Ashe County Mass Care & Sheltering

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Inclusive & Integrated Plan

2020

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INTRODUCTION

Executive Summary

The Ashe County Mass Care Planning Committee evolved from the Special Needs Planning Committee. The Special Needs Planning Committee focused its efforts on care of the most vulnerable during a disaster. The Committee worked to identify those with special needs and concluded that development of a comprehensive plan for all individuals was essential. To this end, in coordination with facilities, organizations, agencies, and programs serving the citizens a comprehensive plan has been developed and maintained, to provide for the care and shelter of individuals with functional or medical needs during times of emergencies or disasters.

However, to broaden its scope to expand into a more inclusive approach for the needs of Ashe County and its citizens during an emergency or a disaster, the Special Needs Planning Committee reformed into The Ashe County Mass Care Planning Committee. The Ashe County Mass Care Planning Committee is still focused on sheltering operations, and the essential care of those most vulnerable, but hopes to address broader needs as well. The committee has members from diverse disciplines which includes public health, social services, behavioral health, the American Red Cross and emergency management, partnering with long term care and other health organizations.

The Ashe County Emergency Management Office is responsible for establishing a comprehensive framework of policy and guidance for local disaster preparedness, response, recovery and mitigation operations. The Emergency Operations Plan (EOP) details capabilities, authorities and responsibilities and it establishes mutual agreements among federal, state, local and other public and private non-profit organizations, to provide for the health, safety and welfare of those persons affected during various emergencies. It is intended in all instances to be consistent with the National Incident Management System (NIMS).

Local government is responsible for the development of capabilities to provide mass care services for its citizens in the event of an emergency and should be prepared, if necessary, to receive and care for people evacuated from the area directly impacted by a disaster. The Ashe County Department of Social Services (DSS) is the lead agency responsible for shelter and mass care matters and is supported in this endeavor by the Appalachian District Health Department and the local behavioral health care agency along with volunteer agencies such as the American Red Cross (ARC). The actions taken to provide services may vary depending upon the nature and phase of the emergency. Local officials must be ready to provide different types of support in response to the unique nature of the situation

North Carolina General Statute (NCGS) Chapter 166A—North Carolina Emergency Management Act, establishes the authority and responsibilities of emergency management in North Carolina. Ashe County's comprehensive shelter system provides for the protection of its citizens from the effects of hazards through the identification of shelters and provision of care in shelters with the abilities allowed in the Ashe County Code of Ordinances**,** NCGS 166A and the Ashe County Emergency Operations Plan.

On July 22, 2004 the President issued Executive Order 13347, entitled "Individuals with Disabilities in Emergency Preparedness". This Executive Order is a decree to ensure the safety and security of individuals with disabilities in all-hazard, emergency and disaster situations.

The action of establishing an emergency Functional and Medical Needs Shelter is authorized through the Emergency Shelter/Health Facilities Waiver, Senate Bill 34 enacted into law in 1999. The act permits the temporary waiver of specific rules for specific licensed health care facilities. The enactment of this legislation amended NCGS 131E-112 and NCGS 131D-7 to permit the

Division of Health Service Regulation to waive certain rules pertaining to adult care homes during declared disasters, allowing facilities to exceed normal capacity in order to be utilized as a shelters.

Definitions

Functional or Medical Needs (previous called Special Needs[i])

For the purposes of disaster/emergency response, “citizens with functional or medical needs” refers to those individuals who have a "need" that should be addressed for sheltering purposes. These needs can include, but are not limited to, physical, emotional, cognitive, and/or medical conditions. A person with a need could be a person with factors that should be addressed or considered when that person is cared for in a shelter. Some of these factors would include individuals with functional needs, medical needs, language barriers, certain diets or family needs. Individuals who have a specific need that should be addressed are not necessarily sheltered in a different fashion or segregated, however the sheltering staff should be aware of these needs so they may be addressed and considered when deciding which shelter is most appropriate for them. It is the intention of this plan to serve the public by addressing everyone’s needs in the most inclusive and integrated way.

Individuals whose physical, emotional, cognitive, and or medical conditions would not allow the individual to be able to minimally meet their own basic needs during a 48 hour emergency period would be considered someone with functional or medical needs.

Shelters

Certain shelter facilities have been designated for Functional or Medical Needs Shelters. The individual may have functional needs but their medical conditions do not require hospitalization. These shelters are for citizens who reside at home but still have functional, medical or emotional/cognitive needs that limit their ability for independent care and seek safety in a shelter. Ashe County Mass Care has utilized care facilities for Functional or Medical Needs Shelters These facilities are required to have an emergency plan in place to designate alternative shelter site(s) for the facility’s residents. These alternative sites could also be considered Functional Medical Support Shelter.

Not every person with a medical condition or a functional need will require this type of sheltering. Every individual will be assessed and placed in the most appropriate shelter setting with every effort made to be inclusive while ensuring needs are met.

General public shelters are usually organized through the ARC and the Department of Social Services who staff and manage shelter operations as a team in order to meet the needs of individuals displaced during disasters. These shelters are intended as safe havens for individuals and families who have been forced either to leave their homes because of an impending disaster or to seek short term emergency sheltering after a disaster.

People that do not require assistance in performing activities of daily living can utilize a general public or ARC shelter. Public shelters of this type are suitable for individuals or families with accessibility needs, modification needs and additional support that can be addressed by the sheltering staff as long as the health of the individual is not compromised in this sheltering format.

Identifying Shelter Needs

Individuals and their families have primary responsibility for being prepared for and surviving disasters. This responsibility extends to the normal caregivers for individuals who are minors, or have functional or medical needs. Under most circumstances, a high percentage of evacuees will seek shelter with friends, relatives, in hotels, or other commercial alternatives rather than go to a public shelter. If those options are not available, shelters are available under emergency conditions. If children are cared for by an individual who may also need medical attention or assistance in a shelter, an assessment will be made by the medical staff, behavioral health staff and the DSS to determine provisions that serve the best interest of the children and also meet the medical needs of the individual.

Local government and the American Red Cross provide assistance as their capabilities allow during disasters. Persons with disabilities, who are capable of performing activities of daily living without assistance, including self-administration of medications, etc., are sheltered in general public shelters. Individuals with pre-existing health problems that require some limited surveillance or assistance by shelter staff may also be housed in general public shelters with accommodations and/or modification as necessary to support them and provide accessibility to all services in the shelter. This is called Functional Needs Support Services. These services and support should enable individuals to maintain their usual level of independence in a general emergency shelter.

However, when the individual's or family's needs or care, goes beyond the scope of the general public services even with adjustments or modifications, and evacuees in this situation cannot be self-sufficient during a 48 hour emergency period, the individual's or family needs may be better met by placement in a Functional or Medical Care Shelter. Functional or Medical Care Shelters are designated by county government whose care requirements are to meet the needs of evacuees beyond the scope of the general public shelters. These shelters are established to provide temporary sheltering and additional resources to individuals who have functional or medical needs. These needs may exceed the basic first aid that is available in general public shelters. There are reasonable modifications, policies, practices, and procedures in place, to ensure nondiscrimination in the pre-designated shelters as a foundation intended to be a benefit to all citizens' health and wellbeing.

Those seeking shelter will be screened by health care professionals to determine the level of care needed. If a person's condition is considered critical and their health jeopardized by staying in a shelter, they may be referred to a hospital for admission. If their condition is self-manageable with limited assistance and/or limited provisions they will be referred to a general public shelter. For those who have a functional need or long-term medical condition that is not deemed critical, but will need additional support, an assessment will be made to determine how their needs can be met and the best shelter setting for their care. Functional or medical care shelters may be considered as a best option. When utilizing a long term or other type of health care facility for a shelter, the person is not considered "admitted" to a facility but is sheltering there. They will still have the same caregiver as at home and should have their needs supported (utilities etc.) during the emergency or disaster.

In order to identify citizens with specific needs prior to an emergency, the Ashe County Emergency Management Office developed a volunteer registry for individuals who may require assistance (see *Voluntary Registry* section for further information). Registration allows emergency service personnel and volunteers to locate the registered individuals to provide

assistance, therefore individuals with needs such as oxygen, life support or feeding tube requirements, ambulatory and transportation difficulties are encouraged to register.

When conditions allow, the individual or their caregivers, relatives or friends are expected to be the primary transporters. When conditions do not permit, the local Emergency Operations Center (EOC) should be consulted for transporting individuals and their caregivers to and from the shelters. Caregivers are expected to accompany individuals that are minors or those with functional or medical needs to the shelter and are responsible for the individuals' care during evacuation and sheltering. When conditions extend the stay in functional or medical care shelters, caregivers are expected to make arrangements for their own relief.

Evacuation

People evacuate a dangerous place seeking a safer place, and they usually need to act in a hurry. Preparing before an emergency by making evacuation plans and discussing them with household members, family, neighbors and or caregivers is the best way to be ready in case an evacuation is necessary. The local office of Emergency Management has information to assist the general public in preparing for emergencies and disasters that may affect the Ashe County area. This information can be utilized in assembling a Disaster Supplies Kit and in making family or independent evacuation plans. When a disaster occurs emergency preparedness will affect how individuals survive the first few hours; making plans at the last minute can be upsetting, create confusion, and cost precious time.

When conditions require response, local governments are responsible for preparing evacuation plans and conducting evacuation operations. The county EOC will be activated and staffed as appropriate to the severity of the situation. Emergency Management will monitor all hazardous situations to determine if evacuation is needed and supervise activities to ensure sufficient shelters are opened as needed. All public shelters will be managed in accordance with applicable American Red Cross regulations and procedures. Individuals should always evacuate their homes when ordered to do so by the proper authorities. If possible, evacuate to the home of either friends or family in a non-vulnerable area.

If individuals have health problems that require medical expertise and must evacuate, it is often best for them to go with family members, friends or their caretakers. Shelters will provide medical support services; however, because of limited staffing, individuals with functional or medical needs that are seeking shelter should have a caregiver to assist with ongoing support and they should bring all necessary supplies (see Provision for Caregivers section, for information on caregiver assistance). The sheltering program is designed to assist those residents who have no other alternative for safe shelter. Individuals who are unable to provide their own transportation and care will be assisted by resources available to the County of Ashe. All minors should be accompanied by a parent, guardian or caregiver.

Items recommended if an individual plans to stay at a shelter:

1. All Required Medications and Medical Support Equipment: (2 WEEK SUPPLY)
2. Dietary Needs—Food and Water/ Liquids: Bring enough nonperishable food to survive for 72 hours per person. (Every endeavor will be made to provide food and water; however it is always best to have your own supply ready if conditions warrant it.)
3. Sleeping Gear: Pillows, blankets for each person
4. Important Papers: Wills, deeds, licenses, insurance policies, home inventory, doctors' orders

5. Do Not Resuscitate, Living Will
6. Identification: with photo and current address, medical identification card
7. Comfort Items: Small games, cards, books, batteries, etc.
8. Personal Hygiene Items: Toothbrush, toothpaste, brush/comb, deodorant, towels, dentures, glasses, hearing aids and batteries, etc.
9. Extra Clothing: A one week supply of comfortable clothing and extra sets of underwear and socks

Sheltering at Home

Deciding to shelter-in-place is appropriate in some conditions. How and where to shelter-in-place depends entirely on the emergency situation and the needs of the person(s). One of the factors determining if an individual should evacuate is whether they are able to stay in their home for several days without electricity or water following an emergency or disaster.

Sometimes, disasters make it unsafe for people to leave their residences for extended periods. Winter storms, floods, and landslides may isolate individual households and make it necessary for each household to take care of its own needs until the disaster abates, such as when snows melt and temperatures rise, or until rescue workers arrive. Each household should be prepared to be self-sufficient for at least three to five days if cut off from utilities and from outside supplies of food and water. Being prepared for two weeks is safer. Maintaining communications with neighbors, relatives or emergency personnel, listening to local radio or television stations for local news updates, and checking official social media sites is essential.

Items recommended if an individual plans to stay at home:

1. Water – 5-7-day supply of bottled drinking water (one gallon per day per person).
2. Food – 3-5-day supply of cooked, canned, or dried food. Check expiration dates each year. Have a hand-operated can opener and a non-electric source for warming foods and liquids.
3. Flashlights – Have 2 flashlights with 2 sets of batteries stored in a zip-lock bag not in the flashlights.
4. Radio – Battery powered. Store 2 sets of batteries in a zip-lock bag not in the radio.
5. Smoke Detector – Battery powered. Check every 3 months and change batteries every 6 months. Store extra batteries in a zip-lock bag.
6. Cellular Phone – Recharge batteries every week. Keep an extra charged battery.
7. Blankets – Have 3 blankets for each person.
8. Heat – Know the type of heating system you have (gas, electric, oil, etc.) and have an alternative heating source when feasible.
9. Medication – Have a 5-7-day supply of all medications.
10. Medical Supplies – Have a 5-day supply of Depends, food supplements, etc. if applicable
11. Medical Equipment (if applicable)
    - Oxygen – Have a full backup tank. Have a plan with oxygen supplier to refill when needed.
    - Feeding Pump – Have feeding and supplies for 5 days.
    - Suction Unit – Must be battery operated or have manual suction devices.

- Ventilator – Generator is strongly recommended.

** GENERATOR – Recommended if on ventilator, oxygen concentrator, or feeding pump powered by AC source. Generator must be adequate in size to support equipment, adequate lighting, and appliances such as refrigerator, freezer, and microwave. Generator must be regularly tested/maintained with a minimum of a 72-hour fuel supply.

Note: **No** charcoal or outdoor grills should be used inside a house or enclosed structure.

Sheltering of Pets

Often residents don't seek shelter during emergencies because they don't want to leave their pets. Ashe County has an Animal Response Plan in place so that residents' animals are cared for. The county has designated co-located pet shelters, when activated, where pets are housed at the same location as the sheltering operation. At other shelters pets will be collected by Ashe County Animal Control and housed in pre-designated pet shelters. Once the disaster is abated, Ashe County Animal Control will return the pets to their owners as they prepare to leave the shelter.

VOLUNTARY REGISTRY

Purpose

When disasters occur, older and disabled persons are the most likely to suffer the direct impact. Physical or mental disabilities may limit their capability to respond, or to seek help. Many older and disabled persons require community support services to live independently. Any emergency that disrupts these lifelines leaves them very vulnerable.

The historic flooding brought by Hurricane Floyd turned into the worst natural disaster ever to hit North Carolina. The mass evacuation of people along the eastern seaboard in anticipation of Floyd's arrival was the largest peacetime evacuation ever in the state. By the time the storm made landfall at Cape Fear, 227 emergency shelters were open in North Carolina housing more than 45,000 people. At the peak of the disaster, more than 62,000 people sought shelter. Many shelters weren't prepared for long-term care or medical needs of some of the individuals, the elderly, residents with functional or medical needs and the physically disabled.

The heightened awareness prompted many public safety agencies to develop improved care plans for these individuals. The Ashe County Medical Support Database/Registry was created in 1999 by the Ashe County Department of Emergency Management. The goal was to provide a method for emergency personnel to identify the functional or medical needs of residents and assist in their safety in the event of emergency or disaster.

Registration Process

The establishment of a voluntary registration process is intended to help identify individuals with functional, medical, transportation needs or those who feel they will need assistance. The database or registry includes information on the individual including address, directions to residence, medical condition, physician, health care provider and transportation needs in the event of an emergency or disaster.

Individuals with needs such as oxygen, life support or feeding tube requirements, ambulatory and transportation difficulties often require additional assistance during disasters and may register by filling out and submitting a simple form. The information may also be used to assist emergency service personnel and volunteers in locating these individuals during disaster events. This is a voluntary registration. The information will be used by emergency personnel in an effort to provide for the safety of those with evacuation needs in the event of emergency or disaster. Each fire department is provided a list of the individuals registered in the database for that fire district as needed. When a natural disaster or other hazardous emergency situation occurs where evacuation and/or shelter is necessary, emergency personnel can use the information to prioritize assistance so that response can be coordinated rapidly.

Individuals who should enroll in this registry include but are not limited to the following:

- Individuals with varying degrees of mobility impairments
- Individuals who are visually impaired and may require assistance during an evacuation
- Individuals with medical conditions such as respiratory problems, life support or feeding tube requirements, ambulatory and transportation difficulties
- Individuals with mental impairments who may become confused during an emergency, lose their sense of direction, or need further assistance.

Updating/Public Awareness

The Ashe County Emergency Management office promotes public awareness by issuing press releases and announcements to traditional media as well as utilizing social media. Ashe County also uses a Community Notification System to help disseminate important or critical information. In addition the registry information has also been disseminated though newsletters, flyers and various community outreach programs that advocate disaster preparedness.

Community support services have also assisted in this endeavor by educating their clients about the program and supplying a copy of the registration form. These agencies for the purpose of the database are known as reporting agencies. They include, but are not limited to home health agencies, council on aging agencies, local fire departments, pharmacies, schools and DSS as well as some state agencies. The office of Emergency Management also works with the local utility companies to increase public awareness and details on how to register for the database.

The database/registry is updated upon submission of a registration form. An update request is mailed out annually to the reporting agencies and the entire database is reviewed for the most accurate information. The office of Emergency Management may call residents listed on the database to verify information and obtain revised data.

Forms

Copies of the database registration forms are available upon request, published in press releases, provided to all reporting agencies and are also provided though community outreach preparedness presentations.

How to Obtain a Form

The easiest way for an individual to obtain a form is to contact the Ashe County Office of Emergency Management by telephone at (336)846-2522, or fax (336)846-2523. Individuals may also ask their home health care provider. Ashe County Emergency Management provides registry forms to the home health agencies serving Ashe County. These agencies often assist their clients in filling out the forms.

Individuals may also make inquiries through the Ashe County Department of Social Services, the Appalachian District Health Department or the local behavioral health care agency Center.

Completed Forms

Once a form has been completed it can be sent to the Ashe County Emergency Management by faxing it to (336) 846-2523, or mailing it to Ashe County Emergency Management, 150 Government Circle Suite 2400, Jefferson, NC 28640. Individuals may also call the office at (336) 846-2522 and the information can be taken over the phone, or the office is located on the second floor of the Ashe County Courthouse in Suite 2400 for those that who wish to summit the form in person.

Notification of an Emergency Situation

The Ashe County E-911 Communication Center serving as the County Warning Point is operated 24 hours a day, 7 days a week and also functions as the alternate Emergency Operations Center. Emergency warning may originate at the national, state or local level of government. Some people may self-evacuate when advance warning of impending disaster is available. Timely warning requires dissemination to the public by all available means such as the following:

1. National Warning System (NAWAS)
2. National Weather Service (NWS)
3. Emergency Alert System (EAS) aka the Emergency Broadcast System (EBS)
4. State Operated Two-Way Radio Systems
5. NC Division of Criminal Information (DCI) [Formerly PIN]
6. Ashe County Emergency Notification System
7. Local Government Radios
8. Sirens, horns, or mobile public address systems
9. Telephone
10. Local Media
11. Official Social Media Sites

Hearing impaired and non-English speaking groups are notified by the most expedient means possible. Phone, text and email notifications are available through the Ashe County Emergency Notification system. Public schools, hospitals and other special warning locations are notified by emergency personnel at the County Warning Point. (Reference: *Ashe County Emergency Operations Plan, Annex C, Notification and Warning)*

The public notification of an approaching potential emergency or natural disaster is achieved through local publications, social media and broadcasts. The local newspaper and radio stations responsibly provide information in the form of press releases and public notifications to assist residents in preparing for impending natural hazards. Area television stations and cable weather channels provide updated tracking of storms and post storm warnings and information on other hazards.

In addition, a state grant enabled the county to provide National Oceanic and Atmospheric Administration (NOAA) weather alert radios to local schools, daycare centers, rest homes, nursing homes, emergency services agencies and individuals who are blind or hearing impaired. This provides 24-hour access to the National Weather Service watches and warnings.

Role of the Local Emergency Services Agencies

The input of local emergency service agencies in disaster planning is vital. These agencies may act as a reporting agency for the database. Local agencies know the communities in which they serve, are familiar with the needs of many of their residents, and can verify important information.

The local Emergency Management Office contacts emergency service agencies with information, news bulletins and intelligence on impending hazards that may affect our area. Along with the updates they receive on the imminent hazard, they also receive an emergency checklist, reporting forms and a fresh copy of the Functional Medical Support Database residents listed in their district. This list is used for the purpose of checking on the residents during times of prolonged utility failure and/or when the area where they live is in jeopardy of becoming isolated or in need of evacuation.

Emergency Management can supply resources such as interpreters, modes of transportation, and other assistance through the county's mutual aid agreements, and Emergency Operations Plan (EOP).

SHELTER PLANNING COMMITMENT

Ashe County Mass Care and Sheltering Planning Committee

Mission Statement

The Ashe County Mass Care and Shelter Planning Committee recognizes the importance of planning for the care and needs of the population of Ashe County in times of emergencies/disasters. This population includes individuals with functional or medical needs that require daily medical attention and those who would be adversely affected by the interruption of services such as utilities, transportation, or daily professional care. Through coordination with facilities, organizations, agencies, and programs serving these individuals, a comprehensive plan has been developed called Ashe County Special Needs and Sheltering plan. However the committee recognized the need to plan for all Mass Care events providing adequate service during emergencies and disasters for all of its citizens. The Ashe County Mass Care and Sheltering Committee believes we can achieve these goals, striving to serve the citizens of Ashe County with integrated and inclusive planning.

Goals

- Practice "Inclusive Mass Care" for the whole community.
- Encouraging independence and self-reliance.
- Identify individuals who have functional or medical needs in the community
- Coordinate with organizations and agencies that have expertise and staff or volunteers available to work in shelters
- Support long-term care (LTC) and other disaster vulnerable facilities in implementing a proactive response.
- Provide essential services to individuals during times of emergencies/disasters
- Create a plan to predetermine actions to be taken by specific agencies

FUNCTIONAL OR MEDICAL NEEDS CATEGORIES & MEDICAL ASSESSMENT

Levels of Care

For the purpose of screening individuals for sheltering, the following support levels are defined and designated. It should be noted that there might be persons with impairments not included on the Ashe County Level of Care Chart who could be appropriately served in a Functional Medical Support Shelter. Each individual's needs and level of care should be assessed on a case by case basis using the Level of Care Chart as a guide only. When necessary the final determination is made on the recommendation of the health care professional by the Mass Care Coordinator, with assistance of other supporting agencies, the individual or family and/or their caregiver.

The Appalachian District Health Department prepared and made recommendations to the committee for the Ashe County Level of Care Chart (see Appendix F). This chart can be used to assist determining shelter placement. This is a tool only. Each individual or family unit's placement will be determined on a case by case basis, using recommendation by medical staff, self-determination by the individual or family unit and shelter management who may be assisted by other agencies along with the EOC and the Mass Care Coordinator when necessary. Not every individual even with the same conditions require the same level of care or have the same accessibility, functional or medical needs. Therefore the chart should be used as a practical guide.

The Support Levels of Care

- **Support Level I** includes individuals whose health would be endangered in requiring recurring professional medical care, functional medical equipment and/or continual medical surveillance and who may need to be considered for admission into a hospital, or a nursing home. It should be noted that regular admission procedures for these facilities would apply.

- **Support Level II** includes individuals requiring some medical surveillance or additional assistance. Assessment for an appropriate facility will be considered on a case by case basis. The care for persons in Support Level II will be provided by their customary caregiver who was providing pre-shelter care. These include but are not limited to home health or hospice care staff, public health staff, other functional medical staff, or friends and relatives who normally provide in-home care.

- **Support Level III** includes individuals who are independent in the pre-shelter phase and are capable of performing activities of daily living. Some of these individuals may need limited additional assistance or some surveillance. Individuals in this support level should be able to stay in general public shelters unless additional health problems arise. If the level of care requires a review then revaluation and a medical assessment may be made to ensure suitable care is provided.

Medical Assessment

Initial screening, admission procedures, and assessments are designed to determine the most appropriate care possible within the resources available to the County of Ashe. These practices will ascertain the condition of the individual or family unit and facilitate proper shelter placement. The process begins with Registration Intake, which communicates with the individual or family unit seeking shelter about their needs. Self-Determination of needs will be sought though out the entire placement process. The medical assessments will be conducted by health care professionals on an individual basis to identify needs, receiving feedback and ensure the appropriate placement within the designated shelter system. This assessment may take place prior to completion of shelter registration or placement. The feedback along with the medical assessment provides shelter operations personnel with information needed to meet the needs, providing integration accessibility and program modifications when feasible.

After initial placement has been made, medical follow-ups and re-assessments should be conducted daily on all evacuees, along with additional accommodations and modifications. These daily assessments are often conducted informally by a staff member checking in with each individual or family unit and asking them basic questions to ascertain any changes since entering the shelter; sometimes additional medical assessments may be require. The daily assessments provide the County of Ashe with information to meet the changing needs of the evacuees, to provide additional support or new support.

The Ashe County Evaluation and Medical Assessment includes a medical history, basic personal information, ongoing medical needs, and known allergies, as well as emotional and physical health conditions. It may be filled out by the individual, their caregiver, family member or shelter staff member. It is reviewed by shelter staff to establish adequate accommodations for the shelter residents. Accommodation considerations include equipment needs, medication needs and level of support and care required. The information is reviewed by a healthcare professional that completes the assessment by evaluating the individual's current health status and makes a final placement recommendation.

The Essential Medical Records and Assessment form is an account of medical status while residing in a shelter. It is a source of current information such as caregiver(s) name(s), medication administration records and medical observations. It serves as a record of care provided to each individual during his or her stay at the shelter and can often alert shelter staff of any changes needed to the individual's care or placement. A copy of this form will be maintained with the shelter reports. **All Shelter records will be located in a central location determined at the discretion of the Shelter Manager.** If any other medical records are generated, the will be preserved for six years in a method agreed upon with the Mass Care Coordinator and the EOC.

The Shelter Manager will be in direct contact with in the Mass Care Coordinator (if applicable) or the Emergency Operations Center (EOC) to convey accurate information to county decision makers ensuring that appropriate actions are made to care for the individuals. If reported to the Mass Care Coordinator, the Coordinator will report the information to the EOC.

PRELIMINARY SHELTER FORMATION

Activation & Deactivation

Purpose

The purpose of emergency planning is to ensure an adequate response to protect life and property during disaster and implement a method of providing resources for response and relief efforts. This includes resources for shelters. Shelters, including those designated for functional or medical needs, will be activated when necessary. Such activations can include response to natural or man-made disasters, when there is a need for an evacuation, or a there is a threat or an act of terrorism.

Ashe County's Emergency Operation Plan and the Mass Care and Sheltering Plan provides temporary sheltering and back-up resources for those who may need shelter. Procedures for opening shelters are in place to ensure the staffing of shelters in times of emergency or disaster and to provide resources for agencies to carry out their responsibilities in the shelter operations.

Identify Location/Facilities

In pre-identifying shelters there are many challenges and issues that must be addressed. The American Red Cross along with Ashe County Emergency Management and the Ashe County Fire Marshal conduct a facility survey and inspection as a part of designating shelters. The Ashe County Mass Care and Sheltering Committee found many advantages in using long term care facilities in providing functional or medical needs sheltering. The rational is that long term facilities are an appropriate and acceptable setting to meet the needs of the individuals with long term medical needs or with functional needs. The staff members of the long term facilities are trained to provide personal and/or medical care and are adept at assisting caregivers with meeting these needs. The admission criteria of health care facilities, adult care homes, and home care agencies are waived in order for the facility to provide temporary sheltering or other services during disasters or emergencies.

Functional and medical needs as well general public shelters are pre-identified to enhance Ashe County's ability to respond efficiently to a disaster or an emergency. Procedures for identifying shelters are necessary to assure consistency and quality of the shelters. The identification process should determine sufficient space and services for the individuals and the essential staff.

Some requirements and recommendations that can be used to pre-identify shelters are as follows:

<u>Required:</u>

- Americans with Disabilities Act (ADA) compliant
- Running water
- Hot water
- Accessible Bathrooms
- Secure storage area
- Electrical power (for refrigeration and medical equipment)
- All other requirements used for congregate shelters

<u>Recommended:</u>

- Residents should be cared for on the ground floor if the facility is in a multistory building

- Bathrooms should be in close proximity to private areas
- Accessible showering facilities
- Separate refrigeration for medications (not with food)
- Electrical outlets in the individual's sheltering areas
- Location not in vulnerable areas (e.g. flood plain)
- Telephone lines accessible to shelter
- Prior to designating as a shelter for functional and medical needs, the facility's emergency plan and its' ability to utilize a generator or alternative power source are reviewed.

General Functions

MOA

The Ashe County Mass Care and Shelter Planning Committee will utilize the memoranda of agreements between the County of Ashe and local facilities for Functional Medical Support Shelter to help meet the needs for individuals who may require additional support. The County of Ashe and the American Red Cross also have MOA or MOU and shelter surveys for general public shelters. These facility-specific agreements define the working relationship which exists between the County of Ashe and the facility to be used as potential shelter. The agreement is a provision for an emergency situation and/or a disaster when there is a need to provide temporary shelter.

Waiver and Release Statement

A Shelter Release form will be signed by each individual and/or his/her responsible party upon admission to the shelter. This helps agencies comply with regulations so that decisions can be made on the various kinds of disaster assistance and suitable placement determined. Each sheltering facility may also require an additional agreement or release form. The individual will also be asked to sign statements or an agreement that explains shelter rules and procedures.

The Sheltering Facilities

Upon request and if feasible, the owner or the facility manger will permit the American Red Cross or the County of Ashe to use the facility on a temporary basis as an emergency public shelter. The Facility Manger will coordinate with the Shelter Manager regarding the use of the Facility. The Facility Manger will identify and secure all equipment that should not be used by shelter staff or shelter residents while sheltering in the facility. The Sheltering facility and Sheltering staff will comply with all arrangements agreed upon in MOA or MOU's.

Long Term Care Facilities that are used to shelter those with functional or medical needs will maintain an emergency plan for their population that can be activated during an emergency/disaster. The facility emergency plan should include food supplies for at least 72 hours, evacuation plans and when feasible, emergency or an alternative power supply. Any individuals that shelter in the long term care facilities will not be considered "admitted" to the facilities. However, the facility may need to obtain basic information about the individual, such as current medications, special diet needs, current treatment, allergies, communication needs, assistive devices, etc. The facility must have a reasonable plan for the safe storage of medications, medical records and other supplies the individual may bring, to the shelter.

During a disaster, a long term care facility may exceed their licensed capacity, but not beyond the level necessary to provide good and adequate care. Since caregivers are expected to accompany

individuals with functional medical needs, the facility should also consider the caregivers when planning physical space, staffing, supplies and other facility needs. As considered necessary, the facility may call in extra part time or temporary staff to assist during an emergency or disaster to accommodate their residents and to assist the caregiver(s) and staff the functional and medical needs of residents if possible.

The Sheltering Individual

Preparedness is a personal responsibility. Citizens should have personal or family Emergency Plan, alternative places to shelter, transportation, food and supplies ready for emergencies or disasters. Individuals should prepare to meet their basic needs and the needs of their family in case of a quick evacuation. All minors should be accompanied by a parent, guardian or caregiver. Citizens should assemble or buy an emergency kit for their home and automobile, and include long shelf-life food and water, a medical or first aid kit, and supplies to meet their basic needs, including critical medications.

People evacuate a dangerous place seeking a safer place, and they usually need to act in a hurry. When conditions require response, local governments are responsible for preparing evacuation plans and conducting evacuation operations. All shelters will be managed in accordance with applicable American Red Cross regulations and procedures. Individuals should always evacuate their homes when ordered to do so by the proper authorities. If possible, evacuate to the home of either friends or family in a non-vulnerable area. Shelters are intended as safe havens for individuals and families who have been forced either to leave their homes because of an impending disaster or to seek short term emergency sheltering after a disaster

When Individuals seek shelter they should try to bring as much of what they might need with them. This is not always possible and there is temporary assistance for those who are without basic items.

The individual should bring all possible necessary supplies, provide for their own transportation, and if applicable provide their own caregiver. The individual or their caregiver must also provide basic information about their needs, such as current medications, special diet, current treatment, allergies, communication needs, assistive devices, etc. Sometimes the individual might be expected to either provide their own food or purchase their meals from the sheltering facility, in accordance with any agreement. However, this is not always possible. Shelter Staff and Committee agencies will work to provide for all such needs when it not possible for the individual to do so their self.

The American Red Cross

The ARC usually assists and or manages general public shelters. ARC may provide items such as cots, blankets, and other comfort accommodations. ARC may divert resources to shelters that are meeting functional medical needs as well when applicable. Resources such as cots and blankets will be directed to the elderly and those with medical needs as an ARC priority when items are not in sufficient quantities to include all sheltered individuals.

Communications

The primary communications link between shelters and the EOC will be telephone, cell phone or VIPER radio. When necessary, amateur radio operators and/or public safety personnel can be assigned to the shelters to provide additional communication support.

Activation of Emergency Operations Center (EOC)

The EOC will activate a diverse assembly of resources and personnel to make decisions, coordinate the flow of information, and formulate strategies required to deal effectively with an emergency. A number of different government agencies and organizations participate during EOC activation, depending upon the severity and nature of the emergency. The EOC can be "Fully Activated" or "Partially Activated" according to circumstances.

EOC Activation normally occurs when:

- The Chairman of the County Board of Commissioners, a Town Mayor or the Governor proclaims a State of Emergency affecting the County of Ashe or one of its jurisdictions.
- The safety and/or security of residents, etc are in peril.
- Critical or vital facility/facilities are in peril.
- When it becomes necessary to evacuate or to establish and activate General Public Shelters (ARC) or/and Shelters for those with functional medical needs.

Activation of Emergency Shelter

Procedures for opening shelters are necessary to ensure that adequate staff, equipment and supplies are available and the shelter is open when residents begin to arrive.

Roles & Responsibilities

Emergency Management

The Emergency Management Coordinator, in coordination with the DSS director (Mass Care Coordinator), is responsible for developing a comprehensive shelter program. Reference: Emergency Operations Plan (EOP Basic Plan Appendix 1, Shelter and Mass Care Organization Structure.) The Emergency Management Office is responsible for:

A. Determining the appropriate level of activation based on the situation as known.

B. Activating the EOP as necessary to deal with volunteer, animal and other community issues.

C. Coordinating with volunteer agencies to ensure food, water, clothing, shelter and other basic necessities are provided for the citizens of the operational area affected by a disaster/event.

D. Supervising the activation and initial arrangements of shelter(s).

E. Initial Administration of Logistics:

1. The primary communications link between shelters and the EOC will be telephone. When necessary, VIPER radios, amateur radio operators and/or public safety personnel can be assigned to the shelters to provide additional communication support.
2. Shelters will be provided the appropriate supplies.

3. Providing equal access to all services and accessibility to all amenities, sheltering will follow a non-discrimination policy; however shelter assignments or placement for evacuees is based on settings that are the most beneficial to their welfare and health.

DSS

The NC Department of Health and Human Services (DHHS) through the NC Division of Social Services (NCDSS) and the County Dept. of Social Services (County DSS) is responsible for shelter and mass care matters as follows:

A. Provision of shelter care.

B. Designated as the lead local governmental agency for shelter operation.

C. Directing and controlling shelter/mass care operations for the County

D. The County DSS and Health Department will coordinate operations, and mutually support shelter operations with shared personnel and support services whenever possible.

E. Works in conjunction with local Emergency Management, Health Department, Behavioral Healthcare as well as the American Red Cross, Salvation Army, Samaritan's Purse and other volunteer organizations to provide care for disaster victims.

F. Initial Administration of Logistics:

1. Mobilize appropriate personnel for the initial activation of the shelter.
2. Respond immediately to shelter site and determine operational status.
3. The shelter supplies should include, but not be limited to, shelter registration forms, shelter occupancy reports, inventory reports and event log forms. Ensure that shelter supplies consisting of appropriate forms, handbooks and identification are provided.
4. Obtain briefing from EOC on what resources are available and information on the Operational Area.
5. Ensure that the shelter is properly set up & ready for operations.
6. Ensure that a shelter staff check-in procedure is established immediately.
7. DSS in coordination with Appalachian District Health Department will provide registration services and inquiries.
8. Ensure home healthcare, caregivers, ARC and other responsible parties provide notification of shelter residents' location and responding to inquiries from relatives or friends **only** when authorized by residents.
9. Will assign a staff member to American Red Cross managed shelters as a Mass Care Liaison that will represent and report to Mass Care Coordinator or the EOC.

Appalachian District Health Department

Appalachian District Health Department responds when notified of shelter activation to perform and/or supervise medical assessment, make recommendations on placement of individuals or family units and also assist, when possible with the registration process. When Appalachian District Health Department is activated for a large shelter operation, two nurses who are qualified to do assessment are needed for the initial opening of the shelter. Other medical personnel such as EMS, the North Carolina (FAST) Functional Assessment Support Teams, and American Red Cross volunteer nurses can supplement Appalachian District Health Department nurses.

Behavioral Health Care

The local behavioral health care agency responds when requested to the appropriate shelter to conduct behavioral assessments and respond to the behavioral health needs of residents and staff. Daymark will provide staff to arrange and link to the appropriate services for the behavioral healthcare of the shelter residents and the shelter staff. Daymark will conduct psychological triage to assess emotional or behavioral needs, as necessary.

Deactivation of a Shelter

Emergency Management, in collaboration with the DSS Director (Mass Care Coordinator), will coordinate the shelter deactivation process. When the Mass Care Coordinator, determines that conditions allow for the deactivation of the shelter, the Mass Care Coordinator or a designee will notify the EOC and request that the shelter begin deactivation.

The shelter staff assisted by the Health Department staff and Daymark staff can counsel shelter residents to facilitate a smooth transition as deactivation begins, to assist in the adjustments required for these individual as they leave the shelter.

If there are any significant changes in shelter resident's condition recorded on the Essential Medical Records and Assessment, Appalachian District Health Department or other designated medical personnel may reevaluate the resident before they are discharged and provide discharge instructions.

The DSS staff, all supporting agencies and the EOC staff will ensure that all resources are returned to their corresponding agency, ensure debriefing, cleanup and final documentation activities are carried out by agencies and individuals involved in the shelter operation. Upon deactivation of a shelter, DSS will verify that the host facility is returned to a state of normal operations, and report status to the EOC.

Issues of concern and/or issues that may need corrective action should be addressed by the EOC. DSS will submit all reports and records to the Mass Care Coordinator and the EOC. Emergency Management will maintain copies of shelter records, files and reports that have been submitted and assist with submission of any expenditure statements, if any, to appropriate authorities for reimbursement.

DSS as the designated lead local governmental agency for shelter operation, will handle

A. Assembly of all records, files and reports. (All Shelter records will be located in a central location determined at the discretion of the Shelter Manager).

B. Discharge for residents to include

1. Do they have a safe place to stay? Enquire whether the dwelling to which individual is going, is safe and inhabitable. Is there a need that should be addressed before they leave the shelter?
2. Are any referrals needed? (Should the shelter resident be referred to a skilled nursing facility, hospital or other agency?)
3. Obtain a point of contact in case there are follow-up issues for which the shelter resident may need assistance.
4. Ensure the shelter resident has a copy of any discharge instructions.
5. Inquire about the transportation mode for leaving the shelter, request transportation when necessary.

C. Supervising Shelter clean-up.

D. Arrangements for supplies and equipment to be inventoried and returned.

E. Inspection of facility, documentation and reporting issues of concern and/or issues that may need corrective action to the EOC.

F. Notifying the EOC when shelter deactivation is complete and request that the shelter status be deactivated.

OPERATIONS

Command Structure

National Incident Management System (NIMS)

NIMS standardizes the incident management processes, protocols, and procedures for use by all responders and mandates use of the Incident Command System (ICS). NIMS also provides a consistent framework for incident management at all jurisdictional levels regardless of the cause, size, or complexity of the incident. Building upon the ICS, NIMS provides the Nation's first responders and authorities with the same foundation for incident management for terrorist attacks, natural disasters, and other emergencies.

Incident Command System (ICS)

ICS is a standardized, all-hazard incident management concept that allows its users to adopt an integrated organizational structure to match the complexities and demands of single or multiple incidents without being hindered by jurisdictional boundaries. ICS helps to ensure the safety of responders and others involved in the achievement of tactical objectives and the efficient use of resources.

It is designed to be interdisciplinary and organizationally flexible. The benefits of ICS are that it meets the needs of incidents of any kind or size, allows personnel from a variety of agencies to meld rapidly into a common management structure, provides logistical and administrative support to operational staff and is cost effective by avoiding duplication of efforts. ICS also ensures that

everyone has a defined responsibility in emergency preparedness. (See Training in the Plan Development section of this plan.)

Preliminary Procedures

Arrival

Arrival of Staff

The appropriate personnel will respond immediately to shelter site for the initial activation of the Shelter. The staff should begin setting up to receive individuals and supplies after the shelter site is deemed as operational by the Shelter Manager. If the shelter manager has any doubt as to whether the facility is structurally sound, the Shelter Manager may contact the EOC for a damage assessment team member to inspect the facility.

All staff reporting to the shelter must report to the Registration Desk, or the Shelter Manager if the Registration station has not been established, and sign in. All volunteers and staff should sign in and sign out every time they enter or leave the shelter. Staff members are expected to report to the shelter under the agreements and/or plans made by each agency. Shift changes should be taken into consideration with situation reporting times. Depending on the nature of the emergency, it may be impossible for staff to report during and immediately after the event. This could lead to shortages in staff and exhaustion of staff on duty. Agencies providing staff should consider two twelve-hour shifts for personnel to relieve one another as this is the typical operational period.

Arrival of Volunteers

All volunteers must sign in at the Registration Desk or the Shelter Manager's station. All volunteers and staff should sign in and sign out every time they enter or leave the shelter. Volunteers should be assigned to an area of the shelter where they feel comfortable. All volunteers should receive orientation and be supervised by the appropriate staff member.

Arrival of Supplies

All supplies that arrive at the shelter must be inventoried and kept in a secure area. The facility management personnel will track their supplies and the shelter manager and logistic personnel will supervise the tracking and recording the receipt of shelter supplies. Supplies once recorded should be distributed to the appropriate area of the shelter. Due to space constraints, supplies may have to be stored in a centralized, secure area, until the staff needs them.

Disbursement of Supplies

It is the duty of the assigned logistic personnel responsible to ensure that supplies are dispensed appropriately (i.e. assignment of Cots/Bedding). It is the responsibility of the Shelter Manager or his/her designee to determine who should receive supplies. The items are limited in number and should be assigned to those who have the greatest needs. Medical Supplies must be kept in a secured area that has been designated. The shelter resident’s medication will also be stored in this secured area and must be signed out by the individual, their caregiver if applicable, or medical staff.

Stations

Registration / Information Area

The registration area should be set up near the main entryway of the shelter to ensure that all persons coming to the shelter are screened and registered. The first person to receive the individual will record basic information first using the Registration Intake sheet. Depending on the individual's present condition and the situation/circumstances they may be sent to a triage area with the basic information before completing the registration or a full medical assessment. The Registration Liaison or a Shelter Attendant may prompt the shelter resident for information by asking a health question to ascertain if they should be assessed by the nurse prior to registering (see Admission Procedures—Registration section for procedures.)

Medical Assessment—Triage

Triage

In the event a large number of individuals arrive at one time, medical staff may be assigned to triage and have to perform a quick assessment of individual status and needs and direct those with immediate needs for treatment. Registration information will then have to be obtained after the individuals are appropriately processed. The following procedures should be followed when triage becomes necessary.

A. At least one medical person will be assigned to triage. Non-medical personnel may also be assigned to assist with required documentation.

B. Triage can take place prior to completing registration to assess individuals' immediate medical needs.

C. Provide any treatment necessary if the individual is awaiting transportation to a medical facility.

D. If an individual does not need immediate medical attention, the triage staff will assess and document the following information on the Primary Medical Assessment form:
    1. Known Diagnoses
    2. Medications
    3. Difficulties or needs
    4. Stability (physical and emotional)
    5. Allergies
    6. Initial vital signs.
    7. Do Not Resuscitate (DNR) status, if applicable

E. Triage assessment personnel may assist with the labeling of medications, medical equipment, and valuables if time permits or these tasks may be done when the individual completes the registration process.

F. Once the initial assessment is completed, personnel will direct each individual, along with his/her caregiver or family unit, medical assessment record, and belongings, to the appropriate staffed stations based on status and needs.

G. Information from each station will be provided on the registration forms or to registration personnel and all records will be preserved and provided to the Shelter Manager or the assigned liaison responsible for records maintenance.

Medical Assessment Area

It is not advisable to utilize the registration area for triage or the medical assessment, as traffic flow may be extremely heavy in that area. The purpose of medical assessment is to efficiently determine individuals into levels of care using individuals' self-determination, medical information, and current condition to enable staff to provide the best care possible to the greatest number of shelter residents.

The medical assessment area may need to be at a different location than the registration area along with a triage area, if triage is necessary, i.e. for large scale events or if there are devastating conditions and/or injuries.

A complete medical assessment must be conducted to determine the appropriate placement recomendation, modifications and support. The individual's or family unit's needs and condition should be assessed by the medical staff using the Ashe County Evaluation Registration and Medical Assessment form. Medical information will be requested and an initial examination may be performed.

The assessment team will:

A. Ensure that a brief history is obtained, either from the individual, their caregiver, or by family members, by completing the history section of the Evaluation and Medical Assessment form during registration.

B. Ensure the assessment includes basic personal information, ongoing medical needs, allergies, Do Not Resuscitate (DNR) or Living Will status, the presence of alcohol or drugs and any language barriers.

C. Evaluate the individual's current health status, feedback along with self-determination and make a final placement recommendation to Shelter Management or Mass Care Coordinator.

D. All medical assessment records will be forwarded with the shelter resident, along with the shelter registration form containing the appropriate information including the date, time and recommendation for placement, to the Shelter Manager. These records must be properly maintained with the management staff and not the originating agency.

Shelter Management Station/ Administrative Office Area

The shelter management station or area should include access to the supply area and be in an area that permits overseeing shelter operations. A shelter log, staff sign in sheet, registration forms and information, along with placement information and situation report information will be maintained by the shelter management.

The shelter management station can be located within the initial registration area on small scale operations but also can be located with the facility's administrative office, the nurse's station, or the medical assessment area, as long as the shelter management staff can easily supervise ongoing shelter operations. On larger scale operations a separate area may need to be designated as the shelter management station.

Staffing

General Guidelines

When shelter staff members are notified to report for duty, they should be provided clear decisive information and directives and clearly identified items staff may need to bring with them. All shelter personnel will utilize the Sign-in/Sign-out Sheet upon entering and leaving the shelter. All DSS personnel and volunteers assigned to the shelter should make arrangements for the care of their dependents and come with an overnight bag prepared to remain in the shelter, if necessary, for the duration of the emergency. In addition to an overnight bag, a flashlight and a bag chair or lounge chair are also suggested as items to bring to the shelter.

The type of information the staff will need when activated is the shelter location, any special instructions, whom to report to and when (time and or day), along with your position or role.

Staff members who are expected to report to work during shelter activation should have and implement a Personal Emergency Preparedness Plan that should adhere to the following guidelines:

A. Securing their home.

B. Making arrangements for family members, dependents and pets during their activation.

C. Locating the personal supplies that they will need during the activation.

D. Ensuring that they have up to date emergency contact numbers for their agency or the person who will be notifying them.

E. Ensuring that any vehicles and/or equipment they will need are operational and that any supplies they may need during the event are on hand.

F. Reviewing this plan so they are familiar with their roles and responsibilities.

Staffing Resources

Shelter staff and volunteers are essential to the operation of a shelter. Both DSS shelter staff and volunteers are present to assure a smooth shelter operation. Shelter staff and volunteers do not replace the caregivers, who remain responsible for the care of the individuals or minors, however staff is available to support a caregiver in his/her performance of primary care-giving responsibilities and assist in providing for any needs.

Staff organizational design, direction and control, and staff positions will be assigned based upon the Incident Command System (ICS). This includes specifying shifts of duty with log-in and out procedures for tracking Operational Periods, staff time and number of days worked at shelter.

The following includes basic staffing agencies and staffing resources.

A. The Mass Care Coordinator will be the Director of DSS or his/her designee. Shelter Manager and Registration Supervisor will also be DSS staff or may be an American Red Cross Volunteer.

B. Medical oversight will be provided by Appalachian District Health Department or other health care personnel.

C. The Shelter Manager, Registration Liaison, Shelter Attendants, Shelter Liaisons and general support will be provided primarily by the DSS. Volunteers from organizations such as the American Red Cross, Community Emergency Response Team (CERT), Salvation Army, Samaritan's Purse and other agencies may also be asked to fill a role in Sheltering services.

D. Behavioral health care will be provided by the local behavioral health care provider and supplemented if necessary.

E. Logistical support and general assistance to the Shelter staff will be provided by Ashe County Office of Emergency Management and the EOC.

F. Direct care will be provided by the caregiver when applicable i.e. such as for minors, or a caregiver for someone with a functional or medical need.

Care at the Shelter

The following basic supportive care will be provided to residents seeking refuge in a Shelter:

A. Triage or Medical Assessments will be conducted to ascertain a recommendation on placement. If the individual is to stay in the shelter, then a history and the registration information will be obtained.

B. Shelter resident's Comfort: Individuals who have functional or medical needs are instructed to bring their normal caregiver that assist with their activities of daily living: (who will remain with them) and all of their own supplies. Individuals who are unable to provide their own transportation, supplies and care will be assisted by resources available to the County of Ashe.

C. Activities of Daily Living: If the shelter resident is a minor or someone with functional or medical need, the caregiver should assume primary responsibility for assisting the resident to the bathroom, with meals and personal care. The Shelter staff is available to provide additional assistance, if needed, on a limited basis.

D. Procedures: Residents, families and/or their caregivers should assume responsibility for managing their own care for any procedures that they have been managing in the home

setting. The Shelter staff will provide supervision and additional assistance only if needed and according to protocol.

E. Medications: The individual, family or their caregiver when applicable, assumes responsibility for administering routine medications as in the home setting. The Shelter staff will secure all medication in a safe location and the responsible individual must sign out medication to administer according to protocol.

F. Oxygen: The individual or their caregiver when applicable assumes responsibility for managing oxygen and equipment.

G. Safety: The Staff assigned to a Shelter are operating in an emergency situation and should exercise reasonable care and judgment to assure individual safety. The following conditions and precautions are to be kept in mind when operating in any Shelter:

1. Standard precautions and body substance isolation precautions are to be utilized
2. Smoking is not allowed unless designated by the sheltering facility (Facility Manager) and the Shelter Manager.
3. Caregivers are required to accompany all minors, and when applicable those who need assistance functional or medical care.
4. Resident placement in the Shelter shall include consideration for environmental safety throughout the sheltering event.
5. Only limited numbers of folding cots and blankets are available in the Shelter. The cots may be hazardous for mobility and may not be suitable for infirmed or individuals with certain conditions. Every effort will be made to find safe bedding when possible.

H. Documentation: Services provided should be documented with the resident's registration and medical records. Arrangements for reimbursement must be made through appropriate sources. All expenses should be appropriately documented to submit for reimbursement.

Food/Feeding Responsibilities

A. The feeding responsibilities in a shelter include supervising safe on-site food preparation and service for individuals and caregivers. The Food Service Liaison is responsible for overseeing this and for ensuring safe food handling. If the resident is on a modified diet, a list of appropriate foods along with written instructions for the diet must be provided to the Food Service staff.

B. It may be the responsibility of the individuals and their caregiver, who are placed in a ~~shelter designated for functional or medical needs, to pay for, or provide for, their food supply.~~ Most host facilities that provide sheltering for functional or medical need residents may prefer that the shelter resident procure food through the facility as not to interrupt the activities of daily living for normal residents in the facility. The sheltering staff will address needs and endeavor to ensure everyone has adequate food and supplies along with times set aside for snacks. Individuals, families and caregiver may leave i.e. go eat and return at

any time as long as staff are notified they plan to return, they sign in/out and lights out procedures are followed.

C. The DSS Mass Care Coordinator shall contact Ashe County Emergency Management when food supplies are needed. Options for providing meals at the shelter include but are not limited to:

1. American Red Cross
2. Ashe Baptist Association
3. Ashe County Sharing Center
4. Ashe Really Cares
5. Ashe Services for the Aging- Delivered Meals Program
6. Helping Hands
7. Hunger Coalition
9. Salvation Army
10. Samaritan's Purse

Medication Storage and Administration—Record Keeping

A. All drugs shall be stored in designated areas within the facility, that are sufficient to insure the proper sanitation, temperature, light, ventilation, moisture control, segregation and security. These conditions must also be considered when drugs are being distributed/transported from one area/facility to another area/facility.

1. There are exceptions an example: a rescue inhaler which must be carried on the resident or in their possession at all times. It should be logged and recorded as dispensed on the Medication Dispensing Log and noted that it is a rescue inhaler. Another example could be an Epipen.

B. All drugs requiring refrigeration must be stored in a refrigerator designated for drug use. The refrigerator and/or freezer must have a thermometer and the temperature must be checked and recorded on a routine basis to ensure the proper temperature range specified for those particular drugs.

C. Drugs for external use must be stored apart from drugs for internal use or injection (segregated at a minimum, by using different shelving or bins).

D. All drugs shall be stored in a secured area. Access to drugs should be limited to specifically authorized personnel, as indicated by this plan, and the area should be sufficiently secure to deny access to unauthorized persons.

E. Documentation required for dispensing a drug pursuant to an order issued in conformity/with a nurse protocol, which must be included on a Drug Dispensing Sign-out Sheet":

1. Name, strength, and dosage form of drug dispensed.
2. Quantity dispensed.
3. Date dispensed.
4. Name of patient
5. Lot number and expiration date, per legal requirements, should be recorded on the current medication list in each resident record. If expiration is not noted it is one year from dispensed date.

F. All records pertaining to drug accountability (from ordering and receipt of drug to actual patient administration) must be kept on file. Any medication discarded or any discrepancy in accountability will be logged and witnessed.

G. No health center or treatment site/shelter in which drugs are handled shall operate in any manner or dispense any drugs under unclean, unsanitary, unhealthful conditions or under any condition which endangers the health, safety or welfare of the public. In the case of a long term care facility as a shelter, all drugs shall be kept beyond reach of the host facility residents. In general public shelters or another type of shelter all drugs shall be kept from unauthorized individuals, minors and visitors.

Visitors

It is probable that the shelter may be visited by other people who are not there to stay. All visitors must sign in at the registration area or they may be directed to the Shelter Management station and state their purpose. The (Facility Manager if applicable and) Shelter Manager should be notified of all visitors on the premises. Visitors should be asked to wait in an area that does not interfere with shelter or facility operations. They should be treated in a courteous manner and asked to wait for the Manager or a management staff member. We do not confirm who is located in a shelter or their shelter location without the evacuee's permission. The *American Red Cross Safe and Well* program can be utilized.

The EOC should be notified if the media arrives and the Public Information Officer (PIO) will instruct the shelter management on how to proceed.

All visitors, volunteers and staff will follow basic shelter policy:

1. Everyone must sign in or register.
2. No smoking is permitted unless designated by the host facility.
3. Courtesy is expected at all times.
4. Children in the shelter must be under the supervision of an adult.
5. Shelter residents are responsible for their own personal belongings and valuables
6. No alcoholic beverages, illegal drugs, firearms, or explosives will be allowed

Registration

Registration/Admission Criteria

A. Referrals to a shelter may come from a variety of sources but in all probability will be referred to the EOC prior to shelter activation. Most common referrals are:

1. Home health or personal care agencies
2. Durable Medical Equipment (DME) or oxygen providers
3. The hospital and/or its emergency department
4. Law enforcement, fire, or rescue services
5. County or private human services agencies
6. The functional or medical needs individual, his/her family, or caregiver
7. The evacuation of a LTC facility or group home

B. Conditions that may constitute **functional or medical needs** include but are not limit to the following :

- Alzheimer's Disease (ALZD)
- Ameliorating Lateral Sclerosis (ALS) wheelchair necessity
- Arthritis –If Limits Ambulatory Status
- Asthma
- Cerebral Palsy—Requiring Assistance
- Continuous Ambulatory Peritoneal Dialysis (CAPD) up to 3 Times Per/Week
- Dementia
- Eating and Swallowing Disorders
- Foley Catheter—Requiring Monitoring
- Fractured Bones—If Limits Ambulatory Status
- Multiple Sclerosis—Requiring Assistance
- Muscular Dystrophy—Requiring Assistance
- Neuromuscular Disorders
- Neurological Deficit
- Osteoarthritis/Osteoporosis—If Limits Ambulatory Status
- Parkinson's Disease—Requiring Assistance
- Psychosis
- Respirator/Ventilator Dependent
- Seizures
- Sleep Apnea
- Wounds—Moderate (Minor served in ARC shelter & Severe treated in a hospital)

C. Appropriate for functional or medical Needs Admittance:

1. Individuals who are non-ambulatory with or without the use of assistive devices.
2. Individuals who are accompanied by a caregiver.
3. Individuals who are dependent on others or in need of assistance by others for routine care (e.g. eating, walking, toileting, etc.).

4. Individuals who need assistance with managing health care or who need assistance with medications or with using medical equipment.
5. Individuals who cannot safely sleep on a cot or mat.

Registration/Admission Procedures

The Registration Liaison and Shelter Attendants may do a quick assessment of the individual's needs and level of care on a case by case basis using the Registration Intake form which is a screening and an initial assessment tool. Registration Intake should enable shelter staff to determine the basic need for each individual or family. The secondary purpose is to assist in recommendations for proper and safe placement of the evacuees. This tool should minimize stress and emphasize the safety and well-being of those we serve during times of disaster. The intake tool is sometimes referred to as the "Two Plus Two" concept. If a family is seeking shelter, the option of using only one Registration Intake for the whole family, is at the discretion of the registration staff as this may be preferable.

Everyone has equal access to the shelters and services. Individuals with accessibilities and functional needs do not necessarily have medical conditions and typically do not require the care that medical shelters provide. Even for those with medical conditions the type of care and support varies, as even individuals with the same medical condition may have different needs.

The Registration Attendant should prompt the individual or family member for information by asking a health question to ascertain what their greatest needs may be or if they should be assessed by the nurse prior to registering. Both the Registration Intake and the Level of Care Chart can assist in determining if acute care is necessary. If an individual has an acute or critical condition they may be referred to triage or a hospital immediately. If the situation allows, the registration staff should attempt to obtain and record basic information first, the resident's name, address, next of kin, date/time of arrival and mode of transportation (i.e. personal car, the bus number, ambulance or van).

Depending on time, the individual's condition, situation and circumstances they may be sent to a Triage or Medical Assessment area before completing the registration process. If the individual is already in the Functional or Medical Needs Database, the database information can also assist with assessment, as this information can be also obtained.

An Ashe County Registration form must be filled out by the individual, caregiver, family member or with the assistance of a Shelter Attendant. The Registration Liaison or Attendant will assist to ensure the forms are completed.

If there were no prior issues once the registration form is completed, the individual should then be directed to the triage and/or medical assessment area. At the medical assessment station a recommendation for shelter placement, support modification or recommendations referring to the appropriate facility, will be made with the feedback, self-determination and the medical assessment.

The registration/information area or station should be near the medical assessment area and should include updated information about the operation, event and the situation. Personnel should remain at the information area to provide updates to the staff in the shelter as operational information can impact care. The sign-in sign-out forms are also maintained at the registration station.

When the individual's immediate needs are met, and a medical assessment is completed, then the registration staff, along with the individual or family should review the registration forms to

ensure they are complete. The registration staff should also provide the shelter resident with any additional information needed about the shelter and review or read the "shelter rules" to the individual.

