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Operational Profile FORM - SAMPLE

COOP Continuity of Operations

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**Operational Profile Form - Sample**

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| --- | --- |
| **Name of Department(s):** | **Revision Date:** |
| **Department Number(s):** | **Creation Date:** |
| **Approved By:** | **EM Approved:** |
| **Reviewed By:** | |

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| --- | --- | --- |
| **Location(s)** | **Building** | **Floor(s)** |
|  |  |  |
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1. **Process/Services**

*Provide an overview of the department/site function.*

1. **Hours of Operation**

*What hours are you regularly staffed? What are your on-call hours? Which days of the week are you closed for business? Which observed holiday(s) are you closed for business? Provide a list of all operational hours including on call.*

1. **Orders of Succession**

*To whom (leadership position title) do you report to? To whom does that position report to? Etc. Does the position receiving the authority have competencies completed? Are there any critical responsibilities that should be noted?*

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| **From - Leadership Position (Title)** | **To - Successor (Title)** | **Competency Required?** | **Responsibilities** |
| *Director of EM* | *Emergency Manager* | *Y* | *None* |
|  |  |  |  |
|  |  |  |  |
| Notes: | | | |

**D. Delegations of Authority**

*Are there any critical authorizations necessary for the operation of the department? What are they and who is next in line to approve? Authorizations must be within the scope of practice. Does the position receiving the authority have competencies completed?*

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| **Authorizations** | **Position(s) Receiving Authority** | **Competency Required?** |
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| Notes: | | |

1. **Essential Function(s)**

What is the main role(s) of the department? Why does your department exist? What is your main function? Visualize your department as the title of a book. What are the chapters (functions) that all processes would fall under? The function is a sum of the processes.

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|  | **Time (0 Min – 90 Days)** | | **Risk**  **(1 High – 4 Low)** | | **Infrastructure**  **(1 High – 4 Low)** | | **Function**  **(1 High – 4 Low)** |
| **Essential Function** | **Failure Point (FP)** | **Diversion Point (DP)** | **Dept** | **Senior Lead.** | **Fac. Ops** | **Senior Lead.** | **Priority** |
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| **Notes** *(Explanation, if necessary, for the ratings noted above)* | | | | | | | |
| **FP -** |  | | | | | | |
|  |  | | | | | | |
| **DP -** |  | | | | | | |
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1. **Minimum Acceptable Level of Service and Staffing**

Describe the minimum (reasonable) acceptable level of service to be provided during a building system downtime. In order to operate, what are the minimal services that are needed? What services must you provide? What processes need to be in place in order to meet the minimum needs of the patient population?

* Minimum Level of Service

*What are the minimum hours of operation you need in order to safely run your department? What is your longest procedure? Are on-call hours are required?*

* Minimum Hours of Operation

Within your department, who is in your budget? What is the minimum number of staff you need to operate? Would you have to increase staff in the event of downtime? Outside of your department, what additional staff are routine to operate your department? Do you have a staffing ratio for nursing positions?

* Staffing

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | **Normal Ratio** | | **Emergent Ratio** | |
| **Title** | **Total Staffing** | **Minimum Essential Staff** | Staff | Patient | Staff | Patient |
| **Department Staff** | | | | | | |
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|  |  |  |  |  |  |  |
| **Non-Department Essential Staff** *(Staff required to be on hand in order to function.)* | | | | | | |
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|  |  |  |  |  |  |  |
| **Contracted Essential Staff** (*Do you have any contracted staff not listed above?)* | | | | | | |
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| **Volunteer Staff** (*Do you need Volunteer staff who assist with the Essential Functions?)* | | | | | | |
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* Total staffing is based on total budgeted employees. Round up for part time.
* Minimum Number of Staffing based on an 8 hour shift.
* Assumption that normal clinical staffing ratio will be returned after 72 hours.
* Alternate Care Site location and patient acuity may impact clinical ratios.
* Some department may increase minimum essential staffing in an adverse event.
* Additional Downtime Staffing Needs and Availability

*Do you need additional clinical or non-clinical staff to support your downtime operations? How many staff will be needed? What do you want them to do? Do they have need to have any special qualifications? How critical are they to maintaining your essential functions? If you need additional staff, give an estimate of how many.*

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| --- | --- | --- | --- | --- |
| **#Clinical** | **# Non Clinical** | **Role** | **Special Qualifications** | **Critical (1-3)** |
| *2* |  | *Registered Nurse* | *RN* | *1* |
|  |  |  |  |  |

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| **Rating** | **Operational Impact** |
| *1* | *Critical - Immediate impact to operations and essential functions* |
| *2* | *Medium impact to operations, may increase operational impact > 4 hours* |
| *3* | *Low impact to operations, can continue with minimal disruption* |

*Do you have clinical or non-clinical staff that can be reallocated to support other departments’ downtime operations? If you don’t need staff, how many staff members could you give up? Can the staff be used as runners? The goal is to reallocate available staff based upon need before sending home at a minimum of 50%.*

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| **#Clinical** | **# Non Clinical** | **Notes *(Any special qualifications?)*** |
| *2* |  | *Registered Nurse* |
|  |  |  |

* Staffing availability based on current staffing level

1. **Patient Scheduling**

Describe how the department/site schedules, cancels, and reschedules patient appointments. Who schedules? Is everything scheduled in an electronic scheduling system?

