Now that CMS and The Joint Commission are placing greater emphasis on emergency management, this book is a must have! The pressure is on safety officers and emergency management coordinators to protect their facility, staff, and patients from emergencies, regardless of size or type. The *Emergency Management Compliance Manual, Second Edition*, provides a detailed look at CMS and The Joint Commission’s Emergency Management expectations and standards. With this essential emergency preparedness resource, you’ll be able to cut through the clutter to better understand best practices and meet requirements.

This book will help you:
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- Define an emergency and complete a hazard vulnerability analysis
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- Understand disaster privileging and assigning responsibilities during an emergency
- Evaluate the effectiveness of your planning
- Recognize hotspots and take action before they happen
- Prepare for the proposed CMS emergency management rule
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About the Author

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Before joining Clarian (now IU) Health, Huser worked for St. Vincent’s Hospital in Indianapolis as the manager of health and safety for the hospital’s organizational safety department and was a consultant for the St. Vincent Health affiliated facilities. A volunteer firefighter for the past 33 years, Huser is a certified National Fire Protection Association fire instructor II/III and a state-certified hazardous materials instructor. He is currently a volunteer with the Cicero Indiana Volunteer Fire Department, where he has been a member since January 2001. He was the healthcare representative on the Marion County, Indiana, Local Emergency Planning Committee and served as a hospital representative on numerous other planning groups.
About the Author

Huser writes for HCPro’s *Briefings on Hospital Safety* and the *Journal of Healthcare Security*. He has given presentations at such gatherings as the Ascension Health Safety Conference, the NFPA World Fire and Safety Conference, and the National Earthquake Conference.

Huser holds a master’s degree in health and safety management from Indiana State University, a bachelor’s degree in business administration from Indiana Wesleyan University, and an associate’s degree in applied fire science from Ivy Tech State College of Indiana.
The Joint Commission’s Emergency Management (EM) section outgrew the Environment of Care (EC) chapter of the Comprehensive Accreditation Manual for Hospitals (CAMH) and in 2009 became a stand-alone chapter in the accreditation manual. In 1995, when the accreditor first created the EC chapter, the section containing the EM standards was the same size as the other sections. However, hospitals gave the EM requirements less attention than the other sections. EM was always thought to be someone else’s problem—and besides, bad things happen to “the other guy,” not to your facility.

Then the United States was hit by a series of catastrophic events that highlighted the growing importance of emergency preparedness. Since 1995, the EM section has grown not only in size but in importance. In June 2001, officials had to evacuate the Houston Hospital complex when floodwaters caused the hospital buildings to lose power and then knocked out their emergency generators. That same year, the country experienced the terrorist attacks on the World Trade Center on September 11. Next came the blackout of 2003 (determined to have been caused by a tree branch), during which eight states and the Canadian province of Ontario lost power, affecting more than 18 million people. Hurricanes Katrina and Rita demonstrated further the vulnerability of emergency preparedness when hospitals in New Orleans were forced to care for patients in squalid conditions and nursing home patients drowned in their beds. In 2008, two hospitals in the southern United States suffered direct hits by tornadoes.
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In addition to these past events, we cannot forget looming disasters, such as a flu pandemic, which experts say is overdue and will cause millions of deaths across the globe. Into this atmosphere, The Joint Commission introduced the new EM chapter.

