

Attachment
Requirements and Expectations By Source
Hospital Emergency Preparedness

A Vision of Preparedness - Hospital Emergency Management

The hospital has policies, plans, and procedures in place that clearly delineate how it will prepare, respond, and recover from a public health emergency. The emergency management plan is coordinated with the local jurisdiction's emergency operations plan (EOP). The hospital has policies, plans, and procedures in place that clearly delineate how it will manage its capacity to accommodate overwhelming medical surge, including training, expansion, and adaptation of staff roles and responsibilities. The hospital has communication systems that cross sectors and are interoperable and redundant. The hospital is prepared to communicate critical information to the public, the media, and key partners. The hospital has the ability to rapidly and safely detect, identify, and contain public health threats and can access the pharmaceutical and medical supplies to do so within the scope of the hospital's responsibility. The hospital regularly tests and improves these capacities through drills and exercises.

Summary of Requirements

This vision contains six goals, each of which requires that specific activities have taken place. These activities derive from multiple sources including:

- Targeted Capabilities List (TCL)
- BHPP Performance Measures and Sentinel Indicators
- JCAHO Standards
- NM Licensing Requirements
- Agency for Healthcare Research and Quality Questionnaire (AHRQ)
- NIMS Implementation Requirements for Hospitals and Healthcare Systems
- OSHA

Detailed Requirements by Goals and by Source

This document contains the detailed requirements of each of these sources, as applicable, for each of the six goals. Detailed requirements are listed by source as follows.

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- Goal II Page 10
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- Goal V Page 30
- Goal VI Page 36

Goal I. The hospital has policies, plans, and procedures in place that clearly delineate how it will prepare, respond, and recover from a public health emergency. The emergency management plan is coordinated with the local jurisdiction's emergency operations plan (EOP).

PLANS AND PLANNING, MANAGEMENT AND ADMINISTRATION

BHPP PERFORMANCE MEASURES AND SENTINEL INDICATORS

MLR 3. There are mutual aid plans for upgrading and deploying EMS units in jurisdictions they do not normally cover to insure the capability of providing EMS triage, transportation and patient tracking for at least 500 adult and pediatric patients per million population. In metropolitan and other high-risk areas, awardees will have established plans to transport patients from an incident scene or from local hospitals to healthcare facilities on adjacent jurisdictions, to temporary healthcare facilities within or near the affected jurisdiction, and to nearby airports for transport to more distance healthcare facilities.

2006 Program Measures

- The hospital actively engages in the integration of their Emergency Operations Plans (EOP) with key response partners to indicate expected roles in a response
- The hospital incorporates National Incident Management System (NIMS) compliant principles and policies in its EOP
- The hospital exercises the Incident Command System(ICS)component of their EOP during drills and exercises

JCAHO

Standard EC.4.11. The organization plans for managing the consequences of emergencies.

1. The organization's leaders actively participate in emergency management planning.
2. The organization conducts an HVA to identify events that could affect demand for its services or its ability to provide those services, the likelihood those events occurring, and the consequences of those events (HVA evaluated annually).
3. The organization prioritizes those hazards, threats and events identified in its HVA.
4. When developing its emergency operations plan, the organization communicates its needs and vulnerabilities to community emergency response agencies and identifies the capabilities of its community in meeting their needs.

For each emergency identified in its HVA, the organization defines:

5. mitigation activities designed to reduce the risk of and potential damage due to an emergency
6. preparedness activities that will organize and mobilize essential resources
7. response strategies and actions to be activated during the emergency, and
8. recovering strategies and actions designed to help restore the systems that are critical to resuming normal care, treatment, and services
9. The organization keeps a documented inventory of the assets and resources it has on-site that would be needed during an emergency (at a minimum, PPE, water, fuel, staffing, medical, and pharmaceutical resources and assets).

10. The organization establishes methods for monitoring quantities of assets and resources during an emergency.
11. The objectives, scope, performance, and effectiveness of the organization's emergency management planning efforts are evaluated at least annually.

Standard EC.4.12. The organization develops and maintains an Emergency Operations Plan (EOP).

1. The organization develops and maintains a written EOP that describes an "all-hazards" command structure for coordinating six critical areas within the organization during an emergency (communication, resources and assets, safety and security, staff roles and responsibilities, utilities, and patient clinical and support activities).
2. The EOP establishes an incident command structure.
3. The EOP identifies to whom staff report in the organization's incident command structure.

The EOP described processes for initiating and terminating the response and recover phases including:

4. Who has the authority to activate the phases; and
5. How the phases are to be activated
6. The EOP identifies the organization's capabilities and establishes response efforts when the organization cannot be supported by the local community for at least 96 hours in the six critical areas.
7. The EOP identifies alternative sites for care, treatment or service that meet the needs of its patients during emergencies.

Standard EC.4.15. The organization establishes strategies for managing safety and security during emergencies.

Revision: The safety and security of patients is the prime responsibility of the organization during an emergency. As emergency situations develop and parameters of operability shift, organizations must provide a safe and secure environment for their patients and staff.

1. The organization establishes internal security and safety operations that will be required once emergency measures are initiated.
2. The organization identifies the roles of community security agencies (police, sheriff, national guard, etc.) and defines how the organization will coordinate security activities with these agencies.
3. The organization identifies processes that will be required for managing hazardous materials and waste once emergency measures are initiated.
4. The plan identifies means for radioactive, biological, and chemical isolation and decontamination.
5. The organization identifies residents who might be susceptible to wandering once emergency measures are initiated.

The organization establishes processes for the following:

6. controlling entrance into and out of the health care facility during emergencies
7. controlling the movement of individuals within the health care facility during emergencies
8. controlling traffic accessing the health care facility during emergencies.

Standard EC.4.17. The organization establishes strategies for managing utilities during emergencies.

Revision: An organization is dependent on the uninterrupted function of its utilities during an emergency. The supply of key utilities, such as power or potable water, ventilation, and fuel must not be disrupted or adverse events may occur as a result.

Organizations identify an alternative means of providing for the following utilities in the event that their supply is compromised or disrupted:

1. Electricity
2. Water needed for consumption and essential care activities
3. Water needed for equipment and sanitary purposes
4. Fuel required for building operations or essential transport activities, and
5. Other essential utility needs (for example, ventilation, medical gas/vacuum systems, etc.)

Standard EC.4.18. The organization establishes strategies for managing patient clinical and support activities during emergencies.

Revision: The clinical needs of patients during an emergency are of prime importance. The organization must have clear, reasonable plans in place to address the needs of patients during extreme conditions when the organization's infrastructure and resources are taxed.

The organization plans to manage the following during emergencies:

1. the clinical activities required as part of patient scheduling, triage, assessment, treatment, admission, transfer, discharge, and evacuation.
 2. clinical services for vulnerable populations served by the organization, including patients who are pediatric, geriatric, disables, or have serious chronic conditions or addictions.
 3. personal hygiene and sanitation needs of its patients
 4. the mental health service needs of its patients, and
 5. mortuary services
6. The organization plans for documenting and tracking patients' clinical information.

NM LICENSING REQUIREMENTS

7.7.2.25 DISASTER AND EMERGENCY MANAGEMENT:

A. Plan: Each hospital shall have in operation a written plan for disaster and emergency management developed with the involvement of the hospital's executive, medical, and nursing staff and designed to ensure that each hospital is prepared to provide effective and efficient response to disasters and emergencies occurring in the community directly served by each hospital and in neighboring communities in New Mexico and adjacent states.

