INSTITUTE FOR QUALITY, SAFETY & INJURY PREVENTION

ENA Topic Brief

Crisis Standards of Care (CSC)

Key Information

At its core, a disaster is the complete imbalance between the resources at hand and the demands for those same resources.

Crisis standards of care are defined as "substantial change in the usual health care operations and the level of care it is possible to deliver."[4]

The World Health Organization (WHO) and International Council of Nurses have published a set of competencies for nurses in disaster situations highlighting the roles emergency nurses play in preparedness activities within their care environment.[7]

Understanding the current knowledge and preparation for working with CSC is critical to ensuring an ability to respond as part of an all-hazards approach to emergency preparedness.

Planning is an integral key to providing the best possible care during events that stress the infrastructure of organizations and government.

Healthcare delivered during disaster events shifts from focusing on individuals to providing the best possible health outcomes for the population within a limited-resources environment.[4]

Purpose

Disasters often occur with little warning and can have catastrophic consequences for the community. Nurses are positioned to have a leadership role in the operational management of these events. At its core, a disaster is the complete imbalance between the resources at hand and the demands for those same resources. In events that impact the health and wellness of the community, healthcare resources can be expected to be an area experiencing significant strain. The resources impacted may be as specific as intensive care beds and ventilators as in the severe acute respiratory syndrome (SARS) outbreak in 2003, or wide-reaching as in the generalized collapse of the healthcare infrastructure in Haiti after the 2010 earthquake.[1] The purpose of this topic brief is to provide emergency nurses with the background and key concepts related to crisis standards of care (CSC) to enable discussions, planning, and education to occur before a crisis materializes.

Overview: Definition of Crisis Standards of Care (CSC)

The after-effects of disasters persist in all areas of the world despite the best efforts of emergency planners to mitigate risks to the general public and other groups. Between 1994 and 2013, there have been 6,873 natural disasters worldwide affecting 218 million people and claiming nearly 68,000 lives.[2] Events in the last 20 years such as Hurricane Katrina, superstorm Sandy, the Joplin tornado, and more recently, the 2017 hurricane season, have demonstrated the vulnerability of healthcare facilities to catastrophic failures because of weather-related events. Global pandemics such as Ebola virus and SARS challenged normal infection control practices and training used in hospitals.[3] These and other similar events have had significant impact on the communities where they occurred, straining their healthcare resources.

In situations where the usual care delivery systems are overwhelmed or unavailable, the need for care will still exist and can be expected to grow. CSC are defined as the "substantial change in the usual healthcare operations and the level of care it is possible to deliver."[4] In any disaster, there will certainly be ethical concerns raised. The existence of structured and vetted guidelines will help clinical staff navigate such challenging situations.

The typical triage process involves collecting pertinent information about patients who present for emergency care and initiating a decision-making procedure that uses a reliable triage acuity-designation system[5] designed to identify the resources needed for patients presenting to the ED. This concept is based on a medical system with nearly unlimited resources. In disaster care, the paradigm changes this process to one of doing the greatest good for the greatest number when resources are limited.

Preparation for events of the magnitude of Hurricane Katrina, Hurricane Harvey, or the Haitian earthquake relies on the awareness of key stakeholders in the healthcare community. In the event of a large-scale pandemic it is anticipated that over 9.9 million people will seek care in healthcare facilities.[6] The 2009 report by the Institute of Medicine (IOM)[4] notes that the education and preparation of the nurse in emergency readiness is essential to ensure the availability of a well-prepared and responsive healthcare workforce when needed.

The need for standards and training requires review of the current knowledge of emergency nurses related to disaster planning and CSC. In the event of a catastrophic incident, the public will certainly look to and depend on the healthcare system as a source of stability. The healthcare response in these situations may be complicated and compromised by a lack of resources and staffing, or the emergence of an illness with no treatment options. The World Health Organization (WHO) and International Council of Nurses (ICN) have published a set of competencies for nurses in disaster situations highlighting the roles emergency nurses play in preparedness activities within their care environment.[7] Criticism of these core competencies includes the lack of established recommendations for education or training in CSC. According to Slepski (2007),[8] no studies have identified or verified the existence of trained groups of volunteer clinicians within medical facilities to care for injured in the event of a mass causality incident (MCI).