Shelter Registration Forms and Procedures

A. Upon arrival, the individual's name and other required information will be entered onto the Shelter Registration Log. A registration or chart number for the individual will be generated at this time and a photo ID may be created with a digital camera and placed with records if applicable.

B. Any names of the caregiver and/or family members accompanying those individuals who are minors, or may need functional or medical assistance, are also recorded on the Shelter Registration. Caregivers that will administer medication will be recorded on the Essential Medical Records and Assessment form.

C. A Waiver and Release form will be signed by each individual and/or his/her responsible party upon admission to the shelter.

D. The individual or family along with caregivers will be provided with a copy of the Shelter Rules.

E. All personal property, durable medical equipment, etc. is the responsibility of the owner or, if applicable, their caregiver.

F. If time permits, the registration, medical assessment, and all other forms should be completed, to include vital signs, medical history, medications, and allergies before placement assignment and prior to moving the individual to the dormitory area.

G. If a Do Not Resuscitate (DNR) order or a Living Will is presented, it should be noted and highlighted on the Shelter Registration, Medical Assessment form and the Essential Medical Records and Assessment form.

H. If appropriate the shelter management and or medical staff will review medications and care with the individual and caregiver.

I. All Medication must be stored in a secured area for everyone's safety.

J. Individual information will be recorded on Shelter Assignment log.

K. All admissions, discharges and/or departures will be reported to the EOC on a daily basis, recorded on shelter log and reported to the Mass Care Coordinator who will complete the operational period's Situation Report, for tracking purposes.

L. Shelter Registration Log will be kept by the Registration Liaison and will be used to provide information to, or assist in the notification of, a family member, a personal representative of the individual, or another person responsible for the care of the individual. The information provided will be the individual's location, general condition, or death.
    1. Shelter management will work through the American Red Cross to notify relatives or a contact person at the sheltering individual's request.
    2. Shelter residents may be registered on the American Red Cross's *Safe and Well List.*
    3. Any inquiries to the shelter about sheltering individuals will be advised to contact the American Red Cross for general information on the individual's condition. Unless the evacuee has gave express permission to disclose information.
        a. During a disaster the American Red Cross will provide a local number that rolls over to the ARC chapter headquarters where volunteers will answer the phone and provide information about shelter residents.
        b. This information provided will be general in nature - that they are located at an Ashe County Shelter and nonspecific information about their condition such as in a health range of poor, fair, good and doing well.
        c. The individual may want to appoint a contact person such as a relative, neighbor or friend for more specific information. The Red Cross can refer inquiries to this contact person. It will be at this contact person's discretion to determine what information is given and to whom.

Rules

Basic Shelter Rules and Policies for Visitors, Volunteers, and Staff

1. Everyone must be identified, and must then sign in or register upon arriving and sign out when discharged or leaving the shelter.
2. No smoking is permitted unless designated by the host facility.
3. Courtesy is expected at all times.
4. Children in the shelter must be under the supervision of an adult.
5. Individuals are responsible for their own personal belongings and valuables.
6. No alcoholic beverages, illegal drugs, firearms, or explosives will be allowed.

Shelter Rules and Policies For the shelter resident and Caregivers

1. The shelter may be crowded. RESPECT the rights and privacy of others.
2. Keep your own space clean and neat.
3. Keep yourself as clean and neat as possible.
4. Speak in a quiet tone: no yelling and no profanity.
5. Keep all noise to a minimum: no loud radios, CD players, TVs, etc. Staff will monitor and provide news updates to avoid disturbing those trying to sleep.
6. Lights will be dimmed at a time designated by the host facility or shelter staff (i.e.11:00 p.m.). However, the care and observation of individuals in the shelter may require brighter lighting at times.
7. If the shelter provides a TV, the majority rules on programs to be watched. Shelter staff will determine what is viewed if an agreement cannot be reached or if something is deemed inappropriate.
8. Shelter phones will be available for emergency calls only and will be limited to 5 minutes. Shelter staff will determine phone use.
9. Shelter staff are not responsible for the loss of money, medications, equipment or other personal items. Please take care of these items. Items can be stored in a locked area upon request.
10. No smoking is permitted unless designated by the host facility
11. No alcohol or illegal drug use will be permitted inside the shelter.
12. No weapons of any kind are allowed in the shelter.
13. No borrowing and no stealing will be permitted.
14. No fighting, either verbal or physical will be permitted.
15. No sexual activity will be permitted.
16. Supplies and food brought to the shelter by individuals belong to them alone and will be shared only if the individual desires to do so. Sharing of personal items is discouraged.
17. Food and beverages (except water) are not to be consumed in sleeping areas.
18. Cots will first be provided to the shelter residents according to functional or medical limitations.
19. Caregivers will only be provided with cots if availability permits
20. Supplies provided by the shelter will be given to all individuals according to need and availability.

21. Functional or medical needs individuals, along with other shelter residents will have food service priority over caregivers/family members and visitors. Second servings of food and beverages will be offered to residents before caregivers/family members can receive second servings. Servings will be moderate.
22. Stockpiling or hoarding of shelter-provided food is not allowed.
23. To the extent possible games, books, and activities will be made available at the shelter. Such activities are to be carried out quietly and with respect for others.
24. Shelter staff, facility staff, volunteers, residents, caregivers and visitors should be treated with courtesy and respect.
25. Areas designated for staff use are off limits to those being sheltered.
26. Caregivers are expected to provide all routine care, as they would do at home. Caregivers must remain in the shelter until the individual for whom they are responsible is discharged. Short leaves or breaks may be permitted if arranged with and approved by shelter staff.
27. No pets are allowed in the shelter. Service animals are permitted but care, feeding, and waste elimination is the responsibility of the individual, caregiver, or family.
28. Caregivers/families of individuals with a functional or medical need are discouraged from bringing children to the shelter to visit. An assessment will be made by the medical staff, behavioral health staff and the DSS to determine if children are allowed to stay at a shelter that serves the functional or medical needs of an adult relative (the determination will be in the best interest of the child as well as the medical care of the individual). If children are present, the parents or caregivers are responsible for keeping them quiet and controlled. No running, shouting, etc. Individuals in this type of shelter are unwell or have conditions that make it difficult to engage in the activities of daily life and undue stress can have an adverse effect on their care.

Shelter Rules Are For The Safety Of Everyone.
Shelter Rules Will Apply Equally To All Individuals In The Shelter

Duties and Responsibilities

Emergency Management

Emergency Management is responsible for developing and implementing a comprehensive Emergency Operations Plan (EOP), which includes emergency procedures and protocols for the activation of emergency shelters, transportation and evacuation. Emergency Management will advise the shelter staff on all aspects concerning emergency management, emergency services and public safety.

Ashe County Emergency Management also works with agencies and long term care facilities on specialized facility emergency plans and is responsible for maintaining and updating the Ashe County Functional or Medical Needs Database.

The Emergency Management Coordinator, in coordination with the DSS Director (Mass Care Coordinator), is responsible for maintaining a sufficient shelter program. Emergency Management will provide essential emergency information to the DSS Director who will in turn notify shelter staff. Emergency Management will ensure that shelters are opened and activated in accordance with the county's EOP. Ashe County Emergency Management will coordinate with local and state agencies to assure food and medical supplies and other necessities are available as requested.

When it is not feasible for individual(s), their family or caregivers to provide for their own transportation to and from the shelter, the Ashe Emergency Management office through the activation of the county's Emergency Operations Plan (EOP) has the capability to assist with transportation.

If necessary, Emergency Management and the Appalachian District Health Department will work with other agencies in providing health care service personnel that will be made available at the shelter to provide assistance for individual(s) that have functional or medical needs and does not have a caregiver to assist in those needs. One appointed caregiver will be provided to assist every five individuals and will be assigned upon placement of the first individual who doesn't have a caregiver. When notified that there is a need at a shelter, Emergency Management will work in partnership with DSS and local resources to assure food and other necessities are supplied.

Emergency Management is responsible for activating the EOC to appropriate level of activation based on the situation as known. During a disaster or emergency, Emergency Management staff will be positioned in the area where they are able to implement plans and allocate resources. In all probability, that location will be the EOC or Command Post.

A. Activating the EOP as necessary to deal with volunteer, evacuations, transportation, sheltering, and other community issues.

B. Include in the Incident Action Plan projected staffing and other support requirements for next 48 hours.

C. Supervising the activation and initial arrangements of shelter(s).
    1. Shelters will be provided the appropriate supplies.
    2. Mobilize appropriate personnel for the initial activation.
    3. Provide briefing from EOC on what resources are available and information on the Operational Area. Organize and brief staff. Assign staff to specific functions.
    4. Logistical support and general assistance to the shelter staff.

5. Coordinate recruitment of additional personnel.
6. Establish a shelter log reporting process and prepare situation reports.
7. Ensure proper system is in place to track expenditures.
8. Assuring adequate food supply for residents and staff/volunteers.
9. Shelter Maintenance – Assure that staff are designated for building maintenance and upkeep if necessary.

D. Coordinating with volunteer agencies to ensure food, water, shelter and other basic necessities are provided for the citizens of the operational area affected by a disaster/event. Options for providing meals and other resources at the shelter include but are not limited to:

1. American Red Cross
2. Ashe Baptist Association
3. Ashe County Sharing Center
4. Ashe Really Cares
5. Ashe Services for the Aging- Delivered Meals Program
6. Helping Hands
7. Hunger Coalition
8. Salvation Army
9. Samaritan's Purse

D. When circumstances permit, assisting the DSS and Appalachian District Health Department with registration services and inquiries; and providing notification and responding to inquiries from relatives or friends.

E. Emergency Management, in collaboration with the DSS Director, will coordinate the shelter deactivation process by:

1. Returning rented or borrowed equipment to owners and saving receipts.
2. Processing invoices promptly for payment and keeping copies.
3. Providing receipts for all purchased items to the Finance Officer.
4. Receiving, inventorying, packing and storing or returning all reusable shelter supplies.
5. Ensuring records and reports are preserved.
6. Addressing issues of concern and/or issues that may need corrective action.

Mass Care Coordinator –Director of DSS

The Mass Care Coordinator will be the Director of DSS or his/her designee. The NC Department of Human Resources (DHR) through the NC Division of Social Services (NCDSS) and the County

Department of Social Services (County DSS) is responsible for shelter and mass care matters including coordinating all Shelter Management. The DSS Director will oversee all shelter and mass care operations including shelters managed by American Red Cross as well as Functional or Medical Needs Shelters. As Mass Care Coordinator, the Director will assign Shelter Managers or Liaison for each shelter as well as other staff.

On a large scale operation it could be feasible that the DSS director may have to serve in a Unified Command, necessitating that the director designate the position of Mass Care Coordinator to another DSS staff member.

On a small scale operation the DSS Director may serve in the position of Mass Care Coordinator as well as a Shelter Manager, as long as the responsibilities are kept separate.

The Mass Care Coordinator is responsible for directing and controlling shelter/mass care operations for the County as follows:

A. Ensuring that DSS notifies the NC Division of Health Service Regulation within 72 hours of the applied waivers for a long term care facilities to serves as a shelter.

B. Coordinate shelter locations and operations, and mutually support shelter operations with shared personnel and support services whenever possible.

C. Working in conjunction with local Emergency Management, Health Department, and Behavioral Healthcare as well as the American Red Cross, Salvation Army, Samaritan's Purse and other volunteer organizations to provide care for disaster victims.

D. Obtain briefings from EOC regarding what resources are available and information on the Operational Area; obtain briefings from shelter operations. Complete situation reports for the EOC.

E. In coordination with the Emergency Management Coordinator, the Mass Care Coordinator is responsible for carrying out activation of shelters and activation duties as follows:
    1. Mobilize appropriate personnel for the initial activation of the Shelter.
    2. Order start up supplies and request additional support as needed through EOC.
    3. Supervise Shelter Managers.
    4. Coordinate recruitment of additional personnel.
    5. Assess needs for the administrative area, equipment, supplies, and staff at the Emergency Shelter.
    6. Assess feeding options and make arrangements through EOC.
    7. Establish staffing schedules.

F. Meet regularly with facility representative to share concerns and resolve potential problems.

G. Maintain communications with EOC, Emergency Management Coordinator and Director of Public Health.

H. Assess protection and preservation of all Emergency Shelter records.

I. During deactivation, the Mass Care Coordinator in collaboration with the EOC will coordinate the shelter deactivation process. When the Shelter Manager determines that conditions allow for the deactivation of the shelter, the manager will notify the Mass Care Coordinator who will contact the EOC and request that the shelter begin deactivation.

J. Arrange for supplies and equipment to be inventoried, used appropriately and then returned.

K. Forward all pending financial issues to the EOC

L. Notify the EOC when shelter deactivation is complete and request that the shelter status be listed as deactivated or closed.

M. Complete final Emergency Shelter Operations Report

Shelter Manager—Shelter Staff and Functions-DSS

Shelter Manager will oversee and advise the Shelter Staff. The DSS staff, in consultation with Appalachian District Health Department staff, will assess the needs of the individual and make decisions as to which facility will best serve the individual's needs. The Shelter Manager may appoint a team of Shelter Liaisons and Shelter Attendants to help manage the shelter and ensure proper care is provided. The Shelter Manager may also have an Assistant and a Deputy to fulfill the manager's role and responsibilities. DSS staff will supervise the operation with a DSS employee(s) present 24 hours per day. DSS employees will not provide any personal care to the residents at the shelter but manage the shelter and its resources.

A. Shelter Manager is responsible for opening of shelter and activation duties as follows:
    1. Respond immediately to shelter site & determine operational status.
    2. Set up the station areas (i.e. registration, medical assessment, administrative)
    3. Ensure that the shelter is properly set up & ready for operations
    4. Ensure that a shelter staff check-in procedure is established immediately.
    5. Ensure home healthcare, caregivers, ARC and other responsible parties provide notification of shelter residents' location, and respond to inquiries from relatives or friends.

B. Shelter Manager is responsible for overseeing the ongoing operation of the Shelter duties as follows:
    1. The DSS Shelter Manager shall contact Mass Care Coordinator or the EOC when food or other necessities are needed.
    2. Assemble all records, files and reports
    3. Facility Manager will compile information for the Mass Care Coordinator's situation report of shelter activities; provide this information to Mass Care Coordinator for each operational period.
    4. Conduct staff meetings to include disaster updates and to identify the residents' needs.

5. Provide updated information to the shelter residents about the status of the disaster or emergency situation.
6. Routinely inspect the safety and sanitation of the shelter.
7. Assess that health protocols for staff and shelter residents are followed
8. Work with the host Facility Manager and food providers, through or with the Food Service Liaison to ensure appropriate menus.
9. Hosting shift briefings and report on shelter census, food service statistics, accomplishments, problems and recommendations.

C. When the Shelter Manager determines that conditions allow for the deactivation of the shelter the manager will notify the Mass Care Coordinator and begin closing actions as follows:
    1. Coordinate closing plans with EOC
    2. Communicate closing plan to shelter staff, shelter resident, caregivers, and facility staff.
    3. Complete an inventory of supplies owned by the host facility that may have been used during shelter operations.
    4. Return rented or borrowed equipment to owners and save all receipts
    5. Arrange for or supervise the cleaning of facility
    6. Forward all pending financial issues to the EOC through the Mass Care Coordinator.

Facility Manager

Facility Manager is the person representing, or is the owner of, the facility being used as a temporary emergency shelter. The Facility Manager will be the primary point of contact for interface with the Emergency Shelter Manager, Mass Care Coordinator and the Coordinator of Emergency Management.

The Facility Manager will notify the Shelter Manager, Mass Care Coordinator or the county EOC if problems occur while sheltering individuals for the county. Facility Manager following specific guidelines will ensure:

A. The facility will maintain an emergency plan for their population that can be activated during an emergency/disaster. The facility emergency plan should include food supply for at least 5 days, evacuation plans and, when feasible, an emergency power supply.

B. Facility Manager's first and primary responsibility is to the facility's residents if applicable.

C. Because the admission criteria of health care facilities, adult care homes, and home care agencies is waived to provide temporary sheltering during disasters or emergencies, the facility may exceed their licensed capacity, but not beyond the level necessary to provide good and adequate care for the facility's residents. Shelter residents in such facilities will not be considered "admitted" to the facility, however the Facility Manager will consider the welfare of residents as well as those sheltering when making care decisions, nevertheless with the residents as their primary responsibility.

D. When analyzing for physical space, staffing, supplies, and other facility needs, the Facility Manager should allow that caregivers are expected to accompany those who need functional or medical assistance and include the caregivers during these considerations.

E. The facility serving as a functional medical shelter may need basic information about the individual, such as current medications, special diet needs, current treatment, allergies, communication needs, assistive devices, etc. Therefore the Facility Manager or the facility's staff may access the shelter resident information contained in shelter records, however the information will only be used to ensure awareness and proper care.

F. Facility Manager will determine when the facility has reached its operational capacity. The Facility Manager agrees to notify the Shelter Manager and the DSS staff as capacity decreases or exceeds what the Facility Manager deems as a safe capacity limit.

G. The Facility Manager must have a reasonable plan for the safe storage of the medications and medical supplies. The caregiver will be expected to administer medications, and sign medication records.

H. As considered necessary, The Facility Manager may call in extra part time or temporary staff to assist during an emergency or disaster to accommodate the functional or medical needs residents and provide personal care services to these residents if needed. (During a "Declared Disaster" the funding for emergency staffing **may be** reimbursable. FEMA may make changes to the reimbursement criteria so use discretion.)

Registration and Admissions Liaison

The Registration Supervisor or Liaison will assist or supervise the registration of the shelter residents. Registration and general support staff will be provided by the DSS, local volunteers, American Red Cross, Salvation Army, Samaritan's Purse and volunteers from other agencies.

On a small scale operation the Shelter Manager may have dual positions such as the Shelter Manager and the Registration Supervisor. During large scale operations the Registration Supervisor will oversee the registration staff and volunteers and will report directly to the Shelter Manager or Shelter Management Support Staff. The registration staff will use the registration forms outlined in this plan and keep an account of a basic census, the number of persons using the shelter during each operational period and the number of individuals that have entered and or left the shelter through-out the event. The Registration Liaison and the Registration Attendants duties are as follows:

A. Ensure those seeking shelter sign-in and out and complete registration forms.

B. Keep a log for sign-in/sign-out of each person using the shelter. The Registration Liaison will keep the Shelter Manager informed of the number of persons using the shelter along with each caregiver assisting shelter residents.

C. Keep all Registration Forms secured and only allow authorized persons access to the shelter resident's information.

D. Ensure each shelter resident has signed a Waiver and Release form.

E. Oversees the registration area.

F. Admits and discharges individuals including their dependent(s) or caregivers when applicable.

G. Registration staff maintains an accurate log by name and placement assignment, number of admissions and discharges, for an accurate bed count.

H. Registration staff will provide information for situation reports for EOC to the Shelter Manager.

I. Will provide resident, caregivers and visitors with appropriate shelter rules.

General Support Staff—DSS

Local DSS staff are primarily responsible for the non-medical aspects of the shelter. In general these duties include:

A. Will assist with the receipt, storage, securing and distribution of supplies and equipment for the shelter.

B. Will follow general guidelines and protocols.

C. Will assist with opening and registration procedures and give the residents, caregivers, and visitors a brief orientation.

D. If necessary, may assist with feeding and other service provided at the shelter.

E. Obtaining refreshments and basic comfort items for the shelter residents as needed (e.g. blankets, pillows, etc.)

F. Shelter staff may relieve caregivers when they take short pre-approved breaks or leaves. Note: these breaks or leaves must be approved by the Shelter Manager.

G. All shelter staff will assist in building security and report any problems to the Shelter Manager.

H. Shelter staff will assist in cleaning and closing procedures.

Clerical/Office

Clerical/office worker (if available) works under the direction of the Shelter Manager and provides administrative support at the shelter. The clerical/office worker performs clerical duties as assigned. Duties include, but are not limited to:

A. Maintaining paperwork

B. Helping residents find right location and setting-up

C. Assist with the protection and preservation of all Emergency Shelter records

D. Assist in maintaining list, log and records

E. Assist in notifying relatives of resident location, if applicable.

F. Reporting information to Shelter Manager, Mass Care Coordinator or the EOC.

G. Assisting residents with arranging for transportation needs.

H. Assisting in distribution of food.

I. Assisting in maintaining an orderly and clean area.

J. Report any problems.

K. Assist with situation reports, planning and problem solving.

L. Participating in briefings

The Role of the Health Department & Health Care Personnel

Appalachian District Health Department will oversee and advise the Shelter Staff on all aspects concerning medical issues. Appalachian District Health Department staff will make recommendations to the shelter staff and supervise the administration of Ashe County Medical Assessment; assist and make recommendation to DSS staff about the needs of the individual and make recommendations to DSS staff as to which facility will best serve the individuals' needs. Appalachian District Health Department and the Ashe County Emergency Management staff will work with other agencies in providing health care service personnel that will be made available at the facility to provide assistance for individuals that have functional or medical needs but are unable to provide their own caregiver. Personnel may be obtained from the following or other local resources:

- Local Council on Aging agency
- Home Healthcare
- Local Hospital nursing staff
- Local LTC centers

Assessment

There should an initial Medical Assessment as part of the registration process. The Registration intake screening process has been altered to offer multiple opportunities for resident's needs to be identified and addressed. An initial intake at the registration desk makes two observations and asks two questions of new shelter residents to help them immediately if needed, and creates an awareness that help is available. The intake is supplemented by a Cot-to-Cot methodology of disaster health services nurses making at least daily rounds of the shelter to interview individuals and families, and assess for activity of daily living (ADL) support, health and/or mental health needs.

Studies by Janice Springer DNP, RN, PHN, an American Red Cross Nursing consultant, have shown that assessing needs should be an ongoing process throughout the duration of the shelter operation. Utilizing the Cot-to-Cot methodology and CMIST assessment. CMIST C-Communication, M- Maintain health, I-Independence, S-Safety, Support Services, and Self-determination and T-Transportation is type of assessment that moves away from defining functional needs in medical terms however it also addresses medical and non-medical needs in an integrative setting. The Continued Assessment form enables the staff or Medical Station Nurse or other medical personnel to conduct additional assessments at least once every 24 hour period.

It is preferable for the nursing or other medical staff to conduct the Continued Assessment. However, nursing staff for shelters are limited and their duties in the shelter can be vast, therefore shelter staff and attendants may conduct the Continued Assessment. This is acceptable because the studies further show that relationship-based assessment is the best practice. Any medical concern should be reported to the nurse or medical personnel immediately and all assessments must be reviewed by a nurse or medical personnel daily. The Continued Assessment must be conducted at least once every 24 hours but can be conducted as often as needed.

Any individual referred to the Nurse or medical station will have Continued Medical Assessment in addition to Continued Assessment as promptly as possible.

Nursing Services

A. Respond immediately to shelter site, set up the Medical Assessment Station and when necessary the Triage Station. For a large shelter operation two nurses are needed for the initial opening of the shelter.

B. Provide staff to perform triage when necessary.

C. Provide staff to conduct a Medical Assessment to identify any accessibility, functional or medical needs of the individual or family. In coordination with the evacuees, the Medical Station provider will make a recommendation on placement, appropriate modification and support needed as admission criteria and recommend placement to which facility will best serve each individual's needs.

D. Review the Continued Assessments conducted by shelter staff or preform Continued Assessments and/or a Continued Medical Assessments as necessary.

E. Ensure all records, including medical assessment are secured daily and copies provided to the shelter manager.

F. Overseeing the health/medical operation of the shelter, including the opening and closing procedures, selection of treatment areas, the receipt, storage, and disbursement of medical supplies and communicating with the Medication Station, Food Station, Registration, the Shelter Manager, the Mass Care Coordinator and the EOC when necessary.

G. Ensuring that approved protocols are utilized by nursing staff.

H. Assess the physical condition of the residents on an on-going as needed basis.

I. Delivering care and assistance to the shelter residents as required using approved protocols, procedures and guidelines.

J. Providing administrative and logistical support to the nursing staff.

K. Nursing staff may reevaluate shelter residents before deactivation and give discharge instructions.

L. Completing situation reports for each shift.

Physician Services

A MOA will be maintained with the Medical Director, of the Ashe County Free Medical Clinic, or other designated licensed personnel. This agreement is to establish Physician Services for the Ashe County Emergency Sheltering System with a licensed physician to act as the medical consultant for shelter operations. Services may be necessary for, but not limited to:

A. A consultation during an assessment

B. Or a consultation if condition changes or deteriorates
   i. in the shelter
   ii. in an individual's health

C. Or a consultation to evaluate or consult with normal medical provider on or about prescriptions and refills.

D. Other medical issues deemed necessary by shelter staff.

Emergency Medical Technician

Emergency Medical Technicians (EMTs) will typically function in the capacity of basic on the scene medical care and transport during an emergency or disaster and it is improbable that they can assist in shelter staffing. If an Emergency Medical Technician is available, they will provide assistance to the Nursing staff when needed. Duties include, but are not limited to:

A. Transportation and evacuation.

B. Providing emergency assistance if needed.

C. Assisting nursing staff as requested

D. Assist or conduct medical assessment and/or triage, practicing within and according to the scope and extent of their education and training.

E. Overseeing transport of the shelter residents via ambulance to the hospital or more appropriate placement for sufficient care.

FAST-Functional Assessment Service Teams

A FAST team is a group of state or local personnel who can conduct assessments of people with functional and/or medical needs and will coordinate with shelter staff to ensure those people get needed resources to be able to maintain their independence while in a shelter setting.

When a shelter is opened, the county or shelter manager can request FAST members who are ready to respond and deploy to disaster areas to work in shelters. The team members work with the shelter nurse and disaster mental health worker to determine, identify and obtain resources like durable medical equipment, consumable medical equipment, prescription medications or even other people who can assist with essential daily living activities. The team stays at the shelter until all needs are met or until the shelter manager releases them from duty.

Caregiver

A caregiver for the purpose of this plan is a person who is responsible for another's care, this includes parents or guardians of minors. A caregiver of someone who has functional or medical needs may be a family member, friend, in home health or another care provider. When conditions allow, individuals or their caregivers are expected to provide transportation to and from the shelter. A caregiver will accompany and stay with an individual that has functional or medical needs to assist with daily living activities as necessary. Caregivers of those with functional or medical needs are expected to provide for their own relief and have a personal emergency plan in place and ready to implement which should adhere to the following guidelines:

A. Securing their home.

B. Making arrangements for family members, dependents and pets during their activation.

C. Locating the personal supplies that they will need during the activation.

D. Ensuring that they have up to date emergency contact numbers.

E. Ensuring that any vehicles and/or equipment they will need are operational and that any supplies they may need during the event are on hand.

The caregiver is expected to work and communicate with all agencies involved in the sheltering of the individual in order to ensure adequate care of the individual. The assigned or designated caregiver of any person using a shelter will be responsible for ensuring quality care is given to that

person. The staff operating the shelter will be able to provide oversight and support but will not be required to administer any direct care. It will be the responsibility of the caregiver to ensure all treatments and medications are given as prescribed.

The caregiver will provide or verify basic information about the individual, such as current medications, special diet, current treatment, allergies, communication needs, assistive devices, etc. The caregiver will ensure that the individual has all necessary supplies including medication. The caregiver will be expected to administer medications, sign medication records, all consent forms if applicable and provide all care for the individual. The shelter is designed to assist the caregiver so they can care for individuals just as they did in the home setting. Various duties include, but are not limited to the following"

A. Assisting the shelter resident with mobility impairments in ambulation and transfer.

B. Assisting the nursing staff as required.

C. Keeping the minor or individual in their care as calm as possible and providing necessary supervision of minors.

D. Monitoring the shelter resident's conditions for changes and immediately reporting changes to the shelter staff.

E. Following directions of shelter management.

F. Reporting particular needs.

G. Assisting minor(s) or persons with functional or medical needs, with getting settled in their space and familiarizing themselves with the facility i.e. regarding location of bathroom, etc.

H. When applicable, assisting in ambulating, transfers, toileting and personal hygiene.

I. Keeping those with functional or medical needs aware of time and inquiring if assistance is needed with self-administered medications and treatments.

J. Providing diversional activities, conversation, etc.

K. Assisting in acquiring food and/or feeding as needed.

L. Assisting in keeping area clean and free of trash.

M. Maintaining standard precautions and infection control.

Provision for Caregivers

When a family seeks shelter together, the parents or guardian of minors are caregivers but are also shelter residents and considered registered at the shelter. If there is a minor who is at a shelter

without a parent or guardian, DSS will work to investigate and provide proper care and supervision for the minor.

It is a requirement of this plan, that a caregiver will accompany an individual with functional or medical needs to the shelter. When the individual who has a functional or medical need is unable to provide a caregiver, then the Ashe County Health Department and the Ashe County Emergency Management will work with various local agencies in providing health care service personnel that will be made available at the facility to provide assistance for the individual(s). One aide will be provided to assist every five individuals that need assistance and will be assigned upon placement of the first individual that doesn't have the resources to provide their own caregiver.

Provision for Transportation

The individual, family or caregivers are expected to be the primary transporters, providing transportation to and from the shelter. When this is not feasible, the Ashe Emergency Management Office through the activation of the county's Emergency Operations Plan (EOP) has the capability to assist with transportation needs.

Long term care facilities should take into consideration their transportation needs and that Emergency Management will be using the resources of the Board of Education and Ashe County Transportation Authority during evacuations. Long term care facilities may want to pre-plan or contract with an outside vendor for their transportation requirements.

Mental Health Services

The local behavioral health care agency will provide staff to arrange and link to appropriate services to meet the behavioral health care needs of the shelter residents and shelter staff. Daymark will conduct psychological triage to assess emotional or behavioral needs, as necessary. Daymark functions as a regional facilitator of mental health care in five counties; and therefore has access to additional resources, when necessary, through the appropriate channels, Daymark can assist with regional coordination. By conducting ongoing assessments, Daymark will have a clearer understanding of the changing needs of the shelter residents and responders and can more effectively participate in routine operations and advise shelter management on changing needs. Daymark can also assist with logging of information, reports and, through regional resources, may assist in seeking available funding.

The Daymark staff, assisted by the DSS and Health Department staff, will arrange for appropriate interventions to facilitate smooth transitions and adjustments throughout individual shelter stays. Daymark duties during crisis management include, but are not limited to:

A. Activated on an as needed basis and responds when requested to the appropriate shelter to conduct psychological triage and/or behavioral assessments.

B. Daymark will provide staff to arrange and link to appropriate services to meet the behavioral health care needs of the shelter residents; and assist with registration, if necessary.

C. Daymark will conduct behavioral assessments, respond to, and arrange for, the behavioral health care needs of individuals and responders, including shelter staff.

D. Behavioral health professionals will be available through the established on-call system for crisis intervention and on-site evaluation.

E. Daymark will be lead agency for mental or behavioral health care, advising, guiding and directing the shelter staff on the appropriate actions.

F. Daymark will report any current, and potential, problems that may need additional intervention to the Shelter Manager, Mass Care Coordinator and/or the EOC.

G. Daymark will participate in decision making activities for the shelter's health/medical care needs.

H. Daymark will assist with tracking and logging information and in completing necessary reports.

I. When deactivation begins, Daymark will coordinate with shelter management to facilitate smooth transitions for individuals as they leave the shelter.

Interpreters

All requests for interpreters should be directed to the EOC for processing. Local interpreters in Spanish, French, and German are available. Each supporting agency may also supply interpreters such as DSS, Health Department, and Behavior Healthcare; all have interpreters however some of those may serve more than just one agency.

Caregivers whenever possible should be able to speak for the individual they care for and act as their interpreter. When this is not possible, the County of Ashe, by activation of its EOP will provide interpreters. Interpreters will be available to carry out the following tasks:

A. Activated on an as needed basis and responds when requested to the appropriate shelter to assist with behavioral assessments.

B. Assist with registration, as required, and assist in determining placement.

C. Interpreters will provide the shelter residents, caregivers and other non-English speaking individuals with appropriate shelter rules and information.

D. Assisting the nursing staff as required.

E. Helping the shelter residents find right location and assist in familiarizing them with their surroundings.

F. Assist in keeping the shelter residents as calm as possible.

G. Reporting particular needs of shelter residents.

H. Providing diversional activities, conversation, etc.

Ensure that when shelter is deactivated the individual and/or their caregiver understand any discharge instructions that are given.

Security

During occupation of the Shelter, it is the responsibility of the Shelter Manager, appointed DSS staff, the Facility Manager if present or any Security Personnel if available, to ensure that the building is secure. Management and/or Security Personnel should make regular rounds of the interior and exterior portions of the building, weather permitting. Exterior areas should only be surveyed when conditions are safe to do so. Emergency situations require that the maintenance of security be accomplished by shelter staff, facility staff, caregivers and visitors working together to provide safety for the sheltering facility. Any suspected security breech will be reported to the EOC and the local law enforcement agency IMMEDIATELY. The primary role of security is to assure the safety of the staff, residents, and the shelter residents. Actions to provide for this safety include, but are not limited to the following:

A. Ensure that **EVERYONE** checks in and out properly.

B. All staff should be alert.

C. Establishing one main entrance for the traffic flow into and out the facility.

D. Watch for people acting suspiciously and report them immediately.

E. Set up a schedule for security checks of facility.

F. Monitoring parking and vehicles at facility site.

G. Directing emergency and supply vehicles to appropriate locations where check in procedures are in place.

H. Ask if you can help when someone enters the area whose actions do not seem to fit the normal business there. Stay calm and appear helpful.

I. Maintaining calm, by ensuring that everyone abides by shelter rules, and by resolving problems that may arise among the shelter residents.

J. Monitoring exits and restricted areas.

K. Informing Facility Manager or Shelter Manager of any concerns or problems.

L. All staff (shelter or facility) are responsible for protecting the safety of all persons.

M. Ensure that the appropriate agency or agencies respond to emergencies at the shelter as needed.

There may be cases when shelter residents or visitors may become agitated or violent. Emergency situations are stressful and the potential for violence is often unpredictable. Actions to take and items to remember are as follows:

A. Report any uneasy "feelings" about a person or something that is said.

B. Deal with a potentially volatile situation before it escalates. Be friendly.

C. Look a potentially violent person straight in the eye. This establishes confidence and conveys knowledge of physical appearance.

D. Never argue or make threats to a potentially violent person as this may cause an escalation of the tension.

E. Be sincere in dealing with a potentially violent person. The individual may be undecided as to his or her actions.

F. Get help from another staff member immediately when dealing with a potentially violent person. Explain that additional assistance will better serve everyone involved. Do not surround the person. It will make them feel trapped. Rather, present a united front that also allows an escape route for the person.

G. Call law enforcement at the first indication of violence or threats. Many times the mere presence of a uniformed deputy has a calming effect on the situation.

H. Avoid being alone in an enclosed area with a potentially violent person.

I. Rules once the situation becomes violent
    1. <u>If the person has a weapon or you believe they have a weapon, HE OR SHE IS IN CHARGE</u>.
        a. If in doubt, assume the person is armed.
        b. Always assume that an armed person will use the weapon if necessary.
    2. <u>Your primary goal in a violent situation is to SURVIVE it</u>.
        a. Set off any alarms or notify law enforcement only if you can do so safely.
        b. Stay calm. A violent situation can be life threatening. There are important decisions to be made and you need a calm clear mind to make them.
        c. There is safety in numbers. Never surround the person, always give them a way out but let them know you are not alone by mentioning others that are around. Always try to keep residents out of harm's way.
        d. If the demands or threats involve a particular person, do not involve the individual without making him or her aware of the possible violence of the situation.
        e. Find out EXACTLY what the problems or demands are.

f. If it is possible to comply, do so immediately. If not, provide an explanation and offer to find the proper person to assist.
g. Don't argue with or quote policy to a violent person. The goal is a quick end to the situation.
h. When it is safe to do so call the Sheriff's Office immediately. Do not assume that the authorities have been notified.
i. Make a mental note of the person's description, should they leave the area prior to the law enforcements arrival.
j. Allow the person to leave the area. Make no attempt to detain or pursue as deputies may mistake staff personnel for the violent person.

ADDITIONAL OPERATIONAL GUIDELINES

Discharge/Transfer

Discharge/Transfer Criteria- Family or friends wishing to remove an individual from the shelter must show valid identification to the shelter staff. The following information will be recorded at the bottom of the Primary Medical Assessment and on the Released or Discharge form.

1. Date and time of discharge
2. Individual's Name
3. Address (of person(s) being released to)
4. Name and Relationship of Responsible Party
5. Telephone number(s) and Contact Information of Responsible Party
6. Mode of transportation
7. Signature for release(Responsible Party, Individual and Witness)

A. The following procedure should also be followed:

B. The discharge/transfer information is to be forwarded to the EOC

C. The bed occupancy tally should be updated on the Placement Assignment logs to account for discharges/transfers.

D. Referrals to hospitals should be handled by the nursing or healthcare staff and any medical information obtained by the shelter should be provided to the hospital.

E. Transportation of these residents from the shelter to the hospital should be established and approved through the EOC.

Limitations of Shelter

A. If during a large scale emergency or disaster the shelters are located in school buildings, churches, or other community buildings, they may not be equipped as a medical care

facility. Many have some form of emergency power generation, although it may be limited. Many have some form of bedding that includes cots, while others require the shelter residents to bring their own or utilizes the American Red Cross cots. (If at all possible the Ashe County Mass Care and Shelter Planning Committee recommends using long term care facilities as a shelter for those who have medical needs not conducive to cots.)

B. Staffing Limitations: Health/medical staffing is dependent on volunteerism of community, health care providers, and DSS. The local health department in partnership with emergency management may contact other local agencies for assistance when staffing needs exceed the available resources.

C. Medical history and health information regarding the shelter residents' conditions and needs will be limited.

D. Safety of shelter residents and staff cannot be assured. The integrity of the building and the safety of performing some of the required medical procedures may be jeopardized in an uncontrolled situation (e.g. provision of IV, peritoneal dialysis, and oxygen therapy) and without the required medical expertise.

E. Lack of Available Supplies: the shelter residents do not always bring needed supplies and the ability to access supplies from the community during an emergency is limited.

Liabilities

The initial sites designated for Shelters include school buildings, churches, or other community buildings within the county. Sites designated as Functional or Medical Needs shelters are the long term care facilities. The facilities used as Shelters will not be liable for any injuries to persons using the Shelter or their caregivers or for any damages to the personal property of individuals using the Shelter. The Facility Manager will be responsible for opening the facility and insuring the facility is lighted and accessible.

Persons assisting in the operation of the Shelter will also be held harmless for actions in the shelter operation as long as they are not negligent. Persons working in the shelter are considered emergency management workers (reference NCGS 166A-14 Immunity and Exemption), while they perform, operate or function in support of a local disaster or emergency condition.

A person, who has medical needs but is not staying in the shelter, may wish to use the Shelter for scheduled treatments only, (i.e. breathing treatments requiring a nebulizer). These individuals will register and sign in and out letting the staff know if they plan to use dormitory services or plan to return the next day. A person utilizing this service should not leave their equipment or medication in the shelter when they are not there without the permission of the Shelter Manager. Special arrangements can be made on a case-by-case basis, although the facility cannot be held liable for the security of any equipment, medication or dietary supplements left unattended.

Responsibilities in a Shelter

A. DSS staff or American Red Cross management team member will be present at all times 24/7 while Shelter is activated.

B. Nurses at each shelter will be assigned responsibility for triage and/or medical assessment of all shelter residents and will make the appropriate recommendation for admittance or referral to the Shelter Manager or Mass Care Coordinator.

C. Appalachian District Health Department is responsible for identifying health/medical staffing needs and making the health/medical staff assignments within the shelter.

D. The local behavioral health care agency is responsible for psychological triage, behavioral assessments and recommendations.

E. The nurse, behavioral health care provider, shelter and facility managers should have ongoing communication. The Shelter Manager will communicate with the Mass Care Coordinator and the EOC to determine the shelter residents' and the staffing needs.

Personnel - Injury/Accidents

To provide a procedure for each person working in the shelter to follow for personal injuries or accidents while in the shelter, the following procedures should be followed:

A. At the time of injury, evaluate and treat according to the injury, determine if staff member can continue in their role at the shelter.

B. If not life threatening, notify EOC of injury. If injury is life threatening, contact 911 following steps in the next section, Critical Illness/Injury or Fatality and then notify EOC.

C. Complete Incident Form to document injury.

D. Provided copy of Incident Form to the EOC, the staff member's primary employer and immediate shelter supervisor.

Missing Individual

Caregivers, shelter staff and shelter management along with facility staff will supervise, observe and/or attend to the sheltering individual's needs. These measures are expected to prevent individuals from becoming misplaced or missing, however, the strange environment, unfamiliar faces and sounds can cause or increase confusion in the sheltering individuals. For these reasons, even individuals who do not wander at home or in their normal care setting might wander and get lost while at a shelter. All shelter residents will be supervised by caregivers.

The caregivers will ensure that all individuals and especially those previously known to stray are continually monitored. The shelter staff should be made aware of any individual's predisposition

to roam and when possible assist the caregiver in keeping the individual occupied and engaged in available activities.

Some individuals may not be safe in certain shelters. An individual that has a predisposition to wander that is particularly at risk may need to be admitted to a facility (a long term care facility or hospital) that may be more suitable to provide for the individual's safety.

A. Known potential wanderers:
    1. Caregiver(s) will monitor individual(s) closely.
    2. Shelter staff will check on individuals and note change in behavior, personal appearance and daily clothing change.
    3. Pre-plan for potential wanderer. Some information can be recorded in advance on a Missing Person Form—A detailed description, recent photo and daily account of what the individual is wearing will be kept in the individual's file.
    4. Must wear an ID:
        a. That includes their name, the shelter's name, name of primary caregiver and telephone numbers.
        b. If the individual continually removes their ID, it is prudent to attach the ID elsewhere on their person, i.e. pinned into a pocket.

B. If an individual is believed missing – act promptly and follow procedures.
    1. Inform shelter management **Immediately**.
    2. Recheck the last area seen, the immediate vicinity and corresponding areas.
    3. Inform all other personnel in shelter; i.e. shelter staff, caregivers and facility staff and give a description of the missing individual.
    4. Have all available personnel search for the person; with each assigned a specific area to search.
    5. In the event that a hasty search proves negative, notify 911 and request assistance.
    6. Inform the Mass Care Coordinator of all action taken.
        a. The Mass Care Coordinator will determine, depending on the patient's known risk factors, when to inform the relatives and/or other caregivers.
    7. The Mass Care Coordinator will contact the EOC.
    8. Every effort will be made to locate and provide for the safe return of the individual.
    9 The shelter staff will complete the following form:
        a. Missing Person's Description –Attached
        b. An incident form and
            i. A log of searched areas,
            ii. A log of the actions taken and outcomes, which will be included in the individual's record.

C. When the individual is found:
    1. Assist the individual back to the appropriate shelter area.
        a. If you are unable to do this because the individual doesn't want to return or displays challenging behavior,
            i. Stay with the individual.

ii. If possible inform other staff members of the location of the individual and yourself—i.e. cell phone or by calling out to them etc.
iii. Talk to the individual calmly and try to persuade him/her to return or not to go any further away from the shelter while awaiting assistance.

b. If you are unable to do this because the individual is sick or injured,
i. Provide first aid or life saving measures you are qualified to perform. Follow sick and injured procedures included in this plan and in the Ashe County Health Service Protocols.
ii. After providing initial care, seek help. Stay with the individual if possible and contact others for help. (i.e. cell phone or by calling out to them etc.) It may be necessary to leave to get assistance—note the location of the individual so you can relocate them.

2. When necessary, arrange appropriate transportation to bring the individual back to shelter and/or to an appropriate facility.
3. Inform Mass Care Coordinator and EOC.
   a. Relatives and/or other caregivers will be advised or updated.
4. An assessment will be made as to whether the individual can still be safely sheltered at present location or must be placed elsewhere.

Critical Illness, Injury or Fatality

A critical illness or injury needs immediate attention. A delay in treatment may endanger the patient's life. Appropriate lifesaving actions must be carried out while another person notifies 911. Contacts with the individual's physician, shelter's physician service or other licensed health professional, when illnesses or accidents occur regarding resident care is acceptable if time allows. The host facility serving as a functional or medical needs shelter should have its own procedures and policies for critical illness/injury, imminent death or in the case of fatality. Abide by the host facilities procedures, which should include but not be limited to the following:

A. Provide necessary treatment in an attempt to sustain life according to capability.

1. Treatment or treatments may not be required if a patient has a DNR or a living will, provide only those treatments that are compatible with patient's wishes.
2. Start treatment immediately. Once treatment is initiated, continue until responsibility of care is transferred to EMS.

B. Call 911.

The following information should be given immediately to the 911 operator:

1. The severity of the call (i.e., is the person requiring the ambulance conscious, having trouble breathing or bleeding uncontrollably?)
2. The location of the patient (911 address, name of the facility and location in the facility)

3. Any information the shelter has on record that could be vital to care (obtained during registration or medical assessment) i.e. allergies, known illness and recent vital signs.

C. A staff member should stay on the phone when possible—do not hang up the phone.

D. Follow any instruction given by 911 operators till EMS arrives.

E. Assist and follow EMS instruction, answering questions and provide EMS with any documentation of DNR or Living Wills.

Patients with DNR orders still remain appropriate candidates for emergency transportation to the hospital, assistance and limited treatment. The "911" emergency number may still appropriately be used to summon emergency assistance for DNR patients who are suffering medical emergencies.

Any patient presenting a completed North Carolina **Do Not Resuscitate** (DNR) form (yellow form) should have the form honored and CPR and ALS therapy should be withheld in the event of cardiac arrest.

A Purpose:

1. To honor the terminal wishes of the patient
2. To prevent the initiation of unwanted resuscitation

B. Procedure**:**

1. When confronted with a patient or situation involving DNR, the following conditions must be present in order to honor the DNR form and withhold CPR and ALS therapy:
    a. Original North Carolina DNR form (yellow form- not a copy)
    b. Effective date and expiration date filled out and current
    c. Form signed by family physician
    d. Patient in cardiac arrest
2. A valid DNR form may be overridden by the request of:
    a. The patient
    b. The guardian of the patient
    c. An on-scene physician

After the individual’s treatment has been turned over to EMS for transport to the hospital:

A. Shelter staff should contact the individual's physician, or physician service.

B. Next of kin or emergency contacts listed on the shelter registration form should be contacted.

C. Shelter staff shall notify the EOC and Mass Care Coordinator of any accident or incident resulting in injury to the individual or requiring referral for emergency hospitalization, or

medical treatment other than first aid or treatment in the shelter's health care protocols or in an incident that results in individual's death.

Fatalities

Catastrophic disasters may affect large areas of the County and medical resources may be damaged, destroyed, or unavailable. Mass Casualty/Fatality is any situation in which there are more human bodies to be recovered and examined than can be handled, by the usual local resources.

A temporary morgue may need to be established in case of a death in the shelter. The morgue area should be an isolated room that is away from the general congregation areas. A sign should be posted to designate the temporary morgue area. The deceased person should be shrouded with a sheet or blanket. On the shroud, identify the deceased with their name and other identifying information. The Shelter Manager should notify the Mass Care Coordinator, EOC and/or the appropriate authorities of any deaths that occur. The Medical Examiner's emergency functions in the EOP will be activated and the Medical Examiner will be called on to examine and receive the remains.

Temporary Morgue Area

In the event that a shelter resident expires in the shelter during the emergency, these procedures are to be followed.

A. Follow steps in Critical Illness, Injury or Fatality section by performing any lifesaving actions, including calling 911.

B. If the disaster situation is so catastrophic that the remains cannot be transported to the hospital morgue, the Shelter Manager should select a site for a Temporary Morgue. It must be located in an area away from the general shelter or facility operations, estimate personnel needs, circumstances, condition, and additional factors. This morgue can be used as a holding area until the Medical Examiner is prepared to receive remains.

C. Notify Mass Care Coordinator, local law enforcement, Medical Examiner, and the EOC of the death.

D. If a caregiver or next of kin is available in the shelter, their wishes for any arrangements can be expressed to the Shelter Manager or Mass Care Coordinator and noted in the deceased records.

E. The individual's record will be annotated with all information concerning the event.

Medical Examiner

Medical Examiner or his/her designee will proceed within the following guidelines:

A. Respond to fatality upon notifications from local authorities and establish an adequate morgue. If at all possible, remains should be transported to County Morgue (usually at the local hospital) or the incident/event's morgue if an emergency morgue has been established.

B. Develop guidelines for the recovery, identification, registration and disposition of remains. These guidelines should include use of professionals and volunteers to establish a morgue that will include respectful care, identification, family notification, decontamination, autopsy if needed and determination of final disposition options.

C. Determine cause of death and issue death certificates.

D. Notify next of kin and release remains and personal effects of the deceased to proper representatives.

E. In a mass casualty incident, will coordinate with funeral directors, ambulance services, pathologists, Mass Care Coordinator, EOC, ARC, dentists, X ray technicians and law enforcement.

PLAN DEVELOPMENT

Training

As a method of ensuring NIMS compliancy and overall efficiency, personnel that may be involved in Sheltering will complete the following courses: ICS 100, 200, NIMS 700, 800, IS197 IS701, IS702, and IS703

Plan Maintenance and Revisions

After the initial approval of this plan, the planning committee will endeavor to meet twice annually. The Facility Partners that have entered into an MOA with the County of Ashe will be invited to one of these meetings.

This is a working plan, various situations or incidents may need additional procedures, modifications, records or forms. To keep this plan current and functioning, immediate decisions or adjustments will be made by the Shelter Manager, who will inform the Mass Care Coordinator or the EOC that modifications are needed on a contingency level. These temporary revisions will have to be approved by the Mass Care Coordinator, Emergency Management Coordinator and the Chairperson for the Mass Care & Sheltering Planning Committee, as soon as feasible.

When revisions are necessary, the Ashe County Mass Care & Shelter Planning Committee will facilitate the review and revision of Ashe County Mass Care & Sheltering Plan. After the review of the plan which would include the consideration of suggested revisions by the planning committee, new regulations pertaining to sheltering activities the functional or medical needs population and any temporary revision implemented during shelter activities, revisions will be brought before the committee to review. After proposed revisions have been identified and amended, a draft of the revisions will be presented to the Ashe County Board of Commissioners for review and approval.

PLAN OR REVISION NUMBER	DATE OF REVIEW	**BRIEF DESCRIPTION**	DATE OF REVISION OR APPROVAL	REVISION MADE BY (SIGNATURE) COMMITTEE CHAIR
00SN	09/07/2010	Draft Special Needs Plan approved by Planning Committee to be presented to the Board of Commissioners	11/15/2010	Teresa H. Richardson
01SN	12/20/2010	Approved by the Board of Commissioners	12/20/2010	Teresa H. Richardson
00MC	02/20/2017	Draft Mass Care Plan approved by Planning Committee to be presented to the Board of Commissioners	2/23/2017	Teresa H. Richardson
01MC	09/26/2019	Draft Mass Care Plan approved by Planning Committee to be presented to the Board of Commissioners		

Ashe County Mass Care & Sheltering Planning Committee

American Red Cross
Brian Womack

Ashe County Department of Social Services

Tracie McMillan
Tommy McClure
Randy Revis
Jamie Shepherd
Robin Richardson
Jeana Arroyo
Grier Hurley
Jennifer Parson
Kelly Surber

Ashe County Emergency Management

Patty Gambill
Teresa Richardson

Ashe County Health Department

Candy Graham
Jennifer Schroeder

Daymark
Paige Stephens

For information about the Ashe County Mass Care Planning & Sheltering Committee, you may contact Teresa Richardson, committee chairperson at 336-846-5522 or at 150 Government Circle, Suite 2400, Jefferson, NC 28640.

Supporting Agencies & Facilities

American Red Cross

Ashe County Department of Social Services

Ashe County Emergency Management

Ashe County Health Department /Appalachian District Health

Ashe Memorial Hospital

Hill View Family Homes

Margate Health & Rehabilitation Center

Daymark

Database Reporting Agencies

Ashe County Board of Education

Ashe County Department of Social Services

Ashe Services for Aging, Inc. (ASA)

Boone Drug & Healthcare Inc

Lincare Inc.

North Carolina Emergency Management

North Carolina Division of Services for the Deaf

Watauga Medical Center Home Health

APPENDIXES

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Appendix A "§ 131E-112

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1999
SESSION LAW 1999-307
SENATE BILL 34

AN ACT TO PERMIT THE TEMPORARY WAIVER OF CERTAIN RULES FOR LICENSED HEALTH CARE FACILITIES THAT PROVIDE TEMPORARY SHELTER OR SERVICES DURING DISASTERS AND EMERGENCIES.

The General Assembly of North Carolina enacts:

Section 1. Part A of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"§ 131E-112. Waiver of rules for health care facilities that provide temporary shelter or temporary services durin2 a disaster or emer2ency.

(a) The Division of Health Service Regulation may temporarily waive, during disasters or emergencies declared in accordance with Article 1 of Chapter 166A of the General Statutes, any rules of the Commission pertaining to facilities or home care agencies to the extent necessary to allow the facility or home care agency to provide temporary shelter and temporary services requested by the emergency management agency. The Division may identify, in advance of a declared disaster or emergency. rules that may be waived, and the extent the rules may be waived, upon a disaster or emergency being declared in accordance with Article 1 of Chapter 166A of the General Statutes. The Division may also waive rules under this subsection during a declared disaster or emergency upon the request of an emergency management agency and may rescind the waiver if, after investigation, the Division determines the waiver poses an unreasonable risk to the health. safety. or welfare of any of the persons occupying the facility. The emergency management agency requesting temporary shelter or temporary services shall notify the Division within 72 hours of the time the pre-approved waivers are deemed by the emergency management agency to apply.

(b) As used in this section, 'emergency management agency' is as defined in G.S. 166 4 (2)".

Section 2. Article 1 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"§ 131D-7. Waiver of rules for certain adult care homes providing shelter or services during disaster or emergency.

(a) The Division of Health Service Regulation may temporarily waive, during disasters or emergencies declared in accordance with Article 1 of Chapter 166A of the General Statutes, any rules of the Commission pertaining to adult care homes to the extent necessary to allow the adult care home to provide temporary shelter and temporary services requested by the emergency management agency. The Division may identify in advance

of a declared disaster or emergency. rules that may be waived, and the extent the rules may be waived, upon a disaster or emergency being declared in accordance with Article I of Chapter 166A of the General Statutes. The Division may also waive rules under this subsection during a declared disaster or emergency upon the request of an emergency management agency and may rescind the waiver if, after investigation, the Division determines the waiver poses an unreasonable risk to the health, safety or welfare of any of the persons occupying the adult care home. The emergency management agency requesting temporary shelter or temporary services shall notify the Division within 72 hours of the time the pre-approved waivers are deemed by the emergency management agency to apply.

(b) As used in this section, 'emergency management agency as defined in G.S. 166A-4(2)

Section 3. This act becomes effective July 1, 1999, and applies to shelter or services provided on and after that date.

In the General Assembly read three times and ratified this the 8th day of July, 1999.

s/ Marc Basnight
President Pro Tempore of the Senate

s/ James B. Black
Speaker of the House of Representatives

s/ James B. Hunt, Jr.

Governor

Approved 9:18 p.m. this 15th day of July, 1999

Appendix B American Red Cross (ARC) Responsibilities

MASS CARE & SHELTERS
AMERICAN RED CROSS (ARC) RESPONSIBILITIES

A. Memorandum of Agreement between Federal Emergency Management Agency (FEMA) and American Red Cross (ARC) Formally designates the ARC and FEMA as co-leads for mass care component of ESF-6, including:

- Feeding
  - ✓ Fixed or mobile feeding operations
- Sheltering/ Mass care
  - ✓ Individual or congregate temporary shelters (including household pets)
  - ✓ Health and/or mental health services
- Distribution
  - ✓ Distribution of relief supplies
  - ✓ Information on recovery assistance
- Family Reunification

B. Other services performed by the (ARC)

- Staffing local Emergency Operations Centers
- Public Affairs & Fundraising
- Reporting disaster information

Public shelters are the responsibility of county government (NC General Statute 166-A) and the American Red Cross (ARC) (Congressional mandate). In those situations where county government opens public shelters and where agreements between ARC and the county's department of Emergency Management exist for the purpose of providing shelter during an emergency or disaster, the responsibility for Functional or Medical Care Shelters normally rests with the county's DSS and may be in coordination with the Public Health Department.

General public shelters usually are in public buildings and usually meet ADA standards. However, these shelters have limitations and operate for those who are self-sufficient and need no outside professional assistance in performing activities of daily living, or for those who are accompanied by family members or other caregivers who assist with activities of daily living. For those individuals whose needs are beyond that available at public shelters, Functional or Medical Care sheltering is available.

General public shelters are selected with consideration of the proximity of the disaster to the facility the size of the shelter, available feeding facilities and other factors. Whenever possible, these shelters are also expected to provide reasonable accommodations (ramps, interpreters, restrooms, effective communication devices, etc.). Temporary accommodations that are in the best interest of the physically challenged (ramps, rails, etc.) may be arranged through the Red Cross Job Director, who has the authority to borrow, rent or construct such

accommodations. However, additions of such modifications to permanent structures can only be done so with the written permission of the facility owner.

The American Red Cross (ARC). The ARC usually manages or assist in general public shelters. Evacuees to all public shelters are encouraged to bring sufficient sleeping and personal needs items to include medications with them when advance evacuation time is possible. In cases where the nature of the disaster is immediate, Red Cross may provide such items as cots, blankets, and other comfort accommodations when the shelter is determined to be open for a period longer than 36 hours and when such items are deemed necessary and appropriate.

The initial availability of cots, blankets, etc. is dependent upon the local ARC's resources, local government resources or other agency stockpiles within that area. Following the incident when non-affected shelters are able to close, resources may be shifted to remaining open shelters. Resources may need to be diverted to shelters due to the condition of the Support Level I and II evacuees as opposed to the healthier evacuees in the shelters. Resources such as cots and blankets will be directed to the elderly and those medical needs as a priority when such items are not in sufficient quantities to include all sheltered individuals.

The level of care needed for Support Levels I and II may exceed medical ARC medical capabilities. The responsibility for care of these individuals rest with the facilities that provide pre-shelter care or with the a functional or medical support shelters. Medical staff for shelters normally will be provided by the county public health department.

American Red Cross (ARC) will provide Disaster Health Services (DHS) personnel in all public shelters as needed and my assist with nursing staff in any shelter. The ARC will provide space and service within their shelters for the Support Level II individuals when appropriate and will make a determination regarding the need to retain or transfer those individuals when such action is in the best health interest of the person being sheltered.

A request for mass care assistance from ARC, does not imply assumption of any financial responsibilities nor liabilities by the American Red Cross. The general scope of the request could include but not limited to general nutritional needs, supplies and additional personnel.

ARC will bear the financial responsibility for those items that are part of the traditional ARC shelter response when such facilities are deemed "ARC shelters". Specialized medical equipment needed for medical needs of individuals is the responsibility of the individual.

It is important that the service delivery equivalents to the needs of the individual are in keeping with the highest health service available under the circumstances. While the ARC operates public shelters with limited functional or medical, it will always provide a place of safe haven and shelter to those in need regardless of their medical condition. It is hoped that this document will provide lead planning time to facilitate the best arrangement and charge those agencies and individuals with providing service through the course of the disaster an implied in NC General Statute 166-A.

As part of their Congressional mandate, ARC will strive to become an advocate to initiate those responsibilities. In cases where there is an absence of service or where local jurisdictions do not or cannot provide service or where the ARC determines that service delivery is inadequate or not to ARC standards, ARC will implement the necessary actions to provide the safest haven for those needing emergency shelter regardless of category.

The ARC will provide support to Support Level I and II shelters when possible and after ensuring that they have met their own disaster responsibilities. In such situations where there is a known deficiency in resources, funding or manpower, parties may negotiate with the ARC to ensure that the interest of the disaster client is best served. Request for mass care support from ARC does not imply assumption of any financial responsibilities or liabilities by the ARC.

