Disaster Health Services Quality Indicators



Fill out this form every 24 hours, and communicate the information to the Disaster Relief Operations leadership for Disaster Health Services by 5:00 p.m. local time.

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| **Stabilization of**  **Oral**  **Medication** | # of Clients  Needing  Medication  Replacement | # of Client’s Receiving  Medication Replacement within 24 hrs. | # of Client’s Waiting for  Medication | Reported to Disaster  Health Services Disaster  Relief Operation Lead | Comments |
| Date: |  |  |  |  |  |
| Date: |  |  |  |  |  |
| Date: |  |  |  |  |  |
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| **Emergency**  **Department (ED)**  **Utilization by**  **Shelter Residents** | # of Clients Transported to an Emergency Department | # of Clients  Returning from  Transport to an  Emergency  Department | # of Clients in  Shelter (Midnight  Count) | # of Clients Returning to  Shelter after transport  # of Clients in Shelter (%)    (Report at >5%) | Reported to  DHS / DRO  Lead | Comments |
| Date: |  |  |  |  |  |  |
| Date: |  |  |  |  |  |  |
| Date: |  |  |  |  |  |  |
| Date: |  |  |  |  |  |  |
| Date: |  |  |  |  |  |  |

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| **Clients of a Shelter Shall Not Have a Decline in 3+ Activities of Daily Living.** | # of Clients | Report to Disaster Health  Services Disaster Relief  Operation Lead | Comments |
| Date: |  |  |  |
| Date: |  |  |  |
| Date: |  |  |  |
| Date: |  |  |  |
| Date: |  |  |  |

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