(1) Description of Plan: The written plan for disaster and emergency management shall:

- (a) identify the responsibilities and authorities of those involved in the conduct of disaster and emergency management activities within the hospital, including the responsibility and authority of chief executive officer of the hospital for the activation of the plan;
 - (b) be consistent with the concepts, principles, standards, guidelines, and terminology of the national response plan and the national incident management system;
 - (c) be coordinated with the local emergency operations plan, or the metropolitan medical response system plan, of the community directly served and with the New Mexico state all-hazard emergency operations plan;
 - (d) address the natural, accidental, negligent, and intentional hazards, identified through a hazard vulnerability analysis, to which the hospitals may be expected to respond;
 - (e) provide for direction, planning, education, training, exercise, drill, staff qualification and certification, equipment acquisition and certification, resource management, communications and information management, and ongoing management, improvement and maintenance;
 - (f) describe the direct responses of the hospital to disaster and emergency occurring in the community directly served by the hospital, the overflow and back-up responses of the hospital to disaster and emergency occurring in neighboring communities not directly served, and the efforts of the hospital in support organized and sponsored health professional disaster and emergency volunteer teams.
- (2) Exercise and Drill of Plan: Exercises and drills of the plan, both internally, and in conjunction with local and state disaster and emergency exercises and drills, shall be conducted at least twice a year to practice response and to serve as a basis for plan improvement.
- (3) Evaluation and Revision of Plan: The appropriateness and adequacy of the plan shall be evaluated on an annual basis, and the plan shall be revised as necessary.

7.7.2.25 D. Mutual Aid Agreements and Regional Response Plans: Coordination of hospital disaster and emergency management plans with local emergency operations plans and with the New Mexico state all-hazard emergency operations plan shall be recognized to serve the purposes of individual mutual aid agreements and of regional response plans.

AHRQ

The hospital has designated a coordinator (or group/committee) who is responsible for overseeing all of the hospital's CBRNE preparedness efforts.

The hospital has designated a medical director (or group) for its CBRNE preparedness efforts.

The hospital uses an Incident Command System (ICS) to manage events that impact normal operations.

All hospital staff are trained on their roles in ICS.

ICS is practiced routinely in exercises/drills.

ICS is updated as needed after exercises/drills.

ICS is incorporated into existing training programs.

ICS is formally incorporated into the emergency operations plan (EOP).

ICS is coordinated with local entities.

The hospital has a plan for a CBRNE event that is reviewed and updated at least every two years.

The hospital's CBRNE/All Hazard plan includes:

- Hospital's roles and responsibilities in a community CBRNE event
- Scenario in which the hospital itself is the target of a CBRNE event
- Plan activation and staff notification procedures
- Shelter in place
- Evacuation
- Initial recognition and presumptive diagnosis of symptomatic CBRNE patients
- Communication to and notification of staff of suspected CBRNE cases
- Diagnostic procedures or tests to make presumptive diagnosis
- Means to access age-specific CBRNE medical management guidelines from the public health departments and other appropriate agencies
- Provision of mental health services for affected patients
- Provision for controlling hospital access to limit contamination of the facility and individuals
- Capability to isolate CBRNE patients from general inpatient population
- Capability to isolate CBRNE patients from general outpatient population
- Provisions for handling suspected CBRNE agents brought to the hospital or sampled within the hospital
- Patient care expansion areas usable for assessing and treating potential victims of CBRNE events
- Memorandums of understanding with external treatment facilities for overflow in the event of treatment site contamination or capacity shortages
- Receipt and management of surge caches of pharmaceuticals and supplies
- Means to access additional supplies of blood and blood products
- Follow up instructions for patients and their home care providers that consider published guidelines from public health departments or the Centers for Disease Control and Prevention (CDC)
- Cost recovery plan coordinated with third party payers
- After-action evaluation of hospital's response to CBRNE event
- Disaster Recovery Procedures

Funds for CBRNE preparedness (i.e., planning, training, operations, etc.) are included into the hospital's budget.

The hospital participates in a regional planning group (i.e., local/State public health department) or other groups responsible for regional CBRNE preparedness.

NIMS IMPLEMENTATION ACTIVITIES - HOSPITALS & HEALTHCARE SYSTEMS

Element 1 - Adoption of NIMS

Adopt the National Incident Management System (NIMS) at the organizational level for all appropriate departments and business units, as well as promote and encourage NIMS adoption by associations, utilities, partners and suppliers.

Element 2 - Incident Command System (ICS)

Manage all emergency incidents, exercises and preplanned (recurring/special) events in accordance with ICS organizational structures, doctrine, and procedures, as defined in NIMS. ICS implementation must include consistent application of Incident Action Planning and Common Communication Plans.

Element 3 – Multi-agency Coordination System

Coordinates and supports emergency incident and event management through the development and use of integrated multiagency coordination systems (MACs). That is, develop and coordinate connectivity capability with Hospital Command Center (HCC) and local Incident Command Posts (ICPs), local 911 centers, local Emergency Operations Centers (EOCs), the state EOC and others as applicable.

Element 5 – NIMS Implementation Tracking

Hospitals and healthcare systems will track NIMS implementation annually as part of the organization's emergency management program.

Element 6 – Preparedness Funding

Develop and implement a system to coordinate appropriate hospital preparedness funding to employ NIMS across the organization.

Element 7 – Revise and Update Plans

Revise and update plans [i.e. Emergency Operations Plan (EOPs)] and standard operating procedures (SOPs) to incorporate NIMS components, principles and policies, to include planning, training, response, exercises, equipment, evaluation, and corrective actions.

Element 8 – Mutual-Aid Agreements

Participate in and promote interagency mutual-aid agreements, to include agreements with public and private sector and/or nongovernmental organizations.

Element 17 – Standard and Consistent Terminology

Apply standardized and consistent terminology, including the establishment of plain English communication standards across the public safety sector.

OSHA

Emergency response plan. An emergency response plan shall be developed and implemented by all employers. Such plans need not duplicate any of the subjects fully addressed in the employer's contingency planning required by permits, such as those issued by the U.S. Environmental Protection Agency, provided that the contingency plan is made part of the emergency response plan. The emergency response plan shall be a written portion of the employer's safety and health program. The employer shall develop an emergency response plan for emergencies which shall address, as a minimum, the following areas to the extent that they are not addressed in any specific program required in this paragraph:

- Pre-emergency planning and coordination with outside parties.
- Personnel roles, lines of authority, training, and communication.
- Emergency recognition and prevention.
- Safe distances and places of refuge.

- Site security and control.
- Evacuation routes and procedures.
- Decontamination procedures.
- Emergency medical treatment and first aid.
- Emergency alerting and response procedures.
- Critique of response and follow-up.
- PPE and emergency equipment.

Procedures for handling emergency incidents. In addition to the elements for the emergency response plan required above, the following elements shall be included for emergency response plans to the extent that they do not repeat any information already contained in the emergency response plan:

- Site topography, layout, and prevailing weather conditions.
- Procedures for reporting incidents to local, state, and federal governmental agencies.

The emergency response plan shall be compatible and integrated with the disaster, fire and/or emergency response plans of local, state, and federal agencies. The emergency response plan shall be rehearsed regularly as part of the overall training program for site operations. The site emergency response plan shall be reviewed periodically and, as necessary, be amended to keep it current with new or changing site conditions or information.

An employee alarm system shall be installed in accordance with 29 CFR 1910.165 to notify employees of an emergency situation, to stop work activities if necessary, to lower background noise in order to speed communication; and to begin emergency procedures.

Emergency response organizations may use the local emergency response plan or the state emergency response plan or both, as part of their emergency response plan to avoid duplication.

Incident Command System. The senior emergency response official responding to an emergency shall become the individual in charge of a site-specific Incident Command System (ICS). All emergency responders and their communications shall be coordinated and controlled through the individual in charge of the ICS assisted by the senior official present for each employer.

