



Development of Standards and Guidelines for Healthcare Surge during Emergencies

Personnel

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80 **NOTE:** This document was developed with input from a broad group of stakeholders representing
81 constituent organizations with diverse perspectives and technical expertise. The purpose of
82 eliciting a wide range of input was to ensure the information contained in this document was as
83 comprehensive and as sound as possible.

84

85 **Although the individuals referenced and the organizations they represent have provided many**
86 **constructive comments, information and suggestions, they were neither asked nor did they agree**
87 **to endorse the conclusions or recommendations represented here or in subsequent iterations.**

88

89 **As a work in progress document, we are attempting to identify resources and solutions for the**
90 **following issues:**

- 91 1. How can liability be extended to personnel practicing outside of the scope of practice?
92 2. What is the standard and authority to authorize use of Federal employees as disaster service
93 workers?
94 3. What are the implications of providing stipends to disaster service workers (public employees) or
95 other responders (private citizens and volunteers) as an incentive to maintain staffing levels in a
96 prolonged surge environment?
97 4. Can a pre-registration and credentialing process be developed for security personnel? Can ESAR-
98 VHP or MRCs include this category of workers? What can be done to facilitate registration of
99 ancillary and support services personnel prior to and during surge?
100 5. Creation of waivers or standby orders for:
101 • Flexed scope of practice (Boards of Licensure)
102 • Flexing or waiving reciprocity requirements (inter-facility and interstate)
103 • Flexing of supervisory ratios (e.g. Physicians permitted to supervise/oversee >2 P.A.s)
104 6. Identification of consequences for individuals who refuse to comply with mandates or authorities
105 during surge (e.g. compelled to serve, mandated vaccinations, quarantine, etc.).
106

107 **Introduction**

108
109 Providing healthcare during a large scale public health emergency presents significant challenges for
110 healthcare facilities, licensed healthcare professionals, and communities. During emergency events,
111 healthcare systems must convert quickly from their existing patient capacity to “surge capacity” - a
112 significant increase beyond usual capacity - to rapidly respond to the needs of affected individuals. The
113 demands of the emergency may prevent compliance with the existing healthcare standards. Just as
114 California has healthcare standards for use with a normal operations, it is essential that California provide
115 guidelines that identify the extent to which existing standards can be flexed or waived for healthcare
116 delivery during emergencies.

117
118 Surge planning for the healthcare system is a substantial and complex challenge. In a time of significant
119 disaster, a successful plan must provide flexibility to address capacity (volumes of patients and
120 requirements) and capabilities (the ability to treat or manage the medical condition) that emerge above
121 baseline requirements. The issues addressed are diverse and include standards of practice during an
122 emergency, liability of hospitals and licensed healthcare professionals, reimbursement of care provided
123 during an emergency, operating alternate care sites, and planning considerations for surge operations at
124 individual hospitals.

125
126 Upon completion of this project, stakeholders will have access to a *Standards and Guidelines Manual* that
127 will serve as a reference manual on existing statutory and regulatory requirements identifying what will be
128 flexed or modified under different emergencies; *Operational Tools* that include forms, checklists and
129 templates to facilitate and guide the adoption and implementation of statutory and regulatory
130 requirements outlined in the Standards and Guidelines Manual; and a *Training Curriculum* outlining
131 intended audience, means of delivery and frequency of training that will enable adherence to the policies
132 and overall readiness of the healthcare delivery system.

133
134 The deliverables will serve as the basis for planning and operations of healthcare facilities, providers and
135 communities during an unexpected increase in demand for healthcare services. The deliverable will
136 focus on eight areas: (1) Declaration and Triggers; (2) Existing Facilities; (3) Alternate Care Sites; (4)
137 Personnel; (5) Supplies, Pharmaceuticals and Equipment; (6) Funding Sources; (7) Administrative; and
138 (8) Population Rights.

139
140
141 **Personnel**

142
143 The Personnel work group will develop content that will be used by existing facilities and alternate care
144 sites (ACS) during surge. Readers may use the recommended guidelines and operational tools identified
145 to begin developing or adapting surge and disaster response plans as necessary. The primary goal of
146 the work group is to enable surge response through analysis of current standards and identification of
147 waivers.

148
149 This document is divided into three sections. The first section focuses on the maintenance and
150 organization of personnel during surge, which will provide guidance around identifying augmented staff,
151 organizing staff (in terms of staffing strategies), and maintaining staff (safeguarding health and safety,
152 providing support provisions, and promoting processes to protect workforce resiliency).

153
154 The second section focuses on analysis of flexing of standards for credentialing and verification of
155 qualifications of personnel during surge. This section will provide specific guidelines and processes as to
156 how credentialing and verifications processes can be flexed and under what circumstances this will occur.

157
158 The third section provides analysis for standards and guidelines related to professional liability and scope
159 of practice as they pertain to personnel working during surge. This section identifies waivers and potential

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160 flexing of current standards that will enable staff members to work during surge with reduced liability, as
161 well as provide staff coordinators with the ability to utilize staff in non-traditional roles that provide for the
162 optimal outcome in an emergency.

163

164 Each section will also contain the recommended operational tools to be used for implementation of the
165 suggested guidelines and recommendations and are accompanied with user instructions.

166

167

168 Management and Organization of Personnel

169
170 This section of the document focuses on three primary areas with respect to personnel management:
171 augmenting existing workforce, or building a new one (at an alternate care site – ACS) to respond to a
172 surge, beginning with the involvement of the Standardized Emergency Management System (SEMS) and
173 the Hospital Incident Command System (HICS); organizing personnel within the facilities during the surge
174 (to include addressing issues surrounding staffing requirements, staffing plans and training); and lastly
175 maintaining the staff through the period of surge (including taking the necessary precautions to safeguard
176 their health and safety, providing support services such as dependent care, and addressing issues
177 surrounding workforce resiliency).

178
179 Specific guidelines with regards to these three areas (augmenting, organizing, and maintaining) are
180 outlined in this section as well, along with recommended tools and templates to enable effective planning.

181 Augmenting the Workforce

182 Current Standards and Analysis

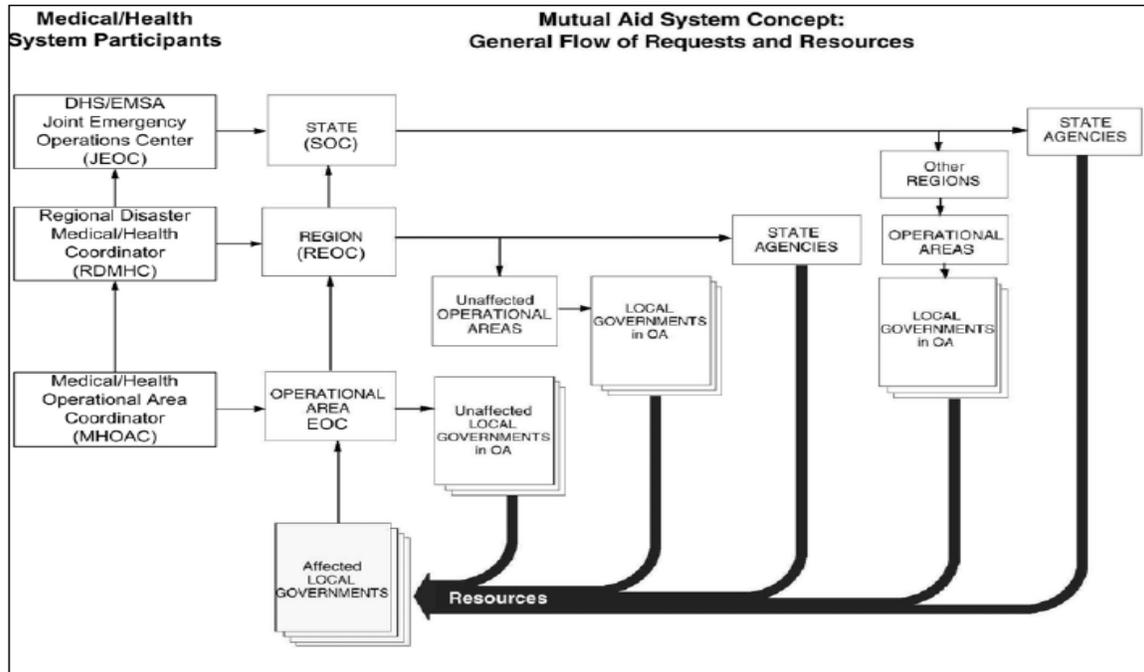
183 Role of SEMS in Acquiring Personnel

184
185 The Standardized Emergency Management System (SEMS) is the system required by [Government Code](#)
186 [§ 8607 \(a\)](#) for managing response to multi-agency and multi-jurisdiction emergencies in California. SEMS
187 consists of five organizational levels that are activated as necessary: field response which includes the
188 on-scene responders, local government which includes county, city or special districts, operational area
189 (OA) which includes the responsible jurisdictions within the boundary of a country, region includes
190 operational areas and state which includes coordination integrated with federal agencies. The five SEMS
191 organization levels, together with the private sector, represent all resources available within the State that
192 may be applied in disaster response and recovery phases.

193
194 According to SEMS, resource requests for response and recovery originate at the level of government
195 where the needs are unmet and are progressively forwarded to the next higher level until filled. All public
196 health functions should be incorporated into SEMS system through the Mutual Aid System concept. The
197 CDHS Emergency Response Plan defines mutual aid as voluntary assistance provided by agencies, local
198 governments, and the State in the form of additional resources, facilities and other support whenever
199 jurisdictions' resources prove to be inadequate to cope with a given situation.

200
201 The following diagram, pulled directly from the CDHS Emergency Response Plan, illustrates the mutual
202 aid system concept and the general flow of requests and resources.
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The authorized local official, usually the Local Health Officer (LHO) has the authority to declare a health emergency. When a health emergency has been declared, the LHO has supervision and control over all environmental health and sanitation programs, personnel and resources employed by the county during the state of emergency.

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Medical and health coordination, at the OA level, is accomplished through the designated Medical/Health Operational Area Coordinator (MHOAC). The position of MHOAC can be filled by either the LHO or a designated representative tasked by the LHO. The MHOAC is responsible for coordinating mutual aid support within the OA, and responding to mutual aid resource requests. During a disaster the MHOAC directs the medical/health branch of the OA EOC, establishes priorities for medical and health related requests, responses and resources.

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The SEMS system is designed for the public sector. Health facilities, whether they are existing facilities or designated at the time of the disaster as alternate care sites, have to understand how to access mutual aid via the SEMS system during a disaster. At the present time, it is not clear how private sector health facilities will access mutual aid via the SEMS system.

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Mutual aid works on the premise that health facilities will exhaust their normal access points for personnel prior to making a formal request via the SEMS system. Some health facilities, such as hospitals, may have multiple access points given existing agreements with other facilities. Other types of facilities, especially alternate care sites that are erected at the time of the disaster, may have considerably fewer access points and would rely primarily on mutual aid to sustain operations in the short-term. As such a process has been developed to enable a consistent and predictable approach for health facilities to access personnel mutual aid via SEMS during a disaster.

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231

Pre-Surge Planning Activities

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During planning, it is essential that health facilities perform two preparatory activities: 1. Identify an Incident Commander and 2. Identify the relevant access point to the SEMS system in their respective OA.

236
237

1. An Incident Commander function should be established that will be responsible for compiling, analyzing and relaying mutual aid requests to the SEMS system during a disaster. The Incident

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238 Commander could represent an individual facility or multiple facilities within an OA that have
239 Memorandum of Understanding (MOU) in place. The Incident Commander function should have
240 24-7 coverage and should be filled by personnel who are trained in the SEMS system and have
241 working knowledge of their facilities' emergency response plan. This function should not be
242 viewed as a new position and could be merged with other existing emergency preparedness roles
243 already in existence at health facilities. For alternate care sites, the LHO should designate a
244 representative to fill the Incident Commander role. The Incident Commander role and Alternate
245 Care Site Administrator role should be filled by different individuals.

- 246
- 247 2. One of the first tasks of the Incident Commander should be the identification of his or her SEMS
248 contacts. It is recommended the following roles should be identified and their names and contact
249 information should be maintained in the respective health facilities' emergency response plans:

- 250
- 251 a. Local Health Department & Officer
 - 252 b. MHOAC
 - 253 c. Local EMS Agency Administrator and Medical Director
 - 254 d. OA Emergency Operations Center (EOC)
- 255

256 It is recommended that the Incident Commander set up an introductory meeting with his or her MHOAC
257 and LHO. The purpose of the meeting will be to begin a working collaborative relationship with active
258 sharing of relevant personnel information. It is important that the Incident Commander understand the
259 staffing (including emergency credentialing) for his or her health facility.

260

261 Role of HICS in Acquiring Personnel

262

263 Within its Frequently Asked Questions document¹, the California Emergency Medical Services (EMS)
264 Authority states that Hospital Incident Command System (HICS) is a methodology for using Incident
265 Command System (ICS) in a hospital/healthcare environment. HICS is an incident management system
266 based on the Incident Command System that assists hospitals in improving their emergency
267 management planning, response, and recovery capabilities for unplanned and planned events. HICS is
268 consistent with ICS and the National Incident Management System (NIMS) principles. HICS will
269 strengthen hospital disaster preparedness activities in conjunction with community response agencies
270 and allow hospitals to understand and assist in implementing the 17 Elements of the hospital-based NIMS
271 guidelines.

272

273 As outlined in the HICS Guidebook², in order for hospitals to respond effectively to the demands
274 associated with surge, support and resource requirements will be coordinated by the Logistics Section of
275 the Hospital Command Center. This Section is charged with the responsibility of acquiring resources
276 from internal and external sources using standard and emergency acquisition procedures and requests to
277 the local Emergency Operations Center (EOC) or Regional Hospital Coordinating Center (RHCC). Each
278 resource request from an area in the hospital should be reported to the Logistics Section using pre-
279 identified ordering procedures outlined in the hospital's Emergency Operation Plan (EOP). When
280 requesting resources from outside sources it will be important that the hospital specify exactly what their
281 need is and not try to identify how that need can be met: that will be done at the local EOC or RHCC.

282

283 Guideline/ Recommendation

284

285 HICS may be implemented by both existing facilities and ACSs. HICS maintains the scalability and
286 flexibility features of NIMS/ICS. The scalability and flexibility are illustrated in new materials (available as
287 updates to the HICS Guidebook) that include examples of which HICS positions can be activated as
288 appropriate to different scenarios and different timelines.

289

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290 Although HICS is constructed for the unique hospital environment, and does not address ICS for non-
291 hospital healthcare facilities, non-hospital healthcare facilities may find the HICS and ICS structure useful
292 in developing their emergency management plans. Should project funding become available, there could
293 be an emergency management system developed for non-hospital healthcare facilities.
294

295 It is recommended that HICS also serve as the disaster response management system to be adapted by
296 ACSs. Depending on the type and function of a given ACS, certain components of HICS should be
297 adopted as appropriate. Using HICS as the model for ACSs will increase the standardization of
298 operations of these facilities. Such standardization can improve operations within the ACS itself as well
299 as minimize the need for learning by staff and volunteers who may move between facilities.
300

301 It is also recommended that all existing facilities, and public health in preparation for operation of ACSs,
302 be trained in HICS methodology. This recommendation is in line with the Homeland Security Presidential
303 Directive (HSPD-5) which requires adoption of the National Incident Management System (NIMS) across
304 all hospitals by August 2008. Compliance is condition for receiving federal assistance (e.g., grants and
305 contracts). This includes hospitals seeing Health Resources and Services Administration (HRSA),
306 Agency for Healthcare Research and Quality (AHRQ), or Centers for Disease Control and Prevention
307 (CDC) monies. For the state of California, the compliance deadline has been set at August 31, 2007.
308

309 Armed with the basic response management system, it is then recommended that facilities familiarize
310 themselves with the various "pools" by which they may acquire staff. Facilities may opt to collaborate with
311 (through the development of MOUs/MOAs) neighboring healthcare facilities or to acquire staff through
312 volunteer agencies such as Emergency System for Advanced Registration of Volunteer Healthcare
313 Professionals (ESAR-VHP), Medical Reserve Corps (MRC), and the Disaster Service Worker Volunteer
314 Program (DSWVP). Upon acquiring staff, facilities need a mechanism by which to (1) register augmented
315 personnel and (2) assign and track job duties.
316

317 Information and guidance related to these recommendations are presented in the next section. Along
318 with a process flow diagram depicting the process by which facilities may accept and deploy augmented
319 staff during surge is included as well.
320

321 Draft deliverable(s) include:

- 322
- 323 • Mutual Aid Memorandum of Understanding (MOU) – Staffing Component
- 324 • List of Potential Staffing Sources during Surge – Background and Activation Information
- 325 • Volunteer Registration Form
- 326 • Job-Action-Sheets Overview
- 327 • Potential Candidates for HICS Command Positions
- 328 • Job-Action-Sheet for Personnel Staging Team Leader
- 329 • Staff Assignment Tracking Sheet
- 330 • Acceptance and Deployment of Augmented Staff during Surge
- 331

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332 Draft Deliverables

333

334 Mutual Aid Memorandum of Understanding (MOU) - Staffing Component

335

336 In the event of a mass medical emergency in the State of California, local and state health and medical
337 infrastructure and associated resources will be quickly committed to providing the necessary treatment
338 and/or prophylaxis to effectively respond. Resources from the state, federal, and private sector will be
339 mobilized and deployed to augment local medical and health resources as soon as possible. In order to
340 support the delivery of care during a surge, it will be necessary to establish ([Mutual Aid] Memorandum of
341 Understanding) MOUs with neighboring healthcare facilities and create partnerships with local volunteer
342 staffing organizations (MRCs, Disaster Councils, Community Emergency Response Teams (CERTs),
343 etc.). MOUs between facilities and other organizations will contain sections including, but not limited to:
344 patient transfer, equipment and pharmaceuticals, and personnel. As related to the sharing of personnel
345 during a surge, the following components should be considered in drafting an MOU.

346

347 Specific Principles of Understanding³

348 A. Medical Operations/Loaning Personnel

349

350 1. Communication of Request: The request for the transfer of personnel initially can be made verbally.
351 The request, however, must be followed up with written documentation. Request will follow the format
352 as defined in Region IV Manual 3 – Medical Health Mutual Aid. This should ideally occur prior to the
353 arrival of personnel at the recipient healthcare facility. The recipient healthcare facility will identify to
354 the donor healthcare facility the following:

355 a. The type and number of requested personnel.

356 b. An estimate of how quickly the request is needed.

357 c. The location where they are to report.

358 d. An estimate of how long the personnel will be needed.

359

360 2. Documentation: The arriving donated personnel will be required to present their donor healthcare
361 facility identification badge at the check-in site designated by the recipient healthcare facility's
362 command center. The recipient healthcare facility will be responsible for the following:

363 a. Meeting the arriving donated personnel (usually by the recipient healthcare facility's security
364 department or designated employee).

365 b. Providing adequate identification, e.g., "visiting personnel" badge, to the arriving donated
366 personnel.

367

368 3. Staff Support: The recipient hospital shall provide food, housing and/or transportation for donor
369 healthcare facility personnel asked to work for extended periods and for multiple shifts. The costs
370 associated with these forms of support will be borne by the recipient healthcare facility.

371

372 4. Financial liability: The recipient healthcare facility will reimburse the donor healthcare facility for the
373 salaries and benefits of the donated personnel at the donated personnel's rate as established at the
374 donor healthcare facility if the personnel are employees being paid by the donor healthcare facility.

375 The reimbursement will be made within ninety days following receipt of the invoice.

376

377 The Medical Director / Medical Staff Office of the recipient healthcare facility will be responsible for
378 providing a mechanism for granting emergency privileges for physicians, nurses and other licensed
379 healthcare providers to provide services at the recipient healthcare facility.

380

381 5. Demobilization procedures: The recipient healthcare facility will provide and coordinate any
382 necessary demobilization procedures and post-event stress debriefing.

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383 [List of Potential Staffing Sources during Surge – Background & Activation Information](#)

384

385 The information contained in the following table is designed to provide surge planners and other
386 appropriate facility representatives with a list of available resources to investigate as potential sources for
387 augmented staffing and develop MOUs/MOAs as deemed necessary.

