The Joint Commission 2010 EM and EC Update

The Healthcare Environment

Michael Chisholm, Engineer
Standard Interpretation Group
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2010 Survey Process Update

- A methodology change from response to mitigation and preparedness.
- Emergency Management will retain its own 90 minute session

Mitigation

Preparedness

Response

Recovery

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2010 Survey Process Update

Pre-Session Documents

- Emergency Operations Plan
  - All hazards approach
  - Addresses the six critical areas
  - Inventory of resources and assets
- Hazard Vulnerability Analysis (HVA)
  - Mitigation and preparedness activities for the top 2 or 3 events
- Disaster drill and real event evaluations
  - Monitors and evaluates the six critical areas

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2010 Survey Process Update

EM Discussion

- Focus on mitigation and preparedness
- No disaster scenarios; use hospital disaster critiques
- Data collection
- Focused discussion on six critical areas
- Look at resources and assets inventory; appropriate storage, expirations, training

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2010 Survey Process Update

Key Concepts

- All hazards approach
- Collaboration with community partners
- Situational awareness
- Active mitigation and preparation, not just a written plan
- Monitor and evaluate

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2010 Survey Process Update

Conduct a Hazard Vulnerability Analysis

- Documented
- Annual Review
- Site specific: one or many
- Organization and community partners prioritize HVA
  - Includes disclosing to community needs and vulnerabilities
- HVA to plan mitigation
- HVA to plan preparedness
  - EP 8 Documented inventory of resources & assets
    - Fuel
    - Personal Protective Equipment (PPE)
    - Water
    - Medical/surgical supplies
    - Other

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Emergency Management Standards

- **EM.01.01.01 - Emergency Management Planning Activities**
- **EM.02.01.01 – Emergency Operations Plan (EOP)**
- EM.02.02.01 - Communications
- EM.02.02.03 – Resources and Assets
- EM.02.02.05 – Security and Security
- EM.02.02.07 - Staff
- EM.02.02.09 - Utilities
- EM.02.02.11 – Patient Care Activities
- EM.02.02.13 – Volunteer Licensed Independent Practitioners
- EM.02.02.15 – Volunteer Practitioners
- EM.03.01.01 – Evaluating Planning Activities
- EM.03.01.03 – Evaluating EOP through Exercises

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EM.01.01.01 EM Planning

- Requires participation from administration, medical staff, clinical staff, and support staff
- A current Hazard Vulnerability Analysis (HVA):
  - Multidisciplinary approach
  - Involves Community
  - Reviewed at least annually
  - Guides emergency managements efforts

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EM.01.01.01
EM Planning

- Hospital must communicate its needs to its community
- Understands the capabilities/limitations of its community to meet its needs
- For each emergency define: **Mitigation, Preparedness, Response**, and **Recovery** activities

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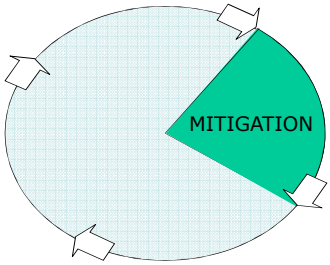
Emergency Management Cycle



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EM.01.01.01
Mitigation Activities

- Hazards Analysis - Internal & External
  - What types of natural, technological and man-caused events threaten the organization?
- Vulnerability Analysis
  - For each threat, ask "What will be the likely impact (considering both direct and indirect effects)?"
- Actions taken to reduce the impacts
  - What can be done to ensure operating systems remain functional?

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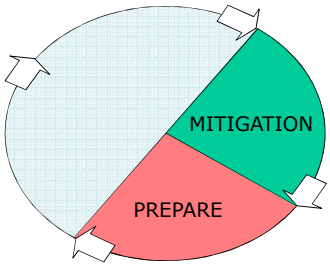
Emergency Management Cycle



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EM.01.01.01 – EM.02.02.15 **Preparedness** Activities

- Resources Listing
  - That provide the back-up for damage to the plant, supplies, equipment, communications, and people
- Pre-arranged agreements
  - Memoranda of understanding (MOUs) and other arrangements that are set up in advance so that resource commitments and working relationships are established before disaster strikes.
- Staff orientation and training on basic response actions
  - Simple guidelines covering actions staff will take during any emergency
- Facility-wide rehearsals
  - That stress organizational mobilization coordination, and communications

