Adapting Standards of Care under Extreme Conditions: Guidance for Professionals During Disasters, Pandemics, and Other Extreme Emergencies

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Adapting Standards of Care Under Extreme Conditions

Guidance for Professionals During Disasters, Pandemics, and Other Extreme Emergencies

Prepared for the
American Nurses Association
by the Center for Health Policy,
Columbia University School of Nursing

Published March 2008

POLICY BY THE PEOPLE

Letter

Starting in 2006, the American Nurses Association (ANA) embarked on a new effort to significantly engage registered nurses and the nursing profession in ANA's policy development process on a timely policy issue impacting the profession. ANA's policy conference, *Nursing Care in Life, Death and Disaster* and the resulting policy document, *Adapting Standards of Care under Extreme Conditions: Guidance for Professionals During Disasters, Pandemics, and Other Extreme Emergencies*, are the first in a series of policy conferences convened by ANA to engage and involve the nursing public. This resulting policy document speaks to individual health professionals who find themselves providing care during an extreme emergency when the usual resources – both human and material – may not be available. Under these conditions, health professionals are often faced with questions and concerns related to the standard of care that can be realistically provided.

In developing this policy paper, ANA sought to engage the nursing public through a variety of feedback mechanisms. First, a multidisciplinary expert panel was convened to advise ANA on the policy questions related to standards of care and to develop strategies that can guide health professionals, institutions and policy makers in such challenging circumstances. Secondly, and more importantly, ANA hosted a conference of nursing professionals to provide participants with an opportunity to review the document and provide significant feedback to ANA and the expert panel. Finally, members of the general nursing public and other stakeholders had an opportunity to review the document and again provide feedback to ANA and the expert panel. This final policy paper reflects much of the input received and is a product of those who participated.

Thank you to all of the conference participants and to the members of the expert panel for participating and offering your professional feedback to ANA. Your comments are valued and were thoroughly considered. ANA looks forward to your participation in future policy conferences.

Sincerely,

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Acknowledgments

This project was supported by grant number 1 R13 HS016894 from the Agency for Healthcare Research and Quality.

The American Nurses Association appreciates the support of the Association of State and Territorial Directors of Nursing (ASTDN) for this project.

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Introduction and Purpose

Policy makers and health professionals, including registered nurses, physicians and others, have asked a range of important questions regarding the ethics and standards that apply to decisions about care made during unusual or extreme circumstances such as those resulting from emergencies, disasters or pandemics. The decisions include changes in usual practices due to changes in resources available, or practice in unusual settings, or practice in a setting or with patient care needs unfamiliar to the clinician.

The American Nurses Association, in response to these questions, convened a multidisciplinary expert panel to identify more precisely the significant policy questions that need to be addressed and to develop strategies that can guide health professionals, institutions and policy makers in such challenging situations. This White Paper is based on the deliberations of that panel, informed by feedback received from participants in a national meeting on care during disasters and a review of state and national guidelines for standards of care in other settings and professions.

Terminology becomes extremely important in any document such as this. One of the most vexing is how to describe the challenging process of making the best use of the competencies of the health professionals who are available to provide care during an emergency event without inadvertently opening ongoing inter-professional debates such as those about scope of professional practice. Even though—under some declared emergency situations in some states—licensing laws may be suspended or altered, licensed health professionals should continue to be bound by professional legal requirements even when applying their skills and knowledge in extreme circumstances. A dentist does not become a surgeon, a nurse does not become a pharmacist, a physician does not become a radiation technologist. The authors of this paper do not intend for it to be used other than to guide sound practice of each health profession by the members of that profession when a community emergency occurs.

The document speaks primarily to the individual professional in a care giver or service provider role, whether:

- at the immediate site of a disastrous event when it happens,
- at the usual place of work when it is affected by the disaster, or
- at some other site because of relocation of usual place of work or work in a volunteer program or unit.

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No document can contain all of the answers to the many questions that will arise during situations such as these. There are no pre-determined answers to the specific questions that arise in any emergency event, but the perspectives provided should assist a registered nurse, advanced practice nurse, physician, dentist, or other professional, whether working in a hospital, office, public health agency, community setting, faith-based organization, shelter, or transport.

