



Healthcare

Emergency Planning: A Risk Management Guide for Healthcare Facilities and Providers

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While **catastrophic occurrences** cannot be entirely **prevented**, careful **planning** by healthcare facilities **and practices** can help **mitigate critical risk exposures and liabilities**.

The COVID-19 pandemic highlighted vulnerabilities of emergency response systems and underscored the need for healthcare entities to anticipate and prepare for long-term disruptions, including extended requirements to shelter in place, critical resource shortages and chronic supply chain inefficiencies, among other lasting effects. While catastrophic occurrences cannot be entirely prevented, careful planning by healthcare facilities and practices can help mitigate the following risk exposures, among others:

- **Negligence** for failing to maintain an up-to-date emergency response plan and/or prepare for emergencies through staff training and simulation exercises.
- **Professional liability**, when healthcare providers are physically and emotionally exhausted, leaving them vulnerable to clinical errors.

- **Unauthorized scope of practice**, when providers transcend legally prescribed practice parameters under the stress of delivering emergency care.
- **Breach of privacy and confidentiality** for failing to protect patients'/residents' privacy and confidentiality during emergencies, in contravention of HIPAA requirements, as well as state statutory and regulatory guidelines.
- **Inappropriate emergency use authorization**, when healthcare facilities and providers disregard important conditions related to these temporary issuances.
- **Discriminatory allocation of resources**, when healthcare settings lack a legitimate process for determining appropriate and reasonable use of limited resources.
- **Regulatory violations** for failing to comply with federal and state emergency preparedness mandates; accommodate patients/residents with disabilities, as prescribed by the Americans with Disabilities Act; or permit access to treatment pursuant to the Emergency Medical Treatment and Active Labor Act, among other sources of noncompliance.
- **Premises liability**, when patients/residents and staff are left to shelter in place despite structural indications for facility evacuation.
- **Gross negligence** for the willful disregard of emergency preparedness mandates and regulatory directives, resulting in reckless acts that endanger patients/residents and staff.

Takeaway: Mitigation of risks associated with disaster preparedness extends beyond a written plan and policy development, requiring a continuous process of review, testing and improvement.

Federal and state statutes provide a degree of immunity to facilities and providers during emergency conditions. However, failure to prepare for crisis situations can nullify those protections. At present, the Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Rule *requires* 17 types of healthcare providers, suppliers and facilities to have a written emergency management plan to guide their response to natural and man-made disasters. (For a quick review of the rule and recent updates, see “The CMS Emergency Preparedness Rule and Updates” below.)

Mitigation of risks associated with disaster preparedness extends beyond policy development, requiring a continuous process of review, testing and improvement. With that goal in mind, this resource serves as a tool to help healthcare organizations, facilities and providers develop a range of emergency management initiatives in response to regulatory expectations, industry guidelines and professional risk management recommendations. It is divided into four major sections, representing the four basic phases of the planning process: prevention, preparation, response and recovery.

Because no two facilities or practice settings are identical, the information included here should be adjusted to the type, size and complexity of a setting or practice. By tailoring risk initiatives to the nature and scope of operations, healthcare settings and providers are poised to respond to the next crisis with practical, realistic and efficient measures.

The CMS Emergency Preparedness Rule and Updates

The Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Rule applies to 17 providers, suppliers and facilities. The designated entities must demonstrate four basic components of emergency readiness: 1) an annual risk assessment utilizing an “all hazards” approach (which focuses on core capacities and capabilities that are critical to emergency and disaster response preparedness); 2) response-related policies and procedures; 3) a communications plan; and 4) a training program.

To fulfill its goal that preparedness plans reflect an “all-hazards” approach to emergency management, the CMS added “emerging infectious diseases (EIDs)” to its requirements and expanded its interpretive guidelines for preventing and managing EIDs in 2021. (To review current EID guidance and recommendations, click [here](#).) For other revisions made in the areas of testing and training, see [Staff Training](#) and [Testing an EPP](#).

Prevention

Goal: Creation of a dedicated leadership team, identification of avoidable risks and drafting of a wide-ranging interdisciplinary emergency preparedness plan.

Establishing a Crisis Management Task Force

Begin the process of identifying disaster-related risks by assembling an interdisciplinary crisis planning and recovery team, representing such areas as administration, human resources, public relations, marketing and communication, information management, medical staff, nursing, ancillary departments, security, risk management, finance and legal. The team should be tasked with identifying and anticipating a full spectrum of emergencies and disasters, developing and implementing the emergency preparedness plan (EPP), and evaluating the effectiveness of the emergency response plan on an annual basis.

The crisis management task force should:

- Identify major risks** utilizing a [hazard vulnerability assessment \(HVA\) tool](#) and develop strategies to minimize hazards, protect lives, calm fears, minimize losses and expedite recovery.
- Create crisis management and communication policies and procedures** that maximize access to senior leadership and reinforce the chain of command.
- Conduct simulations of crisis situations**, including table-top exercises, organization-wide drills, and internal and external testing of disaster-related communication methods.
- Develop an emergency database of contacts and resources**, such as facility leadership, key supply and service vendors, media outlets, government offices, nonprofit agencies, crisis management consultants and neighboring healthcare facilities.
- Compile a list of all available methods of communication**, including the organizational website, patient portals, social media sites, and emergency e-mail and text messaging capabilities.

