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"A Realistic Approach to Emergency Preparedness Core Competency Compliance for Healthcare Facility Staff"

So, you are aware of the regulations on Emergency Preparedness Education in your Facility:

- Joint Commission EM Standards
- CMS Rule: "Demonstrate knowledge of emergency procedures and provide training at least annually" (Nov, 15, 2017)

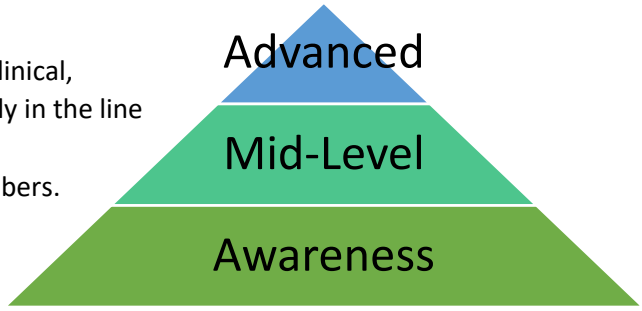
But you're not sure how to put it into motion? Who can afford the accrual of "non-productive" hours on educating ALL staff (contracted or formal) on events that may never occur? Well, this may be the article to help you wrap your head around that! (Example: You are a 600 bed Level II Acute Care Hospital looking to educated 300 RNs on the 8-hour Hospital Emergency Response Training with a max class size of 30 students at a time, and you will need to perform this annually.)

CVHC has searched far and wide for best practices to create a method of guidance for your development of Core Competencies for Healthcare Facility Staff. Please allow this information to assist development of facility-specific annual education as it relates to your Emergency Preparedness Program and plans. This is an over-reaching template you can place specific educational goals into.

Core competencies in this arena should ultimately be a list of disaster preparedness, response skills, knowledge, and abilities required by healthcare facility staff to perform roles successfully during disaster events in support of your Emergency Operations Plan (EOP). However, each and every role's day to day duty in the healthcare setting can vary greatly. So how do you decide what is vital for a competency?

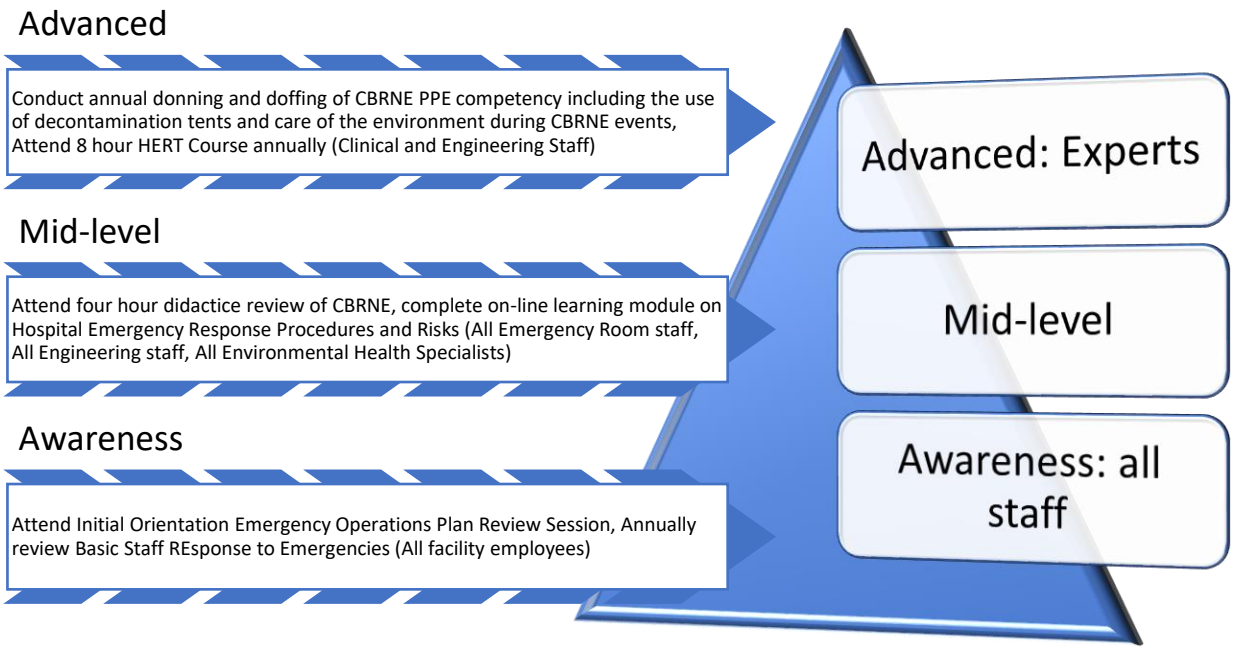
It's based on competencies being offered at three levels:

1. **Awareness:** All Staff
2. **Mid-Level:** Dependent upon response role. This level builds on the awareness competencies, applicable to clinical, non-clinical, and specialty trained personnel not directly in the line of performing emergency response roles.
3. **Advanced:** This level is aimed for direct response members. Advanced level builds on the previous two levels for personnel who are a part of a specialty team (such as the hospital mass casualty response team, a decontamination team, or the incident command team).



How does this translate to action or an education plan?

Let's take the example of HERT mentioned earlier. Of the 300 RNS previously defined to adhere to the mandated 8hour HERT training, how many will be directly responsible for PPE selection, decontamination tent set up, physical decontamination of patients, donning and doffing of PPE, clinical care of patients during and post decon? Do any of these RN's fulfill the role of safety or security during the incident to handle unruly patients? Can they trouble shoot water pressure issues in a hot zone? If the answer is no, chances are your focus is too narrow on a whole pre-set classification of staff (in this case, RNs) and not on what roles are needed during an event. It may appear you have met compliance (all 300 nurses were trained to the highest level) but was anyone else educated on their role? Was this the best use of academic time? How successful will your event be based on the staff you've educated? Now, let's take the model above and relate to this example by creating an education plan for our EOP Annex of CBRNE Event:



An education plan for each annex?

Competencies can be demonstrated and tested through seminar, video education, hands-on training, exercises, or even response to a real event. Make sure you are keeping records of education held. Just in time training along with the initial and refresher competency checks will need to occur to maintain skill and performance levels. You may be able to cover "Awareness" during grand orientation. Overall facility efficiency and effectiveness will grow from the foundation of education and practice. Direct that time correctly based on the annex you are discussing.

Why the entire region should adopt this idea?:

When applied throughout the region and across a variety of healthcare facilities, consistency will assist in the overall regionally development, response, coordination, and in finality the evaluation of disaster preparedness and response training programs. By joining forces in creating standardized competencies, the idea of facility to facility shared staffing during declared disasters doesn't seem so daunting for acute care hospitals, LTCs, Home Health and Hospice member facilities. This also helps meet other requirement/regulations on collaborative and community-based preparedness.

Beyond the Issue:

For more information on what The Joint Commission discusses as an initial orientation need versus an annual competency necessary items please read this: https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=1568

Resources:

Baack, S. & Alfred, D. (2013). Nurses preparedness and perceived competence in managing disasters. Journal of Nursing Scholarship, 45 (3), 281-287.

Department of Health, Division of Emergency Medical Operations, Florida State. (2011) 3rd Edition, *Florida's Recommended Disaster Core Competencies for Hospital Personnel.*

Sorenson, B. S. et al, World Health Organization. The Regional Office for Europe of the World Health Organization (2011) *Hospital emergency response checklist: An all-hazards tool for hospital administrators and emergency managers.*