

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS

**2006 HOSPITAL ACCREDITATION STANDARDS FOR
Emergency Management Planning
Emergency Management Drills
Infection Control
Disaster Privileges**

(Please note that standards addressing emergency management drills and disaster privileges are undergoing additional research; revised standards for these areas are forthcoming)

Standard EC.4.10

The hospital addresses emergency management.

Rationale for EC.4.10

An emergency¹ in the hospital or its community could suddenly and significantly affect the need for the hospital's services or its ability to provide those services. Therefore, a hospital needs to have an emergency management plan that comprehensively describes its approach to emergencies in the hospital or in its community.

Elements of Performance for EC.4.10

1. The hospital conducts a hazard vulnerability analysis² to identify potential emergencies that could affect the need for its services or its ability to provide those services.
2. The hospital establishes the following with the community:
 - Priorities among the potential emergencies identified in the hazard vulnerability analysis
 - The hospital's role in relation to a communitywide emergency management program
 - An "all-hazards" command structure within the hospital that links with the community's command structure
3. The hospital develops and maintains a written emergency management plan describing the process for disaster readiness and emergency management, and implements it when

¹**Emergency** A natural or manmade event that significantly disrupts the environment of care (for example, damage to the hospital's building(s) and grounds due to severe winds, storms, or earthquakes) that significantly disrupts care, treatment and services (for example, loss of utilities such as power, water, or telephones due to floods, civil disturbances, accidents, or emergencies within the hospital or in its community); or that results in sudden, significantly changed, or increased demands for the hospital's services (for example, bioterrorist attack, building collapse, plane crash in the organization's community). Some emergencies are called "disasters" or "potential injury creating events" (PICES).

² **Hazard vulnerability analysis:** The identification of potential emergencies and the direct and indirect effects these emergencies may have on the hospital's operations and the demand for its services.

appropriate.

4. At a minimum, an emergency management plan is developed with the involvement of the hospital's leaders including those of the medical staff .
5. The plan identifies specific procedures that describe mitigation,³ preparedness,⁴ response, and recovery strategies, actions, and responsibilities for each priority emergency.
6. The plan provides processes for initiating the response and recovery phases of the plan, including a description of how, when, and by whom the phases are to be activated.
7. The plan provides processes for notifying staff when emergency response measures are initiated.
8. The plan provides processes for notifying external authorities of emergencies, including possible community emergencies identified by the hospital (for example, evidence of a possible bioterrorist attack).
9. The plan provides processes for identifying and assigning staff to cover all essential staff functions under emergency conditions.
10. The plan provides processes for managing the following under emergency conditions:
 - Activities related to care, treatment, and services (for example, scheduling, modifying, or discontinuing services; controlling information about patients; referrals; transporting patients)
 - Staff support activities (for example, housing, transportation, incident stress debriefing)
 - Staff family support activities
 - Logistics relating to critical supplies (for example, pharmaceuticals, supplies, food, linen, water)
 - Security (for example, access, crowd control, traffic control)
 - Communication with the news media
11. Not applicable
12. The plan provides processes for evacuating the entire building (both horizontally and, when applicable, vertically) when the environment cannot support adequate care, treatment, and services.
13. The plan provides processes for establishing an alternate care site(s) that has the

³ **Mitigation activities** Those activities a hospital undertakes in attempting to lessen the severity and impact of a potential emergency.

⁴ **Preparedness activities** Those activities a hospital undertakes to build capacity and identify resources that may be used if an emergency occurs.

capabilities to meet the needs of patients when the environment cannot support adequate care, treatment, and services including processes for the following:

- Transporting patients, staff, and equipment to the alternative care site(s)
- Transferring to and from the alternative care site(s), the necessities of patients (for example, medications, medical records)
- Tracking of patients
- Interfacility communication between the hospital and the alternative care site(s)

14. The plan provides processes for identifying care providers and other personnel during emergencies.

15. The plan provides processes for cooperative planning with health care organizations that together provide services to a contiguous geographic area (for example, among organizations serving a town or borough) to facilitate the timely sharing of information about the following:

- Essential elements of their command structures and control centers for emergency response
- Names and roles of individuals in their command structures and command center telephone numbers
- Resources and assets that could potentially be shared in an emergency response
- Names of patients and deceased individuals brought to their organizations to facilitate identifying and locating victims of the emergency

16. Not applicable

17. Not applicable

18. The plan identifies backup internal and external communication systems in the event of failure during emergencies.

19. The plan identifies alternate roles and responsibilities of staff during emergencies, including to whom they report in the hospital's command structure and, when activated, in the community's command structure.