Identifying Risk Exposures

Healthcare facilities and providers must be prepared for all types of foreseeable occurrences, including man-made (e.g., violent crime, community hazards, sabotage, arson, riots, terrorism, contamination, power outage, supply shortages), weather-related (e.g., hurricanes, tornadoes, wildfires, floods, blizzards) and disease-related (e.g., infectious outbreaks, epidemics, pandemics). Effective emergency planning also requires a clear understanding of community-based hazards that can affect healthcare providers. If applicable, note the location of nuclear power plants within a 50-mile radius and also identify nearby rail lines, major highways and pipelines that may potentially be the site of hazardous material spills or other disasters.

The following tools and methods may be useful in identifying risk exposures:

- Flowcharts** graphically depict the steps within a clinical or administrative system or process. They may identify gaps and weaknesses in critical response measures, reveal interdependencies between departments and areas, and suggest techniques to minimize inefficiencies. For example, a flowchart can detect overlap between internal emergency response measures and external responders. (For sample emergency procedure flowcharts, click [here](#).)
- Employee interviews** help reveal routines and equipment that are most vulnerable to disruption. They can also elicit suggestions for updating and improving contingency plans.
- Self-assessment tools** track the healthcare setting's overall state of disaster readiness and identify where improvement may be required. (For planning resources, click [here](#) for hospitals and healthcare systems, [here](#) for aging services settings and [here](#) for medical practices.)
- Consultation with external entities** – including police and fire departments, state and federal emergency management agencies, disaster relief organizations, private consultants and other experts – in order to become cognizant of relevant hazards, as well as local and regional emergency response capabilities.

Quantifying Risks

After identifying potential sources of loss, the next step is to quantify the hazards posed by specific events. Using a risk matrix, such as the one displayed in Table 1 from the widely recognized [Kaiser Permanente HVA tool](#), the crisis management task force can prioritize loss exposure by plotting the probability (or frequency) of an occurrence against its potential impact (or severity).

After categorizing, quantifying and prioritizing loss exposures, the crisis management team can identify appropriate response measures, secure resources and project costs.

When measuring the likelihood and impact of adverse occurrences, remember to ...

- Access tools that help define the perceived threat level of potential scenarios**, such as those available through the [Technical Resources, Assistance Center, and Information Exchange \(TRACIE\)](#) of the U.S. Department of Health & Human Services (click on “Plans, Tools, and Templates” under “Sections Navigation”), as well as the [California Association of Health Facilities](#).
- Tailor responses to the level of severity**, for example:
 - High:** Detailed research and senior management action are urgently required.
 - Moderate:** Specific risk control processes should be developed and implemented within a reasonable time frame.
 - Low:** Event can probably be managed using routine procedures.

Drafting a Comprehensive Response Plan

An EPP should encompass HVA, coordination of emergency response measures, mandatory staff training, and testing of vital operational and backup systems. When designing the response plan, request input and active involvement of local authorities and first responders, as partnerships formed during the planning and drafting phases can become useful during an actual emergency.

At a minimum, the EPP should ...

- Incorporate risk assessment findings and recommendations** compiled by the crisis management task force.
- Cover every phase of the planning process**, i.e., risk identification and mitigation, and event response and recovery.
- Address essential needs and tasks**, such as:
 - Plan implementation
 - Emergency notification
 - Incident command
 - Media relations
 - Crisis staffing
 - Phone contact procedures
 - Resource procurement
 - Healthcare information record maintenance
 - Care site establishment
 - Bed utilization
 - Surge capacity/diversion
 - Shelter availability
 - Evacuation and patient/resident tracking
 - Transfer arrangements
 - Child care for staff
 - Mortuary services
 - Debriefing
- Be comprehensive and precise**, describing strategies, actions and responsibilities for each of the articulated goals.
- Undergo regular review** and updating according to the CMS Emergency Preparedness Rule.



Table 1. Hazard and Vulnerability Assessment Tool – Naturally Occurring Events

Event	Probability	Severity = (Magnitude – Mitigation)			Prepared-ness	Internal Response	External Response	Risk
		Human Impact	Property Impact	Business Impact				
	Likelihood this will occur	Possibility of death or injury	Physical losses and damages	Interruption of services	Preplanning	Time, effectiveness, resources	Community/ Mutual Aid staff and supplies	Relative threat (increases with percentage)
Score	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%

Risk = Probability x Severity

Preparation

Goal: Promotion of a state of readiness through mandatory staff training, testing of vital operational and backup systems, safeguarding clinical data, media strategies and guidelines for managing surge conditions.

Staff Training

Training should be mandatory for all staff and providers, temporary/contracted employees and volunteers upon hire, and as required by CMS and other regulatory bodies. Training sessions should include a review of emergency-related policies and procedures, supplemented by regular disaster drills and subsequent evaluation of areas for improvement. Document all training events, drills and other exercises, including dates and names of attendees.