Because emergency nurses play a key role in disaster response, the development of effective hospital and governmental policies on disaster response requires nursing input.[7] When creating policies and guidelines that may be referenced during a CSC situation, such as delegation of duties, the input of emergency nurses is especially critical. Understanding the current knowledge of and preparation for working with CSC is vital in ensuring the ability to respond as part of an all-hazards approach to emergency situations.

Historical Perspective

CSCs are a framework that was first developed at the request of the U.S. Department of Health and Human Services (HHS) and developed by the IOM to guide clinical decision-making.[9] It is critical to have guidelines in place for events where available resources restrict the ability to apply the usual standards of care. Establishing these guidelines as part of mitigation and planning is fundamental to enabling staff to prepare for their role in these crisis situations.

Planning is integral to providing the best possible care during events that stress the infrastructure of organizations and government. This planning, in collaboration and coordination with all stakeholders, can ensure the best outcomes in crisis situations. In 2008, as part of the American Nurses Association's (ANA) efforts to engage nurses in policy development, a series of policy conferences was held. One of the outcomes was the expert opinion policy "Adapting Standards of Care under Extreme Conditions: Guidance for Professionals during Disasters, Pandemics, and Other Extreme Emergencies."[10] The

policy focused on individual health professionals who would provide care during extreme emergency situations. The policy recommended nurse competencies for disaster preparedness and ethical decision-making, but provided no guidance for the overall healthcare system.[10]

To assist with planning at a system level, HHS requested that the IOM (now the National Academies of Science, Engineering, and Medicine) provide guidance to health officials for establishing and implementing standards of care during disasters when resources would be scarce. In 2009, the IOM provided a consensus report "Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report."[4] In this document, CSC was defined as "a substantial change in healthcare operations and the level of care it is possible to deliver … justified by specific circumstances."[4] Healthcare delivered during disaster events shifts from focusing on individuals to providing the best possible health outcomes for the population as a whole within a limited resources environment.[4]

In response to this report, the Department of Veterans affairs and the National Highway Traffic Safety Administration asked the IOM committee to reconvene in 2010 to provide guidance for applying CSC. The resulting report, "Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response," provided templates to assist organizations at the state, regional, and local levels with CSC planning founded on fundamental ethical values to ensure that all providers acted with compassion and justice.[11] The framework called for planning that included both legal and policy changes to provide healthcare professionals and volunteers the ability to perform their duties while maximizing health resources and protecting patients.[11]

The IOM reports provided the foundation for other organizations such the American College of Emergency Physicians (ACEP) to publish their own guidelines. ACEP's "Guidelines for Crisis Standards of Care During Disasters"[12] emphasized that crisis care is not substandard care, but simply what a prudent person would do in the aftermath of a disaster, and listed the following goals for a community at times when resources are limited:

- Minimize death and serious illness by distributing resources to those with the greatest opportunity to benefit
- Maximize appropriate care for the largest number of patients
- Maximize self-care through public health messages
- Delineate which healthcare facilities should provide what level of care based upon capacity and capabilities
- Provide a legal framework for developing triage decisions
- Engage the public and build trust by being inclusive, transparent, and honest

Criteria for Activation

As the intensity and frequency of large scale disaster events increase, developing indicators to initiate CSC is essential. The possibility of extreme situations raises basic concerns about healthcare systems, specifically the criteria for activation. In 2013, the IOM developed categories of indicators that could be triggered by numerous events[13] including:

- **Community and communication infrastructure:** Community-wide impact with prolonged effect on infrastructure affecting homes, businesses, transportation, communication, and utilities

