The Joint Commission

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EC News

ENVIRONMENT OF CARE® | EMERGENCY MANAGEMENT | LIFE SAFETY

Out with the Old, In with the New

TOP ISSUES AND CHANGES ACCREDITED ORGANIZATIONS SHOULD KNOW FOR 2018

As the calendar turns from December to January, people make New Year's resolutions and set improvement goals for the months ahead. Some stick, some don't. If a health care organization were to make a resolution for the coming year, ensuring compliance with new and revised Joint Commission standards and policies would be a good choice. Many changes became effective on January 1, 2018, and some will be effective shortly afterward. (*See* the sidebar on page 5.)

To properly prepare for these changes, health care organizations should review major recent developments that will affect them in the times ahead. These

include significant policy modifications, standard revisions, and new elements of performance (EPs) and requirements related to the Environment of Care (EC), Life Safety (LS), and Emergency Management (EM) standards. As part of this review, organizations should consult their updated accreditation manual or E-dition, as well as past issues of *EC News* and *Perspectives* and The Joint Commission website, https://www.jointcommission.org/standards_information/tjc_requirements.aspx, for additional information and further details.

Hot topics for 2018

Key LS updates

The Joint Commission has continued to update its LS standards to conform with the 2012 edition of the National Fire Protection Association's *Life Safety Code*®* (NFPA 101-2012) and *Health Care Facilities Code* (NFPA 99-2012). In 2016, the US Centers for Medicare & Medicaid Services (CMS) and The Joint Commission began requiring health care organizations to comply with the 2012 edition of the code. Later that year, CMS issued K-tags for the 2012 code; consequently, The Joint Commission crafted a second iteration of corresponding EPs that became effective January 1, 2018.[1]

Fire protection features

Among the important LS standard changes for 2018 are those to Standard LS.02.01.10, which calls for building and fire protection features to be designed and maintained to minimize the effects of fire, smoke, and heat. This is a frequently cited standard. During the first half of 2017, 66% of hospitals and 68% of critical access hospitals were found noncompliant with this standard. Organizations should pay close attention to the following:

- The language for EP 5 has been moved to EP 9. This EP clarifies the fire protection rating and time limits for opening protectives in fire barriers, fire-rated smoke barriers, and fire-rated smoke partitions.
- The language for EP 10 has been moved to EP 14. This EP specifies that the space around pipes, conduits, bus ducts, cables, wires, air ducts, and pneumatic tubes penetrating the walls or floors must be protected with an approved fire-rated material.[2]
- The language for EP 7 has been revised and moved to EP 11; it now clarifies that the positive latching devices and self-closing or automatic-closing devices in fire-rated doors must either be kept closed or activated by release devices that comply with NFPA 101-2012: 7.2.1.8.2.[2]

Means of egress

Another challenging standard that underwent revision effective January 1 is Standard LS.02.01.20, which obligates a hospital to maintain the integrity of the means of egress. During the first half of 2017, 60% of hospitals and 55% of critical access hospitals were found noncompliant with this standard.

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EP 11, concerned with exits, exit accesses, and exit discharges being clear of obstructions or impediments to the public way, has been moved to EP 14.[2] In addition, EP 13 has been moved to EP 16, with revised language indicating that each floor of a building must have at least two exits that are remote from each other and accessible from every part of the floor. Every smoke compartment must also have two distinct egress paths to exits that do not require entry into the same adjacent smoke compartment.[2]

Protection from fire hazards

Big changes occurred in Standard LS.02.01.30, which requires a hospital to provide and maintain building features to protect individuals from the hazards of fire and smoke. The changes include the following:

- A note has been added to EPs 2 and 3, which require that all new or existing hazardous areas (with some exceptions) have self- or automatic-closing doors and a fire barrier with a one-hour fire-resistant rating.[2] The new note, which applies to hospitals using Joint Commission accreditation for deemed status purposes, requires that doors to rooms containing flammable or combustible materials be provided with positive latching hardware and prohibits the use of roller latches on such doors.[2]
- The language in EP 11 has been moved to EP 12, and the words "In new buildings" now precede the existing requirement that "all corridor doors are constructed to resist the passage of smoke, hinged so they can swing, and the doors do not have ventilating louvers or transfer grills" (with some exceptions). Language requiring corridor doors to be fitted with positive latching hardware has been removed.[2]
- The language for EP 18 has been moved to EP 19. It mandates that smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces, and continuously from exterior wall to exterior wall, with all penetrations being properly sealed.[2]
- The language for EP 19 has been moved to EP 20. It details the rules for doors in smoke barriers, the gap between meeting edges of door pairs, and the size of undercuts in new buildings. Additional wording requires that in new buildings, doors in a means of egress must swing in the opposite direction.[2]

