Emergency Management Planning:
Assessing the Risks, Preparing for Recovery

Hurricane Sandy in October 2012 incapacitated four New York City hospitals (including Bellevue Hospital, the city’s major public trauma center), disrupting the city’s healthcare delivery system. Similarly, the massive tornado that flattened much of Joplin, Missouri in May 2011 destroyed one of the town’s two hospitals, killing several patients and staff – exactly when the local populace was most in need of emergency care. The two disasters served as a grim reminder of nature’s ability to inflict catastrophic loss on healthcare facilities of every description, from large systems to small specialty providers.

Hurricane Sandy and the Joplin tornado also demonstrate why all organizations need a workable, detailed, enterprise-wide emergency management plan addressing both natural and man-made crises. The time spent creating this plan – and on reviewing and updating it – can be of vital importance if disaster strikes. It may even mean the difference between organizational survival and failure.

A key element in any risk management strategy is adequate insurance, including professional and general liability, as well as coverage for property damage, fire and business interruption. However, insurance generally will not cover all losses and cannot safeguard patients/residents, prevent loss of vital records and data, or restore the organization’s reputation if care is compromised due to post-disaster operational breakdowns. In the event of a catastrophe, those organizations that have invested sufficient effort in recovery planning will be better able not only to minimize losses and costly interruptions, but also to provide essential emergency services for their community. (For more detailed information about continuity and insurance considerations, see “What’s So Important About Business Interruption Coverage?,” a CNA risk management bulletin. Brokers are another important source of information about business interruption risks and strategies.)

This CNA resource presents general strategies and safety measures to help identify disaster-related risks and potential losses, protect patients/residents and staff from danger, and minimize disruption to both clinical practice and business operations. Sidebars address specific planning considerations for hospitals and aging services settings.

Faced with the pressing concerns of the moment, leadership may be tempted to postpone emergency preparedness planning. However, such delay can have serious consequences for patients, staff and the organization, as well as the larger community. The time to plan for disasters is now.

* “What’s So Important About Business Interruption Coverage?” can be downloaded at http://www.cna.com/vom_content/CNA/Internet/Static%20Files/for%20Download/SalesCenter/NonCo-brandable/Risk%20Control/RC%20Art/Business%20Interruption_CNA.pdf. Readers can also contact CNA Risk Control, which has a team of accredited business continuity specialists on staff, by telephone at (866) 262-0540.
INITIATING THE PLANNING PROCESS
While natural disasters cannot be prevented, their effect may be mitigated through careful planning. According to the American Society for Healthcare Risk Management, a comprehensive emergency management plan has four basic components:

Prevention – Identification and minimization of avoidable risks by an educated and committed leadership team.

Preparation – Drafting of a wide-ranging interdisciplinary plan, encompassing hazard vulnerability analysis, emergency coordination, response measures, mandatory staff training, and testing of vital operational and backup systems.

Implementation – Designation of a command center, evacuation determination, patient/resident tracking, and initiation of emergency security and communication procedures, as well as documentation of decisions and other actions taken during the critical period just before, during and immediately after a disaster.

Recovery – Business continuity planning, as well as such post-event actions as insurance carrier notification, debriefing, and assessing the emergency management plan in terms of both concept and execution.

By understanding all four phases of emergency management – prevention, preparation, implementation and recovery – organizations are better prepared to address a crisis from beginning to end, thus minimizing uncertainty and facilitating recovery.

By understanding all four phases of emergency management, organizations are better prepared to address a crisis from beginning to end, thus minimizing uncertainty and facilitating recovery. Leadership can initiate the planning process and assess organizational readiness by asking certain fundamental questions:

- Does the organization have a top-down commitment to emergency management planning?
- What types of adverse incidents or disasters are most likely to occur?
- Are administrators and staff adequately prepared to respond to these emergency/disaster scenarios?
- What insurance coverage is needed, based on the organization’s specific exposures?
- What other steps can the organization implement in order to reduce its vulnerability to loss?
- Is there an adequate infrastructure in place – e.g., robust communication system, sturdy construction features, established command structure, and backup power and water supplies – to withstand an emergency or disaster?
- Are communication channels in place with local and regional authorities and disaster response agencies?
- Have plans been drafted to safeguard patients/residents in an emergency/disaster situation, whether the decision is made to evacuate or shelter in place?
- Are paper records and files adequately protected in case of a potential fire, flood or other disaster, and are electronic data backed up and stored off site?
- Is a continuity plan in place to help the organization continue operating, even if one or more facilities are damaged or destroyed?

