August 2017

Continuous patient readiness plan: emergency preparedness interpretive guidelines



| Topic/source | Requirement | Operational partner | Current state (gap analysis) | Action/ target dates | Effective date |
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| ***The Centers for Medicare and Medicaid published on June 2, 2017, the Survey and Certification (S&C) 17-29-ALL-Appendix Z, Emergency Preparedness final rule interpretive guidelines and survey procedures. It will be implemented November 15, 2017. The tags for emergency preparedness will be “E” Tags and accessible to both health and safety surveyors and life safety surveyors. State survey agencies will have discretion regarding whether the life safety surveyor or health and safety surveyors will conduct the emergency preparedness surveys.*** | | | | | |
| **E-0001**  **The hospital must develop and maintain a comprehensive emergency preparedness program utilizing an all-hazards approach** | Emergency preparedness describes a facility's comprehensive approach to meeting the health, safety and security needs of their staff and patient population during an emergency or disaster situation. It also addresses how the facility will coordinate with other health care facilities and the whole community during an emergency or disaster.  **Note:** This does not apply to transplant centers.  **Survey procedures**   * Interview the facility leadership and ask them to describe the facility’s emergency preparedness program. * Ask to see the facility’s written policy and documentation on the emergency preparedness program. * For **hospitals** and **critical access hospital** (CAHs) only: Verify the program was developed based on an all-hazards approach by asking their leadership to describe how the facility used an all-hazards approach when developing its program. | Emergency management leaders/  ambulatory leaders/  transplant leaders/  hospice and home health leaders |  |  | November 15, 2017 |
| **E-0004**  **The facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually** | The emergency preparedness program approach is specific to the location of the facility and considers particular hazards most likely to occur in the surrounding area. These include but are not limited to:   * Natural disasters * Man-made disasters * Facility-based disasters that include but are not limited to: * Care-related emergencies * Equipment and utility failures, including but not limited to power, water, gas, etc. * Interruptions in communication, including cyber-attacks * Loss of all or portion of a facility * Interruptions to the normal supply of essential resources such as water, food, fuel (heating, cooking and generators) and in some cases, medications and medical supplies (including medical gases, if applicable)   The facility should take into account:   * Likely durations * Arrangements or contracts to reestablish essential utility services during an emergency   + Set the timeframe within which the contractor is required to initiate services after the start of the emergency.   + Determine how they will be procured and delivered in thefacility's local area.   + Continue to supply the essential items throughout and to the end of emergencies of varying duration.   **Note**: This does not apply to transplant centers.  **Survey procedures**   * Ask facility leadership to identify the hazards (e.g. natural, man-made, facility, geographic, etc.) that were identified in the facility’s risk assessment and how the risk assessment was conducted. * Review the plan to verify it contains all of the required elements. * Verify that the plan is reviewed and updated annually by looking for documentation of the date of the review and updates that were made to the plan based on the review. |  |  |  |  |
| **E-0006**  **Emergency preparedness plan is based on a documented facility-based and community-based risk assessment, utilizing an all-hazards approach and includes strategies for addressing emergency events identified by the risk assessment** | Facilities are expected to develop an emergency preparedness plan that is based on the facility-based and community-based risk assessment using an “all-hazards” approach and document both risk assessments. This approach is specific to the location of the facility considering the types of hazards most likely to occur in the area.  When developing an emergency preparedness plan, facilities are expected to consider, among other things, the following:   * Identification of all business functions essential to the facility’s operations that should be continued during an emergency * Identification of all risks or emergencies that the facility may reasonably expect to confront * Identification of all contingencies for which the facility should plan * Consideration of the facility’s location * Assessment of the extent to which natural or man-made emergencies may cause the facility to cease or limit operations. * Determination of what arrangements may be necessary with other health care facilities, or other entities that might be needed to ensure that essential services could be provided during an emergency.   **Note**: This does not apply to transplant centers.  Long-term care (LTC) facilities should include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and for intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) missing clients.  Hospices include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters and other emergencies that would affect the hospice's ability to provide care.  **Survey procedures**   * Ask to see the written documentation of the facility’s risk assessments and associated strategies. * Interview the facility leadership and ask which hazards (e.g. natural, man-made, facility, geographic) were included in the facility’s risk assessment, why they were included and how the risk assessment was conducted. * Verify the risk-assessment is based on an all-hazards approach specific to the geographic location of the facility and encompasses potential hazards. |  |  |  |  |
| **E-0007**  **Emergency plan addresses patient/client population** | The emergency plan must:   * Specify the population served within the facility, such as inpatients and/or outpatients * Population-unique vulnerabilities in the event of an emergency or disaster * Persons at-risk:   + Infants, children, senior citizens and pregnant women   + Live in institutionalized settings   + From diverse cultures and racial and ethnic backgrounds   + Limited English proficiency or are non-English speaking   + Lack of transportation   + Have chronic medical disorders or pharmacological dependency   + Elderly persons in hospitals and nursing homes   + Those with physical and mental disabilities and others with access and functional needs * Types of services that the facility would be able to provide in an emergency * Identify which staff would assume specific roles in another’s absence through succession planning and delegations of authority * Continuity of operations planning such as:   + Essential personnel   + Essential functions   + Critical resources   + Vital records   + Information technology (IT) data protection   + Alternate facility identification and location   + Financial resources   **Note**: This does not apply to transplant centers.  **Survey procedures**  Interview leadership and ask them to describe the following:   * The facility’s patient populations that would be at risk during an emergency event * Strategies the facility has put in place to address the needs of at-risk or vulnerable patient populations * Services the facility would be able to provide during an emergency * How the facility plans to continue operations during an emergency * Delegations of authority and succession plans * Verify that the entire above are included in the written emergency plan |  |  |  |  |