Fire extinguishment systems

The following four EPs under LS.02.01.35, which requires hospitals to provide and maintain systems for extinguishing fires, have been revised:

- EP 4, which prohibits using piping for approved automatic sprinkler systems to support any other item, includes new wording, referring to NFPA 25-2011: 5.2.2.2 for full text.[2]
- EP 5 mandates that sprinkler heads cannot be damaged and must be free from corrosion, foreign materials, and paint. It also now stipulates that the necessary escutcheon plates be installed and refers organizations to NFPA 101-2012: 18.3.5.1, 19.3.5.3, 9.7.5; NFPA 25-2011: 5.2.1.1.1, 5.2.1.1.2; and NFPA 13-2010: 6.2.6.2.2, 6.2.7.1 for full text.[2]

- EP 6, which says that 18 inches or more of open space must be maintained below the sprinkler deflector to the top of storage, now refers to NFPA 101-2012: 18.3.5.1, 19.3.5.3, 9.7.1.1 and NFPA 13-2010: 8.5.5.2, 8.5.5.2.1, 8.5.5.3 for full text.
- EP 14 now requires a hospital to meet all other *Life Safety Code* automatic extinguishing requirements related to NFPA 101-2012: 18/19.3.5.[2]

LS.02.01.35 was the most challenging standard for hospitals during the first half of 2017, with 86% found noncompliant. It was the second most challenging standard for critical access hospitals, with 80% found noncompliant. *See* the related article in this issue.

New smoke and fire door rules

Another important rule that became effective January 1 relates to *Life Safety Code* requirements for the maintenance, inspection, and testing of fire doors and smoke doors in health care occupancies.

CMS now requires full compliance with annual fire door assembly inspection and testing, in accordance with NFPA 80-2012. Non-rated doors, including smoke barrier doors and corridor doors to patient care rooms, are not subject to the annual inspection and testing requirements of either NFPA 80 or NFPA 105. However, non-rated doors should be routinely inspected as part of the facility maintenance program because all required life safety features and systems must be maintained in proper working order. *Life Safety Code* deficiencies related to the annual inspection and testing of fire doors should be cited under K-tag number K211: Means of Egress—General.[3]

CMS emergency preparedness rule

The Joint Commission has revised its EM standards and added new EPs to align with CMS's final rule on emergency preparedness for Medicare and Medicaid

Emergency Operation Center in Tallahassee, Florida, is in full operation in response to Hurricane Irma.
Photo Credit: Courtesy of Federal Emergency Management Agency.

participating providers and suppliers, which took effect in November 2017. The final rule aims to help health care organizations meet the needs of their patients, clients, and participants during emergency events as well as establish national emergency preparedness requirements these organizations can use to prepare for human- and natural-caused disasters and coordinate with emergency preparedness systems on the federal, state, tribal, regional, and local levels.[4]

The new EPs are designed to address crucial areas, including continuity of operations and succession plans; documentation of collaboration of federal, state, regional, tribal, and local EM officials; integrated health care systems; documented annual training of all new/existing staff, contractors, and volunteers; contact information on tribal groups and volunteers; and transplant hospitals.[4]

REFRESHments, Anyone? Revised Policies and Requirements for 2018

In addition to creating new and revised standards and EPs that took effect in early 2018, The Joint Commission has been busy strengthening other essential areas of relevance to health care organizations, including the following:

