



PHONE NUMBER **647-5355** / AFTER HOURS PRESS **7** FOR NURSE

**\*HOW TO USE:**

For Disaster Emergency	For Medical Problems / Emergency
*SEE pages 2 & 3	*SEE pages 4 to 8
1. In case of a Natural Disaster: Tropical Storm/Typhoon Earthquake Floods / Tsunami	1. When you feel a <b>SYMPTOM</b> occur, look for it on the <b>SYMPTOM LIST</b> . (pg. 4) 2. Go to the assigned page and <b>MATCH</b> your <b>symptoms</b> to those listed in the row. 3. If your <b>symptoms</b> fall under the box <b>“WHEN TO CALL NURSE”</b> , call your <b>NURSE</b> . 4. If your <b>symptoms</b> fall under the box <b>“WHEN TO CALL 911”</b> , call <b>911</b> , <i>then</i> call your <b>NURSE</b> .

**My HSP Clinician(s) [Please Print]:**

Case Manager:  
 \_\_\_\_\_  
 \_\_\_\_\_

Nurse:  
 \_\_\_\_\_  
 \_\_\_\_\_

Therapy:  
 \_\_\_\_\_  
 \_\_\_\_\_

Home Health Aide:  
 \_\_\_\_\_  
 \_\_\_\_\_

Other:  
 \_\_\_\_\_  
 \_\_\_\_\_

\*I have read **My Emergency Plan**. Initial: \_\_\_\_\_ Date: \_\_\_\_\_

\*My Case Manager/Nurse has gone over **My Emergency Plan** with me. Initial: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **ID No:** \_\_\_\_\_

Staff Name & Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Our agency has **nursing staff on call 24 hours a day** including **nights, weekends & holidays**. On Admission and throughout the patient’s course of care, HSP staff will go over **My Emergency Plan**. This plan shows what to do in case of an emergency.



PHONE NUMBER **647-5355** / AFTER HOURS PRESS **7** FOR NURSE

**\*Please keep this information where you can find it.**

1. **My Emergency Plan** is activated when the Governor of Guam declares Guam in **Condition of Readiness 2:**  
A tropical storm/typhoon may possibly hit the island within 48 hours.
  - a. HSP staff will:
    - i. Organize with you and the DME company(s) to make sure that your supply of prescription medications, IV medications and backup oxygen will be able to last for about one week.
    - ii. Make sure that you will have enough wound care supplies to last about one week.
    - iii. If there is a need for safer shelter, HSP will help organize the transfer of you and your family to a reliable shelter

2. **Durable Medical Equipment:**

LIST OF EQUIPMENT	COMPANY WHO ISSUED EQUIPMENT	PHONE NUMBER
1)		
2)		
3)		
4)		

\*In the event there is a Natural Disaster, HSP staff will contact you and your DME Company.

3. **Preparing for any type of Emergency** (Typhoon, Earthquake, or Pandemic Flu).
  - a. Store a two week supply of water and food. During an emergency, if you cannot get to a store, or if stores are out of supplies, it will be important for you to have extra supplies on hand. This can be useful in other types of emergencies, such as power outages and disasters.
  - b. Have any non-prescription drugs and other health supplies on hand, including pain relievers, stomach remedies, cough and cold medicines, fluids with electrolytes, vitamins, soap and tissue/paper towels/wet wipes.
  - c. To limit the spread of germs and prevent infection: Wash hands frequently with soap and water; cover coughs and sneezes with tissues.







<b>Basic Emergency Supply Kit</b> Emergency Supply List from the Homeland Security at <a href="http://www.ready.gov">www.ready.gov</a>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Enough drinking water for 3 days. One gallon/person/day.</li> <li><input type="checkbox"/> Food for 3 days. Non-perishable food such as canned goods is preferred.</li> <li><input type="checkbox"/> 1 week supply of medications</li> <li><input type="checkbox"/> Bring your glasses (reading/vision) and backup glasses</li> <li><input type="checkbox"/> Battery-powered radio. Ensure extra batteries for device.</li> <li><input type="checkbox"/> Flashlight(s) with extra batteries. LED penlights are best to include in kit.</li> <li><input type="checkbox"/> Basic First Aid Kit.</li> <li><input type="checkbox"/> Plastic sheeting or tarps, rope and duct tape to create a temporary shelter is needed.</li> <li><input type="checkbox"/> Moist hand wipes or towelettes, garbage bags and plastic ties for personal sanitation.</li> <li><input type="checkbox"/> Wrench or pliers to turn off utilities</li> <li><input type="checkbox"/> Can opener for food</li> <li><input type="checkbox"/> Fill up the gas in ALL your cars</li> <li><input type="checkbox"/> Cellphone and charger</li> <li><input type="checkbox"/> Pet food and extra water for pet</li> <li><input type="checkbox"/> Important family documents such as copies of insurance policies, identification and bank account records in a waterproof, portable container</li> <li><input type="checkbox"/> Have enough cash for one week</li> <li><input type="checkbox"/> Pack enough clothes for 3 days.</li> <li><input type="checkbox"/> Matches in waterproof container</li> <li><input type="checkbox"/> Mess kits: paper plates, cups, utensils and paper towels.</li> <li><input type="checkbox"/> Paper, pencil and pens</li> <li><input type="checkbox"/> Books, games, puzzles and other activities.</li> </ul>