| **E-0009**  **Emergency management plan includes a process for cooperation and collaboration with local, tribal, regional, state and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency** | Facilities are encouraged to participate in a health care coalition as it may provide assistance in planning and addressing broader community needs that may also be supported by local health department and emergency management resources.  **Note**: This does not apply to transplant centers.  **Survey procedures**   * Interview facility leadership and ask them to describe their process for ensuring cooperation and collaboration with local, tribal, regional, state and federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation. * Ask for documentation of the facility's efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts. * For **end-stage renal** **disease** (ESRD) facilities, ask to see documentation that the ESRD facility contacted the local public health and emergency management agency public official at least annually to confirm that the agency is aware of the ESRD facility’s needs in the event of an emergency and know how to contact the agencies in the event of an emergency. |  |  |  |  |
| **E-0010**  **The emergency management plan must address the location and use of alarm systems and signals and methods of containing fire** | For **clinics, rehabilitation agencies and public health agencies** as providers of outpatient physical therapy and speech-language pathology services, the plan must include the methods used for containing fires, such as fire extinguishers, sprinkler systems and other current methods used.  **Note:** This does not apply to transplant centers.  **Survey procedures**   * Ask facility leadership to show the section of the plan which addresses location(s) and use of fire alarms. * Ask facility staff to describe the facility’s current procedure for containing fires. |  |  |  |  |
| **E-0011**  **The emergency management plan is developed and maintained with assistance from fire, safety and other appropriate experts** | For **clinics, rehabilitation agencies and public health agencies** as providers of outpatient physical therapy and speech-language pathology services, the plan must collaborate with fire, safety and other appropriate experts to develop and maintain its emergency plan. They must document their collaboration with these experts and include them in the annual review of the plan.  **Survey procedures**   * Ask for a list of documentation for which experts were collaborated with to develop and maintain its plan. |  |  |  |  |
| **E-0012**  **A transplant center has policies and procedures that address emergency preparedness in the hospital’s emergency preparedness program. It develops and maintaining mutually agreed upon protocols addressing the duties and responsibilities of the transplant center, the hospital in which the transplant center is operated, and the Organ Procurement Organization (OPO) designated by the Secretary, unless the hospital has an approved waiver to work with another OPO, during an emergency.** | Hospitals which have transplant centers must include within their emergency planning and preparedness process one representative, at minimum, from the transplant center. If a hospital has multiple transplant centers, each center must have at least one representative who is involved in the development and maintenance of the hospital’s emergency preparedness process. The hospital must include the transplant center in its emergency preparedness plan policies and procedures, communication plans, as well is the training and testing programs.  **Survey procedures**   * Verify the hospital has written documentation to demonstrate that a representative of each transplant center participated in the development of the emergency program. * Ask to see documentation of emergency protocols that address transplant protocols that include the hospital, the transplant center and the associated OPOs. |  |  |  |  |
| **E-0013**  **Facilities must develop and implement emergency preparedness policies and procedures, based on the emergency plan, risk assessment and the communication plan. The policies and procedures must be reviewed and updated at least annually.** | The policies and procedures are expected to align with the identified hazards within the facility's risk assessment and the facility's overall emergency preparedness program.  Programs of all-inclusive care for the elderly (PACE**)** -The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to:   * Fire * Equipment * Power * Water failure * Care-related emergencies * Natural disasters likely to threaten the health or safety of the participants * Staff * Public   **ESRD** -These emergencies include, but are not limited to:   * Fire * Equipment * Power failures * Care-related emergencies * Water supply interruption * Natural disasters likely to occur in the facility’s geographic area   **Note**: This does not apply to transplant centers.  **Survey procedures**  Review the written policies and procedures which address the facility’s emergency plan and verify the following:   * Policies and procedures were developed based on the facility- and community-based risk assessment and communication plan utilizing an all-hazards approach. * Ask to see documentation that verifies the policies and procedures have been reviewed and updated on an annual basis. |  |  |  |  |
| **E-0015**  **Facilities must develop and implement emergency preparedness policies and procedures based on emergency management plan, risk assessment and communication provision of subsistence needs for staff and patients whether they evacuate or shelter in place.** | Facilities must be able to provide for adequate subsistence for all patients and staff for the duration of an emergency or until all its patients has been evacuated and its operations cease. Additionally, when inpatient facilities determine their supply needs, they are expected to consider the possibility that volunteers, visitors and individuals from the community may arrive at the facility to offer assistance or seek shelter.  The provision of subsistence needs for staff and patients include, but are not limited to the following:   * Food, water, medical and pharmaceutical supplies * Alternate sources of energy to maintain the following: * Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. * Emergency lighting. * Fire detection, extinguishing and alarm systems * Sewage and waste disposal   **Note:** This does not apply to ambulatory surgery centers (ASCs), outpatient hospice providers (**applies to inpatient hospices**), transplant centers, home health agencies (HHA), comprehensive outpatient rehabilitation facilities (CORFs), community mental health centers (CMHCs), rural health clinics (RHCs), federally qualified health centers (FQHCs), ESRD facilities.  **Survey procedures**   * Verify the emergency plan includes policies and procedures for the provision of subsistence needs including, but not limited to, food, water and pharmaceutical supplies for patients and staff by reviewing the plan. * Verify the emergency plan includes policies and procedures to ensure adequate alternate energy sources necessary to maintain:   + Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions   + Emergency lighting   + Fire detection, extinguishing and alarm systems * Verify the emergency plan includes policies and procedures to provide for sewage and waste disposal. |  |  |  |  |