- **Completion of Phase IV of its Project REFRESH standards review:** The aim of this project has been to streamline Joint Commission standards for all accreditation programs by consolidating existing requirements. Phase IV has resulted in the consolidation of many EPs in the "Human Resources" (HR), "Human Resources Management" (HRM), "Infection Prevention and Control" (IC), and "Rights and Responsibilities of the Individual" (RI) chapters.[5]
- **Data release policy:** The Joint Commission removed a restriction in its policies for data release to government agencies and organizations with which The Joint Commission performs coordinated survey activities. Under certain circumstances, The Joint Commission shares specific accreditation-related information with federal, state, local, or other governmental certification or licensing agencies or public health agencies or any other appropriate enforcement agency. For 2018, The Joint Commission has eliminated the restriction that complaint information can be shared only if allegations result in an on-site visit.[6]
- **Risk areas:** New language indicates that surveyors will assess and display the risk associated with findings using the SAFER Matrix™.[7] Survey findings will now be plotted on the SAFER Matrix according to the likelihood of a deficiency causing harm to patients, staff, and/or visitors and the scope of the problem.
- **Definition of *hospital*:** The Joint Commission replaced its definition of *hospital* in the accreditation manual's Appendix A ("Medicare Requirements for Hospitals"). Language has been updated in this section to maintain alignment with CMS. Among other changes, the revised language indicates that the hospital must be (1) licensed or (2) approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals.[8]

Medication-related requirements in the EC

The Joint Commission's extensively revised Medication Management (MM) standards took effect on New Year's Day as well, as did updates to a key related EC standard—EC.02.05.03: "The organization has a reliable emergency electrical power source."[9]

Two new EPs, 14 and 15, have been added to this standard to better safeguard the dispensing and storage of medications. They require a hospital to implement a policy to provide emergency backup for the following:[5]

- Essential medication dispensing equipment identified by the hospital, such as automatic dispensing cabinets, medication carousels, and central medication robots (EP 14)
- Essential refrigeration for medications identified by the hospital, such as designated refrigerators and freezers (EP 15)

Do your homework—and pass with flying colors

Knowing and monitoring implementation of the latest requirements will help ensure that your organization is compliant, avoids citations on future surveys, and improves safety and security for all occupants in your facility.

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NEXT

Test Your Standards IQ

*How well do you really know the standards? Take this short quiz to test your knowledge and/or educate your staff about the Environment of Care (EC), Emergency Management (EM), and Life Safety (LS) standards and other essential accreditation information. Use the quiz to help brush up on key topics or even to prepare for the Certified Joint Commission Professional™ (CJCP®) exam.**
Click here for the answers, if you don't already know them.

The Questions

1. During an emergency, a hospital must have a system to track which of the following?
   a. The location of on-duty staff
   b. The location of community first responders
   c. The location of visitors

2. Hospitals must perform primary source verification of licensure for volunteer licensed independent practitioners within which of the following time frames during a disaster?
   a. As soon as the disaster is under control or within 24 hours of the individual's arrival at the organization
   b. As soon as the disaster is under control or within 48 hours of the individual's arrival at the organization
   c. As soon as the disaster is under control or within 72 hours of the individual's arrival at the organization

3. If a hospital that is part of a health care system chooses to participate in the system's integrated emergency preparedness program, the hospital's emergency management policies and procedures must include which of the following?
   a. Plans and procedures for integrated training and exercise activities with the system's integrated program
   b. Hospital-specific alternate contingency plans and procedures for instances in which the system's integrated programs do not address the individual hospital's needs
   c. Plans and procedures to consolidate operations within a single hospital in the system

* In 2013, Joint Commission Resources (JCR) launched its credential for accreditation professionals—Certified Joint Commission Professional™ (CJCP®). This column features sample questions similar to those that appear on the examination. Please note that the sample questions are *not* actual examination questions. For more information on CJCP, visit http://www.jcrinc.com/cjcp-certification/. You may also e-mail questions directly to cjcp@jcrinc.com.

The Answers

1. The correct answer is **a.** Standard EM.02.02.07 requires a hospital to prepare for how it will manage staff during an emergency. This must be included in the hospital's Emergency Operations Plan. Element of Performance (EP) 11 of that standard requires the hospital to track the location of on-duty staff during an emergency. This EP applies to hospitals that use Joint Commission accreditation for deemed status purposes.