388

389

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Volunteer Organization Brief Background & History	Who Is Eligible to Volunteer?	Who May Activate?	Additional Information May Be Found at:
<p>American Red Cross (ARC) The mission of American Red Cross Disaster Services is to ensure nationwide disaster planning, preparedness, community disaster education, mitigation, and response that will provide the American people with quality services delivered in a uniform, consistent, and responsive manner. The American Red Cross responds to disasters such as hurricanes, floods, earthquakes, and fires, or other situations that cause human suffering or create human needs that those affected cannot alleviate without assistance. It is an independent, humanitarian, voluntary organization, not a government agency. All Red Cross assistance is given free of charge, made possible by the generous contribution of people's time, money, and skills.</p> <p>The most visible and well-known of Red Cross disaster relief activities are sheltering and feeding.</p>	<p>Various skills and backgrounds</p>	<p>The more than 750 Red Cross chapters across the country are required to respond with services to an incident within two hours of being notified.</p>	<p>http://www.redcross.org</p> <p>Information is available for both the national chapter as well as links to local chapters.</p>
<p>California Medical Assistance Team (CalMAT) The Schwarzenegger Administration proposed the creation of three 120 person California Medical Assistance Teams (CalMAT's) that would be under state control to respond to catastrophic disasters. Each CalMAT would consist of volunteers drawn from the private, not-for-profit, and existing State and local government health care delivery sector.</p> <p>The CalMAT's would maintain caches that contain medical supplies, medical equipment, tents, pharmaceuticals, and interoperable (compatible) communications.</p> <p>The CalMAT program will be supported on-site by an EMS Authority lead Mission Support Team (MST) for administrative direction and logistical direction and re-supply.</p>	<p>Medical, nursing and other health care providers and logistic support staff will be recruited, trained and hired as temporary workers under this first-ever statewide medical response program.</p>	<p>The teams will be geographically located to serve the entire state. CalMAT's would be part of the state disaster medical mutual aid system and would respond to catastrophic disasters, augment medical care, and re-establish medical care in areas of the State where hospitals or medical care systems have been damaged or overwhelmed.</p>	<p>http://www.emsa.ca.gov/def_comm/viii092706_d.asp</p> <p>CalMAT's are to be fully deployable by June 30, 2007.</p>
<p>Community Emergency Response Teams (CERT) The Community Emergency Response Team (CERT)</p>	<p>Various backgrounds</p>	<p>Battalion Call-out Teams respond to local</p>	<p>http://www.citizencorps.gov/cert</p>

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<p>Volunteer Organization Brief Background & History</p>	<p>Who Is Eligible to Volunteer?</p>	<p>Who May Activate?</p>	<p>Additional Information May Be Found at:</p>
<p>Program educates people about disaster preparedness for hazards that may impact their area and trains them in basic disaster response skills, such as fire safety, light search and rescue, team organization, and disaster medical operations. Using the training learned in the classroom and during exercises, CERT members can assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help. CERT members also are encouraged to support emergency response agencies by taking a more active role in emergency preparedness projects in their community.</p> <p>The CERT concept was developed and implemented by the Los Angeles Fire Department (LAFD) in 1985. The Whittier Narrows earthquake in 1987 underscored the area-wide threat of a major disaster in California. Further, it confirmed the need for training civilians to meet their immediate needs. As a result, the LAFD created the Disaster Preparedness Division with the purpose of training citizens and private and government employees.</p>		<p>incidents when they are requested by LAFD Incident Commanders.</p>	<p>Information is available for both the national chapter as well as links to local chapters.</p>
<p>Disaster Medical Assistance Team (DMAT) DMAT is a group of professional and para-professional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide medical care during a disaster or other event. Each team has a sponsoring organization, such as a major medical center, public health or safety agency, non-profit, public or private organization that signs a Memorandum of Agreement (MOA) with the DHS.</p> <p>DMATs are designed to be a rapid-response element to supplement local medical care until other Federal or contract resources can be mobilized, or the situation is resolved. DMATs deploy to disaster sites with sufficient supplies and equipment to sustain themselves for a</p>	<p>Doctors, Nurses, PAs, NPs, Pharmacists and Pharmacy Assistants, Paramedics, EMTs, Respiratory Techs, Lab Techs, Communication Experts, and Logistical/Support Personnel interested in participating in disaster response</p>	<p>In addition to their federal role, DMATs can be mobilized and deployed by the EMS Authority as a medical mutual aid resource for local mass casualty incidents within the State.</p>	<p>http://www.ndms.dhhs.gov/teams/dmat.html</p> <p>California DMAT http://www.emsa.ca.gov/Dms2/dmatinfo.asp</p>

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<p>Volunteer Organization Brief Background & History</p>	<p>Who Is Eligible to Volunteer?</p>	<p>Who May Activate?</p>	<p>Additional Information May Be Found at:</p>
<p>period of 72 hours while providing medical care at a fixed or temporary medical care site.</p> <p>In mass casualty incidents, their responsibilities may include triaging patients, providing high-quality medical care despite the adverse and austere environment often found at a disaster site, and preparing patients for evacuation. DMATs are designed to be a rapid-response element to supplement local medical care until other Federal or contract resources can be mobilized, or the situation is resolved.</p> <p>Under the rare circumstance that disaster victims are evacuated to a different locale to receive definitive medical care, DMATs may be activated to support patient reception and disposition of patients to hospitals. DMATs are principally a community resource available to support local, regional, and State requirements. However, as a National resource they can be federalized</p>			
<p>Disaster Service Worker (DSW) The State of California Disaster Service Worker Volunteer Program (DSWVP) provides workers' compensation insurance coverage in the event a Disaster Service Worker (DSW) volunteer is injured while performing assigned disaster duties.</p> <p>Disaster service worker includes public employees, and also includes any unregistered person impressed into service during a state of war emergency, a state of emergency, or a local emergency by a person having authority to command the aid of citizens in the execution of his or her duties.</p>	<p>There are 13 classifications of DSW volunteers including: Animal Rescue, Care & Shelter Laborer Communications Law Enforcement Community Emergency Response Logistics Team Member Medical & Environmental Health Finance &</p>	<p>All registered DSW volunteers should wait for official activation from their supervising authority before carrying out volunteer work. Official activation ensures the DSW volunteer the benefits and protections of the Disaster Service Worker Volunteer Program. Activation of DSW volunteers should be documented by the authorizing agency or</p>	<p>http://www.oes.ca.gov/Operational/OESHome.nsf/PDF/Disaster%20Service%20Worker%20Volunteer%20Program%20(DSWVP)%20Guidance/\$file/DSWguide.pdf</p>

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Volunteer Organization Brief Background & History	Who Is Eligible to Volunteer?	Who May Activate?	Additional Information May Be Found at:
	Administrative Staff Safety Assessment Inspector Human Services Search & Rescue Fire Utilities	organization.	
<p>Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) ESAR-VHP is an electronic database of health care personnel who volunteer to provide aid in an emergency. An ESAR –VHP system must: (1) register health volunteers, (2) apply emergency credentialing standards to registered volunteers, and (3) allow for the verification of the identity, credentials, and qualifications of registered volunteers in an emergency.</p> <p>Implementation of California’s ESAR-VHP system is currently underway. Some of the remaining activities include: codification of policies and procedures; limited-scope exercises to test operational concepts; extensive marketing, recruitment and outreach efforts; pilots with key hospital/health care system partners; resolution of additional legal and regulatory issues; pursuit of funds for future operations; and training of system administrators.</p> <p>Registration is currently open.</p>	California’s ESAR-VHP system currently accepts registration from licensed nurses, physicians, pharmacists and paramedics.	During a State or national disaster, this system will be accessed by authorized medical/health officials at the State Emergency Operations Center.	<p>http://www.hrsa.gov/esarvhp/guidelines/default.htm</p> <p>California ESAR-VHP https://medicalvolunteer.ca.gov/ (currently serves as a volunteer registration site)</p> <p>Los Angeles ESAR-VHP http://www.vcla.net/esar</p>
<p>Medical Reserve Corps (MRC) The Medical Reserve Corps (MRC) program was created after President Bush’s 2002 State of the Union Address, in which he asked all Americans to volunteer in support of their country. The MRC is comprised of organized medical and public health professionals who serve as volunteers to respond to natural disasters and emergencies. These volunteers assist communities nationwide during emergencies and for ongoing efforts</p>	Practicing, retired, or otherwise employed medical professionals, such as doctors, nurses, emergency medical technicians, pharmacists,	Activation is based on the local MRC unit.	<p>http://www.medicalreservecorps.gov/HomePage</p>

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Volunteer Organization Brief Background & History	Who Is Eligible to Volunteer?	Who May Activate?	Additional Information May Be Found at:
<p>in public health.</p> <p>There is no “typical” MRC unit. Each unit organizes in response to their area’s specific needs. At the local level, each MRC unit is led by an MRC Unit Coordinator, who matches community needs – for emergency medical response and public health initiatives – with volunteer capabilities. Local coordinators are also responsible for building partnerships, ensuring the sustainability of the local unit and managing the volunteer resources.</p>	<p>nurses' assistants, public health professionals, and community members without medical training (can assist with administrative and other essential support functions)</p>		

391

PERSONNEL

392 Volunteer Registration Form²

393
394 The purpose of this form is to serve as a sign-in sheet during the surge. It is initiated by the Labor Pool &
395 Credentialing Unit Leader (designation under HICS) and copies are to be shared with additional
396 stakeholders within the facility.

397 398 **Instructions for Use:**

399
400 **1. FROM DATE/TIME** Indicate starting date/time of period covered by this form. Use the international
401 standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01
402 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the
403 fourteenth day of February in the year 2006 is written as **2006-02-14**. Use the international standard
404 notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and
405 mm is the number of complete minutes that have passed since the start of the hour (00-59). For example,
406 5:04 PM is written as **17:04**. Use local time.

407
408 **2. TO DATE/TIME** Indicate ending date/time of period covered by this form.

409
410 **3. SECTION** Indicate the Section for which this time sheet is being prepared.

411
412 **4. TEAM LEADER** Use proper name to identify the supervisor of the personnel listed.

413
414 **5. REGISTRATION** Use proper name, listing last name first, of volunteers, and record complete address,
415 Social Security number, telephone number, and certification/licensure and number. Indicate work start
416 and end times in the Time IN and Time OUT columns. Have volunteer sign the form.

417
418 **6. CERTIFYING OFFICER** Use proper name to identify who verified the information on the registration
419 form.

420
421 **7. DATE/TIME SUBMITTED** Indicate date and time that the form is submitted to the Time Unit Leader.

422
423 **8. FACILITY NAME** Use when transmitting the form outside of the healthcare facility.

424
425 **WHEN TO COMPLETE:** Throughout activation.

426
427 **HELPFUL TIPS:** Data on this form may be summarized at the end of each operational period. This form
428 is suitable for duplication using carbonless copy paper.

429

Volunteer Registration						
1. From Date/Time:	2. To Date/Time:	3. Section/ Location:	4. Team Leader:	5. Registration:		
Name (Last, First)	Social Security #	Telephone #	Certification/ Licensure #	Time In:	Time Out:	Signature:
6. Certifying Officer:		7. Date/Time Submitted:		8. Facility Name:		

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431 Job-Action-Sheets Overview²

432
433 The following information reflects HICS approach to assignment of roles and activities (Job Action Sheets
434 - JAS) to staff for a surge event. This approach allows planners to prepare for surge events with a
435 framework that is adaptable at existing facilities and Alternate Care Sites (ACS). The benefit of such a
436 framework is that tasks and responsibilities are pre-identified and augmented staff and volunteers can be
437 assigned critical roles during surge. This HICS excerpt provides an overview of JAS design and function.
438 Job Action Sheets are different than job descriptions, in that JAS provide an overview and checklist of the
439 responsibilities for a given position (role) during a surge, while job descriptions provide a detailed outline
440 of how to perform the assigned tasks of a given position. Job descriptions will be provided as an
441 appendix for Alternate Care Sites.

442 **Surge Staff Planning Recommended Approach - Using the Job Action Sheets**

443
444 The Job Action Sheet (JAS) is an incident management tool designed to familiarize the user with critical
445 aspects of the command position he or she is assuming. Information provided on a JAS includes a radio
446 identification title, purpose, to whom they report, and critical action considerations. These tasks are
447 intended to “prompt” the incident management team members to take needed actions related to their
448 roles and responsibilities. The Job Action Sheets included with HICS have been extensively revised and
449 include more action steps listed by time periods; a new Demobilization and System Recovery time period
450 has also been added. The JAS format allows for personnel to document each action undertaken and
451 record decision timeframes. The new JAS also graphically depicts the position within the incident
452 management team and highlights reporting relationships. The information below provides an overview of
453 JAS purpose and format, which will assist the reader in understanding the value of implementing such
454 tools.

455
456 **Purpose:** To provide the user with a series of action options to consider when serving in a particular
457 command role.

458
459 **Use:** The Hospital Incident Command System currently provides 78 Job Action Sheets (JAS) for
460 addressing all types of healthcare facility needs. However, in most cases only a portion of these positions
461 will be necessary for a successful response. The items listed are minimum considerations for developing
462 a JAS. A variety of other considerations may be included, based on healthcare facility size, available
463 resources, or response needs. Thus, each healthcare facility can take the prepared JAS and use them as
464 written, modify them as needed, or craft their own, unique JAS using the HICS model as a template.

465
466 **Format:** The key format considerations for each JAS are the same and include the following information:
467
468 • Command Title – the name of the position
469 • Mission – a brief statement summarizing the basic purpose of the job
470 • Fundamental Information Box – details information pertaining to who is assigned the position, where
471 they are physically located, and basic contact information
472 • Action Considerations – suggested action steps listed by operational periods; the time periods are
473 listed as:
474 – Immediate 0–2 hours
475 – Intermediate 2–12 hours
476 – Extended Beyond 12 hours
477 – Demobilization/System Recovery
478 • Documents/Tools – a listing of pertinent HICS forms this position is responsible for using, along with
479 other tools that will help them fulfill their role and responsibilities.

480
481 The JASs are designed to be customized, but healthcare facilities are encouraged to maintain the
482 prescribed format and terminology as a means of ensuring the standardization benefit of NIMS. Each
483 healthcare facility should look closely at the items listed in the Documents/Tools Section and make
484 modifications appropriate for their facility and community. The format also allows for the JASs to be used

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485 to preliminarily document actions taken during the incident and assist in developing a chronology of
486 events, problems encountered, and decisions made.

487
488 When each JAS review is complete, it is recommended that one set be laminated and multiple paper
489 copies duplicated for use and documentation during response. The JASs should be kept with the Incident
490 Command identification (vest) for the position, along with needed administrative items such as pens and
491 paper.

492
493 All personnel assigned to an incident command role should wear identification that correctly
494 communicates his or her role. Many healthcare facilities use a vest for this purpose. Each vest should
495 clearly identify the HICS position title on the front and back in both normal and low-light conditions. The
496 vests may also be color-coded to the HICS incident management team chart (grey/black – Command
497 Staff; red – Operations; blue – Planning; yellow – Logistics; and green – Finance/ Administration). They
498 should contain large pockets for holding a portable radio, tablet, pens, markers, and a Job Action Sheet
499 (JAS). The vests should be readily available from a secure location and regularly checked to make sure
500 they have the required items

501

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502 Potential Candidates for HICS Command Positions

503

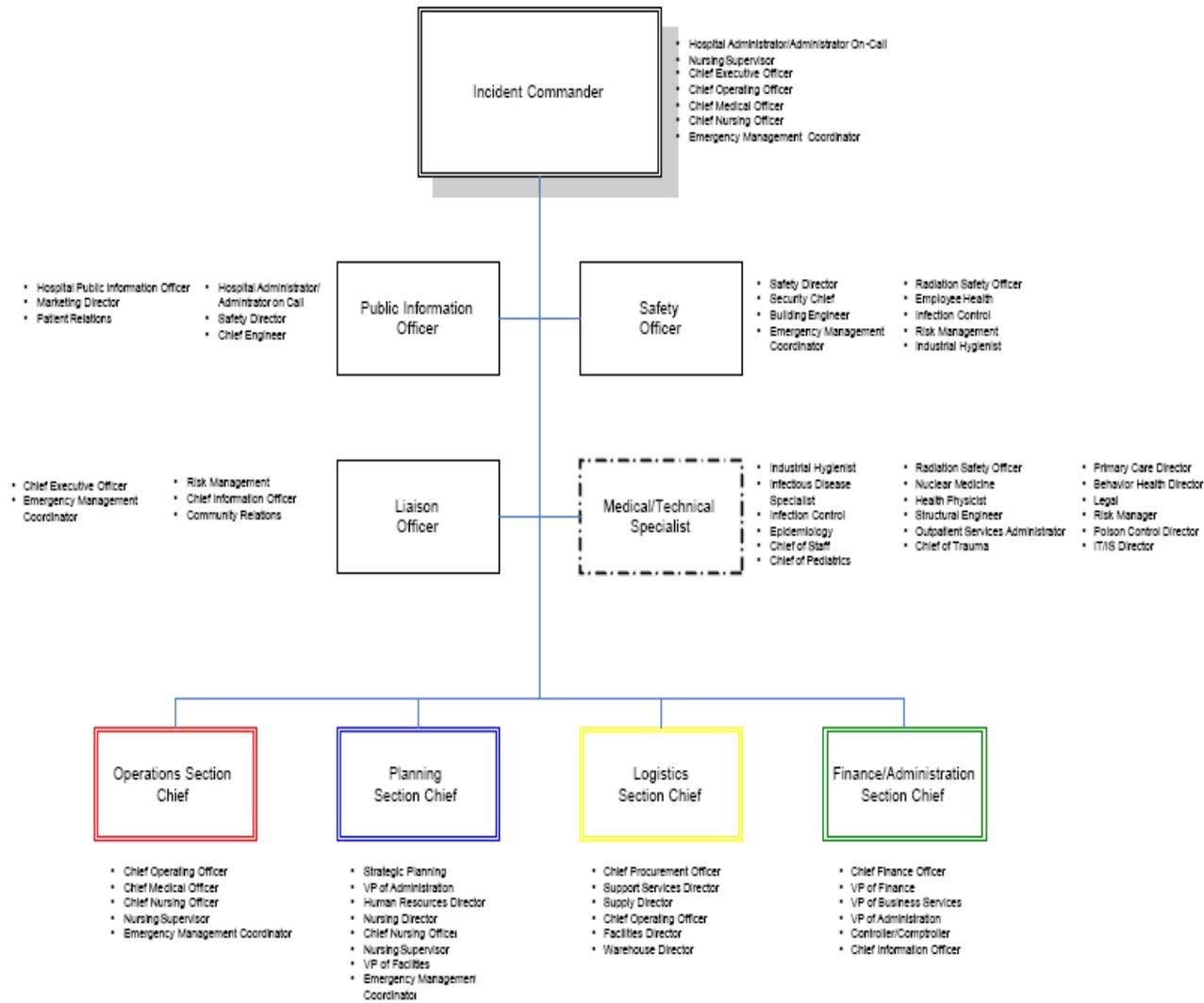
504 **Purpose:** The “Potential Candidates for HICS Positions” crosswalk (next page) provides suggestions for
505 administrative positions commonly found in healthcare facilities and their potential assigned roles in the
506 Hospital Command Center (HCC), when activated. These suggestions are based on similarity to day-to-
507 day position roles during the activation of the assigned role during operation of the HCC.

508

509 **Use:** The crosswalk is intended for pre-event planning and assignment of Hospital Command Center
510 roles. By pre-assigning HCC assignments, the staff can be educated and exercised on their duties and
511 scope of responsibility during an activation, and will be familiar with the associated Job Action Sheet
512 before the event. It is recommended that each HCC Command position have not less than three to five
513 persons pre-assigned to each role to allow for extended operations.

514

515



516

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517 **Job-Action-Sheet for Personnel Staging Team Leader²**

518
 519 The HICS job action sheet (JAS) below identifies the role and responsibilities for the personnel staging
 520 team leader. This particular JAS represents the lead position of the staffing coordinator. This JAS is
 521 intended to provide the reader with an example. There are 78 JASs in HICS and as indicated earlier,
 522 planning for and adopting these JASs and identified positions will depend on the needs and capabilities of
 523 each facility responding during a surge.

524
 525 **PERSONNEL STAGING TEAM LEADER**

526
 527 **Mission:** Organize and manage the deployment of supplementary personnel resources.

528 Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
 529 **Position Reports to: Staging Manager** Signature: _____
 530 Hospital Command Center (HCC) Location: _____ Telephone: _____
 531 Fax: _____ Other Contact Info: _____ Radio Title: _____

532 **Instructions for Use:**

533
 534 For each action item identified for the individual designated as the Personnel Staging Team Leader, the
 535 time it was completed as well as the individual's initials will be documented.

536

Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment and briefing from Staging Manager. Read the Job Action Sheet and put on position identification.		
Develop initial action plan with other Staging Team Leaders. Designate time for follow-up meeting.		
Notify your usual supervisor of your HICS assignment.		
Appoint Personnel Staging Team members and complete the Branch Assignment List (HICS Form 204).		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Coordinate delivery of needed personnel resources to requesting areas in coordination with Labor Pool & Credentialing Unit and Transportation Unit Leader.		
Brief Team on current situation. Designate time for follow-up meeting.		
Establish and maintain contact with Planning Section's Personnel Tracking Manager and Logistics Section's Labor Pool & Credentialing Unit Leader to share information and personnel status.		
Instruct all Team members to evaluate personnel needs; report status to Staging Manager and Labor Pool & Credentialing Unit Leader.		
Assess problems and needs in each unit area; coordinate resource management.		
Establish regular meetings with Staging Manager to discuss plan of action, critical issues and staffing.		

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	Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		
--	---	--	--

537

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Continue coordinating delivery of needed personnel, working with the Logistics Section.		
Ensure prioritization of problems when multiple issues are presented.		
Ensure documentation is done correctly and collected.		
Report resource problems and issues Logistics Section.		
Coordinate use of external resources.		
Continue to meet regularly with Staging Manager for status reports, and relay important information.		

538

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Advise Staging Manager immediately of any operational issue you are not able to correct or resolve.		
Ensure staff health and safety issues being addressed; resolve with Safety Officer, Staging Manager and Employee Health & Well-Being Unit, as appropriate.		

539

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to monitor Personnel Staging Team members' ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Coordinate assignment and orientation of external personnel assigned to Staging Team.		
Work with Staging Manager and Logistics Section on the assignment of external resources.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Staging Manager and Employee Health & Well-Being Unit.		
Rotate staff on a regular basis.		
Continue to document actions and decisions on an Operational Log (HICS Form 214) and submit to the Staging Manager at assigned intervals and as needed.		
Continue to provide Staging Manager with periodic situation updates.		
Request mental health assistance for staff from Employee Health & Well-Being Unit as needed.		