Since the introduction of the EM chapter, we have experienced an H1N1 flu pandemic; “Superstorm” Sandy, which hit the East Coast; Ebola; severe winters and droughts; and the introduction of the Affordable Care Act. What all this has shown is that while time and money have been pumped into preparedness, we are still unprepared. Ebola demonstrated how woefully ready we as a world are for a major biological event. Superstorm Sandy showed that some of the lessons learned from Hurricane Katrina have been taken to heart while others have not. Sandy also showed that hospitals are still hesitant to evacuate in the face of an impending storm, and generators are still the weak link in sustaining patient care in terrible weather and/or flooding. Events in Missouri, Oklahoma, and Arkansas have shown that a hospital does not need to be located in a coastal region to suffer the wrath of Mother Nature and her fury. Caring for children and special-needs populations continues to be a challenge in planning and preparedness for disasters, along with family reunification. For example, the after-action report for the Indiana State Fair stage collapse, which occurred in August 2011, found family reunification and identification of children to be major deficiencies; this is still the case not only in Indianapolis but across the country. We also have more means of communication than ever before in the history of mankind, yet communication continues to be the number one problem identified during postincident and drill evaluations. We are to the point where we may have too many forms of communication to effectively communicate during a disaster.

I highly recommend that anyone who is involved with EM read the after-action report conducted by the Department of Health and Human Resources Office of Inspector General on the Superstorm Sandy response. The report is dated September 2014 and is entitled Hospital Emergency Preparedness and Response During Superstorm Sandy (publication OEI-06-13-00260). Of particular interest are the challenges identified by the participating hospitals. Of the 153 hospitals in the survey, 83 reported challenges with hospital infrastructure, with the top issue being electrical utilities (69), followed by backup generators (35) and structural damage (29). Of the participating hospitals, 74 reported issues with patient surge, 59 reported issues with communications, and 57 reported issues related to staffing. There were also problems related to recovery, supplies, collaboration, patient care, transportation, documentation, and Centers for Medicare & Medicaid (CMS) Conditions of Participation. Also of interest is the fact that during their most recent survey, 157 of the 171 hospitals in the declared disaster areas for Superstorm Sandy had been cited for deficiencies in their emergency preparedness plans.
Changes to Watch For

Although the changes in the standards are minimal since the last manual, the lessons that have been learned have expanded. Response options have changed, communication continues to be an issue, and the continued growth of social media adds to the dynamics of a disaster. The Joint Commission is still identifying issues related to compliance with this chapter during surveys of healthcare facilities. More ideas and suggestions have been added throughout the manual.

As you read this book, you will notice that several changes have occurred to the standards, including the items detailed here.

The need to describe in your plan how you will comply. You will note the frequent use of the word *describes*, which is also found often in the EC chapter. The Joint Commission now not only wants to hear about your plans, but it wants to see them in writing. This wording begins with standard EM.02.02.01. The elements of performance (EP) 1–13 require that a hospital’s emergency operations plan (EOP) “describes” how the facility will undertake a task, such as how to notify staff that it initiated emergency response procedures or how it will communicate information and instructions during an emergency. The fourth word in each of these EPs is *describes*. This cycle then continues through to standard EM.02.02.07.

More specific expectations. You will also note that The Joint Commission literally spells out its expectations for you. For example, the accreditor previously asked for contingency planning for the loss of essential services. Now, The Joint Commission wants to see documented contingency plans for the loss of specific services, such as drinking water, service water, electricity, steam, medical gases, medical vacuum, etc. Each item is spelled out, leaving little room for confusion. Also, The Joint Commission makes clear what identification a licensed independent practitioner (LIP) who is not credentialed by your facility must provide before you can allow him or her to practice medicine in your facility during an emergency.

A clearer time frame. The Joint Commission switches from using *annual* to using 12 months. This has been interpreted by The Joint Commission Standards Interpretation Group (SIG) to mean the date of the last event plus or minus 30 days. This change will come into play with your community drill participation. Previously, you could participate in the community drill in June of one year and January of the next year and meet the requirements for annual participation. You now have a 60-day window in which to participate in the drills (30 days before and 30 days after the date of the previous drill). For example, if you participate in a community drill on June 30 of the previous year, the next drill must occur between June 1 and July 30 of the following year—so drills take place more or less 12 months apart. You will need to work with your community partners to ensure that you comply with the time frame or participate in several community drills throughout the year for continued compliance.
Compliance mandated on all EPs. The Joint Commission is also requiring hospitals to complete all the EPs under each standard.