At the conclusion of emergency preparedness training, participants should understand the following:

- Types of emergency situations** most likely to be encountered by the facility or practice.
- Location of the EPP** and its basic provisions.
- Protocol for reporting an emergency** and activating the response plan.
- Evacuation techniques** or shelter-in-place protocols.
- Individual roles during emergencies** and associated tasks and duties, including delivery of first aid.

(See [CMS Emergency Preparedness Training Online Course](#) and [Quick Links on page 15](#) for training resources.)

Testing the EPP

Notwithstanding the CMS guidelines, many healthcare organizations, facilities and providers subject to the emergency preparedness rule lack a formal emergency plan testing process. Once the EPP is instituted, the first level of testing involves “tabletop” exercises, in which team members review the plan’s effectiveness by analyzing various disaster scenarios. The second level consists of “walk-through” drills, in which responders perform their functions using the methods and communication tools indicated in the plan.

To comply with the testing component of the federal Emergency Preparedness Rule, CMS-designated providers and facilities must ...

- Participate in two qualifying events per year:** a full-scale, community-based exercise, and a tabletop exercise or second full-scale drill. (Note: [CMS regulations](#) have decreased the annual testing requirement for outpatient providers/suppliers from two events to one, and increased testing flexibility for inpatient providers/suppliers, who can now choose between two annual evaluative exercises.)
- Conduct events at different times of the day and night,** as well as weekends and nights, to ensure participation of all personnel.
- Include local first responders and law enforcement agencies in drills and exercises,** in order to decrease the anxiety and disorientation of patients/residents in the event of an actual disaster.
- Preserve documentation pertaining to drill activities,** as well as simulation exercises.
- Include a process within the EPP for reviewing and analyzing exercise results,** in order to make improvements.

Takeaway: A state of perpetual readiness requires staff training, testing of vital operational and backup systems, measures to safeguard clinical data, media strategies and guidelines for managing surge conditions.

Avoiding Long-term Utility Outages

The EPP should include detailed instructions for managing outages involving critical systems, such as electricity, IT, natural gas, water, sewage and ventilation/heating/air conditioning. The [National Fire Prevention Association \(NFPA\) Standard 110](#) outlines performance requirements for emergency and standby power systems in healthcare settings, including weekly and monthly inspections of emergency generator systems. When power interruptions occur, patient/resident lives may depend upon the ability to switch to backup systems within a matter of seconds. Inspections should therefore include testing of response time.

In addition to the NFPA directives, facilities should complete the following tasks, among others that may be adapted to the environment of care:

- Analyze critical power requirements** in relation to available backup generator capabilities, building redundancy into emergency power systems, as needed.
- Ensure that the facility's backup generator is reliable**, documenting all maintenance and testing, as required.
- Determine the generator's fuel requirement** and store an ample supply.
- Identify at least two sources of electricity from different substations**, and arrange with local utility companies for the use of special generators and transformers in case of emergency.
- Label generators, automatic transfer switches and circuit breakers**, and maintain a map of the emergency distribution system.
- Provide training to emergency power system operators** and test their proficiency in mock emergency drills.
- Require generator operators to communicate on a routine basis** with management and clinical leaders.
- Maintain an up-to-date list of local sources of heavy equipment**, including boilers, heaters, compressors and pumps.

Assessing the Supply Chain

During times of crisis, supply chain operations can be adversely affected by inefficient distribution networks, inadequate inventory space, outdated manual processes and data systems that cannot track real-time supply levels, among other deficiencies. As part of the emergency management planning process, measures should be taken to help prevent or mitigate shortages and supply chain breakdowns that may adversely impact patient/resident care and safety.

The following materials management strategies can help enhance supply chain readiness:

- Appoint a supply chain risk team** to review product acquisition-related processes and vulnerabilities.
- Draft a supply chain crisis management plan** and contingency plans for secondary and tertiary sources of supplies.
- Estimate short term supply usage and longer term utilization patterns and trends** in order to avoid product bottlenecks and other disruptions.
- Install inventory tracking technology** to better monitor supply utilization and forecast future needs.
- Track product movement utilizing hands-free methods**, such as barcode or radio frequency identification technology.
- Secure additional storage space for high use products** and maintain adequate backup inventory.
- Ensure that warehouse space is efficiently laid out and secure**, with safeguards against theft.
- Protect essential and theft-prone items**, posting security guards at points of ingress and egress to safeguard medical equipment and supplies, food, water and personal protective equipment.
- Research suppliers for financial stability and reliability** and request contractual protections against counterfeit or poor-quality products.

(For a self-assessment questionnaire designed to help healthcare settings evaluate their readiness to respond to supply chain emergencies, see [CNA AlertBulletin® 2021-Issue 1, "Supply Chain Management: Avoid Disruption by Enhancing Readiness."](#))

Safeguarding Critical Data

Modern healthcare facilities and practices are technologically dependent. By implementing effective measures to protect clinical, personnel and financial records, facilities can recover more quickly from cyber security attacks, blackouts, natural disasters and other emergencies that could potentially disable critical information technology (IT) systems.

