic/Infectious Disease Outbreak										
Electrical Failure										
Communications Failure										
Information Systems Failure										
Water Failure										
Transportation Interruption										
Environmental Pollution/ Altered Air Quality										

Appendix E - Pandemic Planning Checklist

Follow the checklist below to develop your Pandemic Plan.

Section 1

- ☐ Identify members of the facility's planning team, and set up a schedule to meet regularly

Section 2

- ☐ Discuss the roles and responsibilities of the following in pandemic planning and response:
  - ☐ Facility pandemic planning committee/staff
  - ☐ Patients
  - ☐ Caregivers
  - ☐ Local liaisons (public health, local hospital liaison, medical transporters, local emergency management agency, referring physician groups representatives)
  - ☐ Representatives from other associated dialysis facilities and dialysis patient transportation providers
  - ☐ Vendors of critical supplies

Section 3

- ☐ Review these resources for plan development
  - ☐ The CMS Manual Disaster Preparedness: A Guide for Chronic Dialysis Facilities
  - ☐ The HHS Pandemic Influenza Plan
  - ☐ State and/or local influenza plans
  - ☐ The KCER Coalition Pandemic Preparedness Team page at www.kcercoalition.com
  - ☐ Your dialysis company's pandemic plan
  - ☐ The National Strategy for Pandemic Influenza Implementation Plan

Section 4

- ☐ Consider these key elements of a plan for your facility and include them in a written plan:
  - ☐ **Communication Plan (Patients, Partners and Other Agencies)**
    - ☐ Discuss coordination with other facilities, local clinicians, and other agencies
    - ☐ Identify contacts for exchange of information such as facility status, situation in community with respect to disease rates, and resource requests
    - ☐ Outline education plan for staff, patients, and caregivers
    - ☐ Determine the education plan, and evaluate potential messages for inclusion in preparedness education, such as personal stockpiling, infection control, and caring for yourself or a family member with the flu

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Section 4 (Continued)

- ☐ Discuss your communication goals during a response
  - ☐ Facility operational status: Open or Closed?
  - ☐ Where to obtain reputable information on available services (transportation) and infrastructure (hospital status), physician on-call schedules, etc.
  - ☐ Where to learn what's going on in your community (local emergency management agency, department of health, media, etc.)
- ☐ **Infection Control Plan**
  - ☐ Basic prevention and infection control for staff and caregivers
  - ☐ Strategies to socially distance persons to minimize transmission of flu (consider strategies on use of isolation rooms, cohorting dialysis machines, using isolation rooms at partnering facilities and/or potential for use of home hemodialysis to facilitate isolation)
  - ☐ Proper type and use of masks and other personal protective equipment
- ☐ **Staffing Plan**
  - ☐ Acknowledge potential for employee absenteeism and/or possible patient surge
  - ☐ Determine critical number and type of staff to keep facility operational and safe
  - ☐ Work on a plan with other facilities to share staff with like duties
  - ☐ Cross-train duties as able. Provide re-training for clinical staff who may now be in management or other types of positions who may need to help with clinical duties in a
  - ☐ Identify vascular surgeons in advance to deal with fistula issues in patients with influenza and new patients
  - ☐ Develop plan for workforce support/resiliency and mental health support
  - ☐ Develop plan to contact state agency to ask for temporary exception to any applicable staffing ratio requirements
- ☐ **Supplies/Resources Plan**
  - ☐ Review current supply level of critical items (such as dialysate) and work with vendors on how to maintain
  - ☐ Identify supplies that are used outside the provision of dialysis to care for people with flu. This could include saline, syringes, gloves, masks, gauze, bleach, etc. If these items
  - ☐ Define items that can be stockpiled, including appropriate antibiotics to deal with vascular access infections or other medications
  - ☐ Determine current supply per week and estimate the need during a pandemic per week of operation
  - ☐ Maintain current and alternate list of vendors
- ☐ **Transportation Plan for Employees and Patients**
  - ☐ Identify major transportation providers and alternatives (rail, buses, medical transport, volunteers, churches, community agencies) and incorporate their plans into your own plan

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Section 4 (Continued)

