Hospitals
Emergency Management (EM)

Overview

Emergencies can be threats to any health care organization. A single emergency can temporarily disrupt services; however, multiple emergencies that occur concurrently or sequentially can adversely impact patient safety and the hospital's ability to provide care, treatment, and services for an extended length of time. This is particularly true in situations where the community cannot adequately support the hospital. 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 hospital.

About This Chapter

The "Emergency Management" (EM) chapter is organized sequentially to assist hospitals in planning their responses to the effects of potential emergencies that fall on a continuum from disruptive to disastrous. Planning involves those activities that must be done in order to put together a comprehensive Emergency Operations Plan (EOP). This planning results in the EOP document. After the EOP is in place, it must be tested through staged emergency response exercises in order to evaluate its effectiveness. Adjustments to the EOP can then be made.

The four phases of emergency management are mitigation, preparedness, response, and recovery. They occur over time; mitigation and preparedness generally occur before an emergency, and response and recovery occur during and after an emergency. The planning activities described in Standard EM.01.01.01 help the organization to focus its strategy for mitigating the potential effects of emergencies, as well as the approach to preparedness that will help it to organize and mobilize its essential resources. The organization will use its EOP (described in Standard EM.02.01.01 and subsequent standards) to define its response to emergencies and to help position it for recovery after the emergency has passed.

Hospitals should identify potential hazards, threats, and adverse events and assess their impact on the care, treatment, and services provided for their patients. This assessment is known as a Hazard Vulnerability Analysis (HVA) and is designed to assist hospitals in gaining a realistic understanding of their vulnerabilities in order to help them mitigate and respond to emergencies and their subsequent impact. No hospital can predict the

nature of a future emergency, nor can it predict the date of its arrival. However, hospitals can plan for managing the following critical areas of their organizations so that they can respond effectively regardless of the cause(s) of an emergency:

- Communications
- Resources and assets
- Safety and security
- Staff responsibilities
- Utilities
- Patient clinical and support activities

When hospitals consider their capabilities in these areas, they are taking an "all hazards" approach to emergency management that supports a level of preparedness sufficient to address a range of emergencies, regardless of the cause. This approach lays the foundation for developing an EOP that is scalable to emergencies that may escalate in complexity, scope, or duration. For the most extreme type of emergencies—disasters—additional human resources may be necessary. Organizations can choose to assign responsibilities to volunteer practitioners or to privilege volunteer licensed independent practitioners when such volunteers are essential for meeting patient care needs. Hospitals should evaluate their planning efforts and test their EOPs through exercise scenarios so that they can use the lessons learned to improve the effectiveness of their response strategies.

Additional standards in other chapters are integral to hospitalwide emergency preparedness, including processes for the following:

- Maintaining continuity of information (refer to Standard IM.01.01.03)
- Responding to outbreaks of infectious disease (refer to Standard IC.01.06.01)
- Identifying and mitigating impediments to patient flow (refer to Standard LD.04.03.11)

Chapter Outline

I. Foundation for the Emergency Operations Plan (EM.01.01.01)

II. The Plan for Response and Recovery
  A. General Requirements (EM.02.01.01)
  B. Specific Requirements
    1. Communications (EM.02.02.01)
    2. Resources and Assets (EM.02.02.03)
    3. Security and Safety (EM.02.02.05)
    4. Staff (EM.02.02.07)
    5. Utilities (EM.02.02.09)
    6. Patients (EM.02.02.11)
    7. Disaster Volunteers
      a. Volunteer Licensed Independent Practitioners (EM.02.02.13)
      b. Volunteer Practitioners (EM.02.02.15)

III. Evaluation (EM.03.01.01, EM.03.01.03)

IV. Integrated Emergency Management Program (EM.04.01.01)

Standards, Rationales, and Elements of Performance

Standard EM.01.01.01

The hospital engages in planning activities prior to developing its written Emergency Operations Plan.

Note: *An emergency is an unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in a sudden, significantly changed or increased demand for the organization's services. Emergencies can be either human-made or natural (such as an electrical system failure or a tornado), or a combination of both, and they exist on a continuum of severity. A disaster is a type of emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions.*

Rationale for EM.01.01.01

An emergency in a health care organization can suddenly and significantly affect demand for its services or its ability to provide these services. Therefore, the organization needs to engage in planning activities that prepare it to form its Emergency Operations Plan. These activities include identifying risks, prioritizing likely emergencies, attempting to mitigate them when possible, and considering its potential emergencies in developing strategies for preparedness. Because some emergencies that impact an organization originate in the community, the organization needs to take advantage of opportunities where possible to collaborate with relevant parties in the community.