- **Surveillance data:** Natural disaster, pandemic/epidemic, or overcrowding when epidemiologic projections show available resources will be depleted
- **Staff:** Increasing staff requirements owing to increased staff absenteeism or unavailability of specialized staff, high patient census, or alternate care sites opened without supporting resources
- **Space/Infrastructure**: Escalating or sustained demand on hospital or clinic services because of damage to infrastructure affecting critical systems, or increased patient-care demands despite implementation of contingency strategies
- **Supplies:** Demand for supplies exceeds availability owing to disruption of the supply chain, increased patient demand, or exhaustion of resources

In addition to criteria developed earlier, ACEP's "Guidelines for Crisis Standards of Care during Disasters," included:

- Loss of essential services
- Size of affected population
- Sudden increase in the number of patients who were relocated to alternate care sites not equipped to provide necessary care

While these are indicators to initiate introduction of CSC, any change in the level of healthcare delivery that is justified by specific circumstances like a disaster event must be declared formally by the governor of that state.[14] Once a governor has declared a state of emergency, legal and operational resources are made available to respond and CSC are implemented.

Best Practices for Training

CSC best practices for training include regular training, tabletop drills, mock drills, and hot washes (see table below). These do not differ significantly in content from general disaster preparedness training. As part of its CSC recommendations, the National Academies of Science, Engineering, and Medicine recommends training and exercises on the hospital incident command system for key staff, including those on the clinical care committee and potential triage team members.[15] As it is a Joint Commission requirement, most healthcare facilities will offer, if not require, a minimum of one training exercise per year.[16]

There are other options for general disaster preparedness training that will inform the use of CSC. The Federal Emergency Management Agency (FEMA) offers a wide variety of free online classes.[17] The American Red Cross offers community-focused disaster training with options for more specific classes.[18] Those experienced in disaster preparedness can sit for the National Healthcare Disaster Certification offered through the American Nurses Credentialing Center.[19] This interdisciplinary certification designates the holder as having mastered the knowledge and skills related to all phases of the disaster cycle. Joining a disaster response team usually involves a high level of targeted training, such as through the National Disaster Medical System (NDMS).[20,21]

Types of Emergency Preparedness Exercises[22]
Seminar: A seminar is an informal discussion designed to orient participants to new or updated plans, policies, or procedures (e.g., a seminar to review a new Evacuation Standard Operating Procedure).
Workshop: A workshop resembles a seminar but is employed to build specific products, such as a draft plan or policy (e.g., a Training and Exercise Plan Workshop is used to develop a multi-year training and exercise plan).
Tabletop Exercise (TTX): A tabletop exercise involves key personnel discussing simulated scenarios in an informal setting. TTXs can be used to assess plans, policies, and procedures.
Games: A game is a simulation of operations that often involves two or more teams, usually in a competitive environment, using rules, data, and procedures designed to depict an actual or assumed real-life situation.
Operation-Based Exercises: Operation-based exercises validate plans, policies, agreements, and procedures; clarify roles and responsibilities; and identify resource gaps in an operational environment. Types include: • **Drill:** A coordinated, supervised activity usually employed to test a single, specific operation or function within a single entity (e.g., a fire department conducts a decontamination drill). • **Functional Exercise (FE):** An activity that examines and/or validates the coordination, command, and control between various multi-agency coordination centers (e.g., emergency operation center, joint field office, etc.). This exercise does not involve "boots on the ground" personnel (i.e., first responders or emergency officials responding to an incident in real time). • **Full-Scale Exercises (FSE):** A full-scale exercise is a multi-agency, multi-jurisdictional, multi-discipline exercise involving functional (e.g., joint field office, emergency operation centers, etc.) and "boots on the ground" response (e.g., firefighters decontaminating mock victims).

