Patient Safety Tip of the Week

November 1, 2016

CMS Emergency Preparedness Rule

Most of us who have long worked in hospitals are aware of many contingencies in place for certain emergencies. For instance, we know that there are backup electrical generators for power outages and that there are periodic drills to test that the backup generator is working correctly. But not all healthcare venues have such systems. Several years ago we participated in a discussion about what happens in dialysis facilities when there is a power outage. It turns out that in many states there is no requirement that dialysis facilities even have backup power sources. So it becomes even more important that all such facilities have comprehensive plans for what to do in such emergencies. Moreover, hospitals are also vulnerable to emergencies other than just power outages, as experiences with some of the recent hurricanes and other natural disasters have demonstrated.

CMS (Centers for Medicare & Medicaid Services) has now put forward an Emergency Preparedness Regulation (CMS 2016a). This regulation goes into effect on November 16, 2016 and all affected facilities and providers must comply and implement all requirements one year after the effective date, on November 16, 2017. The final rule "Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers" was posted in the Federal Register on September 16, 2016 (CMS 2016b). But the latter is almost 200 pages and difficult to read so we think you'll get the most use from the CMS 2016a website and its links.

The new rule applies to all 17 CMS provider and supplier types, though the exact requirements vary by provider/supplier type as outlined in tabular form on the CMS website. And ASPR TRACIE (Office of the Assistant Secretary for Preparedness & Response. Technical Resources Assistance Center Information Exchange) provides resources and samples to help facilities comply with the new rule (ASPR TRACIE 2016). There are 4 basic elements for each provider type to consider:

- Emergency Plan
- Policies and Procedures
- Communication Plan
- Training and Testing

Emergency plans must take into account not only the facility level but also the community and regional or even statewide level. They need to include a risk assessment and consideration of hazards likely to occur in the geographic area, care-related

emergencies, equipment and power failures, interruption in communications (including cyberattacks), and full or partial loss of the facility or supplies. The emergency plan is to be reviewed and updated at least annually.

While there should be an **all-hazard plan** (fires, bioterrorism, tornadoes, floods, pandemics, etc.), the facility/organization needs to also consider contingencies for emergencies more likely in their geographic area (eg. are they vulnerable to earthquakes? hurricanes? etc.) Consider also that **indirect hazards** affecting the community but not the facility directly may still interrupt services, supplies or staffing. The **specific vulnerabilities** of the facility for each identified hazard should be analyzed to determine the actions to be taken. **Key staff** responsible for executing the plan must be identified, as well as overall **staffing requirements** and defined **staff responsibilities**. That would include designating critical staff, providing for other staff and volunteer coverage. You also need to consider staff needs, including transportation and sheltering critical staff members' family. The plan should include identification and maintenance of sufficient supplies and equipment to sustain operations and deliver care and services for 3-10 days, based on each facility's assessment of their hazard vulnerabilities. Consider how you will communicate with staff, families, patients, and the outside world not only during, but also before and after, the emergency. And you need to have arrangements with your suppliers and vendors to ensure you can increase supplies or provisions in the event you have a surge in capacity as the result of an emergency event.

Your emergency plan, policies and procedures should attempt to include criteria for declaration of the various types of emergency and also for declaration that the emergency condition is over.

The emergency plan should also contain a **"shelter in place" plan** (for example, for a storm, active shooter incidents, etc.) and an **evacuation plan**. We recommend that you have two locations designated as "**command centers**" or "**control centers**". Most hospitals use a designated conference room or board room for their internal command center. However, for emergencies necessitating evacuation of the facility you should have an external command center (eg. nearby building) designated. Both sites should have methods of communicating by multiple means (land phone lines, cell phones, walkie-talkies, keeping in mind they must be kept fully charged at all times), backup power supplies, lists of phone numbers for all key internal and external personnel/agencies, and maps of the facilities and grounds.

The ASPR TRACIE (Office of the Assistant Secretary for Preparedness & Response. Technical Resources Assistance Center Information Exchange) website has sample emergency plans and templates among its many valuable resources (ASPR TRACIE 2016). The ASPR TRACIE resources are terrific and cover the needs for a variety of facility types. For example, it provides links to over 50 articles, plan templates and other resources for dialysis centers with multiple lessons learned from mass power outages, hurricanes, earthquakes, tsunamis, floods, and water contamination alerts.