Reduce the risk of losing vital data by taking these recommended steps:

- Store paper records in fire-resistant and waterproof file drawers**, remembering that documents kept in rooms with sprinklers are highly susceptible to water damage.
- Retain copies of essential documents in a secure and HIPAA-compliant off-site location.** These documents include the disaster response plan, essential emergency contact telephone numbers, contact information for patients/residents and employees, IT system records, insurance policies, leases and business contracts, and a list of assets.
- Physically separate telecommunication network devices** to reduce the likelihood of a single-point failure.
- Install and regularly update protective devices and software**, including anti-virus programs, electronic firewalls and surge protectors.
- Back up data on a routine basis** – including accounting and payroll records, employee information, patient lists, procedures, suppliers and inventory – and store backup files off-site in a secured location.
- Identify third-party IT service providers** outside of the potentially affected area and arrange for emergency backup services on a contingency basis.

Developing a Media Strategy

During a natural disaster, pandemic or other emergency, public perception of an organization may depend upon the ability of leaders to skillfully manage media encounters, and remain ahead of damaging news and social media accounts.

In order to ensure clear, accurate and timely external communications, the organization's media strategy should include ...

- Designating a primary media contact** and an emergency backup, both of whom are authorized by the facility leadership and/or governing body to speak on behalf of the organization.
- Compiling a comprehensive list of local broadcast, print and online media outlets**, including full contact information.
- Utilizing the organization's website and social media tools to promptly disseminate information** and respond to media inquiries via media releases, digital messaging and online postings.
- Providing a location where media representatives can assemble** and receive official press statements.
- Anticipating media questions** and formulating brief, factual and to-the-point responses.
- Pre-drafting statements**, incorporating relevant language from the EPP and reinforcing the organization's commitment to patient/resident safety.
- Reviewing all media releases** for accuracy, completeness and compliance with confidentiality safeguards.
- Coordinating statements with first responders** and designating one individual with final approval of all official statements and news releases.
- Addressing false or misleading reports** by promptly posting statements and links with accurate information.

Anticipating Surge Conditions

Healthcare facilities and providers may be expected to take in large numbers of patients/residents during a disaster or pandemic, potentially exceeding safe care capabilities. In order to enhance readiness for surge conditions, organizations and providers should evaluate their capabilities to care for an increasing patient/resident load, as well as response measures in such areas as access to agency staff, laboratory and diagnostic services, equipment and medical supplies, and space for quarantine and isolation of patients.

These additional measures can help maintain safe, livable conditions within healthcare facilities and ensure continuity of care in outpatient settings during a surge situation:

- Consult in advance with local officials and facilities** to plan a community-wide response and ensure continuity of care during surge conditions.
- Establish mutual relationships with local facilities** to expedite transfer of patients/residents in the event of an emergency.
- Calculate the number and types of employees needed to safely care for patients/residents during a surge**, including physicians, advanced practice providers, registered nurses, licensed practical nurses, nurse aides and support staff.
- Develop alternate outpatient or home care treatment capabilities** for patients receiving life-sustaining outpatient therapies.
- Make prior arrangements to add ancillary personnel on a temporary basis** during surge periods, including food service, housekeeping, security and maintenance staff.
- Identify on-site sleeping arrangements** for staff and consider other basic employee needs.
- Verify the number and type of beds available** in the healthcare setting.
- Retain the daily patient/resident census in hard-copy format** for documentation, notification and payment purposes, in the event that computer data are lost.
- Establish a triage area** and document the arrival of patients/residents using a standard intake form.
- Designate an area for family members of patients/residents to gather** and receive regular updates.
- Offer privacy dividers and call devices to patients/residents in makeshift surge areas**, and provide storage options for their belongings and personal needs equipment.
- Review placement of temporary patients/residents**, ensuring that bed locations do not block escape routes or otherwise compromise safety.

Response

Goal: Designation of a command center, establishment of communication procedures, security maintenance, and development of evacuation and patient/resident tracking protocols, as well as drafting of measures to safeguard clinical records.

Creating a Command Center

Effective emergency response requires a clear chain of command that extends from senior leadership to every level of each facility, practice, unit or service. By creating an incident command center, as well as a designated backup location, healthcare facilities and office practices can ensure that necessary tasks – such as information gathering, staff coordination and debriefing – are achieved in a prompt and efficient manner.

The following strategies help strengthen the incident command structure:

- Staff the incident command center with personnel from various departments** to oversee essential functions, such as coordinating on-scene operations, mobilizing employees and volunteers, and serving as liaisons to local and regional authorities. For a diagram of the incident command structure issued by the Federal Emergency Management Agency, click [here](#) and scroll down to page 25.
- Designate an incident commander** with overall responsibility for declaring the emergency, mobilizing the response, and keeping senior management and others informed. Outpatient settings and physician offices may require managers to assume multiple roles based upon the structure and number of staff.
- Draft emergency procedures** for recalling off-duty personnel and communicating with offsite parties, including patient/resident families, suppliers, community members and the media.
- Post a list of emergency contact names and telephone numbers** – including leadership, fire and police departments, ambulance services, utility companies, contractors, insurance companies, the local Environmental Protection Agency office and other government authorities – in a strategic location.
- Assign responsibility for contacting government agencies**, as well as neighboring healthcare facilities, emergency response organizations and other outside entities.
- Compile an up-to-date list of consultants, vendors and suppliers**, including, but not limited to, telecommunications companies, storage warehouses, construction contractors, document restoration services, and medical equipment/supply and pharmaceutical distributors, among others.