The emergency management plan is an ongoing response to these questions. Once the plan has been created and implemented, it must then be tested for effectiveness, disseminated to staff, and regularly reassessed and updated.

IDENTIFYING RISKS
Begin the process of identifying disaster-related risks by assembling an emergency planning and response team. The team should comprise not only risk management and security personnel, but also managers from such areas as human resources, safety, information management, finance and all clinical disciplines. It should be large enough to function even if some members are incapacitated or out of contact when the event occurs, and should include participation by senior management to ensure enterprise-wide acceptance. The team will also be responsible for implementing the plan in the event of a disaster.
A Sample Fire Safety Plan

Fires are the most common emergency situation and hence serve as a good starting point for emergency planning efforts. During a serious fire or similar emergency, firefighters will probably take command of the facility. Therefore, it is important to develop the fire prevention and safety plan in coordination with local fire departments.

The fire safety plan should assign responsibility for the following measures, among others:

**BEFORE**
- implementing and enforcing proper disposal procedures for flammable materials
- regularly inspecting the electrical system
- ensuring that evacuation routes are well-marked and clear of obstruction
- checking and maintaining fire protection equipment – including extinguishers, smoke detectors, sprinklers, fire doors and alarm systems – according to manufacturer recommendations
- Conducting in-place fire drills at regular intervals, followed by evaluation and recommendations

**DURING**
- declaring an emergency and mobilizing internal emergency responders
- notifying the fire department of the intensity and exact location of the fire
- implementing initial safety steps, such as ensuring that fire doors have closed properly
- dousing smaller and more manageable fires manually, using the facility’s extinguishers or hoses
- evacuating employees, patients/residents and visitors, if necessary
- ensuring that fire protection valves are open and fire pumps are operating
- providing clear access for fire trucks and other emergency vehicles
- meeting arriving firefighters and providing them with necessary information
- removing or covering combustibles, such as oxygen tanks, when possible

**AFTER**
- securing the fire area to avoid reignition
- accounting for all patients/residents and staff by name
- notifying authorities if arson is a possibility
- informing relevant insurance companies as soon as possible, and following their recovery suggestions
- cleaning up excess water quickly to reduce staining, mold and other post-fire damage
- beginning salvage operations, while taking care not to disrupt ongoing insurance or criminal investigations
- debriefing staff and evaluating emergency response protocols and plan execution

This basic format can be followed for other types of disasters, including tornadoes, floods, utility outages, hazardous chemical releases, wildfires and disease outbreaks.
Hospital Planning Considerations

Hospital emergency management plans must address emergency department capacity, triage procedures, equipment loss and other critical demands placed upon physicians, allied healthcare personnel, nursing staff and support areas. The following tasks, organized by department, are fundamental to mitigating disaster-related disruption and expediting recovery:

Administration: Announce disaster conditions, initiate telephone tree procedures, communicate with local emergency agencies, convey emergency policies to personnel in a timely manner and respond to media as indicated.

Admitting: Advise incident commander of bed availability, perform triage, track incoming patients using disaster casualty tags, and manage families and media.

Blood bank: Verify and maintain blood storage and retrieval capabilities in case of power outage.

Emergency department: Assume charge of disaster plan and maintain communication with administration regarding such critical areas as staffing, bed supply, equipment, medications and supplies.

Food service: Distribute meals to patients, staff, volunteers and others following a patient surge.

Housekeeping: Set out beds in hallways and other areas, if necessary, and switch to backup water supply and waste disposal systems.

Morgue: Establish temporary morgue.

Nursing: Redeploy staff to help meet the needs of the emergency department and other vulnerable clinical areas, and supervise patients during evacuation or relocation to emergency shelter.

Operating room and post-anesthesia care unit: Triage scheduled surgical procedures and patients admitted through the emergency department, cancel or postpone procedures scheduled for the next day if necessary, and notify patients of any changes.

Pastoral and social work staff: Deploy staff to a designated area to facilitate communication between the emergency department and families, and provide crisis intervention as needed to patients and families.

Physicians: Assign physicians to clinical areas and utilize labor pools where shortages exist.

Radiology: Implement a plan for increasing bed and stretcher space, using corridors if necessary.

Security: Arrange for traffic control and police protection, secure entrances and storage areas, and implement emergency communication measures.

