2009 Emergency Management Standards

- EM.01.01.01 – Emergency Management Planning Activities
- EM.02.01.01 – Emergency Operations Plan (EOP)
- EM.02.02.01 – Communications
- EM.02.02.03 – Resources and Assets
- EM.02.02.05 – Safety and Security
- EM.02.02.07 – Staffing
- EM.02.02.09 – Utilities
- EM.02.02.11 – Patient Care Activities
- EM.02.02.13 – Volunteer Licensed Independent Practitioners
- EM.02.02.15 – Volunteer Practitioners
- EM.03.01.01 – Evaluating Planning Activities
- EM.03.01.03 – Evaluating EOP through Exercises
EM.01.01.01

EM PLANNING

Requires participation from administration, medical staff, clinical staff, and support staff.

A current Hazard Vulnerability Analysis (HVA):
- Multidisciplinary approach
- Involves community
- Reviewed at least annually
- Guides emergency management efforts

EM.01.01.01

EM PLANNING

Hospital must communicate its needs to its community.
Understands the capabilities/limitations of its community to meet its needs.
For each of the top 3 emergencies from your HVA define: Mitigation, Preparedness, Response, & Recovery activities

EM.01.01.01

Mitigation Activities

Hazards Analysis - Internal & External
- What types of natural, technological and man-caused events threaten the organization?

Vulnerability Analysis
- For each of the top 3 emergencies from your HVA, ask "What will be the likely impact (considering both direct and indirect effects)?"

Actions taken to reduce the impacts
- What can be done to ensure operating systems remain functional?
**EM.01.01.01 – EM.02.02.15**

**Preparedness Activities**

- Resources Listing
  - That provide the back-up for damage to the plant, supplies, equipment, communications, and people
- Pre-arranged agreements
  - Memoranda of understanding (MOUs) and other arrangements that are set up in advance so that resource commitments and working relationships are established before disaster strikes.
- Staff orientation and training on basic response actions
  - Simple guidelines covering actions staff will take during any emergency
- Facility-wide rehearsals
  - That stress organizational mobilization coordination, and communications

**EM.02.01.01-EM.02.02.15**

**Response Activities**

- Take appropriate actions to protect life and conserve property
- Notify persons in charge
- Continue to organize and manage
- Situation assessment
- Warning and notifications
- Setting objectives and priorities
- Facility-wide instructions
- Plan for what happens next
- Liaison with external systems

**EM.01.01.01-EM.02.01.01**

**Recovery Activities**

- Determine present level and extent of patient care capability
- Adjust patient care policies
- Set objectives and priorities for the re-establishment of operating systems that support the environment of care
- Make stress debriefing services available to patients and staff
- Schedule and conduct an incident critique
- Make improvements to the emergency management program
EM.01.01.01
EM Program

- Maintain documented current inventory of assets and resources for emergency use (aligns with NIMS):
  - Personal Protective Equipment
  - Staffing
  - Water/Fuel
  - Medical, surgical, pharmaceuticals
- Develop methods to monitor use of resources during emergency operations

EM.02.01.01
Emergency Operation Plan (EOP)

- EOP addresses the six critical functions
- EOP requires an Incident Command Structure
  - Consistent with community ICS
- EOP identifies procedures for activating and terminating emergency operations
- EOP describes staffing patterns (who staff report to when EOP activated)

EM.02.01.01
Emergency Operation Plan (EOP)

- EOP identifies organization’s capabilities for 96 hours without being able to obtain support from the community.
- EOP establishes response efforts when the organization cannot be supported by the local community for 96 hours for managing the six critical areas.
  - Evacuation is an acceptable strategy but not always the most desirable!
EM.02.01.01, EP3

QUESTION?

- Are we supposed to stand alone for 96 hours?
  - e.g., stockpile supplies on hand, etc?
  - or can we just say we have enough to last 96 hours and then evacuate, etc?
- Why did the Joint Commission pick 96 vs. 72?

The EOP identifies the organization’s capabilities and establishes response procedures for when the organization cannot be supported by the local community for at least 96 hours in the six critical areas.

Note: An acceptable response effort would be to temporarily close or evacuate the facility, consistent with their designated role in their community response plan.

EM.02.01.01, EP3

ANSWER

- The main point is that the organization knows its capabilities.
  - Respond according to this knowledge.
- Regarding the 96 vs 72 hours
  - The Joint Commission onsite evaluations indicated that 96 hours was a more realistic expectation.
  - This was confirmed during Standards Review.

Striving for 96 Hours...

- Normal - Generator Fuel
  - Emergency – shut down some floors, cancel elective surgeries.
- Normal - Clinical Supplies
  - Emergency – curtail some services, discharge some patients.
- Normal - Water (Sanitary)
  - Emergency – water conservation (sponge baths, waste disposal).
EM.02.01.01, EP7
Alternate Care Sites

Expand **existing** space:
- Short-term needs with intact infrastructure.
- Horizontal evacuation or surge demand.

