

## EMERGENCY MANAGEMENT STANDARDS JANUARY 1, 2008

### Hospital and Critical Access Hospital Accreditation Programs

#### Introduction to Emergency Management (CAH, HAP, LTC, LT2)

Catastrophic emergencies are a threat to any health care organization, regardless of size, scope, or location. A single emergency can temporarily affect demand for services; however, multiple emergencies that occur concurrently or sequentially can adversely impact patient safety and the [organization]’s ability to provide care, treatment, and services for an extended length of time. This is especially true in situations where the community cannot adequately support the [organization]. Power failures, water and fuel shortages, flooding, and communication breakdowns are just a few of the hazards that can disrupt patient care, and pose risks to staff and the [organization].

No [organization] can predict the nature of a future emergency, nor can it predict the date of its arrival. However, [organizations] can plan for managing six critical areas of emergency response in order to assess their needs and prepare staff to respond to events most likely to occur regardless of the cause(s) of an emergency situation. The six critical areas of emergency management are:

- 1. Communication (see EC.4.13).** In the event that community infrastructure is damaged and/or an [organization]’s power or facilities experience debilitation, communication pathways, whether dependent on fiber optic cables, electricity, satellite, or other conduits, are likely to fail. [Organization]s must develop a plan to maintain communication pathways both within the [organization] and to critical community resources.
- 2. Resources and assets (see EC.4.14).** A solid understanding of the scope and availability of an [organization]’s resources and assets is as important, and perhaps more important, during an emergency than during times of normal operation. Materials and supplies, vendor and community services, as well as state and federal programs, are some of the essential resources that [organizations] must know how to access in times of crisis in order to ensure patient safety and sustain care, treatment, and services.
- 3. Safety and security (see EC.4.15).** The safety and security of [patient]s is the prime responsibility of the [organization] during an emergency. As emergency situations develop and parameters of operability shift, [organization]s must provide a safe and secure environment for their [patients] and staff.
- 4. Staff responsibilities (see EC.16).** During an emergency, the probability that staff responsibilities will change is high. As new risks develop along with changing conditions, staff will need to adapt their roles to meet new demands on their ability to care for patients. 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.

5. **Utilities management (see EC.4.17).** An [organization] is dependent on the uninterrupted function of its utilities during an emergency. The supply of key utilities, such as power or potable water, ventilation, and fuel must not be disrupted or adverse events may occur as a result.

6. **Patient clinical and support activities (see EC.4.18).** The clinical needs of patients during an emergency are of prime importance. The [organization] must have clear, reasonable plans in place to address the needs of patients during extreme conditions when the [organization]’s infrastructure and resources are taxed.

When [organization]s have a sound understanding of their response to these six critical areas of emergency management, they have developed an “all hazards” approach that supports a level of preparedness sufficient to address a range of emergencies, regardless of the cause. [Organization]s should also identify potential hazards, threats, and adverse events, and assess their impact on the care, treatment, and services they must sustain during an emergency. This assessment is known as a Hazard Vulnerability Analysis (HVA) and is designed to assist [organization]s in gaining a realistic understanding of their vulnerabilities, and to help focus their resources and planning efforts. Finally, [organization]s should use the information from their assessments to develop Emergency Operations Plans, which should be tested regularly, and use the lessons learned to improve.

[Organization]s should note that additional standards in other chapters are integral to [organization]-wide emergency preparedness, including processes for:

- Maintaining continuity of information (Management of Information chapter)
- Responding to an influx, or the risk of influx, of infectious patients (Surveillance, Prevention, and Control of Infection chapter)
- **(CAH, HAP:** Identifying and mitigating impediments to patient flow (Leadership chapter)
- Granting disaster privileges **(CAH, HAP:** Medical Staff chapter) **(LTC, LT2:** Management of Human Resources chapter)
- Assigning disaster responsibilities (Management of Human Resources chapter)

#### **Standard EC.4.11 (CAH, HAP, LTC, LT2)**

The [organization] plans for managing the consequences of emergencies.