Transportation: Secure and deploy adequate wheelchair and cart/gurney inventory.

A catastrophic situation, such as a hurricane or tornado, often results in a sudden spike in patient volume just when local healthcare facilities are most vulnerable. At such times, it may be necessary to establish “surge hospitals,” defined by The Joint Commission as temporary facilities set up in non-hospital settings to provide medical care on a stopgap basis until area healthcare facilities can reopen. Such facilities typically include triage, treatment and even surgical capabilities.

For information about effectively managing an area-wide patient surge, see The Joint Commission’s “Surge Hospitals: Providing Safe Care in Emergencies,” available at http://www.jointcommission.org/Surge_Hospital__Providing_Safe_Care_in_Emergencies/.
The following methods may be useful for exploring the organization’s exposure to different types of emergencies:

**Flowcharts** are an important tool for identifying the vulnerabilities within a system or process. By graphically depicting the steps within a clinical or administrative sequence, flowcharts can help reveal interdependencies and potential bottlenecks in critical operations or equipment, and suggest ways to minimize disaster-related disruptions. Flowcharts can diagram and clarify such critical areas as inventory needs, personnel and administrative issues, and vendor relations. For sample emergency procedure flowcharts, see http://www.continuitycentral.com/EmergencyProcedures%20FlowCharts.pdf.

**Employee interviews** are another important method of identifying vulnerabilities. By talking with key staff, team members can learn what routines and equipment are most vulnerable to disruption. Such interviews can also suggest ways to improve contingency plans and otherwise reduce potential loss.

**Team inspection** of vital backup processes, systems and equipment can help assess the capacity to withstand emergency situations. Inspectors should consider how well primary power, gas and water systems will function in a disaster, and identify alternative sources in case of interruption. They should also evaluate the robustness of telephone and Internet communication systems, as well as alarm systems and emergency lighting.

**Self-assessment tools** are essential for tracking the organization’s overall state of readiness for a disaster and identifying where preparations should be strengthened. See the “Emergency Management Self-assessment Checklist” on pages 10-11, which contains a wide range of evaluative questions regarding disaster preparedness and recovery planning. In addition, the resources listed on page 12 provide more detailed information, standards and requirements.

Consultation with police and fire departments, governmental and private agencies, and other external authorities can aid organizations in ascertaining potentially serious local hazards, as well as regional emergency response capabilities.

**QUANTIFYING RISKS**

After identifying potential types of loss, the emergency preparedness team can then prioritize risks and countermeasures. This is accomplished by plotting the likelihood (or frequency) of an occurrence against its potential consequences (or severity). Once the team has calculated the degree of exposure, it can focus its efforts – and management’s attention – on those scenarios that present the greatest threat of significant loss.

Assigning consequences to different events involves in-depth knowledge of organizational processes, so that potentially crippling occurrences can be distinguished from containable ones. The information-gathering techniques described in the previous section for identifying exposures are also useful for evaluating possible severity. Additionally, the team should review balance sheets, financial statements and other accounting records to help gauge the value of organizational assets and operations, and estimate the costs associated with prolonged interruption.

The following tables demonstrate how the risk quantification process operates. Tables 1 and 2 include common terms used to describe frequency and severity; Table 3 depicts how the two axes chart the “risk value” of events and the risk management actions that should be implemented in response.

Once the team has calculated the degree of exposure, it can focus its efforts – and management’s attention – on those scenarios that present the greatest threat of significant loss.
Table 1: Likelihood of Event

<table>
<thead>
<tr>
<th>DESCRIPTOR</th>
<th>DEFINITION</th>
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<tr>
<td>Likely</td>
<td>Event will probably occur at some time (e.g., flooding in a flood plain).</td>
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<tr>
<td>Possible</td>
<td>Event could reasonably be expected to occur at some time (e.g., a serious fire in the facility).</td>
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<tr>
<td>Rare</td>
<td>Event could occur only in exceptional circumstances (e.g., a bomb threat).</td>
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Table 2: Consequences of Event

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<thead>
<tr>
<th>DESCRIPTOR</th>
<th>DEFINITION</th>
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<tbody>
<tr>
<td>Catastrophic</td>
<td>Event could terminate organization’s functioning.</td>
</tr>
<tr>
<td>Major</td>
<td>Event threatens long-term disruption of operations.</td>
</tr>
<tr>
<td>Manageable</td>
<td>Event should produce only minimal disorder, if effective countermeasures are in place.</td>
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Table 3: Loss Exposure Prioritization Matrix