Healthcare Setting

Hospitals, walk-in clinics, and private practices are the essential healthcare facilities in an emergency. Each healthcare setting is responsible for having response plans that clearly delineate when to move from conventional standards of care to CSC during a disaster.[11] The Joint Commission requires that healthcare facilities periodically assess their preparedness capabilities and performance. These assessments should ideally occur under simulated stressful conditions to mimic an actual emergency.[16]

Essential components for healthcare employees training to implement CSC include:[23,24]

- Recognition of a potential need to move to CSC and implement initial actions
- Effective demonstration and application of the principles of CSC
- Understanding the institutional emergency operations plan
- Demonstration of effective communications during the incident
- Understanding the incident command system and assigned role
- Demonstration of the knowledge and skills needed to fulfill role

Deployment to Austere Environments: Preparation, Healthcare Coalitions, and Resource Allocation

There are multiple studies about deployment to austere environments or settings without standard infrastructure such as running water or electricity.[10,12,25–28,] Nurses must meet basic standards for deployment, including readiness to deploy, physical fitness, and cultural competency.[29] Pre-deployment medical examinations and psychological assessment are also necessary. Medical and psychological support both during and after deployment is a significant need. Some issues surrounding maintenance of the cache and logistics are identified as often overlooked.[29] Multiple case reports are cited under preparedness of teams or providers as well as unintended consequences.[30]

Preparation

At its core, the CSC framework seeks to provide equitable and safe healthcare in situations where there is a substantial change from standard healthcare operations. Situations necessitating CSC can vary widely, from a large-scale disaster in a remote area where resources are limited by infrastructure, to a smaller-scale incident where manpower is limited in the initial response period. As we are unable to accurately predict disasters or the extent of their impact, the highest level of preparedness enables moving to a model of CSC only when absolutely necessary.[4] The decision to implement CSC is made in collaboration with those involved in public health emergency, including health systems and community-based health providers, public safety, emergency management, and public health officials.[31] Examples of best practices that could be initiated to prepare for a CSC incident include healthcare coalitions and resource allocation.

Healthcare Coalitions

Healthcare coalitions are formal collaborations between healthcare facilities, public health departments, emergency management agencies, and other types of healthcare agencies within a region that are organized and committed to respond to mass casualty or other disastrous events.[32] The primary mission of a healthcare coalition is to support healthcare organizations during emergency response and recovery.[33,34] This is best established in advance at the preparedness stage. Healthcare coalitions work with local partners to prepare hospitals and emergency medical services, and to support healthcare organizations to deliver coordinated and effective care during a public health emergency.

One example of a successful healthcare coalition partnership is the Washington, D.C., Emergency Healthcare Coalition. Using grant funds, the coalition replaced an outdated radio system, expanding it to include all members of the coalition, and worked to link the information technology programs of seven district hospitals.[35] These actions served multiple purposes, including increasing situational awareness, a critical component in a surge incident, and increasing communication, including supporting family members in finding loved ones who might otherwise have been considered missing or presumed dead in a disaster.[34] These upgrades are part of the coalition's unified emergency operations plan, which has been tested during two large-scale exercises and later applied in two real-world events in 2009, the Presidential Inauguration and a Washington metro train accident.[34]

Resource Allocation

During a disaster event, resources become limited and the demand for supplies exceed availability, making allocation of resources challenging. Solving the issue of resource allocation depends primarily on the actual resource itself and determining what distribution would be likely to produce the greatest good for the greatest number of individuals.[36] Allocation of scarce resources means determining how to equitably and fairly distribute or use the scarce medical resources that may be available in a contingency or crisis-care environment.[37] However, there are a multitude of competing priorities. For example, several states have specific guidelines for the distribution of certain key supplies and medications such as antivirals, ventilators, N95 respirators, masks, and vaccines. The state of Michigan, for example, identified concerns about running out of ventilators during a pandemic.[38] A coordinated assessment was conducted within Michigan's hospitals and EMS agencies to identify resources and gaps that that could be impacted during a medical surge, including ventilator capacity.[39] The appropriate number of ventilators was determined and, once procured, ventilators were distributed throughout the healthcare coalitions in the state. As a result of this coordinated assessment, the State of Michigan's Department of Community Health Office of Public Health Preparedness published guidelines for ethical allocation of resources and services.[40] The goal of this document is to define how best to minimize mortality and morbidity and sustain a functioning society in a public health emergency.[41] The ethics involved in the resource allocation process are complex, requiring collaboration between all stakeholders. This is necessary to ensure an equitable decision-making process.[42] As an example, one research study used a community-based approach to establish guiding principles for resource allocation in a public health emergency.[43]