| **E-0018**  **A system to track the location of on-duty staff and sheltered patients in the facility’s care during an emergency** | Facilities must develop a means to track patients and on-duty staff in the facility’s care during an emergency event. In the event staff and patients are relocated, the facility must document the specific name and location of the receiving facility or other location for sheltered patients and on-duty staff who leave the facility during the emergency.  Facilities are **not** required to track the location of patients who have voluntarily left on their own or have been appropriately discharged. However, this information must be documented in the patient’s medical record should any questions later arise as to the patient’s whereabouts.  §418.113(b)(6) Inpatient hospice:  Safe evacuation from the hospice, includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance  §485.920(b) CMHCs:  Policies and procedures for safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance  §486.360(b) OPOs:  Policies and procedures for a system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records§494.62(b) ESRD:  Policies and procedures for safe evacuation from the dialysis facility, which includes staff responsibilities and needs of the patients  **Note**: This does not apply to transplant centers, HHAs, clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services, RHCs or FQHCs.  **Survey procedures**   * Ask staff to describe and/or demonstrate the tracking system used to document locations of patients and staff. * Verify that the tracking system is documented as part of the facilities’ emergency plan policies and procedures. |  |  |  |  |
| **E-0019**  [**§418.113(b)(2)**](http://jcrinc.mediregs.com/cgi-bin/_fd/fetch_doc_by_uid?db=dp_ecfr42&uid=42cfr418x113&anchor=42cfr418x113zb-2) **hospice homebound**  [**§460.84(b)(4)**](http://jcrinc.mediregs.com/cgi-bin/_fd/fetch_doc_by_uid?db=dp_ecfr42&uid=42cfr460x84&anchor=42cfr460x84zb-4) **PACE §484.22(b)(2) HHA**  **The procedures to inform state and local emergency preparedness officials about homebound hospice, PACE or HHA patients in need of evacuation from their residences at any time due to an emergency situation based on the patient’s medical and psychiatric condition and home environment** | Policies and procedures must address when and how this information is communicated to emergency officials and also includes the clinical care needed for these patients. This should include, but is not limited to, the following:   * Whether or not the patient is mobile * What type of life-saving equipment does the patient require? * Is the life-saving equipment able to be transported (i.e. battery operated transportable, condition of equipment, etc.)? * Does the patient have special needs (i.e. communication challenges, language barriers, intellectual disabilities, special dietary needs, etc.)?   **Survey procedures**   * Review the emergency plan to verify it includes procedures to inform state and local emergency preparedness officials about patients in need of evacuation from their residences at any time due to an emergency situation based on the patient’s medical and psychiatric condition and home environment. |  |  |  |  |
| **E-0020**  **Safe evacuation from the facility, which includes consideration of care and treatment needs of evacuees, staff responsibilities, transportation, identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance** | The facility should consider development of the policies and procedures and evacuation protocols for not only the evacuees, but also staff members and families or patient representatives or other personnel who sought potential refuge at the facility. Additionally, the policies and procedures must address staff responsibilities during evacuations.  Facilities should consider their triaging system when coordinating the tracking and potential evacuation of patient, residents and clients.  The facility’s policies and procedures must outline primary and alternate means for communication with external sources for assistance.  §491.12(b)(1) RHCs/FQHCs: Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patient*s*  **Note:** This does not apply to HHAs, OPOs and transplant centers.  **Survey procedures**   * Review the emergency plan to verify it includes policies and procedures for safe evacuation from the facility and that it includes all of the required elements. * When surveying an RHC or FQHC, verify that exit signs are placed in the appropriate locations to facilitate a safe evacuation. |  |  |  |  |
| **E-0022**  **A means to shelter patients, staff, and volunteers who remain in the facility** | Facilities are required to have policies and procedures for sheltering in place which align with the facility’s risk assessment.  When developing policies and procedures for sheltering, facilities should consider the ability of their building(s) to survive a disaster and what proactive steps they could take prior to an emergency to facilitate sheltering in place or transferring of patients to alternate settings if their facilities were affected by the emergency.  Hospice inpatient care facilities have additional requirements for policies and procedures that address a means to shelter patients and hospice employees who remain in the hospice.  **Note**: This does not apply to transplant centers, HHAs or OPOs.  **Survey procedures**   * Verify the emergency plan includes policies and procedures for how it will provide a means to shelter patients, staff and volunteers who remain in a facility. * Review the policies and procedures for sheltering and evaluate if they aligned with the facility’s emergency plan and risk assessment. |  |  |  |  |
| **E-0023**  **A system of medical documentation preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records** | In addition to any existing requirements for patient records found in existing laws, facilities are required to ensure that patient records are secure and readily available to support continuity of care during emergency. These policies and procedures must also be in compliance with the Health Insurance Portability and Accountability Act (HIPAA).  **Note**: This does not apply to transplant centers.  **Survey procedures**   * Ask to see a copy of the policies and procedures that documents the medical record documentation system the facility has developed to preserves patient (or potential and actual donor for OPOs) information, protects confidentiality of patient (or potential and actual donor for OPOs) information, and secures and maintains availability of records. |  |  |  |  |