Elements of Performance for EM.01.01.01

1. The hospital's leaders, including leaders of the medical staff, participate in planning activities prior to developing an Emergency Operations Plan.
2. (D) The hospital conducts a hazard vulnerability analysis (HVA) to identify potential emergencies within the organization and the community that could affect demand for the hospital's services or its ability to provide those services, the likelihood of those events occurring, and the consequences of those events. The findings of this analysis are documented. (*See also* EM.03.01.01, EP 1; IC.01.06.01, EP 4) (R)

Note 1: *Hospitals have flexibility in creating either a single HVA that accurately reflects all sites of the hospital, or multiple HVAs. Some remote sites may be significantly different from the main site (for example, in terms of hazards, location, and population served); in such situations a separate HVA is appropriate.*

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Note 2: *If the hospital identifies a surge in infectious patients as a potential emergency, this issue is addressed in the "Infection Prevention and Control" (IC) chapter.*

3. The hospital, together with its community partners, prioritizes the potential emergencies identified in its hazard vulnerability analysis (HVA) and documents these priorities.

   Note: *The hospital determines which community partners are critical to helping define priorities in its HVA. Community partners may include other health care organizations, the public health department, vendors, community organizations, public safety and public works officials, representatives of local municipalities, and other government agencies.*

4. The hospital communicates its needs and vulnerabilities to community emergency response agencies and identifies the community's capability to meet its needs. This communication and identification occur at the time of the hospital's annual review of its Emergency Operations Plan and whenever its needs or vulnerabilities change. (*See also* EM.03.01.01, EP 1)

5. The hospital uses its hazard vulnerability analysis as a basis for defining mitigation activities (that is, activities designed to reduce the risk of and potential damage from an emergency).

   Note: *Mitigation, preparedness, response, and recovery are the four phases of emergency management. They occur over time: Mitigation and preparedness generally occur before an emergency, and response and recovery occur during and after an emergency.*

6. The hospital uses its hazard vulnerability analysis as a basis for defining the preparedness activities that will organize and mobilize essential resources. (*See also* IM.01.01.03, EPs 1 and 2)

7. The hospital's incident command structure is integrated into and consistent with its community's command structure.[*]

[*] The National Incident Management System (NIMS) is one of many models for an incident command structure available to health care organizations. The NIMS provides guidelines for common functions and terminology to support clear communications and effective collaboration in an emergency situation. The NIMS is required of hospitals receiving certain federal funds for emergency preparedness.

Note: *The incident command structure used by the hospital should provide for a scalable response to different types of emergencies.*

8. The hospital keeps a documented inventory of the resources and assets it has on site that may be needed during an emergency, including, but not limited to, personal protective equipment, water, fuel, and medical, surgical, and medication-related resources and assets. (*See also* EM.02.02.03, EP 6) R

Standard EM.02.01.01

The hospital has an Emergency Operations Plan.

Note: *The hospital's Emergency Operations Plan (EOP) is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities during an emergency (refer to Standards EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, EM.02.02.09, and EM.02.02.11). Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This "all hazards" approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the plan's response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.*

Rationale for EM.02.01.01

A successful response effort relies on a comprehensive and flexible Emergency Operations Plan that guides decision making at the onset of an emergency and as an emergency evolves. Although the Emergency Operations Plan can be formatted in a variety of ways, it must address response procedures that are both applicable to the hospital's likely emergencies and adaptable in supporting key areas (such as communications and patient care) that might be affected by emergencies of different causes.

Elements of Performance for EM.02.01.01

1. The hospital's leaders, including leaders of the medical staff, participate in the development of the Emergency Operations Plan. R

2. The hospital develops and maintains a written Emergency Operations Plan that describes the response procedures to follow when emergencies occur. (*See also* EM.03.01.03, EP 5) R

   Note: *The response procedures address the prioritized emergencies but can also be adapted to other emergencies that the hospital may experience. Response procedures could include the following:*

- *Maintaining or expanding services*
- *Conserving resources*
- *Curtailing services*
- *Supplementing resources from outside the local community*
- *Closing the hospital to new patients*
- *Staged evacuation*
- *Total evacuation*

3. The Emergency Operations Plan identifies the hospital's capabilities and establishes response procedures for when the hospital cannot be supported by the local community in the hospital's efforts to provide communications, resources and assets, security and safety, staff, utilities, or patient care for at least 96 hours.

   Note: *Hospitals are not required to stockpile supplies to last for 96 hours of operation.*

4. The hospital develops and maintains a written Emergency Operations Plan that describes the recovery strategies and actions designed to help restore the systems that are critical to providing care, treatment, and services after an emergency.

5. The Emergency Operations Plan describes the processes for initiating and terminating the hospital's response and recovery phases of an emergency, including under what circumstances these phases are activated.

   Note: *Mitigation, preparedness, response, and recovery are the four phases of emergency management. They occur over time: Mitigation and preparedness generally occur before an emergency, and response and recovery occur during and after an emergency.*

6. The Emergency Operations Plan identifies the individual(s) who has the authority to activate the response and recovery phases of the emergency response.

7. The Emergency Operations Plan identifies alternative sites for care, treatment, and services that meet the needs of the hospital's patients during emergencies.