The individual in charge of the ICS shall designate a safety officer, who is knowledgeable in the operations being implemented at the emergency response site, with specific responsibility to identify and evaluate hazards and to provide direction with respect to the safety of operations for the emergency at hand.

When deemed necessary for meeting the tasks at hand, approved self-contained compressed air breathing apparatus may be used with approved cylinders from other approved self-contained compressed air breathing apparatus provided that such cylinders are of the same capacity and pressure rating. All compressed air cylinders used with self-contained breathing apparatus shall meet U.S. Department of Transportation and National Institute for Occupational Safety and Health criteria.

Goal II. The hospital has policies, plans, and procedures in place that clearly delineate how it will manage its capacity to accommodate overwhelming medical surge, including training, expansion, and adaptation of staff roles and responsibilities.

BED CAPACITY AND MEDICAL SURGE

TCL

Respond Mission: Medical Surge (pages 411-427)

Capability Definition

Medical Surge is the capability to rapidly expand the capacity of the existing healthcare system in order to provide triage and then to provide medical care. This includes providing definitive care to individuals at the appropriate clinical level of care, within sufficient time to achieve recovery and minimize medical complications. The capability applies to an event resulting in a number or type of patients that overwhelm the day-to-day acute-care medical capacity. Medical Surge is defined as rapid expansion of the capacity of the existing healthcare system in response to an event that results in increased need of personnel (clinical and non-clinical), support functions (laboratories and radiological), physical space (beds, alternate care facilities) and logistical support (clinical and equipment and supplies).

Outcome

Injured or ill from the initial event are cared for and new cases that arise from initial illness or injury and new illnesses or injuries or exacerbation of pre-existing illness or injury due to disease, contamination or injury including exposure from communicable diseases and/or injuries which are secondary to the primary event are minimized. The at-risk population receives the appropriate protection (countermeasures) and treatment in a timely manner.

Performance Measures

- √ Triage treatment and initial stabilization can be conducted for the following classes of patients within three hours of an emergency:
 - 500 cases per million population for patients with symptoms of acute infectious disease – especially smallpox, anthrax, plague, tularemia and influenza;
 - 50 cases per million population for patients with symptoms of acute botulinum intoxication or other acute chemical poisoning – especially that resulting from nerve agent exposure;
 - 50 cases per million population for patients suffering burn or trauma
 - 50 cases per million populations for patients manifesting the symptoms of radiation-induced injury – especially bone marrow suppression
- √ A 50-bed nursing subunit can be staffed for 12 hours with: (1) Physician (1) Physician's assistant (PA) or nurse practitioner (NP) (physician extenders) (6) RNs or a mix of RNs and licensed practical nurses (LPN) (4) Nursing assistants/nursing support technicians (2) Medical clerks (unit secretaries) (1) Respiratory therapist (RT) (1) Case manager (1) Social worker (1) Housekeepers (1) Patient transporters
- √ Medical surge plans have been developed
- √ The hospital has the capacity to maintain, in negative pressure isolation, at least one suspected case of a highly infectious disease or a febrile patient with a suspect rash or other symptoms of concern who might be developing a highly communicable disease
- √ There is a regional system to ensure a sufficient supply of pharmaceuticals to provide prophylaxis for 3 days to hospital personnel (medical and ancillary staff) and their family members and hospital based emergency first responders and their families – in the wake of a

terrorist-induced outbreak of anthrax or other disease for which such countermeasures are appropriate

- ✓ Adequate PPE is available for current and additional health care personnel during an incident
- ✓ The hospital is capable of providing decontamination to individual(s) with potential or actual hazardous agents in or on their body
- ✓ Hospitals of sufficient size can decontaminate 500 persons in hours per millions population; isolated community hospitals serving a population of 100,000 persons are able to decontaminate 50 persons in 2 hours, or 25 per hour, or about one every 2 1/2 min
- ✓ The hospital has at least one set of equipment to decontaminate ambulatory patients and one set of equipment for non-ambulatory patients
- ✓ The hospital decontamination system addresses the following essential elements: (1) Adequate outdoor or indoor systems with consideration of typical ambient climate or heating systems to support colder climates. There must be adequate lighting and systems to communicate with staff and patients, both indoors and outdoors (2) Provision for separate entrance from typical ambulatory entrance, if the decontamination area is indoors. Some hospitals must combine the decontamination area with the EMS entrance. This is not desirable in the implementation of new systems as hospitals do redesigns (3) Provision for shower heads supplied with warm clean water, sufficient in number to manage the planning volumes (4) Gender and privacy concern (5) Capability to separate, isolate, and secure personal property for later decontamination (6) Provision of supplies (for example, containers and name tags) and procedures for separately securing personal clothing and valuables and a process that allows valuables to be matched back with the patient (7) Provision of clothing for persons to wear following the decontamination
- ✓ The hospital has a secure and redundant communications system that ensures connectivity during a terrorist incident or other public health emergency between health care facilities and state and local health departments, emergency medical services, emergency management agencies, public safety agencies, neighboring jurisdictions and federal public health officials have been established
- ✓ The hospital is utilizing competency-based education and training programs for adult and pediatric pre-hospital, hospital, and outpatient health care personnel responding to a terrorist incident or other public health emergency
- ✓ The hospital has isolation capacity (for contagious biological events)
- ✓ Patients and responders are identified, screened, and monitored after an event
- ✓ Personnel are available to augment treatment facilities
- ✓ Protocols for the set up, staffing and operation of alternate care facilities are established and implemented in the event
- ✓ Adequate supplies, pharmaceuticals, and equipment are available to support facility surge capacity
- ✓ Patients are successfully tracked
- ✓ Patients and responders are identified, screened, and monitored after an event
- ✓ Personnel are available to augment treatment facilities

- ✓ Protocols for the set up, staffing and operation of alternate care facilities are established and implemented in the event
- ✓ Adequate supplies, pharmaceuticals, and equipment are available to support facility surge capacity
- ✓ Patients are successfully tracked
- ✓ Policies for the security of facility and its perimeter are implemented in the event
- ✓ Staff at risk are protected by appropriate PPE
- ✓ Mass decontamination can be performed at the hospital or adjoining/partner facility
- ✓ Affected populations receive definitive medical care and recover from injuries over time
- ✓ Timely public health information is disseminated to improve provision of home healthcare
- ✓ Adequate resources are available to provide post-hospitalization regulating and mass movement/transfer of patients

BHPP PERFORMANCE MEASURES AND SENTINEL INDICATORS

MLR 2-1 The hospital has systems that allow for the triage, treatment, and initial stabilization for the following classes of adult and pediatric patients requiring hospitalization within three hours in the wake of a terrorism incident or other public health emergency:

- 500 cases per million population for patients with symptoms of acute infectious disease - especially smallpox , anthrax, plague, tularemia and influenza;
- 50 cases per million population for patients with symptoms of acute botulinum intoxication or other acute chemical poisoning – especially that resulting from nerve agent exposure
- 50 cases per million population for patients suffering burn or trauma; and
- 50 cases per million population for patients manifesting the symptoms of radiation induced injury – especially bone marrow suppression.

Hospitals are able to report available beds, according (2006)

Sentinel Indicator – Beds

- Predictable high-risk scenarios have been identified through an HVA.
- The number of beds the hospital is capable of surging beyond within 3 hours post event by type of illness or injury is known.
- The number of beds the hospital is capable of surging beyond within 24 hours post event by type of illness or injury is known.

NM LICENSING REQUIREMENTS

Bed Polling: Each hospital shall participate in the electronic bed polling system operated by the New Mexico Department of Health.