- ☐ **Utilities Plan**
  - ☐ Meet with local utility companies and review their plan and get contact information
  - ☐ Review critical needs to operate the facility with local utility company representatives
  - ☐ Discuss prioritization for restoration or maintenance of utilities and how the utility company has incorporated dialysis facility needs into their plan
- ☐ **Treatment Plan**
  - ☐ Review with physician groups and Medical Director treatment changes that might be possible/necessary, such as decreasing from three treatments per week to two for some patients
  - ☐ Determine in advance what level of service the facility would provide at each level of staff absenteeism. Discuss how policies and procedures would change
  - ☐ Determine how to handle new or additional patients
- ☐ **Vaccine and Antiviral Use Plan**
  - ☐ Identify vendor source, first and second priority status, and corporate status on stockpiling

Section 5

- ☐ Participate in local disaster planning efforts with the local emergency management agency

Section 6

- ☐ Commit to a regular schedule of training and performing exercises or mock disaster drills and then (re)evaluating plans

Appendix F - Preparedness Assessment

	Date Completed	Date Reviewed	Name/Title of Individuals Responsible for Completion
Administrative			
Establish incident command structure – Chain of command and lines of authority			
Establish liaison with State and local Emergency Management Agencies – confirm contacts on a regular schedule (e.g., quarterly)			
Establish alternate command center			
Identify a meeting place for all personnel if facility is not accessible			
Establish Memorandum of Understanding (MOU) with other stakeholders/facilities			
Schedule/complete mock drill and performance assessment of drill			
Assign responsibility to staff member to notify the ESRD Network if the facility is impacted by a disaster (not operating normally, building damage, etc).			
Plan for building and staff security and protection			
Supplies			
Examine vendor alternatives and contacts			
Plan for office supply inventory needed to continue operations (3 – 5 days of supplies on hand)			
Determine needed stockpile of clinical supplies			
Plan for the security and protection of supplies			

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	Date Completed	Date Reviewed	Name/Title of Individuals Responsible for Completion
Utilities			
Develop plan for loss of water and power: generator/fuel, potable water			
Plan for removal of biohazards and other facility waste			
Record Protection			
Backup plan in place for electronic records			
Develop plan to protect all medical records			
Plan for off-site/distant storage			
Financial			
Mechanism to track organization costs during disaster or emergency situations			
Develop business continuity plan – Include ability to complete payroll, pay vendors			
Determine the needed cash to have on hand			
Identify funding sources if normal payment structures are interrupted			
Communication			
Determine alternate communication system for both staff and patients (cell phones, pagers, satellite phones)			
Coordinate with local and state Emergency Management policy on communicating with other health facilities			
Establish telephone tree and communicate to staff			
Coordinate with local and state Emergency Management Agencies on information dissemination (media releases, etc.)			

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	Date Completed	Date Reviewed	Name/Title of Individuals Responsible for Completion
Surge Capacity			
Define surge capacity for your organization: maximum caseload, scope of services, length of treatment			
Identify actions to increase surge capacity, including lodging for additional staffing			
Identify which staff will be available to the facility during a disaster			
Communicate plans with local healthcare facilities regarding scope of service and facility ability to deal with surge			
Develop condensed admission requirements (state-specific requirements should be researched prior to disaster)			
Develop and maintain patient tracking system			
Staff			
Develop disaster orientation program for all staff			
Establish a continuing all-hazard education schedule			
Compile and maintain a current list of staff emergency contact numbers			
Establish protocols for communication of staff with office/supervisors			
Develop/establish altered job descriptions/duties identified for each discipline			
Instruct and assist staff to develop personal/family disaster plans			
Plan for food, lodging, transportation, fuel, and mental health resources for employees in need in the recovery phase			