| **E-0024**  **The use of volunteers in an emergency or other emergency as staffing strategies include the process and role for integration of state and federally designated health care professionals to address surge needs during an emergency** | During an emergency, a facility may need to accept volunteer support from individuals with varying levels of skills and training. The facility must have policies and procedures in place to facilitate this support.  Facilities must include any necessary privileging and credentialing processes in its emergency preparedness plan policies and procedures. Non-medical volunteers would perform non-medical tasks. Facilities have flexibility in determining how best to utilize volunteers during an emergency as long as such utilization is in accordance with state law, state scope of practice rules and facility policy.  Facilities are expected to include in its emergency plan a method for contacting off-duty staff during an emergency and procedures to address other contingencies in the event staff are not able to report to duty. This may include, but are not limited to, utilizing staff from other facilities and state or federally-designated health professionals.  **Note:** This does not apply to hospices, transplant centers or OPOs.  **Survey procedures**   * Verify the facility has included policies and procedures for the use of volunteers and other staffing strategies in its emergency plan. |  |  |  |  |
| **E-0025**  **The development of arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients** | Facilities are required to have policies and procedures which include prearranged transfer agreements, which may include written agreements or contracted arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.  **Note:**This does not apply to ASCs, transplant centers, HHAs, CORFs, clinics, rehabilitation agencies and public health agencies as providers of outpatient physical therapy and speech-language pathology services, OPOs or RHCs/FQHCs.  **Survey procedures**   * Ask to see copies of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency. * Ask facility leadership to explain the arrangements in place for transportation in the event of an evacuation. |  |  |  |  |
| **E-0026**  **The role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials** | Facilities must develop and implement policies and procedures that describe its role in providing care at alternate care sites during emergencies. It is expected that state or local emergency management officials might designate such alternate sites and would plan jointly with local facilities on issues related to staffing, equipment and supplies at such alternate sites.  Facility’s policies and procedures must specifically address the facility’s role in emergencies where the President declares a major disaster or emergency under the Stafford Act or an emergency under the National Emergencies Act and the Health and Human Services (HHS) secretary declares a public health emergency.  **Note**: This does not apply to transplant centers, HHAs, CORFs, clinics, rehabilitation agencies and public health agencies as providers of outpatient physical therapy and speech-language pathology services, OPOs or RHCs/FQHCs.  **Survey procedures**   * Verify the facility has included policies and procedures in its emergency plan describing the facility’s role in providing care and treatment (except for religious nonmedical health care institutions (RNHCI) for care only) at alternate care sites under an 1135 waiver. |  |  |  |  |
| **No E-tag §460.84(b)(10) The PACE organization policies and procedures must address management of medical and non-medical emergencies, including, but not limited to: Fire; equipment, power or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff or the public** | The policies and procedures must address the following:   * Emergency equipment, including easily portable oxygen, airways, suction and emergency drugs * Staff knows how to use the equipment. It must be on the premises of every center at all times and be immediately available * A documented plan to obtain emergency medical assistance from outside sources when needed |  |  |  |  |
| **E-0029**  **The facility must develop and maintain an emergency preparedness communication plan that complies with federal, state and local laws and must be reviewed and updated at least annually.** | Facilities must have a written emergency communication plan that contains how the facility coordinates patient care within the facility, across health care providers, and with state and local public health departments. The communication plan should include how the facility interacts and coordinates with emergency management agencies and systems to protect patient health and safety in the event of a disaster.  **Note**: This does not apply to transplant centers.  **Survey procedures**   * Verify that the facility has a written communication plan by asking to see the plan. * Ask to see evidence that the plan has been reviewed (and updated as necessary) on an annual basis. |  |  |  |  |
| **E-0030**  **The facility must develop and maintain an emergency preparedness communication plan that complies with federal, state and local laws and must be reviewed and updated at least annually.** | A facility must have the contact information for those individuals and entities outlined within the standard. The requirement to have contact information for other facilities requires a provider or supplier to have the contact information for another provider or supplier of the same type as itself. Facilities must update contact information for incoming new staff and departing staff throughout the year and any other changes to information for those individuals and entities on the contact list.  The communication plan must include names and contact information for the following:   * Staff * Entities providing services under arrangement. * Patients' physicians * Other facilities * Volunteers   §486.360(c) OPOs also include:   * Other OPOs * Transplant and donor hospitals in the OPO's donation service area (DSA)   §418.113(c) hospices also include:   * Other hospices   §403.748(c) RNHCIs also include:   * Other RNHCIs   **Note**: This does not apply to transplant centers.  **Survey procedures**   * Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information. * Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review. |  |  |  |  |
| **E-0031**  **The facility must develop and maintain an emergency preparedness communication plan that complies with federal, state and local laws and must be reviewed and updated at least annually** | A facility must have the contact information for those individuals and entities outlined within the standard. Facilities have discretion in the formatting of this information; however it should be readily available and accessible to leadership during an emergency event.  The communication plan must include names and contact information for the following:   * Federal, state, tribal, regional and local emergency preparedness staff * Other sources of assistance   §483.73(c) LTC facilities also include:   * The state licensing and certification agency * The office of the state long-term care ombudsman   §483.475(c) ICF/IIDs also include:   * The state licensing and certification agency. * The state protection and advocacy agency   **NOTE**: This does not apply to transplant centers.  **Survey procedures**   * Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information. * Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review. |  |  |  |  |