540

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541

Demobilization/System Recovery	Time	Initial
As needs for Personnel Staging Team staff decrease, return staff to their normal jobs and combine or deactivate positions in a phased manner.		
Continue to participate in briefings and meetings as requested.		
Assist Staging Manager, Operations Section Chief and Team members with restoring healthcare facility resources to normal operating condition.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		

542

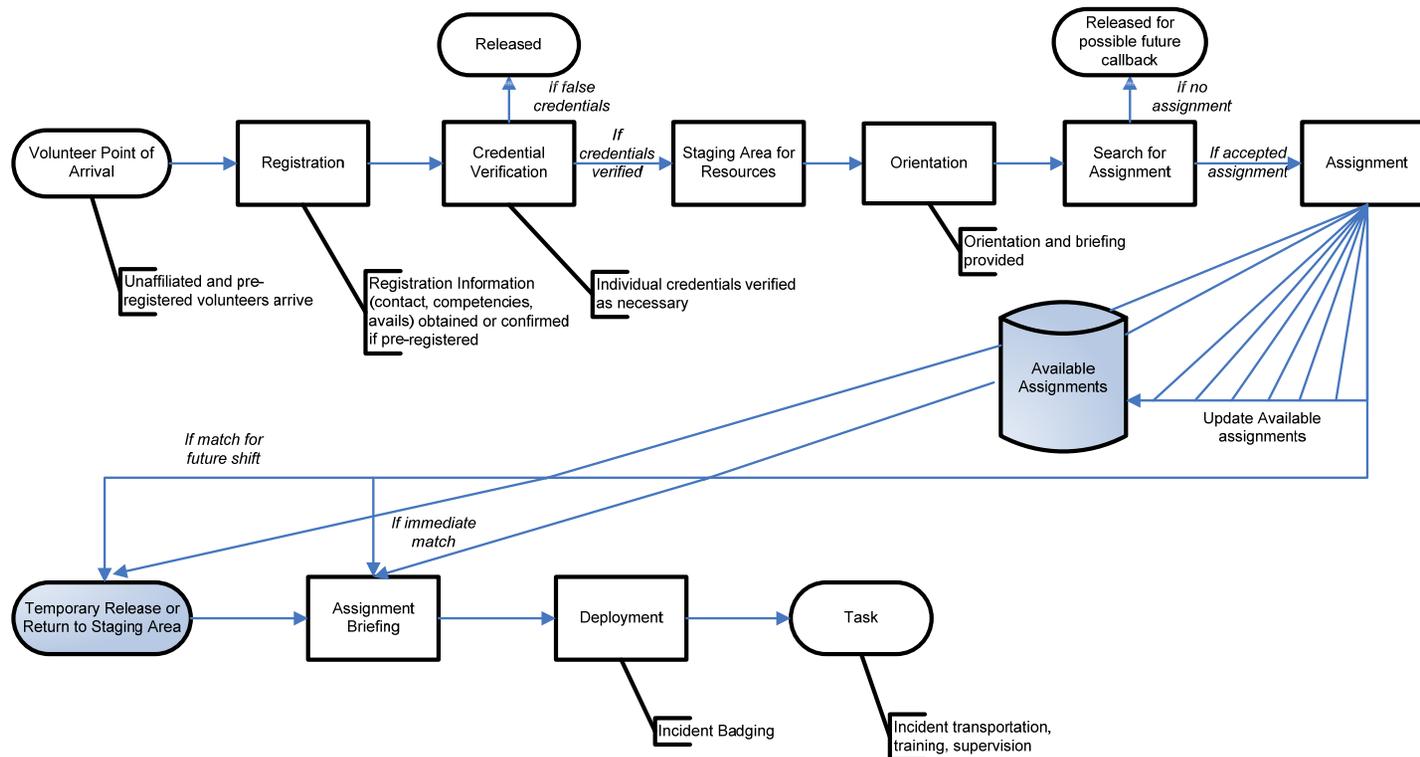
PERSONNEL

563 Acceptance and Deployment of Augmented Staff during Surge⁴

564

565 The following diagram may assist planners and staffing coordinators at existing facilities and ACSs in understanding the process by which
566 augmented staff are accepted and deployed. Although the acquisition process for different types of personnel may differ depending on volunteer
567 organization used, the acceptance and deployment process would essentially be consistent.
568

Acceptance and Deployment of Augmented Staff During Surge



569

570 **Organizing Personnel**

571
572 After potential personnel have been identified, the next challenge for facilities (both existing and ACSs) is
573 to develop plans to address key issues such as staffing regulations, staff assignments and training.
574 During a surge, existing standards and regulations for these issues may be compromised and facilities
575 must be prepared to respond in an not only an effective manner but also a timely one.

576 **Current Standards and Analysis**

577
578 During a surge, there are two types of staffing regulations considered:

579
580 (1) [CCR 22 §70217\(a\)](#) outlines the specific licensed nurse to patient ratios required by each unit in a
581 hospital. [CCR 22 §70217\(q\)](#) indicates that hospitals shall plan for routine fluctuations in patient census.
582 A healthcare emergency may cause a significant volume change; therefore the facility must demonstrate
583 that prompt efforts were made to maintain required staffing levels. However specific compliance
584 guidelines do not exist related to ratio requirements documentation during a surge. Additional nurse to
585 patient ratio requirements, for other types of healthcare facilities are also stipulated by Title 22.⁵
586

587 (2) [Business & Professions Code §3516](#) states that no physician shall supervise more than two physician
588 assistants at any time. Additionally, [Business & Professions Code §3502.5](#) allows for physician
589 assistants, during a state of war emergency, state of emergency, or state of local emergency, to provide
590 patient care regardless of whether the physician assistant’s approved supervising physician is available
591 so long as a licensed physician is available to render the appropriate supervision.
592

593 These standards may be flexed by the California Department of Health Services (CDHS) per general
594 flexibility authority applicable to the licensed facility type⁶. In addition, [Government Code §8571](#) states
595 that during a state of war emergency or state of emergency the Governor may suspend any regulatory
596 statute, or statute prescribing the procedure for conduct of state business, or the orders, rules or
597 regulations of any state agency, including subdivision (d) of Section 1253 of the Unemployment Insurance
598 Code, where the Governor determines and declares that strict compliance with any statute, order, rule or
599 regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.
600

601 **Guideline/ Recommendation**

602
603 Healthcare facilities are to plan for staffing for the first 72 hours of a traumatic incident. During this time
604 period, especially if other healthcare facilities are involved, there may not be the ability to call upon other
605 organizations for assistance or to begin to recruit volunteers to assist, given the time necessary to
606 implement these processes.
607

608 Staffing plans should encompass not only clinical roles such as RNs and how they may be assigned to
609 different duties based on the designated patient care levels, but also ancillary support staff. Matrices
610 should be developed to assist staffing supervisors to identify specific staff types. In preparing these
611 staffing plans and matrices, it should be noted however, that “fewer ancillary staff would necessitate more
612 nursing staff to accomplish tasks normally the responsibility of ancillary staff.”⁷
613

614 Additionally, for alternate care sites, staffing plans should be available to allow for at least the provision of
615 basic patient care for the first 72 hours. Then, as time progresses, alternate care sites must be prepared
616 to augment their staffing to address both increased patient volume and patient acuity. Staff utilization
617 matrices will aid ACS staff supervisors in determining the number and type of clinical and ancillary staff
618 necessary.
619

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620 The following documents present facilities with various options in terms of surge staffing strategies and
621 plans, staff utilization matrices (both for nursing and for ancillary support staff) as well as recommended
622 medical staff bylaw language allowing licensed healthcare practitioners to provide care without
623 supervision during a surge.

624

625 Draft deliverable(s) include:

626 • Staffing Strategy for RNs during Surge

627 • Sample Policy for Surge Capacity Staffing Emergency Plan

628 • Sample Estimated Staffing Levels for Surge Facility Scenarios

629 • Ancillary Support Matrix

630

631

632 Draft Deliverables

633

634 Staffing Strategy for RNs during Surge⁸

635

636 Outlined in the Guidelines for Managing Inpatient and Outpatient Surge Capacity, the Wisconsin State
637 Expert Panel has developed the following staffing strategy to be used as a best practice for planning for
638 surge staffing. As the most current guidance on this topic the Wisconsin Guidelines is referenced here as
639 a model or sample for both existing facilities and ACSs.

640

641 In the first 72 hours of a surge, there will be limited additional staff therefore, the following staffing
642 strategies have been identified to extend the staff capacity of a healthcare facility:

643

- 644 • **Strategy One:** Staffing ratios will need to be adapted to the need. Each of the designated patient
645 care levels (Critical, Complex/Critical, Basic, and Supportive) will require different staffing ratios.
- 646 • **Strategy Two:** 8 hour shifts may be changed to 12 hour shifts.
- 647 • **Strategy Three:** Work tasks are to be prioritized so that only essential patient care tasks are
648 provided by staff.
- 649 • **Strategy Four:** Healthcare facilities are to consider flexing scope of practice of staff to provide
650 necessary care with available staff (when authorized by the Governor during a declared state of
651 emergency to allow flexed scope of practice).
- 652 • **Strategy Five:** The healthcare facilities can put out a call through the media for volunteer health
653 care workers or acquire staff through established MOUs and partnerships with other facilities and
654 alternate labor sources such as MRCs, Community Emergency Response Teams (CERTS), etc.

655

656 In regard to **Strategy Five**, although the healthcare facility may consider a campaign to recruit additional
657 healthcare workers in an incident, this may be a service provided by the local or state Emergency
658 Operations Center (EOC), if the EOC is activated.

659

660 Assignment of Staff to Designated Patient Care Levels

661

662 In a surge incident, it is most likely that the healthcare facility will not have the appropriate staffing
663 complement of RNs and other staff. The organization will need to assign available staff and volunteers to
664 the designated care levels, based on the staff level and scope of practice. A healthcare panel has
665 recommended the following minimum skill sets that staff are to have in order to provide patient care,
666 based the care level designation of the patient:

667

668 1. Staff skills necessary to care for Critical patients: These are to be staff or volunteers, who are acute
669 care RNs and Residents, who can perform primary and secondary assessment of critical care patients.
670 The healthcare facility can also use acute care LPNs, technicians, PCAs and student nurses to assist
671 these RNs and Residents; this will allow for increased productivity of these RNs and Residents.

672

673 2. Staff skills necessary to care for Complex/Critical patients: These are to be staff or volunteers, who are
674 RNs and LPNs, who can perform initial and on-going assessment of patients and who are presently
675 employed either in acute care settings or in non-healthcare facility work sites.

676

677 3. Staff skills necessary to care for Basic and Supportive patients: These are to be staff or volunteers,
678 who are comfortable with death and dying, such as hospice volunteers, clergy, social workers, retired
679 healthcare workers, healthcare facility volunteers, and members of service organizations such as the
680 American Red Cross. It will be necessary to have a RN supervisor and Team Leader in each area to
681 assess these staff, their skills and their stress and rehabilitation needs.

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Sample Policy for Surge Capacity Staffing Emergency Plan⁹

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Purpose:

Provide guidelines for staffing during surges in the patient census and/or for critical needs in staffing.

Policy:

- A. It is the policy of [Facility Name] to maintain a state of readiness in the event of a health disaster or staffing emergency.
- B. The Emergency Staffing Plan will be activated by the Chief Nurse Executive (CNE), or designee when there is a need for rapid deployment of personnel.
- C. This plan will be activated when labor-intensive event occurs that prevents patient care staff from providing care to all assigned patients, and complying with mandated staffing ratios, such as multiple admissions or discharges, or an emergency health crisis.
- D. Components of the Hospital Incident Command System (HICS) model may be used to implement and coordinate emergency staffing (See attached checklist).

Personnel:

All employees

Procedures:

When the decision to activate the emergency staffing plan is made, the following roles will be implemented:

- A. Incident Commander – Mission: To organize and direct Emergency Operations Center (EOC) which will occur in the Staffing Office. The role of the Incident Commander is to provide and give overall direction. The role will be assumed by the staff to maintain smooth hospital operations.
 - a. The Administrator or designee, typically a Nursing Director, Patient Flow Coordinator (PFC) or Operations Supervisor (OPS) will be appointed the Incident Commander.
 - b. Activate the Emergency Staffing Plan.
 - c. Responsible for the overall management and coordination of the response in conjunction with other team leaders. Responsibilities include:
 - i. Coordinate activities with other [Facility Name] facilities if indicated.
 - ii. Collaboration with Marketing's release of appropriate information to media representatives.
 - iii. Collaborate with medical staff, by reviewing all elective procedures and all potential patient discharges and transfers to lower levels of care establishing a priority list.
 - iv. Collaborate with team members, and Finance staff, to authorize the utilization of the financial resources necessary to maintain essential staffing levels.
 - v. Operationalize financial incentives and staffing plans to meet patient care needs.
 - vi. Optimize utilizing existing staff in the facility to promote safe patient care.
 - vii. Coordinate and communicate the prioritization of non-essential meetings and tasks.
 - viii. Collaborate with regulatory resource staff for notification to licensing about the situation.
- B. Planning/Communication Chief – Mission: To ensure that distribution of critical information and data. Compile resource projections from all team leaders and effect short and long term staffing needs. Document and email or distribute daily action plans.
 - a. Nursing Director or designee coordinates a temporary nonclinical labor pool to assist with clerical and support functions as appropriate.
 - b. Maintain a message center to coordinate communication for the facility.
 - c. Act as custodian of all logged and documented communications relating to the event.
 - d. Identify and coordinate public relations activities in conjunction with the Incident Commander.

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- 737 e. Maintain current information on staffing needs of the facility.
738
- 739 C. Finance Chief – Mission: Monitor the utilization of financial assets. Oversee the procurement of
740 supplies and services necessary to carry out the hospital’s medical mission. Supervise the
741 documentation of expenditures relevant to the incident.
742 a. Designee from Access Management or Finance.
743 b. Maintain records of expenditures to be presented during a “cost to date basis” and at the
744 incident debriefing.
745 c. Identify cost centers utilized to respond to the incident and separates these expenditures
746 from normal operating expenses.
747 d. Prepare financial reports necessary for reimbursement if appropriate.
748
- 749 D. Logistics/Materials Management – Mission: Organize and direct operations associated with
750 maintenance of the physical environment, and adequate levels of food, shelter and supplies to
751 support the medical objectives.
752 a. Designee from Materials Management or Facilities.
753 b. Obtain materials, supplies and food during the event.
754 c. Coordinate the physical environment needed to provide additional patient care and
755 treatment areas.
756 d. Coordinate transportation of supplies and equipment within the institution within [Facility
757 Name] or with other sources as indicated.
758 e. Work with security to identify additional needs for patient or staff safety and for parking
759 for additional staff.
760 f. Collaborate with all clinical departments (Pharmacy, Lab, EVS, Radiology, etc) to assure
761 patient care needs can be met.
762
- 763 E. Medical Staff – Mission: Promote patient flow with medical and house staff.
764 a. President of Medical Staff or designee works closely with the Director of Medical
765 Education to set priorities during high census event.
766 b. Provides communication to medical staff as indicated.
767 c. Discusses specific concerns with physician staff as needed.
768 d. In collaboration with Incident Commander, reviews all elective procedures for potential
769 cancellation, potential discharges and transfers and helps execute the process.
770
- 771 F. Patient care areas are to be designated under the direction of the Incident Commander and
772 Response Team in collaboration with Nursing Leaders.
773 Note: Staffing will be based on patient acuity.
774 a. All monitored areas (portable and fixed) will be fully utilized based on patient need.
775 b. Infection Control Practitioner to be consulted if indicated.
776
- 777 G. All departments will maintain an emergency staffing plan.
778 a. Staffing Office personnel will maintain a current list of all licensed patient care staff.
779 b. Staffing Office personnel will contact other [Facility Name] affiliated facilities and
780 supplemental staffing agencies requesting personnel.
781 c. Staffing Office personnel will verify license, BLS status and core competencies on all
782 supplemental and/or volunteer RN/LVN/RCP staff.
783 d. Each department will activate the following action steps in coordination with the Staffing
784 Office personnel, based on patient demand/acuity.
785 i. Call all off duty staff to report to work (each patient care area will maintain an
786 emergency staff roster).
787 ii. Offer incentives for staff to work overtime.
788 iii. Inform Incident Commander of actual and available staff for deployment.
789 iv. Provide basic orientation to supplemental staff.
790 e. All exempt licensed staff will be available to provide direct patient care and support.
791 f. All non-patient care staff not involved in the critical operations of the hospital may be
792 assigned to patient care support duties as needed.

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H. During Event Actions:

- a. All team members will observe co-workers for signs of stress and report concerns to the appropriate unit leaders (on duty manager or supervisor) and/or referral to Employee Assistance Program (EAP) or identified support staff will be made.
- b. Support staff through recognition of efforts on an ongoing basis.
- c. If external event, communicate status of event to employees frequently, to keep them informed.
- d. If needed, hospital transfer agreements will be operationalized by the Incident Commander. Transportation of patients will be coordinated with input from the Base Hospital Station and/or the [Facility Name] Operations Center. Notify the County Medical Operations Center of intent to transfer patients and the request assistance in patient placement.
- e. Provide Employee Assistance Program.

I. Post-Event/Recovery:

- a. Debrief staffing events at scheduled charge nurse meetings.
- b. Acknowledge contributions of staff.
- c. Revise policy and plan based on lessons learned.

The following checklist (Hospital Response Checklist) tracks the various tasks assigned to the roles discussed above.

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815

Hospital Response (Provider Checklist)				
Task	Responsible Person	Yes	No	Date Implemented
1. Add additional triage nurse.	ED Nurse Leader			
2. Call in additional staff.	Staffing Coordinator			
3. Re-align staff assignments.	Nursing Directors, Managers, Supervisors			
4. Use hospital staffing lists if applicable.	Director Resource Management			
5. Stock up on supplies and equipment (contact vendor to order additional supplies/ meds/ etc.).	Materials Management Staff			
6. Offer patient or family ride home at discharge by taxi if they are having problems with transportation.	Case Management Staff			
7. Track obstacles to smooth patient flow.	Operations Supervisor			
8. Expedite admissions/ discharges/ transfers of patients with the critical care and step down unit medical directors.	Chief of Staff or Designee			
9. Patients are not held liable in the emergency department for private physicians to see the patient prior to admission.	Operations Supervisor			
10. Emphasize triage, stabilize and admit with some of the testing being completed for the patient after they have been admitted.	ED Director and/or Operations Supervisor			
11. Share info on hospital volume with neighboring hospitals alerting them to potential requests for transfer or assistance.	Paramedic Coordinator			
12. Enforce bed priority policies.	Operations Supervisor			
13. Conduct meeting with nursing unit, directors and supervisors, discharge planning, and staffing office in the morning and early afternoon to plan for staff, triage, surgery schedules, etc.	Director of Resource Management Operations Supervisor			
14. Initiate STAT team to prepare and turnover beds more quickly.	EVS Staff			
15. Implement a notification system for the emergency physicians so that they can be	ED Charge Nurse/ RN Leads			

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Hospital Response (Provider Checklist)				
Task	Responsible Person	Yes	No	Date Implemented
called in early if needed before their regularly scheduled shifts.				
16. Create or open additional areas for patient such as observation areas, discharge lounges, admitting lounges and other overflow areas.	Operations Supervisor, Nursing Leaders			
17. Alert staff and medical staff of tightening bed condition through signage, e-mail, broadcast fax for physicians who use hospital less frequently, etc. and request early discharges.	Operations Supervisor			
18. Notify hospital department of alert status so that emergency department and other patient care and patient support departments can implement their flexible staffing systems.	Operations Supervisor			
19. Implement available staffing options. <ul style="list-style-type: none"> • per diem staff • enforce weekend availability • 12-hour shifts on weekends • traveling nurses/guaranteed registry hours • cross train • mandatory overtime • cancel vacations • deny time off request • recall of staff 	Nursing Directors			
20. Provide child care service for staff who are asked to come in early, etc.	Human Resources Staff			
21. Expand hours of other departments such as Pharmacy, Cardiopulmonary, Respiratory Therapy, Case Management, Housekeeping, Lab, Transportation, Radiologists, Medical Records, etc.	Chief Operating Officer/ CNE/ Director of Nursing/ Administrator on Call			
22. Determine, on a case-by-case basis, whether direct admits will be held in the physician office, the emergency department, or at home.	Operations Supervisor			
23. Expand emergency department and hospitalist physician hours.	Operations Supervisor, Chief of Staff			
24. Implement employee incentives for working extra	CNE			

PERSONNEL

Hospital Response (Provider Checklist)				
Task	Responsible Person	Yes	No	Date Implemented
hours.				
25. Open closed/ suspended licensed beds; use trailer for physician sleeping rooms as needed. Use outpatient area.	Chief Operating Officer			
26. Use non-nursing staff from other departments to assist with non-nursing tasks.	CNE			
27. Use tent/ trailer for storage to free up patient care areas.	Facilities			
28. Emergency department diversion following improved Patient Destination Guidelines	ED Nursing Leader			
29. Consider re-scheduling of elective procedures.	Chief of Staff/ COO			
30. Implement hospital disaster plan.	Operations Supervisor/ CNE			
31. Request medical mutual aid through the county.	COO/ Finance			
32. Start admission process in identified holding areas to decompress emergency department.	Incident Commander			
33. Modify staff requirements to care for patients regardless of staffing ratio.	CNE			

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817

818 **Sample Estimated Staffing Levels for Surge Facility Scenarios**

819

820 Recommended by the Agency for Healthcare Research and Quality in its report on Reopening Shuttered
 821 Hospitals to Expand Surge Capacity⁷, the following table is presented as a recommendation for staffing
 822 levels at an ACS. It may be customized depending on the level of care provided at each ACS site but
 823 provides an overview of the different roles (both clinical and administrative) whose presence will be
 824 necessary.
 825

Staff Type	Staff	Scenario 1: Medical/Surgical	Scenario 2: Infectious Disease	Discussion
Physician and Physician Extenders	Chief Medical Officer	1	1	One person responsible for medical care 24 hours per day/ 7 days per week. Physically onsite 8 hours/ day, M-F, available off-shift and weekends.
	Internist	3-7 FTEs/ 7AM-7PM 1 FTE/ 7PM – 7AM	3-7 FTEs/ 7AM-7PM 1 FTE/ 7PM-7AM	Each MD, assuming 10-15 minutes per patient, could see 48-72 patients over 12 hours (7A-7P) plus at least one person for night coverage (7P-7A).
	Radiologist	As needed	As needed	Adjust according to patient acuity. May be an increased need with an infectious disease population.
	Infectious Disease Specialist	As needed	As needed	Likely only needed for infectious disease population.
	Nurse Practitioner/ Physician Asst	As needed to supplement internists or nurses	As needed to supplement internists or nurses	Must work under the supervision of an MD, could supplement internist coverage if adequate number of physicians not available or supplement nursing coverage (supervisor or RN).
Nursing	Nursing Director	1 RN	1 RN	One person responsible for nursing care 24 hours per day/ 7 days per week. Physically onsite 8 hours/ day, M-F, available off-shift and weekends.