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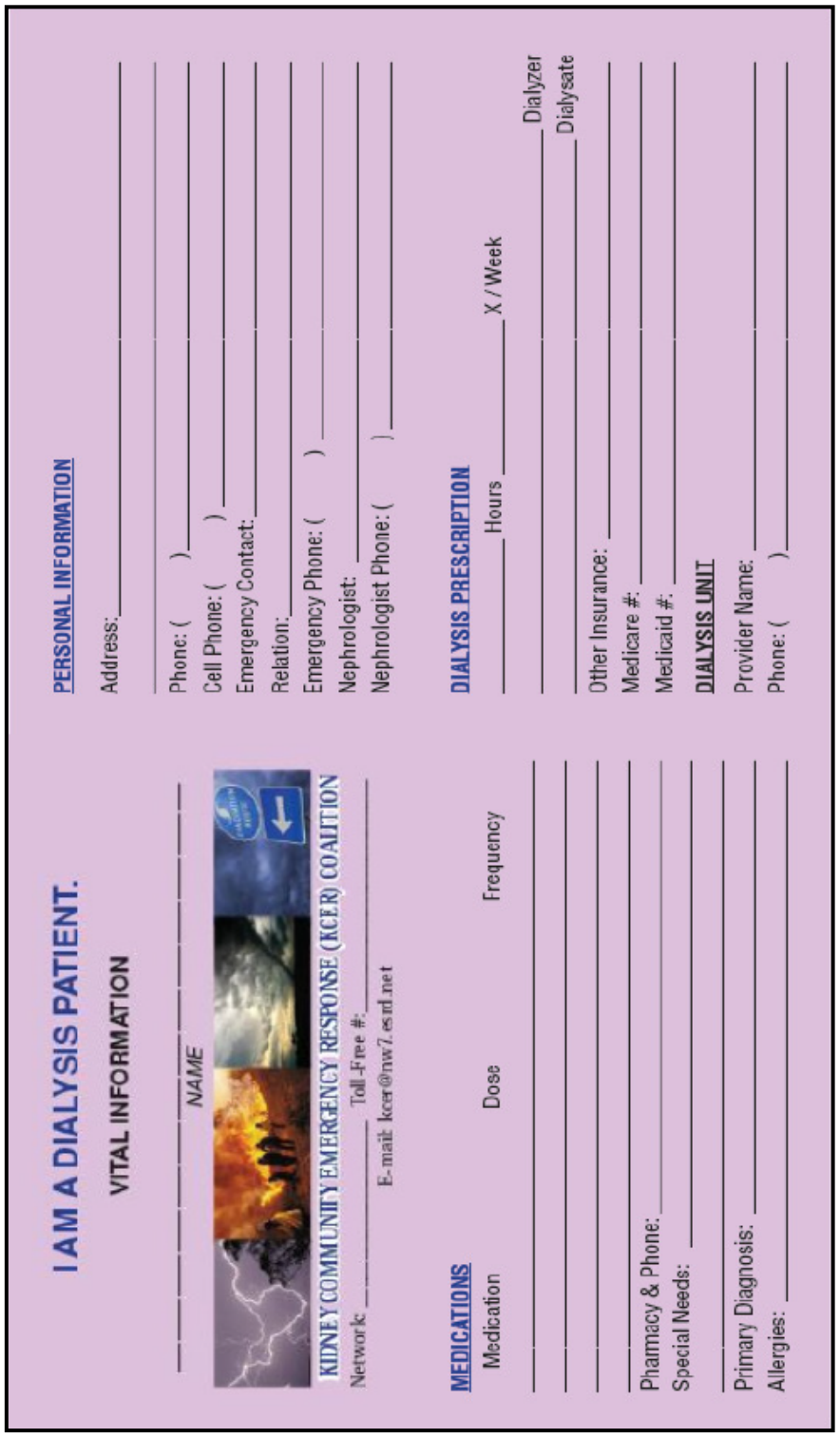
	Date Completed	Date Reviewed	Name/Title of Individuals Responsible for Completion
Patient Education			
Provide educational materials to assist patients in preparing for emergencies and to provide self-care if organization personnel are not available (where applicable)			
Ensure patients are informed of local/state evacuation plan, back-up facility and alternate facility number			
Instruct and assist patients to develop personal/family disaster plans			
Ensure patients are informed of the potential for care to be delayed or unavailable in a disaster			
Review emergency take off procedure (clamp and cap)			
Transportation			
Develop plans for transportation interruptions and road closures			
Arrange alternate transportation plan (include plans for patients and staff)			
Develop plan for gasoline allocation			
Identify gas stations that can operate during power outages			

Appendix G - Patient Identification Card

A lavender Patient Identification Card example is provided below. To download and print these cards, visit www.kcercoalition.com.