8. If the hospital experiences an actual emergency, the hospital implements its response procedures related to care, treatment, and services for its patients.

12. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The Emergency Operations Plan includes a continuity of operations strategy that covers the following:

- A succession plan that lists who replaces key leaders during an emergency if a leader is not available to carry out his or her duties
- A delegation of authority plan that describes the decisions and policies that can be implemented by authorized successors during an emergency and criteria or triggers that initiate this delegation

Note: *A continuity of operations strategy is an essential component of emergency management planning. The goal of emergency management planning is to provide care to individuals who are incapacitated by emergencies in the community or in the organization. A continuity of operations strategy focuses on the organization, with the goal of protecting the organization's physical plant, information technology systems, business and financial operations, and other infrastructure from direct disruption or damage so that it can continue to function throughout or shortly after an emergency. When the organization itself becomes, or is at risk of becoming, a victim of an emergency (power failure, fire, flood, bomb threat, and so forth), it is the continuity of operations strategy that provides the resilience to respond and recover.*

13. **For hospitals that use Joint Commission accreditation for deemed status purposes:** If a hospital has one or more transplant centers (*see* Glossary), the following must occur:
    - A representative from each transplant center must be included in the development and maintenance of the hospital's emergency preparedness program
    - The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant center, and the organ procurement organization (OPO) for the donation service area where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency

14. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has a procedure for requesting an 1135 waiver for care and treatment at an alternative care site.

    Note: *During disasters, organizations may need to request 1135 waivers to address care and treatment at an alternate care site identified by emergency management officials. The 1135 waivers are granted by the federal government during declared public health emergencies; these waivers authorize modification of certain federal*

regulatory requirements (for example, Medicare, Medicaid, Children's Health Insurance Program, Health Insurance Portability and Accountability Act) for a defined time period during response and recovery.

15. Ⓓ The Emergency Operations Plan describes a means to shelter patients, staff, and volunteers on site who remain in the facility.

16. Ⓓ **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has one or more emergency management policies based on the emergency plan, risk assessment, and communication plan. Procedures guiding implementation are defined in the emergency management plan, continuity of operations plan, and other preparedness and response protocols. Policy and procedure documents are reviewed and updated on an annual basis; the format of these documents is at the discretion of the hospital.

Standard EM.02.02.01

As part of its Emergency Operations Plan, the hospital prepares for how it will communicate during emergencies.

Rationale for EM.02.02.01

The hospital maintains reliable communication capabilities for the purpose of communicating response efforts to staff, patients, and external organizations. The hospital establishes backup communication processes and technologies (for example, cell phones, landlines, bulletin boards, fax machines, satellite phones, amateur radio, text messages) to communicate essential information if primary communication systems fail.

Elements of Performance for EM.02.02.01

The Emergency Operations Plan describes the following:

1. How staff will be notified that emergency response procedures have been initiated.
2. How the hospital will communicate information and instructions to its staff and licensed independent practitioners during an emergency.
3. How the hospital will notify external authorities that emergency response measures have been initiated.
4. How the hospital will communicate with external authorities during an emergency.

5. How the hospital will communicate with patients and their families, including how it will notify families when patients are relocated to alternative care sites.
6. How the hospital will communicate with the community or the media during an emergency.
7. How the hospital will communicate with suppliers of essential services, equipment, and supplies during an emergency.
8. How the hospital will communicate with other health care organizations in its contiguous geographic area regarding the essential elements of their respective command structures, including the names and roles of individuals in their command structures and their command center telephone numbers.
9. How the hospital will communicate with other health care organizations in its contiguous geographic area regarding the essential elements of their respective command centers for emergency response.
10. How the hospital will communicate with other health care organizations in its contiguous geographic area regarding the resources and assets that could be shared in an emergency response.
11. How and under what circumstances the hospital will communicate the names of patients and the deceased with other health care organizations in its contiguous geographic area.
12. How, and under what circumstances, the hospital will communicate information about patients to third parties (such as other health care organizations, the state health department, police, and the Federal Bureau of Investigation [FBI]).
13. How the hospital will communicate with identified alternative care sites.

14. The hospital establishes backup systems and technologies for the communication activities identified in EM.02.02.01, EPs 1–13.

17. The hospital implements the components of its Emergency Operations Plan that require advance preparation to support communications during an emergency.

20. **For hospitals that use Joint Commission accreditation for deemed status purposes:** As part of its communication plan, the hospital maintains the names and contact information of the following:
    - Staff
    - Physicians
    - Other hospitals and critical access hospitals
    - Volunteers
    - Entities providing services under arrangement
    - Relevant federal, state, tribal, regional, and local emergency preparedness staff
    - Other sources of assistance

21. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The Emergency Operations Plan describes the following:
    - Process for communicating information about the general condition and location of patients under the organization's care to public and private entities assisting with disaster relief
    - Process, in the event of an evacuation, to release patient information to family, patient representative, or others responsible for the care of the patient

    Note: *These processes are consistent with privacy and disclosure requirements specified under 45 CFR 164.510(b)(1)(ii) and 45 CFR 164.510(b)(4).*

22. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The organization maintains documentation of completed and attempted contact with the local, state, tribal, regional, and federal emergency preparedness officials in its service area. This contact is made for the purpose of communication and, where possible, collaboration on coordinated response planning for a disaster or emergency situation.