Use of **remote** space:
- Site selection
  - Clinical capacities
- Logistics
  - Service
  - Supply
- Patient management
  - Medications
  - Records
  - Tracking
6 Critical Components

1. Communication (EM.02.02.01)
   - Communication is the way information is shared (both internally and externally) by and with the healthcare organization.
   - It is more than a technology issue (not only how but what type of information and with whom).
   - It is likely that day-to-day communication methods may fail during an emergency.
EM.02.02.01
ESTABLISH EMERGENCY COMMUNICATIONS STRATEGIES

- Plans for communicating (once emergency measures are initiated) with:
  - Staff
  - External authorities
  - Patients/families
  - Providers of supplies and equipment
  - The media
  - Other healthcare organizations

EM.02.02.01
ESTABLISH EMERGENCY COMMUNICATIONS STRATEGIES (CON’T)

- Communication with other hospitals within its contiguous geographic area:
  - Elements of command structures
  - Name/roles of individual in command structure, center telephone number
  - Resources and assets that could be shared
  - Names of patients and deceased individuals brought into their organizations in accordance with law and regulations

6 CRITICAL COMPONENTS (CON’T)

2. Resources and assets (EM.02.02.03)

- Organizations must have a solid understanding of the scope and availability of their resources and assets during an emergency.
- Organizations must know how to access essential resources in times of crisis to ensure patient safety and sustain care, treatment, and services
  - Materials and supplies
  - Vendor and community services
  - State and federal programs
EM.02.02.03
Strategies for managing Resources and Assets during emergencies

Plan for:
- Replenishing of supplies and equipment
  - Memorandums of Understanding (MOUs)
    - Over committed? Able to deliver?
- Potential sharing of resources and assets with other health care organizations
- Managing staff support activities
- Managing staff family support needs
- Evacuation

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Alternatives to Evacuations
- Reduce occupancy
  - Employees
  - Patients
    - Discharge stable patients
    - Re-schedule appointments
    - Change admissions policy
Plan for transporting to alternative care sites:
- Patients, their medications, equipment, and necessary staff
- Information pertinent to patient care
6 Critical Components (con’t)

3. Security and Safety (EM.02.02.05)

- The safety and security of patients is the most important responsibility of the organization during an emergency.
- As emergency situations develop and parameters of operability shift, organizations must provide a safe and secure environment for their patients and staff.

EM.02.02.05 Strategies for Managing Security and Safety

- Establish internal security and safety operations
- Identify roles of community security agencies
  - Define how security activities will be coordinated
- Identify process for managing hazardous materials and waste
- Identify means for radioactive, biological, and chemical isolation/decontamination

- Establish processes for:
  - Controlling entrance into and out of building.
  - Controlling movement of individuals within the building (i.e., colored wrist bands).
  - Controlling traffic accessing the building (i.e., setting up remote sites for inoculation).
4. Staff roles and responsibilities (EM.02.02.07)

- During an emergency, the probability that staff responsibilities will change is high.
- If staff cannot anticipate how they may be called to perform during an emergency, the likelihood that the organization will not sustain itself during an emergency increases.
- Staff should practice their roles and their performance should be critiqued (exercises EM.03.01.03).

5. Utilities (EM.02.02.09)

- Identify alternative means for providing:
  - Electricity
  - Water for consumption and essential care
  - Water for equipment and sanitary purposes
  - Fuel for building operations and essential transportation
  - Other essential utilities: Ventilation, Medical gas/vacuum
6 Critical Components (con’t)

6. Patient clinical and support activities (EM.02.02.11)

- The clinical needs of patients during an emergency are of prime importance.
- The organization must have clear, reasonable plans in place to address the care of patients during extreme conditions when the organization’s infrastructure and resources are taxed.
EM.02.02.11

STRATEGIES FOR MANAGING

PATIENT CLINICAL AND SUPPORT ACTIVITIES

- Plan to manage clinical activities related to patient care
  - Scheduling
  - Triage
  - Assessment
  - Treatment
  - Admission
  - Transfer
  - Discharge
  - Evacuation

Clinical services for vulnerable populations
- Patients’ personal hygiene and sanitation needs
- Patients’ mental health service needs
- Mortuary services
- Documenting and tracking patients’ clinical information

Disaster Volunteer Practitioners
EM.02.02.13 & EM.02.02.15

- These standards provide guidance to organizations that choose to utilize clinical disaster volunteers; it does not require organizations to utilize such volunteers
Disaster Volunteer Practitioners
EM.02.02.13 & EM.02.02.15

These standards allow for expedited credentialing and privileging of clinical disaster volunteers only when two conditions are met:
1) The EOP has been activated in response to a disaster
2) The organization is unable to meet immediate patient needs

Disaster Volunteer Practitioners
EM.02.02.13 & EM.02.02.15

Standard EM.02.02.13 applies to volunteer practitioners who are licensed independent practitioners.
Standard EM.02.02.15 applies to volunteer practitioners who are not licensed independent practitioners.