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Staff Type	Staff	Scenario 1: Medical/Surgical	Scenario 2: Infectious Disease	Discussion
	Supervisor	1 RN per shift	1 RN per shift	Prefer RN supervisor, but if none available, an experienced LPN would suffice.
	RN	1:5-1:15 RN to patient ratios	1:5-1:15 RN to patient ratios	Could go as high as 1:40 with adequate LPN, nurse aide and ancillary staff coverage, but highly dependent on patient acuity. Precaution procedures in an infectious disease scenario would require increased staffing levels to accommodate the additional time needed for gowning, disposal of infectious waste, etc.
	LPN	1:5-1:15 RN to patient ratios	1:5-1:15 RN to patient ratios	Could go as high as 1:40 with adequate LPN, nurse aide and ancillary staff coverage, but highly dependent on patient acuity. Precaution procedures in an infectious disease scenario would require increased staffing levels to accommodate the additional time needed for gowning, disposal of infectious waste, etc.
	Nurse Aide	1:6 (day shift) 1:8 (eve shift) 1:15 (night shift) NA to patient ratios	1:6 (day shift) 1:8 (eve shift) 1:15 (night shift) NA to patient ratios	Adjust nurses up or down according to licensed nurse coverage and ancillary staff support. Precaution procedures in an infectious disease scenario would require increased staffing levels to accommodate the additional time needed for gowning, disposal of infectious waste, etc.
Allied Health	Dietitian	1 FTE RD	1 FTE RD	Dependent on the level of supervision needed in Dietary Department, number of admissions

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Staff Type	Staff	Scenario 1: Medical/Surgical	Scenario 2: Infectious Disease	Discussion
				and discharges, level of patient acuity.
	Discharge Planner	2-4 FTEs (M-F normal business hours) Discharge planners or social workers	2-4 FTEs (M-F normal business hours) Discharge planners or social workers	Adjust as needed according to number of admissions and discharges. Assumed one SW per two units (80 beds).
	EKG Technician	1 FTE to cover 7AM-3PM, M-F	1 FTE to cover 7AM-3PM, M-F	In no EKG tech available, EKGs may be done by nurses, NP/PAs, physicians, EMTs. Interpretation done by physician or interpretive software program if available.
	Laboratory Technician	2.1 FTEs (7AM-7PM, 7 days/week) One person to run basic haematology, chemistry, urinalysis, bacteriology tests. Assume no blood bank, no type and x-match needed.	2.1 FTEs (7AM-7PM, 7 days/week) One person to run basic haematology, chemistry, urinalysis, bacteriology tests. Assume no blood bank, no type and x-match needed.	Adjust up according to the number of specimens processed. May not be needed if specimens are sent out. Nursing able to perform certain screens (e.g., dipstick urine, hemocult) on the unit.
	Medical Records	1 FTE	1 FTE	Adjust up according to the number of admissions and discharges.
	Mental Health Worker/ Social Worker	2-4 FTEs (M-F, 8AM-4PM)	2-4 FTEs (M-F, 8AM-4PM)	Adjust up according to patient, family and staff needs. Assumed one SW per two units (80 beds).
	Pharmacist	2.1 FTEs RPh (7AM-7PM, 7 days/week)	2.1 FTEs RPh (7AM-7PM, 7 days/week)	Adjust up according to patient needs. If drugs were supplied from another location, would not be needed.
	Pharmacy Technician	1-2 FTEs CPhTs	1-2 FTEs CPhTs	Adjust up according to patient needs. Must be supervised by pharmacist.
	Phlebotomist	1 FTE able to perform venipuncture 7AM-3PM, M-F	1 FTE able to perform venipuncture 7AM-3PM, M-F	If not available, some nurses, NP/PAs, physicians and EMTs would be able to draw blood.

PERSONNEL

Staff Type	Staff	Scenario 1: Medical/Surgical	Scenario 2: Infectious Disease	Discussion
	Respiratory Therapist	1 FTE RT needed primarily to set up, monitor and troubleshoot problems with ventilators	1 FTE RT needed primarily to set up, monitor and troubleshoot problems with ventilators	Adjust according to patient needs. Nurses/physicians/ NP/PAs, and EMTs are able to assess lung sounds, provide chest physical therapy.
	X-Ray Technician	1 FTE	1 FTE	May not be needed on a daily basis, but requires specialized skills. It's likely that coverage would not be available from other staff types.
All Other Types of Staff	Administrative Support	3-6 FTEs (8AM-4PM, M-F)	3-6 FTEs (8AM-4PM, M-F)	Includes payroll (1 person), billing (1 person) and 1-4 people to assist with unit clerk-level work
	Biomedical Engineering	1 FTE 7AM-3PM, M-F and on-call	1 FTE 7AM-3PM, M-F and on-call	As needed to deal with problems associated with medical monitoring equipment
	Central Supply/ Materials Management	2-4 FTEs 1-2 people covering 7AM-7PM, 7 days/week	2-4 FTEs 1-2 people covering 7AM-7PM, 7 days/week	To oversee ordering, distribution of supplies. Adjust up as needed based on acuity of patients.
	Food Service Supervisor	1 FTE (M-F, 8AM-4PM)	1 FTE (M-F, 8AM-4PM)	To oversee the dietary department, order food and supplies, schedule dietary staff.
	Cook	2-4 per meal	2-4 per meal	Food Service Supervisor may also act as cook.
	Food Service Workers	4-6 per meal	4-6 per meal	Increased staff needed at peak meal times.
	Housekeeping	5-9 people 7AM-7PM 1-2 people 7PM-7AM	5-9 people 7AM-7PM 1-2 people 7PM-7AM	Assuming one person per unit (40 beds) plus one person for common areas, trash from 7AM-7PM. 1-2 people 7PM-7AM.
	Human Resources	1 FTE (M-F, 8AM-4PM)	1 FTE (M-F, 8AM-4PM)	Assist with staff support/ dependent care. May need to recruit dependent care staff/volunteers to cover all shifts as needed.
	Laundry			Adjust depending on equipment available

PERSONNEL

Staff Type	Staff	Scenario 1: Medical/Surgical	Scenario 2: Infectious Disease	Discussion
				and acuity of patients Assuming three complete bed changes per day.
	Maintenance	3-4 FTEs (1-3 people, 8AM-4PM, 7 days per week)	3-4 FTEs (1-3 people, 8AM-4PM, 7 days per week)	May assist with housekeeping, safety and security as needed.
	Morgue Worker	1 FTE	1 FTE	As needed.
	Public Information Specialist	1 FTE	1-2 FTEs	An infectious disease scenario would likely require more communication with media, families, etc.
	Safety Manager	1 FTE	1 FTE	May have maintenance responsibilities also.
	Security	8-12 FTEs (1-3 people per shift, 7 days per week, 24 hours per day)	8-12 FTEs (1-3 people per shift, 7 days per week, 24 hours per day)	Adjust according to scenario, number of entrances, facility location
	Transport	1.5-3 FTEs (1-2 people covering M-F, 7AM-7PM)	1.5-3 FTEs (1-2 people covering M-F, 7AM-7PM)	Adjust according to staff availability. All staff capable of transport.
	Volunteers	As available	As available	Assist with transport, delivery of supplies and meals, administrative/clerical functions, dependent care, etc.

826
827
828

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829 Ancillary Support Matrix

830
831 The following sample staff utilization matrix, is adapted from another example⁸ set forth by the Wisconsin
832 State Expert Panel in its guidance on surge capacity. It provides both existing facilities and ACSs with a
833 template and guidelines for Inpatient Ancillary staffing needs for a facility operating in surge. This
834 document provides recommendations for maintenance of ancillary staff during a surge to maintain day-to-
835 day operations as well as meet the expanded needs; sample matrices are provided. Ancillary staffing
836 recommendations follow the matrices provided below.
837

Ancillary Support Matrix - Housekeeping				
Level	Number of Patients Expected	Critical Rooms	Complex/Critical Rooms	Basic and Supportive Rooms
I	1-10			
II	11-25			
III	26-50			
IV	51-100			
V	>100			

838 839 Instructions for Use

840
841 Ancillary service departments are to consider not only the staffing necessary to care for patients, but also
842 the staffing necessary to care for staff, patients' family members and visitors, who may come to the
843 healthcare facility or ACS with the surge of patients. The following ancillary departments are to complete
844 their staffing plans (based on the template above) and strategies:
845

- 846 • Housekeeping
- 847 • Food Services
- 848 • Security
- 849 Radiology
- 850 • Laboratory
- 851 • Admissions
- 852 • Billing
- 853 • Medical Records
- 854 • Pastoral Care
- 855 • Transport Services
- 856 • Day Surgery
- 857 • Chemotherapy
- 858 • Dialysis

859
860 Each department is to complete its own staff utilization matrix but is to collaborate to determine which
861 staff can be pulled from other departments to assist with these functions so that departments do not
862 identify and depend upon the same staff.
863

PERSONNEL

864

865 Maintaining Personnel

866 Current Standards and Analysis

867

868 Workforce Health & Safety and Workers Rights

869

870 Per the [Occupational Safety Health \(OSH\) Act of 1970, Section 5](#), “each employer shall furnish to each of
871 his employees employment and a place of employment which are free from recognized hazards that are
872 causing or are likely to cause death or serious physical harm to his employees.” Known as the “general
873 duty clause” it very simply states employers’ basic obligation to keep employees safe – a concept that
874 could not be any more applicable than in a time of surge. State-specific CalOSHA regulations further
875 detail this obligation, under [Labor Code §6400](#). One of facilities’ main priorities in planning for, and
876 responding to a surge, is their overarching duty to safeguard the health and safety of their workforce.
877 Without the workforce, there can be no response.

878

879 One of the methods by which facilities (both existing facilities and ACSs) protect the health and safety of
880 their workforce is in the provision of personal protective equipment (PPE). Under [Labor Code §6401](#),
881 “every employer shall furnish and use safety devices and safeguards, and shall adopt and use practices,
882 means, methods, operations, and processes which are reasonably adequate to render such employment
883 and place of employment safe and healthful.” Additional specific guidance for the provision of PPE are
884 outlined in [CCR 8 §3380](#). CalOSHA requirements may not be waived, but in the event that a healthcare
885 facility is unable to meet this requirement, CalOSHA’s response would be to assist the facility in meeting
886 the standard under alternate means. Enforcement of CalOSHA requirements during the surge is handled
887 through ICS, under which the focus is not on citation (or the issuance of tickets or violations) but in
888 resolving the issue.

889

890 A second workforce health and safety issue that may arise and need to be addressed during a surge, for
891 example during a pandemic flu, is that of mandating vaccinations for all employees and volunteers. The
892 Speier Bill, codified at [Health and Safety Code §1288.5 et seq.](#) establishes the Hospital Infectious
893 Disease Control Program, which would require State Department of Health Services, health facilities and
894 general acute care healthcare facilities implement various measures relating to disease surveillance and
895 the prevention of health care associated infection (HAI). This law requires healthcare facilities to provide
896 for example, flu vaccinations to all employees. The various requirements under this statute, some of
897 which are not yet effective, are subject to waiver by the Governor by his authority in a state of emergency.
898 Facilities will be responsible for providing vaccinations to staff unless such requirements are waived by
899 appropriate authority during a state of disaster.

900

901 In conjunction with employers’ obligation to safeguard the health and safety of their workforce is their
902 responsibility to honor employees’ rights. A healthcare surge would affect the way in which employers (in
903 this case facilities or public health) would be able to address workers’ rights, for example requiring staff
904 and administrators to remain at a facility or report to work (after leave) during a disaster. The [California
905 Industrial Welfare Commission Order No. 4-2001, 3\(B\)\(9\)-\(10\)](#) outline the number of hours that healthcare
906 personnel may work during a healthcare emergency and allows, after overall operational status has been
907 considered, certain provisions to be made to extend overtime to staff during a disaster. Per CDHS Legal
908 Counsel analysis, this order is subject to modification or waiver under the Governor’s executive powers
909 during a state of emergency.

910

911 To address employers’ ability to have employees’ return to work (from a leave) during a disaster, [CCR 8
912 §9776.1](#) is referenced which discusses employers’ general requirement of a return to work release with
913 limitations and/or accommodations before returning an employee to work. This can be obtained from the
914 workers compensation approved physician. In order to respond to a surge, this standard may be waived
915 by authority of the Governor under the Emergency Services Act. Doing so would allow facilities to

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916 potentially return certain staff members to work in an expedited manner, thereby increasing the workforce
917 pool.
918

919 Support Provisions for Staff

920
921 Although there are no legal requirements for the provision of support to staff or dependents during an
922 emergency, Joint Commission standards under Environment of Care (EC) 4.10 state that hospitals must
923 address emergency management. In order to fulfil this standard, the hospital emergency plan must
924 provide processes for managing the following elements under emergency conditions¹¹:

- 925
- 926 • Activities related to care, treatment, and services (for example, scheduling, modifying, or
 - 927 discontinuing services; controlling information about patients; referrals; transporting patients)
 - 928 • Staff support activities (for example, housing, transportation, incident stress debriefing)
 - 929 • Staff family support activities
 - 930 • Logistics relating to critical supplies (for example, pharmaceuticals, supplies, food, linen, water)
 - 931 • Security (for example, access, crowd control, traffic control)
 - 932 • Communication with news media
- 933

934 Guideline/ Recommendation

935

936 Workforce Health & Safety and Workers Rights

937
938 Based on the review of the above standards and the ability to flex these regulations and requirements
939 during a surge, it was identified that mandates can be made for staff to comply with certain requirements
940 as a condition of their employment. It is recommended that the standards discussed above, as well as
941 the accompanying analysis, be incorporated into a Workforce Resiliency Policy which is included in the
942 next section.

943
944 Draft deliverable(s) include:

- 945 • Workforce Resiliency Policy
- 946

947 Support Provisions for Staff

948
949 In regards to the provision of child care and dependent care (adults requiring supervision or support), it is
950 recommended that existing facilities identify staff members who can provide child care and dependent
951 care as needed during a surge. Using existing staff increases the likelihood that these individuals have
952 undergone background checks as part of the employment process. In addition, it may be beneficial to
953 establish contracts with outside agencies or vendors who will be responsible for providing qualified and
954 licensed professionals for child and dependent care. In the event where such contracts are not feasible
955 or agencies are not accessible, additional community resources should be identified as part of surge
956 planning. Community resources may include schools, religious organizations, or other service
957 organizations.

958
959 It is recommended that facilities consider specific elements in developing a staff support provision plan –
960 elements that include critical stress management and workforce health and safety. It is also
961 recommended that facilities (both existing facilities and ACSs) develop and implement a dependent care
962 policy. A sample of both of these tools is included in the next section.

963
964 Draft deliverables include:

- 965 • Considerations for Staff Support Provisions
- 966 • Sample Dependent Care Policy

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967 Draft Deliverables

968

969 Policy for Workforce Resilience during Disaster¹⁰

970

971 **Purpose:**

972 This policy offers guidelines for dealing with needs and training to optimize workforce resilience in the
973 event of a disaster. This policy provides minimum standards for existing facilities to incorporate into
974 current workforce resiliency policies. Alternate Care Sites will adopt a modified version of this policy
975 based on staffing type and functional model. It is important that the intent of this policy is carried out
976 when staffing ACSs in order to provide proper support, protections, and training to staff and volunteers.
977 The term worker is used to refer to facility personnel during a time of surge, which could consist of paid
978 employees or volunteers.

979

980

981 **Rationale:**

982 The response to a disaster will pose substantial physical, personal, social, and emotional challenges to
983 healthcare providers. During an influenza pandemic, however, the occupational stresses experienced by
984 healthcare providers are likely to differ from those faced by workers in the aftermath of other disasters.
985 Globally and nationally, a pandemic might last for more than a year, while disease outbreaks in local
986 communities may last 5 to 10 weeks. Workers and their families will be at personal risk for as long as a
987 disaster continues in their community. Special planning is therefore needed to ensure that we are
988 prepared to help employees maximize personal resilience and professional performance.

989

990 Worker Needs

991

992 Physical:

- 993 • Rest areas for each department are located __ (list departments and areas) __.
 - 994 • Provisions for showers are _____.
 - 995 • Food will be served or provided __ (where and how often) __.
 - 996 • Healthcare in case for illness or injury will be provided __ (where and when) __.
 - 997 • Transportation to and from work will be provided __ (situation and contact) __.
- 998 For Pandemic: (describe what will happen if worker too sick to be at work)

999

1000 Personal:

- 1001 • Telephones for personal calls are located __ (include rules) __.
 - 1002 • Televisions, radios, and internet access for keeping apprised of events are located __ (include
1003 rules) __.
 - 1004 • Childcare is provided at _____.
 - 1005 • Care for disabled or elderly family members is provided at _____.
 - 1006 • Pet care is provided at _____.
- For Pandemic: Guide sheets are provided for workers to deal with sickness in their homes.

1007

1008

1009 Emotional:

- 1010 • Management will provide all workers with regular updates of status of disaster in community and
1011 response activities within the organization. Supervisors will brief workers at least once per shift.
- 1012 • Managers and supervisors will be alert to recognize worker distress.
- 1013 • Management will provide a stress control team to help workers deal with stress.
- 1014 • Chaplain or other appropriate religious services.

1015

1016 For Pandemic: Counseling will include techniques for dealing with stigmata that workers may face for
1017 working with victims. Stress control teams will be trained in infection control precautions.

1018

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1019 Training

1020
1021 There are four main categories of training to be addressed in preparation for response to a disaster:
1022 training for all workers, department specific training, training for ad hoc counselors, and information
1023 packets for handout.

- 1024
- 1025 1. All employees will receive training in the following:
 - 1026 • Stressors related to pandemic influenza
 - 1027 • Signs of distress
 - 1028 • Traumatic grief
 - 1029 • Psychosocial aspects related to management of mass fatalities
 - 1030 • Stress management and coping strategies
 - 1031 • Strategies for building and sustaining personal resilience
 - 1032 • Behavioral and psychological support resources
 - 1033 • Strategies for helping children and families in times of crisis
 - 1034 • Strategies for working with highly agitated patients
 - 1035
 - 1036 2. Department specific training will be developed by department managers as appropriate to the type of
1037 services provided.
 - 1038
 - 1039 3. If there are not enough behavioral health specialists available for response to staff needs in a disaster,
1040 (Affiliate name) will provide basic counseling training to selected individuals to assist in meeting
1041 worker emotional needs.
 - 1042
 - 1043 4. (Affiliate name) has developed information packages that will be available for distribution to
1044 workers and their families.

1045 1046 Deployed Workers

1047
1048 In the event of a major disaster, especially one that lasts for weeks, workers may be deployed to other
1049 departments of this organization or even to assist at other locations in the community. Workers may be
1050 requested to use transferable skills to do work that is not in their current job description or scope of
1051 practice. For instance, a nurse may be asked to work in the laboratory to assist with drawing blood.

1052 1053 Deployment within the organization

- 1054
- 1055 • Pre-deployment, workers will be briefed on stress management, coping skills and resilience.
 - 1056 • Supervisors will develop job description (just-in-time) training sheets that outline tasks for a borrowed
1057 worker or volunteer.
 - 1058 • Supervisors will ascertain competency of borrowed workers to do assigned tasks.
 - 1059 • All deployed workers have a responsibility to advise the supervisor when they have been assigned a
1060 task for which they have no training or skills. Supervisors should train the employee to the task if
1061 appropriate, or assign the task to someone else.
 - 1062 • A buddy system will be established to help employees to support each other.
 - 1063 • Workers will be trained on self-help activities.
- 1064

PERSONNEL

1065 Deployment outside of the organization

1066

1067 Local or national government may require assistance and request that healthcare workers be deployed to
1068 other sites. (contact person within affiliate) is responsible for coordinating all external deployment
1069 of employees.

1070

1071 • (Contact person) will coordinate with the HICS Commander to determine how many workers can be
1072 spared, and then will send a call for volunteers for deployment.

1073 • Pre-deployment, workers will be briefed on:

1074 • Status of community or agency that to which they are going

1075 • Work that is expected of them

1076 • Stress management, coping skills and resilience

1077 • Self-help activities

1078 • Approximate time they will be needed

1079

PERSONNEL

1080 Considerations for Staff Support Provisions⁸

1081

1082 **Purpose:** The following information is intended as a starting point for surge planners in outlining
1083 necessary policies and provisions to support staff during a surge event.

1084

1085 **Staff Support Considerations**

1086

1087 The following are issues that the healthcare facility is to consider for its staffing plans and strategies. The
1088 healthcare facility should consider the formation of Staff Disaster Support Committee or have its Human
1089 Resources Department pre-plan for the following (the list is not intended to be inclusive):

1090

1091 1. Some staff will not be able to report to work due to the fact that they or their loved ones may have been
1092 directly involved in the incident. In the absence of existing policies, it is recommended that a policy be
1093 developed or incorporated into current leave (sick time, medical leave, etc.) policies.

1094

1095 2. Some staff will refuse to report to work due to concerns about their own and their family members'
1096 safety and health. In the case of a biological incident, they may have fear of contracting the disease or
1097 bringing the disease home. In the absence of existing policies, it is recommended that a policy be
1098 developed or incorporated into current leave (sick time, medical leave, etc.) policies.

1099

1100 3. Many staff will have concerns about childcare. The normal childcare provider may not be able to
1101 provide these services in an incident. These same concerns apply to staff, who may be caring for their
1102 parents or others. There should be options available for childcare/eldercare so that staff are free to report
1103 to work. Title 42 - Termination if employees chose to volunteer for disaster work (Policy or guideline for
1104 protection of work, possibly consider waiver).

1105

1106 4. Some staff may have concerns about the shelter and care of their pets. Considerations should be
1107 made to plan for pet care during surge. Designated kennel or housing provisions should be part of the
1108 disaster preparedness plan and individual staff member plan.

1109

1110 5. The healthcare facility is to consider the provision of rooms for staff for rest and sleep and for personal
1111 hygiene needs (blankets, pillows, sheets, showers, towels, soap, shampoo, etc.). In the case of a
1112 biological incident, there may be the implementation of work quarantine in addition to staff working longer
1113 shifts or not being able to go home. The healthcare facility may also want to consider what is available in
1114 local hotels, churches, and other such organizations for sleeping accommodations and showers.

1115

1116 6. The healthcare facility is to consider areas for staff to eat and have refreshments.

1117

1118 7. Staff may be away from home for extended shifts and need to communicate with family members and
1119 other loved ones. The healthcare facility is to consider the availability of telephones to call home and
1120 computer access for email.

1121

1122 8. For staff working extended shifts or not able to go home, there may be the need for laundry services or
1123 the provision of scrubs. Staff members are also to consider having an "Emergency Kit" with personal
1124 items such as underwear, socks, toiletries, a supply of medications, etc. readily available so that this "Kit"
1125 is readily available.

1126

1127 9. Staff are to also have a "Family Plan" so that everyone in the family knows what will need to happen
1128 and who is responsible for various duties if a family member, who works at the healthcare facility, needs
1129 to work longer shifts or is quarantined at the healthcare facility.

1130

1131 10. The healthcare facility should also give consideration for back-up of essential services such as food
1132 services, laundry, housekeeping and other services, especially if these services are out-sourced and the
1133 incident affects the ability of the contractor to continue to provide these services and if the surge of
1134 patients and visitors overwhelms the capacity of these contractors.