Appendix C Database Form

Reporting Agency:_____ Date Updated: _____

Name: _____

Street Address: _____

City:_____ NC (Zip)_____ Home Phone(s):_____

Fire District: _____ Language:_____

Ambulance: _____

Direction (To Home)

_____

_____

_____

_____

_____

FUNCTIONAL/MEDICAL NEEDS

☐ Bedridden

☐ Able to get around unaided

☐ Able to get around with the aid of:

☐ Cane ☐ Walker ☐ Wheelchair

(Check all that apply)

☐ Suction Unit ☐ Dialysis

☐ Life Support ☐ Feeding Tube

REFRIGERATED MEDICINES & DIETS

☐ Insulin ☐ IV Fluids

☐ Special Diet ☐ Refrigerated Diet

☐ Special Diet type: _____

☐ Oxygen How often? (i.e. nightly hour/day) _____

☐ Portable ☐ Oxygen Concentrator

Conditions

☐ Hearing Impairment

☐ Sight Impairment

☐ Speech Impairment Contagious Disease

☐ Contagious Disease

☐ Cognitive Impairment or Behavioral Condition

Conditions or Additional Information

Other respiratory info: _____

Any other needs? _____

☐ Require 24-hour care? Name of primary caregiver: _____

☐ Do you have service animal? Description _____ ☐ Vaccines are up to date?

CONTACTS:

Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Home Health: _____ Phone: _____

Relative: _____ Phone: _____

Relative: _____ Phone: _____

LIVING SITUATION

☐ Live in a mobile home? ☐ You live alone ☐ Someone lives with you

Who lives with you?

☐ Do you have pets? How Many? _____ Description _____ ☐ Vaccines are up to date?

☐ I have transportation during an emergency. (or) ☐ I will need transportation during an emergency.

(Check the appropriate type of transportation needed.)

☐ Standard Vehicle ☐ Wheelchair lift equipped ☐ Ambulance

Appendix D -- Memorandum Of Agreements

MEMORANDUM OF AGREEMENT BETWEEN

THE COUNTYOF ASHE AND

MARGATE HEALTH AND REHABILITATION CENTER

FOR SPECIAL CARE SHELTERS

I. **PURPOSE:** This agreement, defines the working relationship which exists between the County of Ashe and Margate Health and Rehabilitation Center. It is a provision for an emergency situation and/or a disaster, in which the County of Ashe has been prompted to open and operate shelter(s}, and it has been determined through an assessment by the Ashe County Emergency Management Department and Department of Social Services, hereafter referred to as "DSS", that there is a need to provide temporary shelter care for the disabled or special needs population.

II. **DEFINITION:** For the purposes, of disaster/emergency response, "the special needs populations" refers to those individuals whose physical, emotional/cognitive, and/or medical conditions are such that they, even with the help from families or friends, would not be able to minimally meet their basic needs during a 48-hour emergency period. People with special needs include individuals who would need assistance with medical care or personal care during evacuations and sheltering because of physical or mental impairments.

Ill. **AUTHORITY:** This action is being accomplished due to the **Emergency Shelter/Health Facilities Waiver (Senate Bill 34)** enacted into law in 1999. The act permits the temporary waiver of certain rules for certain licensed health care facilities. The enactment of this legislation amends G.S. 131E-112 and G.S. 131D-7 to permit the Division of Facility Services to waive certain rules pertaining to adult care homes during declared disasters. (Copy Attached)

1.

a. The Division of Facility Services may temporarily waive, during disasters or emergencies declared in accordance with Article 1 of Chapter 166A of the General Statutes, any rules of the Commission pertaining to adult care homes to the extent necessary to allow the adult care home to provide temporary shelter and temporary services requested by the emergency management agency. The Division may identify, in advance of a declared disaster or emergency, rules that may be waived, and the extent the rules may be waived, upon a disaster or emergency being declared in accordance with Article 1 of Chapter 166A of the General Statutes. The Division may also waiver rules under this subsection during a declared disaster or emergency upon the request of an emergency management agency and may rescind the waiver if, after investigation, the Division determines the waiver poses an unreasonable risk to the health, safety, or welfare of any of the persons occupying the adult care home. The emergency management agency requesting temporary shelter or temporary services shall notify the Division within 72

hours or temporary services shall notify the Division within 72 hours of the time the pre-approved waivers are deemed by the emergency management agency to apply.

b. As used in this section, "emergency management agency" Is as defined in G.S. 166A-4(2). (1999-307, s. 2.)

2.

IV. **THE SPECIAL NEEDS INDIVIDUAL'S REQUIREMENTS AND PROVISIONS GUIDELINES** in the Ashe County Special Needs Plan will be as listed but not limited to the following:

a. **Caregiver:** A caregiver will accompany the special needs individual. The caregiver may be a family member or another special care provider.

b. **Information:** The individual or their caregiver will provide Margate Health and Rehabilitation Center with basic information about the special needs individual, such as current medications, special diet, current treatment, allergies, communication needs, assistive devices, etc.

c. **Provide Supplies:** The individual and their care giver will bring medications, (a 5-day supply), mobility aids (canes, walkers, crutches, wheelchair, etc.), medical and person hygiene supplies, (5-day supply of Depends, food supplements, wound supplies and other essential durable goods), special diets (5-day supply of if on a modified diet, along with wlitten instructions for diet), any other food for the special needs individual and their caregiver 5 day supply, important papers and a 3 day supply of clothing and toiletries. (The special needs facility will provide space to store medications and food along with a place to keep medication records and a place to prepare food (i.e. facility kitchen).

d. Transportation: When conditions allow, caregivers are expected to be the primary transporters, providing transportation to and from the special needs shelter. When conditions do not permit, the Ashe Emergency Management office or the county's operations center (EOC) should be consulted for transporting of the special needs populations and their caregivers to and from the sheltering facility.

V. **GUIDELINES FOR FACILITIES/HOMES:** In the event there is an emergency or disaster and there is a need to open Special Needs Shelter(s), Margate Health and Rehabilitation Center shall cooperate fully with the Ashe County Emergency Management and Department of Social Services. The facilities shall provide shelter for the individuals that have Special needs that are not appropriate for Red Cross or other general shelter(s) because of these needs. The facility will notify the DSS if problems occur while sheltering the special needs individual. The Special Care Sheltering Committee developed the following specific guidelines for health care facilities/adult care homes to follow:

a. **Emergency plan:** The facility will maintain an emergency plan for their population that can be activated during an emergency/disaster. The facility emergency plan should include food supply for at least 72 hours, evacuation plans and when feasible, emergency or an alternative power supply.

b. Admission Criteria: The admission criteria of health care facilities, adult care homes, and home care agencies is waived for the special needs population in order for the facility to provide temporary sheltering or other services during disasters or

emergencies. Special needs individuals will not be considered "admitted" to the facilities. However, the facility serving as a special needs shelter needs to obtain basic information about the special needs individual, such as current medications, special diet needs, current treatment, allergies, communication needs, assistive devices, etc.

c. **Exceed Capacity Limits:** For the purposes of providing special needs sheltering during a disaster or emergency, the facility may exceed their licensed capacity, but not beyond the level necessary to provide good and adequate care. Since caregivers are expected to accompany special needs individuals, the facility should include the caregivers with the special needs individuals when considering physical space, staffing, supplies, and other facility needs.

d. Medication, Record Security & Food Storage: Since special needs individuals are expected to bring a five (5) day supply of their own medications and food, the facility needs to have a reasonable plan for the safe storage of these items. The caregiver will be expected to administer medications, maintain and securely keep the records, as well as prepare food for the special needs individual.

e. **Staff:** As considered necessary, the facility may call in extra part time or temporary staff to assist during an emergency or disaster to accommodate the special needs residents and provide personal care services to these residents if needed.

VI. **GUIDELINES FOR THE COUNTY OF ASHE:** The County of Ashe **will** provide the following services to assist in arranging and coordinating the services for the special needs shelters:

a. Notification of DFS: DSS will notify the NC Division of Facility Services within 72 hours of the time the pre-approved waivers are deemed by the local Emergency Management to apply.

b. **Assessment:** DSS's staff, in consultation with Ashe Health Department staff, will assess the needs of the individual and make the decisions as to which facility will best serve their needs.

c. **Shelter Management:** DSS's staff is to oversee the operation of the Special Needs Shelter(s) with DSS employee(s) present 24 hours per day. DSS employees are not to provide any personal care to the residents at the shelter but manage the shelter and its resources.

d. **Transportation:** Caregivers are expected to be the primary transporters, providing transportation to and from the special needs shelter. When this is not feasible, the Ashe Emergency Management office through the activation of the county's Emergency Operations Plan (EOP) has the capability to assist with transportation.

e. **Caregivers Provision:** A caregiver will accompany the special needs individual to the shelter. When an assessment has been determined that an individual should be sheltered in a special needs facility and that individual is unable to provide a caregiver the Ashe County Health Department and the Ashe County Emergency Management will work with Ashe Services for the Aging or another agency in providing an in-home service aide that will be made available at the facility to provide assistance for the individual(s). One aide will be provided to assist every five individuals and will be assigned upon placement of first individual.

f. **Feeding Responsibilities:** The DSS facility manager shall contact Ashe County Emergency Management when food supplies are needed. (i.e. Special need individual(s) and or caregiver(s) did not bring food or their supply is depleted). Emergency management will work collaboratively with DSS and local resources to assure food is supplied. Options for providing meals at the shelter are not limited to but may include the following.
    i. American Red Cross
    ii. Ashe Baptist Association
    iii. Ashe County Sharing Center
    iv. Ashe Really Cares
    v. Ashe Services for the Aging- Delivered Meals Program
    vi. Helping Hands
    vii. Hunger Coalition
    viii. Meals on Wheels
    ix. Samaritan's Purse

When necessary the County of Ashe may provide food to shelters.

VII. **STATE OF THE MEMORANDUM OF AGREEMENT:** This MOA may be amended or cancelled at any time at the discretion of either party. This Memorandum of Understanding shall remain in force and effect until abrogated by either party upon sixty days' written notice to the other party, notice to begin with date of mailing. Furthermore, it may be amended at any time by execution of a written amendment, signed by the parties.

Each of the signatories hereto shall affix the date of his or her signature. This Agreement shall take effect upon the date of the last signature fixed hereto.

FOR: Ashe County Board of Commissioners

C:

Todd McNeil!, Chairman — 9-7-;/ Date

FOR: Margate Health and Rehab Center

Grayson Hill, Administrator — 8/29/2022 Date

FOR: The Ashe County Department of Social Services

Tracie McMillan, Director of Department of Social Services — 9/7/2022 Date

FOR: The Ashe County Emergency Management

Patty Gambill, Emergency Management Coordinator — 9/7/2022 Date

FOR: The Ashe County Health Department

Ashe County Health Department — 9/8/2022 Date

MEMORANDUM OF AGREEMENT
BETWEEN
THE COUNTY OF ASHE AND
MELINDA D. WONSICK, MD
FOR MEDICAL CONSULTATION
WITH ASHE COUNTY SHELTERS

I. **OVERVIEW:** Any community is susceptible to emergency and disasters, both natural and man-made. All disasters are prepared for, and responded to, at the local level before resources may be requested from regional, state, and/or federal levels. Outside assistance cannot be expected for a minimum period of 72-hours, thus it is imperative for communities to prepare and to be able to take care of themselves for at least this period of time.

Individuals may seek shelter within the Ashe County sheltering system who may need a medical assessment and/or special accommodations either in a general public shelter or a special need shelter.

The admission criteria of health care facilities, adult care homes, and home care agencies is waived for the special needs population in order for the facility to provide temporary sheltering or other services during disasters or emergencies. The special needs individuals will not be considered "admitted" to the facilities.

II. **PURPOSE:** This agreement is to establish Physician Services for the Ashe County Emergency Sheltering System with a licensed physician, to act as the medical consultant for shelter operations.

III. **DEFINITION:** For the purposes, of disaster/emergency response, "the special needs populations" refers to those individuals whose physical, emotional/cognitive, and/or medical conditions are such that they, even with the help from families or friends, would not be able to minimally meet their basic needs during a 48 hour emergency period. People with special needs include individuals who would need assistance with medical care or personal care during evacuations and sheltering because of physical or mental impairments.

IV. **GUIDELINES:** In the event there is an emergency or disaster and there is a need to open shelter(s), Shelters will be opened on an as needed basis. Shelter for individuals that have special needs that are not appropriate for Red Cross or other general shelter(s) because of these needs, will be assessed to ensure they are placed in the appropriate environment. The Special Care Sheltering Committee developed the following specific guidelines:

A. **Medical Assessment and Triage:** Appalachian District Health Department will oversee and advise the Shelter Staff on all aspects

concerning medical issues including communicable disease. Appalachian District Health Department staff will make recommendations to the Shelter Staff and supervise the administration of the Ashe County Special Needs Medical Assessment. In consultation with DSS staff, the Appalachian District Health Department shelter staff will assess the needs of the individual and assist in making decisions as to which facility will best serve the individual's needs.

B. **Shelter resident/Caregiver:** A person seeking shelter and/or a Caregiver accompanying them should:

C.

a) Provide Information: The individual or their caregiver will provide the shelter with basic information about the current medications, special diet, current treatment, allergies, condition, communication needs, assistive devices, etc.
b) Provide Supplies: The individual or their caregiver will bring medications, mobility aids, medical supplies, special diets and clothing, toiletries and person hygiene supplies.
c) Provide a Caregiver: If seeking shelter in a Special Needs Shelter, a caregiver will accompany the special needs individual.

D. **Shelter Staff**: Will work with individuals and or caregivers whenever possible to utilize shelter resident's normal medical provider for routine care and services.

E. **Physician Services:** should be available for medical consultation by phone or in person during shelter operations. Services may be necessary for, but not limited to:

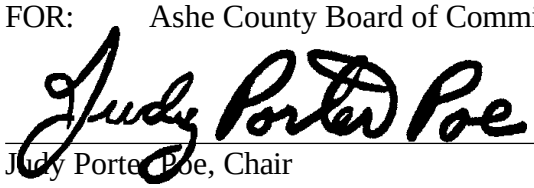
F.

a) A consultation during an assessment
b) Or a consultation if condition changes or deteriorates
    - in the shelter
    - in an individual's health
c) Or a consultation to evaluate or consult with normal medical provider on or about prescriptions and refills.
d) Other medical issues deemed necessary by shelter staff.

VIII. STATE OF THE MEMORANDUM OF AGREEMENT: This MOA may be amended or cancelled at the discretion of either party with sixty days written notice. This Memorandum of Agreement shall remain in force and effect until abrogated by either party upon sixty days written notice to the other party, notice to begin with date of mailing. Furthermore, it may be amended at any time by execution of a written amendment, signed by the parties.

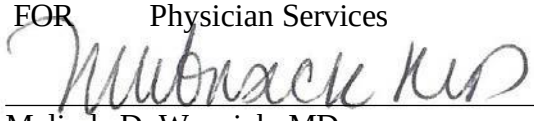
Each of the signatories hereto shall affix the date of his or her signature. This Agreement shall take effect upon the date of the last signature fixed hereto.

FOR: Ashe County Board of Commissioners



Judy Porter Poe, Chair — 11/19/2010 Date

FOR Physician Services



Melinda D. Wonsick, MD — 11/16/2010 Date

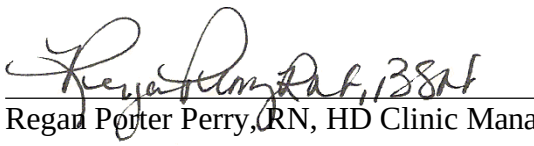
FOR: The Ashe County DSS

Donna Weaver, DSS Director — 11/23/2010 Date

FOR: The Ashe County Emergency Management

Patty Gambill, EM Coordinator — 11/19/2010 Date

FOR: The Ashe County Health Department



Regan Porter Perry, RN, HD Clinic Manager — 11/24/2010 Date

Ashe Disaster Health Services Protocols **2016**

Adapted Protocols of Health Services

Modified to for local use.

Table of Contents
Ashe Disaster Health Services Protocols

I. Introduction

Description of Disaster Health Services

- Disaster Health Services (HS) workers provide health services to individuals affected by a disaster.

HS workers provide health services during

- Initial responses
- Disaster relief operations, including all service delivery sites.

In a disaster situation, HS workers provide

- health assessments
- treatment per protocol
- referrals for care

HS workers also

- assist individuals with the procurement and/or replacement of essential medications and medical equipment when lost or damaged due to a disaster
- collect and document health surveillance data on individuals
    - ❖ to identify illness and injury anomalies
    - ❖ to reduce the transmission of disease
    - ❖ to provide evidence-based research for continuous improvement of the delivery of our services

Disaster Health Services Protocols

Disaster Health Services Protocols describe the parameters within which licensed professionals may deliver medical care when serving as Disaster Health Services workers. These protocols have been researched and reviewed by a panel of healthcare professionals and the treatment guidelines supersede any guidelines or treatment recommendations from any previous version of the Protocols

Expectations of HS Workers

HS workers are expected to use the Protocols and demonstrate sound clinical judgment when providing care to the shelter residents. HS workers must comply with the following:

- Medical orders by local physicians for their patients
    - ❖ supersede HS protocols
    - ❖ must be documented by HS workers appropriately and clearly
- When orders by local physicians for their patients exceed the level of care allowed by the Protocols, HS workers should:
    - ❖ refer the patient to his or her local health care providers or arrange transport/transfer to a health care facility as needed
    - ❖ contact the Emergency Operation Center (EOC) for further guidance when a patient's health needs exceed the level of treatment outlined in the protocols and it is not possible to refer the patient for non-shelter care.
- When over-the-counter medication (OTC) is available and requested by a shelter resident, HS workers may provide OTC medications
    - ❖ according to the manufacturer's dosage guidelines and
    - ❖ after checking with the shelter resident regarding allergies, current medications,

and
- ❖ any possible contraindications

NOTE: HS workers should provide education to the shelter resident about OTC medication use. See the OTC Drug Information Appendix at the end of the Protocols.

- All shelter residents should be referred to his or her health care provider or usual source for medical care as soon as possible after an illness or injury.

Symptom-Based Protocols
The Disaster Health Services Protocols are symptom-based to guide the treatment of the symptom rather than a particular disease or illness. The symptoms were chosen from the illnesses and injuries previously covered in Disaster Health Services Protocols (rev. 1997) and evidence-based analyses of illnesses and injuries documented on recent disaster relief operations.

NOTE: The Protocols sections "Special Considerations", "Communicable Diseases", and "Procedures" are not based on symptoms of the individuals. These sections identify specific medical situations and diagnoses, including related procedures (e.g. assisting with an auto-injector).

Using the Protocols:
- When providing care, Disaster Health Services workers
- find the shelter resident's symptom in the table of contents and
- follow the corresponding treatment guideline

Treatment guidelines include:
- possible causes that represent a range of possible diagnoses – from minor illness to medical emergencies- that are not intended to be all-inclusive
- symptom-based medical history questions
- physical assessment guidelines to help identify situations that require a referral to a medical facility or
- the activation of local EMS for treatment

When a symptom can be treated in the disaster environment by HS workers, the symptom will appear in the Protocols with treatment guidelines.

Protocol Review
A physician will conduct an review of the Protocols to assure that local operations comply with established protocols. The review must be documented using the Review of Disaster Health Services Protocols form found at the end of this document. The physician may make Adjustments or comments about the protocols at the end of each protocol.

Documentation
Workers must document all shelter resident's health information including assessments, interventions, and outcomes.

HS workers provide care to volunteers and employees on a disaster relief operation should record all care on a Staff Illness/Injury Report following established agency procedures as well as a County Incident Report.

Management of Exposures

Health care workers may have accidental exposure to blood or other bodily fluids through

- parenteral (needle stick) contact
- splash to the mucous membranes of the eye, nose or mouth.
- skin that is chapped, cut, has abrasions, acne, dermatitis or other conditions which disrupt skin integrity.

Health care workers must use appropriate levels of Personal Protective Equipment (PPE) as outlined in CDC guidance .

When an accidental exposure to blood or other bodily fluids does occur

1) Wash the affected area and the surrounding skin or tissue immediately.
2) Flush eyes with saline or water rinse when eye splash occurs.
3) Thoroughly clean open scratch or wound and apply appropriate topical antiseptic.
4) Refer to health care professional:
   a. Immediately provide the opportunity to any exposed worker to be seen by a health care professional (worker will be sent to the Health department during normal hours when possible) for possible prophylaxis against Hepatitis B and HIV.
   b. Document the event and the offer on a County Incident Report, regardless of the worker's decision to accept the offer.
5) When the source of the exposure is known, refer that person to the local health care facility for blood testing. The health care facility is responsible for obtaining consent and reporting results, as appropriate.
6) Document the incident on the Staff Health Illness/Injury Record.
7) Report the staff exposure to Shelter Management (or Disaster Health Services leadership if Staff Wellness is not available) on the operation as soon as possible.
8) The Shelter Manager
   c. assists with additional paperwork
   d. notifies the EOC for follow-up

Acknowledgements

These local Protocols are base on American Red Cross Disaster Health Services Protocols. They have been modified for local use at minimum allowing for local physician adjustments.

References

- American Red Cross Disaster Health Services Protocols 1997 - (Disaster Health Services, ARC 3050) June 1997

- American Red Cross Disaster Health Services Protocols 1998 (Revision) (Disaster Health Services, ARC 3050) Adapted and revised in 2000 by Florida DOH- Adopted by Ashe County 2011

- American Red Cross Disaster Health Services Protocols 2010, Rev. July 2010
- American Red Cross Adult/Infant First Aid / CPR Skill Card. Stay Well, 2006
- Center for Diseases Control and Prevention – Emergency Preparedness and Fact sheets specific to diseases www.cdc.gov
- CPR/AED for the Professional Rescuer. American Red Cross, 2006
- First Aid/CPR/AED for the Workplace. American Red Cross, 2006
- Mayo Clinic Health Library www.mayo.edu/library/
- Merck Manual Online Medical Library for Healthcare Professionals http://www.merck.com/mmpe/index.html
- The National Poison Control Center www.poison.org
- Nurses Drug Guide Lippincott, Williams & Wilkins, 7th Edition, 2006
- Faces Pain Scale downloaded from www.wongbakerfaces.org

II. Symptoms and Care

Abdominal Pain

Treatment Goal:

- Prevent Injury to the shelter resident
- Reduce Discomfort
- Assess for more serious health conditions

Possible Causes:

- There are many causes of abdominal pain which may be related to conditions of the heart, stomach, bowels, kidneys, gallbladder, pancreas and uterus. Severe or sudden onset pain may be due to menstrual cramps, miscarriage of pregnancy, ectopic pregnancy, ovarian cyst, kidney stones, gall stones, irritable bowel syndrome, appendicitis or an acute cardiac event. Mild or recurrent pain could be due to spicy and/or fatty foods, gas or menstrual cramping.

History:

- Onset and duration of pain
- Location (generalized discomfort vs. localized pain)
- Quality (dull, sharp, cramping, burning, etc) and amount of pain (0-10 scale)
- Presence and amount of vomiting and/or diarrhea and if blood is present in stool or vomit
- Possibility of pregnancy or pelvic inflammatory disease
- Pain also in back, neck, jaw or left shoulder/arm (cardiac pain)
- Sweating and/or shortness of breath (cardiac pain)

Assessment:

- Obtain vital signs and document level of pain on a scale of 0-10
- Inquire about accompanying symptoms- bloating, gas, abnormal bowel movements, nausea/vomiting
- Listen for presence or absence of bowel sounds
- Gently palpate abdomen for tenderness, rigidity or distention
- Assess for rebound pain and/or guarding

Call Local EMS/911 for:

- Severe pain based on a scale of 0-10
- Tachycardia
- Hypotension
- Blood present in vomit or stool.
- Vaginal bleeding in a pregnant woman
- Vaginal bleeding in a non-pregnant woman unrelated to menstrual Bleeding
- Any tenderness or rigidity noted on palpation.
- Absence of bowel sounds
- Rebound pain or guarding present.
- Individual has pain in the back, neck, jaw or left arm/shoulder or is showing signs of sweating or shortness of breath
- Fever with severe or persistent nausea/vomiting and/or diarrhea
- Any pediatric individual with the following symptoms: forceful vomiting after eating,

red/purple jelly-like stools, green-brown vomit, or hard lump in the scrotum, lower abdomen or groin

Refer to Local Healthcare System:

- Pain has not resolved or diminished in 4 to 6 hours
- Pain occurs during pregnancy

Treatment:

- Discourage eating, drinking, or medication until cause of pain is determined
- Recommend rest in a comfortable position
- If pain is thought to be related to menstrual cramping and individual is requesting a pain reliever, Ibuprofen (Motrin) is appropriate, unless contraindicated. Follow manufacturer's recommended dosage and see Cramps protocol

Additional Considerations:

- Blood in stool often appears black or tar-like
- A common cause of abdominal pain in children is stress and anxiety, although severe pain should be referred to a physician immediately
- Infants who experience abdominal pain cry loudly and draw their knees toward their chest. This may also be a sign of colic.

See also: Bites – Insect, Chest pain/pressure, Cramps – Abdominal, Indigestion, Nausea/Vomiting, Childbirth, Miscarriage, Poisoning, and Pregnancy

Adjustments by Local Physician:

Anxiety

Treatment Goal:

- Protect the shelter resident and others from injury
- Appropriate referral to trained mental health professional- Behavioral Healthcare
- Assess for more serious health condition
- Reduce stress

Possible Causes:

- Anxiety may be caused by a stressful situation which results in acute symptoms (panic attack) or
- chronically in a panic disorder – where feelings of anxiety affect the individual without warning and are not related to situational stress.
- Anxiety and "panic attacks" may be due to a physical condition – difficulty breathing, pain, etc.

History:

- Uncontrollable worry or distress about various issues
- Restlessness and/or irritability
- Fatigue or trouble sleeping
- Difficulty concentrating
- History of anxiety disorder.

Assessment:

- Obtain vital signs and document
- Assess for any potential physical condition which may have triggered the individual's anxiety; these include pain, hypoxia (low oxygen, trouble breathing), low blood pressure and other causes
- Consult with Behavioral Healthcare for mental health assessment

Refer to Local Healthcare System:

- Behavioral Healthcare will make this determination based on their professional assessment.

Treatment:

- Consult with a Behavioral Healthcare worker immediately. Behavioral Healthcare will make the final determination as to management.
- Try to calm and reassure the individual.
- Provide privacy

Additional Considerations:

- A panic attack usually presents as four or more of the following symptoms that appear suddenly: chest pain or discomfort, choking, dizziness/faintness, fear of dying, flushing/chills, fear of "going crazy," nausea/diarrhea, a tingling sensation, fast heart rate or palpitations, shortness of breath, sweating, and/or trembling/shaking.
- It can be difficult to differentiate a "panic attack" from a serious medical illness such as myocardial infarction or pulmonary embolism. When there is any doubt, have the shelter resident transported to the hospital immediately.
- Panic and anxiety may be related to a physical condition – difficulty breathing, pain, etc. All shelter residents with symptoms of anxiety should be assessed for an underlying physical condition which may have caused their symptoms of anxiety.

See also: Breathing Problems, Hyperventilation

Adjustments by Local Physician:

Arm/Hand Injury and Pain

Treatment Goal:

- Determine extent of injury
- Prevent further injury from occurring
- Reduce discomfort

Possible Causes:

- Muscle strain, dislocation, sprain, fracture, tendonitis. Shoulder and arm pain (particularly left arm) can be a sign of a myocardial infarction (heart attack), especially if there has been no injury.
- Other symptoms can be shortness of breath, sweating, nausea and chest pain.

History:

- Type of activity the shelter resident was engaged in when injury occurred
- If the shelter resident felt/heard a bone snap
- Past medical history related to musculoskeletal injury/surgery
- Risk factors for coronary artery disease

Assessment:

- Obtain vital signs and level of pain (scale of 0-10)
- Assess all injuries for presence of a pulse distal to the injury, skin color/temperature, and range of motion – do not force movement
- Point tenderness over a specific area is often a sign of a fracture
- Strain: dull pain in the affected muscle that worsens with movement, swelling
- Tendonitis (e.g. tennis elbow): pain at the joint not associated with any trauma/injury. If the area is warm, swollen or red, an infection of the tendon could be present.
- Dislocation: swelling, deformity, severe pain, discoloration, tenderness, and/or numbness of an affected joint
- Sprain: pain and/or swelling at joint, bruising around area of injury
- Fracture: pain/tenderness at site when touched or moved, individual has difficulty moving the injured part, the shelter resident may feel grating sensation, the injured part may move unnaturally, bruising may be present.

Call local EMS/911 for:

- All cases of severe pain – regardless of suspected cause
- If skin is broken over possible fracture site
- Any evidence of compound fracture (bone protruding through open wound)
- If numbness is noted in hand
- If an infection is suspected, have the shelter resident transported to the hospital immediately.
- Any extremity that is cool, pale or blue, or if a pulse cannot be detected distal to the injury.
- Any arm pain with shortness of breath, sweating, nausea and/or chest pain/pressure.

Refer to Local Healthcare System:

- All suspected dislocations, sprains and fractures.

Treatment

- Strain: Rest the affected area, apply cool packs (chemical or ice/water mixed) intermittently

(less than 20 minutes) for the first 24-48 hours then switch to warm compresses. Elevate the extremity as much as possible. Muscle strains respond well to non-steroidal anti-inflammatory medications (NSAIDs), such as Ibuprofen, if individual is requesting pain relief and does not have any contraindications. Follow manufacturer dosage instructions. Assess for allergy to aspirin or NSAIDs.

- Tendonitis: Rest the affected area and apply cool packs intermittently for the first 24-48 hours. If the individual requests pain relief medication, non-steroidal anti- inflammatory medications (NSAIDs, such as Ibuprofen) work best at relieving
- pain and reducing inflammation, unless contraindicated. Assess for allergy to aspirin or NSAIDs.
- Dislocation: Do not move or try to put a dislocated bone back into place. Immobilize the joint as much as possible. Have the shelter resident transported to a medical facility via EMS if necessary.
- Sprain: Rest the affected area; apply ice packs intermittently for the first 24-48 hours. (Do not apply heat for the first 24 hours). Apply a supportive bandage (ACE wrap) and elevate extremity. Loosen bandage if swelling increases or extremity becomes cold or mottled. Warm compresses can be used after 24-48 hours. If the pain has not resolved or is severe, have the shelter resident transported to a medical facility to rule out fracture.
- Closed Fracture (no break in the skin): Immobilize the affected extremity and have the shelter resident transported to a medical facility.
- Open Fracture (skin is broken): Call local EMS. Using standard precautions, cut clothing away from the wound, being careful not to touch the exposed bone. Cover area with sterile dressing. If bleeding, apply direct pressure to wound. If EMS is not immediately available, splint the fractured area as it is and gently help the shelter resident into a comfortable position until EMS arrives.

<u>Additional Considerations</u>

- When unsure of a diagnosis, treat the injury as a fracture. Definitive diagnosis requires professional assessment and radiologic testing at a medical facility.
- Geriatric individuals are more prone to musculoskeletal injury and bone fracture.
- Never give children under the age of 18 aspirin due to risk of Reye's Syndrome.
- Collarbone injuries should have a sling placed on the affected arm and secured to the body to reduce movement as much as possible.
- If the shelter resident is to be transported to a medical facility for further treatment, do not give anything to eat or drink as surgical repair may be required.

See also: Bites, Bruising, Frostbite, Cramps – Muscular, Cuts and Scrapes.

<u>Adjustments by Local Physician:</u>

Back Pain

Treatment Goal:

- Reduce discomfort.
- Assess for more serious health condition.

Possible Causes:

- Back pain usually involves the lower back and can be caused by a strain/tear of the muscles/ligaments, injury to the disc or vertebrae, nerve pressure or fatigue.
- Cardiac pain may present itself as pain between the shoulder blades.
- Kidney stones or kidney infections are frequently associated with severe flank pain and vomiting.
- Gall bladder or pancreatitis can cause pain to radiate to the back.
- A thoracic or abdominal aneurysm may present as back pain. Labor may present itself as back pain as well.

History:

- Location, quality and amount of pain (0-10 scale).
- Activities performed when back pain started
- Any recent trauma to back, fall, heavy lifting or unusual activity
- History of previous episodes of the same type of pain and the effectiveness of treatments in the past
- Change in bowel/bladder function associated with the back pain (especially loss of control of the bladder or bowels)
- Associated numbness, tingling, weakness or paralysis of one or both legs
- Associated abdominal pain or pain related to a myocardial infarction (shortness of breath, sweating, nausea or chest pain).
- Does pain radiate from the back to either/both legs?
- Hypertension or heart disease.
- Pregnancy

Assessment:

- Obtain vital signs and document level of pain (on scale of 0-10)
- If the pain started due to a fall and the shelter resident is not able to walk afterward, do not attempt to get them up or move them. Call EMS immediately and treat them for comfort only.
- Visually inspect the spine for signs of bruising, swelling or other signs of trauma.
- Observe gait, posture, range of motion, balance and coordination.
- Check for weakness and/or numbness in extremities.

Call local EMS/911 for:

- Pain caused by significant impact injury or trauma.
- Pain is severe and/or the shelter resident is unable to walk.
- Back pain is associated with shortness of breath, chest pain, abdominal pain or tenderness, fever, vomiting, sweating, or pulsating mass in the abdomen.
- There is a new onset of numbness, weakness or paralysis of the lower extremities.
- Presence of blood in the urine or the individual is having difficulty urinating or passing stool.

- Incontinence or inability to n control bladder and/or bowel function.
- Blood pressure is low for the shelter resident and/or they are feeling faint.

Refer to Local Healthcare System:

- Pain is not relieved with rest and analgesics.

Treatment:

- Encourage the shelter residents to avoid activities that exacerbate back pain (lifting).
- Over the counter analgesics are appropriate, if requested by the shelter resident and not contraindicated. Follow manufacturer's dosage instructions.
- For an acute muscle pull, apply cool packs intermittently for the first 24-48 hours to reduce inflammation and swelling.
- For stiffness or fatigue, place a warm compress on the affected area.

Additional Considerations:

- Pregnant women should always check with their physician before taking any medication.

See also: Cramps – Muscular, Neck Pain/Stiffness; Urination, Difficulty with

Adjustments by Local Physician:

Bites-

Animal-Domestic or Wild animals, Marine animals

Treatment Goal:

- Prevent further injury or infection
- Reduce discomfort associated with bite
- Stop bleeding, if present

Possible Causes:

- Animal bites can be caused by any animal – either domesticated pets (dogs, cats) or wild animals (skunks, squirrels, etc.). Examples of marine animals include jellyfish and stingrays.

History:

- Type of animal that bit the individual
- Behavior of animal prior and after bite (if noticed)
- If the animal is domesticated, attempt to determine the name and address of the owner and if it has received appropriate rabies vaccines (provide the name and address to the local animal control authorities).
- Date of the shelter resident's last tetanus vaccine

Assessment:

- Obtain vital signs
- Check skin to identify bite mark or any break in skin and/or bleeding
- Look for signs of local swelling and discoloration
- Assess for
- Marine animals: Check skin for remaining tentacles or stingers

Call the local EMS/911 for:

- All animal bites with significant or poorly controlled bleeding
- Bites on the face or neck or with major tissue damage
- All stings by a marine animal that cause an outbreak of hives, weakness, and shortness of breath or chest pain.
- Before calling EMS determine: patient's age, weight and condition, name of the marine animal and time stung.

Refer to Local Healthcare System:

- All animal bites that break the skin
- Any shelter resident who cannot remember last tetanus vaccine

Treatment

- Stop bleeding immediately. Using standard precautions hold direct pressure to the wound for five minutes or until bleeding stops. Wear gloves or use a barrier whenever possible.
- Mammals: Wash affected area with soap and water or providone-iodine solution.
- If skin is broken and/or bleeding, apply clean dressing and direct pressure. Apply antibiotic ointment. For pain, it is appropriate to provide the analgesic requested by the shelter resident. Follow manufacturer's dosage directions.
- Marine animals: Jellyfish: Soak the area in vinegar, alcohol, seawater, or apply thick paste of baking soda to deactivate stinging cells – fresh water can stimulate cells to release more venom. To remove remaining stinging cells, either shave the area with a razor or rub with

a sand/mud and seawater mixture. For pain, apply a hydrocortisone cream to the affected area and/or provide the analgesic requested by the shelter resident.

- Marine animals: Stingray: Submerge the affected area in hot but not scalding water (110-115˚ F) and call the local EMS. If EMS is not available, keep the affected area submerged in hot water for 90 minutes to deactivate the stingray venom.
- Refer the shelter resident to local healthcare system
- Notify the local animal control authorities if the treating physician is not required to do so
- Do not attempt to capture and/or contain animal as this may result in harm to you.

Additional Considerations:

- Rabies in domesticated animals is rare in the US but can occur, especially along the US-Mexico border.
- Jellyfish are common in Florida, the Chesapeake Bay and the South Pacific. Do not handle dead jellyfish as their stinging cells are still active.
- Stingrays are commonly found on the floor of shallow tropical waters and use their long tail to pierce the skin and inject venom.

See also: Infection, Shock, Bleeding – External.

Adjustments by Local Physician:

Bites –

Human

Treatment Goal:

- Prevent infection of the wound
- Reduce discomfort from bite

Possible Causes:

- Children will sometimes bite other children as well as some adults.
- Cutting knuckles on someone's teeth, as in a fist fight, should also be treated as a human bite.

NOTE: A purposeful bite from another adult is reportable to local law enforcement

History:

- Time/location and circumstances surrounding bite
- Date of last tetanus shot of the person who was bitten
- Underlying medical conditions that would predispose individual to infection
- Consider age of the shelter resident as well as other significant medical history (diabetes, chronic alcoholic use)

Assessment:

- Obtain vital signs and document on Incident Report Form
- Document bite site and appearance
- Presence of broken skin, puncture, tear, and bleeding
- Question time frame since bite occurred

Refer to Local Healthcare System:

- All bites that break the skin.
- Any old bites that show signs of infection: redness, warmth, swelling or pain with movement.

Treatment:

- Using standard precautions, clean wound with soap and water or a providone- iodine solution (1 percent - 5 percent) for five minutes.
- Educate regarding signs of infection, redness, fever and chills.
- Apply antibiotic ointment to wound to help prevent infection.
- Wrap with clean, sterile dressing. If bleeding, hold direct pressure to wound for five minutes or until bleeding stops, or until the shelter resident is in the care of advanced medical personnel
- (if the shelter resident) Request the shelter resident to return to HS area 48 hours after treatment for re-evaluation.

Additional Considerations:

- Human bites, especially those on the hands, over joints, face and lip, skull penetration, can lead to serious infection.
- If certain tissue has been bitten off (ear, nose, digit) wrap the tissue in sterile gauze, place in a plastic bag, submerge bag in cool water and send with individual to the emergency department.
- Human bites are not considered to be a common route of transmission for HIV.

See also: Infection, Shock

Adjustments by Local Physician:

Bites

Insect -Bites/Stings-Bees, wasps, ants, spiders, ticks, scorpions

Treatment Goal:

- Identify and prevent a severe allergic reaction
- Prevent infection/injury
- Reduce discomfort

Possible Causes:

- Bites and/or stings of mosquitoes, fleas, bedbugs, flies, spiders, ticks, bees, wasps, scorpions, etc. Most insect bites and/or stings do not cause serious injury, although stings from bees, wasps, fire ants and scorpions can cause serious pain, anaphylaxis or even death.

History:

- Ask individual if he or she saw the insect that bit or stung him or her and describe it
- Any known allergies to prior stings (especially bees and wasps)
- Date and location of bite or sting
- Symptoms of an allergic reaction or anaphylaxis: lightheadedness, shortness of breath, wheezing or chest 'tightness,' throat 'tightening,' nausea or vomiting.
- Symptoms associated with bites and/or stings (pain, swelling, itching, burning, and redness).
- Severe abdominal pain or eye symptoms (especially in children) could indicate a bite from a black widow spider.

Assessment:

- Obtain vital signs
- Look for bite mark or blister, Bull's eye, spotted or black and blue rash around bite
- Note signs of difficulty breathing or swallowing, profuse sweating or salivation
- Note any tachycardia (heart rate greater than 90 at rest), irregular heartbeat or hypotension (systolic blood pressure less than 100mmHg, or significantly lower than the individual's normal blood pressure). This can be a sign of anaphylaxis.
- Swelling to eyes, lips and tongue, or hives on the skin (indicative of an anaphylactic reaction). See Shock protocol.
- Nausea or vomiting, fever and chills, flu like aches
- Assess affected area for redness or swelling
- Small, itchy bumps which disappear in a couple of days (suspect mosquitoes).
- Tiny red, itchy bumps (suspect bedbugs or possibly fleas if individual has had contact with dogs or cats)
- Painful red bite/sting with or without blistering (suspect spiders or fire ants)
- Itchy excoriated skin in the head or pubic area (suspect lice, see Lice protocol)
- If stung by a bee, wasp, yellow jacket or fire ant, assess the area for any remaining stinger left under the skin.

Call Local EMS/911 for:

- All cases of suspected allergic or anaphylactic reaction
- All cases of multiple stings by bees, wasps, yellow jackets or fire ants

Refer to Local Healthcare System:

- Any possible infections due to insect bite/sting
- Any suspected case of venomous spider bite (black widow, brown recluse contain venom

which can cause tissue damage). If a venomous spider is suspected, place a cold compress on the bite site, keep the individual quiet and Urgently get them into the local health care system

- Any suspected tick bite (red "bulls-eye" shaped rash that appears between 3-30 days after potential exposure to ticks).
- Any tick bite (tick attached to the skin) – early diagnosis and treatment with antibiotics can reduce the severity of Lyme's Disease or Rocky Mountain Spotted Fever.
- Any suspected scorpion sting, especially in the elderly and children.

Treatment: dependent on the type of insect.

- Individuals with a history of severe allergic reactions (suspected anaphylaxis) may be carrying a treatment kit (Epi-Pen) and may be assisted in its use. (See procedure for auto-injector in procedures section)
- For mosquito, bedbugs and fleas – clean the affected area of the body. These bites generally do not pose a health risk and require no treatment.
- Apply cold pack to reduce swelling, baking soda paste to relieve itching
- Apply topical cream containing Hydrocortisone to skin
- Antihistamines (e.g.: Diphenhydramine) may help to alleviate itching/swelling
- Oral Diphenhydramine may prevent allergic reaction. Follow manufacturer's dosage guidelines.
- Spider bites, although frequently painful, usually do not require treatment.
- Wasps, bees and fire ants may leave a stinger under the skin.
    - ❖ Gently remove the stinger without squeezing (this may inject more venom into the tissue).
    - ❖ A credit card can be used to scrape along the skin and gently 'flick' the stinger out.
    - ❖ Cool packs may be applied to reduce swelling/pain.
    - ❖ Corticosteroid and/or antihistamine creams may help to alleviate pain and swelling.
    - ❖ Frequent washing of the area with soap and water will help to prevent infection – especially for fire ant stings which can cause blisters that rupture and can become infected.
    - ❖ Instruct the individual to not break the blisters caused by fire ants as this could cause an infection.
- Tick bites are most easily recognized when the tick is still attached to the skin
    - ❖ Remove the tick with tweezers by firmly grabbing the tick's head as close to the surface of the skin as possible and pulling the tick loose in one piece.
    - ❖ Flush the tick down the toilet or place in a container of alcohol.
    - ❖ Cleanse the area with an antiseptic (such as rubbing alcohol) to help prevent infection.
    - ❖ Refer individual to the local health care system for follow-up.
- If insect habitat is known, treat with an insecticide to kill any remaining insects.

Additional Considerations:

- Symptoms of an anaphylactic reaction include lightheadedness, chest/throat tightness, hives, and shortness of breath, difficulty swallowing, nausea and/or vomiting.
- Individuals with a known allergy to bites/stings should be encouraged to carry an allergy kit/syringe containing epinephrine.

- Identifying the type of insect that caused the bite or sting is important in recommending treatment.
- Black widow spiders are identified by their irregularly-shaped web and black, shiny black with a red hourglass marking on their underside. The bite is usually a sharp pinprick sensation, followed by dull pain and then redness and swelling, 2 small fang marks may be noticed.
- Brown recluse spiders are mostly active at night and are identified by their dark brown, violin-shaped marking on the top front portion of their body. The bite is usually not noticed but localized pain develops an hour or more later. A blood filled blister will develop with eventual erosion of skin, leaving a black scar.
- Brown recluse spiders hide in dark secluded areas of homes and other structures.
- May hide in shoes left outside, as well.
- Scorpions are most common in warm southern climates, and hide under rocks, debris or in sandy area

See also: Infection, Shock.

Adjustments by Local Physician:

Bites –

Snake

Treatment Goal:

- Quick referral to higher level of care (within 30 minutes)
- Prevent venomous poisoning
- Reduce pain associated with bite

Possible Causes:

- Venomous snakes (rattlesnakes, copperhead, water moccasins, cottonmouth, coral snake.)
- Non-Venomous snakes

History:

- Obtain a description of the snake, if possible. Pit vipers typically have triangular- shaped heads, deep pits between the nostrils and eyes and long fangs. An exception to this is the brightly-colored coral snake with a small head, round eyes and red and black rings separated by a yellow ring. Most non-poisonous snakes have rounded heads and round eyes.
- Date of last tetanus vaccine (effective if received within past 10 years)
- Symptoms of adverse reaction to snake venom – severe pain, rapid swelling, discoloration of skin, weakness, nausea/vomiting, numbness of arms or legs, convulsions, and/or blurred vision (all indicators of a poisonous snake).

Assessment:

- Obtain vital signs
- Identify location of bite and appearance of bite site
- Determine time lapse since bite
- Determine extent of tissue damage and presence of bleeding
- Harmless snakebites are usually characterized by four rows of small scratches, separated from two rows of scratches (from upper and lower jaw teeth)
- Venomous snake bites should have one or two puncture wounds produced by fangs, whether other teeth marks are noted. May or may not bleed
- Coral snake bites leave a semicircular mark from the snake's teeth.-usually little or no pain/swelling after bite, but systemic symptoms may arise 1-5 hours after bite.
- Observe the shelter resident for signs/symptoms of an adverse reaction (see above). If there are no symptoms within four hours, the snake is probably non-poisonous.

Call Local EMS/911 for:

- All suspected/known cases of poisonous snake bites. Obtain individuals' age, weight and condition, type of snake if known, time of bite before calling EMS.

Refer to Local Healthcare System:

- All snake bites for follow-up
- Any shelter resident who cannot remember last tetanus vaccine or, if known, to be more than 10 years past

Treatment:

- Use standard precautions:
    - ❖ Poisonous and non-poisonous bites: Keep the affected extremity below the level of the heart, remove all watches/jewelry (in case of swelling), clean the area with

soap and water, and cover with a clean bandage.

- ❖ Poisonous bites: Contact local EMS immediately, keep the individual quiet to slow the circulation of the venom (do not allow the individual to move about) Immobilize the affected extremity, remove watches/jewelry (in case of swelling), and cover with a clean bandage.

- Do not apply a tourniquet, cool pack or cut open the wound as these actions could cause more damage. Do not apply suction to the wound as this has not shown clinical benefit.

Additional Considerations:

- Snakebites occur most frequently in the summer months and usually affect the arms and legs.
- Most snake bite deaths are due to allergic reaction, poor health of individual or delayed medical intervention
- Do not try to capture the snake. If the snake is thought to be poisonous, contact the local animal control authorities and give the last known location of the snake--most snakes can be found, even hours later, within 20 feet of where the bite occurred.
- Coral snakes are uncommon, but rattlesnakes and other poisonous snakes live throughout the continental US.

See also: Infection, Shock, Bleeding – External.

Adjustments by Local Physician:

Bleeding –

External

Treatment Goal:

- Control the bleeding.
- Prevent complications from loss of blood.
- Prevent infection.

Possible Causes:

- Injuries such as cuts, scrapes, punctures, etc

History:

- Type and extent of injury
- History of anticoagulant therapy or clotting problems
- Symptoms of hypovolemia/shock (rapid heart rate, low blood pressure, pale skin. (See Shock protocol)
- History of tetanus vaccine (must have new booster if last one was not within last 10 years)

Assessment:

- Obtain vital signs
- Determine the severity and speed of the bleeding, estimate the amount of blood loss (describe it concretely – e.g. blood soaked shirt six inches in diameter).
- Reassess for further bleeding and vital signs periodically
- Look for bruising of the injured area
- Palpate soft tissue for tenderness, swelling or rigidity

Call Local EMS/911 for:

- All shelter residents with symptoms of shock or hypovolemia
- Any bleeding that is difficult to control (e.g. pulsating)
- All bleeding from a suspected artery (spurting, bright red blood), or large vein
- Any suspicion of a significant blood loss

Refer to Local Healthcare System:

- All shelter residents requiring a tetanus immunization
- Any laceration that may require sutures or surgical repair-should see a provider within first few hours of injury
- All bleeding caused by a puncture wound (for follow-up and possible tetanus vaccine (if last one was not within the past 10 years or individual cannot remember when last one was given)
- Any diabetic individual with puncture wound to the feet, regardless of amount of bleeding

Treatment:

- Using standard precautions, stop bleeding immediately, before any other action.
- With a clean gauze or dressing, apply direct pressure to the wound for five minutes or until bleeding stops.
- Once bleeding has stopped, apply a clean dressing to the wound.
- Instruct the shelter resident to watch for signs of break through or re-bleeding of the wound. If bleeding continues, do not remove existing gauze but place more gauze on top and continue to apply pressure.

- If bleeding does not stop, apply continuous and very firm pressure until EMS arrives.

Additional considerations:

- Tourniquets are no longer recommended for control of bleeding as they can cause additional injury, loss of limb and death.
- There is insufficient evidence to recommend for or against the elevation of a bleeding extremity. You should forego attempting to elevate an extremity when the application of direct pressure may be compromised.
- The amount of blood is not a good indicator of the severity of injury. Head wounds tend to bleed heavily, even if the wound is minor. Conversely, deep puncture wounds may not bleed much externally while most of the bleeding occurs internally.
- Long bone fractures can lead to loss of blood, ending in shock, even if the skin has not been broken.

See also: Cuts and Scrapes, Bruising, Nose Bleeds, Miscarriage, Shock.

Adjustments by Local Physician:

Bleeding –

Internal

(symptoms of gastrointestinal, vaginal, urinary tract, organ, vascular damage)

Treatment Goal:

- Prevent complications from loss of blood. Refer all suspected cases of internal bleeding to emergency care/hospital.

Possible Causes:

- Stomach ulcer, hemorrhoids, early onset or unexpected menstruation, miscarriage of a pregnancy (vaginal bleeding), urinary tract infection, and internal organ vascular damage

History:

- Source of the suspected blood (vomit, rectum, vagina, urine).
- History of anticoagulant therapy or clotting problems.
- History of bleeding in past (ulcers, varices, etc.).
- Recent change in color of stool (frank blood or black/tarry stools indicate the presence of blood).
- Vomit that is coffee-ground colored or dark or bright red.
- Symptoms of hypovolemia/shock (rapid heart rate, low blood pressure, pale skin, changes in mental status). See Shock protocol.

Assessment:

- Obtain vital signs
- Speed of bleeding (continuous, slow to brisk, seeping vs. spurting)
- Estimate the amount of blood lost (describe it concretely – e.g. blood soaked shirt six inches in diameter)
- Abdominal tenderness can indicate other causes of internal bleeding
- Reassess periodically

Call Local EMS/911 for:

- All suspected cases of internal bleeding
- All shelter residents with symptoms of shock or hypovolemia

Treatment:

- Do not give the shelter resident anything to eat or drink. Refer the shelter resident to the local healthcare system.
- **Always use standard precautions** when there is a chance of contact with blood or body fluids

Additional Considerations:

- Suspected internal bleeding is an emergency and requires immediate evaluation.

See also: Cuts and Scrapes, Bruising, Nose Bleeds, Miscarriage, Shock

Adjustments by Local Physician:

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Blisters

Treatment Goal:

- Prevent additional injury to the shelter resident
- Reduce discomfort associated with blister

Possible Causes:

- Usually from persistent or repeated rubbing against the skin. Some illnesses, such as shingles can cause blister like rashes
- Burns, viral infections can also blister the skin

History:

- Exposure to any heat source or chemical which may have caused a burn or blister
- Walking in new or loose fitting shoes
- History of herpes simplex I (oral blisters) or herpes simplex II (genital blisters) or potential exposure to someone who may have these conditions
- Length of time individual has had blister

Assessment:

- Obtain vital signs
- Observe size and location of blister(s)
- Herpes blisters may be painful
- Observe for fluid in the blister (absent, clear or bloody)
- Observe for any skin tear in the blister
- Look for signs of infection – redness, pus or red streaks

Refer to Local Healthcare System:

- Any blister that is large and likely to be broken by routine activity
- Any blistering suspected to be caused by either herpes simplex or the individual has not received confirmed diagnosis
- Any blister with signs of infection

Treatment:

- Small, unopened blisters do not require intervention. Cover loosely with a gauze pad and let the blister heal naturally.
- For open blisters, wash with soap and water and cover with a gauze dressing using standard precautions. Do not remove the loose skin.
- Do not puncture or break blisters

See also: Burns, Rash, Skin Infections, Chickenpox, Shingles, Herpes, and Measles

Adjustments by Local Physician:

Breathing Problems:

Shortness of Breath/Dyspnea

Treatment Goal:

- Assess for more serious health condition
- Relieve sensation of difficulty of breathing when possible and return breathing to normal

Possible Causes:

- Shortness of breath is often a sign of a serious medical condition such as myocardial infarction, cardiac arrhythmia, pulmonary edema, pulmonary embolism, pneumonia or anaphylactic shock. Transient shortness of breath may occur with exercise or overexertion.
- It can also be caused by a variety of environments (high altitudes), chronic and acute illnesses (high fever, severe anemia, kidney disease, COPD, asthma, heart disease) or injury (broken rib).

History:

- Determine the presence of other concerning symptoms – chest pain/pressure or tightness, sweating, nausea, lightheadedness.
- Ask the shelter resident for any past medical history of serious illness – especially lung and heart disease and diabetes.
- Some shelter residents have shortness of breath as their baseline breathing status – determine if this is the case and ask individual if he or she is concerned about his or her current breathing status.
- Any medication the shelter resident is currently taking.
- Any allergies to food, medication or environmental factors.
- Any history of chest pain, high blood pressure, irregular heart rhythm or blood clots in legs or lungs.
- Any trauma or blow to the neck or chest that the individual may have experienced.

Assessment:

- Obtain vital signs
- Assess heart rate and rhythm.
- Listen to breath sounds for the presence of wheezes, rales or rhonchi.
- Assess character and intensity of chest pain (if any).
- Observe for use of auxiliary muscles during respiration (sternal retractions in infants).
- Observe for central and/or peripheral cyanosis (mottled skin, bluish tint to nail beds/lips, etc.).

Call Local EMS/911 for:

- Any suspicion of a serious cause for the shortness of breath
- Any shelter resident with ANY risk factor for a myocardial infarction, including known heart disease or prior heart attack or cardiac surgery, diabetes, high blood pressure, smoking history and obesity
- Acute onset of shortness of breath at rest or not relieved by rest, use of auxiliary muscles during respiration or shortness of breath associated with chest pain
- Shortness of breath with the inability to lie flat (orthopnea)
- Shortness of breath associated with a resting heart rate greater than 115 beats per minute

resting respiratory rate greater than 26 breaths per minute, hypotension and/or central cyanosis

Refer to Local Healthcare System:

- Almost all adults with shortness of breath will require an evaluation by a physician
- Any case in which the shelter resident requests more assistance
- Any case associated with trauma or a blow to the chest

Treatment: Dependant on the cause.

- Asthma: see Breathing Problems- Asthma protocol
- Hyperventilation: see Breathing Problems – Hyperventilation protocol
- Chronic shortness of breath: allow the individual to do whatever they traditionally do to ease breathing (leaning forward, nebulizer, inhaler, etc.)
- Acute shortness of breath – rest in a semi-Fowlers or upright position, in a well- ventilated environment with warm, humidified air (if available) until symptoms are relieved or individual is transported to a local medical facility
- Maintain calm environment and reassure the shelter resident

Additional Considerations:

- Shortness of breath that is associated with chest pain could indicate a pulmonary embolus (blood clot in the lung) or a myocardial infarction (heart attack) and is a medical emergency.
- Shortness of breath associated with orthopnea or the inability to lie flat may indicate fluid in the lungs (heart failure, pulmonary infiltrates) or surrounding the heart and/or lungs (pericardial effusions).
- Abdominal distention (gas, ascites) or morbid obesity may cause shortness of breath in a supine position. Breathing should improve if the individual is placed in a semi-Fowlers (semi-recumbent) position.

See also: Chest Pain/Pressure, Congestion.

Adjustments by Local Physician:

Breathing Problems:

Asthma/COPD

Treatment Goal:

- Return breathing to normal

Possible Causes:

- Asthma and chronic obstructive pulmonary disease (COPD) are grouped together under obstructive breathing problems.
- A history of asthma may be linked to a genetic pre- disposition or exposure to tobacco smoke.
- Asthma attacks may be caused by an allergic reaction to something in the air, physical activity, exposure to tobacco smoke or exposure to certain medications (causing an allergic reaction).
- COPD includes all chronic obstructive airway diseases, including chronic bronchitis and emphysema (of varying causes).

History:

- Determine the presence of other concerning symptoms: chest pain/pressure or tightness, sweating, nausea, lightheadedness
- Ask the shelter resident for any past medical history of serious illness, especially lung and heart disease and diabetes
- Previous history of asthma, emphysema, chronic bronchitis (COPD). Shelter residents with no prior history, but with wheezing or shortness of breath, should be considered a medical emergency
- Asthma attacks: previous triggers and effectiveness of treatment
- Current medications, any medication recently taken

Assessment:

- Obtain vital signs
- Listen to breath sounds while the individual is sitting upright – asthma is characterized by wheezing or whistling sound which can occur with either inspiration or expiration
- Observe for signs of an asthma emergency – difficulty breathing, fright/anxiety, sweating, sitting upright and leaning forward, rapid heart rate and blue-tinged lips (due to inadequate oxygen intake)
- Symptoms of COPD include chronic cough and a individual using pursed lips to exhale (pink puffer). Those with emphysema will frequently have a ruddy complexion and a large, barrel chest.

Call Local EMS/911 for:

- Obvious respiratory distress with difficulty breathing
- Accompanying chest pain, sweating, nausea or dizziness
- If medication to treat an asthma attack is not available
- Any attack that the shelter resident reports is more severe than normal
- Any attack where the shelter resident raises the shoulders and chin to fight for a breath of air – this is indicative of impending respiratory failure
- Any asthma attack that does not improve within 15 minutes of taking medication
- A shelter resident that loses the ability to cough or talk during an attack

- Any shelter resident with COPD who begins to have difficulty breathing

Refer to local Health care system:

- If coughing up yellow, dark brown or bloody mucus
- Any new case of suspected (undiagnosed) asthma
- Any suspected, previously undiagnosed cases of COPD
- If the shelter resident has begun to need asthma medication more frequently than usual

Treatment

- Asthma attacks can frequently be successfully treated with a bronchodilator (inhaler). Most asthmatics carry an inhaler with them and should be encouraged to use their medication. Volunteers can assist the victim with using their bronchodilator if a) the shelter resident states they are having asthma attack and has medication and b) the shelter resident identifies the medication and is unable to administer it without assistance. See protocol for inhaler under procedures.
- Chronic asthma can be managed with daily medication (as prescribed by a physician) that reduces inflammation
- For the shelter residents with COPD, neither antibiotic therapy nor treatment of their cough with cough suppressants is recommended
- Maintain calm environment and reassure the shelter resident

Additional Considerations:

- If a individual does have a reaction to allergens in the air, try to identify what triggered the attack and attempt to reduce or eliminate the irritant.
- Many asthmatics have sensitivity to aspirin and other NSAIDs, which may cause an attack if taken.
- Half of all asthma attacks occur in children under the age of ten. Pediatric symptoms often include constant coughing, flaring of nostrils or grunting (in infants).
- COPD and emphysema are chronic diseases that are almost always associated with smoking and are seen most widely in older adults.
- Some shelter residents require supplemental oxygen on an ongoing basis and, with access to their usual source of oxygen, can be accommodated in shelters.