Beyond individual practitioners, this document can provide valuable guidance to a wide range of health professionals, including employees of health organizations (e.g., hospitals, community-based clinics, public health agencies), emergency planners, other public health partners (public health advisors, public health educators), and health profession educators. It is important to remember that the following material cannot and will not serve as a substitute for two paramount requirements of overarching significance:

- The responsibility of every professional to maintain a state of professional readiness for emergency response.
- The responsibility of every organization or institution to plan for and practice emergency response.

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Definitions and Foundations

The practice expectations for any registered nurse or other health professional are a combination of general standards of professional practice, standards of performance , professional codes of ethics, legal regulation, personal and institutional values, individual competencies and the specific workplace and situational context. The context will change when there is an extreme emergency,[1] even before it can be officially "declared" by an institutional or governmental authority, but how will these other standards, codes, regulations, and values change in such a situation? No emergency changes the basic standards of practice, code of ethics, competence or values of the professional. (Legal structures for health professionals *MAY* change *IF* the emergency is in a state that allows for such alterations under emergency powers.) The specific application of standards will be based on the reality of the specific situation, such as presence or absence of usual equipment, medications or colleagues.

As attention to emergency preparedness has expanded during the early part of the 21st century, multiple deliberations have informed the discussions of expectations, needed skills or institutional requirements. This analysis is based on, and consistent with, the principles of the National Incident Management System (NIMS) and the National Incident Response Plan, particularly the "all hazards" approach. The particular focus here is those times during an emergency when the health professional is in a situation of increased need for logistics/resources, when there are both an increase in the numbers of critically ill or injured patients seeking care and a decrease in the full range of usual structures and supports. Although NIMS and the National Response Plan are very helpful, they are not specifically designed to guide nurses, physicians or other licensed health care professionals working in these unusually challenging situations in ethical, legal, safe, efficient and compassionate care.

While every care decision is an individual one, all emergency preparedness, including NIMS, begins with a community perspective. Health professionals should be actively supporting community engagement in emergency planning that pays attention to population diversity and is culturally competent. Decisions made in the planning process should be transparent to community members, who should receive regular information about preparedness. Nurses and all health professionals, whether their practice is primarily in community settings or within institutions, should be engaged in the planning, training and exercising for emergencies and modeling good preparedness practices to other community members.

[1] The most common cause of an extreme emergency is an unusual environmental condition (e.g. flood, power failure), whether due to forces of nature or human action.

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Foundational documents that inform this discussion include: emergency preparedness and response competencies expected of health professionals, scope and standards of care documents issued by professional organizations such as the ANA Code of Ethics for Nurses, and a wide range of guidelines on care in emergencies produced by professional organizations, governmental agencies (federal, state, and local), or specific institutions.

Standards are authoritative statements by which a profession describes the responsibilities for which its practitioners are accountable. The American Nurses Association (ANA), the professional organization for all registered nurses, has assumed the responsibility for developing generic standards that apply to the practice of all professional nurses. Standards provide direction for professional nursing practice and a framework for the evaluation of this practice. Written in measurable terms, standards define the nursing profession's accountability to the public and the outcomes for which registered nurses are responsible.

The Standards of Nursing Practice consists of "Standards of Practice" and "Standards of Professional Performance" (ANA, 2004). The Standards of Practice describe a competent level of nursing care as demonstrated by critical thinking in application of the nursing process (encompassing all significant actions taken by registered nurses and forming the foundation of the nurse's decision-making), with components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Several themes span all areas of nursing practice (and most health professions), are fundamental to many of the standards, and have emerged as being consistently and significantly influential in current nursing practice. These themes include:

- Providing age-appropriate and culturally and ethnically sensitive care
- Maintaining a safe environment
- Educating patients about healthy practices and treatment modalities
- Assuring continuity of care
- Advocating for patients
- Coordinating the care across settings and among caregivers
- Managing information
- Communicating effectively
- Utilizing technology

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The Standards of Professional Performance describe a competent level of behavior in the professional role, including activities related to quality of practice, education, professional practice evaluation, collegiality, collaboration, ethics, research, resource utilization, and leadership.