20. The plan identifies an alternative means of meeting essential building utility needs when the hospital is designated by its emergency management plan to provide continuous service during an emergency (for example, electricity, water, ventilation, fuel sources, medical gas/vacuum systems).

21. The plan identifies means for radioactive, biological, and chemical isolation and decontamination.

Standard EC.4.20

The hospital conducts drills regularly to test emergency management.

Elements of Performance for EC.4.20

1. The hospital tests the response phase of its emergency management plan twice a year, either in response to an actual emergency or in planned drills.⁵

Note: *Staff in each freestanding building classified as a business occupancy (as defined by the LSC) that does not offer emergency services nor is community-designated as a disaster-receiving station need to participate in only one emergency management drill annually. Staff in areas of the building that the hospital occupies must participate in this drill.*

Note: *Tabletop exercises, though useful in planning or training, are **only** acceptable substitutes for communitywide practice drills.*

2. Drills are conducted at least four months apart and no more than eight months apart.

3. Hospitals that offer emergency services or are community-designated disaster receiving stations must conduct at least one drill a year that includes an influx of volunteers or simulated patients.

4. The hospital participates in at least one communitywide practice drill a year (where applicable) relevant to the priority emergencies identified in its hazard vulnerability analysis. The drill assesses the communication, coordination, and effectiveness of the hospital's and community's command structures.

Note: *"Communitywide" may range from a contiguous geographic area served by the same health care providers, to a large borough, town, city, or region.*

Note: *Tests of EPs 3 and 4 may be separate, simultaneous, or combined.*

5. Not applicable

6. All drills are critiqued to identify deficiencies and opportunities for improvement.

Standard EC.7.20

The hospital provides an emergency electrical power source.

Rationale for EC.7.20

The hospital properly installs an emergency power source that is adequately sized, designed, and fueled, as required by the *LSC* occupancy requirements and the services provided.

Elements of Performance for EC.7.20

1. The hospital provides a reliable emergency power system⁶, as required by the *LSC* occupancy requirements, that supplies electricity to the following areas when normal electricity is interrupted: Alarm systems

⁵ *Drills that involve packages of information that simulate patients, their families, and the public are acceptable.*

⁶ **Reliable emergency power system** For guidance in establishing a reliable emergency power system (that is, an Essential Electrical Distribution System), see NFPA 99-2002 edition (chapters 13 and 14).

2. The hospital provides a reliable emergency power system, as required by the *LSC* occupancy requirements, that supplies electricity to the following areas when normal electricity is interrupted: Exit route illumination
3. The hospital provides a reliable emergency power system, as required by the *LSC* occupancy requirements, that supplies electricity to the following areas when normal electricity is interrupted: Emergency communication systems
4. The hospital provides a reliable emergency power system, as required by the *LSC* occupancy requirements, that supplies electricity to the following areas when normal electricity is interrupted: Illumination of exit signs
5. The hospital provides a reliable emergency power system, as required by the services provided and patients served, that supplies electricity to the following areas when normal electricity is interrupted: Blood, bone, and tissue storage units
6. Not applicable
7. The hospital provides a reliable emergency power system, as required by the services provided and patients served, that supplies electricity to the following areas when normal electricity is interrupted: Emergency/urgent care areas
8. The hospital provides a reliable emergency power system, as required by the services provided and patients served, that supplies electricity to the following areas when normal electricity is interrupted: Elevators (at least one for nonambulatory patients)
9. The hospital provides a reliable emergency power system, as required by the services provided and patients served, that supplies electricity to the following areas when normal electricity is interrupted: Medical air compressors
10. The hospital provides a reliable emergency power system, as required by the services provided and patients served, that supplies electricity to the following areas when normal electricity is interrupted: Medical and surgical vacuum systems
11. The hospital provides a reliable emergency power system, as required by the services provided and patients served, that supplies electricity to the following areas when normal electricity is interrupted: Areas where electrically powered life-support equipment is used
12. Not applicable
13. Not applicable
14. The hospital provides a reliable emergency power system, as required by the services provided and patients served, that supplies electricity to the following areas when normal electricity is interrupted: Operating rooms

