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Emergency Management Standards Revisions 2022

By Steven Hirsch, MPA, FACHE

The Joint Commission has announced revision of its Emergency Management (EM) standards, with the updated standards and elements of performance becoming effective July 1, 2022. The revisions mostly are clarifications of existing standards so that they are more consistent with the CMS Emergency Management Condition of Participation (CoP) 482.15. In this article, a review of the new Chapter is provided.

Key Take-Aways:

- Leaders of the organization appoint an individual to lead the Emergency Management program, with defined responsibilities.
- Predetermined primary and alternate locations of the Incident Command Center need to be established as well a how the organization will maintain and support those locations (Telephonic and Computer Support).
- A defined testing of the functionality of the alternate/back-up communications system needs to be provided.
- Development of a staffing plan to manage staff and volunteers during an emergency patient surge needs to be established.
- Organization is expected to have **written** procedures and arrangements with other hospitals and care providers for how it will share patient care information and medical documentation, and how it will transfer patients to other healthcare facilities and maintain continuity of care.
- Safety and security provisions include a system to track the location of on-duty staff and patients when sheltering in place, relocated, or evacuated. If evacuation or relocation occurs there must be **documentation of the specific name and location** of the receiving facility or evacuation location.
- A written action plan needs to be developed on sustaining the needs of the hospital for up to 96 hours or actions to be taken if the organization is not able to continue to operate.
- The organization is expected to define, **in writing,** the utility systems that are considered essential or critical to the provision of patient care, treatment or services and how they will be maintained for the duration of the emergency, including alternate sources.
- Continuity of Operations Plan (COOP): This now has its own standard in EM.13.01.01. The COOP needs to be developed with key leadership, including finance, and other departmental leadership as appropriate. The COOP should include identification and prioritization of services and functions considered by the organization to be critical to maintaining operations.
- EM.14.01.01 introduces a new requirement for development of a formal Disaster Recovery Plan. The Disaster Recovery Plan **must be in writing**, and should address organization-wide damage assessment, restoration of critical systems and essential services, and return to full operations.

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- A new emphasis is placed on staff training in Emergency Management. The process of education must begin with the general orientation to the workplace, and departmental specific issues must be addressed in the initial department orientation and continue throughout the duration of employment.
- There is an expectation that there will be a written test of comprehension of each employee's emergency management responsibilities that is documented in the Human Resources file and updated as needed.

In support of the Emergency Management standards, the Environment of Care chapter makes reference at EC.02.05.07 to a new EP 11 related to meeting expectations for emergency power as referenced in NFPA 99, Health Care Facilities Code (2012) and NFPA 110, the Standard for Emergency Power and Standby Power Systems (2010). While this is not a significant change in and of itself the NFPA requirements should be reviewed to ensure compliance. CMS makes similar reference to these NFPA Codes in 482.15, the Emergency Management CoP.

The Emergency Management (EM) standards have been re-numbered. EM.09.01.01 addresses the expectation for a comprehensive Emergency Management program that utilizes an "all-hazards" approach. There is emphasis placed on Leadership structure and program accountability, as well as the key elements of the program previously identified in multiple standards. These include Leadership structure and accountability, hazard vulnerability analysis, mitigation and preparedness activities, emergency operations plan and policies and procedures, education and testing, Continuity of Operations Plan, disaster recovery, and program evaluation. There is a separate EP for hospitals that sponsor transplant programs.

EM.10.01.01 addresses the hospital's Leadership accountability and support for Emergency Management program activities. There is a clear expectation that the Leaders of the organization appoint an individual to lead the Emergency Management program, with defined responsibilities. There is also a requirement defined for establishment of a multidisciplinary committee to oversee the Emergency Management program. The Committee should include representatives from senior leadership, nursing, the medical staff, pharmacy, infection prevention and control, facilities, security, and information technology, at a minimum. It is expected that the Committee will provide input and analysis to the Hazard Vulnerability Analysis, Emergency Operations Plan and related policies and procedures, Continuity of Operations Plan, training and education, and planning and coordination of emergency management exercises and evaluating after action reports.

The development of the Hazard Vulnerability Analysis (HVA) is addressed in EM.11.01.01. There is emphasis here on utilizing an "all hazard approach". Organizations need to create a separate hazard vulnerability analysis for all locations if there are significant differences between the main site and any satellite locations, or if the facilities are in different geographic locations, have different hazards or threats, or the services provided and/or the patient population served are unique to the site. The organization is expected to prioritize the findings in the HVA to determine which hazards have the greatest likelihood of occurring, and how those hazards will impact the ability of the organization to continue to provide services to its patients. Based on those priorities, the organization is to define and implement mitigation and preparedness activities to facilitate ongoing operations during an emergency and reduce the potential for disruption.