ANA's *Code of Ethics for Nurses with Interpretative Statements* (2001) is built on nine ethical provisions that, regardless of setting, constitute a framework to support nurses in their practice. The Code addresses the nurse's responsibility and obligation to practice with compassion, respect, and commitment to patients; to preserve integrity and safety; to maintain competence; to collaborate on multiple levels; and to articulate values and shape policy. While the Code of Ethics for Nurses is not a source of concrete answers, every nurse has an obligation to be familiar with and to practice in accordance with the Code and its provisions.

As a basis for ethical decision-making during extreme conditions, the 15 ethical guidelines compiled by the University of Toronto Joint Centre for Bioethics for a Canadian discussion of pandemic influenza planning (2005) provide a comprehensive foundation for the current effort and appear as Table 1. While individual professionals will not have time to contemplate a table such as this while in the midst of an emergency situation, prior familiarity with and training on these concepts would prove helpful. Further, embedding these values in institutional and community plans both prior to and during emergencies will guide individual clinicians as they make specific decisions about individual patients.

In this country, the Joint Commission (JC) has approved revisions to Emergency Management Standards for Hospitals, Critical Access Hospitals and Long Term Care programs, which will become effective January 1, 2008. These revisions (replacing Standard EC.4.10 with Standards EC.4.11 through EC.4.18) reflect an "all-hazards" approach to emergency preparedness that permits appropriate flexibility and effective responses, with a "scalable" approach to manage the variety, intensity and duration of the disaster in six critical areas of emergency management: communication, resources and assets, safety and security, staff responsibilities, utilities management, and patient clinical and support activities.

Additionally, the JC has developed two standards relating to use of volunteers: Standard HR.1.25 allows hospitals to assign disaster responsibilities to volunteer practitioners and Standard MS.4.110 allows the organization to grant disaster privileges to volunteers eligible to be licensed independent practitioners. Many ambulatory programs (such as community health centers) participate in JC accreditation programs, and are expected to have emergency management plans as well.

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Table 1. Ethical Principles in Emergency Care[2]

Substantive Values	
Value	**Description**
Individual liberty	Emergency restrictions to individual liberty should be proportional, necessary and relevant
Protection of the public	Actions that impinge on liberty may be required, but should be clearly explained
Proportionality	Actions that restrict individuals should be proportionate to harm prevented
Privacy	Individual privacy may be overridden during emergency conditions
Duty to provide	Health professionals will weigh their duty to provide care with obligations to their own health and that of their families
Reciprocity	Society has a duty to support those taking extraordinary measures for the public good
Equity Care	Care in emergency conditions may not include all actions ordinarily available to some during ordinary times
Trust	Confidence in the choices being made requires transparency and careful communication
Solidarity	Collaboration is essential in emergency conditions and requires shared vision
Stewardship	Decision must focus on best patient and public health outcomes given the specific circumstances
Procedural Values	
Value	**Description**
Reasonable	Credible, accountable people must clarify the rationale for actions taken
Open and Transparent	Public access to basis for decisions must be assured
Inclusive	Stakeholders should be involved in decisions*
Responsive	New information should be incorporated into decisions
Accountable	Assure mechanisms to hold decision-makers answerable for their actions or inactions*

** These critical ingredients are essential in the planning/guidance development process and in post-event evaluation, but should not be allowed to impede the process while an emergency is in progress.*

[2] University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group (2005). *Stand on guard for thee: Ethical considerations in preparedness planning for pandemic influenza*. Toronto, Ontario: University of Toronto Joint Centre for Bioethics.

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The current competencies in emergency preparedness and response for clinician emergency preparedness training (Columbia University School of Nursing, 2003) make clear the expectation that licensed health professionals will be prepared to make appropriate healthcare decisions in the face of emergency conditions. These 11 core competencies for clinicians are included in Table 2. Supporting these competencies, the International Nursing Coalition for Mass Casualty Education Nursing Emergency Preparedness Coalition has provided a detailed and profession-specific template for education of nurses in the key values and skills in caring for patients under emergency conditions (Conway-Welch & Weiner, 2004), covering domains of competencies (e.g., assessment, technical skills, communication), essential knowledge and professional development. As an additional clinical example, the National Disaster Life Support (NDLS) education program offered through the AMA provides application of these competencies specifically to individual care-giving.