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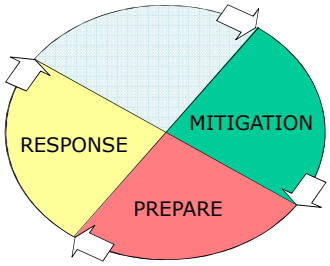
Emergency Management Cycle



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EM.02.01.01-EM.02.02.15 **Response** Activities

- Take appropriate actions to protect life and conserve property
- Notify persons in charge
- Continue to organize and manage

All Staff

- Situation assessment
- Warning and notifications
- Setting objectives and priorities
- Facility-wide instructions
- Plan for what happens next
- Liaison with external systems

Mgmt.

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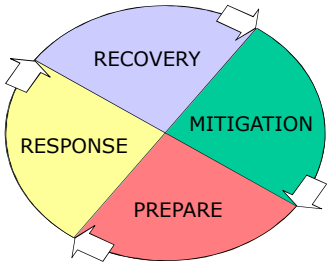
EC Management Cycle



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EM.01.01.01-EM.02.01.01 **Recovery** Activities

- Determine present level and extent of patient care capability
- Adjust patient care policies
- Set objectives and priorities for the re-establishment of operating systems that support the environment of care
- Make stress debriefing services available to patients and staff
- Schedule and conduct an incident critique
- Make improvements to the emergency management program

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EM.01.01.01 EM Program

- Maintain documented current inventory of assets and resources for emergency use (aligns with NIMS):
  - Personal Protective Equipment
  - Staffing
  - Water/Fuel
  - Medical, surgical, pharmaceuticals
- Develop methods to monitor use of resources during emergency operations

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EM.02.01.01 Emergency Operation Plan (EOP)

- EOP addresses the six critical functions.
- EOP requires an Incident Command Structure
  - Consistent with community ICS
- EOP identifies procedures for activating and terminating emergency operations
- EOP describes staffing patterns (who staff report to when EOP activated)

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EM.02.01.01
Emergency Operation Plan (EOP)

- EOP identifies organization's capabilities for 96 hours without being able to obtain support from the community.
- EOP establishes response efforts when the organization cannot be supported by the local community for 96 hours for managing the six critical areas.
  - Evacuation is an acceptable strategy (**but not always the most desirable!**)

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EM.02.01.01.01, EP3
Question

- Are we supposed to stand alone for 96 hours?
  - e.g., stockpile supplies on hand, etc?
  - or can we just say we have enough to last 96 hours and then evacuate, etc?
- Why did the Joint Commission pick 96 vs. 72?

The EOP **identifies** the organization's capabilities and establishes response procedures for when the organization cannot be supported by the local community for at least 96 hours in the six critical areas.
Note: *An acceptable response effort would be to temporarily close or evacuate the facility, consistent with their designated role in their community response plan.*

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EM.02.01.01, EP3
Answer

- The main point is that the organization knows its capabilities.
  - Respond according to this knowledge.
- Regarding the 96 vs 72 hours
  - The Joint Commission onsite evaluations indicated that 96 hours was a more realistic expectation.
  - This was confirmed during Standards Review.

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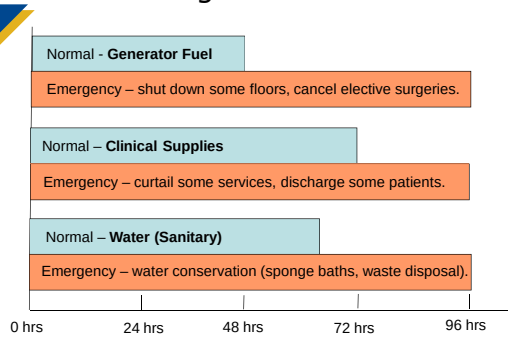
Striving for 96 Hours….



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EM.02.01.01, EP7
Alternate Care Sites

- Expand **existing** space:
  - Short-term needs with intact infrastructure.
  - Horizontal evacuation or surge demand.

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EM.02.01.01, EP7
Alternate Care Sites

Use of **remote** space:

- Site selection
  - Clinical capacities
- Logistics
  - Service
  - Supply
- Patient management
  - Medications
  - Records
  - Tracking

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Emergency Room in Tent

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Temporary Emergency Room

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6 Critical Components

1. Communication (EM.02.02.01)

- Communication is the way information is shared (both internally and externally) by and with the healthcare organization.
- It is more than a technology issue (not only how but what type information and with whom).
- It is likely that day-to-day communication methods may fail during an emergency.