Adjustments by Local Physician:

Breathing Problems–

Hyperventilation

Treatment Goal:

- Identify possible serious causes of respiratory distress.
- Return breathing to a normal rate.

Possible Causes:

- Breathing faster than normal may be due to emotional upset or tension/anxiety. It is also caused by injuries, such as head injuries, severe bleeding or conditions such as high
- fever, heart failure, lung disease, or diabetic emergencies. It can be triggered by asthma or exercise.

History:

- Determine the presence of other concerning symptoms – chest pain/pressure or tightness, sweating, nausea, lightheadedness
- Ask individual for any past medical history of serious illness – especially lung and heart disease and diabetes
- Ask individual or bystander, if possible, to describe the circumstances surrounding the episode of hyperventilation
- Ask individual if they have experienced these episodes previously and what triggers the response and alleviates the symptoms
- Individual may state they feel like they "can't breathe" or "can't catch their breath."
- Individual may feel dizzy or light-headed
- Individual may experience numbness and tingling in the hands and/or feet or around the mouth

Assessment:

- Obtain vital signs (especially respiratory rate)
- Note if breathing is rapid and shallow
- Note if there is any substernal retraction (sucking-in beneath the ribs)
- Listen to breath sounds, which may be either clear or diminished. If wheezing is heard, refer to Breathing Problems Asthma/COPD protocol.

Call Local EMS/911 for:

- If unable to help individual relieve symptoms
- Any risk factor for heart disease, coronary artery disease or heart attack
- Any concerning symptoms (see above)

Refer to Local Healthcare System:

- All cases of hyperventilation for follow-up.

Treatment:

- Encourage the shelter resident to relax and encourage slow, deep breaths through pursed lips or through the nose
- Reassure the shelter resident in a calm, soothing voice
- Have the individual breathe into a paper bag or into their cupped hands to help alleviate symptoms. Symptoms are caused by an imbalance of oxygen and carbon dioxide in the blood. (Do not use this technique if the shelter resident has heart or lung problems or if the altitude is above 6000 feet)

- Plastic bags should never be used due to the risk of suffocation
- Referring the shelter resident to a Behavioral Healthcare volunteer would be appropriate

Additional Considerations

- Rapid breathing creates a situation where there is a low level of carbon dioxide in the blood. This creates the numbness and light-headed sensation associated with hyperventilation.
- Frequently, if the individual should faint, breathing immediately returns to normal.
- Normal respiratory rates:
  - ❖ Newborn to 1 year: 40-60 breaths/minute
  - ❖ 1 through 6 years: 18-26 breaths/minute
  - ❖ 7 years through adult: 12-24 breaths/minute

See also: Anxiety.

Adjustments by Local Physician:

Bruising

Treatment Goal:

- Reduce discomfort
- Reduce or limit damage to tissue

Possible Causes:

- Bruising may be caused by minor bumps and sprains or traumatic blows and internal bleeding

History:

- Determine cause of bruise, if possible
- If injury, determine if disaster related
- Determine whether individual takes aspirin or any blood-thinning medications
- Determine if individual has history of chronic illness

Assessment:

- Obtain vital signs
- Observe size and extent of bruising
- Determine the location of the bruise – if on the abdomen or chest there should be concern about internal injury
- Is bruising around the eye, inspect the eye for blood. Ask if there is any loss of vision, change in vision or inability to move eye in all directions
- Assess level of pain
- Bruises are reddish/blue initially and then green/yellow as they fade
- Assess for presence of lump or hematoma
- Assess for possible signs of abuse

Call Local EMS/911 for:

- Any concern about possible internal injuries
- Any traumatic injury to the eyes
- Severe pain
- Rapid or weak pulse
- Rapid breathing
- Pale ashen appearance
- Nausea or vomiting
- For any traumatic bruising of the back, chest or abdomen, or large areas of tenderness, swelling or firmness at site of bruising, suspect possibility of internal bleeding, possibility of shock.

Refer to Local Healthcare System:

- If bruise is severe, if a painful lump develops, or if there is any suspected underlying injury (broken bone, sprain, etc.)
- Any bruising caused by injury to a individual who is taking a blood thinner
- If the shelter resident has an underlying chronic illness
- If pain increases or ability to move affected body part decreases
- Unexplained recurrent or multiple bruises

Call local law enforcement:

- If the shelter resident reports that bruising was caused by violence from a family member or other shelter resident
- Suspected abuse or maltreatment of a shelter resident (physical abuse is a crime)

Treatment:

- Apply cool pack (chemical or ice/water mixture) to the bruised area for fifteen minutes to reduce swelling and to stop any remaining bleeding under the skin. Repeat several times a day for 48 hours.
- After 48 hours, a warm compress can be used instead of ice to help with tissue healing. Heat should not be applied to the area until after 48 hours due to risk of continued bleeding.

Additional considerations:

- People who have been abused frequently present with bruises on the face, back, abdomen, thighs and around the neck or buttocks. Bruises may have a recognizable shape, such as the shape of a clothes hanger or belt buckle. There are frequently multiple bruises and at varying degrees of healing (some new reddish/blue and some yellow/brown and faded).
- Elderly persons may be more prone to bruising because of thinning supportive tissues and increased capillary fragility.
- The extent and severity of bruising will be worsened in individuals receiving anticoagulant medications and chronic steroid therapy.
- Blood in the subcutaneous tissues not confined to a space is subject to gravity and may spread. Distinguish enlargement of a bruise due to dependent seepage from enlargement due to continued bleeding.

See also: Cuts and Scrapes, Bleeding, Arm/Hand Injury and Pain, Leg/Foot Injury and Pain, Violence/Domestic Abuse.

Adjustments by Local Physician:

Burns-

Chemical

Treatment Goal:

- Limit tissue damage
- Reduce pain associated with burn
- Early contact with Poison Control Center (local or 1-800-222-1222)

Possible Causes:

- Chemical burns are caused by caustic ingredients commonly found in household products (bleach, toilet bowl cleaner, drain cleaners, lawn and garden chemicals etc.) or
- industrial chemicals

History:

- Any known exposure to chemicals – either through household cleaning agents or industrial agents

Assessment:

- Obtain vital signs
- Determine location and extent of injury
- Length of exposure to chemical and if still present on skin
- Try to identify the chemical and its source

Call Local EMS/911 for:

- Any burn that has affected more than 10% of the body
- Any shelter resident showing signs of shock (rapid pulse/breathing). See Shock protocol.
- Any burn that affects breathing or is close to the mouth
- Any chemical burn to the eyes
- Any concern for a chemical contamination that can affect others

Refer to Local Healthcare System:

- Any burn that penetrates the top layer of skin
- Any burn which occurs in the hands, feet, groin, face, buttocks or over a major joint
- Any burn larger than the palm of your hand

Treatment:

- Follow poison control Instructions
- Remove any contaminated clothing and jewelry using impermeable gloves. Store them in a safe place (plastic bag) so that no one else can be contaminated.
- Brush dry or powdered chemicals off with a gloved hand and a cloth
- Flush the affected area with large quantities of running water for 15-30 minutes per instructions of National Poison Control
- If eye is burned by a chemical, continuously flush the eye (from nose outward and downward) with running water until the arrival of EMS
- Wrap the affected area loosely with a clean dressing
- If substance is known or manufacturer's label is available, refer to the information on the bottle for treatment advice or call National Poison Control: 1- 800-222-1222
- Over-the-counter analgesics can be useful for pain relief
- Contact the local poison control center for further advice

Additional Considerations

- Make sure chemicals are being properly stored – in either a locked cabinet or out of the reach of children.
- It is always useful to determine the telephone number for the local poison control center in the area you will be working.

See also: Infection.

Adjustments by Local Physician:

Burns–

Electrical

Treatment Goal:

- Prevent additional injury to the shelter resident
- Reduce pain associated with burn
- Prevent infection

Possible Causes:

- Electrical burns are caused by an electrical current (lightning, electrical appliance, etc.) that passes through the body – sometimes not leaving any outward signs of trauma.

History:

- (Shelter resident may be unable to give any history at time of treatment)
- Determine the circumstances surrounding the electrical injury
- Amount of electricity (volts/watts) to which the shelter resident was exposed
- Amount of time of contact

Assessment:

- Look and care for life-threatening conditions, such as respiratory or cardiac arrest
- Caring for any immediate life-threatening conditions takes priority over caring for burns
- Look for any signs of fractures (including spinal fractures), in those cases, do not move the shelter resident
- Obtain vital signs (specifically heart rate and respiratory rate as these are frequently affected in an electrical situation) and document
- Look for 2 burn sites

Call Local EMS/911 for:

- Cases of individual being struck or nearly struck by lightning
- All shocks from current higher than household plugs (greater than 110 volts).
- Cases that caused loss of consciousness or memory loss
- Cases of electrical burn that leave the individual with breathing difficulty
- Muscle pain or contractions
- Seizures
- Numbness/tingling
- Any abnormal vital sign

Refer to Local Healthcare System:

- All electrical burns because the extent of injury may not be readily apparent

Treatment

- Look at your surroundings before touching the shelter resident – he/she may still be in contact with the electrical device that caused the injury. If in doubt, call EMS immediately.
- Turn off the source of energy, if possible. If unable, do not attempt to pull the shelter resident away from the energy source until the power can be turned off. A non- conductive tool (wood, plastic, etc.) should not be used to drag the shelter resident away from the energy source.
- Check the unconscious shelter resident for potential need for CPR (feel for pulse first) –
- electrical injuries frequently cause cardiac arrhythmias or cardiac arrest.
- Prevent shock by having the shelter resident remain lying down with their feet elevated 8-

12 inches

- Using standard precautions cover any burn injuries with a dry, clean bandage

Additional considerations

- Electrical injury frequently passes through the body without leaving outward signs of injury, although internal damage could be quite severe

See also: Infection.

Adjustments by Local Physician:

Burns–

Thermal (heat)

Treatment Goal:

- Cool and cover the burn
- Quick referral for critical burns
- Limit damage to tissue
- Prevent/minimize/treat for shock
- Reduce discomfort to the shelter resident
- Prevent infection

Possible Causes:

- Fire, sunlight or hot substances cause thermal burns of varying severity

History:

- Type of exposure (hot substance, grease, liquids)
- Length of time exposed
- Where the burned areas are and the extent (body percentage) of those burns
- Head-9%
- Front torso-18% Back torso-18%
- Arm-9%
- Groin-1% Leg-18%

Assessment:

- Obtain vital signs
- Pay close attention to victim's airway-soot or burns around the mouth, nose or face may signal air passages or lungs have been burned
- Assess skin for amount of surface area affected. The size of the palm of the shelter resident's hand is equal to approximately one percent of their body surface area.
- First-degree: injury to only the outside layer of skin causing redness, pain, mild swelling and no blister or break in the skin
- Second-degree: injury to the layers of tissue below the surface of the skin causing blisters, pain, swelling and oozing of moisture from the skin
- Third-degree: Destroys all layers of skin and causes white/leathery skin at burn site and little pain (due to nerve damage)

Call Local EMS/911 for:

- Cases of third-degree burns or burns to the face/neck
- Burns that involve hot grease, melted clothing sticking to skin
- Any difficulty breathing- possible cases of airway and lung burns, smoke inhalation, with or without burns to the skin
- Any burns covering more than one part of the body
- Any circumferential burn (going around an entire limb or digit)
- Any burns resulting from explosions

Refer to Local Healthcare System:

- Cases of second degree burn that affect five percent of the body on an adult and three percent of the body of a child
- Any burns on the hands or feet
- Burns that affect the very young or the very old

Treatment:

- Cool all burns as rapidly as possible with cool water (not ice) by flushing gently and continuously. **Always use standard precautions**.
- Remove individual from source of heat if possible
- First-degree: Run the affected extremity under cool water or apply a cold compress until pain decreases. Clean with soap and water and cover with a clean bandage. Antibiotic ointment is appropriate, if available. Analgesics are appropriate for pain relief, if requested and not contraindicated.
- Second-degree: Run the affected extremity under cool water or apply a cold compress to bring the skin temperature down and limit tissue damage. Do not use ice. Clean with soap and water, pat dry and cover with a sterile bandage. Remove jewelry or restrictive clothing and elevate affected extremity. Do not break blisters. Analgesics and/or anti biotic ointment is appropriate, if requested and not contraindicated.
- Third-degree: Maintain airway, if not breathing, as breathing problems are common with third-degree burns. Call EMS. Place a cool cloth on the affected area, cover with a sterile dressing or clean sheet, elevate affected extremity, and watch for signs of shock (rapid pulse/breathing). Do not attempt to remove clothing or other fibers in burns, apply ointments to burn or put ice or ice water on the affected area.
- Guard individual from hypothermia
- Shock: Keep the individual lying flat unless the neck or face has been burned or the individual is having trouble breathing – then they should be propped up. Elevate the feet 8-12 inches and cover the shelter resident with a blanket to keep them warm but not hot. Give nothing by mouth and wait for EMS to arrive.

Additional Considerations

- Child abuse can present itself through burns as well as bruising. Young children are frequently burned in the bath tub or sink due to inadequate supervision. Burns with distinctive edges (from being immersed), circular cigarette burns and burns at various degrees of healing all suggest child abuse and should be reported.
- Infants and children have a greater surface area relative to their total size which leads to greater loss of fluid and heat. They are at extra risk for shock, airway difficulties and hypothermia.
- The Rule of Nines is commonly used to estimate the percentage of body that has been affected by the burn. In an adult, the head or one arm represents nine percent of the total body surface, and one leg or the front or back of the trunk represents eighteen percent.
- Individuals who have singed nasal hairs or burns around the nose/lips may have experienced smoke inhalation and should be referred to the local health care system
- Skin damaged by burns easily becomes infected due to the body's inability to protect itself from invading organisms
- Older adults are especially vulnerable to burns. Older adults lose their ability to sense heat and will often unintentionally become burned

See also: Infection, Breathing Problems – Shortness of Breath.

Adjustments by Local Physician:

Burns-

Sunburn/Radiation burns

Treatment Goal:

- Determine source of burn (sun, medical, other)
- Cool burn
- Protect from further damage
- Reduce area of exposure
- Reduce length of exposure
- Prevent or reduce possibility of radiation sickness
- Prevent/reduce long term effects of radiation exposure

Possible causes:

- Sun burn, UV light, X-rays, radiotherapy, radiological accident, terrorism (example would be a dirty bomb).
- Release of radiation into the environment can create radioactive dust and dirt (fallout).
- Damage to skin or other biological tissue
- Long periods in the sun without protection (sunbathing, working outdoors)
- Radiation exposure occurs when a person is near a radiation source
- External contamination occurs when loose particles of radioactive material falls on surfaces of skin or clothing
- Internal contamination occurs when radioactive particles are inhaled, ingested or lodge in an open wound

History:

- Reports being present during a radiation emergency, or fear of being contaminated by fall out
- Cancer patient being treated by radiation therapy
- Works in medical, industrial or research site that handles radioactive materials
- Over exposed to sun without sunscreen or appropriate clothing cover

Assessment:

Symptoms may occur from hours to days following exposure. May come in cycles

- Obtain vital signs.
- Intensely painful burn like skin injuries without a history of exposure to heat or caustic chemicals. Other symptoms may be reported as itching, tingling, erythema (redness), edema (swelling), blistering, ulceration, bleeding, hair loss, skin pigment changes
- Note area affected, record skin characteristics and size of affected area

Call Local EMS/911 for:

- Cases of 3rd degree burns or burns to face and neck
- Any burn that is greater than 3 percent of body surface
- Any cause to believe that burn has caused internal tissue damage
- Any suspected burn from radiologic accident or terrorism; make sure to notify EMS of suspicion of radiologic accident or terrorism so appropriate PPE precautions can be taken. Also notify HS Supervisor and Public Health Authorities.

Refer to Local Healthcare System:

- Burns in the very young and the elderly
- Any large burn that is blistered or oozing fluid (second degree)

- All burns that are known to be caused by medical radiation

Treatment-same as for thermal burns:

- Symptom based
- Topical creams containing aloe vera
- Infection control, keep burn area covered with clean
- Pain management with anti-inflammatory medications such as Ibuprofen, following manufacturer's directions
- Psychological support
- Refer to DMH if deemed necessary for added support to the shelter resident

Additional Considerations:

- In cases of Radiation accident or act of terrorism, it is highly possible that shelter residents may have high anxiety or feelings of panic.
- Cases of exposure involving terrorism that were not initially identified immediately after the accident or they develop after individual is in the shelter.
-

Adjustments by Local Physician:

Chest Pain/Pressure

Treatment Goal:

- Early recognition and referral of life-threatening cardiac condition
- Relieve discomfort.
- Provide reassurance

Possible Causes:

Chest pain is caused by both cardiac and non-cardiac conditions.

- Examples of non- cardiac conditions include muscle strain in the ribs, pleuritic pains associated with pneumonia and heartburn. Life-threatening non-cardiac chest pain occurs in a pulmonary embolism or dissecting aortic aneurysm.
- The two main causes of cardiac- related chest pain are angina (temporary chest pain/pressure due to decreased oxygen to the heart muscle) and myocardial infarction (blockage of an artery in the heart muscle causing a heart attack). Hyperventilation can also cause chest pain.

History:

- Onset of symptoms and circumstances surrounding the onset (shelter resident at rest vs. physically active) and if symptoms are relieved by rest
- Quality of pain: sharp, dull, aching, stabbing, burning, etc.
- Location of discomfort: epigastric, between the shoulder blades, radiating down one or both arms or up to the jaw, substernal, etc.
- Severity of pain (0-10 scale)
- Past history of heart attack, family history of heart disease/heart attack
- History of angina and treatment
- Presence of additional symptoms, particularly shortness of breath, sweating, nausea or pain radiating to the arms, back or neck
- Past medical conditions that increase the risk for a serious event include prior heart disease, high cholesterol, smoking, prior coronary artery bypass surgery or stents, diabetes, blood clots in the legs or lungs, prior stroke or transient ischemic attacks (TIAs), angina (chest pain) or high blood pressure
- •All current medications

Assessment:

- Obtain vital signs
- Feel skin for cold/clammy feeling or presence of sweat
- Observe for shortness of breath
- Listen to heart rate/rhythm and breath sounds
- If chest pain can be pinpointed, and pain increases upon touch (most likely chest-wall pain)
- Ask individual if he/she has pain with coughing or deep breathing

Call Local EMS/911 for:

- All new cases of chest pain and all cases of unstable angina in individuals with a history of chest pain
- Any shelter resident with history of angina who experiences chest pain that does not resolve with their normal treatment (e.g. nitroglycerin therapy) after five minutes
- Any chest pain associated with fever and shortness of breath

Treatment:

- Have the shelter resident rest comfortably and loosen tight clothing
- For the shelter residents with a known history of coronary artery disease or stable angina (chest pain upon exertion that resolves with rest), encourage shelter resident to rest and take their own nitroglycerin tablet, if available
- For the shelter residents without a history of coronary artery disease or individuals with unstable angina (chest pain occurring at rest or not responding to usual therapy), encourage the shelter resident to rest and call local EMS immediately
- Make sure that individuals who are already taking daily aspirin have taken their aspirin that day. If not, they should chew an aspirin – unless contraindicated (known allergy to aspirin, etc.)
- If heart attack is suspected- if oxygen is available and staff is trained in its use: administer at 2 liters of nasal oxygen via cannulae and 30% face mask until EMS arrives

Points of Interest:

- Acute cardiac disease can present with vague symptoms, particularly in the elderly, women and those with diabetes. Be very cautious with these groups.
- Sometimes individuals with myocardial infarctions may not have any chest pain, but may only experience shortness of breath, sweating or nausea (particularly in the above groups).
- Millions of Americans experience stable angina which does not constitute a medical emergency. However, immediate referral to the local health care system is necessary if their usual symptoms change or they stop responding to treatment.
- Sudden chest pain associated with breathing difficulty and (maybe) coughing up blood can be indicative of a pulmonary embolism while persistent chest pain with shortness of breath and sweating can be indicative of a heart attack.
- Gastro-esophageal reflux disease (GERD) may be a cause of chest pain and "heart burn" but do not assume that this is the cause.

See also: Abdominal Pain, Back Pain, Breathing Problems, Shortness of Breath, Indigestion, Nausea/Vomiting.

Adjustments by Local Physician:

Choking/Obstructed Airway

Treatment Goal:

- Prevent loss of consciousness or death
- Return breathing to normal

Possible Causes:

- Choking is the most common cause of respiratory emergency. A person whose airway is blocked can quickly stop breathing, lose consciousness, and die.
- The most common causes of choking include:
  - ❖ Trying to swallow large pieces of poorly chewed food
  - ❖ Wearing dentures. Dentures make it difficult for someone to sense whether food is fully chewed.
  - ❖ Eating while talking excitedly or laughing or eating too fast
  - ❖ Walking, playing, or running with food or objects in the mouth
  - ❖ Recent alcohol consumption

History:

- Onset of choking
- Determine whether this is an airway obstruction emergency
- Determine whether the obstruction is partial or complete

Assessment:

- What is blocking the airway - tongue, swollen tissues of mouth or throat, food, small toy, dentures or fluids such as vomit, blood or mucus?
- Partial obstruction-still able to move air to and from lungs
  - ❖ wheezing sounds
  - ❖ clutching at throat (universal sign of distress from choking)
  - ❖ coughing
  - ❖ a partial obstruction can quickly become a complete obstruction
- Complete obstruction-no air movement to and from lungs
  - ❖ unable to speak, cry, breathe or cough effectively
  - ❖ High pitched sound to no sound at all
  - ❖ Dusky appearance

Call Local EMS/911 for:

- All cases of suspected airway obstruction
- Individual is unconscious
- If the shelter resident is an infant, child or elderly
- If ability to cough is not forceful enough to clear the obstruction

Conscious Adult – Cannot Cough, speak or Breathe

- Check Scene. Check Person. First Ask, "Are you choking?"…..if individual says yes, nods, or clutches throat, obtain consent and start the following procedure
- Have someone call 911
- Lean the person forward and give 5 back blows with the heel of your hand. abdominal thrusts to a conscious adult, stand behind victim and wrap arms around his or her waist
- Victim may be seated or standing
- Make a fist with one hand and place the thumb side against the middle of the victim's abdomen just above the navel and well below the lower tip of the breastbone.

- Grab your fist with your other hand and give 5 quick upward abdominal thrusts.
- Continue back blows and abdominal thrusts until- object is forced out, person can breathe or cough forcefully, person becomes unconscious.
- Even if object is removed and individual resumes normal breathing, offer to send him/her to the Emergency Room with arriving EMS or recommend follow up with local physician. If individual declines, document the refusal for follow-up.

Unconscious choking adult – Breaths Do Not Go In

- If victim becomes unconscious, lower victim to the floor
- Open airway by tilting the head back
- Attempt to dislodge and remove the object by sweeping it with your index finger
- Use a hooking action to remove the object, being careful not to push the object deeper into the victim's throat
- Try to open the victim's airway by using the head-tilt/chin lift (as in CPR). Often the throat muscles relax enough after the person becomes unconscious to allow air past the obstruction into the lungs.
- Give 2 rescue breaths-if air does not go in assume the airway is still obstructed
- If the chest does not rise --- Give 30 Chest compressions.
- Tip: Remove breathing barrier when giving chest compressions
- Look for an object – remove if one is seen
- Try 2 rescue breaths. If breaths do not go in, reposition head and repeat
- Repeat sequence until object is expelled, you can breathe air into the victim, or until EMS arrives Give care based on conditions you find.
- Monitor breathing and pulse until EMS arrive
- Even if adult expels object that caused the choking, and seems to be breathing well, adult should be taken by EMS to local Emergency Room, as they may still have unidentified breathing problems

Conscious Choking Child – Age 1 to 12

- Cannot cough, speak or breathe
- Check Scene and then check child
- Have someone call 911.
- Obtain consent form parent or guardian, if present
- Lean the child forward and give 5 back blows with the heel of your hand
- Give 5 quick, upward abdominal thrusts
- Continue back blows and abdominal thrusts until object if forced out, child can breathe or cough forcefully or child becomes unconscious
- Even if the child expels the object and seems to be breathing well, refer for advanced medical follow up at the nearest Emergency Room

Unconscious choking child

- Breaths do not go in
- Retilt child's head
- and try 2rescue breaths
- If chest does not rise- give 30 Chest compressions
- Look for an object and remove if one is seen
- Try 2 rescue breaths

- If breaths go in – check for signs of life, including a pulse
- Give care based on conditions you find.

Conscious Choking Infants – (Under age 1)

- Check scene and then check infant
- Have someone call 911
- Obtain consent to give care from parent or guardian present
- Give 5 chest thrusts
- Continue back blows and chest thrusts until object is forced out and infant can breathe or cough forcefully or infant becomes unconscious
- Even if an infant seems to be breathing well, send to closest emergency room as he/she should be examined by more advanced medical personnel as soon as possible

Unconscious Choking Infant

- Assess ill or injured infant
- Re-tilt infant's head and try 2 rescue breaths
- If chest does not rise give 30 chest compressions
- Look for an object. Remove if one is seen
- Try 2 rescue breaths – If breaths do not go in continue rescue breaths and compressions until signs of life return including a pulse or EMS arrives.
- Give care based on conditions you find and send to closest Emergency Room for assessment.

Additional Considerations

- Breathing may be partially or completely obstructed by an anatomical obstruction or a mechanical obstruction:
- An anatomical obstruction occurs when the airway is blocked by an anatomical
- structure like the tongue or swollen tissues of the mouth and throat. This can also be
- the result of an injury to the neck or a medical emergency such as anaphylactic shock.
- A mechanical obstruction occurs when the airway is blocked by a foreign object,
- such as a piece of food, a small toy, or fluids such as vomit, mucus, or saliva.
- Obstructions can be partial or complete. The airway structures of infants and children are smaller and more easily obstructed than an adult airway. An infant's airway and eating skills may not be fully developed.

Note: If a parent or guardian is present, obtain consent before caring for a conscious choking infant. Tell the infant's parent or guardian your level of training and the care you are going to provide. Consent is implied if the parent or guardian is not available.

Adjustments by Local Physician:

Cold Related Injury–

Frostbite

Treatment Goal:

- Prevent additional injury to the shelter resident.
- Reverse tissue damage.

Possible Causes:

- Exposure to extreme cold, usually affecting the hands, feet, nose and/or ears

History:

- Nature and duration of exposure to cold
- If the shelter resident has sensation in the affected area
- Medical history of peripheral vascular disease, diabetes, smoking or alcohol abuse
- Current medications

Assessment:

- Obtain vital signs and document
- Early stages: skin cold, pale or reddened, with either a "pins and needles"
- burning pain sensation or numbness
- Later stages: skin waxy-looking, red/black/blue discoloration, and swollen usually without pain. Blisters possible.
- Call Local EMS/911 for:
- All suspected cases of frostbite; particularly if there is no sensation or reduced sensation present

Treatment:

- It is important that the tissue not re-freeze once re-warming has begun – this will lead to extreme tissue damage. If re-freezing is a possibility, it is better not to attempt to re-warm prior to transferring the individual to a medical facility.
- Ensure a warm environment and remove any wet or cold clothing from individual
- Do not massage frostbitten extremities
- Re-warm the affected area by placing the extremity in warm water (100-105˚ F) for approximately 30 minutes. Make sure that it is not too hot by testing it yourself. The water may need to be changed frequently.
- If warm water is not available, place warm blankets around extremity – do not place near direct heat as skin may burn
- Encourage individual to move extremities (fingers or toes) but not to walk on affected extremity. Place gauze between fingers and toes.
- Provide the shelter resident with warm, non-caffeinated, non-alcoholic beverages
- If the shelter resident is experiencing pain and requests medication, ibuprofen or acetaminophen is appropriate unless contraindicated
- Do not break blisters

Additional considerations:

- People who take beta-blockers are at increased risk of frostbite due to the decreased blood flow to the skin.
- Shelter residents with a history of atherosclerosis (hardening of the arteries) and Raynaud's

disease are also at increased risk
- Hypothermia and frostbite may occur together

See also: Cold-Related Injury – Hypothermia

Adjustments by Local Physician:

Cold-Related Injury–

Hypothermia

Treatment Goal:

- Return body temperature to normal.
- Prevent injury or death of shelter resident.

Possible Causes:

- Prolonged exposure to icy water or other cold environments which results in a core body temperature less than 95˚ F

History:

- Nature and duration of exposure to cold environment
- Type and extent of injury, if any
- Alcohol use
- Chronic diseases
- Current medications

Assessment:

- Obtain vital signs (especially oral temperature) and document
- Delayed or altered mental state or loss of consciousness is a sign of a serious problem
- The presence of shivering is a good sign – lack of shivering may indicate severe hypothermia (usually associated with mental status changes)
- Pulse rate may be slow and/or irregular
- Check for signs of frostbite. See Cold-Related Injury – Frostbite protocol

Call Local EMS/911 for:

- All cases of near-drowning
- All shelter residents with mental status changes or drowsiness
- Any shelter resident with an oral temperature less than 93˚ F

Refer to Local Healthcare System:

- Any shelter resident with mild hypothermia (93-95˚ F) who is not able to maintain an oral temperature of greater than 95˚ F after attempts are made at re-warming

Treatment:

- Remove individual from cold environment
- If unconscious, handle the individual very gently as sudden movements/jolts can cause cardiac arrest
- Remove wet clothing and cover individual in warm clothes, towels, blankets. Do not apply direct heat to individual or massage limbs
- If conscious, Provide the shelter resident with warm, non-caffeinated, non-alcoholic drinks
- If CPR must be initiated on a individual with hypothermia, continue to perform CPR even if individual appears to be deceased – until the body temperature can be raised above 90˚ F

Additional Considerations

- Diabetics and others with poor circulation, those with congestive heart failure or taking beta-blockers, and alcoholics are more susceptible to hypothermia
- Older adults and young children are especially susceptible to hypothermia
- Most thermometers do not accurately measure temperature below 94˚ F

- Environment does not have to be extremely cold – prolonged exposure to cool or damp environments may also cause hypothermia
- Immersion in cold water rapidly leads to hypothermia

See also: Cold-Related Injury – Frostbite

Adjustments by Local Physician:

Confusion-Altered Mental Status

Treatment Goal:

- Resolve confusion associated with situational disorientation
- Identify and rectify potential safety concerns For the shelter residents with chronic confusion
- Assess for acute and/or serious conditions

Possible Causes:

- Confusion may be a symptom associated with an acute medical problem (e.g. infection, hypoxia, hypotension, low blood sugar, stroke, etc.). Other causes include fever, fluid/electrolyte imbalances, poisoning, the use of certain medications (over-the- counter, prescription and illegal drugs), or chronic disease (e.g. Alzheimer's disease), mental, emotional or behavioral disorders.

History:

- Onset of symptoms – sudden confusion (hours to days) vs. progressive confusion (months to years)
- History of confusion in the past
- Concurrent symptoms indicative of infection – headache, fever, frequency and/or burning of urination, recent respiratory infection, etc
- Recent visual and/or auditory hallucinations
- Recent change in sleep pattern or sleep deprivation.
- Past medical problems
- Current medications taken – both prescription and illegal.

Assessment:

- Obtain vital signs: hypotension, tachypnea or tachycardia are serious findings
- Assess for level of consciousness (awake and talking, awake/not talking, can be aroused by voice, aroused by pain, not aroused)
- Activate Behavioral Healthcare worker to assist with assessment.
- Assess for level of orientation (person, place, time)
- Evidence of Head Injury
- With the assistance of a Behavioral Healthcare worker, interview the individual and determine if they are able to:
    1) Answer questions appropriately.
    2) Follow a conversation.
    3) Understand where they are.
    4) Remember important facts.
    5) Make critical judgments that affect safety.

Call Local EMS/911 for:

- Any case of sudden or rapid-onset confusion
- Any case of unexplained confusion
- Any individual suspected of being a risk to themselves or others

Refer to Local Healthcare System:

- Any case of slow-onset confusion or change in baseline status
- Any case requiring possible adjustment in prescribed medications

Treatment

- Do not administer anything by mouth to confused shelter residents
- Delirium is an acute condition in which there is almost always an underlying physical condition which requires immediate medical diagnosis and treatment
- Those shelter residents experiencing delirium are also at risk of injuring themselves or others, either intentionally or unintentionally. Implement measures to protect the individual and others from injury until EMS arrives.
- Chronic dementia can be managed in the shelter environment as long as the individual is not at risk of harming him or herself or others and has a family member or caregiver with him or her. Encourage the caregiver to re-establish a routine as quickly as possible after the disaster and to re-orient the individual to person, place, time and new environment (if applicable) frequently. Since symptoms of confusion frequently worsen in the evening, closer supervision by the caregiver should be encouraged for the evening hours.

Additional Considerations

- Disorientation is a state of confusion involving time, place or person in an otherwise alert individual. Transient, situational disorientation to time and/or place is often benign.
- If confusion develops or worsens suddenly, this can be an indication of delirium.
- This could be due to a serious medical condition or the affects of drugs, and should be referred to local EMS immediately for diagnosis and treatment.
- Dementia is characterized by a slower, more insidious onset of confusion.
- Abruptly stopping the use of alcohol and many medications, both prescription and illicit, may cause delirium.
- In young people, sudden delirium may be due to a serious infection, like sepsis, meningitis or encephalitis.
- In older adults, sudden confusion may be due to an infection somewhere else in the body – dehydration, urinary tract infection, pneumonia or influenza.

See also: Bleeding, Dizziness, Fainting, Headache, Diabetic Emergencies, Poisoning, Shock, Stroke, Substance Abuse/Withdrawal, Fever

Adjustments by Local Physician:

Congestion–

Lower Respiratory

(Cough, bronchitis, pneumonia, "chest cold" symptoms)

Treatment Goal:

- Alleviate symptoms
- Prevent spread of illness
- Prevent acute respiratory distress

Possible Causes:

- Lower respiratory illness may be caused by bronchitis or pneumonia and is characterized by frequent coughing (productive or non-productive) with or without a fever.
- Pneumonia has many different causes (aspiration into the lungs, decreased breathing volume post-surgery, etc.).

History:

- Any chest or lung pain associated with breathing (pleuritic pain)
- Underlying condition or illness which may predispose a individual to bronchitis and/or pneumonia (emphysema/COPD, heart failure, HIV/AIDS, poor general health, etc.)
- Recent upper respiratory infection or exposure to an individual who had a known or suspected respiratory infection
- Exposure to any known respiratory irritant (chemicals, dust, etc.)
- History of smoking tobacco products
- History of alcoholism
- History of chronic sinus problems or environmental allergies
- Recent extended stay in a hospital or nursing home
- Current medications taken
- History of vaccination – pneumococcal (within five years) or influenza (current year)

Assessment:

- Obtain vital signs
- Tachypnea (respiratory rate greater than 24 per minute) can be a sign of serious lung compromise
- Assess for signs/symptoms of an upper respiratory infection (runny nose, sore throat, fatigue, and perhaps a mild fever) which may lead to a lower respiratory infection
- Assess for presence of phlegm associated with cough which may be clear/white (common in viral infections) or green/yellow (common in bacterial infections) or blood-tinged (common in bacterial infections and pulmonary emboli)
- Listen to breath sounds, rales, wheezes or rhonchi may indicate a significant problem
- Observe for signs of shortness of breath

Call Local EMS/911 for:

- Shelter residents with respiratory distress (shortness of breath, resting respiratory rate greater than 26 per minute)
- Shelter residents with a change in level of consciousness (may indicate hypoxia)
- Shelter residents with acute shortness of breath that may be related to heart disease

Refer to Local Healthcare System:

- Any shelter resident with an acute coughing illness that includes a fever of greater than
- 101˚ F or discolored (green/yellow) or blood-tinged sputum
- Any case of cough (non-chronic), with or without fever, that lasts more than one week, has blood in the sputum, and/or the shelter resident has a history of or possible exposure to tuberculosis
- Any shelter resident that is experiencing trouble breathing due to a cough and/or thick mucus
- Any suspected case of pneumonia or individual with "wet" breath sounds. A
- diagnostic x-ray would be needed to confirm/rule-out pneumonia.

Treatment:

- Comply with **FDA recommendations and disaster health services guidance** that restricts use of cold and cough medications for all children younger than six years old.
- For dry, non-productive coughing, encourage the shelter resident to rest and drink plenty of fluids (non-caffeinated and non-alcoholic). If requested, a cough suppressant would be appropriate, unless contraindicated.
- For productive coughing, cough suppressants should not be encouraged as coughing is an effective means for moving phlegm out of the lungs. Shelter residents should rest and drink plenty of fluids. An expectorant would be helpful to loosen phlegm, unless contraindicated.
- If not contraindicated, an NSAID (Ibuprofen) or acetaminophen would help reduce fever, if present.
- Encourage the individual to breathe the steam from a bath of hot water (with a towel draped over the head). This may help loosen phlegm and dilate narrowed airways.
- Reinforce infection control measures to limit spread of contagious diseases.

Additional Considerations:

- Pleuritic pain, fever and shortness of breath are commonly seen symptoms in cases of pneumonia
- Wheezing may or may not be present in bronchitis or pneumonia
- "Wet" breath sounds are typically present in pneumonia and do not clear with coughing. Wet breath sounds may also be heard in bronchitis but tend to clear or move with coughing.
- Chronic bronchitis and bronchitis that is suspected to be caused by a viral infection (white or clear mucus) do not respond to antibiotic therapy
- Vaccination may prove effective at preventing some pneumonia and should be recommended for all individuals over the age of 65 and high-risk individuals – immune-compromised, diabetics and those with cardiac/pulmonary disease

See also: Breathing Problems, Cough, Fever, Influenza, Sore Throat. Congestion – Upper Respiratory ("cold" symptoms)

Congestion–

Upper Respiratory

("cold" symptoms)

Treatment Goal:

- Alleviate symptoms
- Prevent spread of illness

Possible Causes:

- Symptoms may be caused by viral infection or less frequently, bacterial infection. Allergies ("hay fever") may also cause any or all of the following: headache, sore throat, nasal congestion, cough, sneezing, runny nose, fever

History:

- Specific symptoms the individual is experiencing and when they began
- Any known environmental allergies
- Known exposure to others with similar symptoms
- Recent travel, especially international

Assessment:

- Obtain vital signs. A fever may indicate a bacterial infection.
- Examine back of throat for redness, enlarged tonsils or exudates (pus)
- Palpate (feel) lymph nodes under jaw line and anterior neck for tenderness and/or enlargement
- Observe respiratory effort – count respirations for one minute
- With a stethoscope (listen to) breath sounds for wheezing, rales, rhonchi or diminished sounds
- Note the color and amount of phlegm

Call Local EMS/911 for:

- Individual has chest pain and/or shortness of breath
- Difficulty swallowing, unable to swallow or control saliva, speech is muffled
- Altered mental status

Refer to Local Healthcare System:

- Any individual with a fever greater than 101˚ F or blood-tinged nasal discharge or sputum
- Facial pain, particularly if associated with a fever (may indicate acute sinusitis)
- Any symptom(s) that persist more than 5 days, or that worsen.
- Evidence for Strep Throat or other contagious diseases

Treatment:

- Comply with **FDA recommendations and disaster health services guidance** that restricts use of cold and cough medications for all children younger than six years old.
- Encourage individual to drink plenty of fluids, rest and not come in close contact with others (no sharing of drinks, etc.)
- Encourage individual to cover his or her mouth when coughing and to wash his or her hands frequently throughout the day
- If the individual is requesting medication, over-the-counter medications geared toward treatment of specific symptoms should be used
- Antihistamines are used for congestion caused by hay fever

- Anti-tussives may be effective cough suppressants
- Decongestants work to clear nasal congestion but should be used with caution in shelter residents with a history of high blood pressure
- Expectorants work to loosen phlegm and mucus.
- Analgesics may also be appropriate to help alleviate aches and pains
- Ensure that medications are not contraindicated prior to distributing to individual
- Encourage parents to offer frequent fluids to help alleviate congestion
- Saline nose drops and a bulb syringe can be used in infants with nasal congestion
- Reassure shelter residents and parents that most viral infections will resolve with time
- Reinforce infectious control measures to limit spread of contagious diseases

Additional Considerations:

- A "cold" is not the "flu." Influenza is a rapid-onset acutely febrile illness associated with severe myalgia, but rarely a runny nose.
- Many over-the-counter "cold" treatments have many different medications included and are geared toward treating multiple symptoms. Try to treat only those symptoms presented by the individual by choosing medications with a single active ingredient. Pay special attention to ingredients that may be contraindicated in individuals with high blood pressure.
- Non-seasonal outbreaks of upper-respiratory symptoms may suggest an alternative diagnosis – public health officials should be notified in suspicious cases
- Persons with altered immunity and certain co-morbidities (lung disease, diabetes) are more susceptible to illness and are at higher risk for progression to more serious illnesses like pneumonia and respiratory distress
- Smokers or others with a chronic cough should not be treated with antitussives
- Many over-the-counter medications are not appropriate for pediatric shelter residents younger than 12 years. Medication prepared especially for children ages 6 and over should be used only according to the manufacturer's dosage guidelines.
- Parents should always use a measuring device (dropper, dosing cup or spoon)
- when administering liquid medications
- Parents may not be aware of the recent FDA recommendations regarding cough and cold medicines in children and should be educated accordingly

See also: Breathing Problems, Cough, Fever, Influenza, Sore Throat

Adjustments by Local Physician:

Constipation

Treatment Goal:

- Return bowel habits to normal.
- Reduce discomfort.

Possible Causes:

- Constipation is the infrequent or uncomfortable passing of stool. This condition may be chronic or acute. One cause of constipation is slowing of stool transport through the
- intestines due to inactivity, certain medications or other disorders. Other causes include
- dehydration, low-fiber diet and obstruction.

History:

- Determine the normal bowel habits
- Date of last bowel movement
- Pain either during a bowel movement or between
- Cramping and/or bloating
- Nausea or loss of appetite
- Recent dietary changes
- Current medications taken
- History of chronic bowel problems or surgery

Assessment:

- Obtain vital signs
- Palpate abdomen for distention or tenderness
- Listen to abdomen for bowel sounds

Refer to Local Healthcare System:

- Any case of constipation that causes the individual great concern
- Any marked change from usual bowel habits
- Any case of constipation with abdominal tenderness

Treatment:

- Chronic constipation: Encourage individual to incorporate more fruits, vegetables and bran into his or her diet. Drinking plenty of fluids and increasing activity will help, as well. If a laxative is necessary, recommend the individual take whatever medication has been effective in the past.
- Acute constipation: Encourage the individual to take all of the above actions. When medication is necessary, encourage the individual to take a medication suited to their situation, unless contraindicated. Stool softeners work well to increase the water content in the stool and reduce the effort needed to pass stool; making it a good choice for those individuals who recently underwent surgery or otherwise should not strain. Stimulant laxatives use irritating ingredients to stimulate the walls of the intestine to contract and move stool. Enemas serve to mechanically flush stool out of the colon.

Additional Considerations:

- Older adults are more prone to constipation due physiologic changes that take place in the colon, increased use of medications and inactivity
- Prolonged use of laxatives can cause a change in the lining of the intestines and create a

dependence on the medication
See also: Abdominal Pain, Back Pain, Indigestion

Adjustments by Local Physician:

Cough

Treatment Goal:

- Reduce cough symptoms
- Prevent injury to the shelter resident
- Assess for more serious health condition

Possible Causes:

- Coughing occurs when the airway is irritated and can be caused by allergies or respiratory infection. Common causes of cough are allergies, respiratory infections, asthma and congestive heart failure. Common causes of nocturnal cough (cough at night) are congestive heart failure and gastro-esophageal reflux disease (GERD).

History:

- How long the individual has had the cough
- What time of day the cough occurs
- What factors affect the cough (cold air, eating, lying down, etc?)
- Any associated shortness of breath, chest pain, hoarseness, dizziness, wheezing, chills/fever or night sweats
- Presence of sputum and amount/color of sputum
- History of smoking tobacco products
- History of asthma, emphysema/COPD, bronchitis, GERD, congestive heart failure
- History of immune suppression

Assessment:

- Obtain vital signs (especially temperature and respiratory rate)
- Observe for shortness of breath
- Listen to breath sounds – may be decreased over a certain area or there may be congestion that does or does not clear with coughing
- Observe the individual for effectiveness of cough (is the individual able to clear phlegm?)

Call Local EMS/911 for:

- Any shelter resident who is short of breath or unable to catch their breath due to coughing.

Refer to Local Healthcare System:

- Any individual who is experiencing a cough with fever or has blood in their sputum.

Treatment:

- Comply with **FDA recommendations and disaster health services guidance** that restricts use of cold and cough medications for all children younger than six years old.
- Individuals with a new cough should be encouraged to cover their nose and mouth when they cough, wash their hands frequently, and avoid direct contact with other shelter residents as their cough could be caused by an infectious agent
- Individuals experiencing a new cough or a cough with fever should be encouraged to rest, drink plenty of fluids and take analgesics and/or antipyretics and cough medications as needed.
- Antitussive therapy: May be effective at suppressing a cough, unless contraindicated. Coughs that are productive (able to move phlegm) should not be suppressed but the

underlying cause of the cough should be identified and treated appropriately (i.e., coughing caused by respiratory infection should be treated with antibiotics). These products usually come in the form of a liquid or cough drop.

- Expectorant/Mucolytic therapy: For dry or unproductive coughs, expectorants and mucolytics are effective at loosening and thinning phlegm, unless contraindicated. They do not suppress a cough.
- Non-pharmaceutical therapies include warm, moist vapor (such as a humidifier)
- to reduce airway irritation
- Health teach regarding all OTC drug therapies and advise individual to make good choices to manage symptoms

Additional Considerations:

- Brown, yellow or greenish sputum may, but not always, indicate a bacterial infection
- Blood in the sputum (hemoptysis) may be caused by pneumonia, pulmonary emboli or tuberculosis
- Antihistamines and decongestants are not effective at treating a cough unless the cough is caused by allergic irritants
- Croup is a hacking, bark-like cough sometimes experienced by children – mostly at night and is characterized by a croaking sound upon inhalation and difficulty breathing. Treatment includes a mist vaporizer or sitting with the child in a closed, steam-filled bathroom while working to calm and reassure the child. Call
- 911 if symptoms become worse or do not respond to treatment within 20 to 30 minutes.
- A cough in a child younger than three years may be caused by an aspirated foreign body
- Whooping cough (Pertussis) is a highly contagious disease that, because of immunization, is uncommon in the United States. Pertussis is characterized by fits of coughing that end in a high-pitched, deeply in-drawn breath and affects mostly children younger than five years. If whooping cough is suspected, refer individual to the local healthcare system for diagnosis and treatment.

See also: Breathing problems Asthma/COPD, Congestion, Fever, Influenza, Measles, Tuberculosis.

Adjustments by Local Physician:

Cramps–

Abdominal

Treatment Goal:

- Reduce discomfort
- Assess for more serious health condition

Possible Causes:

- Gastrointestinal: non-specific upset (gas, bloating), food allergies/lactose intolerance, food poisoning, infections (viral or bacterial gastroenteritis)
- Gynecologic/ obstetric: menstrual cramping, uterine contractions (pregnancy)

History:

- Quality of pain (cramps vs. dull ache)
- Location – menstrual cramping is frequently present in the pelvis/lower abdomen, back and legs, while intestinal cramping may be diffuse over the abdomen and may radiate to the back
- Presence of typical symptoms of the individual's pre-menstrual syndrome
- Present, anticipated or missed menstrual cycle
- Known or suspected pregnancy
- Presence of nausea, with or without vomiting, and diarrhea associated with gastrointestinal illness
- Ingestion of unfamiliar food or food not eaten regularly

Assessment:

- Obtain vital signs
- Pain Scale index 0-10
- Assess for tenderness, distention or guarding: these could be signs of a more serious condition. See Abdominal Pain protocol

Call Local EMS/911 for:

- Any possibility of miscarriage or premature labor

Refer to Local Healthcare System:

- Any case of abdominal pain/cramps associated with tenderness to palpation
- All suspected cases of food poisoning or gastrointestinal infections
- Any severe abdominal discomfort of unknown origin
- Diarrhea that continues for more than three days should be reported to a physician

Treatment:

- For suspected GI upset or food poisoning: Encourage the individual to rest in a comfortable position. If individual has been vomiting, wait until vomiting stops and encourage individual to frequently drink small amounts of mild fluids (water, tea, electrolyte fluids such as Gatorade). Do not give food, especially fatty or fried foods.
- For pre-menstrual/menstrual cramping: Non-steroidal anti-inflammatory medications work well to alleviate discomfort, unless contraindicated. Warm compresses may also help. Encouraging the individual to sleep and exercise regularly will also help relieve some of their discomfort.

Additional considerations:

- Menstrual cramps usually begin approximately 24 hours before menstruation and can last up to two days after onset of menstruation.
- Traveler's diarrhea, frequently experienced when traveling outside of the country or to lesser developed countries, can be effectively treated with plenty of water and anti-diarrhea medications.

See also: Abdominal Pain, Constipation, Diarrhea, Indigestion, Nausea/Vomiting, Vaginal Discharge/Itching, Childbirth, Miscarriage.

Adjustments by Local Physician:

Cramps–

Muscular

Treatment Goal:

- Eliminate cramping/pain
- Reduce discomfort

Possible Causes:

- Cramps can occur due to fatigue, over-exercising, tension and infection. Exercise- induced electrolyte imbalance and poor circulation to the leg may also be the cause of muscle cramping. Muscle cramps usually affect the calf muscles and feet.

History:

- Location and severity of the cramp
- The presence of a recent injury
- Recent strenuous or prolonged physical activity
- Amount of water consumption over the past 24 hours – especially in warm climates

Assessment:

- Obtain vital signs
- Assess affected area for injury bruising, lumps, swelling or point tenderness

Refer to Local Healthcare System:

- Any cramp not relieved with rest, massage, analgesics and warm compress

Treatment

- Encourage the individual to gently massage and stretch the cramped muscle
- Encourage the individual to take a hot bath or place a warm compress on the affected area
- For cramps in the feet and/or toes, gently pull the toes up toward the body on the front of the foot to stretch the muscles
- An over-the-counter analgesic may be helpful at reducing pain, if requested by individual and not contraindicated
- For prevention, drink plenty of water and stretch properly before exercise

See also: Arm/Hand Injury and Pain, Back Pain, Dehydration, Heat-Related Illness, Leg/Foot Injury and Pain, Neck Pain/Stiffness.

Adjustments by Local Physician:

Cuts and Scrapes/Lacerations and Abrasions

Treatment Goal:

- Stop any bleeding
- No delay referral if wound(s) need closure
- Prevent further injury or infection

Possible Causes:

- Open wound in which the skin has been broken due to a cut by a sharp object or scrape

History:

- Activity engaged in when the cut or scrape occurred
- Pain score (0-10 scale)
- Type of object that caused the cut and/or scrape
- Date of last tetanus shot
- Current medications, especially anticoagulants or steroids

Assessment:

- Obtain vital signs.
- Assess for bleeding.
- Determine depth of cut and if any tendons and/or ligaments are exposed.
- Check for function distal to the cut/scrape (have the individual move their fingers, toes, etc.).
- Look for objects or dirt embedded in the cut or under the skin, but do not probe

Call Local EMS/911 for:

- Severe bleeding or bleeding that does not stop with direct pressure and/or elevation of limb after 10 minutes.

Refer to Local Healthcare System:

- Any wound that is longer than 1/3 inches, is on the face, is deep or has edges that do not meet up
- Any cut caused by an obviously dirty object
- Any potential nerve or tendon involvement
- All puncture wounds
- Any signs of infection (redness, swelling, skin warm to touch)
- Any shelter resident wishing to receive a tetanus booster

Treatment: Cuts:

- Use standard precautions before handling wound
- If bleeding, apply direct pressure over the wound with sterile dressing for 5-10 minutes or until bleeding stops
- Once bleeding has stopped, wash wound with soap and flush copiously with water. Be sure to clean out any obvious objects or dirt in wound
- Pat dry and apply a dry, sterile dressing. The use of a triple antibiotic ointment to superficial cuts and abrasions may reduce the risk of infection

Treatment: Scrapes:

- Wash your hands with soap and water and apply gloves before handling wound
- Wash wound with soap and water. Minor scrapes should be left open to air.
- Large wounds should be covered with an antibiotic ointment and sterile dressing.

Additional Considerations:

- Wounds to the scalp may be very bloody even if the wound is minor
- Puncture wounds typically bleed very little, if at all, but are at increased risk for tetanus

See also: Bleeding, Bruising, Arm/Hand Injury and Pain, Leg/Foot Injury and Pain, Rape/Sexual Assault, Violence/Domestic Abuse, Shock.

Adjustments by Local Physician:

Dehydration

Treatment Goal:

- Return fluid balance to normal
- Prevent injury to individual
- Treat underlying cause of dehydration
- Assess for more serious health condition

Possible Causes:

- Dehydration occurs when the body loses more water than it takes in. Losses could be due to diarrhea, vomiting and heat stress/excessive sweating.
- Inadequate intake may be due to nausea/vomiting and lack of potable water or other fluids.
- In addition, certain diseases (Addison's disease, uncontrolled diabetes mellitus, diabetes insipidus) and certain drugs (diuretics, lithium, excessive alcohol) cause an increase in urination which may cause dehydration.

History:

- Mental confusion or lethargy (a sign of severe dehydration)
- Recent increase in thirst or constant "dry mouth" sensation
- Decreased sweat
- Diminished or absent urination
- Color of urine (light/clear vs. dark yellow/amber)
- Less than six wet diapers per day for infants
- Recent episode of diarrhea/vomiting
- Current medications
- Weakness, dizziness, lightheadedness, fatigue

Assessment:

- Obtain vital signs – check specifically for orthostatic hypotension
- (lightheadedness or low blood pressure when individual stands up)
- Look at skin and mucous membranes for dryness – lips may be cracked and/or dry. Individual may report "dry mouth"
- Reduced skin elasticity/turgor ('tenting' – loss of ability to "bounce back" when pinched)
- Lack of perspiration if febrile or overheated
- Sunken eyes or, for infants, sunken fontanels (soft spots on head)

Call Local EMS/911 for:

- Signs of moderate dehydration in infants, children or the elderly who can become severely dehydrated more quickly. Sunken eyes, no tears, sunken soft spot on infants head
- All suspected cases of severe dehydration (confusion, lightheadedness, low blood pressure, tachycardia/fast pulse)

Refer to Local Healthcare System:

- Any individual whose symptoms of mild dehydration do not improve with fluid therapy
- Any individual that is not able to take liquids him or herself to rehydrate
- No urination in eight hours (for adults) or fewer than six wet diapers per day (for infants)
- Any individual taking a medication or with a pre-existing disease for which excess fluid loss/dehydration may occur

Treatment:

- Encourage all shelter residents to drink six glasses of water or fluid daily – increasing their intake during hot days or after physical exertion. Avoid caffeine and alcohol.
- Mild dehydration can be treated by drinking plenty of water and replacing lost electrolytes with a sports drink. Children should receive oral rehydration solutions such as Pedialyte. Drink small amounts frequently, rather than a large glassful. Once the individual is re-hydrated, follow-up with him or her to make sure he or she continues to drink plenty of fluids.
- When necessary, oral rehydration solution can be made by mixing ½ teaspoon salt, ½ teaspoon baking soda and three tablespoons sugar in a quart of pure water.
- All fluids should be given slowly and at frequent intervals. A general rule of thumb is to continue giving fluids until urine output increases and the urine color is light yellow.
- Identifying and treating the cause of dehydration will help prevent recurrent episodes (diarrhea, etc.). See Diarrhea protocol.
- Severe dehydration, characterized by low blood pressure, orthostatic hypotension, mental confusion (irritability in infants) and/or reduced consciousness, along with the classic signs of dehydration, should be referred to local EMS immediately.

Additional Considerations:

- Older adults and young children are at increased risk for dehydration
- Globally, dehydration is second to diarrhea as the leading cause of death in children
- Avoid using beverages other than water. Sports drinks and rehydration solutions to treat dehydration can make the condition worse, Coffee and soda are also contra-indicated. Too much fruit juice, especially in children, can also make diarrhea worse.
- Shelter residents with diabetes mellitus, who are not at risk for hypoglycemia, should always be given sugar-free fluids

See also: Bleeding, Cramps – Muscular, Diarrhea, Fever, Heat-Related Illness, Shock

Adjustments by Local Physician:

Diarrhea

Treatment Goal:

- Relieve symptoms
- Prevent spreading of bacterial and viral infection to others

Possible Causes:

- The causes of diarrhea may not always be easy to pinpoint. Some possible causes may be a viral infection. Medications, antibiotics or inflammation of the intestinal lining from illness or food intolerance can cause diarrhea.
- Maybe caused by food or water borne pathogens. In some people, emotional stress and anxiety may cause diarrhea.

History:

- Increase in the volume, frequency and wateriness of stool
- Presence of abdominal pain
- Color of stool (red, maroon or black, tarry stools may an indicator of blood)
- Presence of gas, cramping, urgency, nausea/vomiting
- Onset of symptoms (sudden/acute vs. persistent/chronic)
- Recent changes in diet
- Current medications, especially antibiotics
- Exposure to others with similar symptoms
- Signs/symptoms of dehydration. See Dehydration protocol.

Assessment:

- Obtain vital signs, especially temperature
- Assess for dehydration (see Dehydration protocol)
- Palpate abdomen for tenderness, guarding and distention

Refer to Local Healthcare System:

- Diarrhea associated with fever greater than 101˚ F, passing of painful stool, abdominal pain or blood in stool (red, maroon, black or tarry color)
- Diarrhea that persists for more than 72 hours
- Inability to take oral fluids
- Any child with currant-colored, jelly-like stools (a sign of intussusception or telescoping of the intestine)

Treatment: Dependant on cause

- In cases of non-bloody stool; encourage small frequent sips of water, but no food for several hours. Then advance to eating mild foods, such as rice, dry toast, crackers, bananas and applesauce.
- Have individual avoid spicy foods, fruits, alcohol and caffeine drinks until 48 hours after diarrhea has stopped
- Avoid use of over the counter anti-diarrhea medications for first 6 hours, and then use only if there are no other signs of illness, such as fever, cramping. Symptoms will usually resolve within 24-48 hours. Advise individual to stop taking them as soon as stools thicken.
- Ensure to disinfect surfaces that shelter residents come in contact with-especially dining tables and chairs
- Infectious diarrhea is easily spread to others particularly in crowded conditions. Encourage

the individual to wash their hands frequently (and after every trip to the restroom) and avoid close contact with others. Infectious control measures should be immediately instituted in shelter environments.

- Antibiotic-caused diarrhea: The use of antibiotics may cause diarrhea by killing the good bacteria in the intestines. If symptoms are severe, another antibiotic may need to be prescribed.-refer to local healthcare system, or prescribing physician.
- Inflammation: Encourage the individual to remove the irritant from their diet (coffee, fatty/spicy foods, etc.) and the symptoms should resolve.
- Encourage the individual to increase the amount of fluid (non-alcoholic/non- caffeinated) they take in to help prevent dehydration.