Standard EM.12.01.01 speaks to the expectation for development of an Emergency Operations Plan. The Plan and related policies and procedures are to address mobilizing the incident command structure, activating the communications plan, maintaining, expanding, curtailing or closing operations, protecting critical systems and infrastructure, conserving and/or supplementing resources, surge planning (to include communicable diseases such as influenza and pandemic plans), identifying alternate treatment areas and locations, including an alternate location for the command center, sheltering in place, evacuation (full and partial) safety and security, and securing information and records. There is a new expectation here, that the primary and alternate locations of the incident command center be pre-determined, along with how the organization will maintain and support those locations, including supplies, resources, communications, and information technology.

There continues to be an expectation to provide for vulnerable patient populations. Provisions for sheltering in place should include as necessary, department specific plans, which may vary depending on the type of emergency. Evacuation plans must include consideration of the needs of the patients being served, as well as define staff responsibilities, and provide for transportation.

The standard also requires the organization to provide for essential services, whether sheltering in place or evacuating. This includes provision of food and other nutritional supplies, medications, medical/surgical supplies, medical gasses, related supplies, and potable or bottled water.

The Incident Command structure is expected to describe the overall incident command operations, including specific roles and responsibilities. The Emergency Operations Plan should identify the individual(s) who have authority to activate the Emergency Operations Plan and/or the Incident Command.

The structure should be scalable and flexible to facilitate response to varying types of emergency scenarios. Additionally, the Emergency Operations Plan should provide for cooperation and collaboration with other healthcare facilities and organizations, as well as local, tribal, regional, state, and federal emergency preparedness agencies, to provide an integrated response. Provision should be included for requesting and implementing the CMS 1135 waivers in the event of declaration of a National Emergency.

The requirement for a Communications Plan is described in EM.12.02.01. The Communications Plan would include a list of contacts for individuals and organizations that are to be notified when the hospital's emergency response plans are activated. The Communications Plan should describe how the organization will establish and maintain communications throughout the emergency response with staff, licensed independent practitioners, volunteers, patients and family members, community emergency response agencies, emergency management authorities, and others, as appropriate. There should be a process for sharing or releasing location information and medical documentation for patients under the organization's care to the patient's family, authorized representative, or others involved in the patients' care, disaster relief organizations and authorities, and other care providers, when relocation or evacuation occurs.

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A provision within the Communications Plan for communicating and reporting organizational needs, available capacity, and ability to provide support to other organizations needs to be included. There should also be a defined process to initiate warnings and notification alerts in real time specific to emergency and disaster events when a localized incident occurs.

A process should be developed for primary and alternate means of communications to assure the effectiveness of primary and alternate/back-up communications methods, and to assure compatibility with community responding agencies. This comes with a new expectation for a defined testing of the functionality of the alternate/back-up communications systems.

In EM.12.02.03 there are specific expectations for development of a plan to manage staff and volunteers during an emergency or patient surge. This includes a process for contacting off duty staff, physicians and other licensed practitioners, obtaining staff, physicians and other licensed practitioners from other health care organizations, staffing agencies, health care coalitions, and the use of volunteer staffing. The process of disaster credentialing of volunteer licensed independent practitioners and other healthcare practitioners remains in place. That process needs to identify the individual(s) responsible for granting disaster privileges.

In addition, the staffing plan needs to include provision for providing employee assistance and support. This standard consolidates existing requirements into the staffing plan for meeting staff support needs (i.e.., housing, transportation), family support needs (child and elder care), and mental health and wellness needs.

Provisions for providing patient care and clinical support have been incorporated into EM.12.02.05. The organization is expected to have written procedures and arrangements with other hospitals and care providers for how it will share patient care information and medical documentation, and how it will transfer patients to other healthcare facilities and maintain continuity of care. There should be a plan as well for managing individuals who present at the facility who are not in need of medical care. A plan for the provision of mortuary services, coordinated with the local medical examiner's office also needs to be provided.

Safety and Security during activation of the emergency response needs to be addressed in accordance with EM.12.02.07. A description of the roles that community law enforcement agencies play in event of an emergency and how the organization coordinates with those agencies needs to be maintained as part of the Emergency Operations Plan. Safety and security provisions include a system to track the location of on-duty staff and patients when sheltering in place, relocated, or evacuated. If evacuation or relocation occurs there must be documentation of the specific name and location of the receiving facility or evacuation location.

EM.12.02.09 addresses management of resources and assets during activation of the emergency response. There is no real change to this standard, however, there is clarification of the expectation that the organization define in writing the actions the organization will take to sustain the needs of the hospital for up to 96 hours based on calculations of resource consumption. The organization should define what actions will be taken if operations cannot be sustained in part or in total, during an extended emergency response activation.