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EM.02.02.01 Establish Emergency **Communications** Strategies

- Plans for communicating (once emergency measures are initiated) with:
  - Staff
  - External authorities
  - Patients/families
  - Providers of supplies and equipment
  - The Media
  - Other healthcare organizations

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EM.02.02.01 Establish Emergency **Communications** Strategies (con't)

- Communication with other hospitals within its contiguous geographic area:
  - Elements of command structures
  - Name/roles of individual in command structure, center telephone number
  - Resources and assets that could be shared
  - Names of patients and deceased individuals brought into their organizations *in accordance with law and regulations*

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6 Critical Components (con't)

2. Resources and assets (EM.02.02.03)

- Organizations must have a solid understanding of the scope and availability of their resources and assets during an emergency.
- Organizations must know how to access essential resources in times of crisis to ensure patient safety and sustain care, treatment, and services
  - Materials and supplies
  - Vendor and community services
  - State and federal programs

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EM.02.02.03 Strategies for managing **Resources and Assets** during emergencies

Plan for:

- Replenishing of supplies and equipment
  - Memorandums of Understanding (MOUs)
    - Over committed? Able to deliver?
- Potential sharing of resources and assets with other health care organizations
- Managing staff support activities
- Managing staff family support needs
- Evacuation

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TULANE UNIVERSITY MEDICAL CTR.

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Alternatives to Evacuations

- Reduce occupancy
  - Employees
  - Patients
    - Discharge stable patients
    - Re-schedule appointments
    - Change admissions policy

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EM.02.02.03 Strategies for managing **Resources and Assets** during emergencies

- Plan for transporting to alternative care sites:
  - Patients, their medications, equipment, and necessary staff
  - Information pertinent to patient care

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BRIDGE OUT OF TOWN...

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EM.02.02.03, EP9: Transportation?

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6 Critical Components (con't)

3. Security and safety (EM.02.02.05)

- The safety and security of patients is the most important 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.

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EM.02.02.05 Strategies for managing **security and safety**

- Establish internal security and safety operations
- Identify roles of community security agencies
  - Define how security activities will be coordinated
- Identify process for managing hazardous materials and waste
- Identify means for radioactive, biological, and chemical isolation/decontamination

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EM 02.02.05 Strategies for managing **Security and safety**

- Establish processes for:
  - Controlling entrance **into** and **out of** building.
  - Controlling movement of individuals **within** the building (i.e, *colored wrist bands*).
  - Controlling traffic **accessing** the building (i.e., *setting up remote sites for inoculation*).

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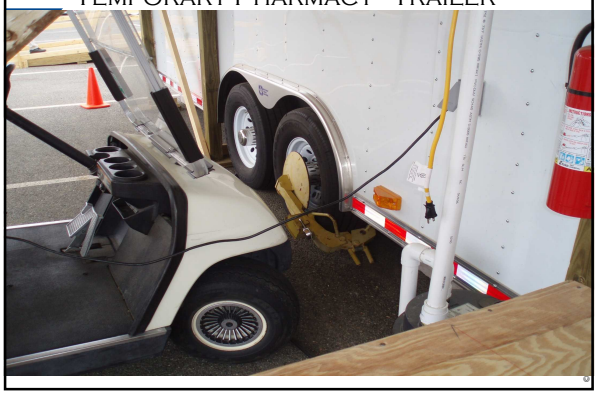
Temporary Pharmacy - Trailer



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EM.02.02.05, EP7 - Question

- How can we control egress?
- National Fire Protection Association (NFPA) says we can't lock anyone in.

The EOP describes how the organization will control entrance into and **out of** the health care facility during emergencies;

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EM.02.02.05, EP7 - Answer

- The Joint Commission would expect operational measures be implemented to compensate for the risks created by the temporary locking of exit doors, similar to our Interim Life Safety Measures (ILSM) requirements.

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6 Critical Components (con't)

4. Staff roles and responsibilities (EM.02.02.07)

- During an emergency, the probability that staff responsibilities will change is high.
- If staff cannot anticipate how they may be called to perform during an emergency, the likelihood that the organization will not sustain itself during an emergency increases.
- Staff should practice their roles and their performance should be critiqued (exercises EM.03.01.03).