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<tr>
<th>CONSEQUENCES</th>
<th>LIKELY</th>
<th>POSSIBLE</th>
<th>RARE</th>
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</thead>
<tbody>
<tr>
<td>Catastrophic</td>
<td>high</td>
<td>high</td>
<td>medium</td>
</tr>
<tr>
<td>Major</td>
<td>high</td>
<td>medium</td>
<td>low</td>
</tr>
<tr>
<td>Manageable</td>
<td>medium</td>
<td>low</td>
<td>low</td>
</tr>
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</table>

The various risk values suggest the following response strategies:
- **High**: Detailed research and senior management action are urgently required.
- **Medium**: Team should develop and implement specific risk control processes by a reasonable scheduled date.
- **Low**: Event can probably be weathered using routine procedures.

For an example of a hazard vulnerability analysis, and to see how the frequency and severity of catastrophic events can be measured, visit the Web site of the American Society for Healthcare Engineering (ASHE) at www.ashe.org.

**CREATING A COMMAND STRUCTURE**

After risks have been identified and evaluated, the next step is to create an emergency response structure and plan. This involves establishing a chain of command that extends throughout the organization, from senior leadership through each facility and service. (For guidance, consult the Hospital Incident Command System, a model disaster management system that has been incorporated into national emergency response systems. It is available online at http://www.emsa.ca.gov/HICS/files/Guidebook_glossary.pdf.)

The following strategies are designed to support the emergency command structure and maintain leadership control during a crisis:

- **Name an incident commander** with overall responsibility for declaring the emergency, mobilizing the response, and keeping senior management and others informed.

- **Appoint an emergency management committee** staffed with personnel from various departments, which reports to the incident commander and has the authority and resources to ensure that necessary tasks are completed.

- **Establish an emergency operations center** and a backup location to manage such tasks as coordination, information gathering and debriefing.

- **Designate one spokesperson** to be in charge of making public statements and responding to the media with approved responses.

- **Draft emergency procedures** for recalling off-duty personnel and communicating with offsite parties, including patient/resident families, suppliers, community members and the media.

- **Assign responsibility for contacting government agencies**, as well as neighboring healthcare facilities, emergency response organizations and other outside entities.

- **Post a list of emergency contact names and telephone numbers in strategic locations**, ensuring that it is available electronically as well. Include all nearby fire and police departments, ambulance services, utility companies, contractors, insurance companies, and the local Environmental Protection Agency office and other government authorities.
Compile an up-to-date list of consultants, vendors and suppliers, including, but not limited to:

- telecommunications companies
- Internet service providers
- forensic accounting firms
- storage companies
- construction contractors
- builders/engineers
- mold remediation specialists
- document restoration services
- information technology companies
- medical equipment/supply distributors
- pharmaceutical distributors
- demolition services
- forensic accounting firms
- storage companies
- construction contractors
- builders/engineers
- mold remediation specialists
- document restoration services
- information technology companies
- medical equipment/supply distributors
- pharmaceutical distributors
- demolition services

**Aging Services Facility Planning Considerations**

Federal law mandates that Medicare- and Medicaid-certified aging services settings have “detailed written plans and procedures to meet all potential emergencies and disasters.” Facilities are further required to “train employees in emergency procedures.” State surveys assess compliance with these legal requirements.

A 2006 report by the Department of Health and Human Services Office of Inspector General (OIG), “Nursing Home Emergency Preparedness and Response During Recent Hurricanes,” suggests that the following provisions (among others) be included in aging service facilities’ emergency management plans:

**Community coordination:** Formalize procedures for working with and submitting plans to local emergency response agencies.

**Decision to evacuate:** Establish criteria and processes to determine whether to evacuate the building or shelter in place, taking into account internal considerations, as well as recommendations or instructions from local authorities.

**Evacuation procedures:** Draft policies and procedures, assign specific roles and responsibilities, and include contingency plans. Specify primary and secondary evacuation routes and estimated travel times.

**Food and water supply:** Ensure that adequate stocks of food and potable water are available, in the event of a breakdown of normal supply channels and pumping systems.

**Medical records:** Implement measures to protect resident records from fire or other disaster, and to ensure that necessary records follow residents during an evacuation.

**Reentry strategy:** Devise post-evacuation inspection procedures, determine who will authorize reentry into the facility and decide how residents will be returned from the temporary host facility.