2. The correct answer is **c.** Standard EM.02.02.13 states that during disasters, the hospital may grant disaster privileges to volunteer licensed independent practitioners. (A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions.) According to EP 8 of this standard, primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent practitioner presents him- or herself to the hospital, whichever comes first. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following:
   - Reason(s) it could not be performed within 72 hours of the practitioner's arrival
   - Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services
   - Evidence of the hospital's attempt to perform primary source verification as soon as possible

3. The correct answer is **a.** Standard EM.04.01.01, which applies to hospitals that use Joint Commission accreditation for deemed status purposes, states that if the hospital is part of a health care system with an integrated emergency preparedness program, and it chooses to participate in the integrated emergency preparedness program, the hospital participates in planning, preparedness, and response activities with the system. EP 3 of this standard requires the hospital's integrated emergency management policies, procedures, or plans to address the following:
   - Identification of the hospital's emergency preparedness, response, and recovery activities that can be coordinated with the system's integrated program (for example, acquiring or storing clinical supplies, assigning staff to the local health care coalition to create joint training protocols)
   - The hospital's communication and/or collaboration with local, tribal, regional, state, or federal emergency preparedness officials through the system's integrated program
   - Coordination of continuity of operations planning with the system's integrated program
   - Plans and procedures for integrated training and exercise activities with the system's integrated program

NEXT

New Year, New Requirements

ENSURING COMPLIANCE WITH REVISED LS.02.01.35

The Joint Commission has rewritten the "Life Safety" (LS) chapter to align with the US Centers for Medicare & Medicaid Services (CMS) requirement to comply with the 2012 edition of the *Life Safety Code*®* (NFPA 101-2012) and *Health Care Facilities Code* (NFPA 99-2012). A portion of these revisions became effective during 2016 and 2017. An additional round of updates became effective January 1, 2018, including changes to Standard LS.02.01.35, which addresses automatic sprinkler systems. (*See* "Related Requirements" on page 10.)

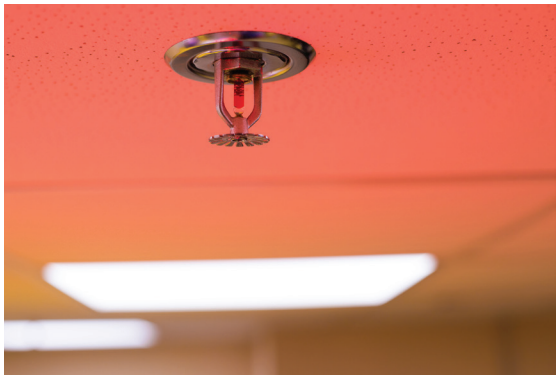
Prior to the revisions, many hospitals struggled to comply with this standard, with only 14% of surveyed hospitals found in compliance during the first half of 2017. The following information and strategies can help organizations comply with Elements of Performance (EPs) 8 through 14. (For information on EPs 1 through 7, *see* the December 2017 issue of *EC News*.)

Fire protection in closets

Sprinklers are not required in clothes closets of patient sleeping rooms in hospitals when the area of the closet does not exceed 6 square feet (EP 8). This provision is limited to hospitals, as nursing homes and many limited-care facilities might have more combustibles within closets. The amount of clothing kept in the small clothes closets in hospital patient rooms is generally less than the amount of combustibles in typical cabinets that do not require sprinkler protection.

Quick-response sprinklers

Quick-response sprinklers, covered in EP 9, are designed to activate more quickly than standard sprinklers. For example, the vital dimension of a quick-response sprinkler is 3 mm, whereas a standard sprinkler is 5 mm. This difference allows the quick-response sprinkler to more quickly react to fire conditions. Sprinklered buildings have proven to create safe environments, and quick-response sprinklers have been shown to provide improved safety in the patient environment. Note that comingling of differing sprinkler types within the same space is prohibited.



Hospitals are required to provide and maintain systems for extinguishing fires.

Portable fire extinguishers

Portable fire extinguishers are intended for staff use when a fire is small and somewhat contained. They must be readily available to building occupants. Spacing of 75 feet from any point in the building to a fire extinguisher should

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allow for rapid access. Regarding this 75-foot distance, EP 10 includes the wording "travel distance from any point," which could include being in a patient room. So simply spacing fire extinguishers every 75 feet down a corridor would not be adequate.

Related Requirements

Standard LS.02.01.35

The hospital provides and maintains systems for extinguishing fires.