In the general ethical framework for health services in the United States, each presenting patient will receive care and attention that will not be diverted to the next patient until (1) care for the first patient is underway, or (2) that patient is transferred or referred. Clinicians are educated, socialized, and supported for a focus on the individual patient or client seeking care and generally make decisions about laboratory or other diagnostic tests, medications, hygiene, and activity needs, pain management or other interventions with only that individual (or the individual and family unit) in mind.

Decision-making during extreme conditions, however, shifts ethical standards to a utilitarian framework in which the clinical goal is the greatest good for the greatest number of individuals. As a result, not everyone may receive the optimal services that might be available at other times or places. This means that care decisions are not about "the most that can be done" or "the best that can be done under perfect conditions" but about what is sufficient given the specific conditions at the time. This might include expanding the role of family members in monitoring patient status, or outpatient care for a condition that might otherwise be treated in an inpatient setting.

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Table 2. Emergency Preparedness Competencies for Clinicians[3]

As a clinician, you should be able to do the following.

- ☐ Describe your expected role in emergency response in the specific practice setting as a part of the institution or community response.
- ☐ Respond to an emergency event within the incident or emergency management system of the practice, institution and community.
- ☐ Recognize an illness or injury as potentially resulting from exposure to a biologic, chemical or radiologic agent possibly associated with a terrorist event.
  - ☐ Recognize uncommon presentations of common diseases and distinguish these from common presentations of uncommon diseases that may be related to a terrorist event or emerging infectious disease.
  - ☐ Recognize emerging patterns or clusters of unusual presentations.
- ☐ Institute appropriate steps to limit spread, including infection control measures, decontamination techniques and use of appropriate personal protective equipment.
- ☐ Report identified cases or events to the public health system to facilitate surveillance and investigation using the established institutional or local communication protocol.
- ☐ Initiate patient care within your professional scope of practice and arrange for prompt referral appropriate to the identified condition(s).
- ☐ Use reliable information sources (e.g., infection control department, state or local public health agency, Centers for Disease Control and Prevention) for current referral and management guidelines.
- ☐ Provide reliable information to others (e.g., institutional administration, other patients) as relevant to the specific practice site and emergency response protocol.
- ☐ Communicate risks and actions taken clearly and accurately to patients and concerned others.
- ☐ Identify and manage the expected stress/anxiety associated with emergency events, making referrals for mental health services if needed.
- ☐ Participate in post-event feedback and assessment of response with the local public health system and take needed steps to improve future response.

[3] Columbia University School of Nursing, Center for Health Policy (2003). Clinician competencies during initial assessment and management of emergency events. Retrieved April 23, 2007, from http://sklad.cumc.columbia.edu/nursing/CHP/orderPubs.php.

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The organization of care under extreme conditions, using this utilitarian framework, should be within an incident command structure (ICS), both in the individual institution and across the affected community. The decision-makers will be collaborating with others whose expertise and authority may have an impact on the professional, such as legal interpretations of the jurisdiction's emergency regulations. The health professional assigned a patient care role is likely to be asked to share care, or delegate some portions of care, to others, such as students from a medical or nursing school, staff displaced from another institution, or volunteers. This will require thoughtful attention to one's own competence and to rapid assessment of the skills of the others available to assist in the patient's care. While there may be some technology specific to the emergency, familiar technological resources such as computer-based order entry for medications may not be present, adequate or appropriate. Finally, there will be increased reliance on all of one's accumulated competence, as there may not be available the usual range of colleagues, experts or support services.