PERSONNEL

- 1135
1136 11. Most healthcare facilities use “calling trees” to notify staff. The healthcare facility is to consider a back-
1137 up system for notifying staff should the telephone lines be down or the circuits busy.
1138
1139 12. The healthcare facility is to consider pre-identifying staff persons, who will manage and supervise
1140 volunteers and in which areas or departments the healthcare facility is likely to utilize volunteers.
1141
1142 13. The healthcare facility is also to consider that there may not be sufficient managers to supervise the
1143 staff in the surge capacity areas.
1144
1145 14. With staff being asked to work in the surge capacity areas, work in these areas may not necessarily
1146 involve their normal work responsibilities (duties as assigned). It is suggested that job descriptions be
1147 available for all positions so that staff can receive “just-in-time” training by reading the job descriptions.
1148
1149 Based on these recommendations, the following support provisions have been identified and should be
1150 considered by surge planners:
1151
1152 • Behavioral/Mental Healthcare care for staff
1153 • Behavioral/Mental Healthcare for dependents
1154 • Dependent Care (Children and Adults)
1155 • Meal Provisions for 3-7 days
1156 • Water for 3-7 days
1157 • Pet Care
1158 • Designated Rooms for Rest/Sleeping
1159 • Designated Restrooms
1160 • Personal Hygiene Provisions (blankets, pillows, sheets, showers, towels, soap, shampoo, etc.)
1161 • Designated Eating Areas
1162 • Email/Telephone Access to communicate with Family
1163 • Clothing or Laundry Services for Staff and Dependents
1164 • Emergency Kits (personal items such as underwear, socks, toiletries, a supply of medications, etc.)
1165 staff store at the place of works
1166 • Family Emergency Plan
1167

PERSONNEL

1168 Sample Policy for Dependent Care⁹

1169

1170 **Purpose:**

1171 This procedure outlines the process by which the Hospital Incident Command System (HICS) at [Facility
1172 Name] provides for sheltering and feeding of staff and volunteer dependents during a disaster or other
1173 emergency situation.

1174

1175 **Definition:**

1176 Dependent Care Area is located in [Facility-Designated Area].

1177

1178 **Policy:**

1179 In the event of an extended emergency response or civil disturbance where staff will remain at [Facility
1180 Name] for long periods, dependents, including children, elderly and disabled persons may be brought with
1181 the staff member, and housed in the designated Dependent Care Area. If no responsible person is
1182 available at home to provide care, these dependents will be housed in the Dependent Care Area for the
1183 duration of the disturbance or until other arrangements are made.

1184

1185 **Responsibilities:**

1186 The Dependent Care Unit Leader shall be responsible for coordinating the dependent care area activities.

1187

1188 **Procedure:**

1189 A. Mobilization – Upon request by the Operations Chief or the Incident Commander, the Dependent
1190 Care Unit Leader shall mobilize sufficient staff and resources to activate a Dependent Care Area.

1191

1192 B. Safety Requirements – Prior to activation of the Dependent Care Area, the Dependent Care Unit
1193 Leader, with assistance of the Safety and Security Officer, shall conduct a safety inspection of the
1194 area to remove any unsafe objects and to secure any equipment that could pose a safety hazard.

1195

1196 C. Staff

1197 a. The Dependent Care Unit Leader will oversee other staff or volunteers requested from the
1198 Labor Pool, two clerical staff for registration, and a nurse to administer medications as
1199 needed.

1200 b. Staff and volunteers shall sign in and out when reporting to assist.

1201 c. Staff shall monitor the area continuously for safety issues and to respond to dependents'
1202 needs.

1203 d. If additional assistance is needed, for example, supplementary support for dependents from
1204 the American Red Cross, staff will communicate those needs through the command
1205 structure.

1206

1207 D. Supplies – Dependent Care Area supplies shall be requested through the Materials Supply Unit
1208 Leader.

1209

1210 E. Food – Meals and snacks for dependents shall be arranged by the Nutritional Supply Unit Leader.

1211

1212 F. Registration

1213 a. Post signs indicating “Dependent Care Area – Responsible Adult Must Register
1214 Dependent.”

1215 b. Assign each family a Family Number.

1216 c. All dependents shall be assigned a Dependent Number and shall register using the
1217 Dependent Care Registration form. Establish the Dependent Number by adding a letter (A,
1218 B, C, D, etc.) to the Family Number for each dependent in a given family.

1219 d. Apply and armband to each dependent upon arrival with name and Department Number.

1220 e. Take a picture of each dependent with person responsible for them, and attach to
1221 Dependent Care Registration form.

PERSONNEL

- 1222 f. Special sign-in and sign-out procedures shall be provided for minor or incompetent
1223 dependents.
1224 i. Implement a positive ID system for all children cared for under 10 years of age.
1225 ii. Provide matching ID for retrieving guardian to show upon release of child.
1226 g. Tag medications, bottles, food and other belongings with dependent's name and Dependent
1227 Number and store appropriately.
1228 h. Assign each dependent to a dependent care provider and record on form.
1229
- 1230 G. Medications
1231 a. Assure that dependents taking medications have a supply to last during the estimated
1232 length of stay.
1233 b. Arrange for a licensed nurse to dispense medications as appropriate.
1234
- 1235 H. Psychological Support – Arrange for the Psychological Support Unit Leader (Social Services) to
1236 make routine contact with dependents in the shelter, as well as responding to specific incidents or
1237 individual needs.
1238
- 1239 I. Documentation
1240 a. Document all care provided to individual dependents, such as medications, psychological
1241 services, toileting or dressing.
1242 b. Document all other actions and decisions and report routinely to the Dependent Care Unit
1243 Leader.
1244
- 1245 J. Checking Out of Dependent Care Area
1246 a. When dependent leaves area, compare picture with dependent and responsible person.
1247 b. Check ID, verify name and obtain signature of responsible person picking up dependent.
1248 c. Retrieve and send all medications and personal items with dependent.
1249 d. Collect arm bands.
1250
- 1251 The following form (Form 1) allows facilities to track the individuals for whom they provide dependent care
1252 during a surge and Form 2 serves as a tracking form to monitor the healthcare services provided to
1253 individuals while they are under dependent care.

PERSONNEL

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Form 1

Check In Date		Time	
Check Out Date		Time	
Staff Name	Relationship to Dependent	Family Number	
Dependent Name	Age	Dependent Number	
Staff's Department		Extension	
Other Family, Relative, etc we can call in an emergency			
Name		Phone Number	
Name		Phone Number	
Special Needs			
Allergies			
Food			
Toileting			
Medical Conditions			
Medications you brought:			
Name	Dose	Times to be given	
Name	Dose	Times to be given	
People who may pick up dependent			
Name		Relationship	
Name		Relationship	
Name		Relationship	

1256

For Dependent Care Area Staff Only:	
<u>Dependent Care Staff:</u>	
<ul style="list-style-type: none"> • Apply armband with name and registration number on each dependent. • Tag all medications, bottles, food and other belongings and store appropriately. • Photograph dependent with person responsible and attach photo to this form. • Use reverse side of this form to document care provided to this dependent. • Retain forms in Dependent Care Area until "All Clear" is announced, then route to Incident Command Center. 	
Dependent Care Providers Assigned	
Name of person picking up dependent	
Signature of person picking up dependent	

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Credentialing/ Personnel Verification

This section of the document provides an overview of the current standards for credentialing and the verification of qualifications of personnel (“personnel verification”) as well as an analysis of how, or the extent to which, these standards may be flexed during a surge. Specific guidelines and processes (in the form of operational tools) as to how these processes may be streamlined during a surge are also provided, as appropriate.

Credentialing & Privileging Standards

Current Standards and Analysis

The Joint Commission Comprehensive Accreditation Manual for Hospitals (2007) defines “credentialing” as the process of obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care services in or for a health care organization. “Privileging” is defined as the process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization, based on evaluation of the individual’s credentials and performance.¹¹

Under normal operations, organizations are obligated (under Joint Commission accreditation requirements) to complete the credentialing procedure for each licensed independent practitioner, including physicians (MDs and DOs), advance practice nurses (APNs) and physician assistants (PAs). These standards are applicable to general, acute psychiatric, pediatric, critical access, surgical specialty, long term acute care, and rehabilitation hospitals as well as any component of these organizations. In the event that an ambulatory care provider, home care organization, or skilled nursing facility are integrated (either organizationally or functionally) with one of the above listed organizations, these same standards may apply.

Specific to ambulatory care providers (and not necessarily to those integrated with hospitals), the Accreditation Association for Ambulatory Health Care (AAAHHC) requires that all licensed healthcare practitioners be credentialed. And, under the Federally Supported Health Centers Assistance Act of 1992, if an ambulatory health center is to qualify for coverage under the Federal Tort Claims Act, it must credential all of its licensed and certified healthcare practitioners but may use the guidelines set forth by Joint Commission or any other nationally recognized accreditation organization.

Although there is no existing authority that has the power to waive Joint Commission requirements, during a surge event, it may be necessary to enable facilities to use personnel that are not currently credentialed staff members. These augmented staff may be pre-registered volunteers, disaster service workers (DSW), or out of state professionals and may be activated under the auspices of the Hospital Incident Command System or the Standardized Emergency Management System (SEMS). Augmented staff may also be walk-in volunteers.

In some instances, existing law automatically facilitates the use of these augmented staff.

[Government Code §178, Article 4](#) recognizes the licensure, credentialing or permit held by a healthcare practitioner in any state as evidence of qualifications to provide disaster assistance within the scope of service of the provider or practitioner.

[Government Code §179.5, Article 5](#) provides deemed recognition to healthcare practitioners holding a current license, certificate, or other permit issued by another state that is part of the Mutual Aid Compact. By virtue of this deemed status as a licensed practitioner, out of state professionals may assist during a disaster without the administrative delay required to verify qualifications of the healthcare practitioner.

PERSONNEL

1311 Or, existing law may provide for the use of certain augmented staff provided that specific conditions are
1312 met or in the event that the Governor would waive or suspend certain requirements.

1313

1314 [Business & Professions Code §921](#), as part of the Health Care Professional Disaster Response Act,
1315 permits the use of providers with lapsed or inactive licenses in disaster areas where shortage exists.
1316 However, the administrative requirements may be prohibitive if time is of the essence. Waiver of these
1317 requirements ([Business & Professions Code §922](#)), by the Governor, would assist in facilitating the use of
1318 retired or inactive licenses.

1319

1320 Guideline/ Recommendation

1321

1322 Perhaps the greatest benefit of the credentialing process is its emphasis on verifying a healthcare
1323 professional's experience, ability and current competence – an act that should not be bypassed even
1324 during (or especially during) a surge. As such, the recommendation is not centered on the flexing or
1325 suspension of this process but rather a mechanism by which the pool of potential personnel may be
1326 increased. The provisions of the first two statutes listed above serve as a step in the right direction in
1327 achieving this goal, however it is recommended that the feasibility of waiving [Business & Professions
1328 Code §922](#) (by way of the Governor's suspension, or of a standing order to be drafted) be considered.

1329

1330 Recognizing that facilities retain the obligation to verify practitioners' competency (by way of
1331 credentialing) and maintain oversight over the care delivered during a surge, a further recommendation is
1332 made to allow for a streamlined way to conduct the credentialing process. This recommendation will be
1333 further discussed in the next section.

1334

1335 There are no draft deliverables for this section.

1336

1337 Streamlined Credentialing for Surge (Licensed Independent
1338 Practitioner)

1339 Current Standards and Analysis

1340
1341 Standard MS.4.110 in the Joint Commission Comprehensive Accreditation Manual for Hospitals (2007)
1342 states that an organization may grant disaster privileges to volunteers eligible to be licensed independent
1343 practitioners. As stated in the previous section, this standard would apply to hospitals and to other
1344 facilities (e.g., ambulatory care provider, home care organization, or skilled nursing facility) as long as
1345 they are organizationally or functionally integrated with an accredited organization.

1346
1347 The Rationale for this standard further states that the organization may implement a modified
1348 credentialing and privileging process for eligible volunteer practitioners (in this case, licensed independent
1349 practitioners) when the disaster plan has been implemented and the immediate needs of the patients
1350 cannot be met. The usual process to credential and privilege practitioners would not allow a volunteer
1351 practitioner to provide immediate care, treatment and services in the event of a disaster due to the length
1352 of time it would take to complete the process.

1353
1354 While this standard allows for a method to streamline the credentialing and privileging process,
1355 safeguards must be in place to assure that volunteer practitioners are competent to provide safe and
1356 adequate care, treatment, and services. Even in a disaster, the integrity of two parts of the usual
1357 credentialing and privileging process must be maintained:

- 1358
1359 • Verification of licensure
1360 • Oversight of the care, treatment, and services provided

1361
1362 The Joint Commission does not provide any formal procedure for carrying out this process, nor does it
1363 make any commitment to suspend accreditation requirements during a disaster. Hospital providers retain
1364 the obligation to verify competency and maintain oversight of the practitioners and care delivered. If
1365 primary source verification cannot be obtained within 72 hours from the practitioner presenting to the
1366 provider, the provider must keep records of why it could not under the circumstances do the required
1367 verification check.

1368
1369 In order to implement this standard, organizations are held to the following criteria or performance
1370 expectations:

- 1371
1372 • Disaster privileges are granted only when the following two conditions are present: the
1373 emergency management plan has been activated, and the organization is unable to meet
1374 immediate patient needs.
1375 • The individual(s) responsible for granting disaster privileges is identified.
1376 • The medical staff describes in writing a mechanism (for example, direct observation, mentoring,
1377 and clinical record review) to oversee the professional performance of volunteer practitioners who
1378 receive disaster privileges.
1379 • The organization has a mechanism to readily identify volunteer practitioners who have been
1380 granted disaster privileges.
1381 • In order for volunteers to be considered eligible to act as licensed independent practitioners, the
1382 organization obtains for each volunteer practitioner at a minimum, a valid government-issued
1383 photo identification issued by a state or federal agency (e.g., driver's license or passport) and at
1384 least one of the following:
1385 ○ A current picture hospital ID card that clearly identifies professional designation
1386 ○ A current license to practice
1387 ○ Primary source verification of the license

PERSONNEL

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- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for the Advanced Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups.
 - Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)
 - Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.
- 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.

1401 **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.*
 - The medical staff oversees the professional practice of volunteer licensed independent practitioners.
 - 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.
- 1409
- 1410
- 1411
- 1412

Guideline/ Recommendation

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1414

1415 An alternative to facilities conducting their own credentialing process is the use of volunteers from registries such as ESAR-VHP and MRC. The credentials of volunteers registered with ESAR-VHP are validated prior to an emergency so that they may be deployed quickly to facilities in need. Similarly

1416

1417

1418 practitioners who are registered with MRCs may also have completed the credentialing process prior to

1419

1420 the emergency; however the determination to offer this process is made at the local MRC Unit level.

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1422 Since there is a fee associated with credential verification, it may be cost-prohibitive for some of the small

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- Process flow diagram to guide facilities in their emergency credentialing process
- Credentialing matrix log for licensed independent practitioners

PERSONNEL

1441 At this time, the credentialing process is disparate and may be duplicative between facilities. Should a
1442 practitioner volunteer at more than one location, and he/she is not registered with ESAR-VHP and MRC,
1443 the credentialing process would have to be repeated. As such, it is recommended that a centralized
1444 database for credentialing information be developed and made available for hospitals, other healthcare
1445 facilities, and public health (for purposes of an ACS). Such a system is in place for the state of
1446 Connecticut where the Connecticut Statewide Emergency Credentialing System serves as the foundation
1447 for Connecticut's ESAR-VHP System and provides a mechanism by which hospitals can identify and
1448 expeditiously contact physicians and other staff to provide volunteer assistance in the case of a declared
1449 emergency. Participating hospitals provide the Connecticut Credentialing System database with verified
1450 information about their active medical staff and affiliated professionals (PAs, APRNs, CNMs, and CNAs)
1451 who wish to volunteer in the event of a mass casualty event. In turn, a hospital is able to access
1452 credentialing information on health volunteers it may request from the statewide database in the event of
1453 a disaster. In a disaster, hospitals that utilize the statewide credentialing database are assured that
1454 registered volunteers have been "pre-qualified" by a peer hospital in Connecticut accredited by the
1455 JCAHO.¹²

1456

1457 Draft deliverables include:

- 1458 • Recommended Policy for Emergency Credentialing and Privileging (Licensed Independent
1459 Practitioners)
- 1460 • Recommended Language for Medical Staff Bylaws/Rules to Allow Licensed Health Practitioners to
1461 Provide Care without Supervision during a Surge
- 1462 • Volunteer Application for Healthcare Practitioners
- 1463 • Temporary Disaster Privileging Process Flow Diagram
- 1464 • Credentialing Matrix Log for Licensed Independent Practitioners (MD, DO, APN, PA)

1465

PERSONNEL

1466 Draft Deliverables

1467 Recommended Policy for Emergency Credentialing and Privileging (Licensed 1468 Independent Practitioners)¹³

1469 Licensed independent practitioners (such as physicians, advanced practice nurses, and registered
1470 nurses) who request temporary disaster privileges during a period of officially declared emergency must
1471 be currently licensed.

1472 Hospital medical staff bylaws/rules that address disaster credentialing should specify identification
1473 requirements for those practitioners requesting disaster privileging. At a minimum, identification should
1474 include a valid government-issued photo identification issued by a state or federal agency (e.g., driver's
1475 license or passport) and at least one of the following:

- 1476 • A current picture hospital identification card.
- 1477 • A current license to practice and a valid picture identification issued by a state, federal, or
1478 regulatory agency.
- 1479 • Identification indicating that the individual is a member of the California Medical Assistance Team
1480 (CalMAT) or of a Disaster Medical Assistance Team (DMAT).
- 1481 • Documentation indicating that the individual has been granted authority to render patient care in
1482 disaster circumstances, such authority having been granted by a federal, state, or municipal
1483 entity.
- 1484 • Presentation by current hospital or medical staff member(s) with personal knowledge regarding
1485 the practitioner's identity.

1486 Immediate temporary disaster privileges may be granted in accordance with the bylaws/rules of the
1487 medical staff. The individual responsible for granting such privileges must be delineated in writing in the
1488 medical staff bylaws/rules and referenced in the hospital's disaster (emergency preparedness) plan. The
1489 bylaws/rules should specify that this individual is not required to grant privileges to any requestor and is
1490 expected to make such decisions on a case-by-case basis at his or her discretion. The privileges should
1491 be effective immediately and continue through the completion of the patient care needs or until the orderly
1492 transfer of the patient's care to another properly credentialed practitioner can be accomplished.

1493 Following disaster credentialing, the practitioner should be provided and maintain on his or her person
1494 written verification of said privileges. The medical staff bylaws, rules and regulations should require that
1495 his or her notations in the medical record reflect that the practitioner is working under disaster privileges.
1496 For quality review purposes, a list of all patient encounters should be kept, if practical.

1497 Allied Health Professionals (AHP) may be similarly considered for temporary privileges, and shall be
1498 subject to the same general conditions of supervision except that supervision may be performed by an
1499 AHP with current like privileges.

1500
1501 Emergency temporary privileges may be rescinded at any time, and there shall be no rights to any
1502 hearing or review, regardless of the reason for such termination.

1503
1504 Temporary disaster privileges are terminated at the end of the declared disaster.

1505
1506 A Volunteer Application for each practitioner must be completed and maintained on file at the facility.
1507

PERSONNEL

1508 Recommended Language for Medical Staff Bylaws/Rules to Allow Licensed Health 1509 Practitioners to Provide Care without Supervision during a Surge

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1511 To the extent that no state law exists to explicitly allow the provision of unsupervised patient care during a
1512 disaster or emergency situation (as there is for physician assistants at [Business & Professions Code](#)
1513 [§3502.5](#)), healthcare facilities should review and revise their medical staff bylaws to be able to facilitate
1514 the prompt delivery of patient care. Furthermore, when drafting the operational guidelines for an ACS,
1515 considerations must be made to include a stipulation that certain licensed health practitioners (e.g.,
1516 physician assistants) will be able to render emergency without (or with limited) supervision.

1517

1518 Suggested language for medical staff bylaws/ rules may state:

1519

1520 In case of an emergency, any member of the medical staff, house staff, and any licensed health
1521 practitioner, limited only by the qualifications of their license and regardless of service or staff
1522 status, shall be permitted to render emergency care. Any [Licensed Health Practitioner] acting in
1523 an emergency or disaster situation shall be exempt from the hospital's usual requirements of
1524 supervision to the extent allowed by state law in disaster or emergency situations.¹⁴

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PERSONNEL

1526 Volunteer Application for Healthcare Practitioners

1527

1528 The following form may serve as the Emergency Credentialing and Privileging form for both existing
1529 facilities (if one has not already been developed) and ACSs.

1530

1531 **Instructions for Use:**

1532

1533

1534 1. For each licensed independent practitioner (MD, DO, APN, or PA) who presents at a facility to apply
1535 for emergency credentials, the Medical Staff office representative* will provide him/her with the
1536 following application form.

1537 2. Each licensed independent practitioner must present to the Medical Staff office representative with
1538 proper identification including a valid government-issued photo identification issued by a state or
1539 federal agency (e.g., driver's license or passport) and at least one of the following:

1540

1541 • A current picture hospital identification card.
1542 • A current license to practice and a valid picture identification issued by a state, federal, or
1543 regulatory agency.

1544 • Identification indicating that the individual is a member of the California Medical Assistance Team
(CaMAT) or of a Disaster Medical Assistance Team (DMAT).

1545 • Documentation indicating that the individual has been granted authority to render patient care in
1546 disaster circumstances, such authority having been granted by a federal, state, or municipal
1547 entity.

1548 • Presentation by current hospital or medical staff member(s) with personal knowledge regarding
1549 the practitioner's identity.

1550

1551 3. Completed application form is then given to the Medical Staff Director** or other designated individual
1552 for review and determination of the practitioner's duties and area of assignment.

1553 4. Concurrently, the Medical Staff Office representative will initiate the primary source verification
1554 process. This process must be completed within 72 hours from the time the practitioner presented to
1555 the organization.

1556

1557

1558 * - For an ACS with limited staffing, the position of a Medical Staff Office Representative may be filled by
1559 an office clerk or other designated individual with similar level of understanding of the credentialing and
1560 privileging process.

1561 ** - For an ACS with limited staffing, the position of a Medical Staff Director may be filled by a supervising
1562 physician with a similar level of understanding of the credentialing and privileging process.

