

## Revisions to the CAMLTC Manual Effective July 1, 2006

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### **Disaster Responsibilities for Non-Licensed Independent Practitioners (new standard HR.1.25)**

#### **Disaster Responsibilities**

##### **Standard HR.1.25**

The organization may assign disaster responsibilities to volunteer practitioners<sup>1</sup>.

##### **Rationale for HR.1.25**

When the disaster plan has been implemented (see Standard EC.4.10 for a description of emergency management planning requirements) and the immediate needs of the residents cannot be met, the organization may implement a modified process for determining qualifications and competence of volunteer practitioners (see Elements of Performance 5-8). The volunteer practitioners that are addressed by this standard only include those practitioners that are required by law and regulation to have a license, certification, or registration to practice their profession. The usual process to determine the qualifications and competence of these practitioners would not allow a volunteer practitioner to provide immediate care, treatment, and services in the event of a disaster (refer to the Glossary for definitions of disaster and emergency) due to the length of time it would take to complete the process. A similar modified process for the assignment of disaster privileges for volunteer licensed independent practitioners exists at Standard HR.4.35.

While this standard allows for a method to streamline the process for determining qualifications and competence, safeguards must be in place to assure that the volunteer practitioners are competent to provide safe and adequate care, treatment, and services. Even in a disaster, the integrity of two parts of the usual process for determining qualifications and competence must be maintained:

1. Verification of licensure, certification, or registration required to practice a profession
2. Oversight of the care, treatment, and services provided

This option to assign disaster responsibilities to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the organization and its residents, and on the qualifications of its volunteer practitioners.

There are a number of state and federal systems engaged in pre-event verification of qualifications that may facilitate the assigning of disaster responsibilities to volunteer practitioners at the time of a disaster. Examples of such systems include the Medical Reserve Corps (MRC2) and the Emergency System for Advance Registration of Volunteer

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1 Individuals who are qualified to practice a health care profession (for example, a nurse) and are engaged in the provision of care and services. Practitioners are often required to be licensed as defined by law.

2 MRC – Medical Reserve Corps units comprise of locally-based medical and public health volunteers who can assist their communities during emergencies, such as an influenza epidemic, a chemical spill, or an act of terrorism. The MRC Program was formed in 2002, in cooperation with the White House's USA

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Health Professionals (ESAR-VHP3). It is expected that additional programs will emerge and evolve.

### Elements of Performance for HR.1.25

A 1. Disaster responsibilities are assigned only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate resident needs.

A 2. The organization identifies in writing the individual(s) responsible for assigning disaster responsibilities.

B 3. The organization describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who are assigned disaster responsibilities.

B 4. The organization has a mechanism to identify volunteer practitioners that have been assigned disaster responsibilities.

B 5. Volunteer practitioners must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

- A current health care organization [such as a long term care, ambulatory care, laboratory, or hospital] picture identification card that clearly identifies professional designation
- A current license, certification, or registration
- Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession)
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT4), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups
- Identification indicating that the individual has been granted authority to render resident care, treatment, and services in disaster circumstances (such

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Freedom Corps, as one of the charter programs of Citizen Corps. Pre-identifying, training and organizing medical and public health professionals to strengthen their communities through volunteerism is at the core of the MRC concept. MRC volunteers offer their expertise throughout the year by supporting local public health initiatives, such as immunization and prevention activities. When an emergency community need occurs, MRC volunteers can work in coordination with existing local emergency response programs.

3 ESAR-VHP – The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program, created by the Health Resources and Services Administration (HRSA), allows for the advance registration and credentialing of healthcare professionals needed to augment a hospital or other medical facility to meet increased resident/victim care and increased surge capacity needs.

4 DMAT – A group of medical and support personnel designed to provide emergency medical care during a disaster or other unusual event. The DMAT is a component of the National Disaster Medical System (NDMS). The Department of Health and Human Services in partnership with other Federal Agencies such as Department of Defense, Department of Veterans Affairs, and the Federal Emergency Management Agency administer the program.

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- authority having been granted by a federal, state, or municipal entity)  
• Identification by current organization member(s) who possesses personal knowledge regarding the volunteer practitioner's qualifications

A 6. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.

*Note: In the extraordinary circumstance that primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster responsibilities.*

B 7. The organization oversees the professional practice of volunteer practitioners.

A 8. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer practitioner) within 72 hours related to the continuation of the disaster responsibilities initially assigned.

### **Disaster Privileges for Licensed Independent Practitioners (new standard HR.4.35)**

#### **Disaster Privileges**

##### **Standard HR.4.35**

The organization may grant disaster privileges to volunteers eligible to be licensed independent practitioners.