Emergency Declarations and Authorities: Legal Issues and Policies

During an event, the decision made by a government entity to declare a state of emergency will help determine the resources available for response activities and any legal ramifications. Accessibility to resources needed to match demand is especially important if the event stresses the community's infrastructure and CSC are enacted. State officials have broad powers to address emergency situations by statutory regulations without issuing an emergency declaration. Federal laws usually do not alter state legislative and regulatory requirements but may be preempted if there are conflicts with federal law. Federal, state, tribal, and local governments strive to create an appropriate legal environment for public health emergencies by defining their emergency authorities and amending or enhancing their legal infrastructure where required.[44] All states have legislation and policies that allow government officials to declare a state of emergency, activating other authorities and resources that are not available in non-emergencies. Declaring a state of emergency empowers a government to execute processes outside of normal operating practices.

State

To declare a state emergency, a governor will issue an executive order and may identify other state rules and regulations that can be waived or suspended. Other state or local executive officers may declare emergencies under specific conditions,

but require approval by a local legislative body, state executive officer, and/or state legislature. State emergency declaration actions and authorities include:[14]

- Activation of state emergency response plans and mutual aid agreements
- Activation of state emergency operation centers and incident command system (ICS)
- Authority to expend funds and deploy personnel, equipment, supplies, and stockpiles
- Activation of statutory immunities and liability protection for response personnel
- Suspension and waiver of rules and regulations (statutes)
- Streamlining of state administrative procedures such as procurement requirements

If an event occurs that appears to require presidential disaster declaration to assist in the recovery of the impacted area, the state or Indian tribal government contacts the local Federal Emergency Management Agency (FEMA) Regional Office and requests a joint Federal, State/Tribal Preliminary Damage Assessment (PDA).[45] Also included in the PDA are local government representatives. The team then conducts a thorough assessment of the area affected and determines the extent of the disaster, including its impact on public facilities and the community, and the types of federal assistance that may be needed.[45] The information obtained from the PDA is then included in the governor or tribal chief executive's request to demonstrate that the severity and magnitude of the event is beyond the capabilities of the state and the affected local governments or Indian tribal government, hence supplemental federal assistance is essential.[45]

Federal

Federal laws designate federal officials with broad powers to respond and assist state officials in an emergency event with or without a federal disaster declaration. The Secretary of Health and Human Services, under the Public Health Service Act (Section 319) and Social Security Act (Section 1135) can provide assistance to states and localities.[14] The president and other federal officials can declare an emergency under specific guidelines found in the Stafford Act and National Emergencies Act. The Stafford Act was created to allow presidential action when the resources of the state have been overwhelmed; it serves as a conduit to allow states to apply for federal assistance and response. With this legislation, Congress intended to foster the comprehensive development of disaster planning, intergovernmental coordination and cooperation, appropriate insurance use, and federal assistance programs for losses incurred from a disaster.[45] When a federal emergency declaration is issued, federal agencies have legal and programmatic responses:[14]

- Activation of federal resources including financial, personnel, services, logistical, and technical assistance
- Triggering of emergency provisions under the Social Security Act (1135 wavier), and statutory immunities/liability protections such as the Public Readiness and Emergency Preparedness Act (PREP Act)
- Easing of regulatory requirements for individuals, organizations, and state/local governments
- Activation of the National Response Framework, National Incident Management System, and other emergency response protocols and systems

A presidential declaration of an emergency triggers other public health emergency response authorities such as the Social