Disaster Volunteer Practitioners
EM.02.02.13 & EM.02.02.15

Identify individuals responsible for granting disaster privileges and responsibilities

Define how organization will oversee the performance of clinical disaster volunteers (for example, by direct observation, mentoring, or medical record review)
Before a clinical disaster volunteer is eligible to provide care, treatment, or service, the organization obtains a government issued photo ID and at least one of the following:
- Current picture from health organization, identifying professional designation
- Current license
- Primary source verification of licensure, certification, or registration
- DMAT/MRC/ESAR-VHP, other recognized state/federal response hospital or group identification
- ID indicating individual has been granted authority by government entity to provide patient care in disaster circumstances
- Confirmation by another clinician of volunteer practitioner’s ability to perform clinical duties

During disaster:
- The organization oversees performance of each clinical disaster volunteer
- Based on oversight:
  - The hospital determines within 72 hours if granted disaster privileges/clinical responsibilities should continue
- Primary source verification of licensure, certification, or registration occurs:
  - As soon as emergency is under control; or
  - Within 72 hrs from when volunteer presents, whichever comes first
- If primary source verification is not completed, document:
  - Reasons
  - Evidence of ability
  - Evidence of hospital’s attempt to perform primary source verification

Annual review of risks, hazards, and emergencies as defined in hazard vulnerability analysis
Annual review of objectives and scope of EOP
Annual review of inventory process
EM.03.01.01
EVALUATE PLANNING ACTIVITIES

Annual Evaluation:
- The Annual Evaluation should result in:
  - Identification of goals and objectives met and not met
  - Goals and objectives for the next year
  - Review Scope of Plan (HVA, inventory of assets and resources, etc.)
  - Evaluation of the performance and effectiveness of the EC program

EM.03.01.03: EOP EXERCISING

Number and types of exercises:
- Twice a year either in response to actual emergency or planned exercise.
- Conduct at least one exercise that includes an influx of actual or simulated patients.

EM.03.01.03: SCOPE OF EXERCISES

Number and types of exercises:
- At least one exercise is escalated to evaluate performance when community cannot support the organization.
- If organization has defined role in community-wide emergency management program:
  - Participate in at least one community-wide exercise/year.
EM.03.01.03: Scope of Exercises

Scenarios are realistic and related to prioritized emergencies from HVA.

During exercises, an individual(s):

- Monitors performance
- Documents opportunities for improvement

EM.03.01.03: Scope of Exercises

The organization’s monitoring includes the six critical areas:

- Effectiveness of communication
  - Internal
  - With external response partners
- Resource mobilization and allocation
- Security and safety
- Staff roles and responsibilities
- Utility systems
- Patient clinical and support care activities

EM.03.01.03: Scope of Exercises

Scope of Exercises:

- Exercises are critiqued.
- Completed exercises are critiqued through a multi-disciplinary process.
- EOP modified in response to critiques
- Improvements to EOP are evaluated during next exercise.
- Strengths/weaknesses are communicated to multidisciplinary team responsible for managing EM issues.
SUMMARY OF 2009 EMERGENCY MANAGEMENT STANDARDS

- Management of six critical functions during emergencies to respond to all hazards
- "Scalable approach" to manage response to combination of escalating events
- Identify capabilities and responses when not supported by community for 96 hours
- Planning, and testing response plans for emergencies during conditions when the local community cannot support the healthcare organization – "test and stress"

SCENARIO

- It is 6:30 am on a Monday morning and visibility is greatly diminished. A train already three hours late, due to coupling problems hurries to get across the city before dawn.
- At 7:20 am the train reaches the downtown switching station. Without warning the train drags to a halt and several rear cars are derailed and deflected into a local commuter train.

ScENARIO

- The collision causes a breach in the railcars and releases a jet of chlorine gas. A plume of yellow-green gas reaches 50 feet (15 meters) into the air. The billowing cloud fills the railway tracks. Three other commuter trains are halted on the approaching tracks to the accident, each crowded with more than 400 people on board. Within minutes the trains are full of the lethal gas.
- In the meantime, a gentle wind carries the chlorine gas northwest. The cloud reaches a local university campus nearly 2 miles (3 km) from the site. Students and faculty begin to complain of chlorine exposure symptoms.
Scenario

TV news channels are providing continuous coverage of the disaster, and broadcasting the pleas from city authorities for people to not commute into the city.

The roadways become choked with cars as people evacuate from the affected areas. Emergency crews in breathing apparatuses battle their way through the crowds to reach the disaster site.

The two local hospitals have exceeded surge capacity and have alerted EMS that they are now on diversion. Clean-up is underway and assistance from your organization is being requested!

Scenario

On day two of the clean-up evidence that a second chemical release will occur becomes evident. Local HAZMAT authorities are mandating evacuation of the local area, including your hospital.

How would your organization address this scenario?

Questions and Answers
Emergency Management in Health Care: An All-Hazards Approach provides you with:

- An in-depth explanation of the revised emergency management standards for hospitals, critical access hospitals, and Medicare- and Medicaid-based long-term care organizations
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