##### **Rationale for HR.4.35**

When the disaster plan has been implemented (see Standard EC.4.10 for a description of emergency management planning requirements) and the immediate needs of the residents cannot be met, the organization may implement a modified credentialing and privileging process for eligible volunteer practitioners (see Elements of Performance 5-8). The usual process to credential and privilege practitioners would not allow a volunteer practitioner to provide immediate care, treatment, and services in the event of a disaster (refer to the Glossary for definitions of disaster and emergency) due to the length of time it would take to complete the process. A similar modified process for the assignment of disaster responsibilities for volunteers that are not independent practitioners exists at Standard HR.1.25.

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While this standard allows for a method to streamline the credentialing and privileging process, safeguards must be in place to assure that volunteer practitioners are competent to provide safe and adequate care, treatment, and services. Even in a disaster, the integrity of two parts of the usual credentialing and privileging process must be maintained:

1. Verification of licensure
2. Oversight of the care, treatment, and services provided

This option to grant disaster privileges to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the organization and its residents, and on the qualifications of its volunteer practitioners.

There are a number of state and federal systems engaged in pre-event credentialing that may facilitate the implementation of disaster privileging of volunteers at the time of a disaster. Examples of such systems include the Medical Reserve Corps (MRC5) and the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP6). It is expected that additional programs will emerge and evolve.

### **Elements of Performance for HR.4.35**

A 1. Disaster privileges are granted only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate resident needs.

A 2. The organization identifies in writing the individual(s) responsible for granting disaster privileges.

B 3. The organization describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who receive disaster privileges.

B 4. The organization has a mechanism to identify the volunteer practitioners who have been granted disaster privileges.

B 5. While disaster privileges are granted on a case-by-case basis, volunteers considered

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5 MRC – Medical Reserve Corps units comprise of locally-based medical and public health volunteers who can assist their communities during emergencies, such as an influenza epidemic, a chemical spill, or an act of terrorism. The MRC Program was formed in 2002, in cooperation with the White House’s USA Freedom Corps, as one of the charter programs of Citizen Corps. Pre-identifying, training and organizing medical and public health professionals to strengthen their communities through volunteerism is at the core of the MRC concept. MRC volunteers offer their expertise throughout the year by supporting local public health initiatives, such as immunization and prevention activities. When an emergency community need occurs, MRC volunteers can work in coordination with existing local emergency response programs.

6 ESAR-VHP – The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program, created by the Health Resources and Services Administration (HRSA), allows for the advance registration and credentialing of healthcare professionals needed to augment a hospital or other medical facility to meet increased resident/victim care and increased surge capacity needs.

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eligible to act as licensed independent practitioners in the organization must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

- A current health care organization (such as a long term care, ambulatory care, or hospital) picture identification card that clearly identifies professional designation
- A current license to practice
- Primary source verification of the license
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT7), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups
- Identification indicating that the individual has been granted authority to render resident care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)
- Identification by current organization member(s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster

A 6. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.

*Note: In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.*

B 7. The organization oversees the professional practice of volunteer licensed independent practitioners.

A 8. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

### **Emergency Management Drills (revised EC.4.20)**

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7 DMAT – A group of medical and support personnel designed to provide emergency medical care during a disaster or other unusual event. The DMAT is a component of the National Disaster Medical System (NDMS). The Department of Health and Human Services in partnership with other Federal Agencies such as Department of Defense, Department of Veterans Affairs, and the Federal Emergency Management Agency administer the program.

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### Introduction

Periodic testing of an emergency management plan enables organizations to assess the plan's appropriateness, adequacy, and the effectiveness of logistics, human resources, training, policies, procedures, and protocols. Exercises should stress the limits of the organization's emergency management system. The goal of this testing is to assess the organization's preparedness capabilities and performance when systems are stressed during an actual emergency or a simulated situation.

Exercises should be developed using plausible scenarios that are realistic and relevant to the organization. Events should be based on each organization's hazard vulnerability analysis (HVA), and should validate the effectiveness of the plan and identify opportunities to improve.

This standard will assist health care organizations to test their emergency management plans, identify deficiencies, and take corrective actions to continuously improve the effectiveness of their emergency management plan. Only a thorough and objective evaluation of performance during an emergency management event or a planned exercise will demonstrate how effective the organization's planning efforts have been.

It is important to communicate the strengths and weaknesses of the performance revealed by the exercise to all levels of the organization, including administration, clinical staff, governing body, and those responsible for managing the resident safety program.