AHRQ

The hospital participates in a regional system to monitor bed availability. Optimally, inpatient ICU, ED, and outpatient beds are all monitored in real-time.

The hospital's CBRNE/all hazards plan addresses policies and procedures for increasing inpatient bed capacity in adult and pediatric critical care, medical, surgical, burn, and trauma. Increased capacity has been tested in drills and/or exercises.

The hospital's CBRNE/all hazards plan addresses alternative treatment sites to serve patients during a CBRNE event. Alternative treatment sites are planned for ED overflow, ED contamination, needs for isolation areas, inpatient overflow, and outpatient overflow. Utilization of alternative treatment sites has been tested in drills and/or exercises.

The hospital has protocols or memoranda of understanding (MOUs) in place with other area treatment facilities (e.g., hospitals, ambulatory care centers, extended care facilities) to transfer patients as a result of a CBRNE event? Transfer protocols have been tested in drills and/or exercises.

The hospital has procedures that allow morgue capacity to be increased in case of mass fatalities. Procedures have been tested in drills and/or exercises.

STAFFING, VOLUNTEERS, AND STAFF AUGMENTATION

BHPP PERFORMANCE MEASURES AND SENTINEL INDICATORS

MLR 2-4. The hospital participates in the State's system that allows qualified, competent volunteer health professionals to work in hospitals or other medical facilities during an emergency situation throughout the grantee's jurisdiction.

JCAHO

Revision: Staff Responsibilities (see EC16). During an emergency, the probability that staff responsibilities will change is high. As new risks develop along with changing conditions, staff will need to adapt their roles to meet new demands on their ability to care for patients. If staff cannot anticipate how they may be called to perform during an emergency, the likelihood that they organization will not sustain itself during an emergency increases.

Standard EC.4.16. The organization defines and manages staff roles and responsibilities.

1. Staff roles and responsibilities are defined in the Emergency Operations Plan for all six critical areas (communications, resources and assets, safety and security, utilities and clinical activities).
2. Staff are trained for their assigned roles during emergencies.
3. The organization communicates to licensed independent practitioners their roles in emergency response and to whom they report during an emergency.
4. The organization establishes a process for identifying care providers and other personnel assigned to particular areas during emergencies.

AHRQ

The hospital's CBRNE/all hazards plan addresses procedures for expanding staff availability (e.g., callback lists, policies for overtime, staffing centers, etc.) during a CBRNE event.

Procedures include expanding staff in the following areas in the following areas:

- Emergency department
- Critical care
- Medicine/surgery
- Pediatrics
- Laboratory
- Housekeeping
- Pharmacy
- Security
- Food service
- Respiratory therapy
- Burn care
- Trauma
- Radiology

Procedures include some or all of the following:

- Callback lists
- Policies for overtime
- Staffing centers
- Professional volunteers (pre-credentialed)

Procedures for expanding staff availability have been tested in drills and/or exercises.

The hospital has policies for the advance registration and credentialing of clinicians needed to augment hospital staff in case of a CBRNE event.

The hospital has provisions for temporary housing and feeding personnel when needed during a CBRNE event.

Capacity exists or can be expanded for temporary housing and feeding of patients, staff, and staff's families.

Mental health support is available as a component of the care provided to staff in a CBRNE event

Mental health support is available 24 hours a day.

TRAINING

BHPP PERFORMANCE MEASURES AND SENTINEL INDICATORS

MLR 2-8. The hospital has identified the minimum behavioral health training competencies for health care professionals responding to bioterrorism or other public health emergencies.

MLR 5. Education and training programs for all health care personnel are competency based.

The hospital has a system for tracking NIMS related training for appropriate personnel [2006 performance measure]

Sentinel Indicator: Education and Preparedness Training

- Health care personnel are trained through competency-based programs.

Sentinel Indicator: Behavioral Health

- Health professionals are trained via competency based education, statewide, in the recognition, treatment and referral of patients exhibiting behavioral health consequences related to bioterrorism and other public health emergencies.

AHRQ

The hospital provides competency-based training on CBRNE events to clinical staff.

Clinical staff are trained on CBRNE events at least every 2 years.

The hospital provides competency-based training on CBRNE events to non-clinical staff.

Non-clinical staff are trained on CBRNE events at least every 2 years.

The hospital provides training in accordance with Occupational Safety and Health Administration (OSHA) standards to personnel who may be part of the decontamination response.

Decontamination training includes the following

- OSHA-level operations training for all staff with designated roles in the hospital decontamination zone (area where contamination may be found and decontamination performed)
- OSHA-level awareness training for all staff assigned to areas proximate to the decontamination zone where contact with contaminated may occur
- Agent identification
- Selection and use of PPE
- Decontamination area setup
- Patient decontamination
- Decontamination area cleanup
- Radiation contamination/exposure management
- Equipment inspection, maintenance, and storage

Decontamination training is tested in drills and/or exercises.

Persons designated in the hospital's CBRNE/all hazards plan receive training on the regional emergency planning group's CBRNE response plan.

Information from the training on the regional emergency planning group's CBRNE response plan has been incorporated into the hospital's CBRNE response plan.

The following personnel have been trained on the regional emergency planning group's CBRNE response plan:

- Infection control practitioner
- Radiation safety officer
- Mental health professional
- Safety officer
- Emergency department representative

Hospital staff members participate in hospital-wide and/or regional CBRNE event exercises/drills.

Participation in hospital-wide and/or regional CBRNE event exercises/drills takes place at least every two years.

The hospital's CBRNE/all hazards plan is revised as necessary as a result of drills and/or exercises.

NIMS IMPLEMENTATION ACTIVITIES – HOSPITALS & HEALTHCARE SYSTEMS

Element 9 – *IS-700 NIMS: An Introduction* should be completed by the hospital personnel that would have a leadership role in emergency preparedness, incident management, and/or emergency response during an incident. Personnel designated to fulfill ICS roles (i.e. hospital emergency manager, hospital administration, department heads) should complete IS-700 or equivalent, though additional participants may include the following hospital and healthcare systems staff: physicians, nursing, ancillary, materials/resource management, security/safety, laboratory, radiology, and/or inter-facility transport.

Element 10 – *IS-800.A: National Response Plan (NRP): An Introduction* should be completed by personnel whose primary responsibility is emergency management within a hospital or healthcare system.

Element 11 – *ICS-100 Introduction to ICS* or equivalent should be completed by the hospital personnel that would have a direct role in emergency preparedness, incident management, and/or emergency response during an incident. Personnel designated to fulfill ICS roles (i.e. hospital emergency manager, hospital administration, department heads) should complete IS-100 or equivalent, though additional participants may include the following hospital and healthcare systems staffs: physicians; nursing; ancillary; materials/resource management; security/safety; laboratory; radiology; and/or inter-facility transport.

ICS-200 ICS for Single Resources and Initial Action Incidents or equivalent should be completed by personnel whose primary responsibility is emergency management, to include (at a minimum) middle management within a hospital or healthcare system. Middle management may refer to physicians, department managers, unit leaders, charge nurses, and any staff that would have a role in an emergency operations center (hospital, local, or state).

Element 12 – Hospitals and healthcare systems should include NIMS and ICS policies and practices into internal and external training and exercises. During trainings and exercises, plans should be reviewed to ensure hospital and healthcare systems staff competency and proper execution of roles and responsibilities during an event.

OSHA

Training. Training for emergency response employees shall be completed before they are called upon to perform in real emergencies. Such training shall include the elements of the emergency response plan, standard operating procedures the employer has established for the job, the personal protective equipment to be worn and procedures for handling emergency incidents.