More coordination with the community and other healthcare facilities. The Joint Commission expects continued involvement with the community and the other hospitals in your vicinity. For example, several counties south of Indianapolis in June 2008 experienced unusually heavy rains in a very short period of time, with some areas receiving 10 inches of rain overnight. The next morning, local television viewers were greeted with reports of dams failing, mass evacuations, road closings, and other news of the disaster. As the flooding progressed, one hospital had to move its emergency department to another building after waters came in through the ambulance entrance doors. Another hospital was harder hit and had to totally evacuate its 100 patients after its basement began to flood. Through the cooperative effort of hospitals located in Seymour and Madison, Indiana, all patients were successfully evacuated from the hospital. However, with the hospital now closed, the state called for a bed count to establish availability in surrounding hospitals 12 hours after the last patient had been evacuated. On the following Monday, the surrounding hospitals held a conference call and offered to temporarily employ the displaced staff so they would be ready to return to the hospital when it reopened.

Because the now-closed facility was the only hospital for the county, hospital officials quickly established a temporary emergency center in a local clinic. The facility requested helicopters to be on standby to transport seriously ill patients. On the first day, six patients were airlifted to other hospitals. Officials moved outpatient services, surgeries, and dialysis to other hospitals that quickly credentialled the physicians so they could continue to care for their transferred patients. Hospital officials expected the facility to remain closed an estimated six months for repairs and remediation. Fortunately, the facility had access to a capital improvement fund to pay for repairs and salaries until it could receive insurance and federal funds. Interestingly, the hospital was not in a declared flood plain; however, water was over 3 feet deep on the first floor of the facility, and the entire basement/lower level was flooded. All the equipment located in these areas was lost.

This scenario demonstrates that you must be prepared for disasters that you may not expect will affect you and that you need to work with your local planning districts and the other hospitals in your area. The hospital that was forced to close had planned to send all patients north to Indianapolis in the event of an evacuation; however, the roads were impassable due to flooding, so the patients had to go to hospitals in smaller local communities. Due to situations like this, hospitals must have multiple contingencies built into their emergency plans. This scenario also demonstrates that you do not need to wait for state or federal help to arrive like the cavalry in old Westerns. Through interhospital cooperation, facilities were able to safely relocate all the patients, keep the staff from the closed hospital employed, and resume services without the assistance of a single government agency. This is not to say the government is not playing
a role in the recovery, but the initial response was handled by the hospitals cooperating with each other.

**Other Issues to Consider**

This incident also demonstrates the potential advantage of electronic medical records. If your facility has gone to digital recordkeeping, make sure your hospital has a remotely located backup computer server that stores all information. For example, a hospital in the Midwest should maintain full duplication of electronic records in a facility located on the East Coast to allow instant access to records should an event render local servers inoperable.

Another hot issue that hospitals need to take into account in their emergency planning is the threat of pandemic influenza. If you are located in an area where you have competitors, consider who has the authority to stop all elective services at the hospitals to allow for surge capability. Elective surgeries are a hospital's bread and butter, and the loss of these surgeries will have a severe effect on your bottom line. If you must stop elective surgeries to accommodate pandemic flu or even a mass casualty incident, how will this affect your revenue, and what will the other hospitals in the area do? Will they maintain business as usual, which will handicap your facility, or does someone in your region have the authority to stop nonemergency services at other hospitals so that they too will be able to accept patients from the event? This is especially a problem where you have investor-owned "for-profit" hospitals, which tend to be more discriminating in the patients they accept. This is not meant as a criticism of these facilities; it merely points out a fact of today's healthcare environment, in which for-profit and joint-venture hospitals are becoming more prevalent. The primary difference between a nonprofit and for-profit hospital is that nonprofits do not pay taxes and in exchange provide charity care to the community. For-profit organizations pay taxes and thus do not have the requirement for charitable care. That is not to say they do not provide charitable care—just that they are not required to do so by law.