Additional Considerations:

- Infectious diarrhea is easily spread to others, particularly in crowded conditions.
- Educate shelter residents about the need for proper sanitation. If there are multiple cases
- of diarrhea in a single facility or from a common food or water source, consult the local health department to investigate.

See also: Abdominal Pain, Cramps – Abdominal, Dehydration, Indigestion, Influenza, Nausea/Vomiting.

Adjustments by Local Physician:

Dizziness- Vertigo

Treatment Goal:

- Assess for more serious health condition
- Relieve uncomfortable symptoms
- Prevent injury to the shelter resident

Possible Causes:

- A false sense of self or surroundings
- Feeling of moving or spinning frequently accompanied by nausea and loss of balance
- Possible causes include inner ear problems, brain disorders, motion sickness, transient ischemic attack, increased intracranial pressure and certain medications

History:

- Onset of symptoms
- Presence of any additional symptoms; nausea/vomiting, headache, vision changes
- Blurry vision and/or headache, slurred speech, weakness in arms or legs, uncoordinated movement (may indicate brain involvement)
- Recent upper respiratory infection
- If sensation is present at rest or with abrupt change of position
- Sense of fullness in one and/or both ears or change in hearing
- Ringing in the ear (tinnitus)
- History of brain and/or inner ear disorder
- Current medications

Assessment:

- Obtain vital signs
- Assess for mental status changes/confusion
- Observe individual's gait and motor control
- Assess for unintentional eye movement (nystagmus, or jerkily moving eyes)
- Listen for slurred speech when individual speaks
- Check for coordinated movement and muscle strength in extremities

Call Local EMS/911 for:

- Any case of vertigo accompanied by slurred speech, severe headache, muscle weakness, or uncoordinated movement

Refer to Local Healthcare System:

- Any case of vertigo that does not resolve itself within two days or prevents individual from being able to sit/walk
- Any case of sudden or rapid onset vertigo.

Treatment:

- Have the individual lay quietly in a position of comfort. Closing eyes may help.
- Encourage the individual to rest and keep their head still or change positions slowly –
- rapid movement or turning the head may exacerbate the condition
- Most vertigo resolves on its own within a day or two
- Vertigo caused by a viral infection of the ear may not subside until the underlying infection is treated

Additional Considerations:

- The majority of cases of vertigo are caused by inner ear disorders but more serious conditions should not be overlooked

See also: Bleeding, Breathing Problems Hyperventilation, Ear Problems, Fainting, Headache, Heat-Related Illness, Neck Pain/Stiffness, Stroke, Substance Abuse/Withdrawal.

Adjustments by Local Physician:

Ear Problems–

Ear ache

Treatment Goal:

- Relieve discomfort

Possible Causes:

- Pain or pressure in or around ear caused by infection, earwax, jaw problems or foreign object lodged in ear

History:

- Onset of symptoms
- Quality of pain – sharp stabbing, dull ache, etc.
- Changes in hearing
- Recent upper respiratory infection
- Recent tooth infection or other jaw injury

Assessment:

- Obtain vital signs (temperature may be slightly elevated with infection)
- Look at affected ear for drainage or obvious signs of a foreign object

Refer to Local Healthcare System:

- Any case where a foreign object lodged in the ear is suspected
- Any case of earache that does not respond to treatment within three days
- Any individual who has drainage coming from the affected ear
- Ear pain associated with fevers, especially in children

Treatment:

- If requested by individual, treat pain with analgesics as recommended by manufacturer's label, unless contraindicated
- Over-the-counter treatment is usually effective and includes antihistamines, nasal spray and analgesia
- If a foreign object is clearly visible in the ear, you may try to gently remove it with tweezers and then refer individual to seek medical attention for follow-up

Additional Considerations:

- Young children frequently suffer from ear problems and will present with crying, irritability and pulling on/rubbing the affected ear
- Aspirin should never be given to children under the age of 18
- Do not place anything inside the ear – cotton swabs, hairpins, etc.

See also: Congestion, Fever, Headache, Neck Pain/Stiffness, Paralysis/Weakness – Facial or Limb, Sore Throat, Toothache, Infection, Measles, Mumps.

Adjustments by Local Physician:

Ear Problems–

Hearing changes

Treatment Goal:

- Assess for more serious health condition

Possible Causes:

- A decreased ability to hear can be progressive (often seen in older adults) or acute – due to a perforated eardrum or ear infection. Tinnitus (ringing in the ears) can be caused by certain disorders/infections in the ear and by taking certain medications.

History:

- Onset of symptoms (rapidly vs. over a period of time)
- Type of hearing change: hearing loss, ringing in ears, etc.
- Symptoms associated with infection or perforation: pain in ear, discharge, etc.
- Current medications, including recent antibiotics, aspirin or chemotherapy

Assessment:

- Obtain vital signs
- Assess for signs of drainage from ear or foreign object in ear

Refer to Local Healthcare System:

- All cases of sudden or rapid onset of hearing changes
- All cases of hearing changes that do not resolve on their own within two days or with treatment of underlying cause (for example, ear infection)
- Any suspected case of foreign object in ear.
- Tinnitus that affects only one ear or pulsates

Treatment:

- Dependant on underlying cause of hearing change
- High doses of aspirin can lead to tinnitus/ringing ears. If hearing loss is thought to be related to aspirin therapy, encourage individual to discontinue medication and follow-up with his or her primary care physician.

Additional Considerations:

- Shelter residents transported on military aircraft, (in repatriation events) and who did not properly use hearing protection may have temporary hearing loss
- Hearing loss is common after a blast incident

See also: Congestion, Earache, Neck Pain/Stiffness, Paralysis/Weakness – Facial or Limb.

Adjustments by Local Physician:

Edema (swelling)

Treatment Goal:

- Reduce swelling
- Prevent injury to individual

Possible Causes:

- Dependent edema is usually found in the lower extremities or other dependent position
- (back and/or buttocks of a bed-ridden individual) and could be caused by heart failure, renal failure, liver disease, deep vein thrombosis (unilateral leg swelling) or musculoskeletal
- injury (see Leg/Foot Injury protocol).
- It is normal for pregnant women to have some dependent edema during last months of pregnancy.
- Non-dependent edema may be seen in kidney disease, liver disease or left-sided heart failure. Depending on cause, lymphedema (swelling caused by lymphatic fluid) is often unilateral.

History:

- Past medical history
- Onset of symptoms (chronic vs. acute)
- History of cardiac, pulmonary, renal or liver problems
- Obesity
- Pregnancy (note which trimester)
- Previous history of blood clots in legs or lungs
- Current medications, specifically diuretics ("water pills"), cardiac medications and anticoagulants
- Sedentary lifestyle or recent physical inactivity (including prolonged travel)
- Recent injury or surgery
- Presence of associated pain/bruising in swollen extremity

Assessment:

- Obtain vital signs
- Listen to heart rhythm and breath sounds. The presence of rales ("wet" breath sounds) indicates heart failure.
- Document whether edema is pitting or non-pitting. If pitting, document number of seconds before indentation resolves.
- Check for abdominal distention
- Document whether edema is unilateral or bilateral. Measure and record circumference of both legs in cases of unilateral leg swelling.
- Check for discoloration of skin, e.g., redness or bruising

Call EMS:

- Any pregnant individual who has significant edema of face and hands, legs
- Any new case of edema that does not resolve with rest and leg elevation or is associated with shortness of breath, abnormal breath sounds and/or tachycardia
- Any chronic case of edema when the individual has not been taking their medication or has shortness of breath or abnormal breath sounds

- Any individual suspected of having or at risk of deep vein thrombosis (unilateral leg swelling)

Treatment:

- Stable edema/chronic heart failure: Individual will most likely be prescribed medications already and should be encouraged to take these medications as prescribed. Also encourage the individual to eliminate smoking and alcohol from his or her lifestyle and reduce sodium in his or her diet. For short-term treatment of symptoms, individual can rest with legs elevated.
- If feasible and a weight scale is available, monitor daily weights in persons with dependent edema who have heart, kidney or liver disease. Shelter residents with progressive or abrupt weight gain should be referred for evaluation.
- Lymphedema: Compression bandages and pneumatic stockings can be used to help the swelling associated with excessive lymphatic fluid in either the arm or leg.
- Injury: see Leg/Foot Injury and Pain protocol.

Additional Considerations:

- The main symptoms of right-sided heart failure is swelling in the legs and feet, while left-sided heart failure is characterized by pulmonary congestion and abdominal swelling (ascites)
- Many people will experience leg swelling unrelated to any medical condition
- (after standing for long periods of time)

See also: Abdominal Pain, Leg/Foot Injury and Pain, Immune-Compromised Shelter residents, Pregnancy.

Adjustments by Local Physician:

Eye Problems–

Pain/Inflammation

Treatment Goal:

- Assess for more serious health condition
- Reduce inflammation
- Relieve discomfort

Possible Causes:

- Redness, irritation and pain in the eye due to infection, environmental allergies, a
- foreign body or a sty. Infections could be caused by numerous types of bacteria, fungus, virus or parasite.

History:

- Any change in vision in one or both eyes
- Onset of symptoms (rapid vs. gradual)
- Sensitivity to light (photophobia)
- Pain score (0-10 scale)
- Watering of eyes
- Environmental allergies
- Sensation of grittiness or "sand" in the eye
- Recent eye procedure or surgery
- Eye crusted close, especially upon awakening in the morning

Assessment:

- Obtain vital signs
- Assess visual acuity in each eye (covering one at a time). Document whether the individual is blind (can see black only), can see light only (not shapes), can count fingers only or can read words. The two eyes should be equal.
- Assess for the presence of a sty (localized swelling of one or more of the glands surrounding the eyelid)
- Presence and character of discharge (e.g. watery, mucous, purulent)
- Blisters on the cornea
- Concurrent painful skin lesions over the body which may indicate herpes zoster (shingles)

Call Local EMS/911 for:

- Any abrupt or rapid change in vision

Refer to Local Healthcare System:

- Any sore or blister on the eyeball/eyelid or pus
- Any change in vision/visual acuity
- Any sty which does not resolve within three days
- Any potential or suspected case of infection (e.g. conjunctivitis)
- Any foreign body sensation that does not resolve with flushing the eye

Treatment: - **Always use standard precautions**

- Sty: Apply warm compress to the affected area for 10 minutes several times per day
- Allergies: Encourage individual to avoid the agent that causes them sensitivity Antihistamines may be effective at reducing eye irritation and other allergic symptoms, unless contraindicated. Artificial tears (without preservatives) may be used to flush irritants

and/or keep eyes moist.

- Infection: Any suspected case of infection should be referred to the local healthcare system and the individual encouraged to wash their hands frequently, not touch their face, and avoid contact with others as eye infections are highly contagious. If contact lenses are worn, the individual should remove them and not use a new pair of contacts until the infection is completely resolved.
- Crusting/discharge: Wash eyelids/lashes gently with a warm, wet washcloth
- Suspected foreign body/dust: Attempt to wash any foreign object out of the affected eye by tilting the individual's head to the side and flushing with clear water or saline solution for up to fifteen minutes. The eyelid should be held open but the eye itself should not be touched. If the object is not able to be washed out, cover the eye with a light bandage and seek medical attention. No attempt should be made to remove any object that does not flush out of the eye or is embedded in the eye.
- Shelter residents should be instructed not to wear contact lenses until all symptoms have resolved

Additional Considerations

- Infants are particularly prone to eye infections
- Viral eye infections spread rapidly from one eye to the next and usually have watery eye discharge which may be copious. This can lead to an outbreak in crowded conditions.
- Hand washing by both the affected individual and staff is critical if an infection is suspected
- Bacterial eye infections usually have a mucous/purulent discharge

See also: Burns – Chemical, Headache, Infection.

Adjustments by Local Physician:

Eye Problems–

Injury

Treatment Goal:

- Prevent further injury to eye
- Reduce discomfort

Possible Causes:

- Foreign object in eye, scratch to the cornea, burn or blunt injury to the eye.

History:

- Trauma to face or eye, including blow to head
- Change in vision
- Exposure to chemicals or extreme heat
- Increased sensitivity to light (photophobia)
- Current medications taken
- Wearing of contact lenses

Assessment:

- Obtain vital signs
- Assess visual acuity in each eye (covering one at a time). Document whether the individual is blind (can see black only), can see light only (not shapes), can count fingers only or can read words. The two eyes should be equal.
- Pain score (0-10 scale)
- Bruising or bleeding under the surface of the skin
- Ability of individual to open eye
- Pupillary reaction (eyes equal and reactive to light)
- Ability of individual to move eye in four directions (up, down, left, right) with or without pain
- Redness/swelling of affected eye
- Bleeding to eye/face region

Call Local EMS/911 for:

- Any injury associated with vision loss or change
- Any bleeding noted in the eyeball or under the conjunctiva
- Presence of blood between iris and cornea (interior chamber)
- Any difference in size of pupils
- Any individual with a puncture wound by a foreign object
- Any possible burn to the eyes
- Any acute onset of severe eye pain with or without known injury

Refer to Local Healthcare System:

- All blunt injuries to the head or face
- Bruising around the eye (black eye) to follow-up for potentially broken facial bones
- Any individual with a foreign object that is not able to be successfully washed out.

Treatment: standard precautions

- If a penetrating injury to the globe (eyeball) is suspected, do not put ANY pressure on the eye with a dressing or by touching. Call EMS.
- Attempt to wash any foreign object out of the affected eye by tilting the individual's head

to the side and flushing with clear water or saline solution for up to fifteen minutes, from inner corner to outer corner (nose to ear direction). The eyelid should be held open but the eye itself should not be touched. If the object is not able to be washed out, cover the eye with a light bandage and seek medical attention. No attempts should be made to remove any object that does not flush out of the eye or is embedded in the eye.

- Cool packs (chemical or ice/water mixed) should be applied to the eye area intermittently for the first 24-48 hours to decrease swelling and pain
- Avoid aspirin therapy or other non-steroidal anti-inflammatory medication which may cause bleeding in the eye

Additional Considerations:

- Corneal abrasions (scratches) are often associated with the sensation of having a foreign body in the eye

See also: Bleeding, Bruising, Cuts and Scrapes, Violence/Domestic Abuse.

Adjustments by Local Physician:

Eye Problems–

Vision Changes

Treatment Goal:

- Assess for more serious health condition

Possible Causes:

- Vision changes that occur over time may be due to macular degeneration, cataracts, retinopathy, or open-angle glaucoma.
- Acute vision changes/distortions could be due to injury (to the head or eye), blood clot to the optic nerve, detached retina or closed-angle glaucoma.

History:

- Onset of symptoms (gradual or rapid)
- Type of vision change (loss of vision, diminished acuity, halos, floaters, decreased peripheral vision, etc.)
- Injury or blunt trauma to head/face
- History of eye surgery, vision problems, or disease involving cranial nerves (e.g.
- Bells' Palsy)
- Presence of other symptoms (eye pain, redness, photophobia, headache, nausea)
- Current medications taken
- Use of and reason for glasses/contact lenses

Assessment:

- Obtain vital signs
- Visually inspect eyes for obvious signs of injury
- Pupil size, shape, reaction to light and uniformity
- Assess visual acuity in each eye (covering one at a time). Document whether the individual is blind (can see black only), can see light only (not shapes), can count fingers only or can read words. The two eyes should be equal.
- Hazy appearance or clouding of the cornea
- Symmetry of eye movements
- Drooping (ptosis) of eyelid

Call Local EMS/911 for:

- Any injury to the head and/or face that results in changes to vision
- Any acute or rapid-onset distortion/loss of vision

Refer to Local Healthcare System:

- Any individual experiencing double vision
- Any individual with changes to the structure of the eye (pupil shape differs from the other pupil, etc.)

Treatment:

- For injury or blunt trauma: Using standard precautions encourage individual to keep eyes closed and apply a cold compress to affected area. Call local EMS.

Additional Considerations:

- Damage to the optic nerve may cause loss of vision. Damage to the cranial nerves that control papillary changes and eye movement may lead to changes in vision.

See also: Headache, Neck Pain/Stiffness, Paralysis/Weakness – Facial or Limb, Stroke.

Adjustments by Local Physician:

Fainting (syncope)

Treatment Goal:

- Prevent injury to individual.
- Regain consciousness
- Assess for more serious health condition

Possible Causes:

- Syncope: A brief loss of consciousness due to a reduction in the amount of oxygen reaching the brain. Possible causes include abnormal heart rhythm, not witnessed seizure, pulmonary embolism, emotional/physical stress, hyperventilation/shortness of breath, exposure to hot temperatures, hypoglycemia, orthostatic hypotension and certain medications (anti-hypertensives and sedatives).

History:

- Conditions surrounding the fainting episode (fear, stress, pain)
- History of an abnormal heart rhythm or palpitations
- Chest pain, shortness of breath or problems breathing
- Previous history of fainting or light-headedness
- Recent exposure to hot climate

Assessment:

- Obtain vital signs, especially blood pressure and respiratory rate as both may be low. Heart rate may be faster than normal, slower than normal or irregular. Consider checking orthostatic blood pressure.
- Assess for mental status changes, level of consciousness or confusion
- Listen to heart rate and rhythm for possible arrhythmias
- Quality of skin (pale, damp, cool)

Call Local EMS/911 for:

- Any individual that stops breathing while unconscious
- Any individual with unstable vital signs after fainting
- Any individual with confusion or altered mental status after fainting
- Any child or elderly individual who faints
- Any individual who does not fully recover from fainting after five minutes
- Recurrent episodes of fainting

Refer to Local Healthcare System:

- All cases of fainting

Treatment:

- In all unconscious shelter residents, first assess the "ABCs" (airway, breathing and circulation) by checking their breathing and looking for a pulse. If any of the ABCs are absent, start CPR and call EMS immediately.
- Individual has fainted: Keep the individual lying down and assist with cooling if fainting due to hot weather. Elevate legs and loosen tight clothing around the neck. If individual vomits, help them turn to his or her side. Check for injuries that may have occurred due to falling. Remain with individual until fully recovered.
- If symptoms are due to breathing problems, refer to Shortness of Breath and/or
- Hyperventilation protocols for further guidance.

- Individual feels faint: Encourage individual to lie down with legs elevated 8 to 12 inches.
- If the condition may be due to hot weather, assist the individual with cooling off – fan, cool cloth to face, etc. Encourage individual to drink plenty of fluids to prevent dehydration.
- If symptoms are due to emotional/physical stress, calm and reassure the individual and remove the source of stress. Ask if individual would like to speak with a Behavioral Healthcare worker.

Additional Considerations:

- Syncope may be associated with serious medical conditions (cardiovascular disease, cerebrovascular disease, neurologic disorders) and many medications
- People taking diuretics are at increased risk of fainting
- Abrupt exposure to hot temperatures frequently leads to increased risk of fainting until the body adapts to the increased temperature

See also: Bleeding, Breathing Problems, Seizures/Convulsions, Dehydration, Dizziness, Ear Problems, Heat-related Illness, Influenza, Diabetic Emergencies, Pregnancy, Shock, Stroke.

Adjustments by Local Physician:

Fever

Treatment Goal:

- Assess for more serious health condition
- Prevent the transmission of infectious diseases
- Return temperature to within normal limits

Possible Causes:

- Elevated body temperature, usually due to illness or infection but may occur with immunizations or environmental exposures

History:

- Onset of symptoms
- Recent illness, injury or surgery
- Other concerning symptoms of an infection (headache, photophobia, confusion, low blood pressure, shortness of breath, productive cough, flank pain, dysuria, high fever, myalgias, etc.)
- Recent exposure (within two weeks) to others with illness
- Location and/or quality of any pain with pain score (0-10 scale)
- Presence of chills, sweating or flushing
- Recent travel, especially overseas
- Medications taken, especially antipyretics (name, dose and time of last dose)

Assessment:

- Obtain vital signs
- A fever is defined as a temperature greater than 99.0˚ F
- Assess the level of consciousness or for signs of confusion
- If fever is thought to be due to injury, assess affected area for signs of infection
- (reddened skin that is warm to touch, pus, pain, etc.)
- Listen to breath sounds for signs
- Check eyes with flashlight for signs of photophobia (sensitivity to light)

Call Local EMS/911 for:

- Any fever associated with severe headache, stiff neck, swelling in the throat, rash, shortness of breath or mental confusion
- Any infant younger than six months with a temperature greater than 101˚ F or any adult/child older than six months with a temperature greater than 105˚ F

Refer to Local Healthcare System:

- Any infant younger than six months with a temperature greater than 100.5˚ F or any adult/child older than six months with a temperature greater than 103˚ F
- All suspected cases of influenza in a shelter should be referred to the isolation care area for assessment
- Any individual with a fever and signs of a specific infection
- Any temperature greater than 101˚ F that persists for more than three days
- Any fever without obvious reason or fever that is accompanied by a rash
- Any fever that occurs within two weeks after surgery

Treatment:

- If fever is thought to be related to an infection, the source of the infection should be

identified and treated by the local health care system.

- Shelter residents with fevers may be infectious and should be referred to the isolation care
- Area of the shelter.
- Encourage the individual to rest and drink plenty of fluids.
- Over-the-counter medications such as aspirin, ibuprofen and acetaminophen are usually effective at reducing fever. Encourage the individual to take antipyretics on a regular schedule to help keep the fever away, unless contraindicated. Never give aspirin to anyone under the age of eighteen. due to the risk of Reye's syndrome.
- Follow manufacturer guidelines in dosages for antipyretic medications
- Cool compresses and sponging with lukewarm water can also help reduce body temperature. Avoid rapid cooling.

Additional Considerations:

- Oral temperatures may be obtained for adults by placing the thermometer under the tongue for three minutes. In infants and young children, the temperature may be obtained by placing the thermometer under the arm for three minutes, although this will register a temperature approximately one degree lower than an oral temperature.
- Influenza causes high fevers and myalgias and is very contagious. If influenza is suspected, the individual or worker needs to be referred to the isolation care area for assessment and possible referral to local health care system.
- Febrile seizures occur in children younger than five years that have a high fever

See Seizures/convulsions protocol for more information.

See also: Congestion, Seizures/Convulsions, Dehydration, Diarrhea, Ear Problems, Eye Problems, Headache, Heat-Related Illness, Influenza, Infection, Nausea/Vomiting, Neck Pain/Stiffness, Rash, Sore Throat, Tooth Problems, Difficulty with Urination, Vaginal Discharge/Itching/Immune-compromised Individuals, Communicable Diseases/Headache.

Adjustments by Local Physician:

Headache

Treatment Goal:

- Assess for more serious health condition
- Reduce discomfort

Possible Causes:

- Most headaches are benign and are related to tension, eyestrain, hunger, or caffeine withdrawal. Frequent use of pain relievers can cause rebound headaches that return as the effect of the last dose wears off.
- Other causes can include sinus infection, fever, high blood pressure, brain tumor, head injury and meningitis, cerebral hemorrhage.
- Headaches in children can be related to stress about school, relationships or peer
- pressures.

History:

- Onset of symptoms: abrupt, rapid or gradual
- Location and quality of pain (sharp, pulsating, dull, etc.)
- Pain score (0-10 scale)
- Recent injury or trauma involving the head or neck
- History of sinus problems or sinus surgery
- History of migraine headaches
- History of high blood pressure
- Current medications
- Sensitivity to light, noise, smells or activity
- Report of visual changes or photophobia
- Recent withdrawal from medication or caffeine
- Nausea or vomiting

Assessment:

- Obtain vital signs, paying particular attention to temperature and blood pressure
- If blood pressure is abnormal, recheck in both arms to verify reading
- Assess for level of consciousness and confusion
- Observe for slurred speech, unilateral limb weakness, lack of muscle coordination or facial droop. See Stroke protocol
- Check pupil size and reaction to light and photophobia
- Assess pain on a scale of 0-10

Call Local EMS/911 for:

- Any injury or trauma to head or neck
- Any headache with severe eye pain
- Any individual who presents with weakness, paralysis, slurred speech, facial droop, visual changes, photophobia or changes in level of consciousness
- Any individual who has a severe headache associated with a systolic blood pressure greater than or equal to 150mmHg and/or a diastolic blood pressure greater than or equal to 110mmHg
- Any sudden onset “thunderclap” or “worst ever” headache

Refer to Local Healthcare System:

- Any severe or persistent headache

- Any headache associated with a fever and/or stiff neck
- Any headache associated with vomiting
- New or frequent headaches in a individual who rarely gets headaches
- Mild headaches that become severe
- Any headache that wakes a individual from sleep
- Any child who is having headaches more than once a week
- Headaches that awaken the child at night
- A headache occurring with other symptoms

Treatment:

- Mild headaches are managed well by resting quietly in a darkened room with a cool compress to the forehead.
- If individual requests, an over the counter pain reliever such as Acetaminophen or Ibuprofen may be dispensed. Instruct individual to follow manufacturer dosage instructions. Aspirin should never be given to anyone younger than 18 years.
- Most tension headaches respond well to rest, a warm compress applied to the back of the neck and/or acetaminophen or non-steroidal anti-inflammatory medications, unless contraindicated.
- Shelter residents with migraine headaches should take medications as prescribed by their physician.
- Headaches associated with a fever and/or stiff neck may be due to meningitis or other infection and should be referred to the emergency department of the local hospital immediately.

Additional Considerations:

- Tension headaches tend to be mild to moderate and cause a generalized aching in the head.
- Headaches due to high blood pressure are frequently referred to as “throbbing”
- or “pulsating.”

See also: Dehydration, Dizziness, Heat-Related Illness, Influenza, Nausea/Vomiting, Neck Pain/Stiffness, Paralysis/Weakness – Facial or Limb, Tooth Problems, Stroke, Meningitis.

Adjustments by Local Physician:

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Heat-Related Illness–

Heat Exhaustion

Treatment Goal:

- Prevent injury to individual
- Return physical status to within normal limits

Possible Causes:

- Heat illness is a continuum from mild heat intolerance, to moderate heat exhaustion, to severe heat stroke.
- Heat exhaustion is caused by an imbalance of nutrients/electrolytes in the body as a result of exposure to heat over a period of time. It is often associated with dehydration.

History:

- Onset of symptoms
- Length of time spent in high temperatures
- Presence of fatigue, weakness, nausea, dizziness, headache, confusion and/or fainting
- Presence of skeletal muscle spasms
- Medication History

Assessment:

- Obtain vital signs, paying particular attention to temperature
- Assess for level of consciousness or confusion
- Assess skin – will be hot to touch, flushed and moist
- Heart rate may be rapid and weak
- Breathing may be fast and shallow

Call Local EMS/911 for:

- All suspected cases of heat stroke (confusion, hypotension, any temperature greater than 105˚ F).

Refer to Local Healthcare System:

- Any suspected case of significant dehydration
- Any individual with a temperature of greater than 103˚ F
- Any individual whose symptoms do not resolve after treatment

Treatment:

- Cool the individual by moving them to shade, into an air conditioned environment or wiping them with a cool wet cloth
- Replace lost fluids by encouraging the individual to drink water

Additional Considerations:

- Certain populations are more vulnerable to heat exhaustion: older adults, chronic alcoholics, the obese and those taking medications such as antipsychotics and antihistamines
- Recovery is usually rapid once actions have been taken to treat the heat exhaustion

See also: Fever, Dehydration.

Adjustments by Local Physician:

Heat-Related Illness–

Heat Stroke

Treatment Goal:

- Rapidly reduce individual's temperature to within normal limits
- Prevent injury to individual

Possible Causes:

- Body fails to regulate its own temperature, and it continues to rise. Body systems become overwhelmed by heat and stop functioning

History:

- Exposure to hot temperatures
- Vomiting
- Confusion
- Delirium.
- Headache
- Vertigo
- Fatigue
- Seizures/convulsions
- Unconsciousness

Assessment:

- Obtain vital signs
- Any temperature greater than 103˚ F (or high body temperature) is an emergency
- Assess for level of consciousness and signs of confusion
- Assess skin – it will be red, hot and dry, even in the arm pits
- Absence of sweating
- Listen to heart rate/breath sounds. Heart rate may be weak and rapid while breathing may be shallow and fast.
- Assess pupils – they may be dilated

Call Local EMS/911 for:

- If individual's temperature exceeds 102.3
- All suspected cases of heat stroke (confusion, hypotension, any temperature greater than 105˚ F (Life threatening)

Refer to Local Healthcare System:

- Any individual who may have symptoms of heat exhaustion

Treatment:

- Call the local EMS immediately
- Remove individual from the hot environment to a cool area
- Elevate legs slightly
- Remove unnecessary clothing
- Reduce body temperature however possible – wrap individual in cool, wet sheets o apply cold packs to the groin, neck and armpits
- Fan the individual to help increase evaporation
- Frequently monitor body temperature to make sure temperature is not lowered too far

- If EMS is delayed call the hospital emergency room for instructions

Additional Considerations:

- Infants and individuals with diabetes, alcoholism, diarrhea and/or vomiting are at increased risk of heat stroke during hot weather.
- Risk of heat stroke is increased for all populations during very humid weather as the body is unable to sweat enough to reduce body temperature.
- Most people can eventually acclimate to a hot environment, but it may take several weeks to do so.

See also: Fever, Dehydration.

Adjustments by Local Physician:

Indigestion–"Heart Burn"

Treatment Goal:

- Assess for more serious health condition
- Relieve discomfort

Possible Causes:

- Generally due to eating unfamiliar or spicy food, eating too fast or too much or drinking alcohol. More serious or chronic causes of indigestion may be due to gastro-esophageal reflux disease, gallbladder disorders, ulcer or stomach cancer.
- Acute myocardial infarction may be described by individual as heart burn or indigestion

History:

- Onset of symptoms
- Location of indigestion (epigastric, behind breast bone, etc.)
- Any worrisome symptoms for a myocardial infarction (heart attack) such as shortness of breath, sweating, nausea, chest pain or radiating pain
- Any risk factors for a myocardial infarction such as prior heart disease, diabetes, family history, hypertension, smoking or obesity
- Recent change in diet
- Type/amount of food eaten
- Alcohol consumption (quantity and frequency)
- Recent changes in bowel habits
- Color of recent stools
- Presence of blood in vomit or stool
- Current medications, especially pain relievers (aspirin, ibuprofen)
- History of stomach ulcers or gastric bleeding

Assessment:

- Obtain vital signs
- Palpate abdomen for tenderness or rigidity
- Assess pain (Scale of 1-10)

Call Local EMS/911 for:

- Indigestion associated with sweating, shortness of breath, or pain radiating to the neck, jaw or arm
- Indigestion associated with abnormal vital signs
- Sudden and/or severe indigestion

Refer to Local Healthcare System:

- Individuals with indigestion who also have risk factors for a myocardial infarction
- Frequent indigestion paired with weight loss or vomiting
- Black, tarry stools or "coffee grounds" in vomit (may need ER)
- Symptoms recur several times per week or wake the individual from sleep

Treatment:

- Encourage individual to eat smaller meals, reduce stress and maintain a healthy weight
- Encourage individuals to avoid fatty foods
- Encourage individuals not to lay down directly after eating

- Antacids may be effective at reducing symptoms
- Over the counter antacids, unless contraindicated is highly effective in relieving most cases of indigestion/mild reflux symptoms

Additional Considerations:

- Symptoms may increase during pregnancy or if the individual is obese.
- Ulcers are characterized by epigastric abdominal pain that is made worse by either eating or by having an empty stomach. Eating small, frequent meals may provide temporary relief of discomfort but symptoms may flare at night.

See also: Abdominal Pain, Chest Pain/Pressure, Cramps – Abdominal, Diarrhea, Nausea/Vomiting.

Adjustments by Local Physician:

Itching–

Head

Treatment Goal:

- Prevent potential spread to others
- Relieve symptoms

Possible Causes:

- Itching of the scalp could be due to dry skin (dandruff) or an infestation of lice

History:

- Intense itching of the head
- Recent close contact with someone known to have lice
- History of dry skin in the past

Assessment:

- Obtain vital signs
- Wearing gloves and using a tongue-depressor, inspect the individual's scalp and hair roots for signs of flaking skin or presence of lice

Refer to Local Healthcare System:

- Suspected lice infestations should be referred to the local healthcare system for diagnosis and to direct treatment
- The overwhelming majority of cases of both dandruff and lice can be effectively managed with over-the-counter treatments

Treatment: **Always use standard precautions**.

- Lice: Instruct the individual to avoid contact with others until the lice infestation is treated with medicated shampoo (RID, for example) and any remaining nits are removed with a fine-toothed comb. Dispose of the comb after use. All furniture, bedding, clothing and cloth items (e.g. stuffed animals) should be sprayed with a product containing the active ingredient permethrin or washed in the hottest water temperature possible. Other items may also be placed in plastic bags for two weeks to allow the lice to die. Check for the presence of lice on all family members, playmates and any potential close contacts.
- Monitor and direct cleaning of bedding, clothing and furniture if lice is discovered on one or more shelter residents
- Dandruff: Encourage the individual to use a shampoo that is geared specifically toward those with dry scalp (e.g. Head & Shoulders) and avoid over-drying the scalp with harsh styling products or hairdryer.

Additional Considerations:

- A lice infestation can be determined by inspecting the scalp and hair root for small white nits (eggs) that are attached to the hair or the insect itself which is small and dark.
- Lice can infest any part of the body with hair

See also: Lice.

Adjustments by Local Physician:

Itching–

Skin

Treatment Goal:

- Assess for more serious health condition
- Identify cause of symptoms
- Relieve symptoms

Possible Causes:

- Contact dermatitis (skin allergy), plants (poison ivy/oak), skin products, detergents, metals, materials (e.g. wool). Hypersensitivity reactions, (insect bites, scabies, drug reactions). Scabies, skin infections, cold weather, prolonged exposure to water.

History:

- Known exposure to someone with itching of the skin
- Exposure to poison ivy, poison oak
- Recent use of an unfamiliar product (bath soap, detergent, perfume, etc.) which may have caused an allergic reaction
- Possible exposure to plants or insects
- Change in medications or new prescription
- History of atopic dermatitis or chronic skin condition

Assessment:

- Obtain vital signs
- Assess for presence of insect bites
- Assess for rash, hives, areas of redness or evidence of scratching
- Assess for raised area on skin or appearance of tunneling under the skin
- Look for evidence of vesicles (blisters) and/or pustules
- Observe the location and pattern (if any) of rash, bites or other skin changes
- If hives are present, assess for breathing difficulties or shortness of breath

Call Local EMS/911 for:

- Any expanding redness of the skin that covers a large area of the body, looks/acts like a burn and/or may be associated with a drug reaction
- Any itching lesions/hives that are associated with lightheadedness, low blood pressure, trouble breathing or other symptoms of anaphylaxis

Refer to Local Healthcare System:

- Any suspected case of fungal/bacterial infection or parasite infestation
- Itching that lasts for more than a few days or that comes and goes frequently should be evaluated for allergic reaction
- Any case of drug reaction
- Anyone with contact dermatitis of the face (especially near the eyes) Treatment: **Always use standard precautions**
- For dry skin, encourage individual to keep baths brief and to use cool/lukewarm water. Pat dry. Body lotion should be applied while still damp.
- For contact dermatitis or poison ivy: Soothing lotions containing menthol, camphor, chamomile, eucalyptus or calamine may be effective at reducing symptoms.
- Corticosteroid creams and/or oral antihistamines may help reduce symptoms due to allergic

reaction or poison ivy/oak, unless contraindicated.

- Parasites, fungal and/or bacterial skin infections will require treatment with prescription medications.
- Check to see if local area as any areas of poison oak/ivy and then alert others to avoid contact

Additional Considerations:

- Itching hands, especially with red streaks and spots, may be a sign of scabies.
- The presence of scabies does not become apparent until approximately three weeks after exposure.
- The presence of hives and/or extensive skin redness suggests a more serious hypersensitivity reaction.
- Plant contact dermatitis usually appears within 24 hours of exposure and new lesions may continue to appear for up to 14 days. Although the blisters themselves are not infectious, the plant oil can remain on objects (clothing, tools, pet fur, etc.) for a long period of time.

See also: Rash, Poisoning, Impetigo, Ringworm, Scabies, Pinworms, Chickenpox, Shingles.

Adjustments by Local Physician:

Leg/Foot Injury and Pain

Treatment Goal:

- Prevent further injury from occurring
- Determine extent of injury
- Reduce discomfort

Possible Causes:

- Muscle strain, dislocation, sprain, fracture, tendonitis, deep vein thrombosis, vascular insufficiency

History:

- Type of activity individual was engaged in when the pain or injury occurred
- If the individual felt and/or heard a bone snap
- Past medical history related to musculoskeletal injury and/or surgery
- If the pain is not related to an injury, assess for symptoms of a pulmonary embolism (chest pain, shortness of breath, hemoptysis, tachycardia)

Assessment:

- Obtain vital signs
- Assess pain scale of 0-10
- Assess all injuries for presence of a pulse distal to the injury, skin color and temperature, and range of motion. Do not force movement.
- Point tenderness over a specific area is often the sign of a fracture
- Strain: dull pain in the affected muscle that worsens with movement, swelling
- Tendonitis: pain at the joint not associated with any injury but may be due to repetitive use or infection
- Dislocation: swelling, deformity, severe pain, discoloration, tenderness and/or numbness of an affected joint
- Sprain/strain: pain and/or swelling at joint that worsens with movement, possible bruising around area of injury
- Fracture: pain and/or tenderness at site (usually with significant point tenderness) when touched or moved, individual has difficulty moving the injured part, individual may feel grating sensation, the injured part may move unnaturally,
- bruising may be present
- If the pain is non-traumatic, check to see if one calf is more swollen than the other, for calf tenderness or for a palpable clotted vein ("cord")
- If tendonitis is suspected, assess for an infection; check for warmth, redness and swelling, and check for pain with passive movement

Call Local EMS/911 for:

- Any extremity that is cool, pale or blue, or if a pulse cannot be detected distal to the injury
- All cases of severe pain, regardless of suspected cause
- Any leg pain with shortness of breath, chest pain or hemoptysis (coughing up blood). Or suspected deep vein thrombosis

Refer to Local Healthcare System:

- All suspected dislocations and fractures
- All suspected cases of tendonitis or infection

- All cases of moderate to severe pain, regardless of suspected cause.

Treatment:

- Sprain/strain: Rest and elevate the affected area, apply cool packs intermittently for the first 24-48 hours then switch to warm compresses. Apply supportive bandage (ACE wrap) to the affected joint. Loosen bandage if swelling increases or extremity becomes cold or mottled. Muscle sprains/strains respond well to NSAIDs (Ibuprofen, Naprosyn, etc.) if individual requests pain relief and does not have any contraindications. Advise individual to follow the manufacturer's recommended dosages.
- Tendonitis: Rest the affected area and apply ice packs intermittently for the first
- 24-48 hours. If individual requests pain relief medication, non-steroidal anti- inflammatory medications work best at relieving pain and reducing inflammation, unless contraindicated. Assess for allergy to aspirin or NSAIDs.
- Dislocation: Do not move or try to put a dislocated bone back into place.
- Immobilize the joint and limb as much as possible. Individual should not put weight on the affected extremity. Have individual transported to a medical facility rapidly, via EMS if necessary.
- Fracture: Closed (no break in the skin): Immobilize the affected extremity and have individual transported to a medical facility.
- Fracture: Open (skin is broken): Call local EMS. Using standard precautions, cut clothing away from the wound, being careful not to touch the exposed bone. Cover area with sterile dressing. If bleeding, apply direct pressure to wound. If
- EMS is not immediately available, splint the fractured area as it is and gently help the individual into a comfortable position until EMS arrives. Individual should not put weight on affected extremity.

Additional Considerations:

- When unsure of a diagnosis, treat the injury as a fracture. Definitive diagnosis requires professional assessment and radiologic testing at a medical facility.
- Geriatric shelter residents are more prone to musculoskeletal injury and bone fracture.
- If individual is to be transported to a medical facility for further treatment, do not give anything to eat or drink as surgical repair may be required.

See also: Bites, Blisters, Bruising, Frostbite, Cramps – Muscular, Cuts and Scrapes, Edema.

Adjustments by Local Physician:

Nausea/Vomiting

Treatment Goal:

- Assess for more serious health condition
- Prevent dehydration

Possible Causes:

- Nausea with or without vomiting can be precipitated by a wide range of conditions –
- many of which are associated with gastrointestinal disorders (e.g. cholecystitis, gastritis, hepatitis, viral infections of the intestines, food poisoning, intestinal obstruction and
- excessive drinking or eating). It could also be triggered by emotional upset, stress,
- migraine headaches or pregnancy. It can also be caused by more serious conditions (non GI) such as allergic reactions to bites/stings, gastrointestinal bleeding, heart attack, heat exhaustion, shock, sepsis and head injury.

History:

- Onset and duration of symptoms
- Differentiate between nausea, vomiting without emesis ("dry heaves") and vomiting with emesis
- Number of times vomiting has occurred within a defined period of time
- Color/amount of emesis (e.g. coffee ground-colored emesis three times a day for two days). Be particularly concerned about bloody, maroon or coffee-ground emesis.
- Recent eating pattern, including foods and medications
- Excessive drinking, including recent use/abuse of alcohol
- An allergic reaction to food, medicines or a bite or sting by an insect. See Bites protocols.
- Possibility of poison ingestion
- Prolonged exposure to high temperatures. See Heat Exhaustion protocol.
- Trauma or serious injury, especially to neck/head
- Recent diarrhea. See Diarrhea protocol
- Chest pain/pressure, sweating, and/or pain radiating to the neck, jaw or left arm
- See Chest Pain/Pressure protocol
- Known/suspected pregnancy
- Emotional upset
- Current medications

Assessment:

- Obtain vital signs, paying special attention to an elevated temperature, tachycardia, or low blood pressure
- Assess skin for presence/absence of sweat and presence or absence of bites and/or stings
- Assess mucous membranes (inside of mouth) for signs of dehydration
- Listen to abdomen for presence or absence of bowel sounds
- Palpate abdomen for tenderness, guarding and/or rigidity

Call Local EMS/911 for:

- All cases of possible head injury, heart attack, sepsis, allergic reaction/
- anaphylaxis or shock
- Any individual who is unconscious and vomiting
- Any individual who is confused or has an altered mental status
- Any individual with emesis that contains blood or is coffee ground-colored

Refer to Local Healthcare System:

- All cases of frequent vomiting that lasts longer than four to six hours, of the individual not able to keep liquid down, or of vomiting that continues for more than one or two days
- Any suspected case of pregnancy that has not been previously diagnosed
- In children younger than two, any projectile vomiting (forceful vomiting that is expelled one to two feet)

Treatment:

- Encourage the individual to rest and take frequent sips of fluids (diluted non- carbonated beverages, apple or grape juice (avoid citrus) or bouillon, weak tea, gelatin desserts) to prevent dehydration. Avoid solid food and fluids that are highly acidic (e.g. orange juice). Once vomiting has stopped, slowly work back to a regular diet.
- Encourage individual who has vomited to attend to oral hygiene (gargle with mouthwash or brush teeth)
- Infants and children who are vomiting should be turned on their side to prevent emesis from entering their lungs. Children should be encouraged to take frequent sips of water or pediatric rehydration solution (e.g. Pedialyte) every 10- 20 minutes to prevent dehydration. No Pepto-Bismol for children
- **Always use standard precautions** when contact with blood or body fluids is a possibility
- Encourage individual to avoid taking in large amounts of food or liquids, even and especially as they begin to feel better
- Refer to Diarrhea protocol, if applicable

Additional Considerations:

- Infants, older adults and those with chronic illnesses are at higher risk for developing dehydration due to vomiting, especially if associated with diarrhea.
- Vomiting in infants and children is common and usually due to a viral infection, food poisoning, car sickness, colic and/or food allergies. Infants frequently spit up food after eating and this should not be confused with vomiting.

See also: Abdominal Pain, Cramps – Abdominal, Diarrhea, Fever, Heat-Related Illness, Indigestion, Influenza, Pregnancy, Substance Abuse/Withdrawal, Poisoning, Chest Pain/Pressure.

Adjustments by Local Physician:

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Neck Pain/Stiffness

Treatment Goal:

- Assess for more serious health condition
- Reduce discomfort

Possible Causes:

- A stiff or painful neck can be due to muscle strain, spinal cord compression, or injury. It may also be a symptom of meningitis or encephalitis

History:

- Onset of symptoms
- Activity surrounding onset of symptoms, including trauma
- History of neck pain/stiffness in past, especially disc or vertebrae disorders
- Presence or absence of shooting pain or tingling sensation down one or both arms
- Recent fever

Assessment:

- Obtain vital signs, paying special attention to an elevated temperature.
- Document on Health Assessment Record
- If injury or trauma can be ruled out, assess neck for range of motion
- Assess hand strength by having individual grip your hands simultaneously
- Assess area of discomfort for outward signs of injury
- Observe for reflex flexion of the hips and knees with passive flexion of the neck while individual is in a supine position

Call Local EMS/911 for:

- In all cases of neck or head injury, do not move individual or neck while waiting for
- EMS to arrive
- Any individual with neck pain not associated with trauma-with headache, fever and pain on passive flexion of neck, nausea, and vomiting
- Any individual with a past medical history of cervical/spinal surgery or disorder who has had a recent worsening of symptoms

Refer to Local Healthcare System:

- Any individual with a suspected muscle strain that does not resolve within two days
- Any individual who has a positive reaction to the passive flexion of the neck while in the supine position

Treatment:

- If a muscle strain is suspected, encourage the individual to avoid engaging in strenuous activities and place a warm compress on the affected area for 24-48 hours
- If requested, non-steroidal anti-inflammatory medications may also be helpful in

- reducing discomfort, unless contraindicated

Additional Considerations:

- An involuntary flexion of the hips and knees when you passively flex the neck of the supine individual is known as a positive Brudzinski sign and may indicate meningitis or subarachnoid hemorrhage.

See also: Back pain, Cramps – Muscular, Earache, Headache, Influenza, Nausea/Vomiting, Sore throat, Meningitis, Fever.

Adjustments by Local Physician:

Nose Bleed

Treatment Goal:

- Stop bleeding
- Assess for more serious health condition

Possible Causes:

- Nose bleeds can be caused by dry air, infection, repeated blowing of the nose, scratching the nose or a blow/injury to the nose.

History:

- Onset of symptoms
- Activity engaged in when nose bleed began
- Any injury/trauma to nose or face
- History of coagulation problems
- Current medications, especially blood thinners

Assessment:

- Obtain vital signs, paying special attention to an elevated temperature
- Estimate amount of blood loss using an objective measure (e.g., bloody cloth 6cm x 8cm)

Call Local EMS/911 for:

- All cases of severe nose bleeds that cannot be stopped, particularly in individuals taking blood thinners
- Individuals who are hypotensive or tachycardic

Refer to Local Healthcare System:

- Any recurrent nosebleed
- Any elderly individual with a nosebleed that does not immediately respond to treatment

Treatment: Always use standard precautions

- Have individual sit with his or her head upright and lean slightly forward, keeping mouth open for breathing
- Have the individual squeeze the nose on the soft cartilage portion – not the bone –
- continuously for at least 5-10 minutes
- Be sure to release the nose slowly and do not allow individual to touch or blow the nose as this may cause a re-bleed.
- If bleeding continues, squeeze the nose for another five minutes and place an ice pack or cold cloth on the bridge of the nose to help constrict blood vessels
- If bleeding does not stop after the second episode of pinching, have individual transported to the hospital (continue to pinch during transport)

Additional Considerations:

- Children frequently get nose bleeds that are not serious and stop in a few minutes nose bleeds in the elderly should be taken seriously

See also: Bleeding.

Paralysis/Weakness – Facial or Limb

Treatment Goal:

- Assess for more serious health condition
- Timely transfer to higher level of car

Possible Causes:

- Paralysis that affects the face could be caused by Bell's Palsy, a transient ischemic attack
- (TIA) or a stroke (cerebrovascular accident – CVA)

History:

- Onset of symptoms: are symptoms still present or have they subsided?
- Presence of headache before or in conjunction with the paralysis/weakness
- Sudden paralysis or weakness on one side of the body with facial drooping
- Loss and/or slurring of speech
- Mental confusion
- Lack of muscular coordination
- Loss of bladder/bowel control
- History of blood clots or previous TIA/CVA
- Current medications, especially aspirin or other blood-thinner

Assessment:

- Call EMS-timely transfer of stroke victims to a hospital can mean better outcomes
- Obtain vital signs, paying special attention to an elevated blood pressure
- Assess hand strength by asking individual to grip hands simultaneously
- Assess individual's ability to speak clearly and to choose appropriate words
- Assess individual's coordination of movements and ability to move upper and lower extremities
- Assess the individual's ability to walk, observing gait and balance
- Check pupil size and reaction to light
- Assess facial symmetry. Look for differences between features of the right and left side of the face (e.g. smile/frown, raise eyebrows) and presence or absence of eyelid drooping.

Call Local EMS/911 for:

- Sudden signals of stroke think F.A.S.T.: Face, Arm, Speech, Time
- All cases of facial drooping or paralysis
- All cases of altered speech or limb weakness or paralysis
- All suspected cases of TIA or stroke

Treatment:

- Get the individual to an acute care facility as quickly as possible. Do not give individual anything to eat or drink. Do not give individual any medications.
- If the individual is having trouble with saliva, place individual on their weakened side so secretions can drain from the mouth.
- Have the individual to rest quietly until local EMS arrives. Comfort the individual and family as much as possible.

Additional Considerations:

- A individual's prognosis improves when they can be transferred to an acute care facility

for diagnosis and treatment quickly

- A stroke is due to a lack of adequate oxygen getting to the brain either because of a blood clot or a brain hemorrhage.
- Bell's Palsy is a sudden weakening or paralysis of one side of the face due to malfunction of one of the cranial nerves. Symptoms mimic that of a stroke minus the weakening of the arm/leg of the affected side as in a stroke. Bell's palsy has been associated with herpes zoster.

See also: Stroke.

Adjustments by Local Physician:

Rash

Treatment Goal:

- Assess for more serious health condition
- Relieve minor symptoms

Possible Causes:

- Allergic reactions, fever, heat, (prickly heat) contact dermatitis (e.g. plants, metals) or
- Infectious diseases

History:

- Recent change/addition in medications taken, Current medications taken
- Sensitivity/allergy to substances
- Pruritic (itchy) or not
- Recent exposure to others with rash
- Immunization history if infectious rash is suspected (e.g. measles, chickenpox)
- Past medical history
- Infant who has been dressed too warmly or exposed to hot weather

Assessment:

- Obtain vital signs, paying particular attention to any fever, tachycardia and hypotension. Document on Health Record
- Assess affected area for quality of rash: size, shape, pattern (linear, scattered, etc.), presence of hives, itching/burning, redness, etc.
- Assess rash for secondary changes (development of blisters, etc.)
- Prickly Heat will look like tiny pimples and usually appear on the head, neck and shoulders

Call Local EMS/911 for:

- Any reaction to food, medication or environmental allergen that causes lightheadedness, difficulty breathing or swallowing
- Any rash with fever or severe illness
- If prickly heat is accompanied by a fever of 100.4 degrees or higher in an infant younger than 3 months and if fever doesn't come down within 20 minutes of removing some of the infant's clothing

Refer to Local Healthcare System:

- Any rash that becomes blue or purple or if blood-red spots appear
- Any rash with large (greater than one inch in diameter) blisters
- Any rash that becomes worse or shows signs of infection
- Any painful rash
- Any rash that results from a bite or sting
- Any rash associated with medications
- Any rash on the face or near the eyes
- Itching is severe
- Rash is present concurrently with other symptoms

Treatment: Always use standard precautions

- For rashes of all origins, it is recommended that the area be kept clean and dry

- Dust powders and soothing lotions on the affected area and encourage individual to wear loose-fitting clothing that will not rub the affected area
- Hydrocortisone cream may relieve minor allergic or inflammatory irritations. Do not use if infection is suspected.
- For contact dermatitis (such as poison ivy), soothing lotions containing menthol, camphor, chamomile, eucalyptus or calamine may be effective at reducing symptoms
- Corticosteroid creams and/or oral antihistamines may help reduce symptoms due to allergic reaction or poison ivy/oak, unless contraindicated.
- Topical anesthetic creams (over-the-counter benzocaine or lidocaine) may relieve the symptoms of minor burning and itching. Do not use on open wounds
- For possible food and environmental allergies, encourage the individual to take an antihistamine (Benadryl), if not contraindicated, and avoid further contact with the allergen
- Diaper rash can be treated with a variety of barrier creams such as A&D ointment, Desitin, etc
- If infectious rash is suspected, contact the local public health department
- Do not overdress children and infants
- Keep children and infants sleeping areas as cool as possible
- Keep children and infant's skin cool and dry

Additional Considerations:

- Rashes are common in infants. Diaper rash being uncomfortable but not dangerous.
- Contact dermatitis caused by plants (poison ivy, oak, etc.) is not infectious.
- However, the plant oils may last on clothing, objects and/or pets for a long period of time.
- A painful rash that is located primarily on one side of the body or runs along a nerve path is suggestive of a herpes zoster (shingles) infection. See Shingles protocol

See also: Bites, Blisters, Burns, Fever, Heat-Related Illness, Influenza, Neck Pain/Stiffness, Impetigo, Ringworm, Scabies, Chickenpox, Herpes, Shingles, Mumps, Measles.

Adjustments by Local Physician:

Seizure/Convulsion

Treatment Goal:

- Protect individual from injury during the seizure
- Ensure an open airway after the seizure

Possible Causes:

- A seizure is caused by abnormal electrical discharges from the brain. Seizures can be caused by a primary disorder (e.g., epilepsy), head injury, stroke, brain damage at birth,
- brain tumor, infection (febrile seizures) or alcohol withdrawal.

History:

- History of previous seizures
- Current medications taken
- Any trauma or injury to the individual
- Loss of memory immediately preceding event

Assessment:

- Obtain vital signs (watch for an elevated temperature, which may cause febrile seizures or temporary loss of breathing)
- Observe for twitching of the face or limbs
- Muscle spasms or tremors
- Loss of consciousness – partial or complete
- Loss of bladder or bowel control

Call Local EMS/911 for:

- All cases of seizure/convulsions especially the person has never had a seizure before and the seizure lasts longer than 5 minutes or seizure is repeated
- Does not regain consciousness
- Is pregnant
- Is a known diabetic
- Has sustained injury
- Shows life threatening conditions

Treatment:

- If the individual starts to fall, try to gently guide their fall to prevent head injury
- Move any dangerous objects away from individual
- DO NOT place anything in individual's mouth
- Do not hold or restrain individual
- Protect the person's head. Place a thin folded towel or clothing beneath it.
- After the seizure has stopped, turn the individual on their side to prevent choking on vomit or secretions. Make sure the airway is clear.
- Check for other injuries post-seizure (i.e. broken bones, chipped teeth, bleeding)
- Febrile seizure: Help to prevent febrile seizures in children by controlling elevated temperatures with acetaminophen or ibuprofen – do not give aspirin to any individual under the age of 18. If a febrile seizure does occur call local EMS and,
- while waiting for their arrival, place cool washcloths on the individual.

Note: Check scene and if injuries are apparent following seizure complete an incident report.

See also: Fainting, Fever, Headache, Stroke, Diabetic Emergencies, Poisoning, Shock, and, Substance Abuse/Withdrawal.

Adjustments by Local Physician:

Sore Throat

Treatment Goal:

- Assess for more serious health condition
- Reduce discomfort

Possible Causes:

- Sore throats (also known as pharyngitis) are frequently caused by the same viruses that cause the common cold.
- Streptococcus (strep throat) is a less common but more serious cause of a sore throat.

History:

- Onset of pain
- History of recent fever
- Amount of pain (0-10 pain score)
- Pain on swallowing, difficulty swallowing or inability to swallow
- Presence of ear pain
- Recent symptoms of an upper respiratory infection

Assessment:

- Obtain vital signs
- Using flashlight, assess back of throat and tonsils for redness, pus, swelling

Call Local EMS/911 for:

- Individuals that cannot swallow their own saliva or are having difficulty breathing

Refer to Local Healthcare System:

- Any sore throat associated with a fever
- Any sore throat with enlargement of the tonsils with or without pus

Treatment:

- Advise individual that sore throats associated with the common cold typically resolve on their own within a day or two
- Sore throat lozenges and/or analgesics may help with discomfort.
- Encourage the individual to drink adequate fluids
- Acetaminophen and non-steroidal anti-inflammatory drugs (NSAIDs) are frequently effective at reducing the pain, if not contraindicated
- Over-the-counter throat lozenges, sprays and gargles may provide temporary relief from pain

Additional Considerations:

- Some throat lozenges contain dextromethorphan which may not be good for elderly shelter residents who are taking multiple medications
- Although children frequently have viral sore throats, strep throat is unusual in children younger than two years
- “Strep” throat is almost always associated with a fever.
- Viral sore throat may or may not have a fever. Shelter residents without a fever usually do not need to be seen by a physician.

See also: Congestion, Cough, Dehydration, Earache, Fever, Influenza, Neck Pain/Stiffness, Toothache, Mumps, Measles, Meningitis.

Adjustments by Local Physician:

Splinter

Treatment Goal:

- Prevent injury to individual
- Remove foreign object from under skin

Possible Causes:

- Splinters can be caused by a sliver of any foreign material (wood, glass, etc.) that becomes lodged under the surface of the skin.

History:

- Type of material believed to have caused the splinter
- Date of last tetanus shot, if known

Assessment:

- Obtain vital signs
- Assess area surrounding splinter for bleeding or other injury

Refer to Local Healthcare System:

- Any splinter that cannot be removed with tweezers
- Any individual with signs of infection around the affected area

Treatment:

Wash hands with soap and water and put on clean exam gloves. Clean the area surrounding the splinter with soap and water, as well

- Place tweezers in boiling water for approximately five minutes to sterilize. If boiling water is not an option, hold instrument over a flame for 30 seconds to sterilize. Let cool before use.
- If splinter is sticking out of the skin, gently pull the splinter out with the tweezers at the same angle at which it entered. Once removed, wash the area with soap and water and apply a clean band aid. Watch for signs of infection such as redness, pus or red streaks leading up the body from the wound.
- Be sure to clean tweezers after use
- If the splinter breaks off under the skin or is deeply lodged, refer individual to a medical facility for removal of the splinter and a possible tetanus shot
- Small splinters can be left untreated. After a few days, a small pocket forms around the splinter and they may come out spontaneously or become more easy to remove with tweezers.

See also: Infection.

Adjustments by Local Physician:

Tooth Problems–

Lost/Broken Teeth

Treatment Goal:

- Prevent injury to individual
- Relieve discomfort

Possible Causes:

- Cavities and infections can often cause teeth to become loose in the gum, thus leading to tooth loss.
- Teeth could also be knocked out by sports activities, fighting or facial trauma in an accident.

History:

- When and where the loss of or injury to the tooth occurred
- Circumstances surrounding loss
- History of dental problems
- Presence or absence of pain
- Pain score (0-10 scale)

Assessment:

- Obtain vital signs and document on Health Record
- Examine mouth for signs of the tooth injury

Refer to Local Healthcare System:

- Any individual with a permanent tooth that has been broken, is loose, or was knocked out.

Treatment: Always use standard precautions

- If the tooth can be found, it should be handled very gently and only by the crown (avoid touching the root). Rinse the tooth off in cool water (no soap) and place it gently into the socket. Have individual bite down on a piece of gauze or clean cloth to hold it in place. If unable to hold the tooth in place, gently wrap the tooth in gauze soaked in saline or water. Do not put the tooth in tap water or milk. Refer individual to a dentist immediately – permanent teeth that have been knocked out may be able to be re-implanted if care is sought within 60 minutes.
- If bleeding is present, fold or knot a piece of gauze and place over the bleeding area in the mouth. Have individual bite down on the gauze to apply pressure to the bleeding site for 20-30 minutes.
- A non-steroidal anti-inflammatory medication (ibuprofen, naprosyn, etc.) or acetaminophen may be helpful if the individual is experiencing discomfort and requests a medication, unless contraindicated. Aspirin should not be taken because it may increase bleeding.