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Challenges to Meeting Usual Care Expectations

As identified above, the circumstances triggering adaptation of standards of care may come in the form of severe natural events such as earthquakes, hurricanes, floods, blizzards or heat waves; human-caused emergencies such as transportation crashes, industrial explosions, terrorist activities; or infectious disease epidemics such as influenza. These events (a) may occur singly, concurrently, or sequentially, and (b) may be local, regional, or national in their impact. In each case, the professional will be challenged to provide care within situational dynamics such as:

1. loss of essential services, including electricity, water or the supply chain;
2. loss of infrastructure, including facilities or electronic information;
3. shortage of workers due to transportation loss, worker or worker family illness/injury, or unwillingness to report to work
4. size of affected population, requiring triage at a community level;
5. sudden increase in the number of patients, in marked excess of capacity or with elevated Injury Severity Score or other extreme patient conditions; and
6. relocation of care to an alternate facility not equipped for patient care.

In situations such as the above, there can be severe consequences if changes are not made in care practices, including a dramatic increase in the loss of life or exposure of patients and staff to unreasonable risks. Essential decisions about allocation of resources should be made at a system level, by the hospital incident command structure or the community-wide incident command structure. The individual clinician is responsible for giving the best possible care to patients within the available resources. Even when these conditions exist and resource allocations or assignments are made, however, many health professionals remain uncertain about their legal liability if unable to fully meet their usual guidelines or practices. A formal declaration of emergency may be associated with legal or regulatory changes (such as suspension of hospital rules regarding staffing levels or rules regarding who can administer injectable medications), providing legal immunity. However, some changes in patterns or content of care may be needed in the absence of or preceding such legal actions, particularly in the first hours of an extreme event.

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It is essential that public health officials, other government officials and healthcare facility spokespersons inform the public about resource allocation, patient relocation, or other decisions that may lead to adaptation in the provisions and standards of care. To minimize confusion, such communication should be coordinated with emergency communications structures at the local level.

For example, if a decision has been made to discharge a large number of patients who would otherwise remain in the hospital to home care or a limited care shelter in order to accommodate those in critical need for care (e.g., those with influenza or other infectious disease during a pandemic or multiple severely injured or burned patients), the community should be informed of the justifications and details of discharges in order to minimize the perception that patients are being abandoned. The communication should further include the steps being taken to provide for patient safety, medications, access to support services for transported patients and safety of the public.

Health professional education has included little explicit consideration of challenges such as those discussed in this document. Even when a clinician is caring for several patients, as is typical for hospital-based nurses, the expectation is that all requested care will be given, even if time is short and care is rushed. While some consider this priority setting in the modern hospital to be "triage," such appropriate priority setting within usual standards of care does not rise to the level of what is often referred to as battlefield triage.[4] It comes as anathema to most health care providers that some patients—those commonly called the "walking wounded" and the "worried well"—might be unable to access care due to resource allocations.

There is the further difficulty in understanding that some extreme conditions might warrant reserving care only for those whose recovery is likely, avoiding the investment of scarce resources in a rescue attempt for those whose likelihood of survival is extremely low. Yet these are exactly the types of resource allocation decisions—such as using the Injury Severity Score, or ISS (Trauma.org, 2007)—that might be required, and it is essential that professionals be prepared to function under such circumstances.

[4] The emergency specialties and military settings are the two places in which triage of the injured or acutely ill is not only taught, but routinely practiced.

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One caveat: this document primarily discusses the changes in role, assignment, approach to or scope of care for the typical nurse or licensed health professional working within a care system under unusual conditions. This "typical" person might be making triage decisions about early discharge or transfer to a less intense level of care. The triage of incoming patients who have been exposed to emergency conditions (explosion, chemical dispersal, massive biologic event) will most likely be made by health professionals with emergency care credentials, or by experienced health professionals under the direction of specialists in triage and disasters. Any health professional working or volunteering in situations in which this role is likely should seek out additional training in emergency triage in order to understand the unusual decision criteria involved in conserving scarce health resources for those most in need of care and most likely to survive if it is provided.

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Meeting These Challenges

In considering how to meet the challenges of providing care under extreme circumstances, an organization must first identify those standards that should be maintained at all times, distinguishing them from those that may more readily be adapted when disastrous circumstances occur. The most critical standards for clinicians providing care (after triage has been performed[5] and patients have been transferred for care) are:

- maximizing worker and patient safety;
- maintaining airway and breathing, circulation and control of blood loss; and
- maintaining or establishing infection control (including continuity of medications for conditions such as tuberculosis).