Utility management during the emergency is addressed in EM.12.02.11. The organization is expected to define **in writing** the utility systems that are considered essential or critical to the provision of patient care, treatment or services and how they will be maintained for the duration of the emergency, including use of alternate sources. The utilities addressed minimally should include water, emergency power, fuel storage, and emergency generators. Provision of power to provide appropriate temperature and humidity, emergency lighting, fire detection, alarm and suppression systems, sewage and waste disposal should be included.

A significant area of non-compliance in past surveys relates to the development of a Continuity of Operations Plan (COOP). This now has its own standard in EM.13.01.01. The COOP needs to be developed with key leadership, including finance, and other departmental leadership as appropriate. The COOP should include identification and prioritization of services and functions considered by the organization to be critical to maintaining operations. The COOP should identify in writing how and where the organization will continue to provide essential business functions when normal operations have been displaced by the emergency. A written leadership succession plan is to be provided identifying who is to assume key leadership responsibilities and management roles when the incumbent is unable to fulfill their assigned role or function. This should in addition, include written delegation of authority that provides the individuals assuming interim responsibility legal authorization to act on behalf of the hospital.

EM.14.01.01 introduces a new requirement for development of a formal **Disaster Recovery Plan. The Disaster Recovery Plan must be in writing,** and should address organization-wide damage assessment, restoration of critical systems and essential services, and return to full operations. Provision in the Disaster Recovery Plan should address family reunification and facilitate coordination with community resources to help with identification of adults and unaccompanied children.

A new emphasis is placed on staff training in emergency management. A **written** education and training program needs to be developed, focused on the most likely emergencies to which the organization may be called upon to respond, based on the hospital's Hazard Vulnerability Analysis. Education and training are expected to be provided as part of initial orientation to all new employees, contract staff, volunteers, members of the medical staff and other licensed practitioners, consistent with their roles and responsibilities. The initial education and training are to include activation and deactivation of the Emergency Operations Plan, Communications Plan, emergency response policies and procedures, evacuation, shelter in place, lockdown, and surge procedures, and where and how to obtain resources and supplies for emergencies. Ongoing education is to be provided at least every two years, unless state regulation requires more frequent instruction, as well as whenever roles and responsibilities change, or significant updates or changes are made to the Emergency Operations Plan or related policies or procedures. In the Note following EP3, education must be provided in a manner that the participants can ask questions of the instructor. A new expectation is that staff trained in emergency management are evaluated for their knowledge in "drills and exercises as well as **post-training tests**…".

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An additional new requirement specifically mandates that incident command staff participate in education and training specific to their roles and responsibilities (i.e., NIMS training). There is a specific expectation that all emergency management related training will be documented.

Emergency management exercises continue to be required twice annually, as reflected in EM.16.01.01. One exercise must be an operations-based full-scale community-based drill, or if this is not possible, a functional facility-based exercise. The second exercise must be either an operations-based drill or a discussion-based exercise, which can be a full-scale, community-based exercise, functional facility-based exercise, a mock disaster drill, or a table-top drill, seminar, or workshop. Verify the local and state requirements related to conduct of emergency management exercises as some states require the conduct of 2 mass casualty disaster drills annually. Internal disaster drills are also required in some states on each shift quarterly.

EM.15.01.01 requires that free-standing outpatient care buildings in which patent care and treatment are provided conduct at least one emergency management operations-based or discussion-based exercise annually. For services licensed as part of a hospital, your staff may require these locations to participate with the hospital twice annually.

Joint Commission standard EM 17.01.01 requires an annual evaluation of the organization's Emergency Operations Plan as well as the Continuity of Operations Plan performed by the multidisciplinary committee charged with responsibility for oversight of the Emergency Management program. This includes review of after-action reports for emergency management exercises and actual activations of the Emergency Operations Plan. Opportunities for improvement identified in the after-action reports and recommended actions are to be forwarded to the hospital's senior leadership for review and prioritization. It is expected that modifications will be made to the Hazard Vulnerability Analysis, Emergency Operations Plan and related policies and procedures, Communications Plan, Continuity of Operations Plan, and the education and training and testing program at least every two years. Be sure to verify your state requirements, as some states require annual evaluation.

While there is significant revision to the Emergency Management chapter that becomes effective July 1, 2022, most of the changes consist of reorganization and consolidation of the standards and elements of performance to better align with CMS Condition of Participation 482.15. Note that while our focus is on hospital compliance, similar expectations exist for Ambulatory Care, Critical Access, and Behavioral Health Care facilities. As noted above, there are several new expectations that your organization will need to build into its Emergency Management program and implement **prior to July 1, 2022**.