1563

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PERSONNEL

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VOLUNTEER APPLICATION (Licensed/Certified/Registered Professional)	
DATE YOU CAN START: / /	
PERSONAL INFORMATION	
First Name:	Middle Initial:
Is there any additional information about a change of your name, use of an assumed name, or use of a nickname that will assist us in checking your work and educational records? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, please explain:	
Previous Address: Street: City: State: Zip:	
Pager/ Cell Phone: ()	
Social Security number:	
Birth Place (City, State):	
NEXT OF KIN & EMERGENCY CONTACT	
Give name, telephone number and relationship of two individuals who we may contact in the event of an emergency.	
Telephone Number	Relationship
()	
()	
DEPENDENTS	
Please list any dependents for which you are responsible.	
Place of Residence/ Telephone Number	Relationship
LICENSURE/ CERTIFICATION/ REGISTRATION INFORMATION	
Do you now have or have you previously had a health care related license, certification, and/or registration? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, License, certification, and/or registration type(s): Issuing State(s): Is your license/certification/registration currently in good standing? <input type="checkbox"/> No <input type="checkbox"/> - Yes If No, explain why not: Has your license/certification/registration ever been revoked or suspended? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, explain reason(s), date of revocation(s) or suspension(s), and date of reinstatement(s):	

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PERSONNEL

Current Place of Practice: Street:	Location Internship/Residency: Street:	Drug Enforcement Administration (DEA) number:
	City: State:	National Provider Identification number (NPI):
City: State:	Zip:	Medical License Number:
Zip:	Year/Month of Graduation:	

AVAILABILITY & AFFILIATION

Please indicate your availability:

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Times of day you may be available: _____

Are you registered with a volunteer organization? If Yes, please select below:

ESAR-VHP Medical Reserve Corps (MRC) California Medical Assistance Team (CalMAT)
 Disaster Medical Assistance Team (DMAT) Other. Please specify _____

EDUCATION & VOCATIONAL TRAINING

	High School	College/University	Graduate/Professional	Vocational/Business
School Name, City & State				
No. Years/Last Grade Completed				
Diploma/Degree				

Do you have any experience, training, qualifications or skills which you would assist labor pool coordinators in assigning an appropriate position? No Yes
 -If Yes, please specify.

Age Specific Practice Criteria:
 Please check the boxes below for each age group for which you have expertise in providing age-appropriate nursing care.

Newborn/Neonate (birth - 30 days) Infant (30 days - 1 year) Toddler (1 - 3 years)
 Preschooler (3 - 5 years) School age children (5 - 12 years) Adolescents (12 - 18 years)
 Young adults (18 - 39 years) Middle adults (39 - 64 years) Older adults (64+)

My experience is primarily in: (Please indicate number of years.)

Critical Care year(s):____
 Emergency Medicine year(s):____
 Home Care year(s):____
 Labor & Delivery year(s):____
 Med Surg year(s):____
 NICU year(s):____
 Pediatrics year(s):____
 Outpatient year(s):____

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PERSONNEL

1568

Do you have any experience, training, qualifications or skills which you would assist labor pool coordinators in assigning an appropriate position? No Yes
 -If Yes, please specify.

Age Specific Practice Criteria:
 Please check the boxes below for each age group for which you have expertise in providing age-appropriate nursing care.

Newborn/Neonate (birth - 30 days) Infant (30 days - 1 year) Toddler (1 - 3 years)
 Preschooler (3 - 5 years) School age children (5 - 12 years) Adolescents (12 - 18 years)
 Young adults (18 - 39 years) Middle adults (39 - 64 years) Older adults (64+)

My experience is primarily in: (Please indicate number of years.)

Critical Care year(s):____
 Emergency Medicine year(s):____
 Home Care year(s):____
 Labor & Delivery year(s):____
 Med Surg year(s):____
 NICU year(s):____
 Pediatrics year(s):____
 Outpatient year(s):____
 Surgery year(s):____
 Trauma year(s):____

Other (specify):_____ year(s):____

Do you speak, write, and/or read any languages other than English? No Yes

If Yes, please identify which other language(s) and rate your proficiency in these languages:

Language	Fluent	Speak	Read	Write
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VERIFICATION OF TRUTHFULNESS AND UNDERSTANDING REGARDING VOLUNTEER AGREEMENT

 Initials I agree that the information I provide and the representations I make will be truthful, complete, accurate, and free of any attempt to mislead.

 Initials I acknowledge that by completing this form that I am of sound physical and mental capacity, and capable of performing in an emergency/disaster setting. I acknowledge that emergency/disaster settings can pose significant psychological and physical hardships and risks to those volunteering their services and the emergency/disaster settings often lack the normal amenities of daily life and accommodations for persons with disabilities. In agreeing to volunteer my services, I agree to accept such conditions and risks voluntarily.

 Initials I understand that I am required to abide by all rules and practices of this facility and affiliated entities as well as all applicable State and Federal laws and regulations.

 Initials I agree to service as a volunteer, without compensation or payment for my services. I agree to hold the State of California and any of its entities or subdivisions harmless from any claims of civil liability, including but not limited to claims of malpractice or negligence, criminal liability, injury or

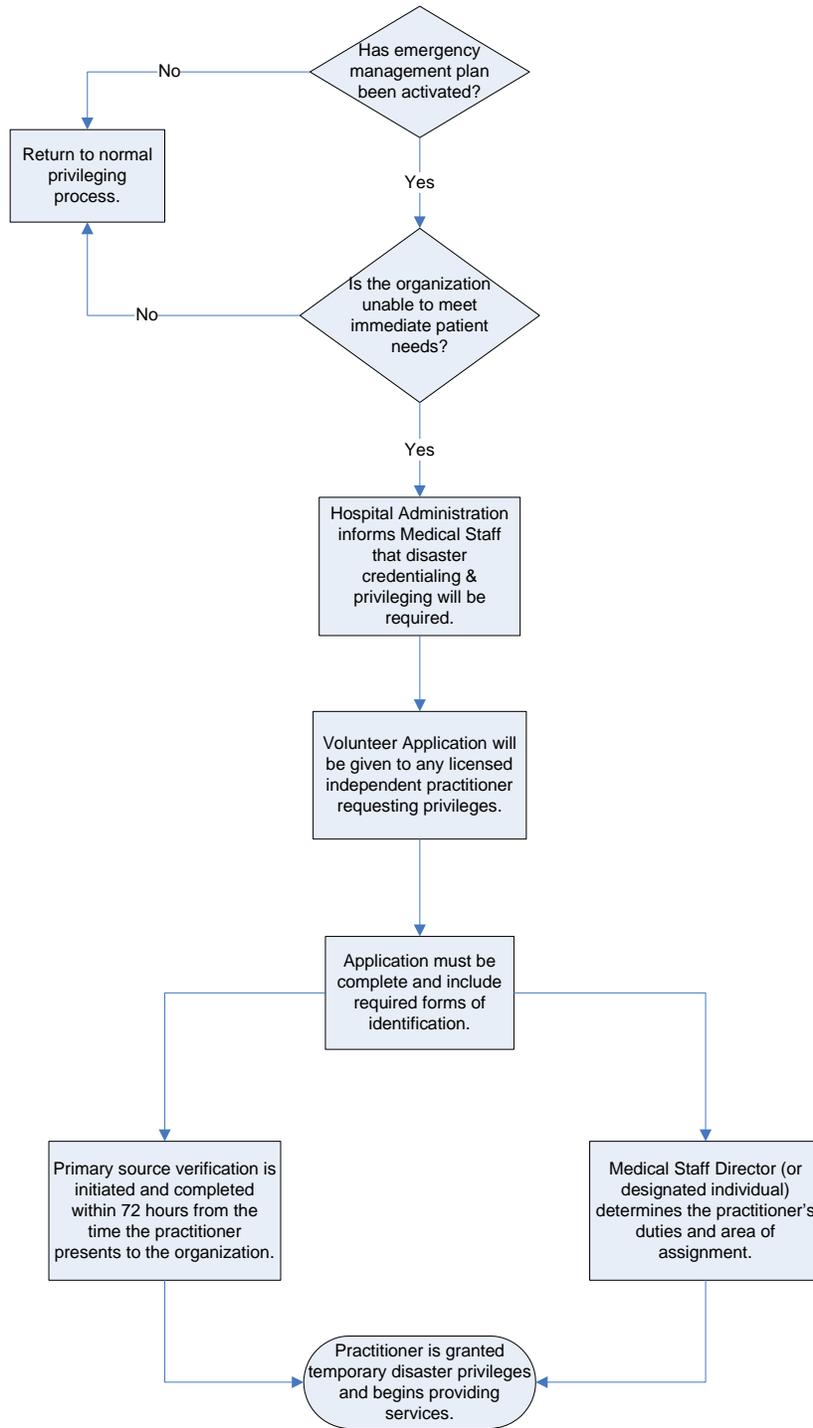
1569

PERSONNEL

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1571 Temporary Disaster Privileging Process Flow Diagram

1572



1573

PERSONNEL

1604

1605 Streamlined Personnel Verification for Surge

1606 Current Standards and Analysis

1607

1608 For all other healthcare providers – other licensed, certified, or registered practitioners – and all other
1609 volunteers, processes should be in place to verify their qualifications and experience as well. To
1610 differentiate this process from that of credentialing, it will be referred to as “personnel verification”. The
1611 (Office of Inspector General) OIG Compliance Program Guidance for Hospitals states that hospitals
1612 should conduct a reasonable and prudent background investigation, including a reference check, as part
1613 of every such employment application. This is recommended as a best practice for all types of other
1614 healthcare facilities, as well as ACSs.

1615

1616 Guideline/ Recommendation

1617

1618 Similar to the recommendation made for credentialing above, facilities are encouraged to consider the
1619 use of volunteer registries such as ESAR-VHP and MRC and benefit from their pre-registration process
1620 which not only encompasses credentialing of licensed independent practitioners but may also fulfil
1621 requirements for personnel verification.

1622

1623 In order to assist facilities in planning, the following tools and templates are included to address the
1624 process for personnel verification. Just as the credentialing tools may be customized, these personnel
1625 verification tools may be revised as well to best fit the needs of the facility or ACS.

1626

1627 Draft deliverables include:

- 1628 • Recommended Policy for Personnel Verification (Other Licensed/ Certified/ Registered Practitioners
1629 and All Other Volunteers)
- 1630 • Volunteer Application for Licensed/Certified/Registered Professionals and All Other Volunteers
- 1631 • Personnel Verification Matrix for Other Licensed/ Certified/ Registered Practitioners and All Other
1632 Volunteers

PERSONNEL

1633

1634 Draft Deliverables

1635

1636

1637 Recommended Policy for Personnel Verification (Other Licensed/ Certified/ Registered 1638 Practitioners and All Other Volunteers)¹⁵

1639

1640 During a local emergency (as declared by local, state, or national officials) in which the emergency
1641 management plan has been activated and the organization is unable to meet immediate patient needs,
1642 licensed or certified personnel, who are not current employees of [Facility Name], [City, County] may be
1643 granted temporary working privileges as needed to assist in staffing during the emergency. The
1644 Administrator or Human Resource Director/Manager or their designees, (as identified under the Hospital's
1645 Emergency Management Plan) will designate these non-employees to work at [Facility Name], [City,
1646 County].

1647

1648 Volunteers considered eligible to act as a licensed or certified personnel may also be considered upon
1649 approval from the Administrator, Human Resource Director/Manager or their designees.

1650

1651 Each non-employee and/or volunteer must present a valid government issued photo identification issued
1652 by a state or federal agency (i.e. driver's license or passport and at least one of the following below to
1653 grant temporary work during the emergency:

1654

- 1655 • A current picture hospital ID card that clearly identifies professional designation
- 1656 • A current license and/or certification to work
- 1657 • Identification indicating that the individual is a member of the California Medical Assistance Team
1658 (CaMAT) or of a Disaster Medical Assessment Team (DMAT) or MRC, ESAR-VHP or other
1659 recognized state or federal organization or groups
- 1660 • Documentation indicating that the individual has been granted authority to render patient care,
1661 treatment, and services in disaster circumstances (if applicable)
- 1662 • Identification by current hospital employee(s) who possesses personal knowledge regarding the
1663 non-employee/volunteer's ability to act as a licensed independent practitioner during a disaster (if
1664 applicable)

1665

1666 The Human Resource department will conduct a primary source verification of licensure (if applicable) as
1667 soon as the immediate situation is under control and is completed within 72 hours from the time the non-
1668 employee or volunteer presents to the organization.

1669

1670 The Labor Pool Unit Leader* shall determine the duties and area of assignment of those with emergency
1671 privileges.

1672

1673 The employee or volunteer will wear an [Facility Name] issued ID badges that indicate they have are a
1674 disaster volunteer. The Labor Pool Unit Leader will have the temporary badges and be responsible for
1675 distributing them to the identified personnel.

1676

1677 The Labor Pool Leader or designee will make a decision (based on information obtained regarding the
1678 license and/or certification of the non-employee/volunteer) within 72 hours related to the continuation of
1679 the disaster.

1680

1681 * - *The Labor Pool Unit Leader is a designation under the Hospital Incident Command System (HICS).
1682 For the hospital to respond effectively to the demands associated with a disaster, support requirements
1683 will be coordinated by the Logistics Section. Under the Service Branch of the Logistics Section, the Labor
1684 Pool & Credentialing Unit is charged with acquiring and credentialing additional personnel. When
1685 activated, this unit is represented by the Labor Pool Unit Leader.*¹⁶

PERSONNEL

1686 Volunteer Application for Licensed/Certified/Registered Professionals and All Other 1687 Volunteers

1688
1689 The following form may serve as the Personnel Verification form for both existing facilities (if one has not
1690 already been developed) and ACSs.

1691 1692 **Instructions for Use:**

- 1693
1694
- 1695 1. For all other licensed, certified, or registered professionals and all other volunteer who present at a
1696 facility to provide service, the Human Resources department representative* will provide him/her with
1697 the following application form.
 - 1698 2. Each professional or volunteer must present to the Human Resources department representative
1699 with proper identification including a valid government issued photo identification issued by a state or
1700 federal agency (i.e. driver's license or passport and at least one of the following below to grant
1701 temporary work during the emergency:
1702
 - 1703 • A current picture hospital ID card that clearly identifies professional designation
 - 1704 • A current license and/or certification to work
 - 1705 • Identification indicating that the individual is a member of the California Medical Assistance Team
1706 (CaMAT) or of a Disaster Medical Assessment Team (DMAT) or MRC, ESAR-VHP or other
1707 recognized state or federal organization or groups
 - 1708 • Documentation indicating that the individual has been granted authority to render patient care,
1709 treatment, and services in disaster circumstances (if applicable)
 - 1710 • Identification by current hospital employee(s) who possesses personal knowledge regarding the
1711 non-employee/volunteer's ability to act as a licensed independent practitioner during a disaster (if
1712 applicable)
 - 1713
 - 1714
 - 1715 3. Completed application form is then given to the Human Resources Director** or other designated
1716 individual for review and determination of the practitioner's duties and area of assignment.

1717
1718
1719 * - For an ACS with limited staffing, the position of a Human Resources Department Representative may
1720 be filled by an office clerk or other designated individual with similar level of understanding of the
1721 credentialing and privileging process.

1722 ** - For an ACS with limited staffing, the position of a Human Resources Director may be filled by a
1723 management representative with a similar level of understanding of the human resources and verification
1724 process.

PERSONNEL

VOLUNTEER APPLICATION (General Staff)	
DATE YOU CAN START: / /	
PERSONAL INFORMATION	
First Name:	Middle Initial:
Is there any additional information about a change of your name, use of an assumed name, or use of a nickname that will assist us in checking your work and educational records? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, please explain:	
Previous Address: Street: City: State: Zip:	
Pager/ Cell Phone: ()	
Social Security number:	
Birth Place (City, State):	
NEXT OF KIN & EMERGENCY CONTACT	
Give name, telephone number and relationship of two individuals who we may contact in the event of an emergency.	
Telephone Number	Relationship
()	
()	
DEPENDENTS	
Please list any dependents for which you are responsible.	
Place of Residence/ Telephone Number	Relationship
AVAILABILITY, AFFILIATION, & EXPERIENCE	
Please indicate your availability:	
<input type="checkbox"/> Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday	
Times of day you may be available: _____	
Are you registered with a volunteer organization? If Yes, please select below:	
<input type="checkbox"/> ESAR-VHP <input type="checkbox"/> Medical Reserve Corps (MRC) <input type="checkbox"/> California Medical Assistance Team (CalMAT)	
<input type="checkbox"/> Disaster Medical Assistance Team (DMAT) <input type="checkbox"/> Other. Please specify _____	
Please check the areas in which you are experienced and can provide services.	
<input type="checkbox"/> Ability to supervise children <input type="checkbox"/> Administrative/ clerical duties	
<input type="checkbox"/> Computer skills <input type="checkbox"/> Facilities management (e.g., electrician, plumbing, maintenance)	
<input type="checkbox"/> First aid (e.g., wound care) <input type="checkbox"/> Other – please specify _____	

1725

EDUCATION & VOCATIONAL TRAINING				
High School				
Do you speak, write, and/or read any languages other than English? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please identify which other language(s) and rate your proficiency in these languages:				
Language	Fluent	Speak	Read	Write
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VERIFICATION OF TRUTHFULNESS AND UNDERSTANDING REGARDING VOLUNTEER AGREEMENT				
_____ Initials	I agree that the information I provide and the representations I make will be truthful, complete, accurate, and free of any attempt to mislead.			
_____ Initials	I acknowledge that by completing this form that I am of sound physical and mental capacity, and capable of performing in an emergency/disaster setting. I acknowledge that emergency/disaster settings can pose significant psychological and physical hardships and risks to those volunteering their services and the emergency/disaster settings often lack the normal amenities of daily life and accommodations for persons with disabilities. In agreeing to volunteer my services, I agree to accept such conditions and risks voluntarily.			
_____ Initials	I understand that I am required to abide by all rules and practices of this facility and affiliated entities as well as all applicable State and Federal laws and regulations.			
_____ Initials	I agree to service as a volunteer, without compensation or payment for my services. I agree to hold the State of California and any of its entities or subdivisions harmless from any claims of civil liability, including but not limited to claims of malpractice or negligence, criminal liability, injury or death.			
Signature of Volunteer Applicant:			Date: / /	

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PERSONNEL

TO BE COMPLETED BY HUMAN RESOURCE - PERSONNEL VERIFICATION	
<u>Initials</u>	Proper identification was verified and copied. <input type="checkbox"/> Government issued photo identification (All Applicants) <input type="checkbox"/> Contractor License # (Human Resources - Unlicensed Personnel only) <input type="checkbox"/> Union or Trade Association identification (Human Resources - Unlicensed Personnel only) <input type="checkbox"/> Professional Certification (Human Resources - Unlicensed Personnel only)
To be completed by Administrator or his/her authorized designee.	
I authorize this individual to volunteer.	
Signature of Administrator:	Date: / /

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Scope of Practice and Professional Liability

During a surge, when the demand for patient care is simply greater than the supply of providers who may provide it, it may be necessary to allow healthcare professionals to practice outside of their licensed scope of practice in order to fulfill the overarching mission of ensuring the best population outcome or “the greatest good for the greatest number” of people. Focus shifts from patient-based care to population-based care and the current standards that allow professional scope of practice to shift (in terms of waiving or flexing these standards) as well must be identified.

To the extent that flexibility is limited, or explicitly prohibited, professional liability (for both employed professionals and volunteers) needs to be clearly defined. Although this section focuses specifically on the practitioner’s liability, the knowledge is essential to facilities (both existing facilities and ACSs) in determining the way in which they staff their facilities.

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Scope of Practice

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Current Standards and Analysis

To date, there is only one type of practitioner who is specifically allowed to provide services outside their licensed scope of practice during a surge: pharmacists.

Per [Business & Professions Code §4062\(b\)](#), under a declared emergency, the pharmacy board has the authority to waive the application of the act if it will aid in the protection of public health or the provision of patient care.

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1794
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Guideline/Recommendation

The recommendation has been made that the Licensing Boards of each of the following practitioners be contacted to determine if flexibility currently exists within their scope of practice or could be drafted for approval.

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- Physicians
- Registered Nurses
- Advanced Practice Nurses
- Physician Assistants
- Dentists
- Emergency Medical Technicians (EMTs) and Paramedics
- Pharmacists
- Respiratory Care Practitioner
- Respiratory Therapy Technician
- Cardiovascular Technologists and Technicians
- Radiologic Technologists and Technicians
- Surgical Technologists
- Medical and Clinical Laboratory Technologists
- Medical and Clinical Laboratory Technicians (Phlebotomists)
- Diagnostic Medical Sonographers
- Veterinarians
- Marriage and Family Therapists

PERSONNEL

- 1816 • Medical and Public Health Social Workers
- 1817 • Psychologists
- 1818 • Mental Health Counselors
- 1819 • Behavioral Health Professionals

1820

1821 This endeavour is currently underway as the California Department of Health Services has reached out to
1822 each of the Licensing Boards to obtain the information. Once obtained, a guideline may be compiled and
1823 appended to this manual.

1824

1825 Based on the flexed scope of practice provided by the Licensing Boards, a table could then be drafted
1826 identifying expected flexed scope of practice for various professional types that could be used to assign
1827 personnel during a surge to meet patient needs with the available staff.

1828

1829 Draft deliverables include:

- 1830 • Guidance from each California Healing Arts Licensing Board (in progress)
- 1831 • Flexed Scope of Practice Plan

1832

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1833 Draft Deliverables

1834

1835 California Healing Arts – Licensing Board Responses

1836

1837 Awaiting response from Boards

1838

PERSONNEL

1839 **Flexed Scope of Practice Plan**

1840
 1841 In order to provide essential services to patients and maintain facility daily operations, it may be
 1842 necessary to flex the scope of practice for personnel to meet clinical and non-clinical needs. The
 1843 following matrix is designed to assist staffing coordinators at existing facilities and ACSs in planning and
 1844 allocation of personnel resources during surge.

1845
 1846 Examples of positions are provided to illustrate classification of staff. Facilities may customize this table
 1847 to their own needs.
 1848

Flexed Scope of Practice Plan		
Position	Competencies/ Skill Sets (Non-Surge)	Allowed Skill Sets (Surge)
Credentialed Staff		
Dentist		
Non Credentialed Staff		
Nurse Practitioner		
In-State Volunteers (Other Facility, Registered Volunteer, Walk-In)		
Out-of-State Credentialed Volunteer*		
Psychiatrist		
Out-of-State Non-Credentialed Volunteers		
Certified Registered Nurse Anesthetist (CRNA)		

1849
 1850
 1851
 1852 **Instructions for Use:**
 1853
 1854 Facilities' staffing coordinators or Medical Staff representatives may complete this table based on the
 1855 information received from the California Licensing Boards. Allowed flexed scope of practice (e.g., the
 1856 procedures each practitioner would be allowed to perform), per the Licensing Boards would be listed
 1857 under the Allowed Skill Sets (Surge) column.

1858
 1859 Under the Competencies/ Skill Sets (Non-Surge) column, each practitioner's "normal" privilege list would
 1860 be indicated.

1861
 1862
 1863 * Current analysis of standards and regulations relating to augmenting staff in the state of California
 1864 during surge indicates that only during a state-wide declared emergency, in which current resources are
 1865 unable to meet the demand for healthcare services, will out-of-state practitioners be allowed to provide
 1866 care within California. Additionally, the Medical Director of EMSA will designate those specialties to be
 1867 requested and location for deployment of service.