Less important actions that could be delayed, eliminated for some period of time or assigned to family members, non-licensed assistants or volunteers include:

- routine care activities (e.g., blood pressure checks in non-acute patients, assisted ambulation);
- administration of oral medications,
- extensive documentation of care;
- maintenance of complete privacy and confidentiality; and
- elective procedures.

A combination of existing guidelines or standards of care in a specific institution and the emergency plan should guide and support changes in clinician behavior. For example, the all hazards plan of the involved institution could pre-determine what routine activities are to be delayed or omitted in the event of a disaster. If there are no pre-established emergency guidelines for needed changes, the judgment of experienced clinicians should be put to use and changes communicated as part of the Incident Action Plan. In considering the potential for such actions pre-event, jurisdictions can develop emergency guidelines, establishing a multidisciplinary critical resource planning committee, conducting critical resource vulnerability analysis and priority setting, and establishing baseline ethical principles to guide responses to a range of unusual or emergency conditions. Pandemic influenza planning for allocation of ventilators is an example of such planning. Based upon these analyses, the committee can develop critical resource response plans and protocols, educational tools and emergency exercises and drills.

[5] Assumes that essential chemical or radiological decontamination will have occurred as a part of the triage/admission process.

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Given such pre-event planning, it may be necessary to restate the goal of care-giving to clarify changes in the standard of care to all involved. In an emergency, the goal will often be minimizing loss of life and assuring emergency services for only priority needs, providing the greatest good for the greatest number. Further, because some level or type of triage will probably be implemented in the community or the emergency department, the goal of triage (e.g., assuring care for those most likely to benefit from treatment; minimizing resource drain on those with self-limiting conditions or injuries so severe as to preclude survival) should be communicated to all professional caregivers to assure consistent allocation of resources.

During an extreme event, it is possible that reconfiguration of human and physical resources may allow the goals of care to be met, even under altered standards of care. To do so, leaders must activate existing plans for an adapted standard of care (or adapt standards ad hoc), identify and confirm critical resource shortages and adjust (or terminate) altered care plans as necessary, communicating those decisions to clinicians and to the public. This might include delegation of some care to technical or support staff or integration of family members directly into the care team. Rather than the current standard of most patients being cared for in single-bed rooms, patients could be grouped in common areas, facilitating a lower staff-to-patient ratio than typical. In the community, use of mass medication dispensing sites might replace individual physician office or clinic visits. Students of health professions should not be overlooked, as emergency response competencies are now being built into curricula.

Volunteers are essential parts of our communities, and it is reasonable to assume that volunteer nurses, physicians, and others will become a part of the clinician team during extreme circumstances. These individuals are not, and should never be, self-directed and self-assigned. Those who wish to volunteer (1) should do so through organized programs such as the Medical Reserve Corps, the National Disaster Medical System, the American Red Cross, or professional volunteer registry and (2) should only proceed to a disaster response site when activated and expected. The one exception to this is the very rare event when a health professional is "volunteered" by virtue of happening to be next to the collapsing building, flooded school, burning train, or other disaster, and who acts as a Good Samaritan until other assistance arrives.

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Recommendations for Emergency Event Care

The many recommendations that flow from this consideration have been referenced in the text above, and are summarized in the following outline. There are three main sections, addressed in turn to individual professionals, the facilities or organizations that employ them or within which they practice, and emergency response planners.

Individual Registered Nurses or Other Health Professionals

Pre-event:

- ☐ Prepare self and family/significant others for potential emergencies, including the potential for the professional to be away for extended periods during an emergency.
- ☐ Participate in continuing education on emergency preparedness, with particular attention to the application of NIMS and the National Response Plan within your current practice setting.
- ☐ Participate in emergency drills and exercises at your practice site.
- ☐ Know the legal basis for professional care, and the legal structure of your state regarding health professionals during emergencies.
- ☐ Provide clear information to any employer or any volunteer organization where you are enrolled about any limitations on availability or any special skills (e.g., experience with community or emergency triage) applicable to emergency conditions.

