

# CAEP Position Statement – Hospital disaster preparedness

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## EXECUTIVE SUMMARY

### INTRODUCTION

Despite evidence to the contrary, most authorities in Canada perceive our healthcare disaster readiness to be far more advanced than it is, while, in fact, we remain dangerously unprepared. What limited scientific review of readiness exists is outdated. Federal, Provincial, and Territorial (FPT) authorities have not engaged in any formal assessment of healthcare disaster preparedness. All levels of government must measure and acknowledge the existing readiness gaps and begin to actively engage frontline clinical care groups in remedying this. Otherwise, it will be difficult to defend the unnecessary suffering and loss of life that will occur.

## LIST OF RECOMMENDATIONS

1. All healthcare facilities (including hospitals, long-term care homes) and agencies (including public health, prehospital, patient transport, community healthcare) must have some degree of competency in disaster preparedness.
2. This competency must include (but need not be limited to):
  - a. Incident command
  - b. Triage
  - c. Mass casualty events/mass gatherings
  - d. Hazardous materials
  - e. Common terminology (including basic knowledge and procedures related to biological, chemical, radiological, and nuclear events)

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The full document is available on the CAEP website: <https://caep.ca/advocacy/position-statements/>.

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3. The planning needs to be high concept and must include an all-hazards approach.
4. The planning must be integrated at all levels of the health system.
5. At the institutional level, the ideal model for emergency management is a dyad model comprising an upper level administrator with formal training and experience in emergency management and a dedicated physician in the medical director role.
6. In addition to the above, institutions and agencies must prepare plans that:
  - a. Are uniform in format and structure, allowing for mutual aid between local facilities and agencies, as well as across and between regions and provinces/territories
  - b. Are coordinated with provincial/territorial and federal initiatives and support
  - c. Have a defined command and control structure based on Incident Management System principles and supported by an emergency operations centre
  - d. Are simple and easy to review rapidly
  - e. Include role description checklists, also known as *job action sheets*, that allow for a quick understanding of the staff's immediate tasks while activating the next level in response
  - f. Are based on best practices
  - g. Identify and, ideally, coordinate in advance with local and regional resources that could be called upon in a disaster, including but not limited to poison control centres, Canadian military, emergency medical services dispatch, volunteer organizations, and other institutions
  - h. Are tested and exercised annually with a formal review every 3 years
  - i. Follow a standardized format and include key components so as to allow uniform and interoperable plans that cross provincial borders. Facilitating this process will require support and guidance from the Federal government within the parameters of the Canada Health Act.
7. Education and training in disaster preparedness should have dedicated annual funding so as to both achieve and maintain said competency.
8. Said competency should be validated through structured cyclical auditing that where applicable should be integrated as a critical factor into the existing evaluation processes of the organization.
9. Disaster response must be a Required Organizational Practice without which healthcare facilities cannot be accredited. Specifically, accredited healthcare facilities and agencies must make disaster preparedness an accreditation requirement that is assessed using specific, measurable, and scientifically driven standards.
10. Facility training must include periodic exercises that involve all components of the disaster response and that are objectively assessed for purposes of quality improvement.
11. Any educational program must promote coordination of services and alignment of disaster plans between the various healthcare providers and health system components within a community, such as first responders, fire, police, and relevant government and local agencies involved in health emergencies in order to ensure ongoing healthcare to all citizens.
12. All planning must take into consideration vulnerable segments of the population, such as children, the elderly, and patients with special needs.
13. In each jurisdiction, all relevant professional colleges must support the development and delivery of professional education in disaster preparedness to any trainees and to practicing professionals who could be called upon to respond to a healthcare disaster.
14. All training and education on Disaster Preparedness across Canada – whether delivered by Federal, Provincial or Territorial (FPT) authorities, should share:
  - a. Common resources for risk assessment, readiness assessment, planning, and reporting
  - b. Common guidelines upon which they can base their planning, with the resultant uniformity in disaster preparedness
  - c. Common structure/education models for maintenance of disaster preparedness competence for all responders/care providers
  - d. Clarification of the division of authority between healthcare facilities, regional authorities, the Ministries of Health, the Public Health Agency of Canada, and other FPT agencies

- e. Common reporting, command, and communications methodology between healthcare facilities, regional authorities, the Ministries of Health, the Public Health Agency of Canada, and other FPT agencies
15. In order to ensure interoperability between regions and all levels of healthcare, the Federal government in cooperation with the provinces and territories must provide the uniform planning tools and resources to achieve the previous point. Ideally, a federal health emergency response plan should include:
    - a. A core set of concepts, principles, terminology, and technologies covering the incident command system
    - b. A multi-agency coordination systems
    - c. A unified command protocol
    - d. A training strategy
    - e. Identification and management of resources
    - f. A process for defining qualifications and certification
    - g. Tactics that support the collection, tracking, and reporting of incident information and incident resources
  16. While the training at the federal and provincial/territorial levels should assist organizations in breaking down their inter-organizational silos, all training should also emphasize the breaking down planning and communication silos *within* healthcare facilities.
  17. A common national database for unidentified patients, ideally with trackable location identifiers, should be created and be available to all healthcare centres in order to ensure effective identification and reunification of patients and families.
4. In the healthcare system, emergency physicians and nurses in collaboration with emergency managers and community resources are best positioned to lead their institutions to better disaster preparedness.
  5. The steps required to remedy this gap in healthcare disaster preparedness are clear and outlined in the recommendations.
  6. Not addressing the issue of healthcare disaster preparedness, particularly at the institutional level, will lead to increased illness and death in the Canadian population.

### **NEXT STEPS**

1. The recommendations should be publicly presented to the Federal Ministers of Health and Public Safety, the Public Health Agency of Canada, Accreditation Canada, and the relevant Provincial/Territorial Health, Provincial/Territorial Public Health, and Emergency Management authorities.
2. In keeping with these recommendations, CAEP should develop and deploy a preparedness curriculum including both education and training so as to assist all FPT agencies, first receivers, and disaster responders achieve a common baseline of proficiency.
3. In presenting these recommendations, CAEP should offer support to FPT authorities, helping them organize and support a public disaster preparedness review – with scientific methodology and quantifiable results – of current disaster readiness at the first receivers' level and repeat said review in 3 years.

**Supplementary material:** The supplementary material for this article can be found at <https://doi.org/10.1017/cem.2020.38>

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### **SUMMARY**

1. What outdated literature exists reveals gaps in Canadian institutional preparedness for healthcare-related disasters.
2. There has been no formal FPT assessment of disaster readiness at institutional and first-receiver levels.
3. Disaster causes morbidity and mortality as does any disease, but, unlike other diseases, there is no Canadian standard of care in disasters, despite that the methodology of disaster response has been well defined and is publicly available.

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