Security Act.[14] A governor of the affected state must request a presidential declaration in response to an emergency that overwhelms the state's capacity to respond unless the emergency involves an area of federal primary responsibility such as a federal building.[14]

Disaster Medical Response Teams

Through the Stafford Act, federal agencies such FEMA and HHS are delegated the responsibility for coordinating government-wide relief efforts. FEMA retains a system of assets, personnel, and training to respond to disaster situations through internal and external resources. Such a response includes the disaster medical assistance team (DMAT), along with other groups such as the medical reserve corps (MRC), Disaster Mortuary Team, and various governmental and non-governmental groups. These groups are a collection of professionals including medical personnel that are organized to provide rapid response medical care during a crisis event like a natural disaster or mass casualty event.[46]

NDMS team members can include advanced practice clinicians such as nurse practitioners, medical officers, registered nurses, respiratory therapists, paramedics, pharmacists, safety specialists, logistical specialists, information technologists, communication and administrative specialists.[20] When NDSM teams are deployed, the team bring enough medical supplies and equipment to sustain themselves for three days and usually are activated for two weeks or longer depending on the complexity of the disaster.[46] DMAT members are considered "intermittent" federal employees, and once activated are protected from tort liability while in operation.[47] Similar to the National Guard, an activated volunteer person is protected under the context of the Uniformed Services Employment and Reemployment Rights Act (USERRA).[48]

Despite the cohesive methodology designed to improve planning and preparedness efforts, there remain ethical and legal challenges in the implementation of CSC in emergencies.[4] Emergency nurses are encouraged to be aware of the applicable laws associated with their practice jurisdiction, especially if they are part of a disaster response team and may be deployed.

Liability

There are both state and federal legal protections against liability for healthcare providers and volunteers in emergency response situations.[49] However, these protections depend on the nature of the services dispensed by the healthcare provider, whether the services are performed as a volunteer or a paid employee, and based on the liability coverage specified under the program in which the healthcare provider is participating.[49] Liability issues for emergency nurses providing care under CSC remain unclear as many state and federal protections are continually evolving and being refined. Emergency nurses choosing to volunteer or work under CSC should educate themselves regarding the state and federal protections available in emergency response situations. The following is a list of state and federal laws and statues regarding liability protections and immunities:

- Federal Government Sovereign Immunity
- Volunteer Protection Act
- Public Readiness Emergency Preparedness Act (PREP Act)

- State Governmental/Sovereign Immunity
- Emergency Powers Statutes
- State General Volunteer Protection Statutes
- State Healthcare Volunteer Protection Statutes
- Good Samaritan Laws
- Entity Liability Statutes
- Mutual Aid Agreements

The listed examples provide varying degrees of coverage and the extent to which liability protections are available to an emergency nurse depends greatly on the particular law or statute and circumstance surrounding the emergency response.[49] In the event of deploying outside the USA where the CSC framework may be applied, it is judicious for emergency nurses to consult the organization in which they are deploying with regard to nursing licensing and scope of practice in that country.

Ethical Issues

Ethical discussions during the time of a disaster or a mass casualty event can be especially difficult. Ethics is composed of moral duty and obligation when considering good versus bad outcomes of a situation.[50] During a disaster, healthcare professionals continue to provide care based on ethical standards and moral obligations to the best of their ability given the situation. Actions performed during a mass casualty situation will vary from the norm. Ethical values can set the precedence and contribute to the justification of the altered standard of care when deliberating legal issues.[51]

During a mass casualty event, specifically considering natural disasters and infectious disease outbreaks, staff may question their obligation to report for duty and may have ethical concerns.[52] In considering the possibility of such an event, it is prudent for emergency nurses to think about the separate obligations of work and family. Healthcare professionals have a duty to provide care to their patients and communities in addition to their obligation to care for their personal and family's health needs.[53]