**(CAH: *Corresponds to COP 485.623 (c)(3) and (c)(4)*)**

#### **Rationale for EC.4.11 (CAH, HAP, LTC, LT2)**

An emergency in a health care [organization] or in its community can suddenly and significantly affect demand for its services or its ability to provide those services. Therefore, it is important that [organization]s define a comprehensive approach to identifying risks and mobilizing an effective response within the [organization] as well as in collaboration and co-ordination with essential response partners in the community. <sup>(CAH, HAP:1)</sup>

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**1(CAH, HAP)** [National Incident Management Requirements \(NIMS\) provide requirements for hospitals to enhance the efficiency and effectiveness of its response and recovery roles in co-ordination with their community. Developing a relationship with local public health, public safety and other emergency](#)

### Elements of Performance for EC.4.11

**B 1. (CAH, HAP, LTC, LT2)** The [organization]’s leaders (HAP: including those of the medical staff) (**LTC, LT2:** including the administrator, the medical director, the nursing leader, and other clinical leaders) actively participate in emergency management planning.

**B 2. (CAH, HAP, LTC, LT2)** The [organization] conducts a Hazard Vulnerability Analysis (HVA) to identify events that could affect demand for its services or its ability to provide those services, the likelihood of those events occurring, and the consequences of those events.

**Note:** *The HVA is evaluated at least annually as part of EP11.*

**A 3. (CAH, HAP, LTC, LT2)** The [organization] (**CAH, HAP:** together with its community partners) prioritizes those hazards, threats and events identified in its HVA.

**A 4. (CAH, HAP, LTC, LT2)** When developing its emergency operations plan (see EC.4.12), the [organization] communicates its needs and vulnerabilities to community emergency response agencies and identifies the capabilities of its community in meeting their needs.

**A 5. (CAH, HAP, LTC, LT2)** For each emergency identified in its HVA, the [organization] defines mitigation activities designed to reduce the risk of and potential damage due to an emergency:

**A 6. (CAH, HAP, LTC, LT2)** For each emergency identified in its HVA, the [organization] defines preparedness activities that will organize and mobilize essential resources;

**A 7. (CAH, HAP, LTC, LT2)** For each emergency identified in its HVA, the [organization] defines response strategies and actions to be activated during the emergency; and

**A 8. (CAH, HAP, LTC, LT2)** For each emergency identified in its HVA, the [organization] defines recovery strategies and actions designed to help restore the systems that are critical to resuming normal care, treatment and services.

**A 9. (CAH, HAP, LTC, LT2)** The [organization] keeps a documented inventory of the assets and resources it has on-site, that would be needed during an emergency (at a minimum, personal protective equipment, water, fuel, staffing, medical, (**CAH, HAP:** surgical,) and pharmaceuticals resources and assets).

**Note:** *The inventory is evaluated at least annually as part of EP11.*

**B 10. (CAH, HAP, LTC, LT2)** The [organization] establishes methods for monitoring quantities of assets and resources during an emergency.

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[management agencies enables hospitals to gain further insight regarding the availability of training, exercises, as well as capabilities \(equipment and procedures\) provided by local agencies.](#)

**B 11. (CAH, HAP, LTC, LT2)** The objectives, scope, performance, and effectiveness of the [organization]’s emergency management planning efforts are evaluated at least annually.

**Standard EC.4.12 (CAH, HAP, LTC, LT2)**

The [organization] develops and maintains an Emergency Operations Plan.

**(CAH: Corresponds to COP 485.623 (c)(3) and (c)(4))**

**Rationale for EC.4.12**

A successful response relies upon planning around the management of six critical areas: communications; resources and assets; safety and security; staffing; utilities; and clinical activities. It is important for [organizations] to develop a comprehensive Emergency Operations Plan (EOP) as documentation to help guide the [organization] in its emergency response and recovery efforts. While the Emergency Operations Plan can be formatted in a variety of ways, it must address these six critical areas to serve as a blueprint for managing care and safety during an emergency.

Some emergencies can escalate unexpectedly and strain the [organization] and the entire community. An [organization] cannot mitigate risks, plan thoroughly, and sustain an effective response and recovery without preparing its staff and collaborating with the community, suppliers and external response partners as well. Such an approach will aid the [organization] in developing a scalable response capability and in defining the timing and criteria for decisions that involve sheltering in place, [patient] transfer, facility closings, or evacuation.