See also: Infection, Fever, Sore Throat

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Adjustments by Local Physician:

Tooth Problem–

Toothache

Treatment Goal:

- Prevent injury to individual

Possible Causes:

- Cavities
- infection

History:

- Onset of symptoms
- Pain score (0-10 scale)
- Location and quality of pain (dull, sharp, stabbing, etc.)
- The presence of fever
- History of dental problems
- Sensitivity to hot or cold

Assessment:

- Obtain vital signs, paying special attention to the presence of fever
- Examine the face for swelling, redness or asymmetry

Refer to Local Healthcare System:

- Recurrent toothache or toothache that does not resolve within 1-2 days
- Any toothache associated with a fever, except in infants who may have a low- grade fever with teething
- Any toothache associated with facial swelling or asymmetry

Treatment:

- If individual requests medication, aspirin, acetaminophen, naproxen or ibuprofen may be helpful at reducing discomfort, unless contraindicated. Avoid aspirin if the individual may require a dental extraction. Do not given aspirin to children younger than 18 years.
- Place a cool compress on the face over the affected area.
- Over-the-counter medications for toothache (like Ambesol) may provide some relief from discomfort

See also: Infection, Fever, Sore Throat

Adjustments by Local Physician:

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Urination, Difficulty with

Treatment Goal:

- Assess for more serious health condition
- Reduce discomfort

Possible causes:

- Kidney stones, urinary retention, urinary incontinence, infection of the urinary tract, enlarged prostate, sexually transmitted disease

History:

- Onset of symptoms
- Presence/absence of pain
- Pain score (0-10 scale)
- Presence of fever
- Frequency and/or urgency of urination
- Color of urine
- Recent increase or decrease in volume of urine produced
- Presence or absence of burning or irritation before, during or after urination
- History of urinary problems in the past
- Presence of penile or vaginal discharge
- Current medications

Assessment:

- Obtain vital signs
- Gently palpate abdomen to assess for bladder distention and/or tenderness
- Inquire as to start of symptoms-time since last urination

Refer to Local Healthcare System:

- Any individual with a distended bladder who is unable to pass urine. Acute urinary retention and bladder distension lasting several hours can become an acute (EMS)medical emergency-the individual is not likely to report this until uncomfortable
- Any individual with urinary difficulties that do not resolve within one to two days or is associated with a fever
- Any individual with urinary difficulties associated with pain and/or burning during urination, with or without a fever
- Any sexually active individual with penile or vaginal discharge

Treatment:

- If individual is able to pass urine and the bladder does not feel distended upon palpation, encourage the individual to drink more fluids than usual (unless contraindicated) but avoid
- caffeine and alcohol.

Additional Considerations:

- Nausea and/or vomiting and chills and/or fever may be indicators of urosepsis. The presence of flank pain may be indicative of kidney infection.
- Incontinence, especially in dependent or debilitated people, may lead to urinary tract infections.

See also: Back Pain, Seizures/Convulsions, Dehydration, Fever, Heat-Related Illness, Confusion/Disorientation, Pregnancy, Rape/Sexual Assault.

Adjustments by Local Physician:

Vaginal Discharge/Itching

Treatment Goal:

- Assess for more serious health condition
- Relieve discomfort

Possible Causes:

- Frequently due to inflammation of the vagina caused by infection (bacterial or fungal) or
- Chemical irritants (bubble bath, synthetic underwear, latex condoms/spermicide, etc.)

History:

- Onset of symptoms
- Color, consistency and amount of discharge
- Presence of foul odor
- Presence of itching, burning or pain
- Previous vaginal infections
- Possibility of sexually transmitted disease
- Recent antibiotic use
- Frequent douching
- Standing waist deep in high flood water for any period of time

Assessment:

- Obtain vital signs and document on Health Record
- Record symptoms as reported by individual

Refer to Local Healthcare System:

- Any individual with vaginal discharge with the exception of known yeast infections which have responded in the past to OTC medications
- Any child experiencing vaginal discharge

Treatment:

- Treatment will be based on the cause of the discharge. Refer individual to the local health care system for diagnosis and treatment recommendation.
- If individual has previously been diagnosed with a yeast infection and is familiar with the symptoms, over-the-counter treatment may prove effective.
- To help prevent future irritation, encourage individual to bathe regularly, keep the groin area dry, wipe from front to back after urination/defecation and wear natural-fibered underclothing.

Additional Considerations:

- Newborns frequently will have vaginal discharge tinged with blood due to estrogen absorption from the mother. This should stop within two weeks after delivery.
- Vaginal discharge (aside from menses) in older children is abnormal and should be referred to a medical professional.

See also: Abdominal Pain, Back Pain, Bleeding – Internal, Cramps – Abdominal, Fever, Difficulty with Urination, Childbirth, Pregnancy, Miscarriage, Rape/Sexual Assault, Infection.

Adjustments by Local Physician:

III. Special Considerations

Altitude Sickness – Acute Mountain Sickness (AMS)

Altitude sickness is divided into three syndromes:

- Acute Mountain Sickness (AMS)
- High Altitude Cerebral Edema (HACE), and
- High Altitude Pulmonary Edema (HAPE)

AMS is the most common form of altitude sickness and will be discussed in this protocol. HACE and HAPE are serious forms and would need immediate urgent care.

Treatment Goal:

- Assess for pre-existing health conditions and need for urgent treatment
- Relieve sensation of difficulty breathing when possible – assess if there is position of comfort or relief

Possible Cause:

- Transient shortness of breath or difficulty in breathing may be caused by high altitudes of 8,000-10,000 feet. Preexisting conditions may be exacerbated.

History

- Determine the presence of other acute symptoms
- Headache is the cardinal symptom sometimes accompanied by poor appetite, nausea, fatigue, dizziness, difficulty sleeping
- Headache onset is usually is usually 2-12 hours after arrival at a higher altitude often after the first night.
- AMS usually resolves with 24-72 hours of acclimatization.

Assessment

- Obtain Vital signs and document
- Listen to breath sounds for the presence of wheezes, rales or ronchi

Call local EMS/011 for:

- Symptoms increase and vital signs become unstable
- Symptoms are not relieved by descent to a lower altitude
- Any suspicion of a serious cause for shortness of breath
- Suspicion of stroke, heart attack or pulmonary embolus

Treatment:

- Observe and refer for urgent care if symptoms
- Stop the ascent or move to lower altitudes
- Supplemental oxygen may be needed and EMS should be called

Additional Considerations

- Volunteers and staff traveling to high altitude areas should be aware of signs and symptoms of AMS and how it could affect pre-existing conditions.

Note: Katrina evacuees to Denver Colorado experiencing acute symptoms were found to be related to altitude sickness

Adjustments by Local Physician:

Blood Pressure, Elevated/High

Treatment Goal:

- Assess for serious health condition
- Identify risk factors and co-morbidity
- Determine need of referral for additional work-up/ treatment for hypertension
- (HTN)
- Prevent serious complications from undiagnosed/untreated high blood pressure such as cardiovascular disease, kidney disease, eye damage or stroke.

Possible Causes:

- An elevated blood pressure can be due to an established diagnosis of hypertension, or as a response to stress and anxiety.
- Elevated blood pressure is often a result of unhealthy life-style habits. The individual may have a previously undiagnosed history of elevated blood pressure and would need follow up and monitoring for the condition.
- An elevated blood pressure can be the result of certain medications or other diseases. It can be hereditary or related to ethnicity.

History:

- Ask the individual's age, the incidence of HTN rises in men after age 35, and in women after age 45, and certainly more likely in the elderly
- Determine presence of other concerning symptoms, such as headaches, chest pain, palpitations, shortness of breath, sweating, dizziness, nausea, or changes in vision
- Ask individual for any past history of serious illness, especially previously noted situations of elevated blood pressure, a diagnosed history of hypertension, heart disease, diabetes, or kidney disease.
- Ask about risk factors such as:
    1) African-American descent
    2) Family history of HTN
    3) Family history of diabetes d. Smoking
    4) Being overweight
    5) Sedentary lifestyle, lack of exercise g. High stress levels
    6) Alcohol consumption
    7) Medication use, including steroids, decongestants, and anti-inflammatory drugs on a regular basis
    8) Low dietary intake of potassium, calcium or magnesium k. Excessive use of salt
    9) A diet that is high in fat, fast food or processed foods m. Individual is pregnant

Assessment:

- Obtain vital signs and document on the Health Record
- Have individual refrain from smoking or ingesting products that contain caffeine for 30 minutes before measurement. (can cause a transient raise in blood pressure)
- Have individual sit in a chair with feet flat on the floor or lay supine, arms bared and supported at heart level
- Rest for at least five minutes before beginning blood pressure measurement. This helps eliminate activity-related factors that can cause elevation in blood pressure.
- Make sure to use the appropriate size cuff for the size of the arm (using the wrong size cuff

results in inaccurate readings)

- Wrap cuff smoothly and snuggly around the upper arm, with the center of the bladder placed directly over the bend in the elbow and the cuff's lower edge placed about 2 fingers width above the bend. (incorrect placement will yield inaccurate readings)
- Take 2 or more readings, separated by 2 minutes and record. (averaging two or more readings from the same arm improves the reliability of the data)

Classification of Blood Pressure for Adults

Classification	**Systolic**	**and**	**Diastolic**
Normal	<120	or	<80
Elevated	120-139	or	80-90
Stage 1 HTN	140-159	or	90-99
Stage 2 HTN	≥160	or	≥100

- ❖ 130/80 is considered the upper limit of normal;
    a. In a pregnant woman, (at any time during the pregnancy)
    b. If a individual has chronic kidney disease or diabetes

Call Local EMS/911 for:

- Chest pain or discomfort or sudden signals of stroke think F.A.S.T.
- Blood pressure is 180/110 or higher
- Swelling of hands, feet and/or face
- Sudden, severe headache
- Sudden, rapid rise in BP
- A pregnant individual with a BP >145/85
- If a pregnant individual has a history of preeclampsia
- A individual with a history of diabetes or kidney disease and a BP >160/95 (or health care system depending on co-morbidity).

Refer to Local Health Care System:

- If individual has any of the risk factors stated above
- If individual has been monitored daily for 5 days, and the average BP is in the elevated stage
- If individual has never been diagnosed or treated for HTN
- If individual has been treated, and following prescribed treatment and BP is still elevated
- If the individual is pregnant
- If the individual has multiple health problems (co-morbidity)

Treatment:

- Confirm elevated blood pressure
- Set up the individual with a daily visit to HS and record the BP on the Health Record on health services record for 5 days in a row. Average the blood pressure readings.
- Complete initial assessment, evaluate, accurately stage and complete risk assessment
- Is secondary cause suspected?
- Engage individual in Lifestyle modification education
- Consider referral

Additional Considerations:

- Despite what many people think, high blood pressure usually does not cause any symptoms. It is often called the "silent killer" for this very reason. By the time a person has symptoms such as severe headaches, dizziness or lightheadedness; they may have had untreated hypertension for an extended period of time, and have already developed complications.

Adjustments by Local Physician:

Childbirth, Emergency

Treatment Goal:

- Prevent injury to individual or child
- Transfer individual to medical facility as soon as possible

Possible Causes:

- Full-term or pre-term delivery:

Note: If early in pregnancy and individual is experiencing contractions/abdominal cramps and/or vaginal bleeding, see Miscarriage protocol.

History:

- Onset of contractions and how frequently (in minutes) individual is having contractions
- Number of pregnancies carried to term in past
- Any medical problems during pregnancy
- Past medical history
- Current medications

Assessment:

- Obtain vital signs and document

Call Local EMS/911 for:

- Contractions that are more frequent than every five minutes
- If the individual feels the need to "push"
- A pregnant individual who is in labor and has history of short labors

Refer to Local Healthcare System:

- Any individual who has reported bloody show or leaking of fluid (water breaking)
- Any individual who reports having "regular" contractions

Treatment: Always use standard precautions

- If at all possible, transfer individual to a medical facility for delivery. If transfer is not possible, attempt to receive guidance from a physician or EMS dispatcher over the telephone.
- Place clean sheets or newspaper over a mattress or, if necessary, on the floor and have the mother lie on her back with her knees bent, feet flat and knees/thighs wide apart. Head and shoulders should be raised.
- Ensure privacy.
- Sterilize a knife or scissors by either boiling in water for at least five minutes or holding over a flame for 30 seconds. If boiling, leave the utensil in the water until ready to use. This will be used to cut the umbilical cord.
- Before delivery, gather together a blanket or towel to wrap the baby, strong string or shoelaces to tie off the umbilical cord, a pail (in case the mother vomits), a large plastic bag or container for the afterbirth (placenta), sanitary napkins and diapers.
- For delivery, wash your hands with soap and water and put on clean exam gloves.
- Do not place your hands or other objects inside the vagina.

- Once the baby's head is out, guide and support it to keep it free from blood and other secretions. Check to make sure the umbilical cord is not wrapped around the baby's neck. If the cord is wrapped around the baby's neck, gently and quickly slip the cord over the baby's head. If too tight to slip over the head, the cord must be cut now to prevent the baby from strangling.
- Continue to support the head as the baby is being born. The baby will be very slippery so be very careful. Once the head and neck are out, the baby will turn on its side to allow passage of the shoulder. The upper shoulder usually emerges first. Carefully guide the baby's head slightly downward. Once the upper shoulder is out, gently lift the baby's head upward to allow the lower shoulder to emerge. Do not pull the baby out by the armpits. Carefully hold the baby as the rest of the body slides out. Note the time of delivery.
- To help the baby start breathing, hold the baby with his or her head lower than the feet so that secretions can drain from the lungs, mouth and nose. Support the head and body with one hand while grasping the baby's legs at the ankles with the other hand. Gently wipe out the nose and mouth with sterile gauze or a clean cloth.
- If the baby has not yet cried, slap your fingers against the bottom of the baby's feet or gently rub the baby's back. If unsuccessful, give artificial respiration through both the baby's mouth and nose, keeping the head extended.
- Once breathing, wrap the baby (including the top and back of the head) in a blanket or sheet to prevent heat loss. Place the baby on his or her side on the mother's stomach with the baby's head slightly lower than the rest of the body and facing the mother's feet. The umbilical cord should be kept loose. It is very important to keep the baby warm and breathing well.
- It is not necessary or desirable to cut the umbilical cord right away. If possible, wait about a minute until the cord stops pulsating. If the mother can be taken to the hospital immediately after the delivery of the afterbirth (which occurs 5 to 20 minutes after delivery of the baby) then the baby can be left attached to the umbilical cord and afterbirth. If you must cut the cord, tie a clean string around the cord at least four inches from the baby's body. Tie the string tight enough to cut off circulation in the cord. Using a second piece of string, tie another tight knot two to four inches past the first knot (approximately six to eight inches from the baby). With the sterilized utensil, cut the cord between the two ties.
- For delivery of the afterbirth, be patient. Do not pull on the umbilical cord to speed the delivery of the afterbirth. The mother's contractions will eventually push out the afterbirth. Place all afterbirth in a container and take it with the mother and baby to the hospital so that it may be examined.
- After delivery, place sanitary napkins against the mother's vagina to absorb blood. To help control bleeding, place your hands on the mother's abdomen and gently massage the uterus, which can be felt just below the mother's navel and feels like a large smooth ball. Do this every five minutes for an hour, unless medical assistance has arrived. If the bleeding is very heavy and/or prolonged, seek medical attention immediately. Keep the mother warm and comfortable.
- Encourage the mother to drink fluids.

See also: Abdominal Pain, Cramps – Abdominal.

Adjustments by Local Physician:

Death/Serious Injury in Shelter or Disaster Facility

Treatment Goal:

- Provide privacy and support to family/other shelter residents
- Contact appropriate authorities
- Document correctly
- Initiate condolence team- Behavioral Healthcare.

Possible Causes:

- Death or serious injury could be due to natural causes ("old age"),
- Exacerbation of a pre- existing condition, acute medical event (myocardial infarction), or
- An accident or criminal activity.

Call Local EMS/911 for:

- All situations requiring emergency medical care beyond the scope of HS protocols

Management:

- Use protocols outlined in the Ashe County Sheltering plan, Additional Operational Guidelines- Critical Illness, Injury or Fatality section.
- Use other shelter personnel to provide for privacy and to support family members or other concerned shelter residents or individuals
- Contact local EMS to provide emergency medical care. EMS will determine the severity of the situation and do further notification if a death is involved. Follow the directions of the local EMS and avoid disturbing the scene of the incident.
- Contact local law enforcement if a criminal act is suspected. Follow the directions given by local law enforcement authorities. Also contact the Life, Safety and Asset Protection manager on the disaster relief operation or, if not available, contact the Life Safety and Asset Protection lead in the Disaster Operations Center at national headquarters.
- Complete a County Incident Report and documenting all known information about the individual and the incident.
- The Shelter Manager will notify Mass Care Coordinator with report of incident. The Mass Care Coordinator will ensure that EOC is notified.
- Fax copies of the Health Record and the County Incident Report to the EOC.

Additional Considerations:

- Any death or serious injury in a shelter should be handled with the utmost consideration and respect for the individual and his or her loved one. Ensure privacy for both the body and the remaining family and friends. Behavioral Health workers should be consulted to provide additional support.
- Document all events on the individual's shelter record and County Incident Report very carefully and provide whatever support is required by local EMS and law enforcement.

Adjustments by Local Physician:

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Diabetic Emergencies

Treatment Goal:

- Prevent injury to individual
- Assess for more serious health condition
- Replace medications if lost/damaged due to disaster

Possible Causes:

- There are two types of diabetic emergencies: hyper- and hypoglycemia. Hyperglycemia (high blood sugar) can be caused by stress, illness, diet or lack of adequate control with diabetic medications. Diabetic ketoacidosis (DKA) is a particularly severe form. Hypoglycemia (low blood sugar) can be caused by over-treatment with diabetic medications and/or lack of adequate food intake.

History:

- Major signs and symptoms of diabetic emergencies are similar
- Type of diabetes: Type I (insulin-dependent) or Type II (non-insulin dependent)
- Normal daily blood sugar, if known (self-monitored)
- Type and dosage of diabetes medication taken and date/time of last dose
- Date/time and content of the last meal consumed and if there has been a recent change in diet
- Recent injury, infection, surgery or emotional stress
- Excessive thirst and/or drinking more water than usual
- Increased frequency and amount of urination
- Nausea and/or vomiting
- Confusion or loss of consciousness
- Abdominal pain
- Increased nervousness/anxiety
- Feeling or looking ill
- Shakiness/tremors
- Hunger
- Sweating (diaphoresis) and/or paleness

Assessment:

- Obtain vital signs and document
- Tachycardia and tachypnea can be a sign of DKA
- Abnormal pulse (rapid or weak)
- Assess mental status for signs of confusion
- Assist individual, if necessary, in checking capillary blood sugar
- Assess level of consciousness
- Assess hydration status (skin turgor, mucous membranes, etc.)

Call Local EMS/911 for:

- Any individual with confusions or a change in level of consciousness
- Any individual with a blood sugar level greater than 300 for insulin-dependant diabetics or greater than 600 for non-insulin dependent diabetics
- Any individual with a blood sugar level less than 50 for adults or less than 40 for infants

and children that does not respond to oral glucose

- Any individual with a symptomatic low blood sugar that does not feel better within five minutes of taking in sugar or carbohydrates

Refer to Local Healthcare System:

Any individual with a blood sugar greater than 300

Treatment:

Note: If blood sugar is unknown, it may not be necessary to differentiate between insulin reaction and diabetic coma because the basic care for both conditions is the same and will not hurt the individual until advanced medical care arrives. If individual is conscious, give him or her sugar. Most candy, fruit juices and non-diet soft drinks have enough sugar to be effective. If the person's problem is hypoglycemia, the sugar will help quickly. If the person has hyperglycemia, the excess sugar will do no further harm.

- **Hyperglycemia** (blood sugar greater than 200): Encourage individual to treat their blood sugar with their normal amount of insulin (sliding scale) or medication, if available. If insulin is unavailable, refer individual to local healthcare system for treatment. Encourage individual to drink water or other sugar-free non-carbonated fluids. Have individual recheck their blood sugar one hour after treatment.
- **Hypoglycemia** (blood sugar less than 50 for adults and less than 40 for infants/children): Have individual recheck their blood sugar as abnormal values are frequently inaccurate. If value is still low or individual is experiencing symptoms of hypoglycemia, encourage individual to eat or drink a snack containing sugar or carbohydrates (fruit juice, candy, crackers, etc.) – but only if fully conscious. If individual is confused but conscious, apply a glucose substance under the tongue (honey or cake frosting work well). Check vital signs frequently and if possible have the individual check blood sugar level every 15 minutes until stable and greater than 70.

Additional Considerations:

- Signs of hyperglycemia include excessive thirst and/or drinking more water than usual, increased frequency and amount of urination, nausea and vomiting, and abdominal pain. Hyperglycemia may lead to diabetic ketoacidosis (DKA) or hyperglycemic hyperosmolar state (HHS). Both are medical emergencies.
- Signs of hypoglycemia include increased nervousness and/or anxiety, shakiness, shivering, hunger, sweating, paleness, hypotension and/or tachycardia. Hypoglycemia is sometimes referred to as "insulin shock" and is a medical emergency.
- Experienced individuals often recognize the difference between hyper- and hypoglycemia by how they feel.
- Blood sugar levels that fall outside of the normal ranges preset in a glucometer are frequently unreliable and should be rechecked. When in doubt, treat for hypoglycemia.
- In severe cases of both hyper and hypoglycemia, individuals can become confused or even unconscious.

See also: Seizures/Convulsions, Dizziness, Fainting, Confusion, Anxiety.

Adjustments by Local Physician:

Immune-Compromised Shelter residents

Treatment Goal:

- Prevent injury to individual
- Reduce risk of infection

Possible Causes:

- Immune deficiencies could be caused by congenital disorders or through acquired means such as cancer, kidney failure, liver/spleen disease, HIV/AIDS or malnutrition.
- Deficiencies in the immune system can also be caused by certain medications, specifically cancer therapies, organ transplant medications and corticosteroids.

History:

- Type of immune-deficiency (congenital vs. acquired infectious vs. noninfectious)
- Presence of any current infections
- Past medical history
- Current medications taken

Assessment:

- Obtain vital signs, paying special attention to temperature
- Assess for signs and/or symptoms of infection

Refer to Local Healthcare System:

- Any illness or infection that may affect the wellbeing of the individual

Treatment:

- Use universal precautions for all possible exposures to blood or body fluids
- Provide all shelter residents with a clean and sanitary environment. Encourage hand washing by verbally reminding shelter residents as well as posting appropriate signage.
- When possible in a shelter, offer the immune-compromised individual a separate living space or arrange for alternate housing (hotel, trailer, etc.)
- Identify shelter residents who may potentially be infectious (with influenza, etc.)
- and move them to the Isolation Care Area of the shelter
- When there has been a spill or accident involving the body fluids of someone infected with the HIV virus, use standard precautions (appropriate for the situation) and an alcohol-based cleaning product to thoroughly clean the soiled equipment and environment. Be sure to dispose of soiled materials in a biohazard container. To prevent exposure, ideally shelter residents could clean up their own spill.

Additional Considerations:

- HIV/AIDS is the most common acquired immune-deficiency
- Individuals who are immune-compromised may be more susceptible to severe infections. Frequently, minor illnesses and infections progress to more serious illnesses in those who are immune-compromised
- Aside from HIV/AIDS, most other causes of immune-deficiency are not infectious and there is no need to treat the individual as such
- HIV/AIDS cannot be spread by touching intact skin, so there is no need to wear gloves unless there is a possibility of blood or body fluid exposure

See also: Infection, Fever.

Adjustments by Local Physician:

Infection

Treatment Goal:

- Identification of infectious process
- Proper treatment or referral
- Reduce complications
- Assess for more serious health condition

Possible Causes:

- Infection can be caused by any number of microorganisms: bacterial, viral or fungal. Signs and symptoms of infection will depend on the location and source of the infection.

History:

- Onset of symptoms
- Location of wound, if present
- Pain score (0-10 scale)
- Nausea and vomiting, generalized malaise, chills
- History of immune-deficiency
- Past medical history
- Current medications taken

Assessment:

- Obtain vital signs, pay particular attention to an elevated temperature and document
- Assess wound (if present) for redness, swelling, pus, hardening of the tissue or red streaks that originate at the wound

Refer to Local Healthcare System:

- All shelter residents with signs and symptoms suggestive of an infection

Treatment

- For wounds, see Cuts and Scrapes protocol
- For potential respiratory infection, see Congestions – Lower Respiratory protocol and Cough protocol
- For potential urinary tract infection, see Urination, Difficulty With protocol
- For potential vaginal infection, see Vaginal Discharge/Itching protocol
- For potential eye infection, see Eye Inflammation/Pain protocol
- For potential ear infection, see Earache protocol
- For potential influenza, see Influenza-Like Illness protocol
- See Fever protocol

See also: Fever.

Adjustments by Local Physician:

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Miscarriage/Missed Abortion/Spontaneous Abortion

Treatment Goal:

- Early recognition and identification of possible miscarriage
- Timely referral for OB/GYN evaluation

Possible Causes:

- Threatened fetal loss or Fetal loss before week 20 of pregnancy: May be complete or incomplete loss of fetal tissue
- Miscarriages are common and can occur naturally or due to trauma and/or injury to
- mother. May be due to uterine anomaly, incompetent cervix, fetal genetic factors

History:

- Onset and type of symptoms (abdominal cramping, abdominal pain, vaginal bleeding, etc.)
- Weeks gestation
- Number of previous pregnancies
- History of miscarriage in the past
- Past medical history; with attention to autoimmune disease, diabetes, infections
- Current medications

Assessment:

- Obtain vital signs and document on Health Record

Call Local EMS/911 for:

- Any pregnant individual who experiences heavy or continuous bleeding
- Any pregnant individual who has abdominal pain
- Any individual that is tachycardic or hyper/hypotensive.
- Any individual that has both cramping and bleeding that occurs together

Refer to Local Healthcare System:

- All pregnant shelter residents who experience abdominal cramping or vaginal spotting

Treatment:

- Encourage the individual to rest in most comfortable position possible until advanced medical assistance arrives
- Protect woman from getting chilled or overheated
- Take steps to minimize shock if profuse vaginal bleeding
- Provide for privacy
- If any tissue or unusual-looking clots pass, save in a container to bring to the doctor's office for inspection

Additional Considerations:

- Miscarriages occur in approximately ten percent of pregnancies, usually within the first twelve weeks of pregnancy

See also: Abdominal Pain, Bleeding, Cramps – Abdominal.

Adjustments by Local Physician:

Poisoning: National Poison Control Center 1-800-222-1222

Treatment Goal:

- Prevent injury, illness or death from poisonous substance
- Appropriate decisions about care and referral-Poison Control Center will direct these decisions
- Determination of life-threatening vs nonlife-threatening exposure to poison

Possible Causes:

- Poisoning can be either intentional or unintentional. Poisons can enter the body through ingestion, injection, inhalation, absorption. Prescription and non-prescription medications, household products, toxic gases and certain foods are the most common causes of poisoning but any substance, taken in sufficient quantity, can be harmful.

History:

- Name and amount and location of substance, if known
- Time frame since poisoning
- How it entered the body
- Intentional (suicidal gesture) or unintentional
- Past medication history
- Current medications taken

Assessment:

- Obtain vital signs and document on Health Record
- Assess for level of consciousness and respiratory and circulatory status
- Question if individual is pregnant or possibly pregnant-important for poison control reporting
- Assess pupil size and reaction to light
- Record symptoms-look for nausea, vomiting, diarrhea, chest or abdominal pain, breathing difficulties, sweating, loss of consciousness, seizures, burn injuries around/in mouth or skin, headache, dizziness, weakness, irregular pupil size, burning or tearing eyes, abnormal skin color

Call Local EMS/911 for:

- Any individual who has been exposed to a toxic substance and is confused or has abnormal vital signs
- Any individual who intentionally exposes himself/herself or another person to a harmful substance

Refer to Local Healthcare System:

- All other cases of exposure or suspected exposure to a harmful substance

Treatment:

- Call local poison control number, then follow-up with either local EMS (for unstable shelter residents) or the national phone number for the poison control center (1-800-222-12220)
- Follow the directions of the poison control center:
    - ❖ If ingested, do not give anything to eat and drink unless specifically directed to do

so by poison control

- ❖ Remove individual from source of poison if necessary and possible
- ❖ For ingested poisons- If directed by poison control center- give individual syrup of ipecac or activated charcoal. Follow dosage instructions per individual age/weight
- ❖ Apply clean exam gloves in situations where contact with the hazardous substance is possible. Remove individual from exposure, if possible (chemical spill, toxic gas, etc.)
- ❖ If dry substance, use gloved hand or cloth to brush off chemical. Even though dry chemicals can be activated by water, continuous running water in most cases will flush the chemical from the skin before the water can activate it
- ❖ If substance is present on the skin or in the eyes, and if directed so by poison control, flush the area with copious amounts of water. (shower with cool water), and continue to do so until advanced medical care arrives. If treatment is required, transfer individual to a local medical facility.
- ❖ If individual vomits, use a clean container to save some of the vomit to send with individual to hospital
- ❖ If it is safe and possible, send the substance or container to the hospital with the individual to assist with diagnosis and treatment
- ❖ Food poisoning symptoms can start between 1-48 hours after eating contaminated food. If suspected food poisoning in a shelter environment, the shelter manager must be notified immediately
- ❖ Victims of inhaled poisons need oxygen as soon as possible. If available and trained to do so, administer oxygen at 2 liters/min until advanced help arrives

Additional Considerations:

- Children and older adults are at highest risk for unintentional poisoning; children from getting into household products and older adults from confusion over medications.
- There is a National Association of Poison Control Centers for more information.

See also: Abdominal Pain, Breathing Problems, Seizures/Convulsions, Diarrhea, Dizziness, Fainting, Indigestion, Confusion/Disorientation, Nausea/Vomiting, Rash.

Adjustments by Local Physician:

Pregnancy

Treatment Goal:

- Maintain a healthy pregnancy

History:

- Weeks of pregnancy and anticipated due date
- Number of previous pregnancies and deliveries
- Past medical history
- Current medications taken

Assessment:

- Obtain vital signs and document.

Refer to Local Healthcare System:

- Any pregnant individual with no prenatal care
- Any vaginal bleeding
- Stomach pain or cramps
- Persistent vomiting
- Severe, persistent headaches
- Swelling of the face or fingers
- Blurring or dimness of vision
- Chills and fever
- Sudden leaking of water from the vagina
- Seizures
- Difficulty breathing
- High blood pressure

Management and Health Teaching:

- Encourage the individual to eat well, including fruits, vegetables and fiber in her diet.
- A prenatal vitamin containing iron and folic acid may be recommended by the individual's physician.
- The individual should consult with her physician before taking any medication, even over-the-counter medications, as they may be contraindicated in pregnancy.
- Ensure all pregnant shelter residents continue with regular prenatal visits, even if she has no complaints. Assist with appointments in local area if individual is displaced for any length of time.

See also: Dizziness, Fainting, Nausea/Vomiting, Abdominal Pain, Emergency Childbirth.

Adjustments by Local Physician:

Rape/Sexual Assault

Treatment Goal:

- Prevent further injury to individual
- Preserve potential evidence

Possible Causes:

- Unwanted fondling or (forceful) intercourse

History:

- Avoid questioning individual about details surrounding the incident as this information may become part of a criminal investigation

Assessment:

- Obtain vital signs
- Assess for cuts, bruises or burns that require immediate attention

Refer to Local Healthcare System:

- All suspected cases of rape and sexual assault

Management and Health Teaching:

- Call the police immediately to report the crime
- Comfort the individual and provide emotional support. Consult with Behavioral Healthcare and the Life Safety and Asset Protection activity. Do not leave the individual alone.
- Treat noticeable injuries like cuts, bruises or burns that require immediate care
- Encourage the individual to NOT change clothes, shower or bathe, brush his or her teeth, or eat and/or drink anything as this may hinder the ability to collect evidence
- Refer individual to a trusted physician or to the local emergency department for medical treatment
- Preserve any evidence
- Maintain safety for yourself as well as individual
- Be aware that in a confused disaster environment, sexual predators may seek out victims that may include children as well

Additional information:

- Rape is a crime in every state
- Sexual assault includes forced vaginal or anal intercourse, oral sex, penetration with an object, and/or forced touching or fondling

Adjustments by Local Physician:

Shock

Treatment Goal:

- Prevent injury to individual
- Assess for more serious health condition

Possible Causes:

- There are several types of shock which are caused by various conditions. Anaphylactic shock is caused by an allergic reaction to a medication, food or insect sting. Cardiogenic shock can result from myocardial infarction or other cardiac disease. Shock can also be caused by a severe injury that results in heavy blood loss or lack of oxygen. Insulin shock is due to hypoglycemia and septic shock is caused by a severe infection

History:

- Known allergies to foods, insect stings or medications
- Past reactions to allergens
- Cardiac disease, past history of MI
- Recent trauma or injury
- Recent fever, infection or illness
- For diabetics, time and amount of last dose of insulin and time and quantity of last meal

Assessment:

- Obtain vital signs and document.
- Pulse may be rapid and weak and breathing may be rapid and shallow
- Drop in blood pressure
- Look for other signs of shock which include: restlessness, irritability, excessive thirst, N&V
- Look for signs of bleeding and, if possible, stop it immediately
- Assess respiratory and circulatory status ; rapid and weak pulse
- Level of consciousness; drowsiness, loss of consciousness
- For diabetics, capillary blood glucose level
- Assess skin for sweating, paleness, ashen, bluish cool, moist skin
- Check pupils for size and reaction to light

Call Local EMS/911 for:

- All cases of suspected shock, regardless of cause

Treatment:

- All types of shock, regardless of cause, are medical emergencies and local EMS
- should be contacted immediately
- If individual is not breathing effectively or has no pulse, initiate CPR
- Keep the individual lying down with feet elevated 8-12 inches (if the individual is conscious and does not have injuries to the back, neck or head)
- Further treatment will depend on the cause of shock
- If available, anaphylactic shock can be treated with an anaphylaxis emergency kit
- (Epi-pen) while waiting for EMS to arrive, if individual has his or her own kit
- For shock due to volume loss (e.g., bleeding), attempt to prevent further loss of fluid
- Insulin shock can be treated with food containing sugar (fruit juice, honey, sugar water), if

individual is conscious
- For suspected septic shock, keep the individual lying down and cover with a light blanket until EMS arrives

Additional Considerations:

- Call 911 immediately for any individual that is confused, hypotensive or severely tachycardic

See also: Bleeding, Seizures/Convulsions, Dehydration, Diarrhea, Fever, Confusion /Disorientation, Infection, Chest Pain/Pressure, Stroke.

Adjustments by Local Physician:

Stroke

Treatment Goal:

- Prevent injury to individual
- Decrease chances of permanent damage by rapid assessment and transport to higher level of care

Possible Causes:

- Strokes are caused by a lack of oxygen to the brain caused by either a bleed in an artery
- (hemorrhage) or by a blood clot

History:

- Onset of symptoms – are symptoms still present or have they subsided?
- Presence of headache before or in conjunction with facial paralysis
- Sudden paralysis or weakness on one side of the body with facial drooping
- Loss and/or slurring of speech
- Loss of vision in one eye or visual field in both eyes
- Mental confusion
- Lack of muscular coordination
- Loss of bladder and/or bowel control
- History of blood clots or previous TIA/CVA
- Current medications, especially aspirin or other blood-thinner
- Pain behind one ear or piercing pain of the face, scalp or ear

Assessment:

- Check scene, then check person
- Obtain Consent
- Sudden signals of stroke, THINK F.A.S.T.
- Face- weakness on one side of the face and ask the person to smile
- Arm- Weakness or numbness in one arm ask the person to raise both arms
- Speech – slurred speech or trouble getting words out Ask the person to speak a simple sentence
- Time- Note time when signals were first observed
- Obtain vital signs, paying special attention to an elevated blood pressure
- Assess individual's coordination of movements and ability to move upper and lower extremities
- Assess the individual's ability to walk, observing gait and balance
- Check pupil size and reaction to light
- Assess facial symmetry. Look for differences between features of the right and left side of the face (e.g. smile/frown, raise eyebrows) and presence/absence of eyelid drooping.

Call Local EMS/911 for:

- All cases of facial drooping or paralysis, and/or can't speak
- All suspected cases of TIA or stroke

Treatment:

- If unconscious, maintain open airway
- Monitor ABCs

- Get the individual to an acute care facility as quickly as possible
- Do not give individual anything to eat or drink
- Do not give individual any medications
- Place individual on their weakened side so secretions can drain from the mouth
- Have the individual to rest quietly until local EMS arrives
- Provide privacy
- Comfort the individual and family as much as possible

Additional Considerations:

- A individual's prognosis improves when they can be transferred to an acute care facility for diagnosis and treatment within 30 minutes of onset of symptoms.

See also: Paralysis/Weakness – Facial or Limb, Seizures/Convulsions, Headache.

Adjustments by Local Physician:

Substance Abuse/Withdrawal

Treatment Goal:

- Early recognition of withdrawal symptoms
- Care appropriate and timely referral to appropriate setting

Possible Causes:

- Substance abuse can be caused by taking in excessive and persistent amounts of alcohol, illicit drugs and/or prescription medications taken outside the usual standards of medical practice or medical need. Steroids, growth hormone, diuretics and laxatives are also commonly abused substances. Withdrawal symptoms are caused when the individual stops using the addictive substance.

History of substance abuse:

- Recent change in mood or behavior
- Slurred or incoherent speech
- Sudden loss of weight or inattention to personal hygiene
- Past drug use/abuse (type of drug, amount taken, last time drug was used)
- Past medical history
- Current medications taken

History of withdrawal:

- Nervousness, sleeplessness
- Nausea, vomiting, diarrhea (heroin)
- Muscle pain
- Agitation, hallucinations (alcohol)
- Last use of substance
- Length and frequency of prior use
- Past medical history
- Current medications taken

Assessment:

- Obtain vital signs, if individual is cooperative and document
- Assess level of consciousness, orientation to person, place and time
- Observe movements for coordination
- Listen for slurring of speech or nonsensical conversation
- Check arms and legs for signs of injection marks
- Smell for the scent of alcohol
- Check pupils for size and reaction to light

Call Local EMS/911 for:

- Any individual who appears to be intoxicated or under the influence of a harmful substance and has an altered level of consciousness (difficult to arouse) as they may experience a drug-related emergency (overdose) or may attempt to harm themselves or others
- Any individual with an altered level of consciousness or confusion
- Call local law enforcement if individual becomes aggressive or uncooperative with efforts to help

Refer to Local Healthcare System:

- Any known or suspected alcoholic that has not had access to alcohol recently and is experiencing symptoms of alcohol withdrawal
- Any known or suspected drug abuser that has not had access to their substance recently and is experiencing symptoms of withdrawal

Treatment:

- First, assess whether the situation is one that can be handled safely or if outside help is needed. If individual is sleeping with normal breathing, and can be easily aroused, no immediate treatment is required.
- If unconscious, make sure the individual is breathing. Initiate CPR, if necessary, and contact local EMS.
- If conscious and under the influence of a harmful substance, ask the individual what drug he or she took, the amount and when it was taken. Contact local EMS and convey this information to them. Keep individual awake and talking until EMS arrives. If individual becomes aggressive, keep yourself and others away from individual until help arrives – DO NOT attempt to restrain individual. Consult with Life Safety and Asset Protection, if necessary.
- If vomiting, place individual on his or her side to help prevent emesis from entering the lungs.
- Alcoholics who are experiencing symptoms of withdrawal typically self-medicate themselves by drinking.
- Refer individual to Behavioral Healthcare worker and the local health care system if individual would like information regarding rehabilitation.

Additional Considerations:

- Signs of drug usage and treatment will depend on the particular substance being abused.
- Nearly eight percent of the US population has a problem with alcohol use, with men being four times more likely than women to become alcoholics.
- Alcohol withdrawal symptoms usually occur 12-48 hours after the individual
- stops drinking and are characterized by sweating, weakness, tremors and perhaps seizures and hallucinations.

See also: Nausea/Vomiting, Anxiety, Diarrhea, Seizures/Convulsions.

Adjustments by Local Physician:

Violence/Domestic Abuse

Treatment Goal:

- Identify potential cases of abuse and/or neglect
- Report such cases to the appropriate authorities
- Maintain safe environment

Possible Causes:

- Abuse can be seen in various forms – emotion, physical or sexual – and usually involves a family member, neighbor or some other adult

History:

- Frequent complaints of pain or illness
- Injury that does not fit the description of what caused it
- Pain during urination
- Frequent broken bones
- Excessive aggression
- Social withdrawal or depression
- Child who has an unusual fear of adults

Assessment:

- Obtain vital signs and document
- Observe for signs of malnutrition or unkempt appearance (possible neglect)
- Check skin for unexplained bruises, burns or cuts that may be at various stages of healing (physical abuse)

Call Local EMS/911 for:

- Any serious injury to a individual
- Notify local law enforcement of any violent or threatening behavior in a individual in shelter

Refer to Local Healthcare System:

- Any individual suspected of being physically or sexually abused

Treatment:

- Provide comfort to the individual and treat noticeable injuries such as cuts, bruises or burns
- Consult with a Behavioral Healthcare worker and Life Safety and Asset Protection regarding the most appropriate referral
- If child abuse or elder abuse is suspected, local authorities should be contacted
- Suspected cases of sexual abuse or rape should be reported to local law enforcement. See Rape protocol.
- Be aware that in the shelter environment that tensions will be heightened and there may be increased risk for violence among shelter residents
- Stay aware of environment
- Consult with Behavioral Healthcare to strategize regarding stress reduction in at risk families and shelter residents

Additional Considerations:

- Many states have laws that require health professionals to report suspected cases of violence, abuse or neglect. If you are unsure of the law in the state where you are working,

refer all suspected cases to the local healthcare system so they may take appropriate actions.

- Children and older adults are at higher risk of being abused than the general population

See also: Arm/Hand Injury and Pain, Bleeding, Bruising, Burns, Cuts and Scrapes, Leg/Foot Injury and Pain, Rape/Sexual Assault.

Adjustments by Local Physician:

IV. Communicable Diseases

COVID 19
SARS-

Prevention:

- Sanitation and protection measures should be in place
- Provide mask and PPE
- Provide hand sanitizer and promote hand-washing with disposable towels
- Provide tissues and no-touch receptacles (i.e., waste container)
- During periods of increased community risk encourage social distancing

Treatment Goal:

- Prevent spread
- Relieve discomfort
- Differentiate from other viral illnesses
- Therapeutic management
- Accelerating recovery

Causes:

- Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus.

History:

- Fever
- Cough
- Tiredness
- Loss of taste or smell
- Difficulty breathing or shortness of breath
- Loss of speech or mobility, or confusion, chest pain

Assessment:

- Obtain vital signs and document on Health Record
- Note presence fever
- Note recent exposure
- Administer rapid test then isolate with-in shelter or place in non-congratulate shelter
- Follow all current CDC protocols

Refer to Local Healthcare System:

- High risk individuals: older adults, those with underlying medical condition, etc.
- Any of the following symptoms: trouble breathing, persistent pain or pressure in the chest, new confusion, inability to wake or stay awake, pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone.

Treatment:

- Antivirals
- Treat symptoms

Additional Considerations:

- Support social distancing
- Consider Non-congratulate shelter operations during community risk
- Developing and implementing sanitation and protection measures

Adjustments by Local Physician:

Fifth Disease

Treatment Goal:

- Relieve discomfort
- Prevent spread to pregnant women
- Differentiate from other viral illnesses causing rashes

Possible Causes:

- Viral disease affecting primarily school aged children, with peak in late winter and early spring generally harmless in children but poses a slight risk to developing fetuses.

History:

- Typical bright red non-tender facial rash producing "slapped cheek" appearance
- Lacy pink rash on the backs of arms, legs, torso, and buttocks
- Rash comes and goes for several weeks in response to changes in temperature and sunlight
- Polyarthritis and arthralgias-usually involving small joints of extremities in symmetric fashion
- Mild fever

Assessment:

- Obtain vital signs and document on Health Record
- Note presence and characteristic of rash
- Note if rash worsened by heat or sunlight
- Note if rash itches or not. (Fifth disease rash is nonpruritic or not itchy)
- Inquire as to initial start of rash (most contagious the week before rash starts)
- Inquire as to who the child was near in week prior to development of rash

Refer to Local Healthcare System:

- Any pregnant woman who reports being exposed to someone with Fifth disease or who exhibits this characteristic rash
- Any child who exhibits high fever (over 102)
- Joint pain worsens or does not improve

Treatment:

- Treatment is supportive only
- Non-steroidal ant inflammatory drugs for arthralgias/arthritis
- Follow manufacturer's dosage instructions for age
- Reassurance to parents that illness is self-limiting and may last 1-2 weeks

Additional Considerations:

- The rash will spare the area around the nose and mouth, so is classic and characteristic of Fifth Disease
- Peak age 5-18 years
- Infection is early pregnancy may result in fetal death (10%) or severe anemia but is usually asymptomatic and is NOT associated with congenital malformations

Hepatitis

Treatment Goal:

- Assist in adequate medical evaluation and referral to public health/health care system
- Prevent transmission of virus to others
- Prevent complications

Possible Causes:

- Inflammation of the liver due to any cause Viral hepatitis (A, B, C, D, E) can be either short lived (acute) or last for at least six months (chronic).
- Non-viral hepatitis is usually caused by excessive alcohol intake or use of certain medications or drugs.
- Hepatitis A and E are caused by infected stool which can be transmitted by improper food handling or eating shellfish taken from a high sewage waterway.
- Hepatitis B, C and D are transmitted through infected blood and body fluids passed to others through sharing of needles (IV drug use or tattoos), contaminated blood, sexual intercourse or from an infected mother to her baby.

History:

- Onset of symptoms
- Poor appetite
- Flu-like symptoms (nausea/vomiting, fever, joint pain)
- Recent darkening of the urine
- Travel overseas or to an underdeveloped country
- Recent bout with food sickness
- IV drug use
- Tattoos
- Unprotected sexual intercourse
- Past medical history
- History of vaccination against Hepatitis A or B
- Current medications

Assessment:

- Obtain vital signs
- Assess skin for presence of red, itchy hives
- Assess skin and the whites of the eyes for a yellow discoloration (jaundice)

Refer to Local Healthcare System:

- All suspected cases of undiagnosed hepatitis
- Any individual with a rash associated with fever
- Any individual who shows signs of jaundice

Treatment

- Prevention: Encourage shelter residents to reduce or eliminate high-risk behaviors – IVdrug use, unprotected sexual intercourse, etc
- Once infected, individual symptoms are managed but there is no treatment for the virus. Alcohol should be avoided.

Additional Considerations:

- Acute viral hepatitis occurs suddenly and usually lasts just a few weeks –

- producing symptoms that range from a mild flu-like illness to liver failure
- Cases of Hepatitis A and E are typically mild (except in pregnancy) and usually resolve without treatment. There are no chronic effects nor does the person become a chronic carrier of the virus. Nonetheless, these cases of hepatitis can lead to outbreaks in unsanitary conditions.
- Vaccination currently exists for only Hepatitis A and B. Those at high-risk of exposure are encouraged to get vaccinated (health care workers, IV drug users, etc.).

See also: Fever, Nausea/Vomiting, Abdominal Pain.

Adjustments by Local Physician:

Herpes

Simplex Viruses (HSV-1 and HSV-2)

Treatment Goal:

- Reduce discomfort
- Prevent transmission to others

Possible Causes:

- HSV-1 and HSV-2 are caused by infection with the herpes simplex virus producing small, painful, fluid-filled blisters on the skin or mucous membranes, is highly contagious and transmitted by direct contact.
    - ❖ Herpes simplex-1 is generally located on the lips or inside the mouth while
    - ❖ Herpes simplex-2 is found on or near the genitalia.

History:

- Onset of symptoms
- Recent occurrence of HSV-1 trigger (fever, menstruation, emotional stress, upper respiratory infection)
- Presence of sores around lips or in the mouth
- Presence of sores in the genital area
- Fever
- Pain score (0-10 scale)
- Headache or body aches

Assessment:

- Obtain vital signs
- Assess inside mouth for swelling of the gums or red, fluid-filled sores on the mucous membranes

Refer to Local Healthcare System:

- Any previously undiagnosed case of potential herpes virus for definitive diagnosis
- If sores have lasted more than 2 weeks
- Any individual with a potential herpes sore in/near the eye

Treatment:

- There is currently no treatment to eradicate the virus. Medication (anti-virals) can help to alleviate some of the symptoms and reduce the time of active infection by a day or two
- Shelter residents experiencing sores should keep the area clean and dry. Placing a cold compress on cold sores may help to alleviate some of the discomfort.
- To help prevent the spread of the virus to others, shelter residents should be encouraged to not kiss, share objects (utensils, cup, toothbrush, etc.), or have unprotected sexual intercourse until the sores have healed completely.

Additional Considerations:

- Although the possibility of spreading herpes virus is higher when sores are present, the virus can be spread to others even when there are no sores present.
- Anyone with eczema (a skin disorder) should avoid a individual with active herpes infection as it may cause a serious skin infection.

See also: Fever; Headaches; Urination, Difficulty With; Vaginal Discharge

Adjustments by Local Physician:

Herpes Virus:

Chickenpox (Varicella Zoster)

Treatment Goal:

- Prevent spread of communicable disease
- Reduce discomfort
- Prevent complications

Possible Causes:

- Exposure to the Varicella-Zoster virus

History:

- Prior immunization for chicken pox
- Medications-especially corticosteroids or cancer chemotherapies
- History of immune disorders
- Onset of symptoms (usually 10-21 days after infection)
- Mild headache
- Fever
- Recent loss of appetite
- Generalized malaise
- Exposure to someone with symptoms of chickenpox

Assessment:

- Obtain vital signs and document on Health Record . Individual may have a slight fever.
- Assess skin for rash. The rash will begin as red flat sores.
- Over 5 days, the rash may spread to cover the trunk of the body extremities, and may cover the face, throat, mouth, ears, groin and scalp as well
- Develops as raised, itchy, fluid-filled blisters
- Gently palpate neck for enlarged lymph nodes
- Be aware of signs of encephalitis: severe headache, stiff neck, unusual sleepiness or lethargy, persistent vomiting

Call Local EMS/911 for:

- Any signs or symptoms of encephalitis
- If there is a fever of 103 or higher

Refer to Local Healthcare System:

- All suspected cases of chickenpox for a definitive diagnosis, and so the individual can be appropriately isolated
- Pregnant or immune-compromised shelter residents who have been exposed to someone with chickenpox
- If sores are in individual's eyes
- Those cases of chickenpox at higher risk of developing complications (elderly adults, infants younger than 12 months, immune-compromised shelter residents, etc.)
- Any rash associated with a fever should be referred for a definitive diagnosis

Treatment:

- Isolate immediately any individual suspected of having chicken pox
- Chickenpox is a highly infectious virus and can be transmitted to others (by airborne droplets) from 2-3 days before onset of symptoms until the last sore has crusted over –

usually about a week after onset of symptoms

- Any individual with chickenpox should be kept isolated from those who do not have immunity (either natural immunity or through vaccination)
- Cool compresses with baking soda added to the water may ease itching
- If asked for medication, oral antihistamines given according to manufacturer direction by age of individual may reduce the itch
- Acetaminophen to relieve the fever, dosage as recommended by manufacturer
- DO NOT give Aspirin to anyone younger than 18 years due to risk of Reye's syndrome
- Keep the skin clean and dry to help alleviate itching and prevent a bacterial infection from developing in the open sores
- It may be helpful to recommend that parents apply mitts or socks over the hands of small children, and to keep their nails trimmed, to help prevent scratching

Additional Considerations:

- Prior to the development of a vaccine in the 1990s, nearly 90 percent of children acquired chickenpox by the age of 15. The vaccine has decreased the number of cases of chickenpox by 70 percent.
- Once an individual recovers from chickenpox, they cannot contract the virus again. However, the virus remains dormant in the body and can reactivate later in life, causing shingles. See Shingles protocol.
- The disease is generally more severe in adulthood
- Encephalitis is a rare but dangerous complication of chicken pox

See also: Rash, Itching – Skin, Headache, Fever.

Adjustments by Local Physician:

Herpes Virus:

Shingles (Varicella Zoster)

Treatment Goal:

- Reduce discomfort
- Prevent complications

Possible Causes:

- Shingles: Re-emergence of the Varicella Zoster virus that has lain dormant since the initial infection with chickenpox. Generally affects one or two of the large nerves that spread outward from the spine. Exact cause of reactivation is unknown but may be linked to a weakened immune system.

History:

- Onset of symptoms
- Presence of chickenpox infection in the past
- Level of pain (0-10 score)
- Generalized malaise
- Presence of fever and/or chills
- Nausea and/or diarrhea
- History of weakened immune system
- History of vaccine

Assessment:

- Obtain vital signs and document on Health Record
- Assess skin for the nerve path along which the sores travel. Sores will be small clusters of fluid-filled blisters.

Refer to Local Healthcare System:

- Early referral may mean effective start of medications that can reduce pain and rash
- Any individual who is showing signs of shingles along a cranial nerve (nerve of the face)
- Any individual who is experiencing a rash with fever to rule-out a more serious condition
- Shelter residents with severe pain not controlled by over-the-counter pain medications

Treatment:

- Until the blisters scab (approximately five days after symptoms start), the affected individual is infectious and should be isolated from those who do not have immunity from Varicella Zoster.
- The pain of shingles can be severe and may even occur before the development of rash.
- For pain management, either a non-steroidal anti-inflammatory drug (ibuprofen or aspirin) or acetaminophen may be effective at reducing discomfort, unless contraindicated. Follow manufacturer's directions for contraindications and dosage.

Additional Considerations:

- During the initial infection with chickenpox, the Varicella virus infects nerve cells (usually the spine or cranial nerves). In a re-emergence, the shingle sores will travel down the nerve path, usually on one side of the body.
- Shingles may affect anyone who has previously had chickenpox but generally affects adults over the age of 50.
- In 25-50 percent of shingles cases in adults over the age of 50, chronic nerve pain (post

herpetic neuralgia) occurs. The pain usually subsides within 1-3 months but, in a few cases, may last for more than a year.

See also: Rash, Itching – Skin, Headache, Fever.

Adjustments by Local Physician:

Influenza (seasonal)

Treatment Goal:

- Assess for more serious health condition
- Prevent spread of infection to others
- Relieve symptoms/discomfort

Possible Causes:

- Various strains of influenza virus

History:

- Rapid or abrupt onset of fever and muscle aches, occasionally associated with a dry cough, headache or sore throat
- Recent contact with a person suspected of having influenza
- History of influenza vaccination (current year only)
- Presence of nausea and/or vomiting may occur in children

Assessment:

- Obtain vital signs
- Temperature will be elevated
- Listen to breath sounds

Call Local EMS/911 for:

- Any individual experiencing problems breathing
- Any individual with confusion or other changes in mental status

Refer to Local Healthcare System:

- Any suspected case of influenza
- Any suspected case of pneumonia
- Any temperature greater than 103˚ F that does not respond to antipyretic therapy

Treatment:

- All suspected cases of influenza in a shelter environment should be isolated and referred to the local health care system for diagnosis before allowing them back in the shelter.
- Confirmed cases of influenza should be isolated in the isolation care area.
- Encourage individual to rest, drink plenty of fluids and avoid exertion until symptoms have resolved.
- Due to the infectious nature of influenza, encourage the individual to minimize contact. Keep in isolation area and assess recovery.
- Fever and muscle aches can usually be managed with acetaminophen and/or non-steroidal anti-inflammatory medications (aspirin, ibuprofen), unless contraindicated.
- Children under the age of 18 should never be given aspirin.

Additional Considerations:

- The influenza virus causes an acute febrile illness usually between the months of December and April in the United States. The classic symptom pattern in adults is rapid onset of fever and Myalgia (muscle aches) occasionally associated with a dry cough, headache or sore throat. Children may present with other symptoms such as rhinitis (runny nose) or vomiting.
- Many people think that a “cold” is the same as the “flu.” Influenza is an infection that causes high fever, chills and severe muscle aches but rarely a runny nose.

- Influenza kills 30,000-40,000 Americans each year, mostly elderly.
- Vaccination against influenza should be encouraged for all at-risk populations on a yearly basis. Vaccinations are generally offered in the fall.
- Children, older adults and those with chronic illnesses are at higher risk for acquiring influenza.
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See also: Back Pain, Congestion, Fever, Headache, Nausea/Vomiting, Neck Pain/Stiffness, Rash, Infection.

Adjustments by Local Physician:

Measles (Rubeola)

Treatment Goal:

- Prevent spread to others
- Prevent or lessen possibility of complications
- Relieve discomfort

Possible Causes:

- Caused by the Rubeola virus

History:

- Onset of symptoms- 2-4 days (runny nose, sore throat, hacking cough and/or red eyes, high fever), 7-10 days, development of rash
- Recent contact with someone presenting with a rash or suspected of having measles
- History of immunization (MMR typically given at age 12-15 months and again at 4-6 years for lifelong immunity)

Assessment:

- Obtain vital signs and document on Health Record. Temperature may get as high as 104˚ F
- Assess skin for red, itchy rash appearing in front of and below the ears and on the neck. After one to two days the rash will spread to the trunk, arms and legs as it fades on the face.
- Assess the mucous membranes inside the mouth for tiny white spots

Refer to Local Healthcare System:

- All suspected cases of measles
- Any case of rash associated with fever

Treatment:

- Measles are highly infectious. Any individual suspected of having measles should be isolated from others who do not have immunity.
- There is no particular treatment for measles. Keep the individual warm and comfortable and give an antipyretic (ibuprofen or acetaminophen) to help reduce fever, unless contraindicated.
- Watch and health teach regarding complications, which can include otitis media, laryngitis, tracheitis, pneumonia, encephalitis

Additional Considerations

- Measles rare today due to the MMR (Measles, Mumps, Rubella) vaccine
- Complications more common in immuno-compromised shelter residents
- The measles are spread by either breathing in infected droplets or by touching items contaminated with infected droplets. Measles is infectious from 2-4 days before a rash presents itself until the rash disappears.
- Immunization is recommended for children between 12 and 15 months of age.
- Immunization is contraindicated for pregnant women or children younger than 12 months.
- A woman who has either had the measles or received vaccination against measles will pass the immunity on to her newborn. The baby will be immune for about the first year of life.

See also: Congestion, Cough, Fever, Rash

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Adjustments by Local Physician:

Meningitis

Treatment Goal:

- Early recognition of illness
- Early treatment
- Early isolation to prevent spread to others
- Prevent or reduce complications

Possible Causes:

- Virus or bacteria that cause inflammation of the meninges in the brain, with increased intracranial pressure. Less frequently, meningitis may be caused by a fungal infection. Transmission is through mucous secretions of mouth and nose (cough, sneeze).