    Note: *Examples of these contacts may be written or e-mail correspondence; in-person meetings or conference calls; regular participation in health care coalitions, working groups, boards, and committees; or educational events sponsored by a third party (such as a local or state health department).*

Standard EM.02.02.03

As part of its Emergency Operations Plan, the hospital prepares for how it will manage resources and assets during emergencies.

Rationale for EM.02.02.03

The hospital that continues to provide care, treatment, and services to its patients during emergencies needs to determine how resources and assets (that is, supplies, equipment, and facilities) will be managed internally and, when necessary, solicited and acquired from external sources such as vendors, neighboring health care providers, other community organizations, state affiliates, or a regional parent company. The hospital should also recognize the risk that some resources may not be available from planned sources, particularly in emergencies of long duration or broad geographic scope, and that contingency plans will be necessary for critical supplies. This situation may occur when multiple hospitals are vying for a limited supply from the same vendor.

Elements of Performance for EM.02.02.03

The Emergency Operations Plan describes the following:

1. How the hospital will obtain and replenish medications and related supplies that will be required throughout the response and recovery phases of an emergency, including access to and distribution of caches that may be stockpiled by the hospital, its affiliates, or local, state, or federal sources.
2. How the hospital will obtain and replenish medical supplies that will be required throughout the response and recovery phases of an emergency, including personal protective equipment where required.
3. How the hospital will obtain and replenish nonmedical supplies (including food, bedding, and other provisions consistent with the hospital's plan for sheltering on site) that will be required throughout the response and recovery phases of an emergency.
4. How the hospital will share resources and assets with other health care organizations within the community, if necessary.

   Note: *Examples of resources and assets that might be shared include beds, transportation, linens, fuel, personal protective equipment, medical equipment, and supplies.*
5. How the hospital will share resources and assets with other health care organizations outside the community, if necessary, in the event of a regional or prolonged disaster.

Note: *Examples of resources and assets that might be shared include beds, transportation, linens, fuel, personal protective equipment, medical equipment, and supplies.*

6. How the hospital will monitor quantities of its resources and assets during an emergency. (*See also* EM.01.01.01, EP 8)

9. The hospital's arrangements for transporting some or all patients; their medications, supplies, and equipment; and staff to an alternative care site(s) when the environment cannot support care, treatment, and services. (*See also* EM.02.02.11, EP 3)

10. The hospital's arrangements for transferring pertinent information, including essential clinical and medication-related information, with patients moving to alternative care sites. (*See also* EM.02.02.11, EP 3)

12. The hospital implements the components of its Emergency Operations Plan that require advance preparation to provide for resources and assets during an emergency.

Introduction to Standard EM.02.02.05

Controlling the movement of individuals into, throughout, and out of the hospital during an emergency is essential to the preservation of safety (freedom from accidental harm) and the security (freedom from intentional harm) of patients, staff, and critical supplies, equipment, and utilities. The hospital determines the type of access and movement to be allowed by staff, patients, 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 on the type of emergency and local conditions (for example, whether or not the hospital has decided to shelter staff members' families, the allowance for or prohibition against firearms, any mutual aid agreements with nearby facilities or vendors).

During an emergency, the campus or immediate environment around the hospital may be under the authority of the local police or sheriff serving the larger community. Access to and from the hospital 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 ongoing communication and coordination with this structure. In the absence of such a command structure, the hospital maintains direct contact with the agencies charged with community security.

Standard EM.02.02.05

As part of its Emergency Operations Plan, the hospital prepares for how it will manage security and safety during an emergency.

Elements of Performance for EM.02.02.05

The Emergency Operations Plan describes the following:

1. The hospital's arrangements for internal security and safety.
2. The roles that community security agencies (for example, police, sheriff, National Guard) will have in the event of an emergency.
3. How the hospital will coordinate security activities with community security agencies (for example, police, sheriff, National Guard).
4. How the hospital will manage hazardous materials and waste.
5. How the hospital will provide for radioactive, biological, and chemical isolation and decontamination.
7. How the hospital will control entrance into and out of the health care facility during an emergency.
8. How the hospital will control the movement of individuals within the health care facility during an emergency.
9. The hospital's arrangements for controlling vehicles that access the health care facility during an emergency.
10. The hospital implements the components of its Emergency Operations Plan that require advance preparation to support security and safety during an emergency.

Standard EM.02.02.07

As part of its Emergency Operations Plan, the hospital prepares for how it will manage staff during an emergency.