PHARMACEUTICALS, MEDICAL SUPPLIES, & PROPHYLAXIS

TCL

**Respond Mission: Medical Supplies Management and Distribution; Mass Prophylaxis
(pages 428-453)**

Medical Supplies Management and Distribution Capability Definition

Medical Supplies Management and Distribution is the capability to procure and maintain pharmaceuticals and medical materials prior to an incident and to transport, distribute, and track these materials during an incident

Medical Supplies Management and Distribution Outcome

Critical medical supplies and equipment are appropriately secured, managed, distributed and restocked in a timeframe appropriate to the incident.

Medical Supplies Management and Distribution Performance Measures

- ✓ The hospital's emergency response plan includes medical material distribution and identifies and prioritizes resource needs
- ✓ The hospital has participated with other medical facilities and state, county and local governments to place pre-planned worst case scenario orders with medical distributors. Pre-planned orders reflect differing needs for various possible scenarios (chemical, biological attacks, natural disaster)
- ✓ The hospital has participated with other medical facilities and state, county and local governments in developing plans to consult local and regional sources of potential medical supplies and pharmaceuticals to lower dependency on federal assets
- ✓ Alternate sources of pharmaceuticals and medical supplies have been identified and are updated periodically

Mass Prophylaxis Capability Definition

Mass Prophylaxis is the capability to protect the health of the population through administration of critical interventions in response to a public health emergency in order to prevent the development of disease among those who are exposed or are potentially exposed to public health threats. This capability includes the provision of appropriate follow-up and monitoring of adverse events, as well as risk communication messages to address the concerns of the public.

Mass Prophylaxis Capability Outcome

Appropriate drug prophylaxis and vaccination strategies are implemented in a timely manner upon the onset of an event to prevent the development of disease in exposed individuals. Public information strategies include recommendations on specific actions individuals can take to protect their family, friends, and themselves.

Mass Prophylaxis Capability Performance Measures

- ✓ The hospital is prepared to provide public information messages that are accurate, consistent, and timely
- ✓ The hospital has sufficient, competent personnel available to staff dispensing centers or vaccination clinics as applicable
- ✓ Hospital staff at potential dispensing center(s) are prepared to deal with potential emotionality of individuals seeking medication

- ✓ Mass prophylaxis and vaccination plans include behavioral recommendations to reduce social unrest and increase the likelihood of adherence with public health recommendations before medication can be dispensed during the distribution process and after available resources may become exhausted (worst case)

BHPP PERFORMANCE MEASURES AND SENTINEL INDICATORS

MLR 2-5. The hospital has access to pharmaceutical caches sufficient to cover hospital personnel (medical and ancillary), hospital based emergency first responders and family members associated with their facilities for a 72-hour time period.

MLR 2-6-1. The hospital possesses sufficient numbers of PPE to protect both the current and additional health care personnel deployed in support of an event.

MLR 2-6-2. The hospital has contingency plans to establish sufficient number of PPE to protect both the current and additional health care personnel expected to be deployed in support of predictable high-risk scenarios.

Sentinel Indicators: Pharmaceuticals

- Access to pharmaceutical caches sufficient to cover hospital personnel (medical and ancillary), hospital based emergency first responders and family member associated with their facilities for a 72-hour time period.
- Access to prophylaxis for essential personnel (medical and ancillary) for a 72 hour time period [*2006 performance measure*]

Sentinel Indicator: PPE

- PPE sets to protect current and additional health care workers during an event [for staff and volunteers at risk – *2006 performance measure*]

JCAHO

Revision: Resources and Assets (see EC.4.14). A solid understanding of the scope and availability of an organization's resources and assets is as important, and perhaps more important, during an emergency than during times of normal operation. Materials and supplies, vendor and community services, as well as state and federal programs are some of the essential resources that organizations must know how to access in times of crisis in order to ensure patient safety and sustain care, treatment, and services.

Standard ED.4.14. The organization establishes strategies for managing resources and assets during emergencies.

The organization plans for:

1. obtaining supplies that will be required at the onset of emergency response (medical, pharmaceutical and non-medical):
2. replenishing medical supplies and equipment that will be required throughout response and recovers, including PPE were required;

3. replenishing pharmaceutical supplies that will be required throughout response and recover, including access to and distribution of caches (stockpiled by the organization or its affiliates, local, state, or federal sources) to which the organization has access;
4. replenishing non-medical supplies that will be required through response and recover (for example, food, linen, water, fuel for generators and transportation vehicles, etc.);
5. managing staff support activities (for example, housing, transportation, incident stress debriefing, etc.);
6. managing staff family support needs (for example, child care, elder care, communication, etc.);
7. potential sharing of resources and assets (e.g., personnel, beds, transportation, linens, fuel, PPE, medical equipment and supplies, etc.) with other health care organizations within the community that could potentially be shared in an emergency response;
8. potential sharing of resources and assets with health care organizations outside of the community in the event of a regional or prolonged disaster;
9. evacuating (both horizontally and, when required by circumstances, vertically) when the environment cannot support care, treatment, and services;
10. transporting patients, staff, and medication, equipment to an alternative care site or sites when the environment cannot support care, treatment, and services; and
11. transporting pertinent information, including essential clinical and medication related information, for patients to an alternative care site or sites when the environment cannot support care, treatment, or services.

AHRQ

Appropriate personal protective equipment (as defined by the hospital's hazard vulnerability assessment) is provided to personnel involved in the decontamination response.

The hospital has identified contingency suppliers of resources needed during a CBRNE event, including pharmaceutical, medical supplies, laboratory supplies, and other resources.

The hospital's CBRNE/all hazards plan address procedures to expand storage capacity for additional supplies/equipment needed during a CBRNE event.

Procedures for expanding storage capacity have been tested in drills.

The hospital maintains its own cache of medications (such as antibiotics and chemical antidotes) for use for 3 days during a CBRNE event.

The cache is not part of the pharmacy's rotation.

The cache is rotated to prevent shelf-life expiration.

The cache is available for patients, staff, and staffs' families

The hospital has agreements in place for accessing additional supplies of medications from outside resources during a CBRNE event.

Agreements cover:

- Primary pharmaceutical vendors
- Other hospitals
- Local pharmacies

- Public health department
- Regional stockpiles

Agreements are tested with drills and/or exercises

The hospital's CBRNE/all hazards plan addresses procedures for receiving and distributing prophylactic and/or treatment medications.

Procedures for receiving and distributing prophylactic and/or treatment medications have been tested in drills and/or exercises.

Procedures for receiving and distributing prophylactic and/or treatment medications include distribution to patients, staff, and staffs' families

NIMS IMPLEMENTATION ACTIVITIES – HOSPITALS & HEALTHCARE SYSTEMS

Element 15 – Response Inventory

Maintain an inventory of organizational response assets.

OSHA

Personal protective equipment (PPE) program. A personal protective equipment program must be part of the employer's safety and health program. The PPE program shall address the elements listed below. When elements, such as donning and doffing procedures, are provided by the manufacturer of a piece of equipment and are attached to the plan, they need not be rewritten into the plan as long as they adequately address the procedure or element.

- PPE selection based upon site hazards,
- PPE use and limitations of the equipment,
- Work mission duration,
- PPE maintenance and storage,
- PPE decontamination and disposal,
- PPE training and proper fitting,
- PPE donning and doffing procedures,
- PPE inspection procedures prior to, during, and after use,
- Evaluation of the effectiveness of the PPE program, and
- Limitations during temperature extremes, heat stress, and other appropriate medical considerations.

Goal III. The hospital has communication systems that cross sectors and are interoperable and redundant.