1868 **Professional Liability**

1869
1870 A resounding concern in planning for a surge response is that of professional liability, even more so when
1871 the discussion of flexing providers’ scope of practice is involved. Protections for employed personnel as
1872 well as available protections for volunteers – under normal conditions - must be clarified as well as the
1873 extent to which they may be expanded during a surge.
1874

1875 **Current Standards and Analysis**

1876
1877 Several statutes apply to the liability of healthcare professionals; it should be noted that those listed below
1878 only address the providers’ liability while they are within the bounds of their “normal” scope of practice. To
1879 date, there are no statues specific to liability and professional malpractice coverage if an injury occurs to
1880 a patient receiving care from a provider whose care is outside his or her scope.
1881

- 1882 • [Government Code §8659](#), under the California Emergency Services Act states that any physician or
1883 surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who
1884 renders services during any state of war emergency, a state of emergency, or local emergency at the
1885 express or implied request of any responsible state or local official or agency shall have no liability for
1886 any injury sustained by any person by reason of such services, regardless of how or under what
1887 circumstances or by what cause such injuries are sustained; provided, however, that the immunity
1888 herein granted shall not apply in the event of a wilful act or omission.
1889

1890 Certain statutes and practices specifically address the liability of practitioners providing service
1891 outside the state by which they are licensed:
1892

- 1893 • [Government Code §178, Article 5](#) provides that “no party state or its officers or employees rendering
1894 aid in another state pursuant to this compact shall be liable on account of any act or omission in good
1895 faith on the part of such forces while so engaged”, the Governor’s suspension authority runs only to
1896 “statutes” not parts of statutes. Additionally, this provision of the Interstate Civil Defense and Disaster
1897 Compact applies to the liability of out-of-state disaster workers and is not a regulatory statute or one
1898 for the conduct of state business.
1899

1900 And certain statutes specifically address the liability of volunteers while providing uncompensated
1901 care
1902

- 1903 • The [Volunteer Protection Act of 1997, Section 4\(a\)](#) provides that a volunteer of a non-profit
1904 organization or government generally will be relieved of liability for harm if the volunteer was acting
1905 within the scope of his responsibilities if he was properly licensed, certified, or authorized for the
1906 activities (whenever such licensing, certification or authorization is appropriate or required).
1907

1908 The Act preempts state law, but allows a State to apply its own law exclusively in any case that does
1909 not involve out-of-State parties. It does not protect volunteer organizations. And as it is a federal
1910 provision, it cannot be suspended or flexed by the Governor.
1911

- 1912 • The Good Samaritan Statutes under [Business & Professions Codes §2395, 2395.5, 2396](#) and [2398](#)
1913 state that no licensee, who in good faith renders emergency care at the scene of an emergency, shall
1914 be liable for any civil damages as a result of any acts or omissions by such person in rendering the
1915 emergency care. “The scene of an emergency” as used in this section shall include, but not be
1916 limited to, the emergency rooms of hospitals in the event of a medical disaster. “Medical disaster”
1917 means a duly proclaimed state of emergency or local emergency declared pursuant to California
1918 Emergency Services act. Acts or omissions exempted from liability pursuant to this section shall
1919 include those acts or omissions which occur after the declaration of a medical disaster and those

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1920 which occurred prior to such declaration but after the commencement of such medical disaster. The
1921 immunity granted in this section shall not apply in the event of a wilful act or omission.
1922

1923 As the Good Samaritan statutes are neither regulatory statutes nor statutes for the conduct of state
1924 business, they cannot be suspended.
1925

1926 • Per the Disaster Service Worker Volunteer Program Guidance¹⁷, the Emergency Services Act
1927 ([Government Code §8657](#)) provides DSW volunteers with limited immunity from liability while
1928 providing disaster service as it is defined [CCR 19 §§2570.2](#) and [2572.2](#). Additionally, the [Volunteer](#)
1929 [Protection Act of 1997](#) also provides them with limited protection. Immunity from liability protects the
1930 political subdivision or political entity, and the DSW volunteer in any civil litigation resulting from acts
1931 of good faith made by the political subdivision or political entity, or the DSW volunteer, while providing
1932 disaster service (e.g., damage or destruction of property; injury or death of an individual). Immunity
1933 from liability does not apply in cases of wilful intent, unreasonable acts beyond the scope of DSW
1934 training, or if a criminal act is committed.
1935

1936 Convergent volunteers (those who have not pre-registered, or been impressed into service) not listed
1937 as DSW volunteers, have some liability protection for disaster service under the Good Samaritan
1938 statutes. They are not, however, provided immunities to the extent as registered DSW volunteers
1939 and are not covered for workers' compensation insurance through the DSW Volunteer Program.
1940

1941 Guideline and Recommendation

1942 It is recommended that facilities (both existing and ACSs) be provided with, and review, a list of qualified
1943 immunities to: (1) be aware of the liability protections that exist for various personnel and (2) to apply this
1944 knowledge in developing staffing plans and policies and procedures. The following draft deliverable
1945 outlines these qualified immunities.
1946
1947

1948 Additionally it is recommended that education of these liability protections be provided for personnel at all
1949 levels (e.g., management, practitioners, and support staff), hand-in-hand with education about the
1950 flexibility to provide "out of scope" services.
1951

1952 Draft deliverable(s) include:

- 1953 • List of Qualified Immunities
- 1954
1955

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1956 Draft Deliverables

1957

1958 List of Qualified Immunities

1959

1960 Qualified immunities refer to the immunity from civil liability that is afforded within a certain range of
1961 circumstances, as by a requirement of good faith or due care. At an ACS, qualified immunities would be
1962 applicable to the facility, volunteer personnel, contracted personnel and paid personnel.

1963

1964 **Qualified Immunities for Facilities** - California [Civil Code § 1714.5](#) defines the qualified immunities for
1965 facility liability claims at an ACS. Per [§ 1714.5](#), no person who enters a designated building or premises
1966 for refuge, treatment, care or assistance during an emergency has a cause of action for personal injuries
1967 against one who owns or maintains any building or premises designated as a shelter or mass care center,
1968 first aid station, temporary hospital annexes or as other necessary facilities for mitigating the effects of an
1969 emergency. Designation obtained from any disaster council or any public office, body or officer of the
1970 state or US, unless willful act of such owner or occupant.

1971

1972 California [Civil Code § 1714.6](#) further defines that no person shall be liable for negligence as a matter of
1973 law, or prosecuted for violation of any statute or ordinance, where the act or omission involved was
1974 required in order to comply with [omitted military order] any regulation, directive, or order of the Governor
1975 under the California Emergency Services Act. During a declaration of a disaster by the Governor, if an
1976 ACS is established to mitigate the effects of an emergency, no liability shall fall on the owners of the ACS
1977 facilities, unless an act of willful omission is committed.

1978

1979 **Qualified Immunities for Volunteer Personnel** - The Volunteer Protection Act of 1997 states that no
1980 volunteer of a nonprofit organization or governmental entity shall be liable for harm caused by an act or
1981 omission of the volunteer on behalf of the organization or entity if: (1) the volunteer was acting within the
1982 scope of the volunteer's responsibilities...etc. (2) if appropriate or required, the volunteer was properly
1983 licensed, certified, or authorized by the appropriate authorities...etc. This statute is very broad and may
1984 apply in broad circumstances, so long as summoned by a proper authority, and possesses the required
1985 first aid and emergency care training; immunity from liability appears to exist for providing any service that
1986 could fall within the definition of emergency services. For the purposes of this statute, emergency
1987 services includes but is not limited to first aid and medical services, rescue procedures, and
1988 transportation or other related activities necessary to insure the safety of the victim who is the object of a
1989 search or rescue operation.

1990 California [Civil Code §§ 1714.2](#) and [1714.21](#) states that if trained in basic CPR by the AHA or ARC and in
1991 good faith renders CPR at the scene of an emergency is not liable for any civil damages unless grossly
1992 negligent. Not applicable to those expecting compensation (e.g., staff/volunteers trained in CPR who
1993 renders aid during duty hours). A person is not liable for any civil damages if rendered AED (defibrillator)
1994 at the scene of an emergency, if complied with applicable requirements of [Health and Safety Code](#)
1995 [§1797.196](#).

1996

1997 **Qualified Immunities for Contracted Services** - Good Samaritan Statutes outline qualified immunities
1998 for contracted healthcare personnel providing services in an emergency situation. California [Business &](#)
1999 [Professional Code § 1627.5](#) applies to dentists and states that no person licensed under this chapter
2000 **[dentists]**, who in good faith renders emergency care at the scene of an emergency occurring outside the
2001 place of that person's practice, or who, upon the request of another person so licensed, renders
2002 emergency care to a person for a complication arising from prior care of another person so licensed, shall
2003 be liable for any civil damages as a result of any acts or omissions by that person in rendering the
2004 emergency care.

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2005 [California Business & Professional Code § 2395](#) applies to physicians and surgeons and states that no
2006 licensee, who in good faith renders emergency care at the scene of an emergency or during a medical
2007 disaster, shall be liable for any civil damages as a result of any acts or omissions by such person in
2008 rendering the emergency care. "The scene of an emergency" as used in this section shall include, but not
2009 be limited to, the emergency rooms of hospitals in the event of a medical disaster. "Medical disaster"
2010 means a duly proclaimed state of emergency or local emergency declared pursuant to the California
2011 Emergency Services Act (Chapter 7 (commencing with Section 8550) of Division 1 of Title 2 of the
2012 Government Code). Acts or omissions exempted from liability pursuant to this section shall include those
2013 acts or omissions which occur after the declaration of a medical disaster and those which occurred prior
2014 to such declaration but after the commencement of such medical disaster. The immunity granted in this
2015 section shall not apply in the event of a willful act or omission.

2016 California [Business & Professional Code § 2727.5](#) applies to nurses and states that a person licensed
2017 under this chapter [**nurse**] who in good faith renders emergency care at the scene of an emergency
2018 which occurs outside both the place and the course of that person's employment shall not be liable for
2019 any civil damages as the result of acts or omissions by that person in rendering the emergency care. This
2020 section shall not grant immunity from civil damages when the person is grossly negligent.

2021 California [Business & Professional Code § 2861.5](#) applies to licensed vocational nurses and states that a
2022 person licensed under this chapter [**licensed vocational nurse**] who in good faith renders emergency
2023 care at the scene of an emergency which occurs outside both the place and the course of his
2024 employment shall not be liable for any civil damages as the result of acts or omissions in rendering the
2025 emergency care. This section shall not be construed to grant immunity from civil damage to any person
2026 whose conduct in rendering emergency care is grossly negligent.

2027 California [Business & Professional Code § 3503.5](#) applies to physician's assistants and states that a
2028 person licensed under this chapter [**physician's assistant**] who in good faith renders emergency care at
2029 the scene of an emergency that occurs outside both the place and course of that person's employment
2030 shall not be liable for any civil damage as a result of any acts or omissions by that person in rendering the
2031 emergency care. This section shall not be construed to grant immunity from civil damages to any person
2032 whose conduct in rendering emergency care is grossly negligent. In addition to the immunity specified in
2033 subdivision (a), the provisions of Article 17 (commencing with Section 2395) of Chapter 5 shall apply to a
2034 person licensed under this chapter when acting pursuant to delegated authority from an approved
2035 supervising physician.

2036 **Qualified Immunities for Paid Personnel** - Immunities for paid personnel would fall under the authority
2037 of the employer. Paid personnel are subject to the terms and conditions of the employment agreement
2038 between an employer and the employee.
2039

Appendix A: Credentialing Glossary of Terms

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2042 **Credentials** are a health volunteer's qualifications. Credentials are used with an ESAR-VHP System to
2043 determine a health volunteer's Emergency Credential Level. According to JCAHO, credentials are the
2044 documented evidence of licensure, education, training experience, or other qualifications and are
2045 applicable to licensed independent practitioners such as physicians (MD or DO), advanced practice
2046 nurses, and physician assistants.

2047 **Credentialing** is the process of obtaining, verifying, and assessing the qualifications of a health care
2048 professional to provide patient care, treatment, and services in or for a health care organization.

2049 **Privileging** is the authorization granted by the health care entity for a qualified health professional to
2050 provide patient care, treatment, and services with or without supervision. Privileging is performed on a
2051 case-by-case basis and the responsibility for assigning privileges resides with the entity that receives
2052 volunteers in response to an emergency.

2053 **Primary source** is the original source of a specific credential that can verify the accuracy of a
2054 qualification reported by an individual health care professional.

2055 **Primary source verification** is the direct verification of a health care professional's credential(s) by the
2056 entity that issued the credential or by means of a Credential Verification Organization (CVO), or a Joint
2057 Commission for the Accreditation of Health Care Organizations (JCAHO) designated equivalent source.
2058 The term verify used in this section will refer to primary source verification unless noted otherwise.

2059 **Indeterminate** describes a credential that is not verified, and therefore, may or may not be possessed by
2060 the health volunteer.

2061 **Emergency Credentialing Standards** are a taxonomy intended to promote interoperability and
2062 integration of medical and health personnel commonly needed in an emergency response. Within the
2063 ESAR-VHP program, the application of emergency credentialing standards is a uniform process of
2064 classifying a health volunteer into an emergency credentialing level based on verified credentials
2065 possessed by the health volunteer.

2066 **Emergency Credentialing Level** is a designation assigned to a health volunteer registered in an ESAR-
2067 VHP System based on possessed and verified credentials, as defined by emergency credentialing
2068 standards. The highest emergency credential level is 1 and indicates that the health volunteer possesses
2069 all of the minimum required credentials and that the credentials have been appropriately verified.

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Appendix B: Regulation Text

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Maintenance & Organization of Personnel

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Government Code §8607 (Standardized Emergency Management System)

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CCR 22 §70217(a) (Nursing Service Staff)

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(a) Hospitals shall provide staffing by licensed nurses, within the scope of their licensure in accordance with the following nurse-to-patient ratios. Licensed nurse means a registered nurse, licensed vocational nurse and, in psychiatric units only, a licensed psychiatric technician. Staffing for care not requiring a licensed nurse is not included within these ratios and shall be determined pursuant to the patient classification system.

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No hospital shall assign a licensed nurse to a nursing unit or clinical area unless that hospital determines that the licensed nurse has demonstrated current competence in providing care in that area, and has also received orientation to that hospital's clinical area sufficient to provide competent care to patients in that area. The policies and procedures of the hospital shall contain the hospital's criteria for making this determination.

Licensed nurse-to-patient ratios represent the maximum number of patients that shall be assigned to one licensed nurse at any one time. "Assigned" means the licensed nurse has responsibility for the provision of care to a particular patient within his/her scope of practice. There shall be no averaging of the number

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2125 of patients and the total number of licensed nurses on the unit during any one shift nor over any period of
2126 time. Only licensed nurses providing direct patient care shall be included in the ratios.

2127
2128 Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Nurses, and other licensed
2129 nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those licensed
2130 nurses are engaged in providing direct patient care. When a Nurse Administrator, Nurse Supervisor,
2131 Nurse Manager, Charge Nurse or other licensed nurse is engaged in activities other than direct patient
2132 care, that nurse shall not be included in the ratio. Nurse Administrators, Nurse Supervisors, Nurse
2133 Managers, and Charge Nurses who have demonstrated current competence to the hospital in providing
2134 care on a particular unit may relieve licensed nurses during breaks, meals, and other routine, expected
2135 absences from the unit.

2136 Licensed vocational nurses may constitute up to 50 percent of the licensed nurses assigned to patient
2137 care on any unit, except where registered nurses are required pursuant to the patient classification
2138 system or this section. Only registered nurses shall be assigned to Intensive Care Newborn Nursery
2139 Service Units, which specifically require one registered nurse to two or fewer infants. In the Emergency
2140 Department, only registered nurses shall be assigned to triage patients and only registered nurses shall
2141 be assigned to critical trauma patients.

2142 Nothing in this section shall prohibit a licensed nurse from assisting with specific tasks within the scope of
2143 his or her practice for a patient assigned to another nurse. "Assist" means that licensed nurses may
2144 provide patient care beyond their patient assignments if the tasks performed are specific and time-limited.

2145 (1) The licensed nurse-to-patient ratio in a critical care unit shall be 1:2 or fewer at all times. "Critical care
2146 unit" means a nursing unit of a general acute care hospital which provides one of the following services:
2147 an intensive care service, a burn center, a coronary care service, an acute respiratory service, or an
2148 intensive care newborn nursery service. In the intensive care newborn nursery service, the ratio shall be
2149 1 registered nurse: 2 or fewer patients at all times.

2150 (2) The surgical service operating room shall have at least one registered nurse assigned to the duties for
2151 the circulating nurse and a minimum of one additional person serving as scrub assistant for each patient-
2152 occupied operating room. The scrub assistant may be a licensed nurse, an operating room technician, or
2153 other person who has demonstrated current competence to the hospitals as a scrub assistant but shall
2154 not be a physician or other licensed health professional who is assisting in the performance of surgery.

2155 (3) The licensed nurse-to-patient ratio in a labor and delivery suite of the perinatal service shall be 1:2 or
2156 fewer active labor patients at all times. When a licensed nurse is caring for antepartum patients who are
2157 not in active labor, the licensed nurse-to-patient ratio shall be 1:4 or fewer at all times.

2158
2159 (4) The licensed nurse-to-patient ratio in a postpartum area of the perinatal service shall be 1:4 mother-
2160 baby couplets or fewer at all times. In the event of multiple births, the total number of mothers plus infants
2161 assigned to a single licensed nurse shall never exceed eight. For postpartum areas in which the licensed
2162 nurse's assignment consists of mothers only, the licensed nurse-to-patient ratio shall be 1:6 or fewer at all
2163 times.

2164
2165 (5) The licensed nurse-to-patient ratio in a combined Labor/Delivery/Postpartum area of the perinatal
2166 service shall be 1:3 or fewer at all times the licensed nurse is caring for a patient combination of one
2167 woman in active labor and a postpartum mother and infant The licensed nurse-to-patient ratio for nurses
2168 caring for women in active labor only, antepartum patients who are not in active labor only, postpartum
2169 women only, or mother-baby couplets only, shall be the same ratios as stated in subsections (3) and (4)
2170 above for those categories of patients.

2171
2172 (6) The licensed nurse-to-patient ratio in a pediatric service unit shall be 1:4 or fewer at all times.

2173
2174 (7) The licensed nurse-to-patient ratio in a postanesthesia recovery unit of the anesthesia service shall be
2175 1:2 or fewer at all times, regardless of the type of anesthesia the patient received.

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2176
2177 (8) In a hospital providing basic emergency medical services or comprehensive emergency medical
2178 services, the licensed nurse-to-patient ratio in an emergency department shall be 1:4 or fewer at all times
2179 that patients are receiving treatment. There shall be no fewer than two licensed nurses physically present
2180 in the emergency department when a patient is present.

2181
2182 At least one of the licensed nurses shall be a registered nurse assigned to triage patients. The registered
2183 nurse assigned to triage patients shall be immediately available at all times to triage patients when they
2184 arrive in the emergency department. When there are no patients needing triage, the registered nurse may
2185 assist by performing other nursing tasks. The registered nurse assigned to triage patients shall not be
2186 counted in the licensed nurse-to-patient ratio.

2187
2188 Hospitals designated by the Local Emergency Medical Services (LEMS) Agency as a "base hospital", as
2189 defined in section 1797.58 of the Health and Safety Code, shall have either a licensed physician or a
2190 registered nurse on duty to respond to the base radio 24 hours each day. When the duty of base radio
2191 responder is assigned to a registered nurse, that registered nurse may assist by performing other nursing
2192 tasks when not responding to radio calls, but shall be immediately available to respond to requests for
2193 medical direction on the base radio. The registered nurse assigned as base radio responder shall not be
2194 counted in the licensed nurse-to-patient ratios.

2195
2196 When licensed nursing staff are attending critical care patients in the emergency department, the licensed
2197 nurse-to-patient ratio shall be 1:2 or fewer critical care patients at all times. A patient in the emergency
2198 department shall be considered a critical care patient when the patient meets the criteria for admission to
2199 a critical care service area within the hospital.

2200
2201 Only registered nurses shall be assigned to critical trauma patients in the emergency department, and a
2202 minimum registered nurse-to-critical trauma patient ratio of 1:1 shall be maintained at all times. A critical
2203 trauma patient is a patient who has injuries to an anatomic area that : (1) require life saving interventions,
2204 or (2) in conjunction with unstable vital signs, pose an immediate threat to life or limb.

2205
2206 (9) The licensed nurse-to-patient ratio in a step-down unit shall be 1:4 or fewer at all times. Commencing
2207 January 1, 2008, the licensed nurse-to-patient ratio in a step-down unit shall be 1:3 or fewer at all times.
2208 A "step down unit" is defined as a unit which is organized, operated, and maintained to provide for the
2209 monitoring and care of patients with moderate or potentially severe physiologic instability requiring
2210 technical support but not necessarily artificial life support. Step-down patients are those patients who
2211 require less care than intensive care, but more than that which is available from medical/surgical care.
2212 "Artificial life support" is defined as a system that uses medical technology to aid, support, or replace a
2213 vital function of the body that has been seriously damaged. "Technical support" is defined as specialized
2214 equipment and/or personnel providing for invasive monitoring, telemetry, or mechanical ventilation, for the
2215 immediate amelioration or remediation of severe pathology.

2216
2217 (10) The licensed nurse-to-patient ratio in a telemetry unit shall be 1:5 or fewer at all times. Commencing
2218 January 1, 2008, the licensed nurse-to-patient ratio in a telemetry unit shall be 1:4 or fewer at all times.
2219 "Telemetry unit" is defined as a unit organized, operated, and maintained to provide care for and
2220 continuous cardiac monitoring of patients in a stable condition, having or suspected of having a cardiac
2221 condition or a disease requiring the electronic monitoring, recording, retrieval, and display of cardiac
2222 electrical signals. "Telemetry unit" as defined in these regulations does not include fetal monitoring nor
2223 fetal surveillance.

2224
2225 (11) The licensed nurse-to-patient ratio in medical/surgical care units shall be 1:6 or fewer at all times.
2226 Commencing January 1, 2005, the licensed nurse-to-patient ratio in medical/surgical care units shall be
2227 1:5 or fewer at all times. A medical/surgical unit is a unit with beds classified as medical/surgical in which
2228 patients, who require less care than that which is available in intensive care units, step-down units, or
2229 specialty care units receive 24 hour inpatient general medical services, post-surgical services, or both
2230 general medical and post-surgical services. These units may include mixed patient populations of diverse
2231 diagnoses and diverse age groups who require care appropriate to a medical/surgical unit.