Then there are the legal issues related to a disaster, which The Joint Commission does not begin to address. During an emergency, what happens to required standards of care, the Emergency Medical Treatment and Labor Act of 1986, and other laws that require hospitals to conduct a full assessment of every patient who comes to the facility? You must consider and plan for legal issues, though this goes beyond the parameters of this book, as they are not directly related to the Joint Commission requirements.

There are also financial issues related to a disaster, which Joint Commission standards also do not address. You should remember that the Federal Emergency Management Authority (FEMA) is a payer of last resort. FEMA will reimburse only for direct property loss after insurance has paid its share, and then FEMA will reimburse for only 75% of the uncovered loss. Also, FEMA does
Chapter 1

not reimburse for direct patient care, nor will it reimburse for loss of revenue, so ensure you have sufficient business interruption coverage for long closures.

I hope you learn from this book and are able to implement a functional EOP for your facility. Emergency planning is sometimes a thankless job that has little support; however, you will have the satisfaction of a job well done when staff members respond appropriately to a disaster in your community.
This chapter establishes the foundation upon which you will build your emergency operations plan (EOP). The EOP encompasses the four sections of emergency preparedness: mitigation, planning, response, and recovery. For too many years, the healthcare industry concentrated its efforts on the planning and response portions of the EOP while paying little heed to mitigation and recovery. Mitigation means the actions taken to lessen or eliminate the potential effects on your hospital by an identified hazard. An example would be moving your emergency generators to higher levels of the hospital if your facility is located in a potential flood plain. However, Superstorm Sandy showed it is equally important to move the generator fuel pumps and electrical switch gear to a higher level, as these pieces are as critical as the generators to the continued supply of emergency power. Recovery actions are those steps taken after the disaster has ended.
to return your facility to “business as usual.” This may seem like a simple task, but depending upon the disaster, it could encompass activities up to and including building a new hospital.

DID YOU KNOW? The novice to emergency management (EM) will find a world filled with foreign acronyms and abbreviations. To better understand this new lingo, refer to the official list of commonly used acronyms and abbreviations from the Federal Emergency Management Agency (FEMA). To find a copy of the list, go to www.fema.gov/glossary/acronyms-0. To understand the commonly used acronyms and abbreviations found in this book, see Figure 2.2.

2015 Emergency Management Scoring

The EPs in the revised EM chapter are not new, but there are some slight modifications from the previous EM standards. Also, surveyors have become more familiar with the requirements and are becoming more critical in their review of the chapter. During our most recent Joint Commission survey in 2013, the EM chapter review took over an hour to complete. Granted, we are a large, complex organization (four hospitals, two of which are level one trauma centers); however, this was the most comprehensive review I had experienced. And as with the environment of care (EC) chapter of the Comprehensive Accreditation Manual for Hospitals (CAMH), The Joint Commission has released its scoring methodology for 2015. It will continue to score all EPs on a three-point scale, as follows:

0 – Not compliant

1 – Partially compliant

2 – Fully compliant

The new twist will be the removal of the “Supplemental Findings” category. Beginning in 2009, The Joint Commission will cite any EP that is not in full compliance as a requirement for improvement (RFI), and the hospital must resolve these deficiencies by submitting an evidence of standards compliance (ESC). The Joint Commission has also changed the amount of time allowed to complete corrective actions related to RFIs to a two-tiered rating system. The time you will have will be based upon the “criticality” of the RFI, which will be determined by The Joint Commission. Criticality will be based upon the number of RFIs and how immediate the risk is (i.e., a direct or indirect effect on patients). In the August 2008 issue of The Joint Commission Perspectives newsletter, the accredits defines criticality as “the immediacy of risk to patient safety or quality of care as a result of noncompliance with a Joint Commission requirement (example, EP, National Patient Safety Goal, Universal Protocol).”
The categories of criticality are as follows.