**Relocation agreements:** Establish written mutual agreements with similar facilities to take in each other’s residents in case an evacuation is necessary.

**Resident needs:** Compile and maintain an up-to-date, portable list of the medical needs of individual residents and the personal belongings that should accompany them if evacuation is necessary.

**Staffing plan:** Make emergency assignments in advance and determine which staff members will accompany evacuated residents.

**Transport issues:** Execute emergency transportation contracts for residents in advance, preferably with multiple vendors. Ensure that residents, while in transit, have access to necessary food, water and medications, and that drugs remain under a nurse’s control.

IMPLEMENTING RESPONSE MEASURES
When lines of control and command are in place, the team can then establish procedures for protecting patients/residents, maintaining essential services and mitigating losses. The written emergency response plan should designate responsibility for the following basic tasks, among others:

Develop procedures for patient/resident evacuation, as well as search and rescue. The evacuation plan should assign staff members from every area to act as floor leaders and monitors.

Emphasize security. In the event of a disaster, it may be necessary to lock down the facility. Security procedures should be time-based and address such concerns as tracking patients/residents and employees, preventing looting, preserving basic order and coordinating with police.

Train personnel in disaster policies, procedures and command structures. Training should include explanation of procedures, regular disaster drills, and subsequent evaluation and discussion. It should be ongoing and mandatory for contracted workers and volunteers, as well as nursing staff and physicians, who should be cross-trained to assume other duties within their scope of practice.

Maintain system functioning. Key systems include power, gas, water, refuse collection, sewage, communication, storage, ventilation and heating/air conditioning. The emergency response plan should contain thorough, enterprise-wide instructions for managing system outages, switching to backup systems if necessary, and repairing structural and non-structural damage to all exposed buildings.

Obtain expert input. Request input and active involvement by local first responders, if possible, when designing and reviewing the emergency management plan, and participate in local and regional emergency drills. The partnerships formed during exercises can prove useful later if a disaster occurs.

Test the plan. Once instituted, the response plan should be thoroughly tested. The first level of testing involves “table-top” exercises, in which team members review the plan’s effectiveness by talking through various disaster scenarios. The second level is “walk-through” drills, in which responders perform their functions using the methods and communication tools indicated in the plan.

Update the plan. The emergency response plan should be evaluated at least annually and updated to reflect organizational changes, lessons learned and emerging exposures.

TAKING CHARGE DURING A DISASTER
The following measures, if effectuated during and just after an emergency situation, can help minimize potential panic and chaos, maintain staff numbers and morale, and facilitate recovery and restoration of services:

Account for all patients/residents, employees, visitors and others who may have been in the facility at the time of the disaster.

During extreme disasters, follow written criteria to determine whether to evacuate the building or shelter in place, taking into consideration patients’ or residents’ condition and mobility level. Patient packing lists and care need descriptions should be prepared in advance.

Using multiple media, maintain constant communication with police and fire departments, as well as patient/resident families, off-duty staff, suppliers, contractors, utility companies, disaster assistance agencies and local media. If regular telephone service is disrupted, employ alternatives, such as cellular telephone “trees,” electronic mail “blasts” and broadcast faxes.

Address security and repair needs, implementing established protocols regarding patient/resident tracking, damage assessment (including contamination threats) and security evaluation (especially regarding drug and food stockpiles). Initiate search and rescue efforts, if necessary, and document injuries, structural damage and the functional level of basic systems.

Manage staff needs, including emergency shelter, meals, child care and other family issues, immunizations and psychological support. Utilize temporary staffing, including borrowing personnel from sister facilities, as needed.

Monitor transportation and supply issues, utilizing backup service providers and supply sources as necessary, including government and charitable organizations.

Maintain a risk management diary, documenting events as they occur, including decisions made, internal and external communications, and the extent of observed damage and disruption, with photographic support if possible. The diary also should contain itemized invoices, receipts, time sheets and other staff records.

Evaluate the plan and its execution, once the immediate crisis has passed.
PLANNING FOR RECOVERY
Recovery and continuity planning covers a wide range of activities, including stockpiling and securing food, medications and emergency supplies; backing up data; reviewing fiscal resources; and protecting property by segregating loss exposures and designing buildings and storage areas to minimize vulnerability to fire and flood damage. The first priority is to secure the safety of patients/residents and staff by minimizing disruptions in care.

