NON-HOSPITAL MEDICAL AND SURGICAL FACILITIES
ACCREDITATION PROGRAM

Accreditation Standards

Emergency Preparedness

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INTRODUCTION

Every non-hospital facility needs to be prepared for medical and non-medical (flood, power outage) emergencies so staff will know what to do in the case of an emergency. The acronym R-E-A-D-Y may be helpful in coordinating emergency drills.

Rehearse: Through rehearsal and practice, actions become second nature.

Exercise: Hold frequent emergency drills (exercises) to fine-tune the emergency skills of staff.

Assess: Assess how well your emergency plans address the situation. Are there things you forgot to plan for? Does the plan need to be updated, edited or enhanced in some way?

Develop: Develop facility-specific and realistic plans and conduct a variety of drill scenarios often to allow individuals to rehearse what their actions would be in the event of a real emergency. It is recommended that facilities have an emergency manual containing the policies and procedures for medical and non-medical emergencies only and that copies of the emergency manual are available in each patient care area (i.e. operating/procedure room, PACU).

Yearly: The facility emergency plans should be re-assessed annually at a minimum.

EMGP1.0 EMERGENCY PREPAREDNESS

EMGP1.1		**There are medical emergency preparedness plans that outline how to respond in the event of an emergency.** *Guidance: Medical emergencies are reported to the College as soon as the immediate danger to patients and staff has been eliminated*
EMGP1.1.1	**M**	There is policy and procedures for cardiac arrest. *Guidance: All facilities are required to have policy and procedures for this medical emergency.*

EMGP1.1.2	**M**	There is policy and procedures for malignant hyperthermia. *Guidance: All class 1 general anesthesia facilities are required to have all of the equipment, supplies and medications to respond to a malignant hyperthermia crisis as specified in the malignant hyperthermia standard. Succinylcholine is a required medication on a class 1 emergency cart. However class 2 IV procedural sedation and class 3 local anesthesia only facilities are not required to stock succinylcholine on their emergency cart. If a class 2 or class 3 facility has succinylcholine on site then the facility is required to have all of the equipment, supplies and medication to respond to a malignant hyperthermia crisis as specified in the malignant hyperthermia standard.*
EMGP1.1.3	**M**	There is policy and procedures for cardiac chest pain. *Guidance: All facilities are required to have policy and procedures for this medical emergency.*
EMGP1.1.4	**M**	There is policy and procedures for respiratory emergencies. *Guidance: All facilities are required to have policy and procedures for this medical emergency.*
EMGP1.1.5	**M**	There is policy and procedures for anaphylaxis. *Guidance: All facilities are required to have policy and procedures for this medical emergency.*
EMGP1.1.6	**M**	There is policy and procedures for hypoglycemia. *Guidance: All facilities are required to have policy and procedures for this medical emergency.*
EMGP1.1.7	**M**	There is policy and procedures for hypotension/hypovolemia. *Guidance: All facilities are required to have policy and procedures for this medical emergency.*
EMGP1.1.8	**M**	There is policy and procedures for syncope. *Guidance: All facilities are required to have policy and procedures for this medical emergency.*
EMGP1.1.9	**M**	There is policy and procedures for neurological emergencies. *Guidance: All facilities are required to have policy and procedures for this medical emergency. Neurological emergencies include but are not limited to unresponsiveness NYD, stroke and seizure.*
EMGP1.1.10	**M**	There is policy and procedures for local anesthetic systemic toxicity. *Guidance: All class 1 facilities are required to have policy and procedures for this medical emergency. Any class 2 or class 3 facilities with bupivacaine or ropivacaine on site are required to have policy and procedures for this medical emergency.*
EMGP1.1.11	**M**	There is policy and procedures for an incapacitated anesthesiologist and/or surgeon. *Guidance: All facilities are required to have policy and procedures for this medical emergency.*
EMGP1.1.12	**M**	There is policy and procedures for patient transfer to hospital. *Guidance: All facilities are required to have policy and procedures for patient transfer to hospital. When patient transfer to hospital is indicated, the patient must be transferred via emergency health services (EHS). The most responsible physician (MRP) determines whether a regulated health professional needs to accompany the patient during transfer. If not accompanying the patient, the MRP must contact the receiving physician immediately by phone or in person to ensure continuity of care. Patient transfer to hospital is a patient safety incident requiring mandatory reporting to the College.*