Appendix H - Sample Facility Preparedness Questionnaire

On a scale of 1 to 5 (1= not prepared, 5=very prepared), how prepared do you feel your facility and patients are for a disaster?	1 2 3 4 5
On a scale of 1 to 5 (1 = not prepared, 5=very prepared), how prepared do you think you are, personally, at home?	1 2 3 4 5
Are any of the facility staff planning to evacuate?	YES NO
If so, have their evaluation plans and location of their evacuation site been documented and shared with management?	YES NO
Does the facility have a disaster manual?	YES NO
Do you know the personal plan of each patient (e.g., evacuate to a shelter, leave the area, or remain in their home)?	YES NO
Is there a designated shelter in your area for dialysis patients?	YES NO
Do the patients have instructions regarding the emergency renal diet (3-day disaster diet)?	YES NO
Were the instructions given verbally?	YES NO
Were the instructions given in writing?	YES NO
Is there a plan in place to provide patients with a copy of their most recent treatment orders, medication lists, and care plans before a disaster?	YES NO
Have patient contact lists been recently updated?	YES NO
Have patient allergy and medication lists been recently updated?	YES NO
Does the facility have a plan for contacting patients both before and after a disaster?	YES NO
Is there a designated person in the facility responsible for contacting patients?	YES NO
Is there also a back-up person for this role?	YES NO
Does the facility have a designated backup facility?	YES NO
If so, do both patients and staff know the name of the facility's name and location?	YES NO
Do the patients know how to contact the facility/backup facility post-disaster?	YES NO
Are there plans in place for protection of both medical records and equipment/building?	YES NO
Is the facility aware that the local ESRD Network and State Survey Agency should be contacted following a disaster and provided an update on the facility status (open/closed), damage, and special needs?	YES NO
Is staff aware of how to contact the local ESRD Network and State Survey Agency?	YES NO
Does staff have appropriate identification/documentation to travel in the event of a curfew? (Don't forget about new hires.)	YES NO
Do patients have identification as dialysis recipients?	YES NO
Have arrangements been made for staff housing, fuel, or food post-disaster?	YES NO
Is there a designated staff person to assess damage post-disaster?	YES NO
Are all attending physicians aware of the facility's disaster plan?	YES NO
Does the facility have a disaster phone tree?	YES NO

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Does the Medical Director know who to contact in the event the facility's telephones are inoperable?	YES	NO
Does the local ESRD Network have your emergency contact numbers?	YES	NO
Are arrangements in place to obtain additional supplies?	YES	NO
Does the facility have written disaster standing orders for each patient?	YES	NO
Does the facility have a non-electric phone available?	YES	NO
Does the facility have a recently serviced generator?	YES	NO
Is the tank full?	YES	NO
Does the facility have an agreement to obtain a generator and know how soon it could arrive?	YES	NO
Does the facility have an agreement with a company to ensure a fuel supply for the generator after a disaster?	YES	NO
In the event that a generator is not available or is not operable, are the staff and patients familiar with the hand-cranking procedure?	YES	NO
Were the patients recently trained on this activity?	YES	NO
Does the facility have appropriate and up-to-date water testing materials?	YES	NO
Are there alternate staff at the facility who know how to do water testing?	YES	NO
In the event there is no water supply for the city, does the facility have the means to hook up a	YES	NO
Is an agreement in place for obtaining potable water after a disaster?	YES	NO
Does the facility have a plan for securing refrigerated medications?	YES	NO
Have provisions been made for infectious waste?	YES	NO

Appendix I - Sample Patient Preparedness Questionnaire

On a scale of 1 to 5 (1= not ready, 5= very ready) do you think you are ready for a disaster?	1 2 3 4 5
Has anyone from your clinic given you information about disasters? If so, what have you received?	YES NO
Do you have a disaster kit at home? If so, what is in the kit?	YES NO
Do you have a supply of medications to use in emergencies?	YES NO
Do you know about the emergency renal diet (3-day disaster diet)? What are the things you aren't supposed to eat or drink?	YES NO
Do you know how to hand crank your machine if the power goes off? Describe the process.	YES NO
In an emergency could you take yourself off the machine? Describe the process.	YES NO
If you had to evacuate from your home, would you go to a shelter?	YES NO
Do you know that shelter's location?	YES NO
Do you know if there is a shelter that is special for dialysis patients?	YES NO
Are you registered at that shelter?	YES NO
Have you thought about leaving the area? If so, where would you go?	YES NO
If you have pets, do you know what you would do with them in a disaster? If so, what is your plan?	YES NO
Do you have a way to get to treatment if the transportation you usually use isn't available? If so, what is your plan?	YES NO
Has your clinic given you phone numbers so that you can contact someone to set up treatment after a disaster?	YES NO
Do you know how to find a dialysis facility if yours is closed? How would you do this?	YES NO