**Elements of Performance for EC.4.12**

**B 1. (CAH, HAP, LTC, LT2)** The [organization] develops and maintains a written emergency operations plan (EOP) that describes an “all-hazards” command structure for coordinating six critical areas (see EC.4.13.through EC.4.18) within the [organization] during an emergency.

**B 2. (CAH, HAP, LTC, LT2)** The EOP establishes an incident command structure **(CAH, HAP: that is integrated into and consistent with its community’s command structure<sup>2</sup>).**

**A 3. (CAH, HAP, LTC, LT2)** The EOP identifies to whom staff report in the [organization]’s incident command structure.

**A 4. (CAH, HAP, LTC, LT2)** The EOP describes processes for initiating and terminating the response and recovery phases, including who has the authority to activate the phases; and

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<sup>2</sup> [National Incident Management Requirements \(NIMS\) is a nationally standardized incident management system, which provides guidelines for common functions and terminology to support clear communication and effective collaboration in an emergency situation.](#)

**A 5. (CAH, HAP, LTC, LT2)** The EOP describes processes for initiating and terminating the response and recovery phases, including how the phases are to be activated.

**B 6. (CAH, HAP, LTC, LT2)** The EOP identifies the [organization]’s capabilities and establishes response efforts 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.*

**A 7. (CAH, HAP, LTC, LT2)** The EOP identifies alternative sites for care, treatment or service that meet the needs of its [patient]s during emergencies.

### **Standard EC.4.13 (CAH, HAP, LTC, LT2)**

The [organization] establishes emergency communications strategies.

**(CAH: Corresponds to COP 485.623 (c)(3) and (c)(4))**

#### **Rationale for EC.4.13**

The [organization] maintains reliable surveillance and communications capability to detect emergencies and communicate response efforts to [organization] response personnel, [patient]s and their families, and external agencies. The [organization] plans for backup communications processes and technologies (e.g., cell phones, land lines, bulletin boards, fax machines, satellite phones, ham radio, text messages) if primary communications systems fail. It is important that responders and incident managers use common terminology; there simply is little or no room for misunderstanding in an emergency situation.

#### **Elements of Performance for EC.4.13**

**B 1. (CAH, HAP, LTC, LT2)** The [organization] plans for notifying staff when emergency response measures are initiated.

**B 2. (CAH, HAP, LTC, LT2)** The [organization] plans for ongoing communication of information and instructions to its staff once emergency response measures are initiated.

**B 3. (CAH, HAP, LTC, LT2)** The [organization] defines processes for notifying external authorities when emergency response measures are initiated.

**B 4. (CAH, HAP, LTC, LT2)** The [organization] plans for communicating with external authorities once emergency response measures are initiated.

**B 5. (CAH, HAP, LTC, LT2)** The [organization] plans for communicating with [patient]s and their families during emergencies, including notification when [patient]s are relocated to alternative care sites.

**B 6. (CAH, HAP, LTC, LT2)** The [organization] defines the circumstances and plans for communicating with the community and/or the media during emergencies.

**B 7. (CAH, HAP, LTC, LT2)** The [organization] plans for communicating with purveyors of essential supplies, services, and equipment once emergency measures are initiated.

**B 8. (CAH, HAP, LTC, LT2)** The [organization] plans for communicating in a timely manner with other health care organizations that together provide services to a contiguous geographic area (for example, among health care organizations serving a town or borough) regarding: essential elements of their command structures and control centers for emergency response;

**B 9. (CAH, HAP, LTC, LT2)** The [organization] plans for communicating in a timely manner with other health care organizations that together provide services to a contiguous geographic area (for example, among health care organizations serving a town or borough) regarding: names and roles of individuals in their command structures and command center telephone numbers;

**B 10. (CAH, HAP, LTC, LT2)** The [organization] plans for communicating in a timely manner with other health care organizations that together provide services to a contiguous geographic area (for example, among health care organizations serving a town or borough) regarding: resources and assets that potentially could be shared in an emergency response; and

**B 11. (CAH, HAP, LTC, LT2)** The [organization] plans for communicating in a timely manner with other health care organizations that together provide services to a contiguous geographic area (for example, among health care organizations serving a town or borough) regarding: names of [patient]s and deceased individuals brought to their [organization]s in accordance with applicable law and regulation, when requested.