EMGP1.2		**There are non-medical emergency preparedness plans that outline how to respond in the event of an emergency.** *Guidance: Non-medical emergencies are reported to the College as soon as the immediate danger to patients and staff has been eliminated.*
EMGP1.2.1	**M**	There is policy and procedures for fire in the building/facility. *Guidance: All facilities are required to have policy and procedures for this non-medical emergency. In accordance with the BC Fire Code, the policy and procedures are to include sounding the fire alarm, notifying the fire department, evacuating occupants including persons requiring assistance such as those in the operating/procedure room or post-anesthesia recovery, confining, controlling and extinguishing the fire, the training of supervisory and other staff in their responsibilities for fire safety, documents showing the type, location and operation of the fire emergency system and the holding of fire drills. The BC Fire Code also requires that these procedures be reviewed at intervals not greater than 12 months. In accordance with the Bylaws, if the facility has been subject to flood, fire, hazardous material incident or suffered significant structural damage, the medical director shall immediately provide written notification to the NHMSFAP Committee and the facility must immediately cease operations until it has been approved by the committee to resume operations.*
EMGP1.2.2	**M**	There is policy and procedures for fire in the operating room. *Guidance: All facilities are required to have policy and procedures for this non-medical emergency. In accordance with the BC Fire Code, the policy and procedures are to include sounding the fire alarm, notifying the fire department, evacuating occupants including persons requiring assistance such as those in the operating/procedure room or post-anesthesia recovery, confining, controlling and extinguishing the fire, the training of supervisory and other staff in their responsibilities for fire safety, documents showing the type, location and operation of the fire emergency system and the holding of fire drills. The BC Fire Code also requires that these procedures be reviewed at intervals not greater than 12 months. In accordance with the Bylaws, if the facility has been subject to flood, fire, hazardous material incident or suffered significant structural damage, the medical director shall immediately provide written notification to the NHMSFAP Committee and the facility must immediately cease operations until it has been approved by the committee to resume operations.*
EMGP1.2.3	**M**	There is policy and procedures for a flood. *Guidance: All facilities are required to have policy and procedures for this non-medical emergency. In accordance with the bylaws, if the facility has been subject to flood, fire, hazardous material incident or suffered significant structural damage, the medical director shall immediately provide written notification to the NHMSFAP Committee and the facility must immediately cease operations until it has been approved by the committee to resume operations.*
EMGP1.2.4	**M**	There is policy and procedures for a gas leak. *Guidance: All facilities are required to have policy and procedures for this non-medical emergency. Depending on the facility, the policy and procedure may include medical gas pipeline systems gas leaks, medical equipment gas leaks (i.e. lasers) and/or building infrastructure (physical plant) gas leaks.*

EMGP1.2.5	**M**	There is policy and procedures for a hazardous spill. *Guidance: All facilities are required to have policy and procedures for this non-medical emergency. A hazardous material spill includes things such as chemicals, radioactive materials, biohazard materials, oil and gas (i.e. liquid nitrogen) and flammable materials. In accordance with the Bylaws, if the facility has been subject to flood, fire, hazardous material incident or suffered significant structural damage, the medical director shall immediately provide written notification to the NHMSFAP Committee and the facility must immediately cease operations until it has been approved by the committee to resume operations.*
EMGP1.2.6	**M**	There is policy and procedures for a power loss. *Guidance: All facilities are required to have policy and procedures for this non-medical emergency. The policy and procedures should outline the essential/critical equipment that require an uninterrupted power supply (UPS) and/or need to be connected to outlets powered by the emergency generator and alternate light sources (i.e. working flashlights in every operating room and on every anesthesia machine).*
EMGP1.2.7	**M**	There is policy and procedures for equipment failure. *Guidance: All facilities are required to have policy and procedures for this non-medical emergency.*
EMGP1.2.8	**M**	There is policy and procedures for an earthquake. *Guidance: All facilities are required to have policy and procedures for this non-medical emergency. In accordance with the Bylaws, if the facility has been subject to flood, fire, hazardous material incident or suffered significant structural damage, the medical director shall immediately provide written notification to the NHMSFAP Committee and the facility must immediately cease operations until it has been approved by the committee to resume operations.*
EMGP1.2.9	**M**	There is policy and procedures for managing violent and aggressive behaviour. *Guidance: All facilities are required to have policy and procedures for this non-medical emergency. The policy and procedures for dealing with the prevention of, and response to, incidents of violence must distinguish between incidents involving two workers ("improper conduct") and incidents of aggressive behaviour from a patient or member of the public ("violence"). WorkSafeBC has publications providing guidance on assessing and mitigating hazards. All incidents of improper conduct and violence must be formally investigated, whether any injury occurred or not.*
EMGP1.2.10	**M**	There is policy and procedures for security of the facility. *Guidance: All facilities are required to have policy and procedures for this non-medical emergency. The policy and procedures for security of the facility should outline safety of patients, personnel and visitors and what to do in the event of a security breach (i.e. theft, unauthorized person).*
EMGP1.3	**The facility is physically prepared for an emergency.**	
EMGP1.3.1	**M**	Facility access and entry points are clearly marked.
EMGP1.3.2	**M**	Emergency exit routes are marked and provide unimpeded exit.
EMGP1.3.3	**M**	Staff know the nearest exit and alternate exit.