History:

- Onset and severity of symptoms (fever, headaches, stiff neck, sore throat, rash, nausea and/or vomiting)
- Weakened immune system, autoimmune disease
- Recent head injury
- Seizure activity
- History of splenectomy or kidney failure
- Current medications taken – especially immune-suppressants and/or corticosteroids
- Frequent infections of the nose, middle ear, or sinuses
- Recent bout with pneumonia
- Recent hospitalization
- History of sickle cell disease

Assessment:

- Obtain vital signs
- Temperature may be elevated and/or blood pressure may be low
- Check for photophobia (sensitivity to light)
- Assess for altered mental state, lethargy
- Ask individual to try and lower chin to the chest. In people with meningitis this is very painful and may be impossible to perform. Knees may also bend involuntarily.
- Assess skin for presence of red and/or purple splotchy rash

Call Local EMS/911 for:

- Any individual experiencing a headache or fever associated with photophobia or a stiff neck

Refer to Local Healthcare System:

- Any case of rash associated with fever

Treatment:

- All cases of suspected meningitis require diagnosis and treatment at a local health care facility
- If bacterial meningitis has been identified in a shelter resident, the local health department should be notified
- All other residents of the shelter should be watched closely for symptoms of meningitis and/or referred to a local health care facility for possible vaccination or prophylaxis

Additional Considerations:

- Bacterial meningitis occurs most often between the ages of one month and two years of age. Among adults, meningitis is most frequently seen in group settings, i.e.: military barracks or college dormitories
- Children are routinely given vaccination for Haemophilus influenza, the most common cause of childhood meningitis. Vaccination is also recommended against Neisseria meningitis when an outbreak occurs within a group.
- Viral and bacterial meningitis cause similar symptoms, although the viral form of the disease is generally more mild.
- There is no way to differentiate between viral and bacterial illness from physical symptoms alone
- Bacteria infected person can become seriously ill, very rapidly
- Untreated, can be fatal

See also: Headache, Neck Pain/Stiffness, Fever.

Adjustments by Local Physician:

Mumps

Treatment Goal:

- Early recognition of illness
- Early isolation to prevent spread to others
- Assess for more serious health condition
- Prevent or reduce complications

Possible Causes:

- Viral infection

History:

- Onset and severity of symptoms (low grade fever, chills, headache, poor appetite, generalized malaise)
- Swelling and tenderness of one or both parotid glands
- Considerable pain, that makes it difficult to chew, speak
- Increased pain with eating and drinking acidic foods
- Recent contact with someone known or suspected of having mumps

Assessment:

- Obtain vital signs. Temperature may get as high as 103-104˚ F
- Assess for swelling of the salivary glands which can be noted on one or both sides of the face

Refer to Local Healthcare System:

- All suspected cases of mumps for definitive diagnosis.

Management and Health Teaching:

- Most cases of mumps resolve without treatment within two weeks
- Isolate the individual to prevent the spread of disease to those without immunity

Additional Considerations:

- In children, mumps generally presents itself as swelling of the salivary glands. In some cases, especially in adulthood, mumps is characterized by swelling of the testes, brain and pancreas.
- Although mumps can occur year-round, it is most often seen in late winter or early spring and mostly affects children between the ages of 5 and 15 years.
- Vaccination against mumps is routine in the United States between the ages of 12 and 15 months. Those who have received vaccination or have previously had the mumps have immunity for life.

See also: Headache, Fever

Adjustments by Local Physician:

Noroviruses

("Norwalk-like viruses")

Treatment Goals:

- Reduce symptoms
- Prevent dehydration
- Prevent transmission of virus

Possible Causes:

- Direct contamination of food by a food handler
- Contaminated food liquid items such as salad dressing or cake icing
- Contaminated water – oysters from contaminated water
- Contaminated wells and recreational water

History:

- Noroviruses are highly contagious
- As few as 10 viral particles may be sufficient to infect and individual
- Viral shedding occurs with onset of symptoms and may continue for 2 weeks
- 50% of all food borne outbreaks of gastroenteritis can be attributed to noroviruses

Assessment:

- Obtain vital signs especially fever
- Observe for dehydration, excessive vomiting, watery non-bloody diarrhea

Refer to local Health Care:

- Anyone with pre-existing conditions that are exacerbated by the virus such as diabetics should be referred
- Children that dehydrate and fluid intake can't be stabilized may need to be re- hydrated

Adjustments by Local Physician:

Skin Infections-

Bacterial–Impetigo

(Boils, Carbuncles and MRSA-

Methicillin-Resistant Staphylococcus Aureus)

Treatment Goal:

- Reduce symptoms
- Prevent spread of infection to others

Possible Causes:

- Skin infection caused by Staphylococcus aureus or Streptococcus pyogenes bacteria. Bacterial infection that is much more common in children than in adults.

History:

- Usually begins with a break in the skin (cut, scratch, blister, burn)
- Recent cold
- Pain or itching at affected area
- Recent sunburn or insect bite

Assessment:

- Obtain vital signs
- Assess skin for scabby, yellow-crusted sores or small blisters filled with yellow pus usually located around the mouth or under the nose

Refer to Local Healthcare System:

- If impetigo covers area larger than 2 inches in diameter
- Any individual with a rash associated with fever
- Any individual with suspected impetigo that does not begin to resolve after two to three days
- Facial swelling or tenderness

Treatment: **Always use standard precautions**

- Wash with soap and water several times a day to remove crust. Apply an antibiotic cream to the affected area.
- Cover area with gauze, taped well away from sores
- Try to prevent individual from scratching or touching the area as it may spread to other parts of the body
- Individual should be kept away from others and instructed to wash hands frequently as impetigo is highly contagious
- Health teaching points:
- Keep child's fingernails short and clean.
- No sharing of towels, washcloths or bath water
- Adult males should not shave over sores

Additional Considerations:

- Impetigo is common in children and appears mostly on the face, arms and legs
- Bacteria frequently live on the skin without causing infection. Infection may occur when there is a break in the skin (allowing entry of bacteria) or in someone with a weakened immune system.

See also: Rash, Itching – Skin, Burn – Thermal, Bites.

Adjustments by Local Physician:

Skin Infections-

Fungal – Ringworm, Athlete's Foot, Jock Itch

Treatment Goal:

- Prevent spread to others
- Relieve discomfort

Possible Causes:

- Fungal skin infection caused by several different fungi and classified by its location on the body

History:

- Warm, moist climate
- Communal living and/or showering
- Contact with someone known or suspected of having a ringworm infection

Assessment:

- Obtain vital signs and document on Health Record
- Ring-shaped, red/pink scaly rash with a clear center, usually with itching
- Athlete's foot-itching, cracking, blistering, peeling of skin between toes and on soles feet
- Jock itch-severe itching, redness, scaly raised areas on skin of groin and upper thighs. May weep, ooze pus or clear fluid

Refer to Local Healthcare System:

- Any suspected fungal skin infection that does not resolve after 10 days of treatment
- Any skin infection or rash associated with fever

Treatment: **Always use standard precautions**.

- Over-the-counter antifungal creams work well to resolve the infection. Cream should be applied to the affected area twice a day for 10 to 20 days.
- Nail lacquer with an antifungal agent is available for nail fungus – although treatment may take up to a year
- Since the fungus is infectious, close contact with others should be avoided until the infection is gone
- For prevention, keep the skin clean and dry and encourage shelter residents to wash their hands frequently and to wear shower shoes in communal showers or locker rooms

Additional Considerations:

- Ringworm is a fungal infection and does not involve worms but got its name from the ring-shaped patches that develop on the skin.
- Fungal infections of the fingernails and toenails cause discoloration, thickening, cracking and often softening of nails. Difficult to treat

See also: Rash, Itching – Skin.

Adjustments by Local Physician:

Skin Infections-

Parasitic-

Lice

Treatment Goal:

- • Prevent potential spread to others
- • Relieve symptoms

Possible Causes:

- Infestation of lice causing itching of the scalp

History:

- Recent close contact with someone known to have lice
- Intense itching of the head and/or pubic area

Assessment:

- Obtain vital signs and document on Health Record
- Wearing gloves and using a tongue-depressor, inspect the individual's scalp and hair roots for signs of nits (eggs) or the presence of lice

Refer to Local Healthcare System:

- Suspected lice infestation should be referred to confirm diagnosis and to direct treatment

Management:

- The overwhelming majority of cases can be effectively managed with over-the- counter treatments.
- Instruct the individual to avoid contact with others until the lice infestation is treated with medicated shampoo (RID, for example) and any remaining nits are removed with a fine-toothed comb. Dispose of the comb after use.
- All furniture, bedding, clothing and cloth items (e.g. stuffed animals) should be sprayed with a product containing the active ingredient permethrin or washed in the hottest water temperature possible.
- Items may also be placed in plastic bags for two weeks to allow the lice to die.
- Check for the presence of lice on all family members, playmates and any potential close contacts.

Points of Interest:

- A lice infestation can be determined by inspecting the scalp and hair root for small white nits (eggs) that are attached to the hair or the insect itself which is small and dark.
- Lice can infest any part of the body with hair

See also: Itching – Skin, Bites.

Adjustments by Local Physician:

Skin Infections-

Parasitic-

Pinworms

Treatment Goal:

- Prevent spread to others
- Relieve discomfort

Possible Causes:

- Intestinal roundworms that are spread from person to person by ingestion of roundworm eggs

History:

- Itching of the skin around the anus, more severe at night
- Recent close contact with someone known to have a pinworm infection

Assessment:

- Obtain vital signs
- To be done by parent or guardian:
- Looking for the presence of white, hair-thin worms on the skin surrounding the anus (one to two hours after the child has gone to sleep) or pick up eggs around the anus with transparent tape (before the child wakes in the morning). The tape should be taken to the doctor's office to assist with diagnosis.

Refer to Local Healthcare System:

- Any suspected case of pinworms for definitive diagnosis and treatment
- Any child who is under 2 with symptoms of pinworms
- If any individual develops fever, abdominal pain, redness, swelling of genital area, or if they report pain when urinating
- If person under treatment for pinworms develops vomiting or pain

Treatment: **Always use standard precautions**

- Prescription medications are available from a local health professional. This should be repeated two weeks after initial treatment.
- Wash all bedding and plush toys, underwear, nightclothes, towels in hot water and detergent. Vacuum the area to help eliminate eggs
- Sanitize toilet and sleeping areas with strong disinfectant
- All members of the family or those who have been in close contact with the infected individual should consider treatment as well
- Health teaching point-teach importance of frequent and thorough hand washing, especially after using toilet and before meals. Keep children's fingernails short and clean.
- Morning showers and daily changes of pajamas and underwear to help prevent re-infection

Additional Considerations:

- Pinworms are the most common childhood parasitic infection in the United Sates
- Pinworms live in the lower region of the intestine and leave the body to lay their eggs around the anus at night
- The eggs are very sticky and can be transferred to bed sheets, toys, etc., that can then infect another child (or re-infect the original carrier) by oral ingestion
- Eggs can survive on clothing and bedding for days

- Children who suck their thumb are at higher risk of acquiring pinworms
- Generally, if one child in the family is infected, any other child between 2 and 10 should be treated as well

See also: Itching – Skin.

Adjustments by Local Physician:

Skin Infections-

Parasitic-

Scabies

Treatment Goal:

- Prevent spread to others
- Relieve symptoms

Possible Causes:

- Scabies is caused by the itch mite *Sarcoptes scabiei* that burrows under the skin. This causes an allergic reaction, itches intensely and is easily spread from person to person through physical contact.

History:

- Intense itching of the skin this is usually worse at night
- Recent exposure to someone with known or suspected infection with scabies

Assessment:

- Obtain vital signs
- Assess the skin for tiny bumps which may or may not have a thin red line (burrow) associated with the bump. These can be located anywhere on the body except the face.
- Check folds of skin on fingers, toes, wrists, underarms and groin

Refer to Local Healthcare System:

- Any individual who does not respond to over-the-counter treatment or has a weakened immune system
- For Prescription medication if OTC not readily available

Treatment: **Always use standard precautions**

- The individual should be instructed to apply a topical cream containing five percent permethrin to the skin at night and wash it off in the morning. A second treatment should be performed one week later. Anyone who has been in close physical contact with the infected individual should be treated as well.
- Mites do not live for long on inanimate objects – laundering of clothing and bed sheets in hot water will effectively at destroy mites

Additional Considerations:

- Itching may last for up to two weeks after successful treatment due to an allergic reaction to the mite bodies, which remain in the skin for awhile
- Children may not attend school until treatment is completed

See also: Itching – Skin, Rash.

Adjustments by Local Physician:

Tuberculosis

Treatment Goal:

- Prevent spread to others
- Prevent injury to individual

Possible Causes:

- Tuberculosis is caused by a highly infectious airborne bacterium known as
- Mycobacterium tuberculosis.

History:

- Onset of symptoms (night sweats, cough for more than two weeks, blood- tinged sputum, fever)
- Generalized malaise
- Decreased appetite and resultant weight loss
- Diagnosed and treated tuberculosis
- Medications currently taking to treat the illness
- Available medications with individual

Assessment:

- Obtain vital signs
- Individual may complain of a longstanding intermittent fever
- Contact Public Health for guidance

Refer to Local Healthcare System:

- All suspected cases of tuberculosis for definitive diagnosis and treatment
- Any individual currently in treatment for TB but who does not know what their medication is, or have it with them

Treatment:

- Tuberculosis is treated with multiple antibiotics taken over a long period of time, usually six months or longer
- Frequently, those with tuberculosis are required to participate in Directly Observed Therapy (DOT) in which a health care worker observes the individual as they take their medicine. This result in improved drug compliance and fewer cases of recurrence.
- Since active tuberculosis is highly infectious, those shelter residents who are exhibiting symptoms of tuberculosis should be isolated until diagnosis by a local healthcare provider can be made and follow local public health guidance for respiratory isolation.
- Only shelter residents with active disease are considered infectious

Additional Considerations:

- Individuals with a positive PPD test but showing no sign of active disease
- (common among health care workers) are welcome in Red Cross facilities
- Individuals who are currently on antibiotic therapy for tuberculosis are also welcome as long as they are no longer showing signs of active disease (cough, fever, night sweats, weight loss)
- Most people are no longer infectious after two weeks of treatment, although antibiotics should continue to be taken until told otherwise by their health care professional
- A chest X-ray may be needed to identify some suspected cases, or for those who have only

recently had a positive PPD

- Illness due to tuberculosis usually occurs long after initial exposure to the bacterium. Symptoms present themselves over time instead of as part of an acute episode.
- Worldwide, there are approximately eight million new cases and three million deaths due to tuberculosis each year.
- Nearly one-third of the world's population is believed to be carriers of the disease in a dormant state, with 90-95 percent of these individuals never experiencing active disease.
- Tuberculosis is spread from one person to another by bacteria in the air.
- Breathing, coughing or sneezing causes bacteria to hang in the air for hours. Anyone breathing in this air is at risk of developing tuberculosis.

See also: Cough, Fever.

Adjustments by Local Physician:

V. Procedures

Automated External Defibrillator

Use of an Automated External Defibrillator (AED)
(Notify National Headquarters when AEDs are used)

ADULT:

- When a cardiac arrest occurs, an AED should be used as soon as it is available and ready to use. Most public buildings are equipped with AED'S
- If the AED advises that a shock is needed, the responder should follow protocols to provide one shock followed by 5 cycles(about 2 minutes) of CPR
- Analyze the heart rhythm
- If at any time, you notice an obvious sign of life, stop CPR and monitor airway, breathing, and circulation (ABCs). Administer emergency oxygen if available and you are trained to do so.

CHILD:

- While the incidence of cardiac arrest in children is relatively low compared with adults, cardiac arrest resulting from V-fib does happen to young children. Most cardiac arrests in children are not sudden.
- Possible causes of cardiac arrest in children are – airway and breathing problems, traumatic injuries or accidents, a hard blow to the chest, congenital heart disease.
- AEDs equipped with pediatric AED pads are cable of delivering levels of energy to children between 1 and 8 years old or weighing less than 55 pounds. Use pediatric AED pads and/or equipment when available. If pediatric equipment is not available, an AED designed for adults may be used on a child. ALWAYS FOLLOW LOCAL PROTOCOLS AND MANUFACTURER'S INSTRUCTIONS.
- After a shock is delivered or if no shock is indicated give 5 cycles (about 2 minutes) of CPR before analyzing the heart rhythm again. IF, at any time you notice obvious signs of life, stop CPR and monitor the airway, breathing and circulation (ABCs). Administer emergency oxygen if available and you are trained to do so.

AED Precautions:

- Do not touch the victim while defibrillating. You or someone else could be shocked.
- Before shocking a victim with an AED, make sure that no one is touching or is in contact with the victim or the resuscitation equipment
- Do not touch the victim while the AED is analyzing. Touching or moving the victim may affect the analysis.
- Do not use alcohol to wipe the victim's chest dry. Alcoholis flammable.
- Do not defibrillate someone when around flammable or combustible materials such as gasoline or free-flowing oxygen
- Do not use an AED in a moving vehicle. Movement may affect the analysis.
- Do not use and AED on a victim who is in contact with water. Move the victim away from the water, swimming pools, puddles, or out of the rain before defibrillating.
- Do not use an AED and/or pads designed for adults on a child under age 8 or less than 55 pounds, unless pediatric pads specific to the device are not available. Local protocols may differ on this and should be followed.

- Do not use pediatric pads on an adult, as they may not deliver enough energy for defibrillation.
- Do not use an AED on a victim wearing a nitroglycerin, nicotine or other patch on the chest. With a gloved hand, remove any patches from the chest before defibrillating.
- Do not use a mobile phone or radio within 6 feet of the AED-this may interrupt analysis.

AEDs Special Situations

- AEDs Around Water
  - ❖ If the victim was removed from the water, be sure there are no puddles of water around you, the victim or the AED.
  - ❖ Remove wet clothing for proper pad placement if necessary. Dry the victim's chest and attach the AED.
  - ❖ If it is raining, ensure that the victim is as dry as possible and sheltered from the rain
  - ❖ Wipe the victim's chest dry but minimize delays to defibrillation
  - ❖ AEDs are very safe, even in rain and snow, when all precautions and manufacturer's operating instructions are followed
- AEDs and Implantable Devices
  - ❖ Sometimes people may have a pacemaker implanted for a weak heart or irregular rhythm. These small implantable devices are sometimes located in the area below the right collarbone and a small lump might be felt under the skin. Sometimes the pacemaker is placed somewhere else.
  - ❖ Others may have an implantable cardioverter-defibrillator (ICD), a miniature version of an AED, which acts to automatically recognize and restore abnormal heart rhythms. When locating this do not place the defibrillator pad directly over the device. This may interfere with the delivery of the shock.
  - ❖ Adjust pad placement and continue to follow the established protocol. If you are not sure, use the AED if needed. It will not harm the victim or the rescuer.
- AED Use for Hypothermia
  - ❖ Some people who have experienced hypothermia have been resuscitated successfully, even after prolonged exposure.
  - ❖ It will take longer for you to do your check or assessment of a victim suffering from hypothermia because you may have to look for movement and check breathing and a pulse for up to 30-45 seconds.
  - ❖ Do not delay CPR or defibrillation to rewarm the victim
    - Check for signs of life and initiate CPR
    - Protect the victim from further heat loss
    - Remove wet garments
    - Do not defibrillate in water
    - Do not shake a hypothermia victim unnecessarily, as this could result in ventricular fibrillation
- AED Use for Trauma
  - ❖ If a victim is in cardiac arrest caused by traumatic injuries, an AED may still be used.
  - ❖ Defibrillation should be administered according to local protocols.
- AED Use with Chest Hair

Lots of hair on the chest can prevent good pad-to-skin contact. Since the time to first shock is critical, attach the pads and analyze as soon as possible.

- Press firmly on the pads to attach them to the victim's chest.
- If you get a "check pads" message from the AED, remove the pads and replace with new ones.
- The pad adhesive will pull out some of the chest hair, which may solve the problem.
- If you continue to get "check pads" message, remove the pads, shave the victim's chest and add new pads to the chest. A safety surgical razor should be included in the AED kit. Be careful not to cut the victim while shaving.

AED Maintenance:

Follow the manufacturer's specific recommendations for maintenance, checking that:

- Batteries are charged with fully charged backup packs
- Expiration dates are current on defibrillator pads
- Correct replacement pads are available
- AED is in proper working order

Adjustments by Local Physician:

Epinephrine Auto Injector EPIPEN:

After determining a person is having a severe allergic reaction, assist with prescribed medication (epinephrine auto-injector), and use disposable gloves and other personal protective equipment. Follow these steps:

- Verify person's name
- Review directions and expiration date
- Grasp the auto-injector firmly and remove safety cap
- At a 90 degree angle, inject medication and hold firmly for 10 seconds
- Continue to monitor airway, breathing and circulation
- Give used auto-injector to EMS personnel
- Notify national headquarters of event

Inhaler

After determining a person is having an asthma attack, obtain consent, and assist with prescribed medication (inhaler). Follow these steps:

- Verify person's name
- Review directions and expiration date
- Shake inhaler and remove cap (if extension or spacer tube is available, attach and use appropriately)
- Have person breathe out and place lips around mouthpiece
- Quickly press down on inhaler canister while person inhales deeply. **NOTE:** if possible have person self-administer the medication
- Have person hold breath for count of 10
- Exhale and rinse out mouth with water
- Note time administered and monitor airway, breathing and circulation
- Document the incident on the Health Status Record and the Incident Report Form
- Notify national headquarters of event

Adjustments by Local Physician:

VI. Practical Applications

Over-the-Counter (OTC)

Appendix Over-the-Counter (OTC) Medications – Uses and Contraindications:

For all medications, check for individual allergies, contraindications and manufacturer's recommended dosage.

- Acetaminophen (Tylenol)

Therapeutic Class	Indications	Dosages	Contraindications
Analgesic, antipyretic	Mild to moderate pain caused by headache, backache, minor arthritic, muscle pain, toothache, common cold, menstrual cramps; fever.	Adults: 325-650mg PO every four to six hours, PRN Children: see manufacturer's recommendations or check with physician.	Hypersensitivity to other drugs. Use cautiously in shelter residents with anemia, liver/kidney disease, the elderly. Pregnant or breastfeeding shelter residents, and children younger than 2 years can safely take Tylenol

- Aspirin

Therapeutic Class	Indications	Dosages	Contraindications
Analgesic, antipyretic, anticoagulant	Mild to moderate pain caused by headache, toothache, arthritis, common cold, flu, muscle aches, menstrual cramps; fever; reduce the risk of heart attack and/or mini stroke (TIA).	Adult: (325mg tablets) one to two tablets PO every four hours, PRN. Children: Check manufacturers labeling. Children under 18 should not be given aspirin due to the risk of developing Reyes syndrome.	Hypersensitivity to other drugs or to NSAIDs. Asthma, ulcers, kidney/liver disease, bleeding problems or stomach complaints. Pregnancy, children under the age of 18.

Adjustments or Recommendation by Local Physician:

Appendix: Over-the-Counter (OTC) Medications (continued)

- Ibuprofen (Motrin, Advil, Nuprin)

Therapeutic Class	Indications	Dosages	Contraindications
Analgesic, antipyretic, anti- inflammatory	Arthritis; mild to moderate pain; menstrual cramps; fever reduction; migraine/tension headaches.	Adult: 400mg PO every four hours, PRN. Children: see manufacturer's label.	Hypersensitivity to other drugs and NSAIDs. Pregnancy. Use cautiously in elderly shelter residents; breastfeeding shelter residents; and those with cardiovascular,

- Diphenhydramine (Benadryl)

Therapeutic Class	Indications	Dosages	Contraindications
Antihistamine	Relieves symptoms of seasonal allergies (hay fever) and the common cold: runny nose, sneezing, watery eyes, scratchy throat, etc.	Adults: one to two pills PO every four to six hours, PRN. Children six to twelve years: one pill PO every four to six hours, PO. Not to be used in children under 6 years, unless prescribed by a physician	Glaucoma enlarged prostate, breathing problems such as emphysema or chronic bronchitis.

Adjustments or Recommendation by Local Physician:

Appendix: Over-the-Counter (OTC) Medications (continued)

- Loperamide Hydrochloride (Imodium)

Therapeutic Class	Indications	Dosages	Contraindications
Anti-diarrhea	Controls the symptoms of diarrhea, including Traveler's diarrhea.	Adults: two caplets PO after first loose stool, one caplet PO after each subsequent loose stool – not to exceed four caplets per 24 hour period. Children nine to eleven years: one caplet PO after first loose stool, one-half caplet PO after each subsequent loose stool, not to exceed three caplets per 24 hour period.	Black or bloody stool, fever, mucous in stool, pregnancy, liver disease, antibiotic use.

- Pseudoephedrine (Sudafed)

Therapeutic Class	Indications	Dosages	Contraindications
Decongestant	Temporary relief of stuffy head/sinuses associated with cold, hay fever or sinus inflammation.	Adult: two tablets PO every four to six hours, PO. Not to exceed eight tablets in a 24 hour period. Children six to eleven years: one tablet PO every four to six hours, PO. Not to exceed four tablets in a 24 hour period. Not for use in children under 6 years	Use of MAO-inhibitors, high blood pressure, heart disease, diabetes, thyroid disease, enlarged prostate.

*Nursing Spectrum Drug Handbook. May 30, 2006. www.nursesdrughandbook.com
*Physician's Desk Reference. 2006.
http://www.pdrhealth.com/drug_info/otcdrugprofiles/drugs/fgotc036.shtml

Appendix

Vital Signs

- – Normal Values

Age	Blood Pressure (mmHg)	Heart Rate (beats per min.)	Respiratory Rate (breaths per min.)
Adults and Children >10years	Systolic: <120 Diastolic: <80	60-80 (at rest)	12-18
Children 3-10 years	Systolic: 80-110	70-110	18-24
Children 1-3 years	Systolic: 80-100	80-120	20-30
6 months to 1 year	Systolic: 80-100	90-120	25-40
Newborn	Systolic: 60-80	100-160	30-60

- Normal Temperatures by Age and Method

Age	**Oral**	**Rectal**	**Auxiliary (Armpit)**	**Ear**
0-2 years	-	97.9-100.4	94.5-99.1	97.5-100.4
3-10 years	95.9 to 99.5	97.9-100.4	96.6-98.0	97.0-100.0
Over age 11	97.6-99.6	98.6-100.6	95.3-98.4	96.6-99.7

- ❖ The best way to take a temperature is rectally. Most parents obviously wish to avoid this method when possible. It is fine to take the temperature another way and then only do rectal temperatures when you suspect your child may be seriously ill.
- ❖ For older children, oral temperatures are reasonably reliable, and many newer thermometers allow you to take a temporal temperature (on the forehead), which is roughly equivalent to a rectal temperature.
- ❖ Auxiliary (armpit) and ear temperatures can be notoriously inaccurate, so always obtain a rectal temperature if your child is showing symptoms of serious illness.

Adjustments by Local Physician:

Appendix

Household Equivalents

Household =	Metric
1 teaspoon (tsp)	= 5 ml
1 tablespoon (Tbs)	= 15 ml
1 ounce (oz)	= 30 ml
2 Tbs	= 30 ml
1 ounce	= 30 g
1 pound (lb)	= 454 g
2.2 lb =	1 kg
1 inch = (cm)	2.54 centimeters

Taken from: Nursing Spectrum Drug Handbook, May 30, 2006 www.nursesdrugbook.com

Appendix

Metric Conversions

Metric Conversions of Weight, Volume, Length	
Nonmetric to Metric	**Metric to Non-metric**
Weight	
1 pound (lb) = 16 ounces (oz) = 0.454 kilogram (kg)	1 kilogram = 2.2 pounds
1 ounce = 28.35 grams (g)	1 gram = 0.035 ounce
Volume	
1 gallon (gal) = 4 quarts (qt) = 3.785 liters (L)	1 liter = 1.057 quarts
1 quart = 2 pints (pt) = 0.946 liter	
1 pint = 16 fluid ounces (fl oz) = 0.473 liter	
1 cup = 8 fluid ounces = 16 tablespoons (tbsp)	
1 fluid ounce = 29.573 milliliters (mL)	
1 tablespoon =1/2 fluid ounce = 3 teaspoons (tsp)	
Length	
1 mile (mi) = 1,760 yards (yd) = 1.609 kilometers (km)	1 kilometer = 0.62 mile
1 yard = 3 feet (ft) = 0.914 meter (m)	1 meter = 39.37 inches (in)
1 foot = 12 inches = 30.48 centimeters (cm)	1 centimeter = 0.39 inch
1 inch = 2.54 centimeters	1 millimeter (mm) = 0.039 inch

Excerpt taken from the online Merck Manual

Appendix

Spanish Medical Terminology

- Parts of the Body

Cabeza	Head
Cuello	Neck
Braso	Arm
Mano	Hand
Pecho	Chest
Espalda	Back
Estomago	Stomach
Pierna	Leg
Pie	Foot

- Common Phrases

Tienes dolor?	Do you have pain?
Es un dolor sordo o punzante?	Is the pain dull or stabbing?
Cuando comenzo?	When did it start?
Yo quiero medir sus muestras vitales.	I want to measure your vital signs.
Ha tinedo este problema antes?	Have you had this problem before?
Que hizo al respecto?	What have you done for it?
Quales medecinas estas tomando?	What medications do you take?
Tu tienes allergias?	Do you have any allergies?
Hay alguna otra persona en su trabajo o en su casa que tenga los mismos sintomas?	Does anyone else at work or in your home have the same symptoms?
Tienes seguro de salud?	Do you have health insurance?
Tienes un doctor?	Do you have a doctor?

- Vital Signs Terminology

Temperatura	Temperature
Pulso	Pulse
Respiraciones	Respirations
Presion de la sangre	Blood pressure

Appendix

Wong-Baker Faces

This form is available for download at http://www.wongbakerfaces.org/

TRANSLATIONS OF WONG-BAKER FACES PAIN RATING SCALE©

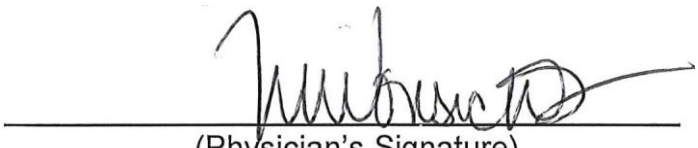
0–5 coding	0	1	2	3	4	5
0-10 coding	0	2	4	6	8	10
ENGLISH	No hurt	Hurts little bit	Hurts little more	Hurts even more	Hurts whole lot	Hurts worst
SPANISH	No duele	Duele un poco	Duele un poco más	Duele mucho	Duele mucho más	Duele el máximo
FRENCH	Pas mal	Un petit peu mal	Un peu plus mal	Encore plus mal	Très mal	Très très mal
ITALIAN	Non fa male	Fa male un poco	Fa male un po di piu	Fa male ancora di piu	Fa molto male	Fa maggior-mente male
PORTUGUESE	Não doi	Doi um pouco	Doi um pouco mais	Doi muito	Doi muito mais	Doi o máximo
BOSNIAN	Ne boli	Boli samo malo	Boli malo više	Boli još više	Boli puno	Boli najviše
VIETNAMESE	Không dau	Hôi dau	Dau hôn chût	Dau nhiêu hôn	Dau thât nhiêu	Dau qúa dô
CHINESE†	無痛	微痛	輕痛	更痛	很痛	劇痛
GREEK	Δεν Πονάϊ	Πονaϊ Λιγο	Πονaϊ Λιγο Πιο Πολν	Πονaϊ Πολν	Πονaϊ Πιο Πολν	Πονaϊ Παρα Πολν
ROMANIAN	No doare	Doare puţin	Doare un pic mai mult	Doare şi mai mult	Doare foarte tare	Doare cel mai mult

Explain to the person that each face is for a person who has no pain (hurt) or some, or a lot of pain. Face 0 doesn't hurt at all. Face 2 hurts just a little bit. Face 4 hurts a little more. Face 6 hurts even more. Face 8 hurts a whole lot. Face 10 hurts as much as you can imagine, although you don't have to be crying to have this worst pain. Ask the person to choose the face that best describes how much pain he has.

VII. **Review of Disaster Health Services Protocols**

APPROVAL OF MEDICAL - NURSING PROTOCOLS

The foregoing protocols for disaster nursing and care of the shelter residents in the Ashe County Shelter System have been approved or modified as noted by me. They are to be used by Shelter personnel subject to the policies, regulations, and procedures contained in the PHN Disaster Resource Guide. These guidelines have been approved for use as standing medical orders to be administered by any registered nurse licensed to practice in the State of North Carolina while functioning as a community volunteer in a Shelter during a disaster.



(Physician's Signature)

I oillJ ?J

(Date)

200 Hospital Avenue, Jefferson, NC 28640

(Address)

336-846-7433

(Phone)

These protocols are not intended to limit the scope of practice. Nurses should practice to the full extent of their education and training as recommended by the Institute of Medicine Report- The Future of Nursing Leading Change, Advancing Health.

Appendix F Medical Forms

Shelters Levels of Care

Condition	Level By Shelter Type		
	American Red Cross (ARC) General Shelter	**Special Needs Shelter (SNS)**	**Medical Management Facility (Hospital or Nursing Home)**
Alzheimer's Disease (ALZD)		✓ Most/ Wandering Not Bedfast	✓ Bedfast / Comatose
Ambulation assistance (walker, cane, crutches)	✓		
Ameliorating Lateral Sclerosis (ALS) (wheelchair)		✓	✓ End Stage
Aphasia (difficulty communicating)	✓ If Only Need		
Arthritis	✓		
Asthma	✓ If Stable And Self Manage	✓ If Unstable	
Bronchitis	✓		
Cardiac abnormalities	✓ If Stable		
Cerebral Palsy	✓ Mild	✓ Requiring More Assistance	✓ Total Needs
Cerebro-Vascular Accident (recent CVA)			✓ Recent
Chronic Obstructive Pulmonary Disease (COPD)	✓ If Independent		
Colostomy (uncomplicated)	✓		
Comatose			✓
Contagious disease or infection			✓
Continuous Ambulatory Peritoneal Dialysis (CAPD)	✓ 1-2 Times Per/Week	✓ 3 Times Per/Week	✓ Daily
Cystic Fibrosis	✓ If Stable		✓ Unstable
Dementia		✓	
Diabetes/Hyperglycemia	✓ Controlled		✓ Unstable

Eating and swallowing disorders		✓	
Edema	✓		✓ Severe
Emphysema	✓ If Stable		
Foley Catheter	✓ If Self Manage	✓ Requiring Monitoring	
Fractured Bones	✓ If Received Treatment	✓ If Limits Ambulatory Status	✓ If Untreated
High Blood Pressure / Hypertension	✓		
Hip Replacement			✓
Ileostomy	✓ If Self Manage		
Knee Replacements	✓ If Stable		
Hi-tech Medical Equipment			✓
Migraine Headaches	✓		
Multiple Sclerosis	✓ If Self Manage		✓ If End Stage
Muscular Dystrophy	✓ If Self Manage		✓ If End Stage
Neuromuscular Disorders		✓	
Neurological Deficit		✓	✓ Acute
Osteoarthritis/Osteoporosis	✓		
Parkinson's Disease	✓		✓ End Stage
Psychosis		✓	✓ Severe
Respirator/Ventilator Dependent			✓
Seizures	✓		✓ Grand Mal-Uncontrolled
Skin Rashes	✓		
Sleep Apnea		✓	
Upper Respiratory Infection	✓		
Urinary Tract Infection	✓		
Wheelchair Transferable	✓		
Wounds	✓	✓ Moderate	✓ Severe

Medical Information and Consent.

Name of personal Doctor or Clinic: _____ Phone: (_____) _____

Office Location (City and State): _____

Assisting Agencies: Name: _____

☐Home Health ☐In Home Nurse ☐Other: _____

Pharmacy Name: _____ Location (City & State) _____

Mobility needs: Do you need the assistance of a ☐Cane ☐Walker ☐Wheelchair
Are you bedridden or non-ambulatory? ☐Yes ☐No
If Yes, can you be moved in a wheelchair? ☐Yes ☐No
Have you had any recent Operation(s)? ☐Yes ☐No
If Yes, when and what type of operation: Date: ___/___/___ Type: _____

MEDICAL INFORMATION (Check all disabilities/conditions that you may have)

☐AIDS/HIV
☐Anemia
☐Anxiety / Nerves
☐Arthritis, Severe
☐Asthma
☐Back Injury
☐Blind
☐Breathing Impaired
☐Cancer
☐Complete Paralysis
☐Diabetes ☐Oral ☐Insulin
☐Dependency
☐Alcohol ☐Other_____
☐Electrically dependent life support
☐Hearing Impaired
☐Heart Condition
☐Hepatitis (circle all types that apply:)
{ A B C D E }
☐Hypertension (High Blood Pressure)
☐Incontinence
☐Kidney disease:
Dialysis ☐Yes ☐No
☐Memory Impairment
☐Ostomy
☐Oxygen Supported: L/Min____
Tank ____ 02 Converter _____
☐Partial Paralysis
☐Pregnant
☐Pulmonary Disease
☐Psychological Disorder
☐Seizures
☐Service Animal
☐Skin Disease/Rash
☐Transplant Recipient:
☐Tuberculosis
☐ Active Disease
☐ positive skin test only
☐Wounds
☐Other medical information: _____

IMMUNIZATION HISTORY:

Have you had a Tetanus shot in the last ten years?	☐Yes	☐No	☐Unknown
Have you had a Hepatitis A vaccination?	☐Yes-How many? ____	☐No	☐Unknown
Have you had a Hepatitis B vaccination?	☐Yes-How many? ____	☐No	☐Unknown
Have you had a Meningococcal vaccination?	☐Yes-How many? ____	☐No	☐Unknown
Have you had a vaccination in the last month?	☐Yes	☐No	Type(s):_____
Have you had a flu vaccination this year?	☐Yes- Month? _____	☐No	☐Unknown

RELEASE OF MEDICAL INFORMATION

I, _____, GIVE MY AUTHORIZATION FOR THE MEDICAL INFORMATION CONTAINED HEREIN TO BE RELEASED TO THE APPROPRIATE HEALTH AUTHORITY. I UNDERSTAND THAT THIS INFORMATION WILL BE USED SOLELY FOR THE PURPOSE OF EVALUATING MY NEEDS AND PROVIDE FOR MY CARE IN A TIME OF AN EMERGENCY. I PROVIDE THIS INFORMATION ON A VOLUNTARY BASIS.

SIGNATURE: _____ DATE: ___/___/__

WITNESS: _____ DATE: ___/___/___

Primary Medical Assessment

To Be Completed By Health Care Professional:

Name: _____ Birth date: ___/___/___ Age:
SS#: _____ Race: ___ Sex: __ Phone: (__) _____ Cell phone: (__) _____
Address: _____ City/St/Zip: _____, _____

VITAL SIGNS:

T_____ P_____ R _____ B/P _____

Note overall health: _____

_____

Behavioral Concerns? ☐Yes ☐No
If yes referred to behavioral care counselors - Date: ___/___/___

Reason: _____

_____

What was done to address current illness/condition(s):

_____

_____

_____

_____

Additional Comments:

_____

_____

Shelter Placement appropriate ☐Yes ☐No (If No see release or discharge)
If yes -Recommended Shelter Assignment:

Name: _____ Location _____

_____ ___/___/___
Health Care Professional Signature and Title Date

Released or discharge from shelter___/___/___, to: ☐another shelter ☐hospital ☐self
☐family member ☐other:_____
Name (shelter/hospital/family member/self/other): _____
Address: _____ City/State/Zip: _____Telephone: (___) _____

_____ ___/___/___
Shelter Resident Signature and Address **Date**

Shelters Medical Records

Shelter Resident Name: _____

Check In: ___/___/___Date _:_____Time ☐AM ☐PM

Primary need or condition_____

_____

Advance Directive (Do Not Resuscitate -DNR or Living Will) ☐**Yes** ☐**No**

Any Advance Directives must be present at all times and kept with this record.

Significant Medical Updates: (information noteworthy during an assessment or reassessment)

___/___/___Date_____

___/___/___Date_____

___/___/___Date_____

___/___/___Date_____

___/___/___Date_____

Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Continued Medical Assessment or Reassessment

To Be Completed By Health Care Professional:

Name: _____ Birth date: ___/___/___ Age:____

VITAL SIGNS:

T_____ P_____ R _____ B/P _____

Note any changes in health _____

_____

_____

Behavioral Concerns? ☐Yes ☐No

If yes Referred to behavioral care counselors - Date: ___/___/___

Reason: _____

_____

What was done to address current illness/condition(s):

_____

_____

_____

_____

Additional Comments:

_____

_____

Shelter stay still appropriate ☐Yes ☐No (If No see release or discharge)

If yes -Recommended Shelter Assignment:

_____ ___/___/___

Health Care Professional Signature and Title Date

Released or discharge from shelter___/___/___, to: ☐another shelter ☐hospital ☐self ☐family member ☐other:_____

Name (shelter/hospital/family member/self/other): _____

Address: _____ City/State/Zip: _____Telephone: (___) _____

_____ ___/___/___

Shelter Resident Signature and Address **Date**

Appendix G- Shelter Management Forms

Emergency Shelter Operation Forms
and Responsibility for Completion

1. Mass Care Coordinator Shelter Report	Mass Care Coordinators
2. Shelter Activation Sheet for Personnel	Shelter Manager and Asst. to M.C.C.
3. Shelter Briefing Guidelines	Shelter Managers
4. Shelter Staff Time Sheet	Shelter Managers
5. Shelter Registration Log	Registration Liaison
6. Visitor Sign In	Registration Liaison
7. Registration Intake	Registration Liaison
8. Shelter Registration Form	Registration Liaison
9. Rules & Policy For the shelter residents	Registration Liaison
10. Shelter Waiver	Registration Liaison
11. Volunteer Assignment Log	Shelter Management Support
12. Daily Census	Shelter Managers
13. Expense Sheet	Shelter Manager
14. Shelter Incident Report	Shelter Manager
15. Released or Discharge	Shelter Management Support
16. Deactivation Checklist	Logistics & Shelter Manager
17. Meals Ordered Worksheet	Food Services Liaison
18. Meals Served Report	Food Services Liaison
19. Allergies/Special Diet Needs Log	Food & Medication Liaisons
20. Current Medication Listing	Medical Liaison
21. Medicine Dispensing Log	Medical Liaison
22. Medication Schedule	Medical Liaison
23. Continued Assessment Cot to Cot & CMIST	Non-specific Shelter Attendant or Nurse
24. Blank for future need	
25. Blank for future need	
26. Blank for future need	
27. Inventory Sheet	Logistics-Supply & Distribution Liaison

Activated Shelters Report

Operation Period
Date_____
Times _____to_____

Shelter Name	Number Admitted	Functional or medical Needs	Meals Served	Resource Requested	Census Reported Time	Agencies Activated or Managing

Appendix G-Shelter Management- Form 1

Shelter Name_____

SHELTER ACTIVATION SHEET FOR PERSONNEL

Operation Period
Date_____
Times _____**to**_____

Person called	Results of Call to Person	Time Called	Arrival Time	Assignment

Appendix G-Shelter Management- Form 2

SHELTER BRIEFING GUIDELINES

For the Shelter Managers to Brief Staff

1. **Current conditions/status, including date, time and the type of incident.**
2. **If known, the anticipated conditions of those seeking shelter, known needs, an estimation of population effected.**
3. **Any special instructions about location, the physical condition of building etc. (Including parking, heating, cooling, electricity etc.)**
4. **What has been prearranged? What procedures are in place and what resources are being deployed and the status of those resources? (Such as supplies, cots, blankets, food and water; i.e. on the way, being set up)**
5. **Are there any noteworthy situations? Any complications? Is there an emergency contact hotline or a reunification location? Other operations or developments separate shelter functions the staff should be made aware.**
6. **Instructions for staff. (This should include all other details such as job assignment, station set-up, supervisors, chain of command communication and any scheduling i.e. next briefing or meeting.)**

SHELTER BRIEFING GUIDELINES

For Shelter Manager to Report to the Mass Care Coordinator

1. **Report the number of shelter residents.**
2. **Report the status and overall condition of shelter residents.**
3. **Report the physical condition of building and environment (Including heating, cooling, electricity etc.)**
4. **Are medication dispensation policies being followed?**
5. **Report food and water status. Number of meals served.**
6. **Report personal supplies status.**
7. **Are there any noteworthy situations? (Such as security issues, mental health issues, etc.)**
8. **Report the number of staff working.**
9. **Report number of volunteers if applicable.**

Shelter Name_____ **SHELTER STAFF TIME SHEET**

SIGN IN/SIGN OUT

Ops Period Date & Times	Name Signature & Print	Agency Representing	(Military) Time Dispatched	(Military) Time of Arrival	Military) Time of Departure	Comments

Shelter Manager _____ **Reg/Admissions** _____ **Appendix G-Shelter Management- Form 4**

Shelter Name ______________________

SHELTER REGISTRATION LOG

Shelter Location ______________________

Activation Date ______________

Record Cot/Rm Number	Date	Name	Time In	New or Returning	Time Out	Temporary or Final Exit	Contact Information (cell phone)	Notes or Destination
				□ New □ Returning		□ Temporary □ Final		
				□ New □ Returning		□ Temporary □ Final		
				□ New □ Returning		□ Temporary □ Final		
				□ New □ Returning		□ Temporary □ Final		
				□ New □ Returning		□ Temporary □ Final		
				□ New □ Returning		□ Temporary □ Final		
				□ New □ Returning		□ Temporary □ Final		
				□ New □ Returning		□ Temporary □ Final		
				□ New □ Returning		□ Temporary □ Final		
				□ New □ Returning		□ Temporary □ Final		
				□ New □ Returning		□ Temporary □ Final		
				□ New □ Returning		□ Temporary □ Final		
				□ New □ Returning		□ Temporary □ Final		
				□ New □ Returning		□ Temporary □ Final		

Shelter Manager 1st Shift ______________________ Reg/Admissions 1st Shift ______________________ Page _____ of ________

Shelter Manager 2nd Shift ______________________ Reg/Admissions 2nd Shift ______________________

Appendix G-Shelter Management- Form 5

Shelter Name_____ **VISITOR SIGN IN SHEET**

Activation Date_____ **Deactivation Date**_____

Visitor's name	**Reason of visit** (Delivery, etc- if visiting a shelter resident then list the resident's name)	Date	Time In	Time out	Comments

Shelter Manager _____ **Reg/Admissions**_____

Appendix G-Shelter Management- Form

Appendix G-Shelter Management- Form 6

Name of individual or family member _____
(If speaking for the whole family, please note) _____

Registration Intake

These are questions and observations to support the registration staff in identifying needs of the individuals entering the shelter and techniques for addressing those needs and obtaining assistance when required. Ask a question to ascertain information about the individual or a family member's needs. (Alternative questions allowed if the same information is obtained, as long as it is phrased in a polite and professional manner.)

Questions:

1. I**s there anything you or a member of your family need right now to stay healthy while in the shelter?**
   ☐ **Yes** ☐ **No**
   Follow-up question-If NO, Ask: **Is there anything you will need right now or in the next 6-8 hours?**
   ☐ **Yes** ☐ **No**
   If **Yes**, **STOP** the registration process and do one or more of the following:
   - If situation is critical and no support is available, call 911.
   - Contact Health Services and/or activate Mental Health worker if needed.
   - If the situation is not critical; the registration process may need to take place at a different station; direct them to the appropriate station.
   - Direct your concerns to the Shelter Manager for additional support when needed.

   If **NO**, continue the registration process
2. **Do you or a family member have a health, mental health, disability, or other condition about which you are concerned or need assistance?**
   ☐ **Yes** ☐ **No**
   If **Yes**, **STOP** the registration process and do one or more of the following:
   - Acknowledge their need and offer assistance, this may include contacting a health services worker.
   - The registration process may need to take place at a different station; direct them to the appropriate station.
   - Or direct your concerns to Shelter Management for additional support when needed.

   If **NO**, continue the registration process

Observations

1. **Does the individual or a family member appear to be in need of immediate medical attention, appear too overwhelmed or agitated to complete registration, or are they a threat to themselves or others?**
   ☐ **Yes** ☐ **No**
   If **Yes**, **STOP** the registration process and do one of the following:
   - If situation is critical and no support is available, call 911.
   - Contact Health Services and/or activate Mental Health worker.
   - If no health or mental health resource on site, direct concern to the Shelter manager.

   If **NO**, continue the registration process.
2. **Does the individual or a family member have a service animal, use a wheelchair/walker or demonstrate any other circumstance where it appears they may need help in the shelter.**
   ☐ **Yes** ☐ **No**
   If **Yes**, **STOP** the registration process and do one of the following:
   - Acknowledge their need and offer assistance, this may include contacting a health services worker.
   - The registration process may need to take place at a different station; direct them to the appropriate station.
   - Or direct your concerns to Shelter Management for additional support when needed.

   If **NO**, continue the registration process.

Attendant's Name _____

Additional Notes

Notes for response to questions:

Notes for Observations:

Registration Form

Date: _____ Incident name: _____ Shelter Name/Location: _____

HOUSEHOLD INFORMATION		
Family Name (Last Name) :		Head of Household (First Name)
Pre-disaster Address:		Post-disaster Address (if different):
Number of Family members registered: 0-3 yrs: 3-7 yrs: 8-12 yrs: 13-18yrs: 19-65 yrs: 65+ yrs: Total:		
Primary Phone:	Other Phone:	Email:
Primary Language:	If Not English, Family Member Present Who Speaks English:	
Method of Transportation:	If Personal Vehicle, Lic. Plate #/State (for security purposes only):	

INDIVIDUAL FAMILY MEMBER INFORMATION (for additional names, use back of page)

Name (Last, First)	Age	Gender (M/F)	Arrival Date	Record Cot/Rm Number	Volunteer? (Yes/No)	Departure Date	Notes

☐Yes ☐No Someone in the household is required by law to register with a state or local government agency.

☐Yes ☐No Someone in the household is a veteran or active military.

☐Yes ☐No I agree to have my/family information shared with other agencies providing disaster relief services.

By signing here, I acknowledge that the information on this form is accurate, including the three statements above. I further acknowledge that I have read/been read and understand the shelter rules and agree to abide by them.

Signature:_____ Date:_____

Shelter Attendant

Shelter Attendant Name/Signature: _____

Use the initial Shelter Initial Intake Form to determine if further assistance or accommodation is needed. Contact the Shelter Manager, for placement if there are complicating issues, such as legal monitoring, health issues or concerns.

SHELTER RULES AND POLICY
FOR RESIDENTS AND CAREGIVERS

1. The shelter may be crowded. RESPECT the rights and privacy of others.
2. Keep your own space clean and neat.
3. Keep yourself as clean and neat as possible.
4. Speak in a quiet tone: no yelling and no profanity.
5. Keep all noise to a minimum: no loud radios, CD players, TV's, etc. Turn off by ll:00 p.m. Staff will monitor and provide news updates to avoid disturbing those trying to sleep.
6. Lights will be dimmed at 11:00 p.m., if possible, but the care and observation of individuals in the shelter may require brighter lighting at times.
7. If the shelter provides a TV, the majority rules on programs to be watched. Shelter staff will determine what is viewed if there is not agreement or if something is deemed inappropriate.
8. Shelter phones will be available for emergency calls only and will be limited to 5 minutes. Shelter staff will determine phone use.
9. Shelter staff are not responsible for the loss of money, medications, equipment or other personal items. Please take care of these items. Items can be stored in a locked area upon request.
10. No smoking is permitted unless designated by the host facility
11. No alcohol or illegal drug use will be permitted inside the shelter.
12. No weapons of any kind are allowed in the shelter.
13. No borrowing and no stealing will be permitted.
14. No fighting, either verbal or physical will be permitted.
15. No sexual activity will be permitted.
16. Supplies and food brought to the shelter by individuals belong to them alone and will be shared only if the individual desires to do so. Sharing of personal items is discouraged.
17. Food and beverages (except water) are not to be consumed in sleeping areas.
18. Cots will first be provided to residents according to functional or medical limitations.
19. Caregivers will only be provided with cots if availability permits
20. Supplies provided by the shelter will be given to all individuals according to need and availability.
21. Functional or medical needs individuals, along with other shelter residents will have food service priority over caregivers/family members and visitors. Second servings of food and beverages will be offered to residents before caregivers/family members can receive second servings. Servings will be moderate.
22. Stockpiling or hoarding of shelter-provided food is not allowed.
23. To the extent possible games, books, and activities will be made available at the shelter. Such activities are to be carried out quietly and with respect for others.
24. Shelter staff, facility staff, volunteers, residents, caregivers and visitors should be treated with courtesy and respect.
25. Areas designated for staff use are not to be entered by those being sheltered.

26. Caregivers are expected to provide all routine care, as they would do at home. Caregivers must remain in the shelter until the individual for whom they are responsible is discharged. Short leaves or breaks may be permitted if arranged with and approved by shelter staff.
27. No pets are allowed in the shelter. Service animals are permitted but care, feeding, and waste elimination is the responsibility of the individual, caregiver, or family.
28. Caregivers/families of individuals with a functional or medical need are discouraged from bringing children to the shelter to visit. An assessment will be made by the medical staff, behavioral health staff and the DSS to determine if children are allowed to stay at a shelter that serves the functional or medical needs of an adult relative (the determination will be in the best interest of the child as well as the medical care). If children are present, the parents or caregivers are responsible for keeping them quiet and controlled. No running, shouting, etc. Individuals in this type of shelter are unwell or have conditions that make it difficult to engage in the activities of daily life and undue stress can have an adverse effect on their care.

Shelter Rules Are For The Safety Of Everyone.
Shelter Rules Will Apply Equally To All Individuals In The Shelter.

Signature of Shelter resident_____ Date _ /___ /_

Signature of Caregiver _____ Date __ /___ /_
(If Applicable)
Signature of Staff _____ Date __ /___ /_

Basic Shelter Rules and Policy for Visitors, Volunteers and Staff

Everyone must sign in or register upon arriving at shelter
No smoking is permitted unless designated by the host facility
Courtesy is expected at all times
Children in the shelter must be under the supervision of an adult
Individuals are responsible for their own personal belongings and valuables
No alcoholic beverages, illegal drugs, firearms, or explosives will be allowed

SHELTER WAIVER AND RELEASE

Name of Individual Seeking Shelter
or a Head of Household: _____

Family Members or Dependents_____
(If Applicable)

Home Address: _____

Name of Accompanying Caregiver_____
(If Applicable)
Home Address: _____

We the above named individuals (jointly and separately) for and in consideration of, the opportunity to seek refuge in an Ashe County Shelter do hereby agree to waive, release, and hold harmless any participating organization or facility, its directors, officers, agents, employees, members, subsidiaries, and volunteers from any and all injuries, claims, losses, damages, death, and liabilities arising out of or in any way connected with our stay in a shelter.

We understand and agree that it is the responsibility of the caregiver to provide primary (routine) care of minor(s), or someone with a functional or medical need, the same care as would be provided them at home, for as long as we remain at a sheltering site.

We understand and agree that it is our responsibility to provide our own supplies and medications that we may need. However, in the event that we do not bring the needed supplies and medications or run out of such supplies and medications that the shelter will furnish only what is needed while at the shelter.

Permission is given for a photograph to be taken, if necessary, for identification and security purposes.

We understand and agree to follow the shelter rules, policies, and procedures during the time that we stay in the shelter.

We have carefully read and/or had this Waiver and Release explained to us and we understand its contents and significance.

_____ _____
Individual Date

_____ _____
Caregiver of a Minor or Someone with a Functional or Medical Needs Date

_____ _____
Witness Date

Appendix G-Shelter Management- Form10

VOLUNTEERS ASSIGNMENT LOG

Volunteers Name	Volunteers Phone Number	Availability	Assignment	Location	Emergency Contact Name & Number

Appendix G-Shelter Management- Form 11

DAILY CENSUS REPORT

(*Shelter Name and Location)*	*Date of shelter Activation* / /	Shelter Deactivated? ☐ YES ☐ No
(Shelter Manager's Name)	Operation Period _____:_____to_____:_____	___/___/____ _____:_____ If YES Date & Time

Date of report ___/___/____ **Time of report:** _____:_____	**Numbers Last Report**	**Number in the Shelter at time of this report**	**Number of meals served in the last 24 hours**	**Transferred to another shelter or hospital**	**Left or Discharged**	**Shelter Needs that should addressed**	**Notes**
RESIDENTS							
CAREGIVERS							
OXYGEN DEPENDENT							
ELECTRICALLY DEPENDENT							
STAFF							
	Peak Census for this shelter in the last 24 hours: _____ Peak Census for this shelter since activation_____ *(Peak Census is highest total number people in the shelter, excluding staff,)*						

REPORT PREPARED BY (*signature)*_____**Appendix G-Shelter Management- Form 12**

EXPENSE SHEET

(*Shelter Name and Location)*	*(Person other than Manger who keeps expenses etc. Logistic, Clerk, Assistant, or Deputy - Name and position)*	Incident Name
(Shelter Manager's Name)		*Date of shelter Activation* ___/___/____

	Requested					**Received**					
#	**Date**	**Time**	**Initials**	**Need**	**Reason**	**Date**	**Time**	**Initials**	**Supplier**	**Amount**	**Invoice/ Receipt Attached**
1										$	
2										$	
3										$	
4										$	
5										$	
6										$	
7										$	
8										$	
9										$	
10										$	
11										$	
12										$	
13										$	
14										$	
15										$	
16										$	

Appendix G-Shelter Management- Form 13

INCIDENT REPORT

Employee (Shelter Resident):_____ Organization (shelter name):_____
If applicable: Job Title: _____ Employment Status:_____
If applicable: How long Employed: _____Hours worked per day: _____Pay Rate per Day_____
Home Address:_____
Home Phone:_____ Work Phone:_____
SSN:_____ If applicable: Hire Date:_____
Date of Birth:_____ Gender:_____
Date of Incident: _____Time of Incident_____ Date Reported_____
Location of Incident_____

Nature of Injury (specify if injury is to right side/left side etc: _____

_____

_____

Employee (Shelter Resident) Treated by Physician? ☐Yes or ☐No
Name of Treatment Facility :_____
Phone # of Facility: _____ Address of Facility: _____
ER visit: ☐Yes or ☐No Overnight Stay: ☐Yes or ☐No

Nature of Property Damage: _____

_____

_____

If applicable: vehicle involved, indicate type/make/model/year/license number:

_____

_____

Weather conditions: _____Road Conditions: _____
Law Enforcement Report: ☐Yes or ☐No Reporting Officer: _____
Supervisor or Department Head incident reported to: _____
Date and time incident reported to accepted organization: _____

Description of Incident (describe exactly what happened; include exactly what the injured party doing and any surrounding circumstances – use additional sheets if needed):

_____

_____

_____

_____

Witnesses to Incident (include name, address and telephone number):

_____

_____

If applicable: Employee's Supervisor: _____
If applicable: Department Head of the Employee: _____

CAUSATION FACTORS

(To be filled out by Supervisor or Department Head)

What, if any, job procedure issues may have contributed to the incident?

_____

_____

Are there established procedures?_____
If so, what are the procedures?

_____

_____

_____

Was the employee trained in this procedure(s)?_____
Did the employee follow the established procedures?_____
If not, what procedures was/were not followed?_____

_____

_____

What, if any, behaviors may have contributed to the incident? _____

_____

_____

(Consider: lack of knowledge, disregard of instruction(s), inadequate training, emotional upset, haste)

Based on observation of the incident location and/or property involved please indicate:

Lighting: Good___ Deficient___ Action Needed:_____

Walking/Working surfaces:
Good___ Deficient___ Action Needed:_____

Housekeeping:
Good___ Deficient___ Action Needed:_____

Machinery and Equipment:
Good___ Deficient___ Action Needed:_____

Layout: Good___ Deficient___ Action Needed:_____

Maintenance: Good___ Deficient___ Action Needed:_____

Noise level: Good___ Deficient___ Action Needed:_____

Safety guards and equipment:
Good___ Deficient___ Action Needed:_____
Other_____:
Good___ Deficient___ Action Needed:_____

Signature of Department Head or Supervisor (Shelter Manager): _____

RELEASED OR DISCHARGE

Released or discharge from shelter___/___/___, to:

☐another shelter ☐hospital ☐self/home

☐family member ☐other:_____

Name (shelter/hospital/family member/self/other): _____

Address: _____ City/State/Zip: _____Telephone: (___) _____

Were all issues addressed? ☐Yes ☐No
If no please list any residual issues that need to be addressed:

_____

_____

Do you have all your belongings that you brought with you? ☐Yes ☐No
If no, please list:

_____

_____

May we follow up with you? ☐Yes ☐No
If yes, please list ways to contact you?

