



EMERGENCY MANAGEMENT REQUIREMENTS EXPANDED

by Dave Gourley RRT

The Joint Commission has been increasing its focus on the emergency preparedness process since 2001. Starting with the terrorist attacks of 9/11, through the anthrax scares, and finally the devastation of Hurricane Katrina, accreditation requirements for emergency planning have been steadily growing. There isn't a week that passes without seeing some news-cast demonstrating the need for healthcare emergency management. Blizzards, tornados, earthquakes, widespread power failures, and the latest wildfires in California all stand to reinforce the need for healthcare organizations of all sizes and services to be prepared to manage emergencies when they occur.

The Joint Commission recently released their revisions to the Emergency Management standards. These standards are included in the Management of the Environment of Care chapter. It is rumored that Emergency Management may be separated out into its own chapter in subsequent updates.

A new concept introduced in this revision is a health care system model for classifying emergencies. They are as follows:

Emergency: Infrastructure is intact, the organization can sustain the response, and there are no deaths directly related to the impact of the event. The organization responds in the usual fashion and the standard of care is maintained.

Disaster: Infrastructure is damaged, the organization can sustain the response, and there are a few deaths directly related to the impact of the event. The organization is able to respond for 96 hours and sufficient care is administered.

Catastrophe: Infrastructure is damaged, the organization cannot sustain the response independently, and many deaths are possible. The organization may need to evacuate and basic or primitive care is expected.

The Joint Commission is expecting organizations to address the reality that it is not sufficient for healthcare providers to plan for one single event. They need to be flexible to respond to a series of escalating events. For example, during a hurricane and flood, the hospital may need to respond to loss of power, flooding, heat extremes, lack of supplies, and lack of staff.

The new standards are effective 1/1/08 and apply to hospitals, critical access hospitals, and long term care facilities. The emphasis is on the "scalable approach". It is meant to help manage the response to a combination of escalating events. The organization must define its capabilities to self-sustain for 96 hours.

The revised standards include the following six distinct areas for emergency response:

- Communications (EC.4.13)
- Resources and assets (EC.14)
- Safety and security (EC.15)
- Staff responsibilities (EC.4.16)
- Utilities management (EC.4.17)
- Patient clinical and support activities (EC.4.18)

There were 21 Elements of Performance (individual item contained within each standard) in the old standards. These Elements of Performance (EP) are contained within the new standards. In addition, more than 30 new EPs have been added.

A major focus of the new standards is integration with the community. The hazard vulnerability analysis must be conducted with the community in order to prioritize events. The organization must communicate its needs and vulnerabilities to the community responders.

The emergency response plan must include a documented inventory of assets and resources. At a minimum, this must include personal protective equipment (PPE), staffing, water and fuel, and medical, surgical, and pharmaceutical supplies. In addition, there must be a method in place to monitor quantities of assets and resources during the emergency.

There are additional requirements to the Emergency Operations Plan (EOP). The organization must establish an incident command structure. This structure must be integrated and consistent with the community command structure. The Hospital Incident Command

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"I'll have my people call your people, assuming my people return my phone calls."

System (HICS), formerly HEICS, is the model most often employed. The EOP must establish the response when the organization cannot receive outside support for at least 96 hours. Communications is frequently identified as a problematic area in an emergency. The EOP must include a plan for ongoing communication. This includes communication of information and instructions to staff, and communication with external authorities, patients, families, and providers of supplies, equipment, and services.

Management of resources and assets is another important addition to the standards. Organizations must plan for obtaining supplies at the beginning of the emergency. In addition, replenishing for response and recovery is needed. Human resource needs include staff support activities and support of staff's families. The EOC needs to plan for sharing of resources and assets with other healthcare organizations. If evacuation is considered, transporting patients, their medications, equipment, staff, and patient medical records is needed.

Safety and security measures are another essential element of the new standards. Methods for management of hazardous materials and waste need to be addressed. Also, means for isolation and decontamination of radioactive, biological, and chemical agents is required. Security includes controlling entrance in and out of the building, movement within the institution, and traffic accessing the facility all need to be in the plan. The EOP needs to define staff roles and responsibilities for all of the six critical areas. This includes staff training for assigned roles and methods for identifying all personnel. In addition, communication with licensed independent practitioners (LIP) must be included in the plan.

Strategies for utility management are the fifth essential element of the revised standards. Alternative methods of providing electricity, water, fuel, ventilation, and medical gases need to be part of the EOC. The last critical element of the new standards is managing clinical and support activities. Issues related to patient care include scheduling, triage, assessment, treatment, admission, transfer, discharge, and evacuation. Additional activities include services for vulnerable populations, hygiene and sanitation needs of patients, mental health services, mortuary services, and patient documentation and tracking systems.

The last requirement in the revised standards is exercises. They are still required twice a year, either in response to an actual emergency or as a drill. At least one exercise needs to be escalated to assess isolated performance, one needs to be community-wide. Individual monitors must assess performance and evaluate the six critical areas. Any modifications as a result of exercises must be evaluated during the next drill.

The increased requirements in emergency management are significant. All healthcare organizations will need to dedicate the resources necessary to meet these standards. However, it will not be unwarranted. Each of us just needs to watch the evening news to see that emergencies are occurring across the country with increased regularity. In order to meet the needs of our patients and staff, consistent emergency management planning is essential.

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