**A:** This includes EPs that:

- Have structural requirements that either do not exist or do exist and are scored as either a 0 or a 2. These include policies or plans.
- Address issues that must be in full compliance, such as a National Patient Safety Goal, even though it may focus on outcome or performance.
- Relate to a standard that requires full compliance at all times, such as the Medicare Conditions of Participation.

**B:** No longer used

**C:** Scoring for these EPs is based on the number of times an organization fails to meet a particular EP, such as a score of:

- 2 if there is one or no noncompliant occurrences
- 1 when there are two noncompliant occurrences
- 0 when there are three or more noncompliant occurrences

Upon completion of a survey, the organization will receive a report broken down by chapters from The Joint Commission. The report will include the standards, EPs, and other requirements that surveyors found to be not fully compliant, along with the observations from the survey team.

The survey report will no longer contain a potential accreditation decision. This information will now be posted in the organization's secure area on The Joint Commission's website and will be the official report containing the potential accreditation decision. The report should be posted within two days of survey completion unless The Joint Commission determines that the survey requires additional review. The intent is to post the final accreditation report after The Joint Commission has received and approved the organization's ESC. However, it is possible for an organization to receive a preliminary denial of accreditation or conditional accreditation prior to the receipt of the ESC by The Joint Commission.

Those standards that will require documentation as proof of compliance will have a “D” enclosed in a circle to the left of the EP, and those that require a measure of success (MOS) will have an “M.” Throughout this book, each EP will have a string of letters and numbers that correspond to the prepublication scoring categories. Please refer to the following key, and be sure to review the final version when it becomes available.
EM.01.01.01: Advance Planning

What the standard says

The facility develops a written EOP after it has engaged in planning activities.

Why the standard is important

As communitywide disasters continue to show, an emergency can place a sudden and significant demand upon the resources of the community as well as upon the healthcare providers. Organizations are therefore expected to be able to identify these risks and develop an effective response in conjunction and coordination with others handling similar responsibilities within the community.

Elements of performance

1. The organization’s EOP is developed with the involvement of leadership and medical staff (administrator, nursing director, medical director, and others, as necessary), at a minimum.

The Joint Commission does not want the disaster committee to operate in a vacuum. Because both the organization’s leadership and medical staff play a vital role in the success of any plan activation, it is important that you involve both when developing the plans. It is also important that both leadership and medical staff understand and support the disaster plans, because a disagreement with leadership during a disaster will only compound the problem, slow
the response, and cause a loss of credibility among responders. There is nothing more embarrassing or confusing than having multiple management-level personnel giving conflicting orders during a disaster. Ensure that everyone is on the same page before you have to open the book for an actual emergency. It is also important to include community partners in your planning. Emergency responders are used to dealing with nonmedical facilities in which everyone evacuates and the fire department is the sole commander. Hospitals, on the other hand, may not totally evacuate and will establish their own incident command structure, which must integrate with the fire department’s IC to prevent confusion and conflicting orders and requests. Practice with your fire department; the hospital IC concept and purpose is foreign to most fire departments, so an understanding of how to integrate the response is needed before the incident and not during.

2. The organization completes a hazard vulnerability analysis (HVA) to identify potential emergencies that could affect its ability to provide services (also see EM.03.01.01, EP 1).

The first requirement calls for hospitals to complete the HVA. You’ll find a sample HVA matrix form in Figure 2.2 at the end of this chapter. You will also find a sample HVA form with the downloads that accompany this book. Further HVA tools are available at the Hospital Safety Center at www.hospitalsafetycenter.com. For more examples of an HVA, the American Society of Healthcare Engineers (ASHE) also has a sample form on its website at www.ashe.org. The form is free to ASHE members and can be purchased by nonmembers. The Kaiser-Permanente health system also has created a sample HVA tool, which is widely used by hospitals. You can find a copy at www.calhospitalprepare.org/hazard-vulnerability-analysis.

