

EMERGENCY EVACUATION PLAN COMPONENTS

License Capacity: _____

Facility: _____

License #: _____

NOTE: A blank space in the first column indicates component of plan has not been met (reviewer must explain on a separate sheet, what corrective action is needed and attach it to this form). N/A indicates component is not applicable. A check indicates the component of the plan was met. Components associated with a shaded box in the first column are included as guidance only and are not specifically required for a plan to be approved. * Indicates elements of particular interest to local emergency preparedness divisions.

MET	COMPONENT CRITERIA TO BE MET
	A Sheltering Plan that includes:
	a. An alternate location to house patients or residents (Sheltering Facility);
	b. Full provisions for at least the number of licensed beds at Sheltering Facilities;
	c. A letter of agreement between the facility and the sheltering facility(ies) signed by an authorized representative of each Sheltering Facility. The letter shall be current (within the last year) and must include the number of relocated patients or residents that can be accommodated;
	d. The name, address, and phone number of the Sheltering Facility; *
	e. Facilities located in Beaufort, Charleston, Colleton, Horry, Jasper, and Georgetown counties, at least one Sheltering Facility shall be located in a county other than these counties. *
	A Sleeping Plan for the patients or residents that should address topics such as:
	a. Beds, cots, sleeping bags, or mattresses required;
	b. Pillows, blankets, <i>etc.</i> required;
	c. Arrangements to provide special bed equipment, <i>e.g.</i> , egg crate mattress, air mattress, <i>etc.</i>
	A Feeding Plan for the patients or residents that should address topics such as:
	a. Food and water provisions for preparing or catering at least 3 meals per day;
	b. Arrangements to provide the special diets required;
	c. Equipment and supplements necessary for patients or residents that are tube feeding. (Unless otherwise prohibited by regulation)
	A Medication Plan for the patients or residents that should address topics such as:
	a. Arrangements for all medication regimens (including standing orders) to accompany each patient or resident relocated;
	b. Arrangements for medications to accompany each patient or resident relocated;
	c. Arrangements for Medication Administration Records to accompany each patient or resident relocated;
	d. Measures to be taken to secure and store medications;
	e. Provisions to include medication reference materials in the relocation.
	A Transportation Plan for the patients or residents that includes:
	a. Number and type of vehicles required to relocate patients or residents; *
	b. How the vehicles will be obtained; *
	c. When the vehicles will be obtained; *
	d. Who, <i>e.g.</i> , individual or company, will provide the drivers of the vehicles; *
	e. Procedures for providing medical support and medications for the patients or residents during the relocation;
	f. Estimated time to accomplish the relocation of the patients or residents; *
	g. The primary route to be taken to the Sheltering Facility; *
	h. The secondary route to be taken to the Sheltering Facility. *
	A Staffing Plan that includes:
	a. A detailed outline that indicates how care will be provided to the relocated patients or residents;
	b. The number and type, <i>e.g.</i> job titles, of staff;
	c. Provisions for accommodating relocated staff must be addressed if staffing is to be provided by the relocating facility;
	d. The Staffing Plan must be co-signed by an authorized representative of the Sheltering Facility if staffing is to be provided by the Sheltering Facility.
	Annual updating or whenever significant changes occur.
	Documentation of communication/coordination with county Emergency Preparedness Division in the development and implementation of the Emergency Evacuation Plan.*
	Plan rehearsed annually (if required by regulation) and documented to include:
	a. Time and date;
	b. Summary of actions and recommendations; *
	c. Names of Participants.

Reviewed By: _____
(DHEC or Health Regulation Representative)

Date: _____

Reviewed By: _____
(Health Licensing Representative)

Date: _____