15. The hospital provides a reliable emergency power system, as required by the services provided and patients served, that supplies electricity to the following areas when normal electricity is interrupted: Postoperative recovery rooms

16. The hospital provides a reliable emergency power system, as required by the services provided and patients served, that supplies electricity to the following areas when normal electricity is interrupted: Obstetrical delivery rooms

17. The hospital provides a reliable emergency power system, as required by the services provided and patients served, that supplies electricity to the following areas when normal electricity is interrupted: Newborn nurseries

Standard EC.7.40

The hospital maintains, tests, and inspects its emergency power systems.

Rationale for EC.7.40

Note: This standard does not require hospitals to have the types of emergency power systems discussed below. However, if a hospital has these types of systems, then the following maintenance, testing, and inspection requirements apply.

Elements of Performance for EC.7.40

1. The hospital tests each generator 12 times a year with testing intervals not less than 20 days and not more than 40 days apart. These tests shall be conducted for at least 30 continuous minutes under a dynamic load that is at least 30% of the nameplate rating of the generator.

Note: Hospitals may choose to test to less than 30% of the emergency generator's nameplate. However, these hospitals shall (in addition to performing a test for 30 continuous minutes under operating temperature at the intervals described above) revise their existing documented management plan to conform to current NFPA 99 and NFPA 110 testing and maintenance activities. These activities shall include inspection procedures for assessing the prime movers' exhaust gas temperature against the minimum temperature recommended by the manufacturer.

If diesel-powered generators do not meet the minimum exhaust gas temperatures as determined during these tests, they shall be exercised for 30 continuous minutes at the intervals described above with available Emergency Power Supply Systems (EPSS) load, and exercised annually with supplemental loads of

- *25% of name plate rating for 30 minutes, followed by*
- *50% of name plate rating for 30 minutes, followed by*
- *75% of name plate rating for 60 minutes for a total of two continuous hours.*

2. The hospital tests all automatic transfer switches 12 times a year with testing intervals not less than 20 days and not more than 40 days apart.

3. The hospital tests all battery-powered lights required for egress. Testing includes (a) a functional test at 30-day intervals for a minimum of 30 seconds; and (b) an annual test for a duration of 1.5 hours.

4. The hospital tests Stored Emergency Power Supply Systems (SEPSS) whose malfunction may severely jeopardize the occupants' life and safety.⁷ Testing includes (a) a quarterly functional test for 5 minutes or as specified for its class,⁸ whichever is less; and (b) an annual test at full load for 60% of the full duration of its class.

Standard IM.2.30

Continuity of information is maintained.

Rationale for IM.2.30

The purpose of the business continuity/disaster recovery plan is to identify the most critical information needs for patient care, treatment, and services and business processes, and the impact on the hospital if these information systems were severely interrupted. The plan identifies alternative means for processing data, providing for recovery of data, and returning to normal operations as soon as possible.

Elements of Performance for IM.2.30

1. The hospital has a business continuity/disaster recovery plan for its information systems.
2. For electronic systems, the business continuity/disaster recovery plan includes the following:
 - Plans for scheduled and unscheduled interruptions, which includes end-user training with the downtime procedures
 - Contingency plans for operational interruptions (hardware, software, or other systems failure)
 - Plans for minimal interruptions as a result of scheduled downtime
 - An emergency service plan
 - A back-up system (electronic or manual)
 - Data retrieval, including retrieval from storage and information presently in the operating system, retrieval of data in the event of system interruption, and back up of data
3. The plan is tested periodically as defined by the hospital (or in accordance with law or regulation) to ensure that the business interruption back-up techniques are effective.