Enhancing Emergency Communication Procedures

Whether an emergency requires evacuating a setting, initiating a lockdown, diverting patients/residents or establishing a controlled external perimeter, promptness, clarity and accuracy of communication is critical to maximizing safety and minimizing loss. Consider that the stress of an emergency may affect the robustness of telephonic and online systems, as well as internal alert mechanisms, necessitating planned redundancy.

These following actions, among others, can help enhance emergency communications:

- Identify a primary and alternate means of conveying information** to key internal and external audiences, such as cellular telephone “trees,” electronic mail “blasts,” text messaging, online portals, satellite telephones and two-way radios.
- Maintain electronic and hard copy contact information** for key stakeholders, including fire and police departments, ambulance services, utility companies, contractors, insurance companies and relevant government agencies.
- Explain emergency care provisions to patients/residents** – including evacuation and sheltering-in-place procedures, as well as ways to contact the facility during an emergency – utilizing brochures, fact sheets, videos and/or a dedicated website.
- Determine the audiences – e.g., providers, patients/residents, staff, community members and/or others – who are most affected by the situation,** and ensure that core messages respond to their questions and concerns.
- Be cognizant of privacy rules and requirements when releasing patient/resident information** and comply with HIPAA, as well as applicable state laws and regulations. (For information about disaster-related PHI disclosure rules and limitations, see [Disclosures for Emergency Preparedness – A Decision Tool: Overview](#), the “At a Glance” disclosure process flowchart from CMS, and “HIPAA and Disasters: What Emergency Professionals Need to Know” from TRACIE.)
- Use clear, jargon-free language** when making emergency announcements – e.g., “fire, second floor, evacuate building” – rather than obscure and sometimes confusing codes, such as “Red Alert.”

- Establish an emergency hotline** to relay urgent instructions and safety messages to employees, and also to summon appropriate on-call personnel if the incident occurs after business hours.
- Train command center leaders to respond to calls** from family members and community leaders about an unfolding event. Draft a script, if necessary.

(For training materials, tools and resources, see [Crisis & Emergency Risk Communication](#) on the website of the Centers for Disease Control and Prevention.)

Maintaining Security

In the event of a disaster, it may be necessary to lock down the facility or provider offices. Written security procedures should address such concerns as tracking patients/residents and employees, preventing looting, preserving basic order and coordinating with law enforcement.

The following safety and security measures, among others, are integral to an effective response plan:

- Appoint a safety officer** to the crisis management task force.
- Delegate search and rescue operations to trained professionals** in the event of structural collapse or damage.
- Train security staff, if available, on crowd control skills,** as well as shelter-in-place and evacuation procedures where appropriate.
- Consult with police and government agencies** when creating security policies.
- Implement measures to minimize property loss and damage,** possibly by contracting with a private security firm.
- Develop protocols to safeguard the personal health information and valuables of patients and residents** in the aftermath of a disaster, as well as the facility’s cash, medications, supplies and equipment.

Preparing to Shelter in Place

Certain emergencies – such as a contained hazardous materials release, armed intruder situation or inclement weather – may require patients/residents and staff to shelter-in-place. In such an event, failure to anticipate and provide for the full range of needs of sheltered patients/residents can compromise their health and safety and lead to costly, reputation-damaging lawsuits.

The following measures can help mitigate some of the risks associated with sheltering in place:

- Identify areas of higher and lower risk within the premises** and move patients/residents to safer zones, such as higher floors within a building threatened by rising floodwaters or the basement during a tornado alert.
- Reduce hazards in designated safe areas** by moving patients/residents away from windows and exterior doors during extreme wind conditions, as well as locking windows, closing gates and storm shutters.
- Arrange for additional security personnel**, which may include bolstering internal capabilities, as well as requesting support from the state government and/or local and county law enforcement agencies.
- Devise a checklist to guide emergency decision-making**, including criteria for determining whether it is safe to shelter in place. (For a sample checklist issued by the Los Angeles County Emergency Medical Services Agency, click [here](#) and see “Download Part 1.”)
- Stockpile water, durable food and medications for potential emergencies**, as well as basic supplies, including portable radios, first aid kits, eating utensils, mattresses, extra blankets, towels, flashlights, batteries, duct tape, plastic sheeting, toilet paper and garbage bags.
- Anticipate waste management issues and needs**, including disposal of sewage, recyclables, run-off water, and chemical and biomedical waste.
- Periodically reassess the safety of sheltering-in-place arrangements** and be prepared to order an evacuation if it becomes the safer option.