Elements of Performance 8–14 for LS.02.01.35

8. In both new buildings and existing buildings, the clothing closets in patient sleeping rooms are not required to have sprinkler protection if the closet does not exceed 6 square feet. (For full text, refer to NFPA 101-2012: 18/19.3.5.10)
9. In new buildings, quick response sprinklers are installed in smoke compartments with patient sleeping rooms. (For full text, refer to NFPA 101-2012: 18.3.5.6)
10. The travel distance from any point to the nearest portable fire extinguisher is 75 feet or less. Portable fire extinguishers have appropriate signage, are installed either in a cabinet or secured on a hanger made for the extinguisher, and are at least four inches off the floor. Those fire extinguishers that are 40 pounds or less are installed so the top is not more than 5 feet above the floor. (For full text, refer to NFPA 101-2012: 18/19.3.5.12; 9.7.4.1; NFPA 10-2010: 6.2.1.1; 6.1.3.3.1; 6.1.3.4; 6.1.3.8)
11. Class K–type portable fire extinguishers are located within 30 feet of grease-producing ranges, griddles, broilers, or cooking appliances that use vegetable or animal oils or fats, such as deep fat fryers. A placard is conspicuously placed near the extinguisher stating that the fire protection system should be activated prior to using the fire extinguisher. (For full text, refer to NFPA 101-2012: 18/19.3.2.5.1; NFPA 96-2011: 10.10.2; NFPA 10-2010: 5.5.5; 6.6.2)
12. Grease-producing cooking devices such as deep fat fryers, ranges, griddles, or broilers have an exhaust hood, an exhaust duct system, and grease removal devices without mesh filters. (For full text, refer to NFPA 101-2012: 18/19.3.2.5.1; NFPA 96-2011: 6.1)
13. The automatic fire extinguishing system for grease-producing cooking devices does the following: deactivates the fuel source, activates the building fire alarm system, and controls the exhaust fans as designed. (For full text, refer to NFPA 101-2012: 18/19.3.2.5.1; NFPA 96-2011: 10.4; 10.6.1; 10.6.2; 8.2.3)
14. The hospital meets all other *Life Safety Code* automatic extinguishing requirements related to NFPA 101-2012: 18/19.3.5.

Mounting on a wall or in a cabinet is acceptable—with certain provisions. If mounted on a wall, an extinguisher must be secured on an appropriate hanger to prevent the extinguisher from being bumped off the hanger. Also, the fire extinguisher should not be less than 4 inches off the floor. For extinguishers that weigh 40 or fewer pounds, the top should not exceed 60 inches (5 feet). If the extinguisher is in a cabinet and not obvious, a sign or placard may be needed to identify its location. The Joint Commission recommends using non-ferrous extinguishers in some magnetic resonance imaging (MRI) locations to protect those near the magnet, as well as the equipment.

Class K-type portable fire extinguishers

A Class K-type extinguisher is designed specifically for combustible cooking media such as animal or vegetable oils and fats. These wet-chemical extinguishers are intended to form a thick "skin" over the grease fire to contain the fire until it is extinguished.

Usually extinguishers are used as soon as possible when a fire breaks out. However, EP 11 indicates that the primary fire suppression system should be activated prior to using a K-type extinguisher. An organization must post a sign to this effect. In addition, an organization is required to train staff on these procedures.

Grease-producing cooking devices

EP 12 addresses fire safety requirements for grease-producing cooking devices. Grease can become trapped in mesh filters, and even if attempts are made to clean the mesh filter, it may still contain a potential fuel source. To remove this possible hazard, mesh filters are prohibited in areas where grease may collect, including above deep fat fryers, ranges, griddles, and broilers. One alternative to mesh filters is some form of baffle to collect the grease-laden vapor from the exhaust and drain it into a container for cleaning or removal.

The process for managing airborne grease includes a required exhaust hood and an exhaust duct system. The duct system is made of a heavier-gauge material than conventional heating and cooling ductwork, and it has liquid-tight welds to protect the occupants by containing and directing the grease by-products to a safe location.

Automatic fire extinguishing system for grease-producing cooking devices

EP 13 covers automatic fire extinguishing systems that work in tandem to accomplish the following three actions:

- Remove the fuel source
- Notify occupants
- Control air movement

When a fire starts, it is important to remove the fuel source to help prevent possible reignition. A manual reset of the automatic extinguishment system helps

reduce the risk of reignition until the cooking oil cools. Also, upon initiation of the fire, the fire alarm system activates and begins occupant notification, including controlling the exhaust fans as designed. The exhaust fans may either shut down or ramp up, depending on the system's design.