⁷ **Stored Emergency Power Supply Systems (SEPSS)** Are intended to automatically supply illumination or power to critical areas and equipment essential for safety to human life. Included are systems that supply emergency power for such functions as illumination for safe exiting, ventilation where it is essential to maintain life, fire detection and alarm systems, public safety communications systems, and processes where the current interruption would produce serious life safety or health hazards to clients, the public, or staff. **Note:** *Other non-SEPSS battery back-up emergency power systems that an hospital has determined to be critical for operations during a power failure (for example, laboratory equipment, electronic medical records) should be properly tested and maintained in accordance with manufacturer's recommendations.*

⁸ **Class** Defines the minimum time for which the SEPSS is designed to operate at its rated load without being recharged (for additional guidance, see NFPA 111 (1996 edition) *Standard on Stored Electrical Energy Emergency and Standby Power Systems*).

4. The business continuity/disaster recovery plan is implemented when information systems are interrupted.

Standard LD.3.15

The leaders develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital.

Rationale for LD.3.15

Managing the flow of patients through the organization is essential to the prevention and mitigation of patient crowding, a problem that can lead to lapses in patient safety and quality of care. The Emergency Department is particularly vulnerable to experiencing negative effects of inefficiency in the management of this process. While Emergency Departments have little control over the volume and type of patient arrivals and most hospitals have lost the “surge capacity” that existed at one time to manage the elastic nature of emergency admissions, other opportunities for improvement do exist.

Overcrowding has been shown to be primarily an organization-wide “system problem” and not just a problem for which a solution resides within the emergency department. Opportunities for improvement often exist outside the emergency department.

This standard emphasizes the role of assessment and planning for effective and efficient patient flow throughout the organization. To understand the system implications of the issues, leadership should identify all of the processes critical to patient flow through the hospital system from the time the patient arrives, through admitting, patient assessment and treatment, and discharge. Supporting processes such as diagnostic, communication, and patient transportation are included if identified by leadership as impacting patient flow. Relevant indicators are selected and data is collected and analyzed to enable monitoring and improvement of processes.

A key component of the standard addresses the needs of admitted patients who are in temporary bed locations awaiting an inpatient bed. Twelve key elements of care have been identified to ensure adequate and appropriate care for admitted patients in temporary locations. These elements have implications across the organization and should be considered when planning care and services for these patients. Additional standard chapters relevant to these key elements are shown in parenthesis.

- Life Safety Code issues (for example, patients in open areas) (EC)
- Patient privacy and confidentiality (RI)
- Cross training and coordination among programs and services to ensure adequate staffing, particularly nursing staff (HR)
- Designation of a physician to manage the care of the admitted patient in a temporary location, without compromising the quality of care given to other ED patients (HR)
- Proper technology and equipment to meet patient needs (PC, LD)
- Appropriately privileged practitioners to provide patient care beyond immediate emergency services (HR)

- Access to other practitioners for consult and referral (for example, Intensivist) (PC)
- Assurance of appropriate communication between all health care providers (LD)
- Access to ancillary services (for example, pharmacy, lab, dietary) which permit the prompt disposition of patient care needs (LD)
- Patient access to medical assistance in an emergency, or for immediate care if needed (for example, call bell) (PC)
- A comprehensive written care plan carried out in a timely fashion, inclusive of intensive care issues (PC)
- Patient education on rights and access to services(PC)

Planning should also address the delivery of adequate care and services to those patients for whom no decision to admit has been made, but who are placed in overflow locations for observation or while awaiting completion of their evaluation.

Additionally, the standard calls for indicator results to be made available to those individuals who are accountable for processes that support patient flow. These results should be regularly reported to leadership to support their planning. The organization should improve inefficient or unsafe processes identified by leadership as essential in the efficient movement of patients through the organization. Criteria should be defined to guide decisions about ambulance diversion.