Gather a team of representatives from security, engineering, safety, nursing (inpatient/outpatient/emergency), finance, biomedical, IT, administration, and any other department you believe can contribute important information. Do not be afraid to invite outside responders, such as the fire department, EMS, law enforcement, and utilities to attend as well. Expect the analysis to take at least several hours to conduct a meaningful assessment. Consider scheduling separate assessments for each of the three sections—technological, manmade, and natural hazards. You can then prioritize plans and funding for mitigation according to the ratings of the committee after the assessment.

Take into account how climate change is affecting your area. FEMA is now requiring states to take climate change into account in their future responses. Consult with your local National Weather Service office for climatic data and for consultations on what is changing in your region. As we are seeing, areas are receiving more snow (over 100 inches for New England in 2014–2015), drought (the western states), flooding, more severe tornadoes, and stronger and more frequent hurricanes. No section of the world is exempt from these changes, so there is a need to include them in your planning.
DID YOU KNOW?
The team should regularly update the HVA form. Threats, as well as internal and external conditions, can change, so it is important to maintain your facility’s capability via this form. Note that The Joint Commission originally mandated that hospitals complete the initial assessment in 2001. Although there is no requirement for subsequent assessments, it is a good idea to perform a regular evaluation to complement the EM program.

Other resources to help identify potential disasters your hospital may face may be your state department of health, EM agency, or other agencies involved in emergency response. In 2005, Indiana’s state department of health issued a list of what it considered to be the most likely disasters for which hospitals in the state must prepare. This was followed in 2013 when Indiana mandated the HVA format to allow for uniform responses, and this also permits the data to be compiled and integrated into regional and statewide informational sharing databases.

Check whether your state has such a list. Indiana’s list included manmade, biological, and chemical disasters. Hospitals can add to the list or eliminate events unlikely to affect their particular services.

3. The hospital identifies priorities among the potential emergencies in the HVA together with its partners in the community.

The Joint Commission wants to see how the hospital response plans fit into the overall plan established by the local emergency response planning agency. The HVA process offers an excellent opportunity for the local authorities to involve you and your organization in their plans. In most cases, there is an annex to the primary plan that addresses the response by hospitals and other healthcare facilities to a community emergency (referred to as an emergency service function, or ESF). Hospitals should obtain a copy of the plan and review it for effectiveness and applicability. You’ll need to make sure the information and capabilities listed in the plan are accurate and up to date. You do not want to learn during an actual disaster that expectations and reality differ. Consider coordinating mitigation activities with the local agency. FEMA may have funds available for such projects through grants—for example, one hospital in a seismic area received money to install a seismic-resistant well. It’s also important to work with the local agency in the event of a declared disaster. Your facility can be eligible for reimbursement of up to 75% of any disaster-related expenses, excluding patient care and business interruption costs. To receive the funds, the federal government must make a disaster declaration, and you must show documentation of the expenditures. This is applicable only for those communities that have an EM agency.
4. During the development of the EOP, the organization shares its needs and vulnerabilities with emergency responders in the community and establishes the community’s ability to support those needs (also see EM.03.01.01, EP 1).

The Joint Commission is looking to ensure that as part of your planning, you share not only your ability to support the community during a disaster but also your expectations of support from your community. Too often, community planning is a one-way street, asking what the facility can do for the community and not what the facility will need from the community. In this age of hospital overcrowding and limited bed space, support from outside services will become increasingly critical to the continued operation of healthcare during a communitywide disaster. Include plans for alternative care sites and support that will be needed for successful implementation of these locations. Also have plans on how to communicate needs, implementation of diversion, and shortages to community responders. Include these aspects in future drills; also be sure to meet regularly with your local counterparts so you are already on a first-name basis before the emergency. Having preestablished communications can save headaches and possibly lives.

5. The hospital bases mitigation activities upon hazards identified by the HVA. These are activities that will lessen or eliminate the potential for loss or damage from the identified hazard.