The following guidelines can enhance continuity even in the most adverse circumstances:

Investigate potential substitutes for specific vaccinations and other medications that are likely to spike in demand due to a disaster. Instruct staff to make use of these alternatives as circumstances dictate.

Identify multiple suppliers of key medicines, equipment and services, and maintain relationships with them. Have this list on hand in case normal supply channels are disrupted.

Ensure that the facility’s backup generator is reliable, well-fueled and of adequate capacity in the event of a prolonged power outage, and know how to switch to backup power quickly. In addition, identify at least two sources of electricity from different substations, and arrange with local utility companies for the use of special generators and transformers in case of emergency.

Maintain an up-to-date list of local sources of heavy equipment, including boilers, heaters, compressors and pumps. This equipment is often available on trailers and can be brought to sites quickly.

Contract in advance with other healthcare providers to assume service obligations that cannot be fulfilled in the wake of a disaster, and identify organizations and locations designated as “surge” facilities. (See page 4 for more information.)

Retain the daily census in hard-copy format for documentation, notification and payment purposes, in case computer data are lost.

For more detailed information, see “Business Continuity Planning Reference Guide,” a CNA Risk Control resource that outlines the seven phases of continuity planning. It is available at https://www.cna.com/vcm_content/CNA/internet/Static%20File%20for%20Download/Act%20Now/CNABusinessContinuityBrochure.pdf.

PROTECTING ELECTRONIC DATA
Business and operational continuity requires access to essential clinical, personnel and financial records. The following guidelines can reduce the risk of losing vital data due to disruption of the information processing system:

Place servers in their own controlled-access room, equipped with smoke and heat detectors, and maintain a spare server for emergency use. Computer rooms should never be situated in a basement or other vulnerable area.

File computer-related invoices, shipping lists and other documentation off site for rapid reference and replacement, if necessary.

Install and regularly update protective devices and software for computers, including anti-virus software, electronic fire walls and surge protectors.

Back up data – including accounting and payroll records, employee files, patient/resident lists, procedures, suppliers and inventory – on a daily, hourly or continuous basis. Retain off site a backup copy of the computer’s operating system, boot files and essential software.

Identify third-party electronic data processing service providers and sources of new and rental computer equipment outside of the potentially affected area, and arrange with them for services on a contingency basis. Vendors exist who can provide and set up hundreds of computers with necessary software within 24 hours.

REBUILDING AND REOPENING
Despite the best precautions, there is always a possibility that a healthcare facility may be rendered inoperable by a natural calamity, accident or attack. The following strategies can help organizations relocate and restart operations as quickly as possible:

Prepare a reconstruction plan in advance, including an updated list of contractors, movers, equipment vendors and staffing agencies, in order to facilitate rebuilding and reopening.

Store copies of the building and layout blueprints off premises to aid in reconstruction.

Track the availability of nearby empty buildings for short-term resumption of activities, as well as vacant land in the area for rebuilding, if necessary.

In a crisis, a sound emergency management plan can be a lifesaver for patients/residents and staff. The guidelines included in this publication, and in the outside resources listed on page 12, can help organizations maintain order and safety, prevent major disruptions and reduce disaster-related loss. Nature cannot be controlled, but it is possible to respond to events in such a way as to minimize chaos and fulfill our responsibilities to those in our care.
## Emergency Management Self-assessment Checklist