You'll find particularly useful the Emergency Preparedness Checklist downloadable from the CMS Emergency Preparedness Rule website. This allows you to track where you stand on all the tasks necessary to meet the requirements of the new rule.

CMS is looking for the following elements in an **Evacuation Plan**:

- Identification of person responsible for implementing the facility evacuation plan (even if no outside evacuation order is given)
- Multiple pre-determined evacuation locations (contract or agreement) with a "like" facility have been established, with suitable space, utilities, security and sanitary facilities for individuals receiving care, staff and others using the location, with at least one facility being 50 miles away. A back-up may be necessary if the first one is unable to accept evacuees.
- Evacuation routes and alternative routes have been identified, and the proper authorities have been notified. Maps are available and specified travel time has been established.
- Adequate food supply and logistical support for transporting food is described.
- The amounts of water to be transported and logistical support is described (1 gal/person).
- The logistics to transport medications is described, including ensuring their protection under the control of a registered nurse.
- Procedures for protecting and transporting resident/patient medical records.
- The list of items to accompany residents/patients is described.
- Identify how persons receiving care, their families, staff and others will be notified of the evacuation and communication methods that will be used during and after the evacuation
- Identify staff responsibilities and how individuals will be cared for during evacuation and the back-up plan if there isn't sufficient staff.
- Procedures are described to ensure residents/patients dependent on wheelchairs and/or other assistive devices are transported so their equipment will be protected and their personal needs met during transit (e.g., incontinent supplies for long periods, transfer boards and other assistive devices).
- A description of how other critical supplies and equipment will be transported is included.
- Determine a method to account for all individuals during and after the evacuation
- Procedures are described to ensure staff accompany evacuating residents.
- Procedures are described if a patient/resident becomes ill or dies in route.
- Mental health and grief counselors are available at reception points to talk with and counsel evacuees.
- Procedures are described if a patient/resident turns up missing during an evacuation:
    - Notify the patient/resident's family
    - Notify local law enforcement
    - Notify Nursing Home Administration and staff

- Ensure that patient/resident identification wristband (or equivalent identification) must be intact on all residents.
- Describe the process to be utilized to track the arrival of each resident at the destination.
- It is described whether staff's family can shelter at the facility and evacuate.

When you must perform a facility evacuation for something like a fire, you need to include in your plan the sites where you will congregate and do a patient and staff count. In the event of an evacuation, you also need to determine how residents will be identified and ensure the appropriate identifying information will be transferred with each resident (eg. name, date of birth, social security number, photograph, etc). But you also should make sure that information regarding diagnosis, current medications, diet are provided as well as information about health insurance, family/caregiver contact, advance directives, etc. Your plan should include how this information will be secured and transported (e.g., laminated documents, water proof pouch around resident's neck, water proof wrist tag, etc.).

And part of your evacuation plan should be a **Facility Reentry Plan**. That should detail who will authorize reentry to the facility after an evacuation, the procedures for inspecting the facility, how it will be determined when it is safe to return to the facility after an evacuation, and how patients will travel back to the facility.

Facility transfer agreements are typically done among regional facilities. The CMS site has a link to a Facility Transfer Agreement Example. But your emergency plan should include not only what to do if there is an emergency in your facility or region but also contingencies for remote disasters. For example, hospitals as far away as western New York needed to have plans to handle excess capacity if patients in the New York City area or New Jersey were forced to evacuate during Hurricane Sandy. Border towns and cities may also need to include cooperation with facilities across the border in, for example, a neighboring Canadian province.

The CMS Emergency Preparedness Checklist also has a nice section on suggested principles of care for relocated patients/residents, including addressing their fears, anxieties, and psychological needs. It also reminds you to make sure that any vendors or volunteers who will help transport residents and those who receive them at shelters and other facilities are trained on the needs of the chronic, cognitively impaired and frail population and are knowledgeable on the methods to help minimize transfer trauma.

The **Communication Plan** must include a system to contact staff, including patients' physicians, other necessary persons, and also comply with Federal and State Laws. It should be well-coordinated within the facility, across health care providers, and with state and local public health departments and emergency management agencies. Your communication plan should also include phone numbers for families to call.