| **E-0032**  **The communication plan must include: Primary and alternate means for communicating with staff, federal, state, tribal, regional and local emergency management agencies** | Facilities are required to have primary and alternate means of communicating with staff, federal, state, tribal, regional and local emergency management agencies. Facilities have the discretion to utilize alternate communication systems that best meets their needs. However, it is expected that facilities would consider pagers, cellular telephones, radio transceivers (that is, walkie-talkies) and various other radio devices.  **Note**: This does not apply to transplant centers.  **Survey procedures**   * Verify the communication plan includes primary and alternate means for communicating with facility staff, federal, state, tribal, regional and local emergency management agencies by reviewing the communication plan. * Ask to see the communications equipment or communication systems listed in the plan. |  |  |  |  |
| **E-0033**  **The communication plan must include a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care a means, in the event of an evacuation, to release patient information and a means of providing information about the general condition and location of patients under the facility's care** | Facilities are expected to provide patient care information to receiving facilities during an evacuation, within a timeframe that allows for effective patient treatment and continuity of care.  Facilities should send all necessary patient information that is readily available and should include at least:   * Patient name * Age * Date of birth * Allergies * Current medications * Medical diagnoses * Current reason for admission (if inpatient) * Blood type * Advance directives * Next of kin and emergency contacts   **Note**: This does not apply to transplant centers.  **Survey procedures**   * Verify the communication plan includes a method for sharing information and medical (or for RNHCIs only) documentation for patients under the facility's care, as necessary, with other health (or care for RNHCIs) providers to maintain the continuity of care by reviewing the communication plan.   + For RNCHIs, verify that the method for sharing patient information is based on a requirement for the written election statement made by the patient or his or her legal representative. * Review the communication plan to verify the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients. |  |  |  |  |
| **E-0034**  **The communication plan must include a means of providing information about the facility’s occupancy, needs, its ability to provide assistance, to the authority having jurisdiction and the incident command center or designee** | Facilities must have a means of providing information about the facility’s needs and its ability to provide assistance to the authority having jurisdiction (local and State emergency management agencies, local and state public health departments, the Incident command center, the emergency operations center, or designee). For hospitals, CAHs, RNHCIs, inpatient hospices, psychiatric residential treatment facilities (PRTFs), LTC facilities and ICF/IIDs, they must also have a means for providing information about their occupancy.  **Note**: This does not apply to outpatient hospices or transplant centers.  **Survey procedures**   * Verify the communication plan includes a means of providing information about the facility’s needs, and its ability to provide assistance to the authority having jurisdiction, the incident command center or designee by reviewing the communication plan. * For hospitals, CAHs, RNHCIs, inpatient hospices, PRTFs, LTC facilities and ICF/IIDs, also verify if the communication plan includes a means of providing information about their occupancy. |  |  |  |  |
| **E-0035**  **§483.73(c)(8)**  **LTC facility and ICF/IID have a method for sharing information from the emergency plan that the facility has determined what is appropriate with residents or clients and their families or representatives** | **LTC facilities and ICF/IIDs** are required to share emergency preparedness plans and policies with family members and resident representatives or client representatives. Facilities have flexibility in deciding what information from the emergency plan should be shared, as well as the timing and manner in which it should be disseminated.  **Survey procedures**   * Ask staff to demonstrate the method the facility has developed for sharing the emergency plan with residents or clients and their families or representatives. * Interview residents or clients and their families or representatives and ask them if they have been given information regarding the facility’s emergency plan. * Verify the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan. |  |  |  |  |
| **E-0036**  **The facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan and updated at least annually.** | An emergency preparedness training and testing program must be documented, reviewed and updated on at least an annual basis. The training and testing program must reflect the risks identified in the facility’s risk assessment and be included in their emergency plan including but not limited to:   * How the facility will communicate the facility closure to required individuals and agencies * Testing patient tracking systems * Testing transportation procedures for safely moving patients to other facilities * For facilities with multiple locations, such as multi-campus or multi-location hospitals, the facility’s training and testing program must reflect the facility’s risk assessment for each specific location.   **Note**: This does not apply to transplant centers.  **Survey procedures**   * Verify that the facility has a written training and testing (and for ESRD facilities, a patient orientation) program that meets the requirements of the regulation. * Verify the program has been reviewed and updated on, at least, an annual basis by asking for documentation of the annual review as well as any updates made. * Verify that ICF/IID emergency plans also meet the requirements for evacuation drills and training. |  |  |  |  |
| **E-0037**  **The facility must provide testing for all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. Training should be held at least annually, should be documented and should demonstrate staff knowledge of emergency procedures.** | Facilities are required to provide initial training in emergency preparedness policies and procedures that are consistent with their roles in an emergency to all new and existing staff, individuals providing services under arrangement and volunteers. This includes individuals who provide services on a per diem basis such as agency nursing staff and any other individuals who provide services on an intermittent basis and would be expected to assist during an emergency.   * Additional requirements for PACE organizations: provide initial training to contractors and PACE participants * Additional requirements for CAHs: include initial training on the prompt reporting and extinguishing of fires; protection; and where necessary, evacuation of patients, personnel, and guests, fire prevention and cooperation with firefighting and disaster authorities   **Note**: This does not apply to transplant centers and ERSD facilities.  **Survey procedures**   * Ask for copies of the facility’s initial emergency preparedness training and annual emergency preparedness training offerings. * Interview various staff and ask questions regarding the facility’s initial and annual training course to verify staff knowledge of emergency procedures. * Review a sample of staff training files to verify staff has received initial and annual emergency preparedness training. |  |  |  |  |