This is the first step in a true emergency response plan. For each item identified as a potential threat to your facility on the HVA, you need to list any steps taken to reduce or eliminate the potential impact of that particular threat. See Figure 2.3 for an HVA-identified hazard form. For example, if you listed flooding as a potential problem, mitigation activities could include relocation of emergency generators to higher levels of the building, installation of floodgates and floodwalls, or relocation of the facility to higher ground less prone to flooding. Other forms of mitigation are well-developed response plans. Because well-developed and tested plans allow the organization to respond in an efficient and effective manner, this may lessen the effects of the disaster. Do not forget to partner with local and state agencies to obtain grants for mitigation projects. For example, two hospitals located in a seismic area obtained grants for the installation of automatic gas shutoff valves. The valves will shut off the gas supply to the building in the event of an earthquake, thus eliminating the risk of fire from broken or damaged gas lines.

6. The hospital bases preparedness activities upon the findings of the HVA (also see IM.01.01.03, EPs 1–4).

This is the step in which a hospital plans its response to a potential disaster. For example, in the event of flooding, you would practice using floodgates in the levees, putting down sandbags for added protection, and evacuating all or part of the
facility. This is also the basis for staff training and sharing with the community, which may be able to aid in the response. In the case of floods, water will rise faster than you believe possible. One hospital had a plan to use sandbags along the top of their receiving dock and to move any vehicles from the dock area. The reality was the water rose so quickly there was not even time to move vehicles much less place sandbags before the dock area was flooded and water was entering the hospital. Be realistic in your plans, because Mother Nature will not wait for you to implement your response.

7. The hospital establishes in its EOP an incident command structure that can be integrated into and is consistent with that of the community.

The Joint Commission is again ensuring that your command structure is not isolated from that of the community. Your EOP needs to define how your command structure is consistent with that of the local community and how, in the event of a communitywide emergency, it can integrate with the community’s command structure. This will allow for smooth and consistent communication between all parties who may be involved in the response to the emergency. Have staff members trained in basic ICS and in ICS 300 and ICS 400 so they can be integrated into the community’s Unified Command structure. The Hospital Incident Command System (HICS) is great for internal implementation; however, there is also the need for representatives to have the ability to “speak the language” of outside agencies when they respond.

8. The organization must keep on site a documented inventory of resources and assets it would need during an emergency, including at least the following: personal protective equipment, water, fuel, and medical, surgical, and pharmaceutical resources (also see EM.02.02.03, EP 6).

New in the 2008 standards was the requirement to document what you would have on hand during an emergency and to conduct an annual evaluation of the inventory. This can be interpreted to now require that the hospital constantly monitor its inventory to ensure it maintains levels of supplies. This is where an excellent relationship with your materials management department will pay big dividends. As for what to document, The Joint Commission is quite vague. Some of the items are self-explanatory, such as what the average fuel level is in the storage tanks or how much bottled water is maintained on site. Other areas, such as medical supplies, are open to interpretation. Does The Joint Commission want to know the par level for items such as small bandages, or only whether you possess an overall ability to care for a certain number of critical or noncritical patients? Be sure to account for any contracts you have with outside vendors. Test the vendors: Call them at 3 a.m. on a Sunday and request supplies you know you will need, such as crutches, splints, etc., and see how they respond. A hospital in our area conducted such a drill and found holes in the response as well as in the contract that needed to be addressed.
Now that CMS and The Joint Commission are placing greater emphasis on emergency management, this book is a must have! The pressure is on safety officers and emergency management coordinators to protect their facility, staff, and patients from emergencies, regardless of size or type. The *Emergency Management Compliance Manual, Second Edition*, provides a detailed look at CMS and The Joint Commission’s Emergency Management expectations and standards. With this essential emergency preparedness resource, you’ll be able to cut through the clutter to better understand best practices and meet requirements.

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