In disaster situations, it is a concept shift and unlikely that healthcare workers will be able to continue to provide care to every patient owing to the surge of ill and injured. This becomes even more difficult as staff, resources, and supplies become limited. Having in place written guidelines and plans that have been practiced is beneficial during emergencies. Established policies and procedures can help guide staff through potential ethical dilemmas and help direct staff in adjusting care to meet the needs of the community.[54] When developing the guidelines and plans for CSC, it is essential to include the seven components identified by the IOM that support ethical behavior and ethical decision making: fairness, duty to care, duty to steward resources, transparency, consistency, proportionality, and accountability.[11] Additionally, when planning resource allocation, it is important to provide fair treatment of patients based on objective and consistent treatment standards. For example, following the utilitarian rule, to save the most lives, planning may address prognosis, increased years of life saved, and age of patient, specifically giving priority to those who have not had the opportunity for a full life.[51]

Decision-making regarding alterations to care in any disaster situation come directly from the Incident Command Center. Decisions such as these are made at a high level with appropriate leaders included in the decision-making process and then communicated to staff as applicable.[53] Healthcare workers provide care for the patients as directed from the incident command structure and also continue to advocate for their patients to the best of their ability.

Conclusion

A disaster event may strain healthcare resources and necessitate a shift in care from being attentive to the individual to a focus more on doing the most good for the greatest number. Implementing CSC in no way suggests providing substandard care, but rather delivering healthcare that is reasonable given the available resources. Planning care in these situations is overwhelming, but preparation can assist healthcare providers in taking a proactive approach. As discussed above, planning and proactive steps may become insufficient and resources may become scarce or depleted, which may make reallocation decisions difficult and, in some instances, mean switching to promoting benefits to the population over benefits to individuals. In these austere situations, planning is vital to avoid greater illness, injury, and death. Crisis situations are complex and stressful; it is therefore important for healthcare organizations to prepare, discuss, and practice potential scenarios with staff.

A plethora of literature explores the role and responsibilities of nurses during a disaster. In the past decade, federal, state, tribal and local governments, the IOM, and other public health agencies have worked diligently on developing CSC plans and guidance.[4] There remains an opportunity, however, for development of specific guidance for emergency nurses in CSC situations. Emergency nurses need to be aware of their professional role and responsibilities during a disaster, and become educated on institutional policies and legal requirements to prepare for an appropriate and adequate response for the greater good. Hospitals administrators and educators also need to take responsibility to ensure emergency nurses and essential healthcare providers are given appropriate training and education to prepare for crisis events. More research in this area would be helpful in developing specific CSC competencies and practice guidelines for the emergency nurse.

Resources

The following is a partial list of key emergency response policies:[55]

- **Emergency Management Assistance Compact (EMAC)** – congressionally authorized interstate mutual aid agreement (compact) which provides a mechanism allowing states to provide assistance to other states. EMAC agreements are adopted into state statues and address reimbursement, liability, compensation, and licensure issues.
- **Federal Employees Compensation Act (FECA)** – provides workers' compensation to civilian federal employees who are injured or killed during an event. Volunteers who deploy under federal programs such as the National Disaster Medical System are deemed to be federal employees during the event.
- **Federal Tort Claims Act (FTCA)** – permits lawsuits to be brought against federal government employees if injured by federal employee(s) acting within the scope of their duties. The act immunizes federal employees from tort liability; the federal government assumes the employees' role as the defendant. Volunteers of federal agencies are entitled to FTCA coverage.
- **Homeland Security Policy Directives (HSPDs) and Presidential Policy Directives (PPDs)** – establish policies, strategies, and frameworks directing executive agency activities for preparedness and response
- **National Emergencies Act (NEA)** – allows the president to declare a national emergency which triggers emergency authorities in other federal statutes
- **National Incident Management System (NIMS)** – system of roles and responsibilities developed to coordinate emergency response activities at all levels of government and the private sector. Scalable system that can be used for all events regardless of federal emergency declaration.
- **National Strategy Documents** – federal legislation and directives that mandate the creation of various strategies and plans to chart national emergency planning and response activities. These plans address coordination of state, local, territorial and tribal governments, and private sector efforts. Examples are: National Health Security Strategy, National Strategy for Pandemic Influenza, and National Strategy for Homeland Security.
- **Pandemic and All Hazards Preparedness Act (PAHPA)** – addresses the public health emergency preparedness and response activities, authorizes programs for medical surge capabilities, outlines the capacity of states and localities to prepare for and respond to public health emergencies, and covers the development of countermeasures against biological threats. The needs of the at-risk populations in emergency planning and response are addressed in this act.
- **Social Security Act Section 1135** – authorizes the HHS secretary to temporarily waive or modify some Medicare, Medicaid, Children's Health Insurance Program (CHIP), and Health Insurance Portability and Accountability Act (HIPAA) requirements. The waivers are implemented on a case-by-case basis regulated by the Centers for Medicare & Medicaid Services, HHS regional offices, and state health-facility survey agencies.
- **Stafford Act** – The Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121-5207, otherwise known as the Stafford Act, states "All requests for a declaration by the President that a major disaster exists shall be made by the Governor of the affected State"[45]
- **Volunteer Protection Act** – provides immunity from ordinary negligence to volunteers of nonprofit organizations or governmental entities. This act does not require a declared emergency.