Appendix J - Sample Quality Improvement Plan

Problem or Process to Improve	Measure	Baseline Result	Root Cause(s)	Action(s) and Person(s) Responsible	Goal(s)	Time Frame	Evaluation Process
Measure identified for improvement.		*Enter the baseline (current) result for measure including date and %.*	*Enter cause(s) that have been identified by your facility that contribute(s) to the facility's current performance rate. (Enter each cause on a separate line below).*	*For each identified cause, describe the action step(s) the facility will use to achieve improvement. Indicate who in your facility is responsible for each action step.*	*Enter the goal to be achieved including date (e.g., "To improve our baseline of % to ___% by ___.*	*For each action step, indicate the beginning date (date action step was started) and the end date (date action step to be completed).*	*Describe how the facility will continuously evaluate each action step taken to see if improvement is being achieved. (e.g., tracking tools, meetings, monitoring) Include who will be responsible for evaluation and compliance.*
Dialysis facility staff unaware of disaster plans for nursing home patients, and no documentation of plans in patient chart.	The percentage of nursing home patients with documented disaster plans. **Numerator:** # of nursing home patients with documented plan **Denominator:** Total # of nursing home patients	Only 3 out of 8 nursing home patients had disaster plans documented in chart (38%).	Infrequent communication with nursing homes. No assigned staff member to obtain and document information from Nursing Home.	Use Quarterly Update Tool to document nursing home plans. Social worker will be responsible for reviewing and documenting contact with Nursing Home and disaster plans.	To increase percentage of disaster plans for nursing home patients documented in patient chart to 90%.	Begin: 9/1/11 End: 12/1/11	The social worker will conduct follow-up audit of charts for nursing home patients in December to determine progress. If goal not met, the social worker will review and revise actions.

Date QIP Developed: _____

Facility: _____

Appendix K - Drill Critique Form

Date: _____ Critique Completed By: _____

Time Drill Began: _____ Time Drill Completed: _____

Communications		
Was the disaster signal heard in all areas?	YES	NO
Was the Fire Department notified (simulation)?	YES	NO
If YES, time of notification:		
Evacuation Team Personnel		
Did team members report to their assigned areas?	YES	NO
Did team members carry out all assigned duties?	YES	NO
If applicable, were the elevators brought to the main lobby and deactivated?	YES	NO
Were evacuation techniques demonstrated?	YES	NO
Containment of Fire		
Were all doors closed but not locked?	YES	NO
Were all windows closed?	YES	NO
Was a fire extinguisher taken to fire location (if applicable)?	YES	NO
Patient Education		
Was emergency take off demonstrated?	YES	NO
Was there a previous review of *Preparing for Emergencies: A Guide for People on Dialysis* and the emergency diet?	YES	NO
Communication Procedures		
Was contact information current?	YES	NO
Were key phone numbers available and distributed?	YES	NO
Evacuation/Relocation		
Were corridors and exits clear?	YES	NO
Did the evacuation proceed in a smooth and orderly manner (simulated)?	YES	NO
Did visitors to the building take part in the drill?	YES	NO
Utilities (Simulated)		
Were electric and gas appliances turned off?	YES	NO
Was the ventilation system shut down?	YES	NO
Was the oxygen valve shut off?	YES	NO
Were all water treatment machines and other ancillary equipment shut off?	YES	NO
Availability of Emergency Packs		
Were the emergency packs complete and all supplies in-date?	YES	NO
Were the emergency packs accessible to staff and patients?	YES	NO

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Contaminated Water		
Dialysate into bypass (simulated)?	YES	NO
Was the water shut off (simulated)?	YES	NO
Was ascorbic acid available for chloramine breaking through the carbon tanks?	YES	NO
Hazardous Spills		
Were spill kits available?	YES	NO
Were ANSI respirators with appropriate filters available?	YES	NO
Remarks and Recommendations		

Appendix L - Drill Attendance Roster Form

Drill Date: _____ Scenario: _____

ANNOUNCED or UNNANOUNCED (circle) Drill Conducted By: _____

Staff Participating	Title

Patients Participating	

Appendix M - Disaster Drill Evaluation and Action Form

Area for Improvement	Facility Action	Who is Responsible	By When	Others Needed	Specific Resources Needed	Status/ Outcome