Rationale for EM.02.02.07

To provide safe and effective patient care during an emergency, staff roles are well defined in advance, and staff are oriented in their assigned responsibilities. Staff roles and responsibilities may be documented in the Plan using a variety of formats (for example, job action sheets, checklists, flowcharts). Due to the dynamic nature of emergencies, effective training prepares staff to adjust to changes in patient volume or acuity, work procedures or conditions, and response partners within and outside the hospital.

Elements of Performance for EM.02.02.07

The Emergency Operations Plan describes the following:

2. The roles and responsibilities of staff for communications, resources and assets, safety and security, utilities, and patient management and evacuation during an emergency.

3. The process for assigning staff to all essential staff functions.

4. The Emergency Operations Plan identifies the individual(s) to whom staff report in the hospital's incident command structure.

5. The Emergency Operations Plan describes how the hospital will manage staff support needs (for example, housing, transportation, incident stress debriefing).

6. The Emergency Operations Plan describes how the hospital will manage the family support needs of staff (for example, child care, elder care, pet care, communication).

7. The hospital trains staff for their assigned emergency response roles.

8. The hospital communicates, in writing, with each of its licensed independent practitioners regarding his or her role(s) in emergency response and to whom he or she reports during an emergency.

9. The Emergency Operations Plan describes how the hospital will identify licensed independent practitioners, staff, and authorized volunteers during emergencies. (*See also* EM.02.02.13, EP 3; EM.02.02.15, EP 3)

   Note: *This identification could include identification cards, wristbands, vests, hats, or badges.*

10. The hospital implements the components of its Emergency Operations Plan that require advance preparation to manage staff during an emergency.

11. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has a system to track the location of on-duty staff during an emergency.

13. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Initial and ongoing training relevant to their emergency response roles is provided to staff, volunteers, and individuals providing on-site services under arrangement. This training is documented and then reviewed and updated annually and when these roles change. Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization.

14. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The Emergency Operations Plan describes the use of volunteers in an emergency, including emergency staffing strategies, such as the role and process for integration of state or federally designated health care professionals to address surge needs during an emergency.

Standard EM.02.02.09

As part of its Emergency Operations Plan, the hospital prepares for how it will manage utilities during an emergency.

Rationale for EM.02.02.09

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, and building operations. Organizations, therefore, must have alternative means of providing for essential utilities (for example, alternative equipment at the hospital; negotiated relationships with the primary suppliers; provision through a parent entity; Memoranda of Understanding (MOU) with other organizations in the community). Hospitals should determine how long they expect to remain open to care for patients and plan for their utilities accordingly. Because some emergencies may be regional in scope or of long duration, organizations should not rely solely on single source providers in the community. Where possible, hospitals should identify other suppliers outside of the local community in case the communities' infrastructure is severely compromised and unable to support the hospital.

Elements of Performance for EM.02.02.09

As part of its Emergency Operations Plan, the hospital identifies alternative means of providing the following:

2. Electricity and lighting.
3. Water needed for consumption and essential care activities.
4. Water needed for equipment and sanitary purposes.
5. Fuel required for building operations, generators, and essential transport services that the hospital would typically provide.
6. Medical gas/vacuum systems.
7. Utility systems that the hospital defines as essential (for example, vertical and horizontal transport, heating and cooling systems, and steam for sterilization).

   Note: *The essential utility systems include mechanisms for maintaining temperatures at a level that protect patient health and safety and the safe and sanitary storage of provisions.*

8. The hospital implements the components of its Emergency Operations Plan that require advance preparation to provide for utilities during an emergency.
9. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, TIA 12-6); *Life Safety Code* (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, TIA 12-4); and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

Standard EM.02.02.11

As part of its Emergency Operations Plan, the hospital prepares for how it will manage patients during emergencies.

Rationale for EM.02.02.11

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 activities are so fundamental to patient safety (this

can include decisions to modify or discontinue services, make referrals, or transport patients) that the organization should take a proactive approach in considering how they might be accomplished.

The emergency triage process will typically result in patients being quickly treated and discharged, admitted for a longer stay, or transferred to a more appropriate source of care. A disaster may result in the decision to keep all patients on the premises in the interest of safety or, conversely, in the decision to evacuate all patients because the facility is no longer safe. Planning for clinical services must address these situations accordingly, particularly in the face of escalating events or in potentially austere care conditions.

Elements of Performance for EM.02.02.11

The Emergency Operations Plan describes the following:

2. How the hospital will manage the activities required as part of patient scheduling, triage, assessment, treatment, admission, transfer, and discharge.
3. How the hospital will evacuate (from one section or floor to another within the building, or, completely outside the building) when the environment cannot support care, treatment, and services. (*See also* EM.02.02.03, EPs 9 and 10)
4. How the hospital will manage a potential increase in demand for clinical services for vulnerable populations served by the hospital, such as patients who are pediatric, geriatric, disabled, or have serious chronic conditions or addictions.
5. How the hospital will manage the personal hygiene and sanitation needs of its patients.
6. How the hospital will manage its patients' mental health service needs that occur during an emergency.
7. How the hospital will manage mortuary services.
8. How the hospital will document and track patients' clinical information.