| **E-0039**  **Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for one year following the onset of the actual event.** | Facilities must conduct exercises to test the emergency plan on an annual basis, which for LTC facilities also includes unannounced staff drills using the emergency procedures. Facilities are required to conduct a tabletop exercise and participate in a full-scale community-based exercise or conduct an individual facility exercise if a community-based exercise is not available.  Facilities that are not able to identify a full-scale community-based exercise can instead fulfill this part of their requirement by either conducting an individual facility-based exercise, documenting an emergency that required them to fully activate their emergency plan, or by conducting a smaller community-based exercise with other nearby facilities.  Each facility is responsible for documenting their compliance and ensuring that this information is available for a period of no less than three years. Facilities should also document the lessons learned they have incorporated any necessary improvements in their emergency preparedness program.  **Note:** This does not apply to transplant centers.  **Survey procedures**   * Ask to see documentation of the annual tabletop and full scale exercises and any additional documentation used by the facility to support the exercise. * Ask to see the documentation of the facility's efforts to identify a full-scale community based exercise if they did not participate in one (i.e. date, personnel, agencies contacted and the reasons for the inability to participate in a community based exercise). * Request documentation of the facility's analysis and response and how the facility updated its emergency program based on this analysis. |  |  |  |  |
| **E-0041**  **The hospital must implement emergency and standby power systems based on the emergency plan.** | **Hospitals, CAHs and certain LTC** facilities are to install, maintain, inspect and test an essential electric system (EES) in areas of a building where the failure of equipment or systems is likely to cause the injury or death of patients or caregivers. An EES is a system which includes an alternate source of power, distribution system and associated equipment that is designed to ensure continuity of electricity to elected areas and functions during the interruption of normal electrical service.   * Emergency generator location must be in accordance with the location requirements found in the Health Care Facilities Code. * Emergency generator power system is inspected, tested and needed maintenance according to requirements found in the Health Care Facilities Code. * Emergency generator fuel is maintained onsite to power emergency generators. The organization should have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.   **Survey procedures**   * Verify that the hospital, CAH and LTC facility has the required emergency and standby power systems to meet the requirements of the facility’s emergency plan and corresponding policies and procedures. * Review the emergency plan for shelter in place and evacuation plans. Based on those plans, does the facility have emergency power systems or plans in place to maintain safe operations while sheltering in place? * For hospitals, CAHs and LTC facilities which are under construction or have existing buildings being renovated verify the facility has a written plan to relocate the emergency power supply system(EPSS) by the time construction is completed.   For hospitals, CAHs and LTC facilities with generators:   * For new construction that takes place between November 15, 2016 and is completed by November 15, 2017, verify the generator is located and installed in accordance with national fire protection association (NFPA) 110 and NFPA 99 when a new structure is built or when an existing structure or building is renovated. The applicability of both NFPA 110 and NFPA 99 addresses only new, altered, renovated or modified generator locations * Verify that an onsite fuel source is maintained in accordance with NFPA 110 for the generator and have a plan for how to keep the generator operational during an emergency, unless they plan to evacuate. | **maintenance** |  |  |  |
| **E-0042**  **If a facility is part of a health care system consisting of multiple separately certified health care facilities that elects to have a unified and integrated emergency preparedness program, the facility may choose to participate in the health care system's coordinated emergency preparedness program.** | Health care systems that include multiple facilities that are each separately certified as a Medicare-participating provider or supplier have the option of developing a unified and integrated emergency preparedness program that includes all of the facilities within the health care system instead of each facility developing a separate emergency preparedness program.  Unified and integrated emergency preparedness program must:   * Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program * Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations and services offered * Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program * The unified and integrated emergency plan must also be based on and include the following:   + A documented community-based risk assessment utilizing an all-hazards approach.   + A documented individual facility-based risk assessment for each separately certified facility within the health system utilizing an all-hazards approach.   **Note** This does not apply to transplant centers.  **Survey procedures**   * Verify whether or not the facility has opted to be part of its health care system’s unified and integrated emergency preparedness program. Verify by asking to see documentation of its inclusion in the program. * Ask to see documentation that verifies the facility within the system was actively involved in the development of the unified emergency preparedness program. * Ask to see documentation that verifies the facility was actively involved in the annual reviews of the program requirements and any program updates. * Ask to see a copy of the entire integrated and unified emergency preparedness program and all required components (emergency plan, policies and procedures, communication plan, training and testing program). * Ask facility leadership to describe how the unified and integrated emergency preparedness program is updated based on changes within the health care system such as when facilities enter or leave the system. |  |  |  |  |