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EM.02.02.07 Define and manage **Staff Roles and Responsibilities**

- Organization defines staff roles and responsibilities *for all six critical areas*
- Organization **trains** staff for assigned roles
- **Organization communicates** with LIPs about their roles and reporting
- Organization defines process for identifying care providers and other personnel

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6 Critical Components (con't)

5. Utilities management (EM.02.02.09)

- Healthcare organizations are dependent on the uninterrupted function of utilities. However, during an emergency, uninterrupted function of utilities is not guaranteed.

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EM.02.02.09 Strategies for managing **Utilities**

- Identify alternative means for providing:
  - Electricity.
  - Water for consumption and essential care.
  - Water for equipment and sanitary purposes.
  - Fuel for building operations and essential *transportation*.
  - Other essential utilities:
    - Ventilation
    - Medical gas/vacuum

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Sentinel Event Alert #37

- Perform a gap analysis on the emergency power system
  - Match the critical equipment and systems needed in an extended emergency against the equipment and systems actually on the emergency power system
  - Use disaster scenario planning to identify critical systems that could potentially be lost:
    - potable water
    - elevators
    - water pumps in high-rise facilities
    - sewer pumps in low areas
    - heating, air conditioning and fan units in intense climate regions
    - air handlers in isolation rooms
      - protective environment rooms
      - laboratory
      - pharmacy hoods

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Sentinel Event Alert #37

- Maintain a complete, labeled inventory:
  - emergency power supply systems (EPSS)
  - the loads that the EPSS serve
- Provide competency training and testing for all operators and others responsible for system maintenance of the emergency power supply system
- Test generator fuel oil:
  - track expiration dates
  - replace stale fuel oil not consumed within its storage life

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6 Critical Components (con't)

6. Patient clinical and support activities (EM.02.02.11)

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

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EM.02.02.11 Strategies for managing **Patient Clinical and Support Activities**

- Plan to manage clinical activities related to patient care
  - Scheduling
  - Triage
  - Assessment
  - Treatment
  - Admission
  - Transfer
  - Discharge
  - Evacuation

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EM.02.02.11 Strategies for managing **Patient Clinical and Support Activities**

- Clinical services for vulnerable populations
- Patients' personal hygiene and sanitation needs
- Patients' mental health service needs
- Mortuary services
- Documenting and tracking patients' clinical information

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Disaster Volunteer Practitioners EM.02.02.13 & EM.02.02.15

- These standards provide guidance to organizations that choose to utilize clinical disaster volunteers; it does not require organizations to utilize such volunteers

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Disaster Volunteer Practitioners EM.02.02.13 & EM.02.02.15

- These standards allow for expedited credentialing and privileging of clinical disaster volunteers only when two conditions are met:
  - 1) The EOP has been activated in response to a disaster
  - 2) The organization is unable to meet immediate patient needs

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Disaster Volunteer Practitioners EM.02.02.13 & EM.02.02.15

- Standard EM.02.02.13 applies to volunteer practitioners who are licensed independent practitioners
- Standard EM.02.02.15 applies to volunteer practitioners who are not licensed independent practitioners.

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Disaster Volunteer Practitioners EM.02.02.13 & EM.02.02.15

- Identify individuals responsible for granting disaster privileges and responsibilities
- Define how organization will oversee the performance of clinical disaster volunteers (for example, by direct observation, mentoring, or medical record review)

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Disaster Volunteer Practitioners EM.02.02.13 & EM.02.02.15

- Before a clinical disaster volunteer is eligible to provide care, treatment, or service, the organization obtains a government issued photo ID and at least one of the following:
  - Current picture from health organization, identifying professional designation
  - Current license
  - Primary source verification of licensure, certification, or registration
  - DMAT/MRC/ESAR-VHP, other recognized state/federal response hospital or group identification
  - ID indicating individual has been granted authority by government entity to provide patient care in disaster circumstances
  - Confirmation by another clinician of volunteer practitioner's ability to perform clinical duties

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Disaster Volunteer Practitioners EM.02.02.13 & EM.02.02.15