Communication with community facilities and resources is not a one-time event. Hospitals typically hold drills with other community resources at least annually in the

form of a "**disaster drill**". Those are usually coordinated by some form of regional planning and emergency response agency. But we also encourage hospitals and other healthcare facilities to meet with and drill with their local fire department (see our October 21, 2014 Patient Safety Tip of the Week "The Fire Department and Your Hospital") and police department (for active shooter drills, absconds, kidnappings, etc.). There are certain aspects of facilities that those first responders must be familiar with, such as the dangers inherent in MRI suites.

While it may not be formally required by CMS, one of the emergencies you must be prepared for is that of a missing patient. We refer you to our April 7, 2015 Patient Safety Tip of the Week "Missing Patients and Death" for details on what you need to do in the case of a missing patient, including how to announce the problem, set up a command center, perform grid search, alert appropriate authorities (and family), and what to do when you find the patient.

The other emergency you need a plan for is infant abduction. We refer you to our Patient Safety Tips of the Week for December 20, 2011 "Infant Abduction" and September 4, 2012 "More Infant Abductions" for details.

Critical to emergency preparedness is **training** and **drills**. Everyone who works in your facility needs to be knowledgeable about your emergency preparedness plan(s). While most often staff are educated about the plan(s) during initial orientation, you must re-educate them at least annually and reinforce it with periodic drills. Unfortunately, the staff that tend to slip through the cracks are those temporary hires or per diem floating staff that are only at your facility for short periods. The same applies to housestaff that may rotate through your facility for only short periods.

The only way to be truly prepared for emergencies is to practice ahead of time. This is done through drills. Our readers have heard us harp on the need for drills for surgical fires, elopements, absconds, missing patients, infant abductions, fires and others. So here we just want to remind you of two things about drills. First is that we are often disappointed with the lack of detail and formal assessment about the drills. You should always have designated observers who are recording important aspects of the drill and then have a formal evaluation with appropriate constituents. Second is a reminder that certain emergencies might be piggybacked (eg. an elopement or an infant abduction occurring when a fire alarm is triggered). So we recommend that periodically you include both types of drill at the same time (eg. initiate an infant abduction drill during a fire drill).

CMS also stresses that your training also needs to address psychological and emotional aspects on caregivers, families, residents, and the community at large. And your plan needs to consider more mundane issues like mechanisms for patients to make claims for personal effects lost during the emergency.

Just as you need to conduct a review of all your emergency drills, you need to at least **annually review your Emergency Preparedness Plan**(s). Such review should include

lessons learned from your drill reviews, any actual emergencies, newly identified threats or hazards, and any new regulations or infrastructure changes.

Lastly, let's get real – **no one could possible remember all the things they need to do for each type of emergency**. Even as a hospital medical director, I had to keep with me checklists of what my responsibilities were for each type of emergency. There are a couple ways to do it. You can't fit much more than the "RACE" acronym for fires on the back of your facility ID badge. Lots of facilities have notebooks or packets of letter-sized paper with instructions. No one will carry those around! So there are other options. One is to have **thin packets of small laminated cards** with instructions for each emergency/drill so that each individual could have a tailored set that could fit on a **key ring** and fit in one's pocket. That also provides an easy way to help those temporary individuals who will only be at your facility for short periods. The other method, given that almost everyone nowadays has a **smartphone**, is to provide the role-specific instructions for them on their smartphone. Those could be easily found by a PDF reader on the smartphone. But we find that putting them in the notes section of most **smartphone contact lists** is the best way to make them more easily accessible. For example, under the "last name" or "company" field in your contact list enter "missing patient" and then under the "notes" field enter all the steps you must follow. You can even use the phone number fields for any key phone numbers someone might need to call (eg. one for your command center, another for the police department, etc.). You can even customize your headings for when you have different roles. For example, you could have them under multiple listings such as "Fire – charge nurse" or "Fire – staff nurse" or "Fire – nurse supervisor" for when you have roles that might change. Lastly, so you don't have to use the search function in your contact list, either put the entries in your "favorites" list of phone numbers or precede each with whatever letter/number/symbol that your particular smartphone sorts to the top of your contact list.

Hopefully, your facility is already in compliance with most of these requirements but the new CMS Emergency Preparedness Rule provides additional incentive to take a look at the gamut of your emergency preparedness activities and update them to ensure you meet all the CMS requirements.

References:

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