11. The hospital implements the components of its Emergency Operations Plan that require advance preparation to manage patients during an emergency.

12. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has a system to track the location of patients sheltered on site during an emergency. This system includes documentation of the name and location of the receiving facility or alternate site in the event a patient is relocated during the emergency.

    Note: *The name and location of receiving facilities or alternate sites may be defined in the emergency management plan, formal transfer agreements, or other accessible documents.*

Introduction to Standards EM.02.02.13 and EM.02.02.15

When the hospital activates its Emergency Operations Plan in response to a disaster and the immediate needs of its patients cannot be met, the hospital can choose to rely on volunteer practitioners to meet these needs. These practitioners may be volunteer licensed independent practitioners or volunteer practitioners who are not licensed independent practitioners but who are required by law and regulation to have a license, certification, or registration to meet these needs. Under these circumstances, if the usual credentialing and privileging processes cannot be performed because of the disaster, the organization may use a modified credentialing and privileging process on a case-by-case basis for eligible volunteer practitioners. While this standard allows for a method to streamline the process for determining qualifications and competence, safeguards must be in place to assure that the volunteer practitioners are competent to provide safe and adequate care, treatment, or services. Even in a disaster, the integrity of two specific parts of the usual process for determining qualifications and competence must be maintained:

1. Verification of licensure, certification, or registration required to practice a profession
2. Oversight of the care, treatment, and services provided

A number of state and federal systems engaged in pre-event verification of qualifications can help facilitate the assigning of disaster privileges to volunteer licensed independent practitioners at the time of a disaster. Examples of such systems include the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and the Medical Reserve Corps (MRC). The ESAR-VHP, created by the Health Resources and Services Administration (HRSA), allows for the advance registration and creden-

tialing of health care professionals needed to augment a hospital or other medical facility to meet increased patient/victim care and increased surge capacity needs. MRC units are comprised of locally based medical and public health volunteers who can assist their communities during emergencies, such as an influenza epidemic, a chemical spill, or an act of terrorism.

Standard EM.02.02.13

During disasters, the hospital may grant disaster privileges to volunteer licensed independent practitioners.

Note: *A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions.*

Elements of Performance for EM.02.02.13

1. The hospital grants disaster privileges to volunteer licensed independent practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.
2. The medical staff identifies, in its bylaws, those individuals responsible for granting disaster privileges to volunteer licensed independent practitioners. (*See also* MS.01.01.01, EP 14)

3. The hospital determines how it will distinguish volunteer licensed independent practitioners from other licensed independent practitioners. (*See also* EM.02.02.07, EP 9)

4. Ⓓ The medical staff describes, in writing, how it will oversee the performance of volunteer licensed independent practitioners who are granted disaster privileges (for example, by direct observation, mentoring, medical record review).

5. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following: R
   - A current picture identification card from a health care organization that clearly identifies professional designation
   - A current license to practice
   - Primary source verification of licensure
   - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
   - Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
   - Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster

6. During a disaster, the medical staff oversees the performance of each volunteer licensed independent practitioner.

7. Based on its oversight of each volunteer licensed independent practitioner, the hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue.

8. Ⓓ Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent practitioner presents him- or herself to the hospital, whichever comes first. If

primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following:

- Reason(s) it could not be performed within 72 hours of the practitioner's arrival
- Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services
- Evidence of the hospital's attempt to perform primary source verification as soon as possible

9. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible.

   Note: *Primary source verification of licensure is not required if the volunteer licensed independent practitioner has not provided care, treatment, or services under the disaster privileges.*

Standard EM.02.02.15

During disasters, the hospital may assign disaster responsibilities to volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification, or registration.

Note: *While this standard allows for a method to streamline the process for verifying identification and licensure, certification, or registration, the elements of performance are intended to safeguard against inadequate care during a disaster.*

Elements of Performance for EM.02.02.15

1. The hospital assigns disaster responsibilities to volunteer practitioners who are not licensed independent practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.

2. The hospital identifies, in writing, those individuals responsible for assigning disaster responsibilities to volunteer practitioners who are not licensed independent practitioners.

3. The hospital determines how it will distinguish volunteer practitioners who are not licensed independent practitioners from its staff. (*See also* EM.02.02.07, EP 9)

4. The hospital describes, in writing, how it will oversee the performance of volunteer practitioners who are not licensed independent practitioners who have been assigned disaster responsibilities. Examples of methods for overseeing their performance include direct observation, mentoring, and medical record review.