### ~~Standard EC.4.20~~

~~The organization conducts drills regularly to test emergency management.~~

### ~~Elements of Performance for EC.4.20~~

~~A 1. The organization tests the response phase of its emergency management plan twice a year, either in response to an actual emergency or in planned drills.<sup>8</sup>~~

~~**Note:** *Tabletop exercises, though useful in planning or training, are **only** acceptable substitutes for communitywide practice drills.*~~

~~A 2. Drills are conducted at least four months apart and no more than eight months apart.~~

~~A 3. Organizations that offer emergency services or are community-designated disaster receiving stations must conduct at least one drill a year that includes an influx of volunteers or simulated residents.~~

~~A 4. The organization participates in at least one communitywide practice drill a year (where applicable) relevant to the priority emergencies identified in its hazard~~

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~~<sup>8</sup> *Drills that involve packages of information that simulate residents, their families, and the public are acceptable.*~~

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~~vulnerability analysis. The drill assesses the communication, coordination, and effectiveness of the organization's and community's command structures.~~

~~**Note:** "Communitywide" may range from a contiguous geographic area served by the same health care providers, to a large borough, town, city, or region.~~

~~**Note:** Tests of EPs 3 and 4 may be separate, simultaneous, or combined.~~

~~5. Not applicable~~

~~**B 6.** All drills are critiqued to identify deficiencies and opportunities for improvement.~~

### Standard EC.4.20

The organization regularly tests its emergency management plan.

### Elements of Performance for EC.4.20

#### Number and Types of Exercises

A 1. The organization tests its emergency management plan twice a year, either in response to an actual emergency or in a planned exercise.

**Note:** Tabletop sessions, though useful, are **not** acceptable substitutes for exercises.

A 2. Organizations that offer emergency services or are community-designated disaster receiving stations conduct at least one exercise a year that includes an influx of actual or simulated residents.

A 3. Organizations that have a defined role in the communitywide emergency management program participate in at least one communitywide exercise a year.

**Note 1:** "Communitywide" may range from a contiguous geographic area served by the same health care providers, to a large borough, town, city, or region.

**Note 2:** Exercises for Element of Performance 2 and 3 may be conducted separately or simultaneously

**Note 3:** Table top sessions are acceptable in meeting the community portion of this exercise.

A 4. Not applicable.

#### Scope of Exercises

**B 5.** Planned exercise scenarios are realistic and related to the priority emergencies identified in the organization's hazard vulnerability analysis.

**B 6.** Not applicable

A 7. During planned exercises, an individual whose sole responsibility is to monitor performance and who is knowledgeable in the goals and expectations of the exercise.

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documents opportunities for improvement.<sup>9</sup>

A 8. During planned exercises the organization monitors at least the following core performance areas: Event notification including processes related to activation of the emergency management all hazards command structure, notification of staff, and notification of external authorities;

A 9. During planned exercises the organization monitors at least the following core performance areas: Communication including the effectiveness of communication both within the organization as well as with response entities outside of the organization such as local governmental leadership, police, fire, public health, and other healthcare organizations within the community.

A 10. During planned exercises the organization monitors at least the following core performance areas: Resource mobilization and allocation including responders, equipment, supplies, personal protective equipment, transportation, and security.

A 11. During planned exercises the organization monitors at least the following core performance areas: Resident management including provision of both clinical and support care activities, processes related to triage activities, resident identification and tracking processes.

B 12. All exercises are critiqued to identify deficiencies and opportunities for improvement based upon all monitoring activities and observations during the exercise.

B 13. Completed exercises are critiqued through a multi-disciplinary process that includes administration, clinical, and support staff.

B 14. The organization modifies its emergency management plan in response to critiques of exercises.

B 15. Planned exercises evaluate the effectiveness of improvements that were made in response to critiques of the previous exercise.

*Note: When improvements require substantive resources that can not be accomplished by the next planned exercise, interim improvements must be put in place until final resolution.*

B 16. The strengths and weaknesses identified during exercises are communicated to the multidisciplinary improvement team responsible for monitoring environment of care issues (see EC.9.20).

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<sup>9</sup> This individual may be a staff member of the organization who is not participating in the exercise.

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### Revisions to the Medication Management Standards (Standards MM.2.20, MM.4.20, MM.8.10)

#### Standard MM.2.20

Medications are properly and safely stored.

#### Rationale for MM.2.20

Appropriate medication storage increases resident safety. Medication storage is designed to assist in maintaining medication integrity; promote the availability of medications when needed, minimize the risk of medication diversion and reduce potential dispensing errors.

*Note: This standard is applicable only to organizations that store medications at their sites.*

*Note: The following elements of performance also apply to emergency medications. Additional requirements for emergency medications are addressed at standard MM.2.30.*

#### Elements of Performance for MM.2.20

(M) A 1. Only approved medications are routinely stocked or stored.<sup>10</sup>

(M) A 2. Medications are stored under conditions suitable for product stability.