1. **Risk Description**

Describe the impact to the patient, department, or system of your department not operating? What does this mean if you are no longer operating? What within your department could significantly impact your operations? What within your department will shut you down? Any processes, equipment, supply, or operations. What do you know that no one else knows? What don’t you have a backup plan for? Examples: MRI – only one, key drug – one supplier, human error – uncooked food, utilities – fire extinguishing system.

* + Impact to the Patient, Department, or System

Department Process Driven Risk Assessment

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| **Risk Assessment** | | |
| **Risk** | **Plan in Place?** | **What is the plan? Do you have any agreements?** |
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* Flood, fire, staffing, etc., are rated on the CHVA
* Legal Agreements Not in ETracts (electronic legal document tracking system).

Do you have any legal agreements or important documents affecting operations that are not backed up? (Includes Memorandums of Understanding – MOU)

|  |  |
| --- | --- |
| **Description** | **Location of Vital Record** |
|  |  |
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* Other Organizational Identified Risks

*What other organizational risks are not listed? I.e. Communications plans, etc.*

1. **Dependencies/Relationships**

*Describe significant dependencies or relationships with other departments within CHCO or outside organizations. Who depends on you? This is a “spider web” to help the organization understand how the departments interact.*

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| **Internal Department** | **Critical** | **Description of Dependencies/Relationship** |
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| **External Organizations** | **Critical** | **Description of Dependencies/Relationship** |
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*How would you rate each dependency/relationship based on priority for the department? (1 – Critical, 2 – High, 3 – Moderate, 4 – Low)*

1. **Vendors (Additional)**

List any vendors not tracked in the vendor management system. May be specific to the operation of the department.

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| --- | --- | --- | --- |
| **Vendor Name** | **Service Provided** | **Primary Contact Info** | **Secondary Contact Info** |
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1. **Information Technology (Additional)**

List any Information Technology (IT) applications not covered or supported by IT.

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| --- | --- | --- | --- |
| **IT Vendor Name** | **Name of Application** | **Primary Contact Info** | **Secondary Contact Info** |
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1. **Facilities Related Needs**

Describe required facilities-related needs specific to your department. What facilities needs are required for an alternate care location? Items related to the office environment are not included – desks, chairs, computers, phone, and internet connection.

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| **Type** | **Yes** | **Comments** |

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| --- | --- | --- |
| **Ventilation** | | |
| HVAC |  |  |
| Negative pressure air |  |  |
| Positive pressure air |  |  |
| Humidity |  |  |
| **Plumbed Gases** | | |
| Medical air |  |  |
| Nitrogen |  |  |
| Nitrous oxide |  |  |
| Oxygen |  |  |
| Suction/Vacuum |  |  |
| **Waste** | | |
| Biohazardous waste |  |  |
| Chemical waste |  |  |
| Pharmaceutical waste |  |  |
| Radiological waste |  |  |
| **Other** | | |
| Back-up power supply |  |  |
| Phone |  |  |
| Potable water |  |  |
| Laundry services |  |  |
| Refrigeration |  |  |
| Network |  |  |
|  |  |  |

1. **Special Considerations**

*Describe any unique processes or special considerations that should be listed in the COOP critical for operating an alternate care site.*

* Critical Conditions for alternate care site *– What facilities requirements did we miss?*
* Deliveries *– What supplies/materials are routinely delivered -- I.e. Lab results, records, and food?*
* Security and Safety *– Are there any required security or known safety issues to be considered?*
* Other *– Other special considerations?*
* Space Requirements – *What type of space requirements best meets your area’s needs?*

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| --- | --- |
| **Type** | **Notes** |
|  |  |
|  |  |

1. **Potable Water**

List any processes which require potable water. Is it critical to facility operations? (Drinking and sanitation needs are evaluated separately.)Identify all process/equipment requiring potable water to operate. How much water is normally used for each process/cycle? Is the process/equipment critical to operational continuity? How much water is necessary to function if water availability is restricted? Are there any waterless alternatives?

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| **Processes Requiring Potable Water** | **Water Under Normal Operating Conditions (gpd)** | **Critical? (Y or N)** | **Water Under Water Restriction (gpd)** | **Waterless Alternatives?** |
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(**gpd** – gallons per day)

Do you have an eye wash station, emergency shower, or combination? How many?

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| --- | --- | --- | --- | --- |
| **Type of Device** | **Quantity** | **Location(s)** | **Essential (Y/N)** | **Comments** |
| Eye wash |  |  |  |  |
| Emergency shower |  |  |  |  |
| Combination |  |  |  |  |

1. **Licensing and Regulations**

*Describe any required licensing, certifications, regulations/standards. Are there any licenses that need to be inspected after an event, for example, fire/life safety?*

* Licensing
* Certifications
* Regulations/Standards
* Other

1. **Alternate Work Location(s)**

*Describe plans for an internal and external alternate care location. Is remote work an option? If there are no designated internal or external primary locations, where could the department/site be moved to?*

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| --- | --- | --- | --- |
| **Internal to the Facility/System** | | **External to the Facility/System** | |
| **Designated Primary Alternate Location** | **Undesignated Alternate Location** | **Designated Primary Alternate Location** | **Undesignated Alternate Location** |
|  |  |  |  |
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*Are there alternative resources within the region that can assist with continuation of patient care or department Essential Functions?*

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| --- | --- | --- | --- |
| **Facility Name** | **Location** | **Primary Contact Info** | **Secondary Contact Info** |
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