COMMUNICATION, INTEROPERABILITY, AND REDUNDANCY

TCL

Common Target Capability: Communication (pages 92-103)

Capability Definition

Communications is the fundamental capability within disciplines and jurisdictions that practitioners need to perform the most routine and basic elements of their job functions. Agencies must be operable, meaning they must have sufficient wireless communications to meet their everyday internal and emergency communication requirements before they place value on being interoperable, meaning being able to work with other agencies.

Communications interoperability is the ability of public safety agencies (police, fire, EMS) and service agencies (public works, transportation, hospitals, etc.) to talk within and across agencies and jurisdictions via radio and associated communications systems, exchanging voice, data and/or video with one another on demand, in real time, when needed, and when authorized. It is essential that public safety has the intra-agency operability it needs, and that it builds its systems toward interoperability.

Outcome

A continuous flow of critical information is maintained as needed among multi-jurisdictional and multi-disciplinary emergency responders, command posts, agencies, and the governmental officials for the duration of the emergency response operation in compliance with National Incident Management System (NIMS). To accomplish this, the jurisdiction has a continuity of operations plan for public safety communications to include the consideration of critical components, networks, support systems, personnel, and an appropriate level of redundant communications systems in the event of an emergency.

Performance Measures

- √ Plans are in place, including a multi-agency and multi-jurisdictional governance structure that includes the hospital, to improve communications interoperability planning and coordination:
 - Participating entities in the governance structure have developed an interoperability communications plans as needed
 - Formal interoperable communications agreements exist among jurisdictions and disciplines
 - Governance committees have developed a plan to acquire and influence sustained interoperability and systems maintenance funding
 - A statewide set of communications Standard Operating Procedures (SOPs) that conform to NIMS are in place and implemented to include operational and technical elements
 - Command and control policies are in place to achieve interoperability as necessary

- Interoperability policies and procedures are in place to allow information sharing between levels of government and Federal installations involved in the incident as necessary
- Communications continuity of operations plan is in place that outlines the back-up systems available at a state and local level as well as the protocol for use of those systems
- An assessment of standard communication capabilities for the PSAPs/Public Safety Communication Centers, and Emergency Operations Centers (EOC), has been completed to ensure an appropriate continuity of operations plan (COOP) is in place for public safety and service agencies' communications
- √ Individual agencies across the jurisdiction, including the hospital, have operable communications systems in place to meet their everyday internal agency requirements
- √ Redundant interoperable communication systems are available
- √ All personnel are trained to operate communications systems according to their role at an incident
- √ Plans, procedures, and use of interoperable communications equipment are regularly tested and/or exercised
- √ Interoperability systems are used in pertinent everyday activities as well as emergency incidents to ensure users are familiar with the system and routinely work in concert with one another
- √ The hospital can provide continuous communications back-up during emergencies when conventional modes of communications fail or become overloaded
- √ Staff are trained and can be available for alternate communications centers or systems

BHPP PERFORMANCE MEASURES AND SENTINEL INDICATORS

MLR 2-10 The hospital has secure and redundant communication systems that allow connectivity to all other healthcare entities and emergency response agencies responding to a terrorist event or other public health emergency [and can demonstrate such during each exercise per *2006 performance measure*]

Sentinel Indicator: Communications/IT

Redundant communications systems with:

- Public health
- Local EOC
- EMS
- Law Enforcement
- Emergency Management

Hospital communications systems include:

- Phones
- Dedicated phones
- Fax

- Ham radio
- Sat. Phones
- Email
- 800 MHz radio
- HAN

The hospital can demonstrate the ability to communicate in a two-way fashion, with the incident commander and all tier 2 response partners during each exercise – *2006 performance measure*

The hospital can test and verify functionality of internal and external communications systems used during an emergency at least once per month – *2006 performance measure*

JCAHO

Revision: Communication (see EC.4.13) – In the event that community infrastructure is damaged and/or an organization's power of facilities experience debilitation, communication pathways, whether dependent on fiber optic cables, electricity, satellite, or other conduits, are likely to fail. Organizations must develop a plan to maintain communication pathways both within the organization and to critical community resources.

Standard EC.4.13 – The organization establishes emergency communication strategies.

1. The organization plans for notifying staff when emergency response measures are initiated.
2. The organization plans for ongoing communication of information and instructions to its staff once emergency response measures are initiated.
3. The organization defines processes for notifying external authorities when emergency response measures are initiated.
4. The organization plans for communication with external authorities once emergency response measures are initiated.
5. The organization plans for communicating with patients and their families during emergencies, including notification when patients are relocated to alternative care sites.
6. The organization defines the circumstances and plans for communicating with the community and/or the media during emergencies.
7. The organization plans for communicating with purveyors of essential supplies, services, and equipment once emergency measures are initiated.

The organization plans for communicating in a timely manner with other health care organizations that together provide services to a contiguous geographic area (for example among health care organizations serving a town or borough) regarding:

8. Essential elements of their command structures and control centers for emergency response;
9. Names and roles of individuals in their command structures and command center telephone numbers;
10. Resources and assets that potentially could be shared in an emergency response; and
11. Names of patients and deceased individuals brought to their organizations in accordance with applicable law and regulations when requested.

12. The organization defines the circumstances and plans for communicating information about patients to third parties (such as other health care organizations, the state health department, police, FBI, etc.)
13. The organization plans for communicating with identified alternative care sites.
14. The organization establishes backup communication systems and technologies for the activities identified above.

NM LICENSING REQUIREMENTS

Communications Systems: With the assistance of the New Mexico Department of Health each hospital shall establish and maintain connections with the various disaster and emergency management communications systems in New Mexico.

NIMS IMPLEMENTATION ACTIVITIES – HOSPITALS & HEALTHCARE SYSTEMS

Element 16 – Resource Acquisition

To the extent permissible by law, ensure that relevant national standards and guidance to achieve equipment, communication, and data interoperability are incorporated into acquisition programs.

Goal IV. The hospital is prepared to communicate critical information to the public, the media, and key partners.

PUBLIC INFORMATION AND RISK COMMUNICATION

TCL

Respond Mission Area: Emergency Public Information and Warning (pages 387-397)

Capability Definition

Emergency Public Information and Warning is the capability to develop, coordinate, and disseminate accurate alerts and emergency information to the media and the public prior to an impending emergency and activate warning systems to notify those most at-risk in the event of an emergency. By refining its ability to disseminate accurate, consistent, timely, and easy-to-understand information about emergency response and recovery processes, a jurisdiction can contribute to the well-being of the community during and after an emergency.

Outcome

Members of the public receive prompt, accurate and useful information regarding threats to their health, safety and property, and receive clear, consistent information and periodic updates outlining protective measures that can be taken by individuals and their communities.

Performance Measures

The hospital emergency operations plan (EOP) contains provisions for public information, including provisions for information channels when normal information sources are lost.

The hospital is trained and participates in the emergency alert system (EAS) State activation plan and the exercise thereof.

The hospital's public awareness and education plan is in place with all appropriate agencies and partners

The hospital participates in the Joint Information Center (JIC) and the exercise thereof.

The hospital has a public awareness and media guide which includes:

- Protocols for interfacing with the media and the community, citizens and tribal, city, county, State, Federal, and private industry leaders
- Protocols for interfacing with the media, legislative interests, and other very important persons
- A listing of homeland security and emergency management sources of information
- Protocols for operating in a Joint Information Center
- Protocols for identification of resources and responsibilities in advance of an accident

Plans and procedures are tested periodically to ensure accuracy and completeness.

The public awareness and education plan is exercised annually.