Appendix N - Emergency Equipment/Supply Record

Facility: _____ Requested By: _____

Date	QTY	Items/Description/Serial #	Received By

Approved By: _____ _____ _____
(Signature) (Printed Name) (Date)

Appendix O - Emergency Dialysis Patient Record

Facility: _____	Date: _____
Name: _____	Physician: _____
Address: _____	City/State/ZIP: _____
Social Security Number: _____	Phone Number: ( )
Medicare? □ Yes □ No	Other Insurance: _____
Contact Person: _____	Relationship: _____
Address: _____	City/State/ZIP: _____
Phone Number: ( )	Usual Dialysis Facility: _____

Treatment Modality (Check One):	□ Hemo □ CAPD □ IPD □ CCPD □ Transplant

Treatment Log

Date	Services Provided	Observations/Notes	Staff Name

Appendix P - Dialysis Treatment Supply Checklist

Use the following guide to help you determine what supplies are necessary to dialyze patients.

Product	Description	Quantity
Master list of patients		
Alcohol wipes		
Basic/comprehensive first aid kits		
Blood pressure cuff		
Catheter caps		
Clamps		
Dialysate Bicarbonate Concentrate		
Dialysate Acid Concentrate		
Dialysis tubing A & V		
Dialyzers		
Fistula needles		
Gloves (latex)		
Gloves (vinyl)		
Heparin		
IV infusion lines		
Normal saline, 0.9%		
Writing pens		
Port caps		
Povidine iodine		
Power adapters		
Standard treatment packs (or supplies needed if packs not used)		
Stethoscope		
Syringes with needles		
Tape		
Thermometer		
Transducer protectors		
Treatment forms		
Xylocaine		

Appendix Q - Emergency Succession for Decisions

Use this form to designate individuals in charge during a disaster. Instruct staff that if the first person is not present or available, they should go to the next person listed. Determine the appropriate contact order for your senior staff including the Medical Director, charge nurse, technicians, social workers, and dietitians.

Name/Position	Email Address	Business Phone	Cell Phone	Home Phone	Pager

Appendix R - Sample Public Service Announcement (PSA)

Use this sample PSA as a starting point and adapt it to meet the facility and patient needs. Complete SHADED areas to customize your PSA.

Introduction
This is an announcement from FACILITY NAME , located at FACILITY STREET ADDRESS .
To Our Employees
DO/DO NOT report to work. Our Dialysis Center is temporarily OPEN/TEMPORARILY CLOSED. Facility Staff should report to LOCATION WHERE STAFF SHOULD REPORT .
To Our Patients
Our Dialysis Center is OPEN/CLOSED TEMPORARILY. You SHOULD REMAIN AT HOME UNTIL WE NOTIFY YOU TO COME IN or SEEK DIALYSIS AT AN ALTERNATE CENTER. Follow the emergency renal diet (3-day disaster diet). These local centers are operating: _____ _____ _____ If you have a life-threatening injury or illness, report to the nearest emergency room.
Other Information

Signed By: Date:

Appendix S - Damage Assessment Form

Use this form to list employees responsible for damage assessment.

Considerations for the damage assessment:

- Personal safety first!
- Use professional consultants (structural engineers, fire department, etc) as indicated.
- Use licensed vendors such as electrical and plumbing contractors.

Staff Person	Tasks	Telephone

Team Title	Team Member	Telephone
Structural Engineer		
Plumber		
Electrician		
Generator Vendor		
Fuel Supplier		

Appendix T - Record for Temporary Disaster Staff Members

Facility: _____ **Date**: _____

Name: _____ **Professional Title**: _____

Address: _____ **City/State/ZIP**: _____

Social Security Number: _____ **Phone Number**: _____

Professional License Number: _____ **State of Licensing**: _____

CPR Certified? YES / NO

Usual Facility of Employment: _____
(Name) (City/State)

Authorized By: _____ **Date**: _____

Date(s) Worked	Inclusive Hours Worked

Approved By: _____ **Date**: _____

Appendix U - Volunteer Management Log

Facility: _____ **Date**: _____

Volunteer Name: _____ **Affiliation**: _____

Address: _____ **City/State/ZIP**: _____

Phone Number: _____ **Skills**: _____

Date	Inclusive Hours Worked	Tasks Performed

Approved By: _____ Date: _____