EMGP1.3.4	**M**	Staff know the emergency assembly point/muster point location. *Guidance: There must be a designate place or area where all staff and patients assemble following building evacuation.*
EMGP1.3.5	**M**	Fire and smoke detectors are unobstructed and located throughout the facility.
EMGP1.3.6	**M**	Fire and smoke detectors are inspected annually at a minimum.
EMGP1.3.7	**M**	Fire alarms are unobstructed and located throughout the facility.
EMGP1.3.8	**M**	Fire alarms are inspected annually at a minimum.
EMGP1.3.9	**M**	Fire extinguishers are unobstructed and located throughout the facility. *Guidance: Section 6.2 of the BC Fire Code requires that fire extinguishers be checked monthly to confirm that they are located in their designated place, there is no obstruction to access or visibility, there is no obvious physical damage, corrosion or leakage, safety seals and tamper indicators are not broken or missing.*
EMGP1.3.10	**M**	Fire extinguishers are inspected annually at a minimum. *Guidance: Documentation of fire extinguisher inspection is on file and each fire extinguisher has a tag confirming that it has been inspected and tested by an authorized fire protection professional.*
EMGP1.3.11	**M**	Staff know the location of the utility shut-offs . *Guidance: There must be at least two staff members on site each surgical day that know the location of the utility shut-offs and how to shut off the utilities. Utility shut-offs include but are not limited to natural gas, medical gas, water, electricity.*
EMGP1.3.12	**M**	Staff know how to shut off the utilities. *Guidance: There must be at least two staff members on site each surgical day that know the location of the utility shut-offs and how to shut off the utilities. Utility shut-offs include but are not limited to natural gas, medical gas, water, electricity.*
EMGP1.3.13	**M**	Emergency telephone numbers and the facility address are posted near patient care areas and wherever there is a telephone available.
EMGP1.3.14	**M**	There is a process/system to alert staff members when an emergency occurs. *Guidance: There is a system (voice communication system, public announcement system, paging system) to alert staff of an emergency.*
EMGP1.4	**Emergency medications and equipment supports the early treatment of medical emergencies.**	
EMGP1.4.1	**M**	The emergency cart is portable. *Guidance: The rolling/mobile cart transports the emergency cart medication and equipment to the location of the medical emergency.*
EMGP1.4.2	**M**	The emergency cart is located in a common patient care area. *Guidance: The emergency cart is located near the operating room and post-anesthesia recovery areas and allows for a target collapse-to-shock interval of less than three minutes. The emergency cart is not located in the operating/procedure room.*
EMGP1.4.3	**M**	The emergency cart is checked before the start of the first case of the day.
EMGP1.4.4	**M**	The emergency cart is checked every surgical/procedural day to ensure the cart is appropriately stocked.

EMGP1.4.5	**M**	The emergency cart equipment is checked every surgical/procedural day to ensure proper working order.
EMGP1.4.6	**M**	The duty of checking the emergency cart is rotated among all staff. *Guidance: Both operating room staff and post-anesthesia care staff are included in the rotating duty. This practice will familiarize all clinical staff with the contents of the cart and how to operate the equipment so that in the event of an emergency, locating items in the cart and operating the equipment becomes second nature.*
EMGP1.4.7	**M**	The emergency medications are within their labeled expiry date.
EMGP1.4.8	**M**	The emergency medications are accessible and organized.
EMGP1.4.9	**M**	The emergency equipment is within its labeled expiry date.
EMGP1.4.10	**M**	The emergency equipment is accessible and organized.
EMGP1.4.11	**M**	Emergency cart checks are documented.
EMGP1.5	**Periodic emergency drills ensure that the facility is physically prepared and staff ready to act in the event of an emergency.**	
EMGP1.5.1	**M**	All personnel receive emergency readiness training. *Guidance: Personnel include physicians, dentists, oral maxillofacial surgeons, podiatric surgeons, nurses and other staff. Training should occur at the following time points: orientation, changes in emergency cart medications and/or equipment; changes in roles and/or responsibilities; and changes in facility emergency policy and procedures. This training is recorded in a log.*
EMGP1.5.2	**M**	Periodic simulated emergency drills are performed every six months at a minimum. *Guidance: A written evaluation (drill report) should be completed following each drill that includes any additional training needs or policy, procedures or practice changes identified in the evaluation of the simulated emergency drill as well as the action(s) taken. All personnel attendance/participation in emergency drills is recorded. The BC Fire Code requires fire drills to be conducted at intervals not greater than 12 months. Malignant hyperthermia drills should be conducted every six months.*
EMGP1.5.3	**M**	All personnel participation in simulated emergency drills is documented.

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