**B 12. (CAH, HAP, LTC, LT2)** The [organization] defines the circumstances and plans for communicating information about [patients] to third parties (such as other health care organizations, the state health department, police, FBI, etc.).

**B 13. (CAH, HAP, LTC, LT2)** The [organization] plans for communicating with identified alternative care sites.

**B 14. (CAH, HAP, LTC, LT2)** The [organization] establishes backup communication systems and technologies for the activities identified above.

**Standard EC.4.14 (CAH, HAP, LTC, LT2)**

The [organization] establishes strategies for managing resources and assets during emergencies.

**(CAH: *Corresponds to COP 485.623 (c)(3) and (c)(4)*)**

**Rationale for EC.4.14**

During emergencies, health care organizations that continue to provide care, treatment and services to their [patient]s must sustain essential resources, materials, and facilities. The emergency operation plan should identify how resources and assets will be solicited and acquired from a range of possible sources, such as vendors, neighboring health care

providers, other community [organization]s, state affiliates, or a regional parent company. To address emergencies of long duration or broad geographic scope, the [organization]’s plan must proactively identify, locate, acquire, distribute and account for critical resources and supplies. The plan should also recognize the risk that some assets may not be available from planned sources and that contingency plans will be necessary for critical supplies. This situation may occur when multiple [organization]s are vying for a limited supply from the same vendor.

The infrastructure for supplying and supporting the health care organization is complex, and the Hazard Vulnerability Analysis will help identify risks to this infrastructure that can be mitigated. Planning must address managing and maintaining the facility, but also must consider evacuation of the entire facility when the environment is no longer deemed safe.

#### **Elements of Performance for EC.4.14**

**B 1. (CAH, HAP, LTC, LT2)** The [organization] plans for: obtaining supplies that will be required at the onset of emergency response (medical, pharmaceutical and non-medical);

**B 2. (CAH, HAP, LTC, LT2)** The [organization] plans for: replenishing medical supplies and equipment that will be required throughout response and recovery, including personal protective equipment where required;

**B 3. (CAH, HAP, LTC, LT2)** The [organization] plans for: replenishing pharmaceutical supplies that will be required throughout response and recovery, including access to and distribution of caches (stockpiled by the [organization] or its affiliates, local, state or federal sources) to which the [organization] has access;

**B 4. (CAH, HAP, LTC, LT2)** The [organization] plans for: replenishing non-medical supplies that will be required throughout response and recovery (for example, food, linen, water, fuel for generators and transportation vehicles, etc.);

**B 5. (CAH, HAP, LTC, LT2)** The [organization] plans for: managing staff support activities (for example, housing, transportation, incident stress debriefing, etc.);

**B 6. (CAH, HAP, LTC, LT2)** The [organization] plans for: managing staff family support needs (for example, child care, elder care, communication, etc.);

**B 7. (CAH, HAP, LTC, LT2)** The [organization] plans for: potential sharing of resources and assets (e.g., personnel, beds, transportation, linens, fuel, PPE, medical equipment and supplies, etc.) with other health care organizations within the community that could potentially be shared in an emergency response;

**B 8. (CAH, HAP, LTC, LT2)** The [organization] plans for: potential sharing of resources and assets with health care organizations outside of the community in the event of a regional or prolonged disaster;

**B 9. (CAH, HAP, LTC, LT2)** The [organization] plans for: evacuating (both horizontally and, when required by circumstances, vertically) when the environment cannot support care, treatment, and services;

**B 10. (CAH, HAP, LTC, LT2)** The [organization] plans for: transporting [patient]s, their medications and equipment, and staff to an alternative care site or sites when the environment cannot support care, treatment, and services; and

**B 11. (CAH, HAP, LTC, LT2)** The [organization] plans for: transporting pertinent information, including essential clinical and medication-related information, for [patient]s to an alternative care site or sites when the environment cannot support care, treatment, and services.

**Standard EC.4.15 (CAH, HAP, LTC, LT2)**

The [organization] establishes strategies for managing safety and security during emergencies.