| **EP-043**  **If a hospital has one or more transplant centers, a representative from each transplant center must be included in the development and maintenance of the hospital’s emergency preparedness program. Develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant center and the OPO for the DSA where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO during an emergency** | Hospitals which have transplant centers must include within their emergency planning and preparedness process one representative, at minimum, from the transplant center. If a hospital has multiple transplant centers, each center must have at least one representative who is involved in the development and maintenance of the hospital’s emergency preparedness process. The hospital must include the transplant center in its emergency plan’s policies and procedures, communication plans, as well is the training and testing programs.  **Survey procedures**   * Verify the hospital has written documentation to demonstrate that a representative of each transplant center participated in the development of the emergency program. * Ask to see documentation of emergency protocols that address transplant protocols that include the hospital, the transplant center and the associated OPOs. |  |  |  |  |
| ***Transplant centers only*** | | | | | |
| **E-0002**  **§482.78 A transplant center must be included in the emergency preparedness planning and the emergency preparedness program for the hospital in which it is located** | A representative from each transplant center must be actively involved in the development and maintenance of the hospital's emergency preparedness program. Transplant centers are still required to have their own emergency preparedness policies and procedures, as well as participate in mutually-agreed upon protocols that address the transplant center, hospital, and organ procurement organizations (OPO's) duties and responsibilities during an emergency. However, a transplant center is not individually responsible for the emergency preparedness  **Survey procedures**   * Verify that a representative from the transplant center was included in the planning of the emergency preparedness program of the hospital in which the transplant center is located. |  |  |  |  |
| **E-0005**  **§482.78(a) A transplant center must have policies and procedures that address emergency preparedness and are included in the hospital’s emergency preparedness program** | The transplant center needs to be involved in the hospital's risk assessment because there may be risks to the transplant center that others in the hospital may not be aware of or appreciate.  .  **Survey procedures**   * Verify the transplant center has emergency preparedness policies and procedures. * Verify that the transplant center’s emergency preparedness policies and procedures are included in the hospital’s emergency preparedness program. |  |  |  |  |
| **E-0014**  **§482.78(b) A transplant center must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the transplant center, the hospital in which the transplant center is operated, and the OPO designated by the Secretary, unless the hospital has an approved waiver to work with another OPO, during an emergency** | Transplant centers must be involved in the development of mutually agreed upon protocols that address the duties and responsibilities of the hospital, transplant program and the designated OPO during emergencies. The hospital in which a transplant center is located (i.e., a transplant hospital) would be responsible for ensuring that the transplant center is involved in the development of an emergency preparedness program.  **Survey procedures**   * Verify the transplant center has developed mutually agreed upon protocols that address the duties and responsibilities of the transplant center, the hospital in which the transplant center is operated, and the designated OPO * Ask to see documentation of the protocols |  |  |  |  |
| ***OPOs only*** | | | | | |
| **E-044**  **§486.360(e) Each OPO must have a plan to continue operations during an emergency** | * The OPO develops and maintains protocols with transplant programs that address the duties and responsibilities of the transplant program, the hospital in which the transplant program is operated, and the OPO during an emergency. * The OPO must have the capability to continue its operation from an alternate location during an emergency. The OPO could either have: * An agreement with one or more other OPOs to provide essential organ procurement services to all or a portion of its DSA in the event the OPO cannot provide those services during an emergency; * If the OPO has more than one location, an alternate location from which the OPO could conduct its operation   OR   * A plan to relocate to another location as part of its emergency plan   **Survey procedures**   * Verify that the OPO has mutually-agreed upon protocols with every certified transplant program it is associated with which includes the duties and responsibilities of the hospital, transplant program and OPO during emergencies. * Verify that the OPO has a plan in place to ensure continuity of its operation from an alternate location during an emergency. |  |  |  |  |
| **E-0008**  **Address the type of hospitals with which the OPO has agreements** | The emergency plan must address:   * Type of hospitals with which the OPO has agreements * Type of services the OPO has the capacity to provide in an emergency * Continuity of operations, including delegations of authority and succession plan   **Survey procedures**   * Interview leadership and ask them to describe the following: * Services the OPO would be able to provide during an emergency * How the OPO plans to continue operations during an emergency * Delegations of authority and succession plans * How the OPO has included/addressed all of the hospitals with which it has agreements into its emergency plan * Verify that all of the above are included in the written emergency plan. |  |  |  |  |
| ***Home health and hospice only*** | | | | | |
| **E-0016**  **§418.113(b)(1) The hospice has policies and procedures to follow up with on duty staff and patients to determine services needed in the event that there is an interruption in services during or due to an emergency. The hospice must inform state and local officials of any on-duty staff or patients that they are unable to contact.** | Hospices have the flexibility to determine how best to develop these policies and procedures. Information regarding patient services that are needed during or after an interruption in their services and on-duty staff and patients that were not able to be contacted must be readily available, accurate and shareable among officials within and across the emergency response system, as needed, in the interest of the patient.  **Survey procedures**   * Review the emergency plan to verify it includes policies and procedures for following up with staff and patients. * Interview a staff member or leadership and ask them to explain the procedures in place in the event they are unable to contact a staff member or patient. |  |  |  |  |
| **E-0017**  **§484.22(b)(1) The HHA policies and procedures address developing individual plans for each patient as part of the comprehensive patient plan during a natural or man-made disaster assessment.** | Individual plans for each patient must be included as part of the comprehensive patient assessment.  **Survey procedures**   * Through record review, verify that each patient has an individualized emergency plan documented as part of the patient’s comprehensive assessment. |  |  |  |  |