During an event:

- ☐ Use your professional competence to provide the best care possible given the resources and physical conditions under which you are working.
- ☐ Use assigned or announced information resources to clarify any changes in protocols or staff roles.
- ☐ Use available rapid training to update readiness to respond to the specific event.
- ☐ Communicate difficulties responding as expected through the assigned chain of command as quickly as possible.

Post-event:

- ☐ Participate in post-event evaluation.
- ☐ Do a psychosocial needs assessment for self and family, and seek assistance if indicated.
- ☐ Participate in activities to facilitate return to pre-event status.

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Health Facilities or Practice Sites

Pre-event:

- ☐ Develop descriptions of potential reconfigurations of clinician teams or physical resources as a part of emergency planning.
- ☐ Anticipate the inclusion of volunteers with varying levels of professional or technical training into care teams during emergency situations by at least these two actions:
  - Coordinate access to volunteers with local public health and emergency management agencies.
  - Establish a mechanism for credentialing of volunteer staff consistent with federal and state standards (e.g., ESAR-VHP, the Emergency System for Advanced Registration of Volunteer Health Professionals).
- ☐ Ensure that emergency plans include capacity for rapid education of staff specific to the event (just-in-time training by a knowledgeable professional), including any changes in protocols needed to:
  - Maintain a regular inventory of web and other resources specific to a wide range of potential emergency conditions.
  - Include human resources and staff development personnel in all emergency planning processes so they are familiar with the range of potential training needs and prepare templates in advance.
- ☐ Include opportunities for professional decision-making about adapting standards in drills and exercises on a regular basis.

During an event:

- ☐ Distribute daily information on staffing expectations, including role of volunteers, to at least:
  - Inform your staff how volunteer credentials are being established, and
  - Specify any unusual expectations, such as delegation to unlicensed personnel.
- ☐ If legal changes such as governor's declaration of emergency has been invoked, communicate this to staff.
- ☐ Provide just-in-time training specific to the event, including any changes in protocols.

Post-event:

- ☐ Participate in post-event evaluation.
- ☐ Do a psychosocial needs assessment for those responding, and arrange assistance if indicated.
- ☐ Return to pre-event status as quickly and smoothly as reasonable.

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Emergency Response Planners

Pre-event:

- ☐ Ensure that health institutions and professionals are included in all planning for legal declarations of emergencies to assure that concerns about patient care guidelines and relevant regulations are considered.
- ☐ Ensure that legal counsels to all organizations (public and private) that employ health professionals are included in community planning for patient care under extreme emergency conditions, including the implications of emergency declarations and the resources for emergency-related legal guidance through the local emergency response organization.

During an event:

- ☐ Record all changes in expectations about care to be provided, and the impact on patients and community, for use in evaluating response and improving plans for future events.

Post-event:

- ☐ Participate in post-event evaluation.
- ☐ Assist in developing plans to return to pre-event status as quickly and smoothly as reasonable.

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Post-Event Considerations

No response to an extreme circumstance is complete until the participants have moved to the recovery phase, including reestablishing the medical and public health infrastructure, both physically and in human resources, disrupted by the disaster. This does not necessarily require fully returning to the pre-emergency *status quo* (e.g., in the case of major damage to a hospital) but simply achieving a level of staffing and supplies that justifies returning to an ordinary level of care for most, if not all, patients and re-directing those not being served locally to a suitable alternate facility. As with the discussion of communication earlier, this phase should include collaboration across a community and consistent messages to the public about where and when to seek care.

Extreme conditions may arise with or without warning, due to weather, geology, utility failure, industrial explosion, transportation crash, or deliberate human action. The response of the entire health workforce may make the difference in the degree of suffering in the community, and in the rate at which recovery occurs. Being ready to adapt and provide essential care under extreme conditions is a professional responsibility. It is a responsibility that can be better met if health professionals have considered the ethics and issues in advance, participated in planning and practice, and remain committed to delivering the best care possible in the circumstances.

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All health professionals who have been a part of the emergency response in any role have an obligation to participate in the evaluation of that response, taking a thoughtful look at what was done, how it worked, and what could be done better in subsequent events with improved planning, training, equipment or communication. During and in the aftermath of an event, there should be attention to the ongoing health (physical and mental) of all responders, their families and significant others.

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ASCEC08