Evacuating a Setting

The decision to evacuate requires consideration of several factors, including the urgency of the threat, the type of damage sustained and especially the capability of staff and providers to meet the medical needs of patients/residents. Immediate threats to life, such as a fire or explosion, will require emergent evacuation, while other situations may permit a planned and phased evacuation. When selecting an evacuation site, leaders must consider both the short- and long-term needs of patients/residents, and also address special care requirements.

During an evacuation, the following measures can help minimize stress and confusion, enhancing quality and continuity of care:

- Enter into written transfer agreements with at least two other facilities** that can provide an equivalent level of care to evacuated patients/residents. One of the transfer facilities should be located at least 50 miles away, in the event of a disaster.
- Prepare detailed diagrams of the facility and surrounding area**, showing all critical access and evacuation routes.
- Assign an acuity level to patients/residents before selecting a relocation destination**, and evacuate to a licensed facility capable of meeting their acuity needs.
- Create patient/resident packing lists and care need descriptions** during the planning phase, considering their condition and mobility level.
- If circumstances permit, ask family members to care for evacuated patients/residents at home** until the facility reopens post-emergency.
- Plan ahead for appropriate transportation**, and select the safest mode based upon the acuity needs of patients/residents.
- Draft an emergency transfer protocol**, emphasizing the need for staff to properly monitor patients/residents en route, irrespective of the mode of transportation.
- Assign responsibility in advance for verifying transporters**, as well as monitoring patients/residents while in transit and identifying the individual who will receive them at the accepting facility.
- Prior to transport, print out the patient/resident baseline history** and medication administration record, and include these documents with patients/residents.
- Evacuate the highest-priority patients/residents first**, one wing or floor at a time.

- Inform vendors and suppliers of the planned relocation site(s)**, and establish back-up sources for food, medical supplies, medication and equipment in the event that a primary vendor is unable to deliver to the alternative site.
- Provide evacuated patients/residents with sufficient quantities of medications and supplies**, contemplating that time spent in the transfer facility may exceed estimates.
- Swiftly inform family members of the decision to evacuate the facility**, and provide them with the address and telephone number of the transfer setting.
- Check all examination rooms** in ambulatory and acute care settings to ensure that no patients are left behind.
- Implement a voicemail system during the period of evacuation**, in order to convey ongoing evacuation details to families of patients/residents, relay information to staff, and provide daily updates on the status of evacuation.
- Identify the individual responsible for authorizing re-entry to a setting** and reassess patients/residents upon arrival.

For additional resources on evacuation planning, see [Topic Collection: Healthcare Facility Evacuation/Sheltering](#) and [Shelter Medical Group Report: Evacuation, Care, and Sheltering of the Medically Fragile](#).

Takeaway: An effective response to emergencies entails designating a command center, establishing communication procedures, maintaining security, and developing patient/resident evacuation and tracking protocols, as well as drafting measures to safeguard clinical records.

Tracking Evacuated Patients/Residents

In a large scale disaster, patients/residents may be evacuated to multiple, widely dispersed sites. It is essential to know where patients/residents and employees are located both during the crisis and afterward.

To enhance the accuracy and efficiency of evacuation tracking, the healthcare facility should implement the following measures, among others:

- Adopt written tracking procedures** to account for evacuated patients/residents.
- Create a patient/resident evacuation tracking form** to capture a wide range of evacuation-related information, including patient/resident ID band numbers, destination, mode of transport, time of evacuation and arrival at receiving facility or their home, as well as to document healthcare information records, orders, equipment and medications accompanying the patient/resident. (For sample forms click [here](#) and [here](#).)
- Request the names of staff members from outside facilities/agencies authorized to transport patients/residents**, and confirm their identity upon arrival by cross-checking name badges with government-issued photo IDs.
- Address the logistics of transporting and tracking healthcare information records**, medications and supplies that accompany evacuated patients/residents.
- Comprehensively document the handoff process**, including the patient/resident condition and the name of the person assuming care in the healthcare information record.

(For additional strategies, see [Patient Movement and Tracking](#) on the TRACIE website.)

Maintaining Access to Patient/Resident Healthcare Information Records

Sound patient/resident care during a crisis requires ready access to complete healthcare information records. When a disaster impedes access to electronic healthcare records (EHRs), or connectivity is interrupted due to software flaws, malware attacks, power outages or hardware failures, documentation and continuity of patient/resident care will be adversely affected.

The following readiness and response strategies can help protect patients/residents and mitigate potential losses during an EHR outage:

- Position servers in a controlled-access room**, which should be equipped with smoke and heat detectors.
- Install and regularly update protective devices and software for computers**, including anti-virus software, electronic firewalls and surge protectors.
- Consistently back up data** – including patient/resident lists, financial and payroll records, employee files, policies and procedures, supplier accounts and inventory – on a daily, hourly or continuous basis.
- Retain offsite a copy of the computer's operating system**, boot files and essential software, as well as computer-related invoices, shipping lists and other documents that can facilitate system repair or replacement.
- Identify electronic data processing firms and sources of new and rental computer equipment** outside of the potentially affected area, and arrange for services on a contingency basis.
- Develop a downtime policy reflecting how care will be documented on paper** in order to ensure consistent notation of condition and treatment, and maintain a hard copy record of basic patient/resident data. (For additional recommendations, see CNA *AlertBulletin*® 2021-Issue 4 "[EHR System Outages: Minimizing the Impact of Downtime.](#)"

Recovery

Goal: Planning for business continuity, as well as performing post-event debriefing and assessing the EPP in terms of both concept and execution.