BHPP PERFORMANCE MEASURES AND SENTINEL INDICATORS

2006 Program Measures

The hospital has protocols to gather, collate, and communicate public health and clinical threat information to key response partners in accordance with NIMS

The hospital has identified a Point of Contact (department or staff member) within the facility to be notified of a significant event in the community that may impact hospital operations and have communicated to its key response partners the means by which to reach this Point of Contact

The hospital has designated in its EOP a Public Information Officer (PIO) who coordinates dissemination of public health and clinical threat information with partner agency PIOs and the Joint Information Center (JIC).

AHRQ

The hospital has a mechanism in place for the rapid receipt and posting of public health alerts during a CBRNE event from agencies such as Public Health, poison control, Health Alert Network, Centers for Disease Control and Prevention, etc.

Public health alerts are made readily available throughout the clinical areas of the hospital.

The hospital has a dedicated system for staff information and call-in inquiries during a CBRNE event.

The dedicated system for staff information and call-in inquiries includes multiple methods of access.

The Emergency Department has Internet access located in the ED.

The internet is accessed by a high-speed connection.

The hospital is a participant in a regional system to monitor Emergency Department diversion status.

Emergency Department diversion status is monitored in real-time.

The hospital's CBRNE/all hazards plan designates a position or individual (such as a Public Information Officer) to communicate about a CBRNE event to the media.

Protocols are in place for the release of information regarding the number of CBRNE casualties to the appropriate external agencies.

Protocols are have been coordinated with appropriate external agencies.

The hospital's CBRNE/all hazards plan address procedures that staff should follow in reporting a suspected CBRNE event to the appropriate external agencies.

Procedures that staff should follow in reporting a suspected CBRNE event to the appropriate external agencies have been communicated to the staff.

The hospital has a procedure in place for providing patient tracking (from initial triage to hospital admission or discharge).

The procedure for providing patient tracking has been tested in drills and/or exercises.

NIMS IMPLEMENTATION ACTIVITIES - HOSPITALS & HEALTHCARE SYSTEMS

Element 4 - Public Information System

Implements processes and/or plans to communicate timely accurate information through a Joint Information System (JIS) and Joint Information Center (JIC).

Goal V. The hospital has the ability to rapidly and safely detect, identify, and contain public health threats and can access the pharmaceutical and medical supplies to do so within the scope of the hospital's responsibility.

ISOLATION, QUARANTINE, AND DECONTAMINATION

TCL

Respond Mission: Isolation and Quarantine (pages 371-378)

Capability Definition

Isolation and Quarantine is the capability to protect the health of the population through the use of isolation and/or quarantine measures in order to contain the spread of disease. Isolation of ill individuals may occur in homes, hospitals, designated health care facilities, or alternate facilities.

Quarantine refers to the separation and restriction of movement of persons who, while not yet ill, have been exposed to an infectious agent and may become infectious. Successful implementation will require that sufficient legal, logistical, and informational support exists to maintain these measures. Most experts feel that isolation and quarantine will not stop the outbreak and that if used, the focus will be on cases that might introduce the disease into the state or other geographic area.

Outcome

Individuals who are ill, exposed, or likely to be exposed are separated, movement is restricted, basic necessities of life are available, and their health is monitored in order to limit the spread of a newly introduced contagious disease (pandemic influenza). Legal authority for these measures is clearly defined and communicated to the public. Logistical support is provided to maintain measures until danger of contagion has elapsed.

Performance Measures

- ✓ The hospital's emergency response plan addresses coordination of quarantine activation and enforcement with public safety and law enforcement
- ✓ The hospital's emergency response plan includes tracking the details of individuals placed in Isolation or Quarantine Personal Health Identification Number (PHIN).
- ✓ The hospital's emergency response plan addresses the implementation of infection control precautions
- ✓ The hospital's emergency response plan identifies the legal authority to isolate and/or quarantine individuals and groups
- ✓ The hospital's emergency response plan addresses how to ensure adequate stockpiles of appropriate PPE
- ✓ The hospital's emergency response plan includes assignment of a case manager to persons under isolation and quarantine
- ✓ The hospital's emergency response plan includes the coordination of release of educational information to the public after isolation or quarantine is ordered
- ✓ The hospital's emergency response plan includes a tracking system (database) that tracks an isolated or quarantined person's details (e.g., health monitoring, provision of care, adverse event from treatment or prophylaxis, etc.)

BHPP PERFORMANCE MEASURES AND SENTINEL INDICATORS

MLR 2-2-1. The hospital has the capacity to maintain at least one suspect highly infectious disease case in negative pressure isolation.

MLR 2-2-2. The hospital has participated in the identification and upgrading, as needed, or a regional healthcare facility to support the initial evaluation and treatment of at least 10 adult and pediatric patients at a time in negative pressure isolation within 3 hours post-event.

MLR 2-7. The hospital possesses sufficient numbers of fixed and/or portable decontamination facilities for managing adult and pediatric victims as well as health care personnel who have been exposed during a chemical, radiological, biological or explosive incident.

Sentinel Indicator: Isolation Capacity

- Capacity to maintain at least one suspected highly infectious disease case in negative pressure isolation.
- Capacity to maintain at least one suspected highly infectious disease case in negative pressure isolation, within 3 hours post-event.
- Capacity to maintain at least one suspected highly infectious disease case in negative pressure isolation, within 24-hours post-event.

Sentinel Indicator: Decontamination

- Number of ambulatory and non-ambulatory persons that can be decontaminated within a three-hour period.

AHRQ

The hospital's CBRNE/all hazards plan addresses decontamination and is updated annually.

The hospital's CBRNE/all hazards plan's decontamination component includes:

- Personnel roles, lines of authority, and communication
- Initiating and concluding an emergency decontamination operation
- Emergency alerting and response procedures
- Emergency recognition of contaminated patients
- Patient triage and tracking
- Procedures to provide individual privacy during the decontamination process
- Rapid removal, handling, tracking and/or disposition of contaminated clothing and personal items
- Rapid removal, handling, and disposition of patients' medical devices (e.g., contact lenses, glasses, braces, prosthetics, wheelchairs)
- Emergency medical treatment of contaminated individuals
- Procedures for decontaminating non-ambulatory patients
- Procedures for decontaminating ambulatory patients
- Procedures for decontaminating skin and hair
- Procedures for decontaminating eyes
- Procedures for decontaminating open wounds

- Procedures for removing contaminated fragments
- Procedure for bodily fluid sample collection as a marker of exposure
- Procedures for evidentiary chain of custody
- Safe disposal of contaminated waste
- Procedures for proper handling of contaminated human remains
- Decontamination runoff collection and disposal
- Procedures for decontaminating equipment (including re-usable patient equipment)
- Procedures for decontaminating the facility

The hospital has designated an individual to manage and maintain its decontamination capability. The individual assigned to manage and maintain its decontamination capability has the following responsibilities:

- Inspecting, inventorying, storing, and purchasing personal protective equipment (PPE) when needed.
- Upkeep and maintenance of the decontamination equipment.
- Maintenance of training records.
- Ongoing training.
- Recruitment of new team members.
- Maintenance of exposure records.

The hospital's CBRNE/all hazards plan's decontamination component is tested with drills and/or exercises.

The hospital has access to decontamination showers.

Emergency Department personnel (or the emergency decontamination team) have 24-hours-a-day/7-days-a-week access to appropriate radiation detectors (as defined by the hospital's hazard vulnerability assessment).

Training on procedures for the use of radiation detectors has been provided.

Emergency Department personnel (or the emergency decontamination team) have 24-hours-a-day/7-days-a-week access to appropriate personal dosimeters (as defined by the hospital's hazard vulnerability assessment)?

Training on procedures for the use of dosimeters has been provided.