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<tr>
<th>QUESTION</th>
<th>YES</th>
<th>NO</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td><strong>RISK IDENTIFICATION</strong></td>
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<tr>
<td>1. Have all foreseeable sources of disaster been identified?</td>
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<td>2. Has a broad-based team representing all aspects of the organization participated in the risk identification process?</td>
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<td>3. Have the concerns of the team been adequately addressed?</td>
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<td>4. Have the team’s recommendations been implemented?</td>
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<tr>
<td><strong>RISK ASSESSMENT</strong></td>
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<td>1. Have identified loss exposures been categorized and quantified?</td>
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<td>2. Has a matrix been developed to help prioritize loss exposures?</td>
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<td>3. Has a decision been made as to those risks requiring senior management attention?</td>
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<td>4. Have response measures and their projected costs been identified?</td>
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<td>5. Has the potential impact of a disaster on vendors, suppliers and utility companies been considered and evaluated?</td>
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<td>6. Have interdependencies between departments and areas been identified and evaluated?</td>
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<td><strong>EMERGENCY MANAGEMENT PLANNING AND PREPARATION</strong></td>
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<tr>
<td>1. Has an emergency management/disaster recovery team been established?</td>
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<td>2. Are the roles and responsibilities of team members clearly delineated?</td>
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<td>3. Has the team’s chain of command been firmly established?</td>
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<td>4. Has the team been trained in all aspects of the emergency plan?</td>
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<td>5. Has an emergency operations center been designated?</td>
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<td>6. Have emergency communication methods (including backup systems) been identified, and is equipment available to support these methods?</td>
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<td>7. Is a current emergency contact list, with names and telephone numbers clearly noted, available in both hard-copy and electronic form?</td>
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<td>8. Has a list of preferred and alternative vendors/suppliers been drafted, including telephone numbers and Web sites?</td>
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<td>9. Are mutual, contractual disaster and evacuation arrangements in place with other healthcare organizations?</td>
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<tr>
<td>10. Have emergency evacuation, search and rescue procedures been developed?</td>
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<tr>
<td>QUESTION</td>
<td>YES</td>
<td>NO</td>
<td>COMMENTS</td>
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<tr>
<td><strong>EMERGENCY MANAGEMENT PLANNING AND PREPARATION (CONTINUED)</strong></td>
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<tr>
<td>11. Have detailed diagrams been developed of the facility and surrounding area, depicting all critical access/escape routes?</td>
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<td>12. Have all staff members, temporary/contracted employees and volunteers been trained in emergency procedures, and has this training been documented?</td>
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<td>13. Have incident-specific procedures been developed for identified risks?</td>
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<td>14. Are computer records and other important documents backed up and securely stored?</td>
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<tr>
<td>15. Are arrangements in place for post-crisis psychological counseling of patients/residents and employees?</td>
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<td>16. Have risk control and mitigation measures been upgraded, as needed, to address changing conditions and emerging exposures?</td>
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<tr>
<td>17. Do response plans meet the requirements of the Occupational Safety and Health Administration, Environmental Protection Agency and other regulatory bodies?</td>
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<td>18. Is the disaster recovery plan in writing and available for review?</td>
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<tr>
<td><strong>PLAN IMPLEMENTATION AND TESTING</strong></td>
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<tr>
<td>1. Have all parties involved with the emergency management plan received initial training, and do they undergo ongoing refresher training?</td>
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<tr>
<td>2. Have “table-top” exercises been performed to evaluate the thoroughness and effectiveness of the plan?</td>
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<td>3. Have team members been trained using walk-through drills (i.e., simulation testing)?</td>
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<td>4. Have public agencies been included in walk-through drills?</td>
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<td>5. Is the plan regularly updated to reflect mistakes made and lessons learned during testing/drills?</td>
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<tr>
<td><strong>DISASTER RECOVERY</strong></td>
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<tr>
<td>1. Have different disaster scenarios been considered?</td>
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<tr>
<td>2. Have recovery priorities been built into the plan?</td>
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<tr>
<td>3. Have procedures been developed to contact families, government agencies, suppliers, media and community representatives immediately after the disaster?</td>
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<td>4. Are arrangements in place to establish alternate care locations, if necessary?</td>
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<td>5. Have all insurance options, conventional and alternative, been fully considered?</td>
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</table>
Emergency planning involves a wide range of regulatory issues. Start by reviewing local laws regarding life safety and fire prevention. Other resources for emergency planning include the following Web sites, standards, tools and publications:

- American Health Information Management Association (AHIMA), at www.ahima.org
- CNA Act Now! Web site, at http://www.cna.com/portal/site/cna/menuitem.8d87d3c63eb4a81fc7c9eca0a86631a0/?vgnextoid=08ab5ccd1ceceb010VgnVCM1000008966130aRCRD
- CNA Risk Control Web site, offering a wide range of safety resources, at www.cna.com/riskcontrol
- International Association for Disaster Preparedness and Response (DERA), at http://www.disasters.org
- The Joint Commission’s Emergency Management Standards, addressing disaster planning, drills, infection control and related issues for ambulatory surgery centers and aging services facilities, available at www.jointcommission.org
- National Oceanic and Atmospheric Administration (NOAA), at www.noaa.gov
- Occupational Safety and Health Administration (OSHA) standards and tools, available at www.osha.gov (click on “Emergency Preparedness”)
- United States Environmental Protection Agency (EPA), which offers information on hazardous materials release and the Emergency Planning and Community Right-to-Know Act, among many other related topics, at www.epa.gov

For more information, please call us at 888-600-4776 or visit www.cna.com.