| **E-0021**  **§484.22(b)(3)The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform state and local officials of any on-duty staff or patients that they are unable to contact.** | During an emergency, if a patient requires care beyond the capabilities of the HHA, there is an expectation that care of the patient would be rearranged or suspended for a period of time, as most HHAs in general would not necessarily transfer patients to other HHAs during an emergency.  HHAs policies and procedures should clearly outline what surrounding facilities, such as a hospital or a nursing home, it has a transfer arrangement with to ensure patient care is continued. Additionally, these policies and procedures should outline timelines for transferring patients or under what conditions patients would need to move.  **Survey procedures**   * Verify that the HHA has included in its emergency plan these procedures to follow-up with staff and patients and to inform state and local authorities when they are unable to contact any of them. * Verify that the HHA has procedures in its emergency plan to follow up with on‐duty staff and patients to determine the services that are needed, in the event that there is an interruption in services during or due to an emergency. * Ask the HHA to describe the mechanism to inform State and local officials of any on‐duty staff or patients that they are unable to contact. |  |  |  |  |
| ***ESRD facilities only*** | | | | | |
| **E-0003**  **§494.62 The dialysis facility must comply with all applicable federal, state, and local emergency preparedness requirements. These emergencies include, but are not limited to, fire, equipment or power failures, care related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.** | The End Stage Renal Disease (ESRD) emergency preparedness program must describe a facility's comprehensive approach to meeting the health and safety needs of their patient population during an emergency as well as the whole community during and surrounding an emergency event (natural or man-made). The emergency preparedness plan must be evaluated and updated at least annually.  **Survey procedures**   * Ask to see written or electronic documentation of the program |  |  |  |  |
| **E-0027**  **§494.62(b)(8) The dialysis facility policies and procedures must address how emergency medical system assistance can be obtained when needed.** | ESRD facilities must include in its emergency plan, policies and procedures for obtaining emergency medical assistance when needed. Medical system assistance can be considered, but not limited to, outside assistance such as from a nearby hospital or assistance from other ESRD facilities including personnel to assist during a single-facility disaster.  **Survey procedures**   * Verify the ESRD facility has included in its emergency plan, policies and procedures for obtaining emergency medical assistance when needed. |  |  |  |  |
| **E-0028**  **§494.62(b)(9) The dialysis facility has policies and procedures that address a process by which the staff can confirm that emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs are on the premises at all times and immediately available.** | ESRD facilities must include policies and procedures in its emergency plan that addresses a process that confirms that the specific equipment is on the premises at all times and immediately available in the event of an emergency. The process must be in writing.  Survey procedures   * Verify the dialysis facility has a process in place by which its staff can confirm that emergency equipment is on the premises and immediately available. * Verify that the process includes at least the listed emergency equipment within its emergency plan by asking to see a copy of the written processes or policy on emergency equipment and medications. * Check to see that all of the above equipment is available and in working order. Ask to see procedures or checklist for ensuring equipment is checked. * Check that all emergency drugs are not out of date. |  |  |  |  |
| **E-0038**  **§494.62(d)(1) The dialysis facility must provide training in emergency preparedness policies and procedures at least annually** | The ESRD facility is required to train new and existing staff on their emergency preparedness policies and procedures on an annual basis. Additionally, individuals providing services under arrangement and volunteers are required to undergo the training as applicable to their roles and responsibilities within the facility.  Staff training includes:   * Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement and volunteers consistent with their expected roles * Emergency procedures, including informing patients:   + What to do   + Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated   + Whom to contact if an emergency occurs while the patient is not in the dialysis facility including an alternate emergency phone number (unless the facility has the ability to forward calls to a working phone number under such emergency conditions)   + How to disconnect themselves from the dialysis machine if an emergency occurs * Demonstrating that, at a minimum, its patient care staff maintains current cardiopulmonary resuscitation (CPR) certification * Properly training nursing staff in the use of emergency equipment and emergency drugs * Maintaining documentation of the training   **Survey procedures**   * Verify the facility has an emergency preparedness training program and that it is updated annually. * Interview staff and ask them to describe the evacuation procedures and plan. * Verify current copies of CPR certifications for all patient care staff are on file. |  |  |  |  |
| **E-0040**  **§494.62(d)(3)**  **The dialysis facility must provide appropriate orientation and training to patients.** | ESRD facilities are required to implement an orientation and training program which educates patients on:   * How they would be notified of an emergency * What particular procedures they are expected to follow * How they would evacuate the facility (if required) * Location of potential transfer sites or services * Communication protocols for contacting the ESRD facility * Scenarios which were identified in the ESRD facility's risk assessment and address specific actions required for the emergency situation   **Survey procedures**   * Verify the ESRD facility has implemented their policies and procedures and are actively providing orientation and training of all their patients for the emergency preparedness program. * Interview a patient and ask them to describe their orientation to the facility in terms of emergency protocols and procedures. |  |  |  |  |
|  | **Recommendations: The facility should risk assesses compliance with requirements in all facility types applicable to the organization. Emergency management leaders should work with staff to develop action plans of identified gaps. Successful adoption of the requirements will enable all providers and suppliers wherever located to better anticipate and plan for needs, rapidly respond as a facility, as well as integrate with local public health and emergency management agencies and health care coalitions’ response activities and rapidly recover following the disaster.** |  |  |  |  |

**Resource: CMS Survey and Certification 17-19-ALL** <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-29.pdf>

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