- During disaster:
  - The organization oversees performance of each clinical disaster volunteer
- Based on oversight:
  - The hospital determines within 72 hours if granted disaster privileges/clinical responsibilities should continue
- Primary source verification of licensure, certification, or registration occurs:
  - As soon as emergency is under control; or
  - Within 72 hrs from when volunteer presents, whichever comes first
  - If primary source verification is not completed, document:
    - Reasons
    - Evidence of ability
    - Evidence of hospital's attempt to perform primary source verification

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EM.03.01.01 Evaluate Planning Activities

- Annual review of risks, hazards, and emergencies as defined in hazard vulnerability analysis
- Annual review of objectives and scope of EOP
- Annual review of inventory process

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EM.03.01.01 Evaluate Planning Activities

Annual Evaluation:

- The Annual Evaluation should result in:
  - Identification of goals and objectives met and not met
  - Goals and objectives for the next year
  - Review Scope of Plan (HVA, inventory of assets and resources, etc.)
  - Evaluation of the performance and effectiveness of the EC program

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EM.03.01.03 EOP **Exercising**

Number and types of exercises:

- Twice a year either in response to actual emergency or planned exercise.
- Conduct at least one exercise that includes an influx of actual or simulated patients.

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EM.03.01.03: **Scope of Exercises**

Number and types of exercises:

- At least one exercise is escalated to evaluate performance when community cannot support the organization.
- If organization has defined role in community-wide emergency management program:
  - Participate in at least one community-wide exercise/year.

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EM.03.01.03: **Scope of Exercises**

Scope of Exercises

- Scenarios are realistic and related to prioritized emergencies from HVA.
- During exercises, an individual(s):
  - Monitors performance
  - Documents opportunities for improvement

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EM.03.01.03: **Scope of Exercises**

- The organization's monitoring includes the six critical areas:
  - Effectiveness of communication
    - Internal
    - With external response partners
  - Resource mobilization and allocation
  - Security and safety
  - Staff roles and responsibilities
  - Utility systems
  - Patient clinical and support care activities

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EM.03.01.03: **Scope of Exercises**

Scope of Exercises:

- Exercises are critiqued.
- Completed exercises are critiqued through multi-disciplinary process.
- EOP modified in response to critiques
- Improvements to EOP are evaluated during next exercise.
- Strengths/weaknesses are communicated to multidisciplinary team responsible for managing EM issues.

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2010 EC UPDATE

THE HEALTHCARE ENVIRONMENT

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Human Factor

- Trust
- Report
- Improve

Communication

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EP Scoring Categories

- A: Structural requirements
  - EP's scored yes (2) or no (0)
  - May address issues requiring full compliance
- C: Based on number of times an EP is not met
  - Score 2: 0-1 instances of non-compliance
  - Score 1: 2 instances of non-compliance
  - Score 0: > 3 instances of non-compliance
    - Above is based on a sample of 10

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Example: Category A

- EC.02.04.03 EP 2:
- The hospital inspects, tests & maintains all life support equipment. These activities are documented.
  - Did you do it? Yes or No [100%]
  - Is there documentation?

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Example: Category C

- EC.02.04.03 EP 3:
- The hospital inspects, tests & maintains all non-life support equipment identified on the medical inventory. These activities are documented.
  - How many times did you not do it?
  - Is there documentation?

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Criticality of Findings & Immediacy of Risk

The amount of time for submitting the ESC is based on the criticality of the finding and the immediacy of risk as follows:

- Direct Impact Within 45 Days
- Indirect Impact Within 60 Days

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Criticality

- Criticality defined as "the immediacy of risk to patient safety or quality of care as a result of noncompliance with a Joint Commission requirement."
- 4 Levels of Criticality
  1. Immediate Threat to Life (ITL)
     - PDA until resolved
  2. Situational Decision Rules
     - Based on specific situations at time of survey
  3. Direct Impact Requirements
     - Noncompliance may create an immediate risk to patient safety or quality of care
  4. Indirect Impact Requirements
     - Based on planning and evaluation or care processes

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What Triggers ITL (Immediate Threat to Life)

- Significantly compromised fire alarm system
- Significantly compromised sprinkler system
- Significantly compromised emergency power supply system
- Significantly compromised medical gas master panel
- Significantly compromised exits
- Other situations that place patients, staff or visitors at extreme danger

