

ASSINIBOINE RHA – FACILITY STATUS REPORT

FULL REPORT INTERIM UPDATE

FACILITY NAME: _____ DATE: _____ TIME: _____ EVENT: _____

SECTION A: CLIENT STATUS REPORT

	ACUTE	PCH
1. Number of clients in facility:	_____	_____
2. Number of empty beds:	_____	_____
3. Number of clients eligible for discharge home	_____	_____
4. Number of current outpatients	_____	_____
5. Number of event specific outpatients	_____	_____
6. Number of event specific deaths	_____	_____

LEGEND for Sections B & C: S – Satisfactory L – Low C - Critical Shortage X – Not Functioning N - Not Applicable

SECTION B: STAFFING STATUS REPORT – (In COMMENTS indicate OTHER staff present)

Department	Staff Numbers Current Shift			Staff Numbers Next Shift		
	Currently Present (#)	Status (S,L,C)	Additional Required (#)	Expected (#)	Status (S,L,C)	Additional Required (#)
Maintenance						
Nursing						
Physicians						
Aides						
EMS						
Diagnostics						
Nutrition Services						
Housekeeping						
Laundry						
CSR						
Admin/Med Rec.						
Activities						
Home Based Serv.						
Public Health						
Mental Health						
Pharmacy						
Volunteers						
Comments:						

SECTION C: FACILITY STATUS REPORT – Indicate operational status of each system using Legend above

Services	Status (S,L,C,X,N)	Comments
Communications (Fleet Net, Phone, IT)		
Facility Structure (Physical Damage – safe to occupy?)		
Fire Alarm System		
Gas/Propane		
Generator (Is Fuel Required?)		
HVAC (Heat, Ventilation, Air Conditioning)		
Hydro		
Waste Disposal (Garbage, Bio-hazard)		
Water/Sewer		
Supplies (Type/Department)	Status (S,L,C)	Comments

COMPLETED BY _____ SENT TO _____
 PRINT – Name and Title SENDER – Please Retain a COPY for your records