**(CAH: *Corresponds to COP 485.623 (c)(3) and (c)(4)*)**

**Rationale for EC.4.15**

Controlling the movement of individuals into, throughout, and out of the [organization] during an emergency is essential to the safety of [patient]s and staff, and to the security of critical supplies, equipment, and utilities. The [organization] determines the type of access and movement to be allowed by staff, [patient]s, visitors, emergency volunteers, vendors, maintenance and repair workers, utility suppliers, and other individuals when emergency measures are initiated. Factors influencing access and movement vary depending upon the type of emergency and local conditions (i.e. the decision by the [organization] to shelter staff families, the allowance for or prohibition against firearms, mutual aid agreements with nearby facilities or vendors, etc.)

During an emergency, the campus or immediate environment around the [organization] may be under the authority of the local police or sheriff serving the larger community. Access to and from the [organization] on local roads and interstates could be subject to local, state or even federal control. As an incident evolves, this responsibility and authority may shift from one agency to another. For this reason, it is important that the Emergency Operations Plan includes reference to any existing community command structure to provide for on-going communication and coordination with this structure. In the absence of such a command structure, the [organization] maintains direct contact with the agencies charged with community security.

**Elements of Performance for EC.4.15**

**B 1. (CAH, HAP, LTC, LT2)** The [organization] establishes internal security and safety operations that will be required once emergency measures are initiated.

**B 2. (CAH, HAP, LTC, LT2)** The [organization] identifies the roles of community security agencies (police, sheriff, national guard, etc.) and defines how the [organization] will coordinate security activities with these agencies.

**B 3. (CAH, HAP, LTC, LT2)** The [organization] identifies a process that will be required for managing hazardous materials and waste once emergency measures are initiated;

**B 4. (CAH, HAP)** The plan identifies means for radioactive, biological, and chemical isolation and decontamination.

**B 5. (LTC, LT2)** The [organization] identifies residents who might be susceptible to wandering once emergency measures are initiated.

**B 6. (CAH, HAP, LTC, LT2)** The [organization] establishes processes for the following: controlling entrance into and out of the health care facility during emergencies;

**B 7. (CAH, HAP, LTC, LT2)** The [organization] establishes processes for the following: controlling the movement of individuals within the health care facility during emergencies; and

**B 8. (CAH, HAP, LTC, LT2)** The [organization] establishes processes for the following: controlling traffic accessing the health care facility during emergencies.

#### **Standard EC.4.16 (CAH, HAP, LTC, LT2)**

The [organization] defines and manages staff roles and responsibilities.

**(CAH: *Corresponds to COP 485.623 (c)(3) and (c)(4)*)**

#### **Rationale for EC.4.16**

To provide safe and effective [patient] care during an emergency, staff roles are well defined; staff are oriented and trained in their assigned responsibilities; and staff maintains their competencies over time. Staff roles in emergencies are determined largely by the priority emergencies defined in the Hazard Vulnerability Analysis, and the reporting relationships in the command and control operations of the [organization]. As such, staff must stand ready to adjust to changes in [patient] volume or acuity, work procedures or conditions, and response partners within and outside the [organization]. (**Note:** Standards in the **(CAH, HAP: Medical Staff)(LTC, LT2: Management of Human Resources)** chapter) define the processes for accepting **(CAH, HAP: licensed independent practitioners as volunteers)(LTC, LT2: volunteer practitioners)** during emergencies.) Staff roles and responsibilities may be documented in the EOP using a variety of formats: job action sheets, checklists, flow charts, etc.

#### **Elements of Performance for EC.4.16**

**B 1. (CAH, HAP, LTC, LT2)** Staff roles and responsibilities are defined in the Emergency Operations Plan for all six critical areas (communications, resources and assets, safety and security, utilities and clinical activities).

**B 2. (CAH, HAP, LTC, LT2)** Staff are trained for their assigned roles during emergencies.

**B 3. (CAH, HAP, LTC, LT2)** The [organization] communicates to licensed independent practitioners their roles in emergency response and to whom they report during an emergency.

**B 4. (CAH, HAP, LTC, LT2)** The [organization] establishes a process for identifying care providers and other personnel (such as identification cards, wrist bands, vests, hats, badges,

computer print-outs, etc.) assigned to particular areas during emergencies.