5. Before a volunteer practitioner who is not a licensed independent practitioner is considered eligible to function as a practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and one of the following: R
   - A current picture identification card from a health care organization that clearly identifies professional designation
   - A current license, certification, or registration
   - Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice)
   - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
   - Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
   - Confirmation by hospital staff with personal knowledge of the volunteer practitioner's ability to act as a qualified practitioner during a disaster

6. During a disaster, the hospital oversees the performance of each volunteer practitioner who is not a licensed independent practitioner.

7. Based on its oversight of each volunteer practitioner who is not a licensed independent practitioner, the hospital determines within 72 hours after the practitioner's arrival whether assigned disaster responsibilities should continue.

8. Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice) of volunteer practitioners who are not licensed independent practitioners occurs as soon as the disaster is under control or within 72 hours from the time the volunteer practitioner presents him- or herself to the hospital, whichever comes first. If primary source verification of licensure, certification, or registration (if required by law and

regulation in order to practice) for a volunteer practitioner who is not a licensed independent practitioner cannot be completed within 72 hours due to extraordinary circumstances, the hospital documents all of the following:

- Reason(s) it could not be performed within 72 hours of the practitioner's arrival
- Evidence of the volunteer practitioner's demonstrated ability to continue to provide adequate care, treatment, or services
- Evidence of the hospital's attempt to perform primary source verification as soon as possible

9. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible.

Note: *Primary source verification of licensure, certification, or registration is not required if the volunteer practitioner has not provided care, treatment, or services under his or her assigned disaster responsibilities.*

Standard EM.03.01.01

The hospital evaluates the effectiveness of its emergency management planning activities.

Rationale for EM.03.01.01

The risks and hazards facing an organization or an area of the organization may change over time. The scope or goals of the hospital's planning activities may evolve in response to changes in the organization, its structure, patient population, community planning partners, or a number of other factors. Such changes can have an impact on the hospital's response capabilities, including decisions about its inventory of resources and assets needed during an emergency. The hospital conducts an annual review of its planning activities to identify such changes and support decision making regarding how the hospital responds to emergencies.

Elements of Performance for EM.03.01.01

1. (D) The hospital conducts an annual review of its risks, hazards, and potential emergencies as defined in its hazard vulnerability analysis (HVA). The findings of this review are documented. (*See also* EM.01.01.01, EPs 2 and 4) R

2. (D) The hospital conducts an annual review of the objectives and scope of its Emergency Operations Plan. The findings of this review are documented. R

3. The hospital conducts an annual review of its inventory. The findings of this review are documented. R

4. The annual emergency management planning reviews are forwarded to senior hospital leadership for review. (*See also* LD.04.01.10, EP 2)

   Note: *Senior hospital leadership refers to those leaders with responsibility for organizationwide strategic planning and budgets (vice presidents and officers). The hospital may determine that all senior hospital leaders participate in reviewing emergency management reviews, or it may designate specific senior hospital leaders to review this information.*

Standard EM.03.01.03

The hospital evaluates the effectiveness of its Emergency Operations Plan.

Rationale for EM.03.01.03

The organization conducts exercises to assess the Emergency Operations Plan's appropriateness, adequacy, and effectiveness in regard to logistics, human resources, training, policies, procedures, and protocols. Exercises should stress the limits of the plan to support assessment of the organization's preparedness and performance. The design of the exercises should reflect likely disasters but should test the organization's ability to respond to the effects of emergencies on its capabilities to provide care, treatment, and services.

Elements of Performance for EM.03.01.03

1. As an emergency response exercise, the hospital activates its Emergency Operations Plan twice a year at each site included in the plan. R

   Note 1: *If the hospital activates its Emergency Operations Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises.*

   Note 2: *Staff in freestanding buildings classified as a business occupancy (as defined by the* Life Safety Code[†] *) that do not offer emergency services nor are community designated as disaster-receiving stations need to conduct only one emergency management exercise annually.*

[†] The *Life Safety Code*® is a registered trademark of the National Fire Protection Association, Quincy, MA. Refer to NFPA 101-2012 for occupancy classifications.

Note 3: *Tabletop sessions, though useful, are not acceptable substitutes for these exercises.*

Note 4: *In order to satisfy the twice-a-year requirement, the hospital must first evaluate the performance of the previous exercise and make any needed modifications to its Emergency Operations Plan before conducting the subsequent exercise in accordance with EPs 13–17.*

2. For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital's two emergency response exercises includes an influx of simulated patients.

   Note 1: *Tabletop sessions, though useful, cannot serve for this portion of the exercise.*

   Note 2: *This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 3 and 4.*

3. For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital's two emergency response exercises includes an escalating event in which the local community is unable to support the hospital.

   Note 1: *This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 2 and 4.*

   Note 2: *Tabletop sessions are acceptable in meeting the community portion of this exercise.*

4. For each site of the hospital with a defined role in its community's response plan, at least one of the two emergency response exercises includes participation in a community-wide exercise.