Appropriate personal protective equipment (as defined by the hospital's hazard vulnerability assessment) is available and provided to personnel involved in the decontamination response.

Decontamination team staff have been trained in the proper usage of the personal protective equipment.

The hospital has a written respiratory protection program that is in compliance with OSHA standards.

The hospital has negative-pressure isolation room(s) within the facility.

The hospital provides training in accordance with Occupational Safety and Health Administration (OSHA) standards to personnel who may be part of the decontamination response.

LABS

BHPP PERFORMANCE MEASURES AND SENTINEL INDICATORS

MLR 4-1 The hospital has protocols for rapid referral of clinical samples and associated information to labs in the Laboratory Response Network (LRN).

MLR 4-1 Hospital lab personnel demonstrate competency in determining what situations warrant the initiation of these protocols as well as competency in following the protocols.

Sentinel Indicator: Hospital Labs

- Hospital lab personnel trained in the protocols for referral of clinical samples and associated information.

AHRQ

The hospital has a laboratory support plan for managing CBRNE events.

The hospital laboratory support plan is updated every two years.

The hospital laboratory support plan includes:

- Guidelines for presumptive identification of biological agents
- Chain of custody requirements
- Standard operating procedures for safe handling of suspected CDC category A agents
- Written procedures for safe transportation of specimens (including packaging and shipping)
- Use of OSHA approved bio-safety cabinets
- Safe disposal of contaminated waste
- Electronic reporting of laboratory results
- Protocol for working with laboratory response network (LRN) or other CDC-funded laboratory
- capacity
- Protocols for reporting to appropriate in-house professionals
- Protocols for contacting local and State public health departments in accordance with reporting requirements
- Protocols for contacting health physics labs
- Memorandums of understanding to expand lab capacity

The hospital laboratory support plan is tested in drills and/or exercises.

SURVEILLANCE SYSTEMS

BHPP PERFORMANCE MEASURES AND SENTINEL INDICATORS

MLR 4-2 The hospital reports data that is suggestive of terrorism to their local and state health departments on a 24-hour-a-day, 7-day-a-week basis through an established surveillance system that also includes emergency medical services systems and poison control centers.

AHRQ

The hospital has the capability to report syndromic data of a CBRNE event to the local, regional or State health department.

Reporting of syndromic data of a CBRNE event to the local, regional or State health department occurs 24 hours a day/ 7 days a week.

Goal VI. The hospital regularly tests and improves these capacities through drills and exercises.

DRILLS, EXERCISES, AND AFTER-ACTION

BHPP PERFORMANCE MEASURES AND SENTINEL INDICATORS

MLR 6. Conduct terrorism preparedness exercises/drills that:

- Contain elements addressing the needs of special populations;
- Emphasize a regional approach; and
- Are coordinated with other state, local and Federal drills and exercises to maximize resources.

Sentinel Indicator: Preparedness Exercises

Drills or exercises that focus on:

- Chemical
- Biologic
- Improvised Explosive Device
- Nuclear
- Other

2006 Program Measures

- The hospital conducts and/or participates in at least 2 exercises/ actual incidents per year, one of which is an operations-based exercise with the community
- The hospital participating in an exercise or responding to an actual event develops an after-action report within 60 days to identify weaknesses in their training, plan and/or response
- The hospital develops corrective actions/improvement plans and initiate execution of corrective actions
- Drills include hospital personnel, equipment, and/or facilities
- Table-top exercises include hospital personnel, equipment, and/or facilities
- Functional exercises include hospital personnel, equipment, and/or facilities

JCAHO

Standard EC.4.20. The organization regularly tests its emergency operation plan.

1. The organization tests its Emergency Operations Plan (EOP) twice a year, either in response to an actual emergency or in a planned exercise. (Tabletop sessions, though useful, are not acceptable substitutes for exercises.)
2. Organizations that offer emergency services or are community-designated receiving stations conduct at least one exercise a year that includes an influx of actual or simulated patients.
3. At least one exercise a year is escalated to evaluate how effectively the organization performs when it cannot be supported by the local community.

4. Organizations that have a defined role in the community-wide emergency management program participate in at least one community-wide exercise a year.
5. NA

Scope of Exercises

6. Planned exercise scenarios are realistic and related to the priority emergencies identified in the HVA.
7. NA
8. During planned exercises, an individual whose sole responsibility is to monitor performance (and who is knowledgeable in the goals and expectations of the exercise) documents opportunities for improvement.

During planned exercises, the organization monitors, at minimum, the following six critical areas:

9. communication, including the effectiveness of communication both within the organization as well as with response entities outside of the organization, such as local governmental leadership, police, fire, public health, and other health care organizations within the community
10. resource mobilization and allocation, including responders, equipment, supplies, personal protective equipment, and transportation
11. safety and security
12. staff roles and responsibilities
13. utility systems, and
14. patient clinical and support care activities
15. Exercises are critiqued to identify deficiencies and opportunities for improvement based upon monitoring activities and observations during the exercise.
16. Completed exercises are critiques through a multi-disciplinary process that includes administration, clinical, and support staff.
17. The organization modifies its emergency operations plan in response to critiques of exercises.
18. Planned exercises evaluate the effectiveness of improvements that were made in response to critiques of exercises
19. The strengths and weaknesses identified during exercises are communicated to the multidisciplinary improvement team responsible for monitoring environment of care issues.

AHRQ

Hospital staff members participate in hospital-wide and/or regional CBRNE event exercises/drills.

Participation in hospital-wide and/or regional CBRNE event exercises/drills takes place at least every two years.

The hospital's CBRNE/all hazards plan is revised as necessary as a result of drills and/or exercises.

NIMS IMPLEMENTATION ACTIVITIES – HOSPITALS & HEALTHCARE SYSTEMS

Element 12 – Training and Exercises

Hospitals and healthcare systems should include NIMS and ICS policies and practices into internal and external training and exercises. During trainings and exercises, plans should be reviewed to ensure hospital and healthcare systems staff competency and proper execution of roles and responsibilities during an event.

Element 13 – All-Hazard Exercise Program

Hospitals and healthcare systems should participate in an all-hazard exercise program based on NIMS that involves responders from multiple disciplines, multiple agencies and organizations.

Hospitals and healthcare systems should participate in local, regional, and/or state multi-discipline and multi-agency exercises twice per year to every 2 years (dependent on the type of drill or exercise to be held). Exercise activities should address internal and external communications, receiving, triage, treatment, and transfer of mass casualties, progression of casualties through the hospital system, resource management, security procedures, specialty lab testing, and/or site/facility safety. Exercises can be conducted through drills, tabletop, functional, and/or full-scale exercises.

It is strongly encouraged that personnel conducting drills or helping to plan exercises should have the experience and documented training to facilitate these events. Such exercise design and evaluation training is available from federal and state emergency management agencies. Additionally, a system to provide a critical evaluation process for use in every exercise, drill and actual event in which the hospital or healthcare system would participate is strongly encouraged. Such evaluations should provide both quantitative and qualitative data / information upon which to define a process for improvement in future drills, exercises or actual events. The ability to identify both strengths and areas for improvement is critical to effective drill and exercise management over time and helps to strengthen Element 14– Corrective Actions.

Element 14 – Corrective Actions

Hospitals and healthcare systems will incorporate corrective actions into preparedness and response plans and procedures.

After a hospital or healthcare system has participated in a drill or exercise, a corrective action report should be created. In the corrective action report, the following points should be addressed for each identified issue:

- The identified action to correct the issue or deficiency,
- The responsible person or group of people to implement the action,
- The due date for completion of the action, and
- The resulting corrective action should be incorporated into plans and procedures once completed.