Please contact Steven Hirsch at (800) 624-3750 or stevenhirsch@shassociates.com if you have any questions about the revisions to the Emergency Management Standards or to inquire about getting assistance with updating your Emergency Management program.

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Don't Forget to Include Dialysis in Your Nursing Care Plan

By Joann Saporito, RN, MBA

Between 2008 and 2018 the incidence of people who are being dialyzed has increased 71.5% (www.nccd.cdc.gov). Some of these are being treated at home or in the outpatient setting, while others are being treated in the hospital. With this rise in patients receiving dialysis your facility may be planning to start, or already have, a dialysis program. Whether the patient is in acute renal failure or the objective is just to maintain their treatment regimen the ultimate goal is to provide needed, quality care in a safe environment while keeping them in your facility and your community.

So let's imagine Bob Smith, a patient who regularly receives hemodialysis at a local outpatient dialysis center, falls down and breaks his hip. He is admitted to the hospital following hip replacement surgery due to confusion that appears to be a result of the anesthesia. As the night progresses nursing staff notice his urine output is quite poor and his morning laboratory results indicate a rising potassium level. Because it is clear Mr. Smith will have to remain in your hospital for at least a few days, the surgeon consults with nephrology who orders Mr. Smith's hemodialysis treatments to be resumed and continued through discharge. So the nursing staff initiate the orders and begin his dialysis treatments, which ultimately aid in his recovery. But have the nurses done all they are required to do?

In this situation, as in many others, it would be required that the nursing staff update Mr. Smith's care plan. A nursing care plan "contains all of the relevant information about a patient's diagnoses, the goals of treatment, the specific nursing orders (including what observations are needed and what actions must be performed), and a plan for evaluation" (What are Nursing Care Plans? (nurse.org). And because it is so fundamental in nursing care, it comes as no surprise that staff will often create nursing care plans almost immediately upon admission for their patients. What has made this even easier is the adoption of standardized nursing care plans whereby nurses can simply select and assign a care plan based on the admitting diagnosis and their nursing assessments. But over the course of a patient's stay and as changes occur, the nursing care plan is to be regularly updated with documentation of progress towards established goals as well as adding any new nursing diagnoses. If potential problems related to hemodialysis had not been added to Mr. Smith's care plan on admission, they surely should have been once dialysis was started.

The expectations, however, go beyond just simply adding dialysis to the care plan. It is important for nursing staff to go beyond adding a cut-and-paste hemodialysis care plan; they must take it a step further and tailor the plan so that it is customized and adjusted to be particular to the patient to whom it is being assigned. The requisite is that the care plan is *individualized* as much is applicable to the particular patient. In the case of Mr. Smith, interventions and goals might include among others: monitoring the site, whether it is a shunt or central line, for dislodgement; potential for infection; potential for volume depletion or overload; weighing the patient pre-dialysis and post-dialysis; potential for electrolyte imbalance; potential for injury; poor renal perfusion; deficient knowledge; and psycho/social issues. Remember, though, the standardized care plan is really the framework from which the staff should build the individualized plan. Review the standardized plan and remove what does not apply and adjust what should remain.

It is a requirement by the accrediting body (such as The Joint Commission or "TJC", Healthcare Facilities Accreditation Program or "HFAP", and most recently the Center for Improvement in Healthcare Quality or "CIHQ") that the patient/resident/client have a nursing care plan, and that it is individualized to the patient and updated regularly. For nursing homes and both acute care and critical access hospitals the Standards can be found in the Joint Commission manuals in the Provision of Care, Treatment and Services chapter (PC.01.03.01 EPs 1, 5, 22 and 23 and PC.02.01.01 EP1). For acute care and critical access facilities accredited by HFAP the Standards can be found in the Nursing Services chapter (16.00.08 and 06.08.03 respectively). For hospitals accredited by CIHQ the Standards can be found in the Standard NS-3 "Delivery of Nursing Care."

For both chronic dialysis patients and those with acute kidney injury (AKI) or acute renal failure (ARF) staff can easily get caught up in beginning therapy, especially if the patient is doing poorly. Perhaps they might even feel they are too busy for the care plan. But remember that the nursing care plan is not only the roadmap for treating your patient, but it is also an important interdisciplinary tool amongst staff. It is one way that progress towards goals will be communicated from shift to shift until the patient is discharged. In the case of Mr. Smith, any surveyor will expect and verify that you have included dialysis in your care plan.

References:

https://nccd.cdc.gov/ckd/, obtained 2/9/2022

What are Nursing Care Plans? (nurse.org), obtained 2/8/2022

For further information on how Steven Hirsch & Associates can assist you with your Nursing Care Plan, call (800) 624-3750.