Additional Resources

American Red Cross: Disaster Training

Association of State and Territorial Health Officials (ASTHO). 92017). Emergency Authority and Immunity Toolkit: ASTHO legal preparedness series, emergency authorization and immunity toolkit: Immunity issues in emergencies. [Fact Sheet].

Department of Homeland Security: Prepare My Family for a Disaster

FEM: Emergency Planning Exercises

The Joint Commission: Emergency Management Resources: Legal/Ethical Issues

The National Academies of Sciences, Engineering, and Medicine: Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response

National Disaster Medical System (NDMS) Response Teams

State by State Comparison Table-Healthcare Volunteer Liability Protection

U.S. Department of Health & Human Services Technical Resources, Assistance Center, and Information Exchange (TRACIE)

U.S. Department of Health and Human Services: Public Health Emergency

Definitions of Terms

Austere environment: An area that often experiences considerable environmental hazards such as heat, cold, or altitude, that could exacerbate existing medical conditions when protection (such as climate control) is not available.

Crisis standards of care: A substantial change in the normal health care operations and the level of care it is possible to deliver.[4]

Disaster triage: The process of sorting injured individuals into categories according to their need for or benefit from immediate medical treatment based on a system of priorities designed to maximize the number of survivors.

Healthcare coalition: Formal collaborations between healthcare facilities, public health departments, emergency management agencies, and other types of healthcare agencies within a region that are organized and committed to respond to mass casualty or other disastrous events.[32]

Hot wash: Immediate debriefing after an incident sometimes referred to as "after-action." These are discussions and evaluations of performance following an exercise, training session or major event, such as Hurricane Harvey or Irma.

Incident Command Center (ICS): A management system created to allow effective and efficient incident management by incorporating a combination of facilities, equipment, personnel, procedures, and communications functioning within a common organizational structure, intended to enable effective and efficient incident management.

Nurse Licensure Compact: The license issued by the nurse's primary state of residence which gives the nurse the privilege of practicing in other compact states (both physically and via technology) without having to secure an additional license.[56]

State of emergency: Each state has unique statutes, but generally each state permits the governor to declare a state of emergency for any type of emergency or natural disaster, which can be interpreted broadly to include public health emergencies.[49] The governor of the state in which the event occurred may declare an emergency by issuing an executive order or other type of declaration to that effect. The declaration specifically addresses the effective dates, duration, geographic areas affected, conditions causing the emergency, and the agencies leading the response activities.[49]

Utilitarian rule: The idea that following rules that tend to lead to the greatest good will have better consequences overall than allowing exceptions to be made in individual instances.[57]

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ENA Topic Brief

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