"All other requirements"

EP 14 addresses many NFPA codes as referenced from NFPA 101-2012: 18/19.3.5, including NFPA 25, NFPA 13, NFPA 10, and NFPA 17A. Some of the provisions of these standards, especially NFPA 25, are also addressed in the Environment of Care standards.

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NEXT ↓

Knowledge from Experience

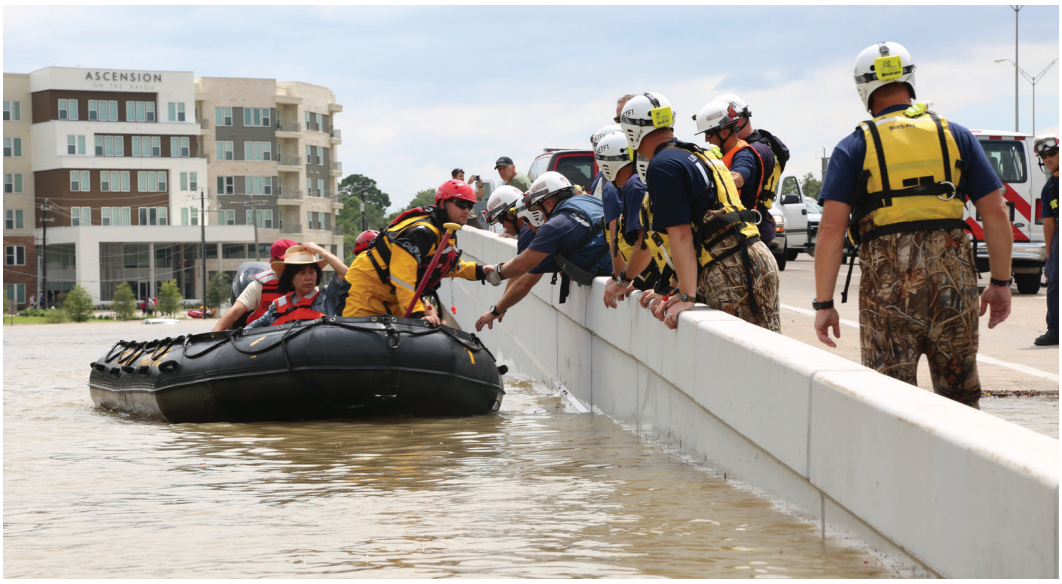
TEXAS HOSPITALS SHARE POST-HURRICANE INSIGHTS

The Joint Commission participates in post-disaster debriefings with health care organizations around the country to identify lessons learned that can be shared with other organizations preparing for similar types of emergencies. The following lessons learned were gleaned from discussions with several Texas hospitals that were impacted by Hurricane Harvey in August 2017. Although these health care organizations faced unique challenges and experiences during the 2017 hurricane season, based on their locations and capabilities, themes emerged that are instructive for general preparedness, response, and resilience.

Lessons learned

The hospitals identified the following opportunities for improvement:

- **Highlight the importance of internal and external evacuation drills.** Because hospitals are built and upgraded to withstand ever stronger storms, sheltering in place is typically the safest approach. However, drills that allow staff to practice evacuating and reoccupying clinical spaces help point out gaps in the emergency plan that can inform preparedness and performance improvement efforts.
- **Develop communications plans for alternate care sites.** Ensure that the community is made aware of alternate care sites and their locations. Keep in mind that some people may lack power or access to TV or radio during a disaster.
- **Plan to assist vulnerable populations.** Identify the most vulnerable patients in the population your organization serves—such as dialysis or home ventilator



Members of FEMA's Urban Search and Rescue Nebraska Task Force One (NE-TF1) perform one of many water rescues in the aftermath of Hurricane Harvey.

Photo Credit: Courtesy of Federal Emergency Management Agency.

patients. Work proactively with community partners to facilitate the needs of these vulnerable patients during emergency response and recovery. This can include coordinating information and services with ambulatory health care or home care partners. Some ambulatory dialysis providers, for instance, have their own water, fuel sources, and arrangements with alternate sites such as hotels for delivering care to their patients.