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What Triggers CON 04

- CON 04 is only related to previously accepted PFIs
  - Failure to make sufficient progress (LS.01.01.01 EP 2)
  - Failure to implement appropriate ILSMs (LS.01.02.01 EP 3)
- Failure to manage previously accepted PFIs affects the Joint Commission
  - Both organizations are aware of deficiencies that have been managed using the PFI process

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CMS Deeming Issue

- Joint Commission is required to reconcile our Elements of Performance (EP) with CMS Conditions of Participation (COP)
- COPs are the expectations of compliance CMS has related to Medicare/Medicaid reimbursements
  - COPs are federal laws
- To reconcile the Joint Commission has added 2 additional EPs
- None of these are beyond the current expectations of the Joint Commission

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CMS Deeming Issue: Specifics

- EC.02.04.03 EP 14
  - Staff maintain nuclear medicine equipment annually
- LS.01.01.01 EP 4
  - Maintain documentation of any inspections or approvals by AHJs related to fire safety

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Top 5 Most Cited Standards in the First ½ of 2010

Hospitals	Critical Access Hospitals
1. 62% RC.01.01.01	1. 47% EC.02.03.05
2. 50% LS.02.01.20	2. 44% LS.02.01.10
3. 44% LS.02.01.10	3. 40% EC.02.05.07
4. 38% EC.02.03.05	4. 33% LS.02.01.20
5. 37% LS.02.01.30	5. 27% EC.02.06.01

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#2: LS.02.01.20 (50%)

Up From 45% in 2009

- The hospital maintains the integrity of the means of egress.
  - EP 13 Corridor Clutter
  - EP 12 Projections
  - EPs 16 – 22 Suites issues
    - Equivalize > 5000 sq ft
  - EP 1 Doors locked in means of egress

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#3: LS.02.01.10 (44%)

Up From 43% in 2009

- Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.
  - EP 9 Penetrations
  - EPs 5 – 7 Door issues
  - EPs 1 & 2 Building Type issues
  - EP 8 Duct issues

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#4: EC.02.03.05 (38%)

No Change From 2009

- The hospital maintains fire safety equipment and fire safety building features.
  - Features of fire protection

NOTE: #1 for Critical Access Hospitals

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#5: LS.02.01.30 (37%)

Up From 36% in 2009

- The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.
  - EPs 16 – 23 Smoke Barriers & Doors
  - EP 2 Hazardous Areas

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Deficiency Resolution

- Resolution to a deficiency:
  - Resolve it immediately
  - Correct it within 45 days:
    - Management process that documents the deficiency and actions to resolve
    - ILSM must be considered
  - Plan For Improvement located in the Statement of Conditions™
    - Corrected within 6 months of the Projected Completion Date
    - ILSM must be considered

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45 Day Corrective Action

- Documented
  - Origination date
  - Completion date
  - Kept available for rolling 3 years
- Life Safety deficiencies
  - Must not exceed 45 days
  - If greater than 45 days create a Plan For Improvement (PFI)
    - If originally a work order, close out as complete and generate the PFI
- Must be made available to the Joint Commission
  - During survey to confirm management of the deficiency
  - During CMS/Joint Commission validation process upon request

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Equivalencies

- The Joint Commission accepts two forms of equivalencies
  - Traditional Equivalency
    - A process of field verification identifying alternative methods of fire safety that off-set the identified deficiency
  - Fire Safety Evaluation System (FSES)
    - A process of calculating the features of life safety and deducting any deficiencies, with the outcome determining if the building is equivalized based on the FSES

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Life Safety Code Specialist

- LSCS Background
  - Facilities or Environment of Care based
  - Prefer CHFM certification
- LSCS Agenda
  - On-Site one day (typically on day 1 or day 2)
  - Interfaces with survey team member(s)
- LSCS Survey Focus
  - Life Safety Chapter
  - EC.02.05.03
  - EC.02.05.07
  - EC.02.05.09
- Other "Observations"

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Life Safety Code Specialist

- May also survey
  - LD.04.01.05 EP 4
  - LD.03.03.01 EP 4
  - LD.04.04.01 EP 2
- All HAP and CAH will be surveyed for a minimum of 2 days by a LSCS
  - Greater than 1.5 million sq ft will be surveyed for a third day by the LSCS
  - An additional day is added for every three buildings that are classified as healthcare
- Example: for a HAP organization with 2 million square feet of healthcare occupancy and 5 buildings classified as healthcare occupancy:
  - the number of LSCS days would be 4