   Note 1: *This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 2 and 3.*

   Note 2: *Tabletop sessions are acceptable in meeting the community portion of this exercise.*

5. Emergency response exercises incorporate likely disaster scenarios that allow the hospital to evaluate its handling of communications, resources and assets, security, staff, utilities, and patients. (*See also* EM.02.01.01, EP 2)

6. The hospital designates an individual(s) whose sole responsibility during emergency response exercises is to monitor performance and document opportunities for improvement.

   Note 1: *This person is knowledgeable in the goals and expectations of the exercise and may be a staff member of the hospital.*

   Note 2: *If the response to an actual emergency is used as one of the required exercises, it is understood that it may not be possible to have an individual whose sole responsibility is to monitor performance. Hospitals may use observations of those who were involved in the command structure as well as the input of those providing services during the emergency.*

7. During emergency response exercises, the hospital monitors the effectiveness of internal communication and the effectiveness of communication with outside entities such as local government leadership, police, fire, public health officials, and other health care organizations.

8. During emergency response exercises, the hospital monitors resource mobilization and asset allocation, including equipment, supplies, personal protective equipment, and transportation.

During emergency response exercises, the hospital monitors its management of the following:

9. Safety and security.

10. Staff roles and responsibilities.

11. Utility systems.

12. Patient clinical and support care activities.

13. Based on all monitoring activities and observations, including relevant input from all levels of staff affected, the hospital evaluates all emergency response exercises and all responses to actual emergencies using a multidisciplinary process (which includes licensed independent practitioners).

14. The evaluation of all emergency response exercises and all responses to actual emergencies includes the identification of deficiencies and opportunities for improvement. This evaluation is documented.

15. The deficiencies and opportunities for improvement, identified in the evaluation of all emergency response exercises and all responses to actual emergencies, are communicated to the improvement team responsible for monitoring environment of care issues and to senior hospital leadership. (*See also* LD.04.01.10, EP 2)

16. The hospital modifies its Emergency Operations Plan based on its evaluation of emergency response exercises and responses to actual emergencies.

    Note: *When modifications requiring substantive resources cannot be accomplished by the next emergency response exercise, interim measures are put in place until final modifications can be made.*

17. Subsequent emergency response exercises reflect modifications and interim measures as described in the modified Emergency Operations Plan.

Introduction to Standard EM.04.01.01

Each individual health care organization must have an emergency plan that reflects the risks facing the organization and the strategies, resources, and capabilities it can deploy to serve its patients safely during a time of disaster. Hospitals in systems with integrated emergency preparedness programs can increase resilience through integrating their plans with the system and leveraging system expertise, resources, and other capabilities. System participation extends the ability of the hospital to serve its patients, protect its facilities, mobilize its staff, and aid its system and/or community by serving more patients.

Depending on the hospital's risks, services, and capabilities, some aspects of integration with the system may be at an early stage rather than an advanced stage. However, because disasters can occur at any time, the hospital must implement communication procedures immediately in order to stand ready to actively use and align with the system's emergency response procedures.

In terms of format, the system's plan can be an annex to the hospital's plan, the hospital's individual emergency plan can be integrated into the system's plan, or there can be a single universal system plan that has sections for each organization—no specific format is prescribed. However, the hospital must be able to readily access and use its

individual plan for its preparedness, response, and recovery efforts. The hospital must be able to readily access the system's plan and use it to carry out its role effectively within the system's integrated emergency preparedness program.

Standard EM.04.01.01

For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital is part of a health care system that has an integrated emergency preparedness program, and it chooses to participate in the integrated emergency preparedness program, the hospital participates in planning, preparedness, and response activities with the system.

Elements of Performance for EM.04.01.01

1. Ⓓ **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital demonstrates its participation in the development of its system's integrated emergency preparedness program through the following:
   - Designation of a staff member(s) who will collaborate with the system in developing the program
   - Documentation that the hospital has reviewed the community-based risk assessment developed by the system's integrated all-hazards emergency management program
   - Documentation that the hospital's individual risk assessment is incorporated into the system's integrated program
   - Documentation that the hospital's patient population, services offered, and any unique circumstances of the hospital are reflected in the system's integrated program
   - Documentation of an integrated communication plan, including information on key contacts in the system's integrated program
   - Documentation that the hospital participates in the annual review of the system's integrated program
2. Ⓓ **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has implemented communication procedures for emergency planning and response activities in coordination with the system's integrated emergency preparedness program.
3. Ⓓ **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital's integrated emergency management policies, procedures, or plans address the following:

- Identification of the hospital's emergency preparedness, response, and recovery activities that can be coordinated with the system's integrated program (for example, acquiring or storing clinical supplies, assigning staff to the local health care coalition to create joint training protocols, and so forth)
- The hospital's communication and/or collaboration with local, tribal, regional, state, or federal emergency preparedness officials through the system's integrated program
- Coordination of continuity of operations planning with the system's integrated program
- Plans and procedures for integrated training and exercise activities with the system's integrated program