Business Continuity Planning

Despite the best precautions, there is always a possibility that patient/resident care and business functions will be brought to a halt by the disaster. By formulating a detailed, up-to-date recovery and continuity plan, facilities and providers are poised to restart operations as quickly as possible. The plan should include recovery goals, communication priorities and relocation arrangements, if necessary.

The following guidelines can help enhance clinical and operational continuity even in the most adverse circumstances:

- Store copies of critical documents and materials offsite**, such as a listing of financial resources and insurance policies, building blueprints and related plans, inventory of equipment and other assets, and reconstruction plans, including a current list of contractors, movers, equipment vendors and staffing agencies who can facilitate rebuilding and reopening.
- Establish an alternative mailing address** in the event that the building is seriously damaged or destroyed, and reroute mail and telephone calls as needed.
- Draft guidelines for safeguarding vital clinical and business data** against potential disruption of the information processing system.
- Promptly inform the insurance company of the facility or provider** of the disaster.
- Conduct salvage operations** and maintain a scrupulous accounting record of all damage-related costs.

See CNA, *Risk Control Bulletin*, "[Business Continuity Planning](#)," 2019.

Debriefing After a Crisis Event

Post-crisis debriefings are necessary to assess the effectiveness of response and recovery measures. Feedback should be used to modify and improve future educational programs and simulations for staff and administrators. By continuously refining the plan and educating staff members about their roles and responsibilities, it is possible to significantly diminish the chaos and confusion that often accompany an emergency situation.

At a minimum, the crisis management task force should ask the following questions during a debriefing:

- Was the EPP followed**, and were protocols properly implemented?
- Were emergency communication efforts timely, clear and efficient**, using all available media?
- How was the organization portrayed** in the various media?
- What was the community response to the event** and to organizational readiness and execution?
- What lessons can be learned** from the experience, and what changes should be made?

(For a generic event evaluation form presented by the U.S. Department of Homeland Security Exercise and Evaluation Program, click [here](#).)

Takeaway: Swift and efficient recovery depends upon a detailed, up-to-date business continuity plan, as well as provisions to evaluate response measures and update the emergency preparedness plan, as needed.

Evaluating an EPP

The emergency response plan should be evaluated biennially (except for aging services facilities that must conduct an annual review) and after each crisis event, in order to evaluate its effectiveness and update the plan to reflect organizational changes, emerging exposures and lessons learned.

The following measures can help enhance the annual review process:

- Maintain a risk management diary during the crisis**, documenting events as they occur, including decisions made, internal and external messages sent, and extent of damage and disruption observed, with photographic support, if possible.
- Retain itemized invoices and receipts**, as well as time sheets and other staff records for review.
- Test the response phase of the plan** in a mock drill or through a tabletop exercise.
- Review the following documents and databases**, at a minimum, and update, as needed:
 - Names and contact information of employees and volunteers, as well as patients'/residents' responsible parties.
 - Lists of first responders, vital service providers, law enforcement and fire departments, regional emergency management agencies, utilities and transit agencies.
 - Agreements for mutual aid and/or reciprocal host facility arrangements, as well as vendor service contracts.
 - Detailed maps of preferred and alternative evacuation routes, including the names of receiving facilities and directions for transporters.

Emergency preparedness planning should be a core component of every healthcare setting's risk management program. Only by anticipating disaster and crafting an effective response can leadership and providers maintain some degree of control during an emergency; minimize injury, damage and disruption; and expedite recovery. While facilities vary widely with respect to risk profile and patient/resident population, the prevention-preparation-response-recovery format presented in this publication can serve as an emergency planning template that may be adapted to healthcare settings of every description depending upon specific needs of an organization.

Six Guidelines to Enhance Pandemic Readiness

The following strategies can help healthcare organizations protect patients/residents and staff in the event of a community-wide infectious outbreak:

1. Disease surveillance. Develop clinical procedures for the initial screening and assessment of patients/residents with suspected symptoms of infection and communicate them to frontline health workers. In addition, distribute to staff members and clinical department leaders the protocol for reporting suspected and confirmed cases of the disease to facility leadership, as well as to local, state and national public health officials.