#### **Standard EC.4.17 (CAH, HAP, LTC, LT2)**

The [organization] establishes strategies for managing utilities during emergencies.

**(CAH: *Corresponds to COP 485.623 (c)(3) and (c)(4)*)**

#### **Rationale for EC.4.17**

Different types of emergencies can have the same detrimental impact on an [organization]'s utility systems. For example, brush fires, ice storms, and industrial accidents can all result in a loss of utilities required for care, treatment, services, related transport and building operations. [Organization]s, therefore, must have alternative means of providing for essential utilities, whether through: negotiated relationships with the primary suppliers; Memoranda of Understanding (MOUs) with other [organization]s in the community; alternative equipment at the [organization]; or provision through a parent entity, etc. [Organization]s should determine how long they expect to remain open to care for [patient]s, and plan for their utilities accordingly. Because some emergencies may be regional in scope or of long duration, [organization]s should not rely solely on single source providers in the community. Where possible, [organization]s should identify other suppliers outside of the local community in case the communities' infrastructure is severely compromised and unable to support the [organization].

#### **Elements of Performance for EC.4.17**

**B 1. (CAH, HAP, LTC, LT2)** [Organization]s identify an alternative means of providing for the following utilities in the event that their supply is compromised or disrupted: electricity;

**B 2. (CAH, HAP, LTC, LT2)** [Organization]s identify an alternative means of providing for the following utilities in the event that their supply is compromised or disrupted: water needed for consumption and essential care activities;

**B 3. (CAH, HAP, LTC, LT2)** [Organization]s identify an alternative means of providing for the following utilities in the event that their supply is compromised or disrupted: water needed for equipment and sanitary purposes;

**B 4. (CAH, HAP, LTC, LT2)** [Organization]s identify an alternative means of providing for the following utilities in the event that their supply is compromised or disrupted: fuel required for building operations or essential transport activities; and

**B 5. (CAH, HAP, LTC, LT2)** [Organization]s identify an alternative means of providing for the following utilities in the event that their supply is compromised or disrupted: other essential utility needs (for example, ventilation, medical gas/vacuum systems, etc.).

#### **Standard EC.4.18 (CAH, HAP, LTC, LT2)**

The [organization] establishes strategies for managing [patient] clinical and support activities during emergencies.

**(CAH: *Corresponds to COP 485.623 (c)(3) and (c)(4)*)**

### **Rationale for EC.4.18**

The fundamental goal of emergency management planning is to protect life and prevent disability. The manner in which care, treatment and services are provided may vary by type of emergency. However, certain clinical activities are so fundamental to safe and effective care that the [organization] should determine how it will re-schedule or manage [patient] clinical needs even under the most dynamic situations or in the most austere care environments.

The emergency triage process will typically result in [patient]s being quickly treated and discharged, admitted for a longer stay, or transferred to a more appropriate source of care. It is especially important to identify and triage [patient]s whose clinical needs are outside of the usual scope of service of the [organization]. A catastrophic emergency may result in the decision to keep all [patient]s on the premises in the interest of safety or, conversely, in the decision to evacuate all [patient]s because the facility is no longer safe. Planning for clinical services must address these situations accordingly.

### **Elements of Performance for EC.4.18**

**B 1. (CAH, HAP, LTC, LT2)** The [organization] plans to manage the following during emergencies: the clinical activities required as part of [patient] scheduling, triage, assessment, treatment, admission, transfer, discharge, and evacuation;

**B 2. (CAH, HAP, LTC, LT2)** The [organization] plans to manage the following during emergencies: clinical services for vulnerable populations served by the [organization], including [patient]s who are pediatric, geriatric, disabled, or have serious chronic conditions or addictions;

**B 3. (CAH, HAP, LTC, LT2)** The [organization] plans to manage the following during emergencies: personal hygiene and sanitation needs of its [patient]s;

**B 4. (CAH, HAP, LTC, LT2)** The [organization] plans to manage the following during emergencies: the mental health service needs of its [patient]s; and

**B 5. (CAH, HAP, LTC, LT2)** The [organization] plans to manage the following during emergencies: mortuary services.

**B 6. (CAH, HAP, LTC, LT2)** The [organization] plans for documenting and tracking [patient]s' clinical information.