- **Monitor available doses of vaccines.** Hospitals should coordinate with public health departments and other stakeholders to monitor the sufficiency of vaccine doses, as well as other pharmaceuticals and supplies that public health partners provide. Consider that staff deployed to work in shelters, volunteers, and other response teams increase the demand for available vaccines. Also, communication channels may be compromised, and contingency strategies are important for keeping patients and staff informed of where and when vaccines will be available.
- **Plan for the long term.** Longer-term contingency planning beyond 96 hours may be needed as climate-related disasters continue to impact communities. For example, health care organizations may need to plan to arrange and receive shipments of blood products from other locales when local supplies run low.
- **Work on forecasting.** Consider the use of more robust forecasting models, scenarios, and algorithms to help monitor safety conditions relative to triggers for sheltering in place, suspending services, and internal or external evacuation. For example, dynamic forecasting models may incorporate wind speed and direction, hurricane severity, building systems, calculations of patient throughput, and so forth. The duration of an event is as important as the actual trigger; a 5-foot overflow may be high, but it may only last for 10 hours. Evacuating may be the least safe option, depending on external conditions.
- **Fortify your defenses.** When possible, build or renovate facilities to a standard higher than current requirements, such as installing submarine doors. Steps taken to harden facilities following Tropical Storm Allison in 2001 helped them mitigate damage from subsequent storms, including Harvey.
- **Anticipate how staff might be impacted.** Remember that employees also most likely live within the disaster zone. Review staff support needs prior to the season to verify that staff assigned to critical response or relief teams can be ready to report for their assigned duties. For example, if family dependent needs have changed significantly, consider reassigning a staff member to a team that is not required to report during the immediate response period. Work with staff in advance to identify shelter locations for family safety. School closures can become a bigger issue during recovery than response; many staff will need support for day care for days or weeks if their usual provider becomes inaccessible or displaced. To accommodate this need, some hospitals set up agreements directly with day care providers. In all cases, provide information to all staff in advance so they are aware of what support can and cannot be available so that they can adjust their family emergency plans accordingly.

- **Arrange for psychological support.** Patients, staff, leaders, and first responders may need emotional and psychological support throughout response and recovery. Plan with behavioral health partners in advance, particularly those with expertise in disaster mental health. Coordinate individual and group services and support as appropriate with social workers, case managers, psychologists and psychiatrists, employee assistance programs, hospice grief counselors, chaplains, and faith-based providers in the community.
- **Consider alternate modes of transportation for supplies or staff.** Identify and coordinate efforts with local community transportation resources. For example, in Texas and Louisiana, private boat owners self-mobilized to help community members evacuate. These individuals, nicknamed the "Cajun Navy," also helped resupply a psychiatric residential center with medications when supplies were dwindling. In another case, clinical staff used kayaks to navigate floodwaters to report to work.
- **Focus on logistics.** Plan to receive patients and supplies via helicopter. A robust logistics command is necessary to maximize limited air support assets in transporting patients, staff, supplies, and equipment.
- **Consider how the impact of an incident on other organizations can affect the hospital.** The following factors throughout communities led to complications for hospitals:
  - **Coordinate with home care organizations.** Enhanced coordination with home health providers, particularly for personal care and support assistance, is important in assisting vulnerable patients. Although clinical and nonclinical staff (administrative, clerical, and so forth) were deployed to shelters, there was a gap in that not enough staff were assigned to help shelter patients with activities of daily living, such as bathing, turning, and mobility assistance.
  - **Communicate proactively with residential communities serving elderly individuals.** This is essential. Some assisted living residents in residential facilities with out-of-state owners were vulnerable. Some of the local administrators awaited communication from owners before making the decision to evacuate. This created delays, and despite deteriorating local conditions, some facilities did not evacuate until after the hurricane or storm surge made conditions unsanitary or dangerous for already frail residents.

Emergency management standards: A blueprint for planning, coordination, and response

The Joint Commission accredits the full spectrum of health care providers, including hospitals, ambulatory health care, home care, nursing care centers, behavioral health care programs, and laboratories. Many of The Joint Commission's Emergency Management (EM) standards apply to settings across the care continuum. These standards provide a valuable foundation and guide for health care organizations to coordinate planning and response

efforts among providers within their systems and with community health care coalitions. In addition, the US Centers for Medicare & Medicaid Services (CMS) has implemented its final rule on emergency preparedness, which extends disaster planning and preparedness across the full continuum of care, providing a blueprint for coordination across health care settings that can help improve care, build capacity among community-based providers, and—most importantly—help save more lives.

Editor's Note: Staff from The Joint Commission's Department of Standard and Survey Methods, the Department of Engineering, and the Division of Accreditation and Certification Operations contributed to this article.

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