2. Infection prevention. Contain the spread of known cases through adherence to these measures:

- **Standard precautions**, particularly hand hygiene and secretions contamination.
- **Contact precautions**, i.e., double gloving, impermeable gown use, and wearing of shoe and leg coverings when in contact with copious bodily secretions.
- **Personal protective equipment**, such as donning of gloves, gown, eye protection and facemask when entering patient rooms.
- **Patient isolation** if infection is suspected.
- **Use of a fit-tested respirator** when conducting aerosol-generating procedures.
- **Disinfection of clinical equipment** according to manufacturers' instructions and facility policies.
- **Management of hazardous waste** in accordance with organizational protocols.
- **Treatment of contaminated materials and surfaces** with hospital-grade quaternary ammonium or phenolic products.

Also, consider hosting a [vaccination/booster clinic](#) as part of the facility's infection control activities. See CNA Special Resource, February 2021, "[COVID-19 Vaccination Program Planning](#)" for additional information.

3. Rapid diagnosis. Screen all symptomatic patients/residents in order to identify and contain the spread of infection. Distribute guidelines concerning laboratory diagnostics and specimen handling to all laboratory personnel, and consider additional space and staff for expanded testing.

4. Infection control. Quarantine patients/residents in a single treatment area, unit or floor. The following simple interventions can enhance containment efforts during triage and assessment:

- **Establish a separate entry and/or waiting room** for patients/residents arriving with suspicious symptoms.

- **Erect a temporary structure near the facility entrance** to treat arriving symptomatic patients.
- **Screen all patients/residents upon admission** according to a standardized protocol.
- **Admit all infected patients/residents to a designated floor** for monitoring and care.
- **Move potentially infected patients/residents into isolation units** until diagnostic tests are negative for the virus.

To further curtail the spread of an outbreak, provide patients/residents and visitors with educational materials on preventive measures that are prepared in their commonly spoken language and tailored to their reading and medical literacy level.

5. High-demand supplies. Conduct a baseline inventory of food, water, medications, medical supplies and equipment, portable oxygen and other essentials, in order to identify quantities and expiration dates. Consider building up a stockpile of critical medical resources and investigate potential substitutes for key medicines, equipment and other supplies in the event of rationing. Lastly, explain to staff the process of obtaining medical approval for emergency or off-label use of alternative products.

6. PPE forecasting. Determine the PPE needs in the event of a pathogen outbreak or pandemic scenario. (For a sample projected needs evaluation sheet, see [Hospital Personal Protective Equipment Planning Tool](#), issued by TRACIE, scrolling down to pages 7 through 14.) The assembled team should include the following steps in their planning process:

- **Identify local and regional sources of PPE**, and join a network of organizations in order to share supplies in emergency situations.
- **Maintain expanded stockpiles of PPE** and triage supplies according to the manufacturer's "use-by" dates.
- **Monitor the availability of federal PPE stockpiles** and know how to mobilize these resources.
- **Store all PPE according to the manufacturer's recommendations**, and consult with makers and distributors regarding the advisability of using recently expired supplies.
- **Consider the possibility of supply contamination**, as well as damage and early discarding by providers.
- **Document compliance with the manufacturer and CDC guidance on reuse of supplies**, especially in regard to N95 facial respirators.

Quick Links

CNA Publications

- CNA *AlertBulletin*® Republished 2020, "[Active Shooter Response: Precautionary Measures Can Save Lives.](#)"
- CNA *AlertBulletin*® Republished 2017, "[Crisis Management: Responding Effectively to Media Inquiries.](#)"
- CNA *AlertBulletin*® 2022-Issue 4, "[EHR System Outages: Minimizing the Impact of Downtime.](#)"
- CNA *AlertBulletin*® 2021-Issue 1, "[Supply Chain Management: Avoid Disruption by Enhancing Readiness.](#)"
- CNA *CareFully Speaking*® 2019-Issue 2, "[Emergency Preparedness: Crafting a Sound Disaster Response Plan.](#)"
- CNA *Risk Control Bulletin*, "[Business Continuity Planning.](#)" 2019.
- CNA *Healthcare Risk Control Bulletin*, "[COVID-19: Achieving Recovery Through Risk Management.](#)" January 2021.

Resource Organizations

Centers for Disease Control and Prevention:

- [Clinical Resources.](#)
- "[Clinician Outreach and Communication Activity \(COCA\).](#)"
- "[Disaster Preparedness and Response Training.](#)"
- "[Healthcare Preparedness and Response.](#)"
- [Planning Resources by Setting.](#)
- [Public Health Preparedness Resources.](#)

Centers for Medicare & Medicaid Services:

- [Emergency Preparedness and Response Information and Resources.](#)
- [Health Care Provider Guidance.](#)
- [Resources.](#)

Federal Emergency Management Agency:

- "[Developing and Maintaining Emergency Operations Plans.](#)" Version 2, November 2010.
- [National Preparedness System.](#)
- [National Risk and Capability Assessment.](#)

National Fire Protection Association:

- "[Emergency Evacuation Planning Guide for People with Disabilities.](#)"

Occupational Safety and Health Administration:

- "[Emergency Preparedness and Response.](#)"

U.S. Department of Health & Human Services:

- [Response and Recovery Resources Compendium.](#)
- [Technical Resources, Assistance Center, and Information Exchange \(TRACIE\).](#)

For more information, please call us at 866-262-0540 or visit www.cna.com/healthcare.