A 3. There is a written policy addressing the storage of medication between receipt of a medication by an individual health care provider and medication administration. At a minimum, the policy addresses:

- Safe storage
- Safe handling
- Security and
- Disposition of these medications including return to the medication storage area at the end of the individual's shift.

(M) C 4. The policy addressing the storage of medication between receipt of a medication by an individual health care provider and medication administration is implemented.

A ~~3~~ 5. Unauthorized persons, in accordance with the organization's policy and law and regulation, cannot obtain access to medications.

A ~~4~~ 6. Controlled substances are stored to prevent diversion and according to state and federal laws and regulations.

A ~~5~~ 7. All expired, damaged, and/or contaminated medications are segregated until they are removed from the organization.

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<sup>10</sup> *Note: See standard MM.2.40 for the exception to this standard: The organization has a process to safely manage medications brought in by the resident or the resident's family.*

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**A ~~68~~**. Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.

*Note: The preceding requirement is not scored here. It is scored at NPSG 3, Requirement 3C.*

**A ~~79~~**. Medications and chemicals used to prepare medications are accurately labeled with contents, expiration dates, and warnings.

**A ~~810~~**. Standardize and limit the number of drug concentrations available in the organization.

*Note: The preceding requirement is not scored here. It is scored at NPSG 3, Requirement 3B.*

**(M) A ~~911~~**. Concentrated electrolytes are removed from care units or areas, (unless resident safety is at risk if the concentrated electrolyte is not immediately available on a specific care unit or area, in such situations, specific precautions are taken to prevent inadvertent administration).

~~1012~~. Not applicable

~~1113~~. Not applicable

~~1214~~. Not applicable

**(M) C ~~1315~~**. All medication storage areas are periodically inspected according to the organization's policy to make sure medications are stored properly.

### Standard MM.4.20

Medications are prepared safely.

### Rationale for MM.4.20

*Note: This standard is applicable to all organizations that dispense or prepare medications for administration.*

### Elements of Performance for MM.4.20

**B 1.** When an on-site, licensed pharmacy is available, only the pharmacy compounds or admixes all sterile medications, intravenous admixtures, or other drugs except in emergencies or when not feasible (for example, when the product's stability is short).

**A 2.** The organization has a written policy that addresses the safety and use of medications acquired by a practitioner from sources other than the organization for use in resident care in that organization. The policy addresses:

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- Whether such medications are allowed to be used.
- If allowed, a process to evaluate the integrity of medications brought in by a practitioner prior to use in resident care.

A 3. The written policy that addresses the safety and use of medications acquired by a practitioner from sources other than the organization for use in resident care is implemented.

(M) C ~~24~~. Wherever medications are prepared, staff uses safety materials and equipment while preparing hazardous medications.

(M) C ~~35~~. Wherever medications are prepared, staff uses techniques to assure accuracy in medication preparation.

(M) C ~~46~~. Wherever medications are prepared, staff follow techniques to avoid contamination during medication preparation including, but not limited to the following:

- Using clean or sterile techniques
- Maintaining clean, uncluttered, and functionally separate areas for product preparation to minimize the possibility of contamination
- Using a laminar airflow hood or other class 100 environment while preparing any intravenous (IV) admixture in the pharmacy, any sterile product made from non-sterile ingredients, or any sterile product that will not be used within 24 hours)
- Visually inspecting the integrity of the medications

### **Standard MM.8.10**

The organization evaluates its medication management system.

#### **Elements of Performance for MM.8.10**

**B 1.** The organization evaluates its medication management system for risk points and identifies areas to improve safety.

**B 2.** The organization identifies opportunities for improvement by routinely evaluating the literature for new technologies or successful practices that have been demonstrated to enhance safety in other organizations to determine if it can improve its own medication management system.

**B 3.** The organization reviews internally generated reports to identify trends or issues in its medication management system (*see standards PI.2.10 and PI.2.20*).

**B 4.** The organization acts to implement improvements based on

- evaluation of its medication management system

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- review of new technologies
- external data
- successful practices that have been demonstrated to enhance safety.

**B 5.** The performance of new and modified medication management processes is measured.

**B 6.** The organization uses information from data analysis to identify subsequent changes to improve its medication management system.

**B ~~47~~.** The pharmacy and long term care facility collaborate to determine whether the medication management system is effective.

**B ~~58~~.** When a pharmacy is the primary provider of pharmaceutical services to a long term care facility, the pharmacy collaborates with the long term care facility to implement a medication management system to control all medications.

**B ~~69~~.** When a pharmacy is the primary provider of pharmaceutical services to a long term care facility or consultant pharmacist services are provided, the pharmacy or pharmacist participates in educating the long term care facility about the following:

- The collection and use of performance measures for medication management
- Techniques to reduce medication errors and minimize waste of medications