Elements of Performance for LD.3.15

1. Leaders assess patient flow issues within the hospital, the impact on patient safety, and plan to mitigate that impact.
2. Planning encompasses the delivery of appropriate and adequate care to admitted patients who must be held in temporary bed locations, for example, post anesthesia care unit and emergency department areas.
3. Leaders and medical staff share accountability to develop processes that support efficient patient flow.
4. Planning includes the delivery of adequate care, treatment, and services to non-admitted patients who are placed in overflow locations.
5. Specific indicators are used to measure components of the patient flow process and address the following:
 - Available supply of patient bed space
 - Efficiency of patient care, treatment, and service areas
 - Safety of patient care, treatment and service areas
 - Support service processes that impact patient flow
6. Indicator results are available to those individuals who are accountable for processes that support patient flow.

7. Indicator results are reported to leadership on a regular basis to support planning.
8. The hospital improves inefficient or unsafe processes identified by leadership as essential to the efficient movement of patients through the organization.
9. Criteria are defined to guide decisions about initiating diversion.

Standard IC.6.10

As part of its emergency management activities, the hospital prepares to respond to an influx, or the risk of an influx, of infectious patients.

Rationale for IC.6.10

The health care hospital is an important resource for the continued functioning of a community. A hospital's ability to deliver care, treatment, or services is threatened when it is ill-prepared to respond to an epidemic or infections likely to require expanded or extended care capabilities over a prolonged period. Therefore, it is important for a hospital to plan how to prevent the introduction of the infection into the hospital, how to quickly recognize that existing patients have become infected, and/or how to contain the risk or spread of the infection.

This planned response may include a broad range of options including the temporary halting of services and/or admissions, delaying transfer or discharge, limiting visitors within a hospital, or fully activating the hospital's emergency management plan. The actual response depends upon issues such as the extent to which the community is affected by the epidemic or infection, the types of services the hospital offers, and the hospital's capabilities.

The concepts included in these standards are supported by standards found elsewhere in the manual including standard EC.4.10.

Elements of Performance for IC.6.10

1. The hospital determines its response to an influx or risk of an influx of infectious patients.
2. The hospital has a plan for managing an ongoing influx of potentially infectious patients over an extended period.
3. The hospital does the following:
 - Determines how it will keep abreast of current information about the emergence of epidemics or new infections which may result in the hospital activating its response
 - Determines how it will disseminate critical information to staff and other key practitioners
 - Identifies resources in the community (through local, state and/or federal public health systems) for obtaining additional information

Standard MS.4.110

Disaster privileges may be granted when the emergency management plan has been activated and the organization is unable to handle the immediate patient needs (see standard EC.4.10).

Rationale for MS.4.110

During disaster(s) in which the emergency management plan has been activated, the CEO or medical staff president or their designee(s) has the option to grant disaster privileges.

Elements of Performance for MS.4.110

A 1. The medical staff identifies in writing the individual(s) responsible for granting disaster privileges.

A 2. The medical staff describes in writing the responsibilities of the individual(s) granting disaster privileges. (The responsible individual is not required to grant privileges to any individual and is expected to make such decisions on a case-by-case basis at his or her discretion.)

B 3. The medical staff describes in writing a mechanism to manage individuals who receive disaster privileges.

A 4. The medical staff includes a mechanism to allow staff to readily identify these individuals.

A 5. The medical staff addresses the verification process as a high priority.

A 6. The medical staff begins the verification process of the credentials and privileges of individuals who receive disaster privileges as soon the immediate situation is under control.

A 7. This verification process is identical to the process established under the medical staff bylaws or other documents for granting temporary privileges to meet an important patient care need (see standard MS.4.100).

B 8. The CEO or president of the medical staff or their designee(s) *may* grant disaster privileges upon presentation of any of the following:

- A current picture hospital ID card
- A current license to practice and a valid picture ID issued by a state, federal, or regulatory agency
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT)
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)

- Presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity