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:  |   |   |   |   |   |
| 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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