PHONE NUMBER **647-5355** / AFTER HOURS PRESS **7** FOR NURSE




**\*SYMPTOM LIST:**




Symptom:		Page Number:
<b>Pain</b> <b>Difficulty Breathing</b> <b>Fever</b> <b>Fall</b>	“I hurt” “I have trouble breathing” “I have fever or chills” “I fell down”	<b>Page 4</b>
<b>Mood Changes</b> <b>Wound Changes</b>	“I am anxious or depressed” “My wound has changed”	<b>Page 5</b>
<b>Movement Difficulty</b> <b>Bleeding</b> <b>Confusion</b>	“I have trouble moving” “I see blood” “I have trouble thinking”	<b>Page 5</b>
<b>Body Function Changes</b>	“My weight or appetite changed” “I don’t feel right” “I feel sick to my stomach”	<b>Page 5</b>
	“I’m having bowel troubles” “I’m having trouble urinating”	<b>Page 6</b>
<b>Diabetes</b>	“I have Diabetes and I’m...”	<b>Page 6</b>
<b>Other</b>	“Other problems”	

PHONE NUMBER **647-5355** / AFTER HOURS PRESS **7** FOR NURSE

WHAT TO DO?	CALL MY HOME HEALTH AGENCY WHEN:	CALL 911 WHEN:
 <b>I hurt</b>	New pain OR pain is <u>worse</u> than usual Unusual bad headache Ears are ringing My blood pressure is above: ____/____ Unusual low back pain Chest pain or tightness of chest RELIEVED by rest or medication	Severe or prolonged pain Pain/discomfort in neck, jaw, back, one or both arms, or stomach Chest discomfort with sweating/nausea Sudden severe unusual headache Sudden chest pain or pressure & medications don't help (e.g. Nitroglycerin as ordered by physician), OR Chest pain went away & came back
 <b>I have trouble breathing</b>	Cough is worse Harder to breathe when I lie flat Chest tightness RELIEVED by rest or medication My inhalers don't work Changed color, thickness, odor of sputum (spit)	I can't breathe! My skin is gray OR fingers/lips are blue Fainting Frothy sputum (spit)
 <b>I have fever or chills</b>	Fever is above _____ F Chills/can't get warm	Fever is above _____ F with chills, confusion or difficulty concentrating
 <b>I fell</b>	Dizziness or trouble with balance Fell and hurt myself Fell but didn't hurt myself	Fell and have severe pain
WHAT TO DO?	CALL MY HOME HEALTH AGENCY WHEN:	CALL 911 WHEN:
 <b>I am anxious or depressed</b>	Always feeling anxious Loss of appetite Unable to concentrate Trouble sleeping Loss of hope Constant sadness	I have a plan of hurting myself or someone else
 <b>My wound changed</b>	Change in drainage amount, color or odor Increase in pain at wound site Increase in redness/warmth at wound site New skin problem Fever is above _____F	Fever is above _____ F with chills, confusion or difficulty concentrating Bleeding that won't stop

PHONE NUMBER **647-5355** / AFTER HOURS PRESS **7** FOR NURSE

WHAT TO DO?	CALL MY HOME HEALTH AGENCY WHEN:	CALL 911 WHEN:
 <b>Trouble Moving</b>	One of my arms or legs is sore My back is stiff / sore I'm walking slower	Suddenly my face, arm or leg is weaker / numb / won't move Suddenly one hand grip is weaker or dropping things such as a spoon When "sticking out" my tongue is not in the middle of mouth When I smile, my mouth is uneven When I raise my eyebrows, they are uneven My face is numb or drooping
 <b>I see blood</b>	Bloody, cloudy, or change in urine color or foul odor Gums, nose, mouth or surgical site bleeding Unusual bruising	Bleeding that won't stop Bleeding with confusion, weakness, dizziness and fainting Throwing up bright red blood or it looks like coffee grounds Large amount of bright red blood
 <b>Trouble thinking</b>	Confused Restless, agitated Can't concentrate	Sudden difficulty speaking Unable to remember important names (my own, spouse, children) Suddenly I am unable to read. I can hear others talking but can't understand what they are saying

