Critical Asset Survey Worksheet

Please complete this worksheet prior to reporting on-line. After completing online reporting, Please keep a copy of this worksheet for your records.

FACILITY INFORMATION:

Facility Name: ____

Address: ____

____

City: ____________________ County: ____________________

State: ____________________ Zip Code: ____________________

Phone: ____________________ Fax: ____________________

Emergency Contact Person: ____

Emergency Contact Email: ____

Emergency Contact Cell: ____

Can Receive Text Messages? ______ Yes ______ No

Facility Location: (Check One)

______ Hospital Based
______ Freestanding
______ Nursing Home
______ Satellite
______ Other

Affiliation: (Check One)

______ American Renal Associates
______ DaVita
______ Dialysis Clinic, Inc. (DCI)
______ Diversified Specialty Institutes (DSI)
______ Fresenius Kidney Care
______ Other
______ Independent
______ Renal Care Group, Inc.
______ Renal Research Institute
______ US Renal Care, Inc.
______ Veterans Administration

TREATMENT AND MODALITY OPERATIONS:

1) Census by Modality:
   - # of patients on HD ___________________________
   - # of patients on PD ___________________________
   - # of patients on Home Dialysis ___________________
   - Pediatrics? (Yes or No) ________________________
     - If yes, # Hemo? ________ # PD? ________
2) # HD stations: ___________________________________
3) # HD isolation stations: ____________________________
4) Total # of Hemo Dialysis machines: ____________________

5a) Primary Type Hemo Dialysis Machines (List all that apply):

Manufacturer	Model	# of Machines
Althin	____________________	__________
Baxter	____________________	__________
Cobe	____________________	__________
Fresenius	____________________	__________
Phoenix	____________________	__________
Other (Specify)	____________________	__________

5b) Primary Peritoneal Dialysis Machines:

______ Baxter

______ Fresenius

______ Other (Specify)

Primary Machine Model: ______________________________

Number of machines: ________________________________

6) The facility has the capacity to provide treatment using______ (Check all that apply):

	How Many?
______ Bed(s)	______
______ Stretcher(s)	______
______ Large Capacity/Bariatric Chair(s)	______
______ Hoyer	
______ Ventilators	

OPERATING HOURS:

7) Days of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Days Open (Check all that apply)						
# of Shifts						
Nocturnal Shifts Available (Check applicable days)						

SUPPLIES:

8) Please list you Home Hemo vendor emergency contact information (i.e. NxStage, Fresenius, etc.):

Note: Enter 'None' if there is no emergency contact

Name: ____

Telephone: ____

9) # of days of 'on-hand' supply storage capabilities? (i.e. 30 days) _________

10) Water treatment back up capabilities? (i.e. DI tanks, water delivery, etc.)

______ Yes ______ No

If yes, please specify: ____

DIALYZERS USED:

11) List dialyzers used in your facility:

Manufacturer	Model

12) Do you reuse dialyzers?

______ Yes ______ No

If yes, please specify: ____

EMERGENCY PREPAREDNESS: FACILITY

Service Providers

13) Who is your electrical provider? ____

14) Who is your water provider? ____

15) Who are your transportation providers? ____________________________________

____

____

Emergency Plan

16) Which of the following components are included in your facility's disaster plan? (Check all that apply)

______ A fire in unit
______ Bomb threats
______ A power outage in unit
______ Terrorist attacks or natural disasters
______ A community-wide power outage
______ Pandemic Flu
______ Water problems in unit
______ Patient evacuation/relocation
______ Weather related disasters
______ Other (please specify) _________________________________

17) How often does your facility review and update its emergency plan?

______ Monthly
______ Quarterly
______ Semi-annually
______ Annually
______ Never
______ Other (please specify) ____

18) How often does your facility have emergency drills?

______ Monthly
______ Quarterly
______ Semi-annually
______ Annually
______ Never
______ Other (please specify) ____

Back-up Provider

19) Who is your ESRD facility backup agreement with?

____

20) How often do you meet with your backup facility to discuss treating patients during an emergency?

_______ Monthly _______ Quarterly

_______ Semi-annually _______ Annually

_______ Never _______ Other (please specify)

____

21) Has your facility established contacts with outside agencies, such as the local Office of Emergency Management (OEM), with whom you may need to communicate in the event of an emergency?

_______ Yes (Please specify) _______ No

Name	Organization	Phone	Email

EMERGENCY PREPAREDNESS: PATIENTS

22) How often does your facility communicate with patients regarding how to prepare for a disaster?

_______ Monthly _______ Quarterly

_______ Semi-annually _______ Annually

_______ Never _______ Other (please specify)

____

23) Which of the following emergency procedures have you discussed with patients? (select all that apply)

_______ How to contact the dialysis facility

_______ How to maintain contact with family and friends

_______ How to contact backup dialysis facility

_______ How to contact the ESRD Network

_______ When to call 911

_______ Transportation

_______ Renal Diet

_______ Other (please specify)

____

DURING AND FOLLOWING AN EMERGENCY

24) Have you established a process for communicating with the following individuals during an emergency and following and emergency?

(select all that apply)

_______ Patients in the unit

_______ Patients not in the unit

_______ Family members

_______ Staff including medical director

_______ Local transportation providers

_______ Utility providers

_______ Professional/ ancillary volunteer staff to fill in for staff shortages

_______ ESRD Network

_______ Office of Emergency Management

_______ State Health Department

25) Are the following individuals aware of the facility's communication plan? (select all that apply)

______ Patients

______ Family members of patients

______Dialysis unit staff

26) How often is the emergency contact information for patients collected/ updated?

______ Monthly ______ Quarterly

______ Semi-annually ______ Annually

______ Never ______ Other (please specify)________________

27) How often is the emergency contact information for patient's family collect/updated?

______ Monthly ______ Quarterly

______ Semi-annually ______ Annually

______ Never ______ Other (please specify)_________________

28) How often is the emergency contact information for staff collected/updated?

______ Monthly ______ Quarterly

______ Semi-annually ______ Annually

______ Never ______ Other (please specify)

____

If yes, please specify: ____

30) Does your dialysis clinic have a communication system for use if the phones aren't working? (Radio, Nextel, emergency test messaging system to cell phone)

______ Yes ______ No

If yes, please specify: ____

31) Do you have an electrical generator? (If no, please fill out generator specifications on page 7)

______ Yes ______ No

32) Does your facility have electrical generator quick connect transfer switch capabilities?

______ Yes ______ No

GENERATOR SPECIFICATIONS *(If facility does not have a generator or quick connect)*

To complete this section, you may need to contact a qualified electrician and work with your biomed-technician. This information will expedite the acquisition of a generator in the event of an emergency or disaster.

1) Building Use ______________________________

2) Longitude ______________________ 3) Latitude ______________________

4) Site/Generator Point of Contact ______________________________

5) Phone ______________________ 6) Cell Phone ______________________

7) Email ______________________ 8) Fax ______________________

9) KW (asses generator size) ______________________________

10) Generator Required Amperage ______________________________

11) Phase (assessed generator phases) ______________________________

12) Voltage (assessed generator voltage) ______________________________

13) Configuration ______________________________

14) Load Cable Size (MCM or #awg) ______________________________

15) Load Cable Size Qty/UI (load cable length) ______________________________

16) Load Cable Size Notes ______________________________

17) Ground Cable Size (MCM or #awg) ______________________________

18) Ground Cable Size Qty/UI (load cable length) ______________________________

19) Ground Cable Size Notes ______________________________

20) Remarks ______________________________