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LD.04.01.05 EP 4: *What to do when the documentation isn't there…*

- During survey documentation is reviewed
- If the information is not readily available, but will be available later in the survey this may result in a finding at LD.04.01.05 EP 4
  - The requested information should be utilized by the organization, so not having the information may indicate a lack of responsibility by the organization
- If the documentation arrives late, non-compliance has already been established
  - Scored at LD.04.01.05 EP4
    - Leaders hold staff accountable for their responsibilities

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How Many Open PFIs Are Too Many?

- The PFI process was created to allow organizations to self assess and create a Plan for Improvement
- The self disclosure has never defined how many is too many
- The ILSM process was created to allow both the organization and The Joint Commission to be aware of Life Safety Code deficiencies
- Failure to make progress on previously accepted PFIs, including failure to implement ILSMs results in Conditional Accreditation

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How Many Open PFIs Are Too Many?

- Survey Process:
  - Evaluate both closed and currently open PFIs in the View All screen
  - Spot check during building tour both some closed and open PFIs to evaluate how well the organization is managing the PFI process
  - Evaluate the scope of PFI entries
    - Are there life safety deficiencies
    - Are they greater than maintenance items (i.e. screws missing from a door hinge)

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Statement of Conditions: PFI

- PFIs should be related to the LS Chapter
  - Corridor clutter is not a legitimate PFI
- PFIs should provide specific information
  - No blanket statements
    - "…penetrations on 3rd floor"
  - Specific references to Life Safety Drawings is acceptable
    - 32 penetrations as identified on LS Drawing 3rd Floor, Center Tower dated 3/3/2010
    - Projected Completion Date is for all listed items (i.e. "32 penetrations")

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PRA EC.02.06.03

Preconstruction Risk Assessment (PRA)
Construction or renovation in occupied healthcare facilities can result in environmental problems such as:

- Noise
- Vibration
- Creation or spread of contaminants
- Disruption of essential services
- Emergency Procedures
- Air quality

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Interim Life Safety Measures

- Order of Standards (LS.01.02.01)
  - EP 1 & 2 regardless of ILSM policy
  - EP 3 must clearly define the ILSM policy including
    - CON 04 Process
    - When to implement
    - What to do to protect occupants
    - Both construction related and non-compliance with the LSC
  - EPs 4 – 14 align with policy and implementation strategies

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Contingency Planning

- Utilities exist to provide a safe and comfortable environment of care
- Failure of utilities could directly impact patient care delivery
- Activities associated with managing utilities are designed to ensure the reliability of the systems day to day
- Contingency plans are developed to ensure reliability of utilities systems
- Contingency plans address at least two issues:
  - Utility/Equipment failure or disruption
  - Emergency related failures or disruption

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Contingency Planning: Survey

- Organizations ensure their contingency plans are current and accurate
- Discuss the organization Memorandum of Understanding and its impact in the community
- Evaluate against Standards & Elements of Performance
- Suggest the organization include exercising these contingency plans with their Emergency Exercise

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EC.02.05.01 Utilities Mgmt.

- EP 7 The hospital maps the distribution of utility systems
- EP 8 The hospital labels controls for a partial or complete emergency shutdown
- EP 9 The hospitals has procedures for responding to utility system disruptions
- EP 10 The hospitals' procedures address shutting off the malfunctioning system and notifying staff in affected areas
- EP 11 The hospitals procedures address performing emergency clinical interventions during utility systems disruptions
- EP 12 The hospitals procedures addresses the following: How to obtain emergency repair services
- EP 13 The hospital responds to utility system disruptions as described in its procedures

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EM.02.02.09: Utility Disruption

Emergency Operations Plan identifies alternative means of providing:

- EP 2 electricity
- EP 3 water needed for consumption and essential care activities
- EP 4 water needed for equipment and sanitary purposes
- EP 5 fuel required for building operations or essential transport activities
- EP 6 medical gas/vacuum systems
- EP 7 Utility systems defined as essential, ***such as***
  - Vertical & horizontal transport
  - Heating & cooling systems
  - Steam for sterilization
- EP 8 Utility needs identified in the HVA

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Questions
and
Answers

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