WHAT TO DO?	CALL MY HOME HEALTH AGENCY WHEN:	CALL 911 WHEN:
 <b>My weight or appetite changed</b>	I don't have an appetite Lost ___ lbs in ___ days Gained ___ lbs in 1 day OR ___ lbs in ___ days Feet/ankles/legs are swollen	
 <b>I don't feel right</b>	Weaker than usual Dizzy, lightheaded, shaky Very tired Heart fluttering, skipping or racing Blurred vision	Sudden numbness or weakness of the face, arm or leg Sudden difficulty speaking/slurred words Suddenly can't keep my balance
 <b>I feel sick to my stomach</b>	Throwing up New coughing at night	Can't stop throwing up Throwing up blood

PHONE NUMBER **647-5355** / AFTER HOURS PRESS **7** FOR NURSE

WHAT TO DO?	CALL MY HOME HEALTH AGENCY WHEN:	CALL 911 WHEN:
 <b>Bowel troubles</b>	Diarrhea Black/dark OR bloody bowel movement No bowel movement in ____ days No colostomy/ileostomy output in _____hours/days	
 <b>Trouble urinating</b>	Leaking catheter No urine from catheter in _____ hours Have not passed water in _____ hours Urine is cloudy Burning feeling while urinating Belly feels swollen or bloated	

WHAT TO DO?	CALL MY HOME HEALTH AGENCY WHEN:	CALL 911 WHEN:		
 <b>I have Diabetes and I'm . . .</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">                             Thirsty or hungry more than usual                              Urinating a lot                              Vision is blurred                              I'm feeling weak                              My skin is dry and itchy                              Repeated blood sugars greater than _____mg/dl                         </td> <td style="width: 50%;"> <b>Take:</b> 3 glucose tablets, OR                              ½ glass of juice, OR                              5-6 pieces of hard candy, OR    <b>wait:</b> 15 minutes &amp; re-check blood sugar    <b>IF</b> your blood sugar is still low and symptoms do not go away: Eat a light snack:                              ½ peanut butter OR                              meat sandwich, ½ glass milk    <b>Wait:</b> 15 minutes &amp; re-check blood sugar                         </td> </tr> </table>	Thirsty or hungry more than usual Urinating a lot Vision is blurred I'm feeling weak My skin is dry and itchy Repeated blood sugars greater than _____mg/dl	<b>Take:</b> 3 glucose tablets, OR ½ glass of juice, OR 5-6 pieces of hard candy, OR  <b>wait:</b> 15 minutes & re-check blood sugar  <b>IF</b> your blood sugar is still low and symptoms do not go away: Eat a light snack: ½ peanut butter OR meat sandwich, ½ glass milk  <b>Wait:</b> 15 minutes & re-check blood sugar	Fruity breath Nausea/throwing up Difficulty breathing Blood sugar greater than _____mg/dl  Low blood sugar not responding to treatment Unable to treat low blood sugar at home Unconsciousness Seizures
Thirsty or hungry more than usual Urinating a lot Vision is blurred I'm feeling weak My skin is dry and itchy Repeated blood sugars greater than _____mg/dl	<b>Take:</b> 3 glucose tablets, OR ½ glass of juice, OR 5-6 pieces of hard candy, OR  <b>wait:</b> 15 minutes & re-check blood sugar  <b>IF</b> your blood sugar is still low and symptoms do not go away: Eat a light snack: ½ peanut butter OR meat sandwich, ½ glass milk  <b>Wait:</b> 15 minutes & re-check blood sugar			
 <b>Other problems</b>	Feeding Tube clogged Problems with my IV/site	Sudden loss of vision in one or both eyes		

Developed by Quality Insights of Pennsylvania in conjunction with Carol Siebert, MS, OTR/L, FAOTA, American Occupational Therapy Association and Karen Vance, OTR/L, BKD Healthcare Group and American Occupational Therapy Association. Based on MyEmergency Plan created by Delmarva in conjunction with OASIS Answers, Inc.