_____

_____

_____ ___/___/___
Shelter Resident Signature and Address **Date**

_____ ___/___/___
Witness **Time** **Date**

Appendix G-Shelter Management- Form 15

DEACTIVATION CHECKLIST

☐	**Cots are cleaned, inventoried, and put away?**	☐**YES**	☐**NO**	☐**N/A**
☐	**Generator(s) are returned or stored properly?**	☐**YES**	☐**NO**	☐**N/A**
☐	**Verify that building is vacated?**	☐**YES**	☐**NO**	
☐	**Supplies are inventoried and returned?**	☐**YES**	☐**NO**	
☐	**Shelter Manager has done a "walk through"?**	☐**YES**	☐**NO**	
☐	**The facility has been cleaned.**	☐**YES**	☐**NO**	
☐	**Bathrooms have been checked and cleaned?**	☐**YES**	☐**NO**	
☐	**Keys have been handed over/returned.**	☐**YES**	☐**NO**	☐**N/A**

List any building conditions, inventory notes, etc. that should be recorded:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEALS ORDERING WORKSHEET

SHELTER NAME _____ **How Many Children under 10** _____ **How Many with Modified Diets** _____

Notes:

SHELTER LOCATION _____ **How Many Elderly** _____

DATE _____ **Page number** _____ **of** _____

Meal Type ☐Breakfast ☐Lunch ☐Dinner	Amount	Items Ordered	Cost	Location / Organization and total cost	Time Ready	Picked-up By Logistics Liaison
Supplies						

Attach all receipts.
Meal planning may require more than one worksheet per meal. Start a new worksheet or set of worksheets for each meal. The space for supplies is applicable, only when needed.

MEALS SERVED

Shelter Name	SUNDAY Date				MONDAY Date				TUESDAY Date				WEDNESDAY Date				THURSDAY Date				FRIDAY Date				SATURDAY Date			
Shelter Location Name	Breakfast	Lunch	Dinner	Snack	Breakfast	Lunch	Dinner	Snack	Breakfast	Lunch	Dinner	Snack	Breakfast	Lunch	Dinner	Snack	Breakfast	Lunch	Dinner	Snack	Breakfast	Lunch	Dinner	Snack	Breakfast	Lunch	Dinner	Snack
Totals by Type Per Day																												
Total Meals Per Day (Daily Totals)																												
Weekly Meal Consolidation	BREAKFAST							LUNCH							DINNER							SNACK						

Allergies

MEDICATION / SPECIAL DIET NEEDS LOG

Shelter Resident's Name	Shelter ID	Allergy	Special Diet

Appendix G-Shelter Management- Form 19

Both Food Services and Medication Storage may need this information

CURRENT MEDICATION LIST

NAME_____ **SHELTER ID**_____

Please list all the medications, prescriptions and over the counter items that you are presently taking:

Appendix G-Shelter Management- Form 20

Must file in individual's file after shelter closes or they are discharged

MEDICATION DISPENSING LOG

NAME_____ **SHELTER ID**_____

A signature must accompany all entries.

Date / Time	Medications Given	Signature
Observations / Notes:		
Date / Time	Medications Given	Signature
Observations / Notes:		
Date / Time	Medications Given	Signature
Observations / Notes:		
Date / Time	Medications Given	Signature
Observations / Notes:		
Date / Time	Medications Given	Signature
Observations / Notes:		
Date / Time	Medications Given	Signature
Observations / Notes:		
Date / Time	Medications Given	Signature
Observations / Notes:		
Date / Time	Medications Given	Signature
Observations / Notes:		

Appendix G-Shelter Management- Form 21

Record kept at Medication Storage Station

	MEDICATION SCHEDULE	
	0000/12:00am	Date:
NAME & ID #	MEDICATION	ADMINISTERED BY

Appendix G-Shelter Management- Form 22

Continued Assessment
Cot to Cot & CMIST

Date_____ Time_____

Name _____

Family members present at shelter: _____

Cot assignment number(s) _____

How many days has the resident or family been at the shelter? _____

1. Does the resident or a family members appear to be in need of immediate medical attention, appear overwhelmed or agitated or is a threat to themselves or others?

☐ **Yes** ☐ **No**

2. Does the resident or a family member have a health, mental health or other medical type of need that isn't being addressed?

☐ **Yes** ☐ **No**

If yes please note the need: _____

If **Yes to either question 1 or 2**, **STOP** the assessment and do one of the following:

If situation is critical and no support is available, call 911.
Contact Health Services and/or activate Mental Health worker.
If no health or mental health resource on site, direct concern to the Shelter Manager.

Follow up for official use:

Was the resident evaluated by Health Services Service and/or Behavioral Health care?

☐ **Yes** ☐ **No**

Was Continued Medical Assessment conducted and attached?

☐ **Yes** ☐ **No**

3. Is there anything the resident one of their family members need today?

☐ **Yes** ☐ **No**

If yes please note the need: _____

4. Can the resident **Communicate** effectively? ☐ Yes ☐ No Is communication assistance needed? ☐ Yes ☐ No If yes what type. ☐ Qualified interpreters ☐ Written materials in alternate format ☐ Visual (i.e. the "Show Me book") ☐ Access to communication device (teletypewriter, skype, cell phones) ☐ Other _____. Does the resident need replacement of communication equipment? ☐ Yes ☐ No If yes what type. ☐ Batteries for hearing aid ☐ Replacement eye glasses ☐ Low vision aids ☐ Other _____

5. Is the Shelter resident "**Maintaining Their Health"**? ☐ **Yes** ☐ **No** Does the resident have any special or modified diets? ☐ Yes ☐ No If yes, are they maintaining their special or modified diet? ☐ Yes No Are they eating adequately? ☐ Yes ☐ No Do they have any allergies? ☐ Yes ☐ No Have they had any allergy flare –ups while at the shelter? ☐ Yes ☐ No Are they able to perform daily living activities

such as: Able to get around inside the shelter? ☐ Yes ☐ No Able to get on and off their cot? ☐ Yes ☐ No Perform own hygiene task? ☐ Yes ☐ No

6. Is the resident able to maintain their **Independence**? ☐ Yes ☐ No Do they have all their needed supplies or equipment? ☐ Yes ☐ No Is durable medical equipment needed? ☐ Yes ☐ No If yes what type. ☐ Wheelchair ☐ Walkers ☐ Canes ☐ Raised toilet seats ☐ Other _____ Is Bariatric accommodation needed? ☐ Yes ☐ No **Provide details about any supplies or equipment needed**

Does resident have a service animals? ☐ Yes ☐ No Is all the animals need being met? ☐ Yes ☐ No

Notes_____

If the resident or family has an infant or children at the shelter are all their needs being met? ☐ **Yes** ☐ **No** If no, what do the Children need? ☐ Diapers ☐ Hygiene supplies ☐ Formula ☐ A nursing area ☐ Other supplies_____ ☐ Toys ☐ Activities ☐ Additional supervision

☐ Other _____

Is there any safety issues concerning the resident or their children? ☐ Yes ☐ No If yes how can we address these issues? _____

---

7. Has the resident or family received **Services** or/and **Support**? Does the resident have any personal support at the shelter, such as family, friends, caregivers, or an agency? ☐ Yes ☐ No Does resident or family seem proactively occupied and exhibits **Self Determinati**on? ☐ Yes ☐ No Does the resident or any family member seem confused, frustrated or melancholy? ☐ Yes ☐ No If yes, was counseling provided and by who? (Activate behavioral health care) ☐ Yes ☐ No _____

8. List any unmet needs, observation or situation that should be noted:

Notes_____

Transportation needs does not need evaluated daily, unless transportation is an issue or upon when the discharged of the resident or when the shelter is closing.

9. Is **Transportation** needed for medical care, doctor appointment(s) or treatment(s)? ☐ Yes ☐ No
Does the resident need transportation to conduct personal business, such as meeting with insurance agents, working on repairs, or employment? ☐ Yes ☐ No Does the resident have a transportation need in order to return home? ☐ Yes ☐ No Does the resident need personal assistance (an attendant) to assist the resident getting to their destination safely? ☐ Yes ☐ No If yes is the answer to any of these transportation questions, coordinate with the Shelter Manager, Mass Coordinator and the EOC to assist with these transportation needs. What type of transportation is needed? ☐ Ambulance ☐ Assistance walking ☐ Regular car or van ☐ Van w/lift ☐ Other _____

Reserved For future use

Appendix G-Shelter Management- Form 25

Reserved For future use

Appendix G-Shelter Management- Form 26

INVENTORY SHEET

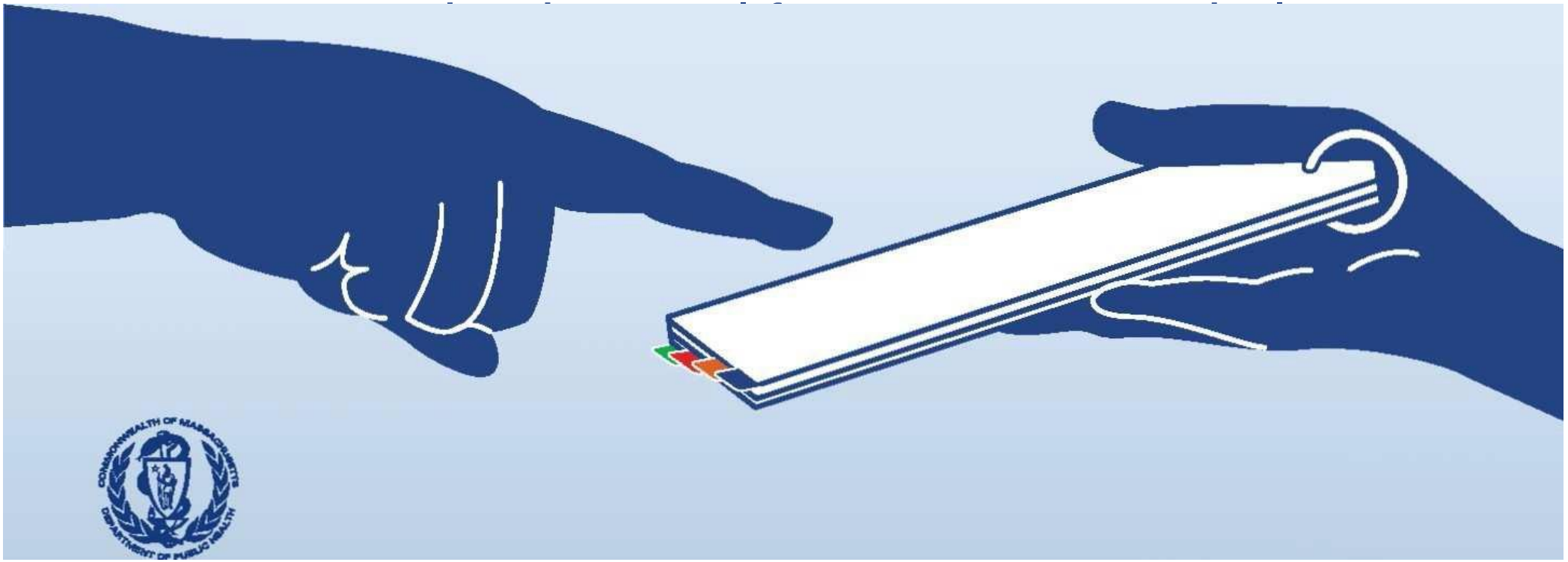
(*Shelter Name and Location)*		*Date of shelter Activation* ___/___/____		Shelter Deactivated? ☐ YES ☐ No ___/___/____ _____:_____ If YES Date & Time	
(Shelter Manager's Name)		Incident Name		Operation Period _____:_____to_____:_____	
Item	Received	Dispersed	Remaining	Needed for next Operation Period	Comments

Appendix G-Shelter Management- Form 27

Appendix H Shelter Resources & Tools

Attachment 1-Show Me Tool

Show Me

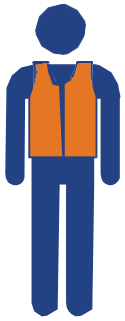


Instructions

This tool has been tested with and co-created by public health professionals and the populations it is designed to help, including:

- People who have cognitive disabilities
- People who are deaf or hard of hearing
- People who have limited English proficiency
- Anyone who may struggle to communicate verbally during an emergency

Tips to help you use this tool:



- ✓ Speak clearly and slowly.
- ✓ Look directly at the person when asking questions or giving instructions.
- ✓ Give directions one step at a time. Check for understanding after each step.
- ✓ Give the person time to respond to questions or instructions.
- ✓ Use hand gestures (movements) to help communicate.

Remember, good communication is key to helping people feel safe and calm during an emergency.

Language

Interpreter

Sign Language

Language

I speak...

Español (Spanish)

Português (Portuguese)

Français (French)

Italiano (Italian)

Deutsch (German)

Polski (Polish)

Русский (Russian)

Ελληνικά (Greek)

Shqip (Albanian)

Kreyòl (Haitian Creole)

Kriolu (Cape Verdean Creole)

Language

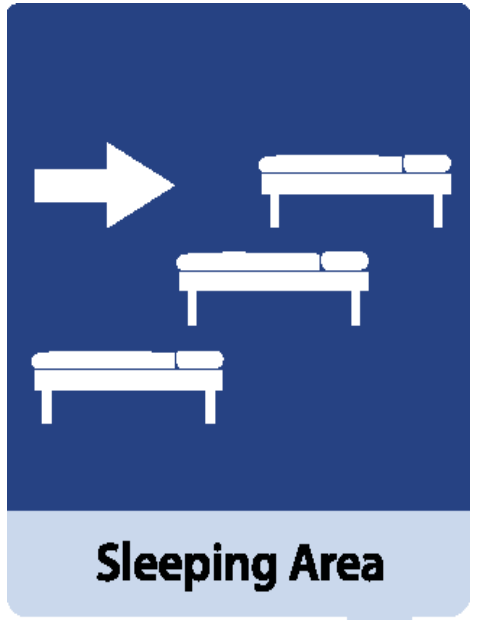
Arrival

Arrival


Arrival

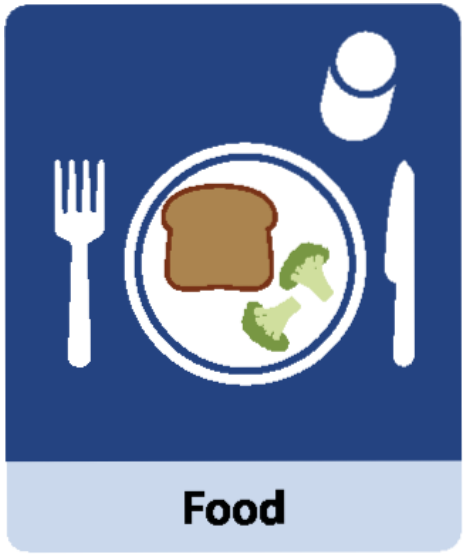

Wait in Line


Sign In

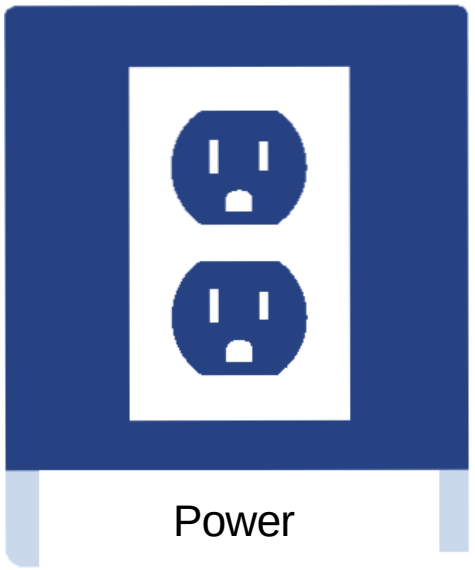

Sleeping Area

Arrival

Arrival

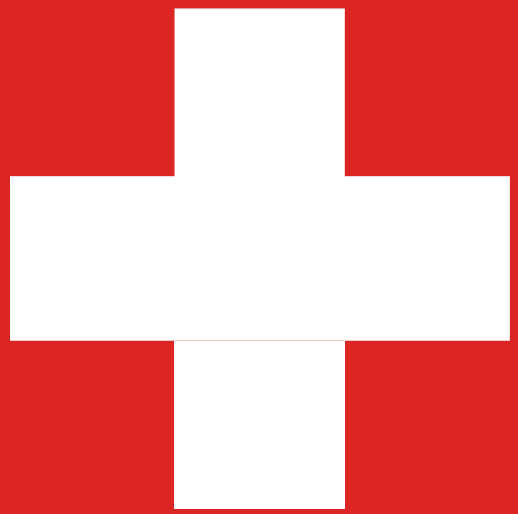


Arrival



Notes

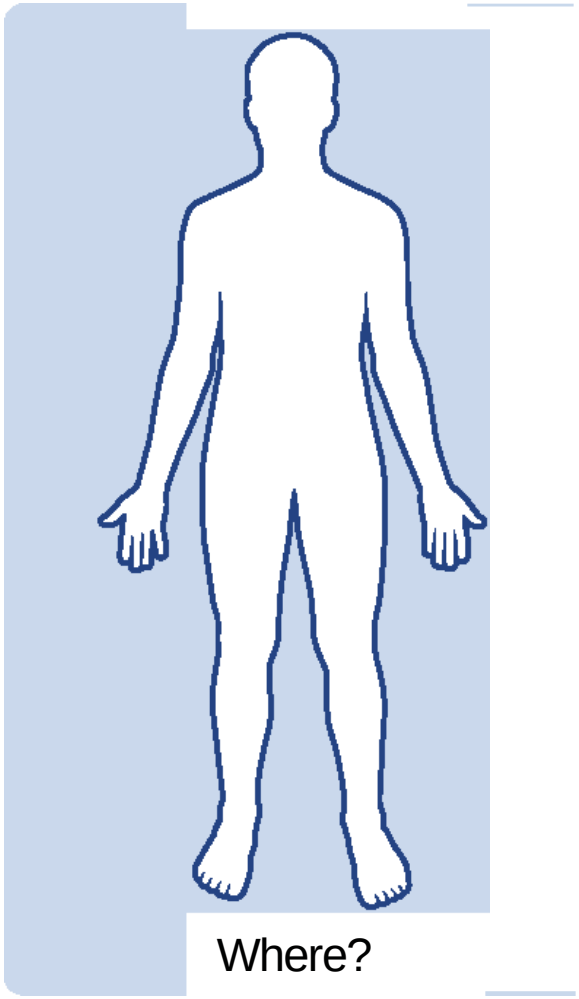
Medical Needs



Medical Needs

Medical Needs

Medical Needs



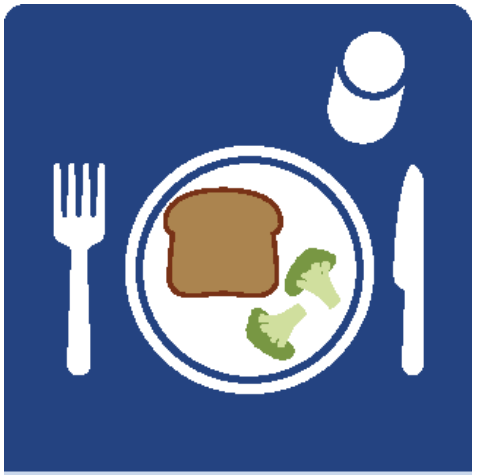
Medical Needs

Notes


I need...
SOAP

Basic Needs

Water



Food

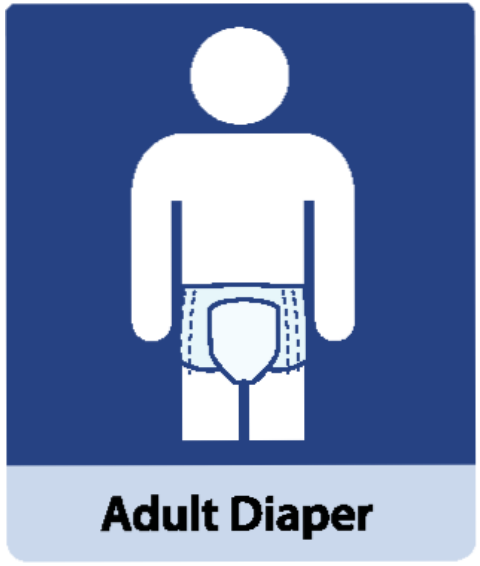
Bathroom

I need...

Help

Bathroom Help

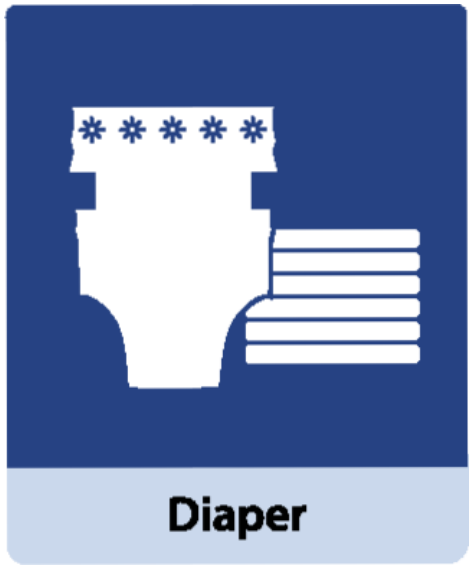
Shower Help



Adult Diaper

Personal Care Items

Baby Needs

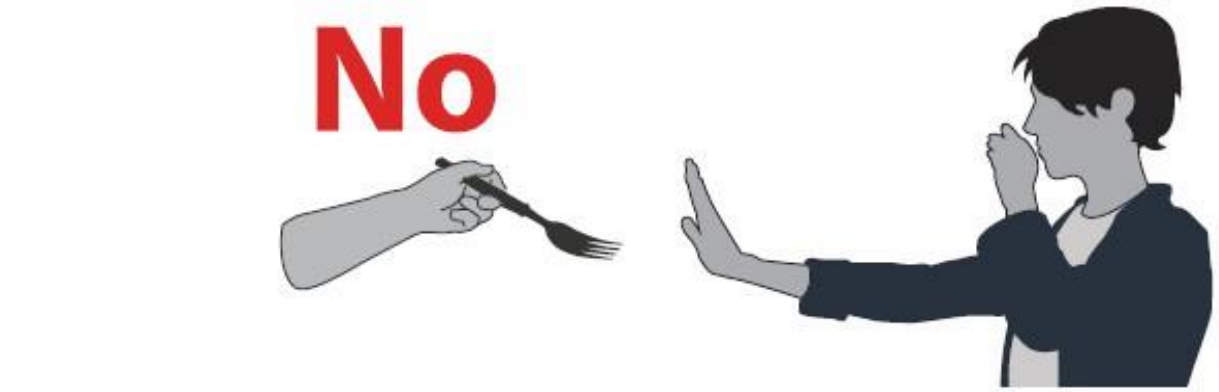


Notes

Food Allergies

Food Allergies

Food Allergies



Allergic to Eggs

Allergic to Peanuts

Allergic to Shellfish

Food Allergies

Notes

People and Places

People
& Places

People

People & Places

Family

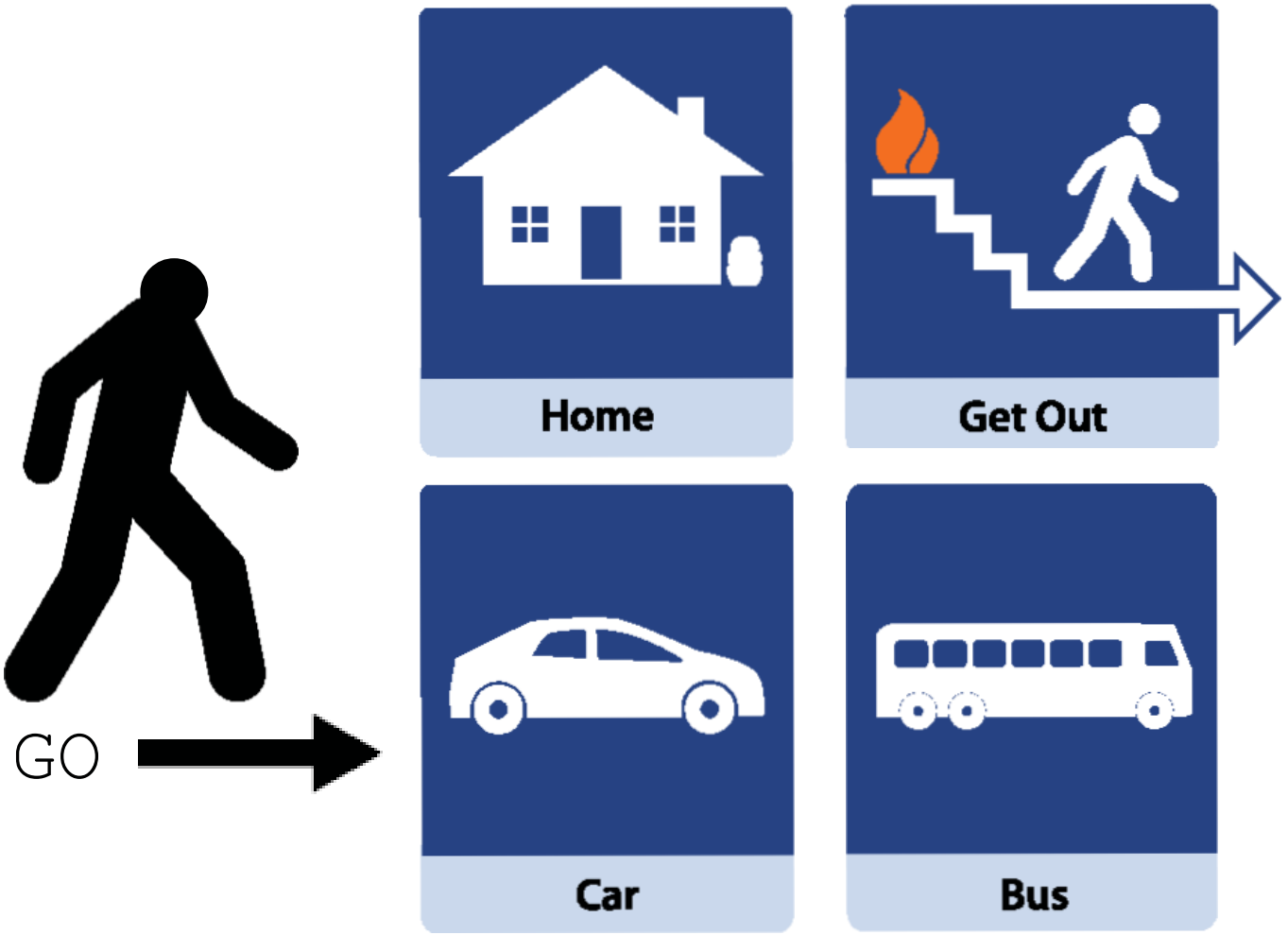
Police

Medical Staff

My Home

Notes

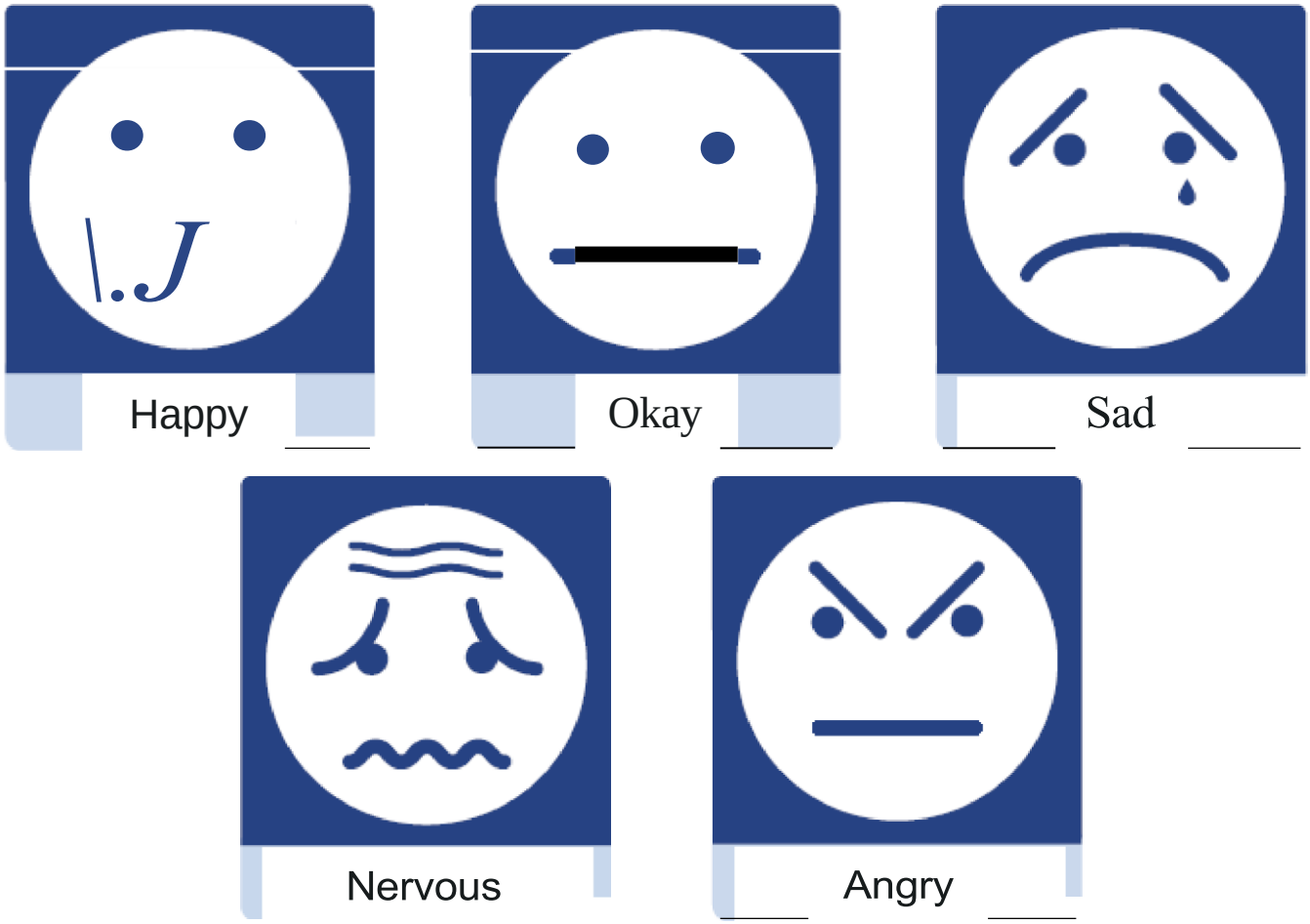
Places to Go



Notes

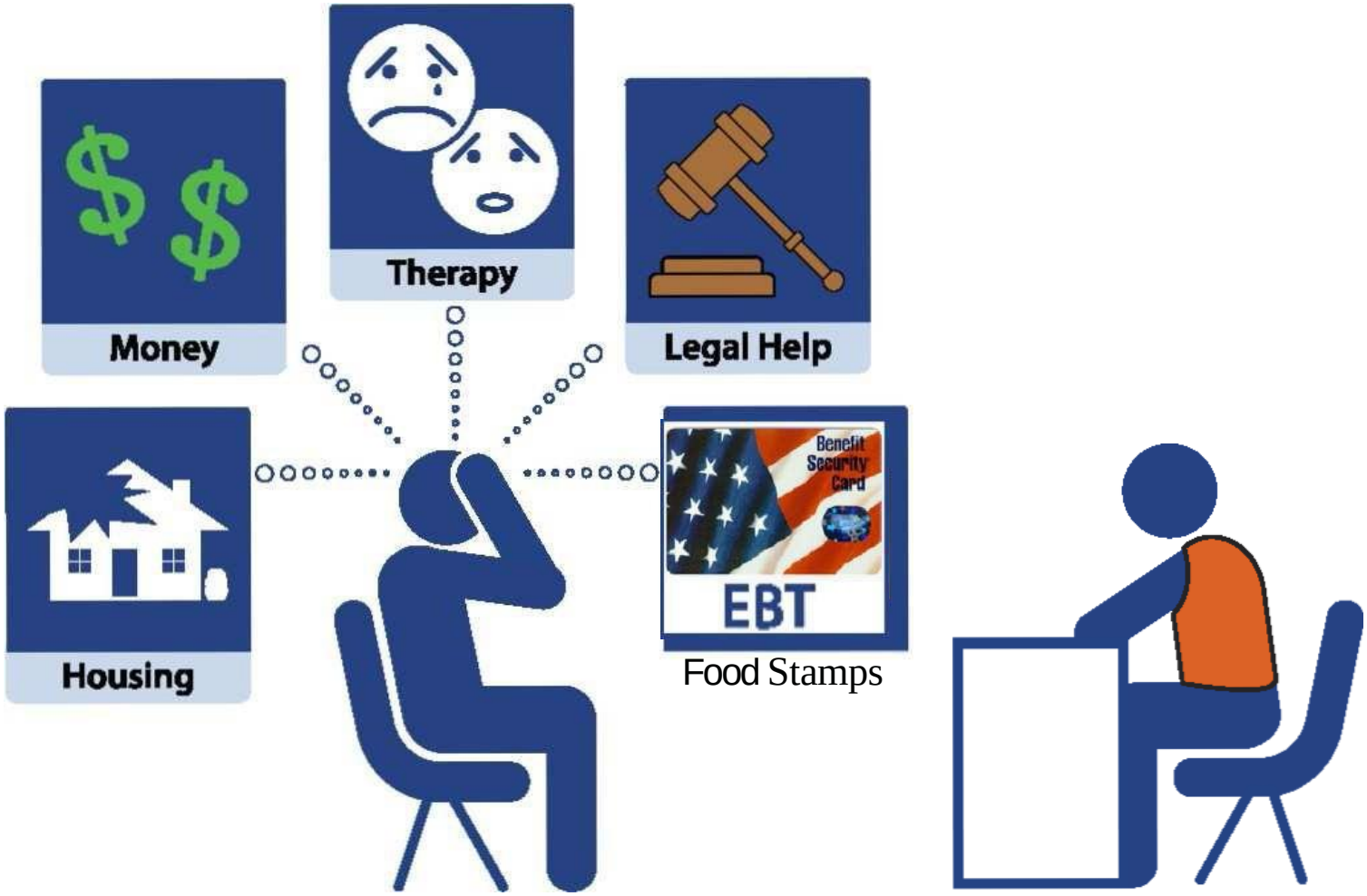
Feelings and Support

Feelings

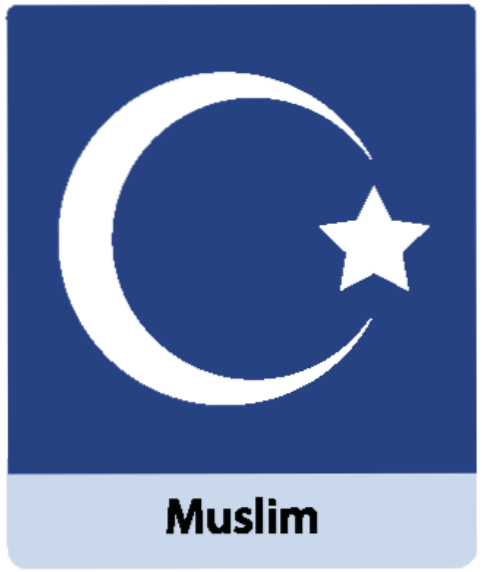


Feelings & Support

Support


Money
Therapy
Legal Help
Housing
Benefit Security Card
EBT
Food Stamps

Religious Support



Time

Time

Time

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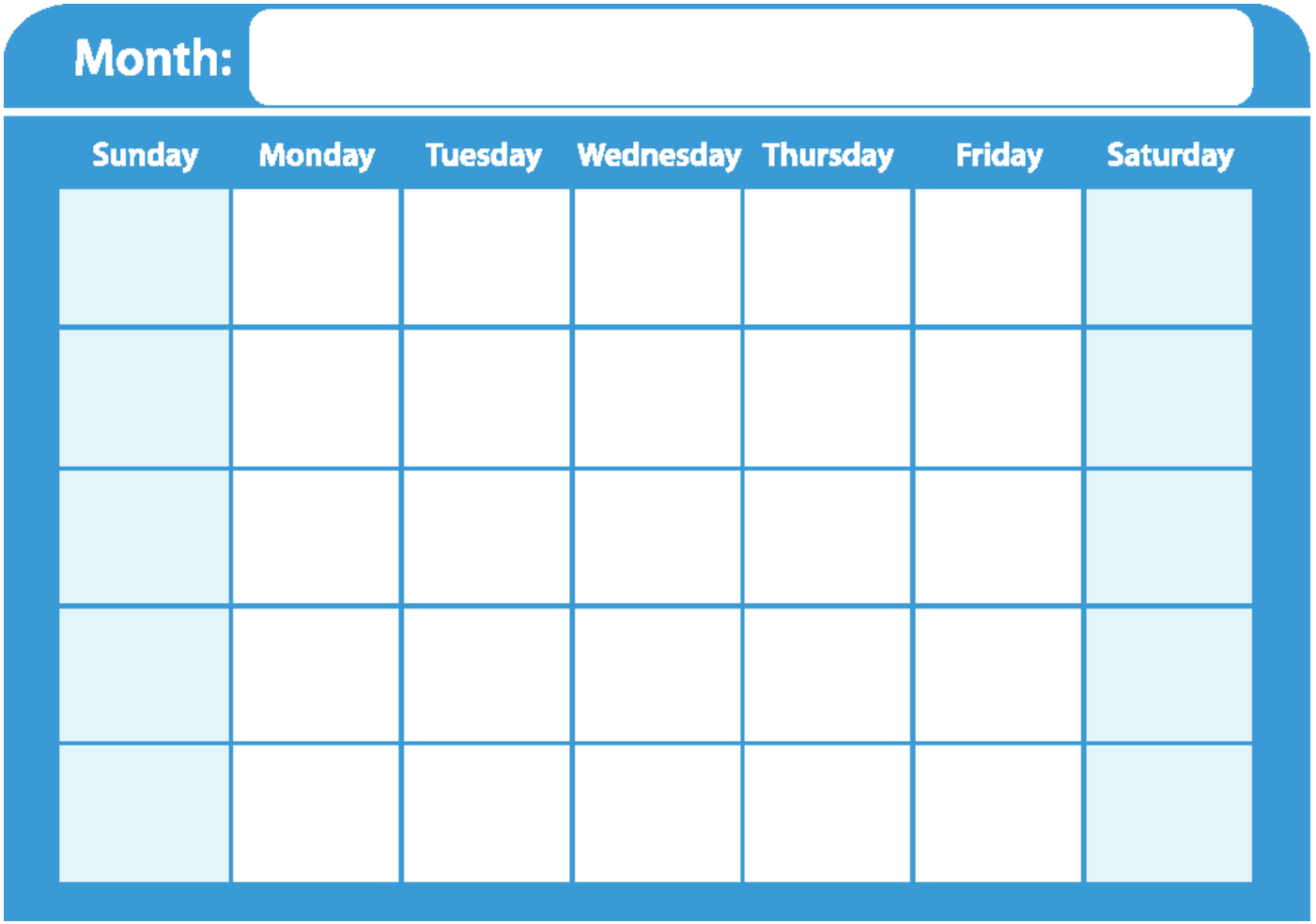
Month:
Sunday
Monday
Tuesday
Wednesday
Thursday
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Saturday

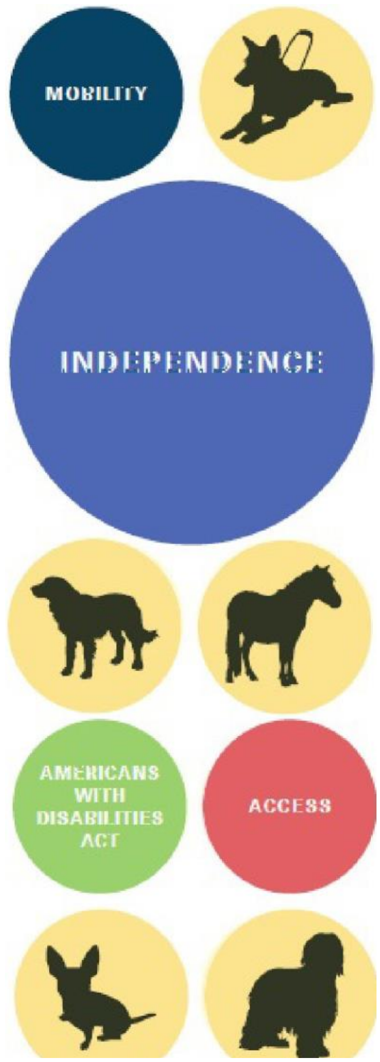
Notes

This project was developed by the Emergency Preparedness Bureau at the Massachusetts Department of Public Health, with funding from the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program and Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness Program.

Welcoming Your Cust,o,mers

WHO USE SERVICE ANIMALS

AService Animal is any dog or miniature horse that is trained to do work or perform tasks for an individual with a disability..



WHAT BUSINESSES NEED TO KNOW:

Are Service Animals allowed in my place of business?

Yea.thC'y are allowed in all businesses including those that serve food.

What questions can I ask a person with a Service Animal?

Is the animal a Service Animal required for a disability?

What has the animal b!!en trained to do for the indi11idual?

What am I responsible for when Service Animal is present?

Only to treat the person the same as any other customer.

Is there anyrequited tdenti fleati on for Service Animals?

No. A Scr11iceAnimal may W!!ar a 11est, hamess or display an m. but this Is not required.

Download a,dditiona,l resources. and find more information on•line at www.1ncd hh s.gov/ serv ic ea1n imal s.

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ADDITIONAL INFORMATION

What is a Service Animal?

A service animal as defined by the Americans with Disabilities Act is as follows:

"**Service animal** means any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Other species of animals, whether wild or domestic, trained or untrained, are not service animals for the purposes of this definition. The work or tasks performed by a service animal must be directly related to the individual's disability. Examples of work or tasks include, but are not limited to, assisting individuals who are blind or have low vision with navigation and other tasks, alerting individuals who are deaf or hard of hearing to the presence of people or sounds, providing non-violent protection or rescue work, pulling a wheelchair, assisting an individual during a seizure, alerting individuals to the presence of allergens, retrieving items such as medicine or the telephone, providing physical support and assistance with balance and stability to individuals with mobility di sabilities, and helping persons with psychiatric and neurological disabilities by preventing or interrupting impulsive or destructive behaviors. The crime deterrent effects of an animal's presence and the provision of emotional support, well-being, comfort, or companionship do not constitute work or tasks for the purposes of this definition." (Service Animal as defined by the ADA, Title III, subpart A 36.104 definitions, July 2010)

In addition to the provisions about Service Dogs, the U.S. Department of Justice's revised ADA regulations have a new, separate provision about miniature horses that have been individually trained to do work or perform tasks for people with disabilities. (Miniature horses generally range in height from 24 inches to 34 inches measured to the shoulders and generally weigh between 70 and 100 pounds.) Entities covered by the ADA must modify their policies to permit miniature horses where reasonable. The regulations set out four assessment factors to assist entities in determining whether miniature horses can be accommodated in their facility. The assessment factors are (1) whether the miniature horse is housebroken; (2) whether the miniature horse is under the owner's control; (3) whether the facility can accommodate the miniature horse's type, size, and weight; and (4) whether the miniature horse's presence will not compromise legitimate safety requirements necessary for safe operation of the facility.

The ADA limits the definition of Service Animals to dogs and miniature horses.

Therapy dogs, emotional support dogs and companion dogs are not Service Animals as defined by the ADA.

In North Carolina, this law also applies to animals in training to become Service Animals. Training organizations and people training a Service Animal have the same access rights as people with disabilities using a Service Animal. The animal must wear a collar and leash, harness or cape that identifies it as a Service Animal in Training. The trainer is liable for any damage caused by the animal while in a place of business.

State of North Carolina | Pat McCrory, Governor | Department of Health and Human Services
Aldona Z. Wos, M.D., Secretary | www.ncdhhs.gov | N.C. DHHS is an equal opportunity employer and provider. 5/15

FREQUENTLY ASKED QUESTIONS

for Businesses regarding access for Service Animals

What Questions can I ask of a person with a Service Animal?

There are only two questions you can ask the handler/owner of a Service Animal.

1. Is the animal a Service Animal required for a disability'
2. What work or task related to the individuars disability has the animal been trained to perform,

You may not ask the handler about the nature of his.or her disability.

How can I be sure that the animal is a Service Animal and not a pet?

The animal must be accepted unless it displays unruly or aggressive behavior. relieves itself in an inappropriate area. or appears unmanaged by its handler.

In general. a Service Animal will not normally behave in public as an untrained pet would behave. A trained animal will appear calm and comfortable and will usually sit. stand or lay quietly beside the handler but may also provide an alert to the handler.

Can I charge a deposit or fee for a Service Animal?

No. Under ADA guidelines. neither a deposit nor a surcharge can be imposed on an individual with a disability However. customers with disabilities may be dharged **if** the animal causes damage while visiting the facility as long as it is the regular practice to charge people without disabilities for the same type of damages

What rules apply to Service Animals in businesses such as barbersho,ps or nail salons, which are required to pass health inspections?

Establishments that provide services to the public must allow Service Animals in all public areas.

Are Service Animals allowed in my place of business?

Yes. A Service Animal must be allowed to accompany the individual to all areas of the facility where customers are normally allowed to go. An individual with a Service Animal may not be segregated from other customers. If another customer in the business has an allergy to animals. it is acceptable to separate the two customers to separate areas of the business.

Is there any required identification for Service Animals?

No. There is no requirement for the Service Animal to wear special gear or have identification. Sometimes handlers will carry identifying paperwork. and some animals wear harnesses due to the nature of their work. but it is NOT required that they do so.

What is the difference in a Service Animal and a therapy animal, support animal or companion animal?

A Service Animal is trained to perform **a** specific task for an individual with a disability A therapy animal. support animal or companion animal provides comfort and/or companionship to an individual. These non-service animals are not afforded the same privileges in public places.

Can my business be sued for damages, held liable, or fined for refusing entry to a person with a Service Animal?

Yes. You may not discriminate against a person with a disability or his or her Service Animal and will be held to the federal. state and civil laws governing your business.

Treat the person the same as any other customer.

Should I suspect that a young dog/puppy/ miniature horse or that a small dog is not a Service Animal?

No. A young dog/puppy/ miniature horse may be in training. and. while it must also be identified or declared as a Service Animal in Training. it is afforded the same rights and privileges as a fully trained/ adult Service Animal. A small dog may be trained for seizure alert or other medically necessary service. Refer to the questions you may ask of a person with a Service Animal.

What am I responsible for when a Service Animal is present?

The business is not responsible for the feeding or care of the Service Animal. It is acceptable to offer water to the animal if you choose to do so. but always ask permission of the handler first. Please do not pet the Service Animal.These animals are working animals and are not to be touched unless permission is given by the handler.

I have a "No pets policy". Do I still have to allow Service Animals?

Yes. Under ADA guidelines. a Service Animal is a working animal. not a pet. A ··no pets policy·· does not apply to Service Animals.

What rules apply to Service Animals in restaurants?

Establishments that sell or prepare food must allow Service Animals in public areas even **if** state or local health codes prohibit animals on the premises.

What can I do if the Service Animal exhibits disruptive behavior?

A Service Animal must be under the control of the handler at all times. A Service Animal must not show aggression toward people or other animals. A Service Animal does not bark. growl or whine unless trained to do so as a warning sign to the handler. A Service Animal does not solicit food or other items from the general public. A Service Animal·s work does not disrupt the normal course of business. If any of these instances occur. you are allowed to ask the handler and animal to leave the business or refuse entry to the business. You are still expected to provide the handler access to the product or service that he or she has visited your business to receive.

Attachment 3- Additional Signage

Basic Shelter Rules

Shelter Rules Are For The Safety Of Everyone.

Shelter Rules Will Apply Equally To All Individuals In The Shelter

Everyone must sign in or register upon arriving at shelter.

No smoking is permitted unless designated by the host facility.

Courtesy is expected at all times!

Children in the shelter must be under the supervision of an adult.

Individuals are responsible for their own personal belongings and valuables

NO alcoholic beverages, illegal drugs, firearms, or explosives will be allowed!

SHELTER RULES AND POLICY FOR RESIDENTS AND CAREGIVERS

1. The shelter may be crowded. RESPECT the rights and privacy of others.
2. Keep your own space clean and neat.
3. Keep yourself as clean and neat as possible.
4. Speak in a quiet tone: no yelling and no profanity.
5. Keep all noise to a minimum: no loud radios, CD players, TV's, etc. Turn off by ll:00 p.m. Staff will monitor and provide news updates to avoid disturbing those trying to sleep.
6. Lights will be dimmed at 11:00 p.m., if possible, but the care and observation of individuals in the shelter may require brighter lighting at times.
7. If the shelter provides a TV, the majority rules on programs to be watched. Shelter staff will determine what is viewed if there is not agreement or if something is deemed inappropriate.
8. Shelter phones will be available for emergency calls only and will be limited to 5 minutes. Shelter staff will determine phone use.
9. Shelter staff are not responsible for the loss of money, medications, equipment or other personal items. Please take care of these items. Items can be stored in a locked area upon request.
10. No smoking is permitted unless designated by the host facility
11. No alcohol or illegal drug use will be permitted inside the shelter.
12. No weapons of any kind are allowed in the shelter.
13. No borrowing and no stealing will be permitted.
14. No fighting, either verbal or physical will be permitted.
15. No sexual activity will be permitted.
16. Supplies and food brought to the shelter by individuals belong to them alone and will be shared only if the individual desires to do so. Sharing of personal items is discouraged.
17. Food and beverages (except water) are not to be consumed in sleeping areas.
18. Cots will first be provided to residents according to functional or medical limitations.
19. Caregivers will only be provided with cots if availability permits
20. Supplies provided by the shelter will be given to all individuals according to need and availability.
21. Functional or medical needs individuals, along with other shelter residents will have food service priority over caregivers/family members and visitors. Second servings of food and beverages will be offered to residents before caregivers/family members can receive second servings. Servings will be moderate.
22. Stockpiling or hoarding of shelter-provided food is not allowed.
23. To the extent possible games, books, and activities will be made available at the shelter. Such activities are to be carried out quietly and with respect for others.
24. Shelter staff, facility staff, volunteers, residents, caregivers and visitors should be treated with courtesy and respect.
25. Areas designated for staff use are not to be entered by those being sheltered.
26. Caregivers are expected to provide all routine care, as they would do at home. Caregivers must remain in the shelter until the individual for whom they are responsible is discharged. Short leaves or breaks may be permitted if arranged with and approved by shelter staff.
27. No pets are allowed in the shelter. Service animals are permitted but care, feeding, and waste elimination is the responsibility of the individual, caregiver, or family.
28. Caregivers/families of individuals with a functional or medical need are discouraged from bringing children to the shelter to visit. An assessment will be made by the medical staff, behavioral health staff and the DSS to determine if children are allowed to stay at a shelter that serves the functional or medical needs of an adult relative (the determination will be in the best interest of the child as well as the medical care). If children are present, the parents or caregivers are responsible for keeping them quiet and controlled. No running, shouting,

etc. Individuals in this type of shelter are unwell or have conditions that make it difficult to engage in the activities of daily life and undue stress can have an adverse effect on their care.

NO FIREARMS OR WEAPONS ALLOWED ON THIS PROPERTY

Please Wash Your Hands Before Handling or Eating Food

"

"

Food or Beverage Should NOT Leave This Area

Please Dispose of ALL Trash Properly

Appendix I Signs And Symptoms Of Stress

COMMON STRESS REACTIONS OF DISASTER WORKERS

Psychological and Emotional
Feeling heroic, invulnerable, euphoric
Denial
Anxiety and fear
Worry about the safety of self or others
Anger
Irritability
Restlessness
Sadness, grief, depression, moodiness
Distressing dreams
Guilt or "survivor guilt"
Feeling overwhelmed, hopeless
Feeling isolated, lost, abandoned
Apathy
Identification with survivors

Cognitive
Memory problems
Disorientation
Confusion
Slowness of thinking and comprehension
Difficulty calculating, setting priorities, making decisions
Poor concentration
Limited attention span
Loss of objectivity
Unable to stop thinking about disaster
Blaming

Behavioral
Change in activity
Decreased efficiency and effectiveness
Difficulty communicating
Increased use of humor
Outbursts of anger and frequent arguments
Inability to rest or "let down"
Change in eating habits
Change in sleeping patterns
Change in patterns of intimacy and sexuality
Change in job performance
Periods of crying
Increased use of alcohol, tobacco and drugs
Social withdrawal, silence
Vigilance about safety of environment
Avoidance of activities or places that trigger memories
Proneness to accidents

Physical
Increased heartbeat, respiration
Increased blood pressure
Upset stomach, diarrhea, nausea
Change in appetite, weight gain or loss
Sweating or chills
Tremor (hands or lip)
Muscle twitching
"Muffled" hearing
Tunnel vision
Feeling uncoordinated
Headaches
Soreness in muscles
Lower back pain
Feeling a "lump in the throat"
Exaggerated startle reaction
Fatigue
Menstrual cycle changes
Changes in sexual desire
Decreased resistance to infection
Flare-up of allergies and arthritis
Hair lost

Symptoms of Worker Burnout

Thinking: mental confusion, slowness of thought, inability to make judgments and decisions, loss of ability to conceptualize alternatives or to prioritize tasks, loss of objectivity in evaluating own functioning

Psychological: depression, irritability, anxiety, hyper-excitability, excessive rage reactions

Somatic: physical exhaustion, loss of energy, gastrointestinal distress, appetite disturbances, hypochondria, sleep disorders, tremors

Behavioral: hyperactivity, excessive fatigue, inability to express self verbally or in writing

The syndrome may appear early or from two weeks to a year after the disaster. On the average, it seems to take about 4 to 6 weeks for most symptoms to appear. Be alert for early signs in yourself and in co-workers. Contact a supervisor if symptoms are apparent. Intervention will involve temporarily relieving the worker of their duties to allow for a short recuperation. The worker will be able to return to the site when their energy level is back to normal.

Reference And Sources

Reference
American Red Cross Disaster Health Services Protocols
Ashe County Emergency Operation Plan
Ashe County Hazard Mitigation Plan

Index

Glossary

Amateur Radio - A service of radio communications, performed by persons interested in the radio art solely for personal gain and without pecuniary interest. Operates in the public interest, convenience or necessity, therefore is available for use in emergency situations.

Catastrophic Disaster - For the purposes of this plan, a catastrophic disaster is defined as an event that results in large numbers of deaths and injuries; causes extensive damage or destruction to facilities that provide and sustain human needs; produces an overwhelming demand on state and local response resources and mechanisms; causes a severe long term effect on general economic activity; and severely affects State, local and private sector capabilities to begin and sustain response activities.

Disaster/Emergency - Any natural or man-made event, which causes sufficient damage to life and property. Disaster and emergency are used interchangeably whenever a situation calls for a crisis response; however emergencies can be handled with resources routinely available to the community. A disaster calls for a response that exceeds local capabilities.

Emergency Management (EM) - Organized analysis, planning, decision-making, assignment, and coordination of available resources for the mitigation of preparedness for, response, to or recovery from major community-wide emergencies.

Emergency Management Coordinator (EMC) - The individual who is directly responsible on a day to day basis for the jurisdictions effort to develop a capability for coordinated response and recovery from the effects of disaster.

Emergency Medical Services (EMS) - Local medical response teams, usually rescue squads or local ambulance services which provide medical services during a disaster.

Emergency Operations Center (EOC) - A protected site from which government officials and emergency response personnel exercise direction and control in an emergency. The Emergency Communications Center (ECC) is normally an essential part of the EOC.

Emergency Operations Plan (EOP) - An all-hazards document, which clearly specifies actions to be taken or instructions to be given in the event of natural disasters, technological accidents, or other emergencies. The plan identifies authorities, relationships, and the coordinated actions to be taken based on predetermined assumptions, objectives, and existing capabilities.

Evacuation - Relocation of civilian population to safe areas when disaster, emergencies or threats thereof necessitate such action.

Facility - means any building, structure, or installation.

FAST -the North Carolina Functional Assessment Support Teams. A team is a group of state or local personnel who can conduct assessments of people with access and functional needs and coordinates with shelter staff to ensure those people get needed resources to be able to maintain their independence while in a shelter setting.

General Statute (G.S.) - The specific form of State Law, codified and recorded for reference.

Hazard - Any situation that has the potential for causing damage to life, property, and the environment.

Incident Action Plan - The plan that is usually prepared at the beginning of each operational period that contains general control objectives reflecting the overall operational strategy and specific action plans for the next operational period.

Incident Command System (ICS) – A combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure with responsibility for management of assigned resources to effectively direct and control the response to an incident. Intended to expand as situation requires larger resource, without requiring new, reorganized command structure.

Local Government - Political subdivision of the state usually county or municipal levels.

Local Warning Point - A facility in a city, town, or community that receives warnings and activates the Public Warning System in its area of responsibility.

Mass Care - Efforts to provide shelter, feeding, first aid and distribution of relief supplies following a catastrophic or significant natural disaster or other event to disaster victims.

Memorandum of Agreement (MOA) - A document negotiated between organizations or legal jurisdictions for mutual aid and assistance in times of need. An MOA/MOU must contain such information as who pays for expense of operations (financial considerations), who is liable for personal or property injury or destruction during response operations (liability considerations), and appropriate statements of non-competition of government resources with private enterprise (commercial considerations).

N. C. General Statute (NCGS) - State Law by applicable statute.

National Incident Management System (NIMS) - A system intended to integrate effective practices in emergency preparedness and response into a comprehensive national framework for incident management. The NIMS enables responders at all levels to work together more effectively to manage domestic incidents no matter what the cause, size or complexity.

Operational Period – A period of time set for execution of operational actions specified in the Incident Action Plan. Traditionally these periods are initially 12 to 24 hours in length. As the incident winds down, they may cover longer periods of activity.

Self Evacuate - Persons who evacuate before evacuation is ordered or recommended by proper authority based on a perceived or actual dangerous situation.

Shelter - A facility to house, feed, and care for persons evacuated from a risk area for periods of one or more days. For the risk areas the primary shelter and the reception center are usually located in the same facility.

Shelter Coordinator - The Shelter Coordinator will be the Director of DSS or their designee and is responsible for shelter and mass care matters including coordinating all Shelter Management.

Shelter Manager - An individual who provides for internal organization, administration, and operation of a shelter facility.

Special Needs Shelter - Special Needs", was used for providing shelter or disaster service refers to an extremely broad group of people with disabilities, people with serious mental illness, minority groups, the non-English speaking, children, and the elderly. The term was too broad and was ineffective in its purpose, as defining a specific shelter or sheltering service. "Functional or Medical Needs" term has replaced "Special Needs" term

Support Agency - A State department or agency designated to assist with available resources, capabilities, or expertise in support of the Common Function response operations, under the coordination of the Primary agency.

Unified Command - A team which allows all agencies (with geographical or functional responsibility for the incident) to co-manage an incident through a common set of objectives and strategies. Agencies' accountability, responsibilities, and authorities remain intact.

Warning Point - A facility that receives warning and other information and disseminates or relays this information in accordance with a prearranged plan.

[i]"Functional or Medical Needs" term has replaced "Special Needs" term. The prior term, "Special Needs", was used for providing shelter or disaster service refers to an extremely broad group of people with disabilities, people with serious mental illness, minority groups, the non-English speaking, children, and the elderly. The term was too broad and was ineffective in its purpose, as defining a specific shelter or sheltering service. The original "Special Needs Shelters" entitled in the agreements with the cooperating facilities who agreed to host as shelters for individuals with functional or medical needs may remain in place and the term change not effecting the agreement.