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2232
2233 (12) The licensed nurse-to-patient ratio in a specialty care unit shall be 1:5 or fewer at all times.
2234 Commencing January 1, 2008, the licensed nurse-to-patient ratio in a specialty care unit shall be 1:4 or
2235 fewer at all times. A specialty care unit is defined as a unit which is organized, operated, and maintained
2236 to provide care for a specific medical condition or a specific patient population. Services provided in these
2237 units are more specialized to meet the needs of patients with the specific condition or disease process
2238 than that which is required on medical/surgical units, and is not otherwise covered by subdivision (a).
2239

2240 (13) The licensed nurse-to-patient ratio in a psychiatric unit shall be 1:6 or fewer at all times. For purposes
2241 of psychiatric units only, "licensed nurses" also includes licensed psychiatric technicians in addition to
2242 licensed vocational nurses and registered nurses. Licensed vocational nurses, licensed psychiatric
2243 technicians, or a combination of both, shall not exceed 50 percent of the licensed nurses on the unit.
2244

2245 (14) Identifying a unit by a name or term other than those used in this subsection does not affect the
2246 requirement to staff at the ratios identified for the level or type of care described in this subsection.
2247

CCR 22 §70217(q) (Nursing Service Staff)

2249 The hospital shall plan for routine fluctuations in patient census. If a healthcare emergency causes a
2250 change in the number of patients on a unit, the hospital must demonstrate that prompt efforts were made
2251 to maintain required staffing levels. A healthcare emergency is defined for this purpose as an
2252 unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to healthcare
2253 delivery requiring immediate medical interventions and care.
2254

Business & Professions Code §3516 (Physician Assistants)

2256 Notwithstanding any other provision of law, any physician assistant licensed by the committee shall be
2257 eligible for employment or supervision by any physician approved by the board to supervise physician
2258 assistants, except that: (a) No physician shall supervise more than two physician assistants at any one
2259 time, except as provided in Sections 3502.5, 3516.1, and 3516.5. (b) The board may restrict physicians
2260 to supervising specific types of physician assistants including, but not limited to, restricting physicians
2261 from supervising physician assistants outside of the physician's field of specialty.
2262

Business & Professions Code §3502.5 (Physician Assistants)

2264 Notwithstanding any other provision of law, a physician assistant may perform those medical services
2265 permitted pursuant to Section 3502 during any state of war emergency, state of emergency, or state of
2266 local emergency, as defined in Section 8558 of the Government Code, and at the request of a
2267 responsible federal, state, or local official or agency, or pursuant to the terms of a mutual aid operation
2268 plan established and approved pursuant to the California Emergency Services Act (Chapter 7
2269 (commencing with Section 8550) of Division 1 of Title 2 of the Government Code), regardless of whether
2270 the physician assistant's approved supervising physician is available to supervise the physician assistant,
2271 so long as a licensed physician is available to render the appropriate supervision. "Appropriate
2272 supervision" shall not require the personal or electronic availability of a supervising physician if that
2273 availability is not possible or practical due to the emergency. The local health officers and their designees
2274 may act as supervising physicians during emergencies without being subject to approval by the board. At
2275 all times, the local health officers or their designees supervising the physician assistants shall be licensed
2276 physicians and surgeons. Supervising physicians acting pursuant to this section shall not be subject to
2277 the limitation on the number of physician assistants supervised under Section 3516. No responsible
2278 official or mutual aid operation plan shall invoke this section except in the case of an emergency that
2279 endangers the health of individuals. Under no circumstances shall this section be invoked as the result of
2280 a labor dispute or other dispute concerning collective bargaining.
2281

Occupational Safety Health (OSH) Act of 1970, Section 5 (OSH Act)

2283 Each employer shall furnish to each of his employees employment and a place of employment which are
2284 free from recognized hazards that are causing or are likely to cause death or serious physical harm to his
2285 employees.
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2288 ***Labor Code 6400 (CalOSHA)***

2289 (a) Every employer shall furnish employment and a place of employment that is safe and healthful for the
2290 employees therein. (b) On multiemployer worksites, both construction and nonconstruction, citations
2291 may be issued only to the following categories of employers when the division has evidence that an
2292 employee was exposed to a hazard in violation of any requirement enforceable by the division: (1) The
2293 employer whose employees were exposed to the hazard (the exposing employer). (2) The employer
2294 who actually created the hazard (the creating employer). (3) The employer who was responsible, by
2295 contract or through actual practice, for safety and health conditions on the worksite, which is the employer
2296 who had the authority for ensuring that the hazardous condition is corrected (the controlling employer).
2297 (4) The employer who had the responsibility for actually correcting the hazard (the correcting employer).
2298 The employers listed in paragraphs (2) to (4), inclusive, of this subdivision may be cited regardless of
2299 whether their own employees were exposed to the hazard. (c) It is the intent of the Legislature, in adding
2300 subdivision (b) to this section, to codify existing regulations with respect to the responsibility of employers
2301 at multiemployer worksites. Subdivision (b) of this section is declaratory of existing law and shall not be
2302 construed or interpreted as creating a new law or as modifying or changing an existing law.
2303

2304 ***Labor Code 6401 (CalOSHA)***

2305 Every employer shall furnish and use safety devices and safeguards, and shall adopt and use practices,
2306 means, methods, operations, and processes which are reasonably adequate to render such employment
2307 and place of employment safe and healthful. Every employer shall do every other thing reasonably
2308 necessary to protect the life, safety, and health of employees.
2309

2310 ***CCR 8 §3380 (CalOSHA)***

2311 (a) Protection where modified by the words head, eye, body, hand, and foot, as required by the orders in
2312 this article means the safeguarding obtained by means of safety devices and safeguards of the proper
2313 type for the exposure and of such design, strength and quality as to eliminate, preclude or mitigate the
2314 hazard. Note: In order that safety devices or safeguards, which may include personal protective
2315 equipment, be acceptable as to proper type, design, strength and quality they shall be at least equivalent
2316 to those complying with the standards approved by The American National Standards Institute, Bureau of
2317 Standards, or other recognized authorities, except that where no authoritative standard exists for a safety
2318 device or safeguard, the use of such safeguard or safety device shall be subject to inspection and
2319 acceptance or rejection by the Division. (b) Protective equipment shall be distinctly marked so as to
2320 facilitate identification of the manufacturer. Exception: Employer manufactured shields, barriers, etc.
2321 (c) The employer shall assure that the employee is instructed and uses protective equipment in
2322 accordance with the manufacturer's instructions. (d) The employer shall assure that all personal
2323 protective equipment, whether employer-provided or employee-provided, complies with the applicable
2324 Title 8 standards for the equipment. The employer shall assure this equipment is maintained in a safe,
2325 sanitary condition. (e) Protectors shall be of such design, fit and durability as to provide adequate
2326 protection against the hazards for which they are designed. They shall be reasonably comfortable and
2327 shall not unduly encumber the employee's movements necessary to perform his work.
2328

2329 ***Health & Safety Code §1288.5 et seq (Speier Bill)***

2330 By July 1, 2007, the department shall appoint a Healthcare Associated Infection (HAI) Advisory
2331 Committee that shall make recommendations related to methods of reporting cases of hospital acquired
2332 infections occurring in general acute care hospitals, and shall make recommendations on the use of
2333 national guidelines and the public reporting of process measures for preventing the spread of HAI that are
2334 reported to the department pursuant to subdivision (b) of Section 1288.8. The advisory committee shall
2335 include persons with expertise in the surveillance, prevention, and control of hospital-acquired infections,
2336 including department staff, local health department officials, health care infection control professionals,
2337 hospital administration professionals, health care providers, health care consumers, physicians with
2338 expertise in infectious disease and hospital epidemiology, and integrated health care systems experts or
2339 representatives.
2340

2341 ***California Industrial Welfare Commission Order No. 4-2001, 3(B)(9)-(10)***

2342 No employee assigned to work a 12-hour shift established pursuant to this order shall be required to work
2343 more than 12 hours in any 24-hour period unless the chief nursing officer or authorized executive

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2344 declares that: a “health care emergency”, as defined above, exists in this order; and all reasonable steps
2345 have been taken to provide required staffing; and considering overall operational status needs, continued
2346 overtime is necessary to provide required staffing. Provided further that no employee shall be required to
2347 work more than 16 hours in a 24-hour period unless by voluntary mutual agreement of the employee and
2348 the employer, and no employee shall work more than 24 consecutive hours until said employee receives
2349 not less than eight (8) consecutive hours off duty immediately following the 24 consecutive hours of work.
2350 Notwithstanding subsection (B)(9) above, an employee may be required to work up to 13 hours in any 24-
2351 hour period if the employee scheduled to relieve the subject employee does not report for duty as
2352 scheduled and does not inform the employer more than two (2) hours in advance of that scheduled shift
2353 that he/she will not be appearing for duty as scheduled.
2354

CCR 8 §9776.1

2355 An HCO shall maintain a return to work program in conjunction with the employer and claims
2356 administrator to facilitate and coordinate returning injured workers to the workplace, to assess the
2357 feasibility and availability of modified work or modified duty, and to minimize risk of employee exposure
2358 after return to work to risk factors which may aggravate or cause recurrence of injury. The duties of the
2359 HCO shall be specified in the contract between the HCO and the claims administrator.
2360
2361

Credentialing/ Personal Verification

Government Code §178, Article 4 (Interstate Civil Defense and Disaster Compact)

2362
2363
2364
2365 Whenever any person holds a license, certificate or other permit issued by any state evidencing the
2366 meeting of qualifications for professional, mechanical or other skills, such person may render aid involving
2367 such skill in any party state to meet an emergency or disaster and such state shall give due recognition to
2368 such license, certificate or other permit as if issued in the state in which aid is rendered.
2369
2370

Government Code §179.5, Article 5 (Emergency Management Assistance Compact)

2371 Whenever any person holds a license, certificate, or other permit issued by any state party to the compact
2372 evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such
2373 assistance is requested by the receiving party state, such person shall be deemed licensed, certified, or
2374 permitted by the state requesting assistance to render aid involving such skill to meet a declared
2375 emergency or disaster, subject to such limitations and conditions as the governor of the requesting state
2376 may prescribe by executive order or otherwise.
2377
2378

Business & Professions Code §921 (Health Care Professional Disaster Response Act)

2379 (a) The Legislature finds and declares the following: (1) In times of national or state disasters, a shortage
2380 of qualified health care practitioners may exist in areas throughout the state where they are desperately
2381 required to respond to public health emergencies. (2) Health care practitioners with lapsed or inactive
2382 licenses could potentially serve in those areas where a shortage of qualified health care practitioners
2383 exist, if licensing requirements were streamlined and fees curtailed. (b) It is, therefore, the intent of the
2384 Legislature to address these matters through the provisions of the Health Care Professional Disaster
2385 Response Act.
2386
2387

Business & Professions Code §922 (Health Care Professional Disaster Response Act)

2388 (a) A physician and surgeon who satisfies the requirements of Section 2439 but whose license has been
2389 expired for less than five years may be licensed under this chapter. (b) To be licensed under this chapter,
2390 a physician and surgeon shall complete an application, on a form prescribed by the Medical Board of
2391 California, and submit it to the board, along with the following: (1) Documentation that the applicant has
2392 completed the continuing education requirements described in Article 10 (commencing with Section 2190)
2393 of Chapter 5 for each renewal period during which the applicant was not licensed. (2) A complete set of
2394 fingerprints as required by Sections 144 and 2082, together with the fee required for processing those
2395 fingerprints. (c) An applicant shall not be required to pay any licensing, delinquency, or penalty fees for
2396 the issuance of a license under this chapter.
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2398

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2400 **Government Code §8571**

2401 During a state of war emergency or a state of emergency the Governor may suspend any regulatory
2402 statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or
2403 regulations of any state agency, including subdivision (d) of Section 1253 of the Unemployment Insurance
2404 Code, where the Governor determines and declares that strict compliance with any statute, order, rule, or
2405 regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.
2406

2407

2408 **Scope of Practice and Professional Liability**

2409

2410 **Business & Professions Code §4062(b)**

2411 a) Notwithstanding Section 4059 or any other provision of law, a pharmacist may, in good faith, furnish a
2412 dangerous drug or dangerous device in reasonable quantities without a prescription during a federal,
2413 state, or local emergency, to further the health and safety of the public. A record containing the date,
2414 name, and address of the person to whom the drug or device is furnished, and the name, strength, and
2415 quantity of the drug or device furnished shall be maintained. The pharmacist shall communicate this
2416 information to the patient's attending physician as soon as possible. Notwithstanding Section 4060 or any
2417 other provision of law, a person may possess a dangerous drug or dangerous device furnished without
2418 prescription pursuant to this section. (b) During a declared federal, state, or local emergency, the board
2419 may waive application of any provisions of this chapter or the regulations adopted pursuant to it if, in the
2420 board's opinion, the waiver will aid in the protection of public health or the provision of patient care.
2421

2422 **Government Code §8659 (Emergency Services Act)**

2423 Any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse,
2424 or dentist who renders services during any state of war emergency, a state of emergency, or a local
2425 emergency at the express or implied request of any responsible state or local official or agency shall have
2426 no liability for any injury sustained by any person by reason of such services, regardless of how or under
2427 what circumstances or by what cause such injuries are sustained; provided, however, that the immunity
2428 herein granted shall not apply in the event of a willful act or omission.
2429

2430 **Government Code §178, Article 5**

2431 No party state or its officers or employees rendering aid in another state pursuant to this compact shall be
2432 liable on account of any act or omission in good faith on the part of such forces while so engaged, or on
2433 account of the maintenance or use of any equipment or supplies in connection therewith.
2434

2435 **Volunteer Protection Act of 1997, Public Law 105-19, Section 4(a)**

2436 Except as provided in subsections (b) and (d), no volunteer of a nonprofit organization or governmental
2437 entity shall be liable for harm caused by the act or omission of the volunteer on behalf of the organization
2438 or entity if – (1) the volunteer was acting within the scope of the volunteer's responsibilities in the
2439 nonprofit organization or governmental entity at the time of the act or omission; (2) if appropriate or
2440 required, the volunteer was properly licensed, certified, or authorized by the appropriate authorities for the
2441 activities or practice in the State in which the harm occurred, where the activities were or practice was
2442 undertaken within the scope of the volunteer's responsibilities in the non-profit organization or
2443 governmental entity; (3) the harm was not caused by willful or criminal misconduct, gross negligence,
2444 reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed
2445 by the volunteer; and (4) the harm was not caused by the volunteer operating a motor vehicle, vessel,
2446 aircraft, or other vehicle for which the State requires the operator or the owner of the vehicle, craft, or
2447 vessel to – (A) possess and operator's license; or (B) maintain insurance.
2448

2449 **Business & Professions Code §2395 (Good Samaritan Laws)**

2450 No licensee, who in good faith renders emergency care at the scene of an emergency, shall be liable for
2451 any civil damages as a result of any acts or omissions by such person in rendering the emergency care.
2452 "The scene of an emergency" as used in this section shall include, but not be limited to, the emergency
2453 rooms of hospitals in the event of a medical disaster. "Medical disaster" means a duly proclaimed state of

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2454 emergency or local emergency declared pursuant to the California Emergency Services Act (Chapter 7
2455 (commencing with Section 8550) of Division 1 of Title 2 of the Government Code). Acts or omissions
2456 exempted from liability pursuant to this section shall include those acts or omissions which occur after the
2457 declaration of a medical disaster and those which occurred prior to such declaration but after the
2458 commencement of such medical disaster. The immunity granted in this section shall not apply in the
2459 event of a willful act or omission.
2460

Business & Professions Code §2395.5 (Good Samaritan Laws)

2461 (a) A licensee who serves on an on-call basis to a hospital emergency room, who in good faith renders
2462 emergency obstetrical services to a person while serving on-call, shall not be liable for any civil damages
2463 as a result of any negligent act or omission by the licensee in rendering the emergency obstetrical
2464 services. The immunity granted by this section shall not apply to acts or omissions constituting gross
2465 negligence, recklessness, or willful misconduct. (b) The protections of subdivision (a) shall not apply to
2466 the licensee in any of the following cases: (1) Consideration in any form was provided to the licensee for
2467 serving, or the licensee was required to serve, on an on-call basis to the hospital emergency room. In
2468 either event, the protections of subdivision (a) shall not apply unless the hospital expressly, in writing,
2469 accepts liability for the licensee's negligent acts or omissions. (2) The licensee had provided prior
2470 medical diagnosis or treatment to the same patient for a condition having a bearing on or relevance to the
2471 treatment of the obstetrical condition which required emergency services. (3) Before rendering
2472 emergency obstetrical services, the licensee had a contractual obligation or agreement with the patient,
2473 another licensee, or a third-party payer on the patient's behalf to provide obstetrical care for the patient, or
2474 the licensee had a reasonable expectation of payment for the emergency services provided to the patient.
2475 (c) Except as provided in subdivision (b), nothing in this section shall be construed to affect or modify the
2476 liability of the hospital for ordinary or gross negligence.
2477
2478

Business & Professions Code §2396 (Good Samaritan Laws)

2479 No licensee, who in good faith upon the request of another person so licensed, renders emergency
2480 medical care to a person for medical complication arising from prior care by another person so licensed,
2481 shall be liable for any civil damages as a result of any acts or omissions by such licensed person in
2482 rendering such emergency medical care.
2483
2484

Business & Professions Code §2398 (Good Samaritan Laws)

2485 No licensee, who in good faith and without compensation renders voluntary emergency medical
2486 assistance to a participant in a community college or high school athletic event or contest, at the site of
2487 the event or contest, or during transportation to a health care facility, for an injury suffered in the course of
2488 such event or contest, shall be liable for any civil damages as a result of any acts or omissions by such
2489 person in rendering such voluntary medical assistance. The immunity granted by this section shall not
2490 apply to acts or omissions constituting gross negligence.
2491
2492

Government Code §8657 (Emergency Services Act)

2493 (a) Volunteers duly enrolled or registered with the Office of Emergency Services or any disaster council of
2494 any political subdivision, or unregistered persons duly impressed into service during a state of war
2495 emergency, a state of emergency, or a local emergency, in carrying out, complying with, or attempting to
2496 comply with, any order or regulation issued or promulgated pursuant to the provisions of this chapter or
2497 any local ordinance, or performing any of their authorized functions or duties or training for the
2498 performance of their authorized functions or duties, shall have the same degree of responsibility for their
2499 actions and enjoy the same immunities as officers and employees of the state and its political
2500 subdivisions performing similar work for their respective entities. (b) No political subdivision or other
2501 public agency under any circumstances, nor the officers, employees, agents, or duly enrolled or
2502 registered volunteers thereof, or unregistered persons duly impressed into service during a state of war
2503 emergency, a state of emergency, or a local emergency, acting within the scope of their official duties
2504 under this chapter or any local ordinance shall be liable for personal injury or property damage sustained
2505 by any duly enrolled or registered volunteer engaged in or training for emergency preparedness or relief
2506 activity, or by any unregistered person duly impressed into service during a state of war emergency, a
2507 state of emergency, or a local emergency and engaged in such service. The foregoing shall not affect the
2508 right of any such person to receive benefits or compensation which may be specifically provided by the
2509

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2510 provisions of any federal or state statute nor shall it affect the right of any person to recover under the
2511 terms of any policy of insurance. (c) The California Earthquake Prediction Evaluation Council, an
2512 advisory committee established pursuant to Section 8590 of this chapter, may advise the Governor of the
2513 existence of an earthquake or volcanic prediction having scientific validity. In its review, hearings,
2514 deliberations, or other validation procedures, members of the council, jointly and severally, shall have the
2515 same degree of responsibility for their actions and enjoy the same immunities as officers and employees
2516 of the state and its political subdivisions engaged in similar work in their respective entities. Any person
2517 making a presentation to the council as part of the council's validation process, including presentation of a
2518 prediction for validation, shall be deemed a member of the council until the council has found the
2519 prediction to have or not have scientific validity.

2520

2521 **CCR 19 §2570.2 (Definition of Disaster Service)**

2522 (1) Disaster service means all activities authorized by and carried on pursuant to the California
2523 Emergency Services Act, including approved and documented training necessary or proper to engage in
2524 such activities. (2) Exclusion. Disaster service does not include any activities or functions performed by a
2525 person if the disaster council with which the person is registered receives a fee or other compensation for
2526 the performance of that person's activities or functions.

2527

2528 **CCR 19 §2572.2 (Definition of Disaster Service)**

2529 Each disaster service worker in any classification shall, without regard to a formal designation or
2530 assignment, be considered to be acting within the scope of disaster service duties while assisting any unit
2531 of the emergency organization or performing any act contributing to the protection of life or property, or
2532 mitigating the effects of an emergency or potential emergency either:
2533 (a) under the authorization of a duly constituted superior in the emergency organization; or, (b) under the
2534 supervision and direction of the American Red Cross while carrying out its programs in consonance with
2535 state and local statements of understanding, or in carrying out a mission assigned to that agency by a
2536 responsible state or local authority.

2537

2538 **Civil Code §1714.5**

2539 There shall be no liability on the part of one, including the State of California, county, city and county, city
2540 or any other political subdivision of the State of California, who owns or maintains any building or
2541 premises which have been designated as a shelter from destructive operations or attacks by enemies of
2542 the United States by any disaster council or any public office, body, or officer of this state or of the United
2543 States, or which have been designated or are used as mass care centers, first aid stations, temporary
2544 hospital annexes, or as other necessary facilities for mitigating the effects of a natural, manmade, or war-
2545 caused emergency, for any injuries arising out of the use thereof for such purposes sustained by any
2546 person while in or upon said building or premises as a result of the condition of said building or premises
2547 or as a result of any act or omission, or in any way arising from the designation of such premises as a
2548 shelter, or the designation or use thereof as a mass care center, first aid station, temporary hospital
2549 annex, or other necessary facility for emergency purposes, except a willful act, of such owner or occupant
2550 or his servants, agents or employees when such person has entered or gone upon or into said building or
2551 premises for the purpose of seeking refuge, treatment, care, or assistance therein during destructive
2552 operations or attacks by enemies of the United States or during tests ordered by lawful authority or during
2553 a natural or manmade emergency. No disaster service worker who is performing disaster services
2554 ordered by lawful authority during a state of war emergency, a state of emergency, or a local emergency,
2555 as such emergencies are defined in Section 8558 of the Government Code, shall be liable for civil
2556 damages on account of personal injury to or death of any person or damage to property resulting from
2557 any act or omission in the line of duty, except one that is willful.

2558

2559 **Civil Code §1714.6**

2560 The violation of any statute or ordinance shall not establish negligence as a matter of law where the act or
2561 omission involved was required in order to comply with an order or proclamation of any military
2562 commander who is authorized to issue such orders or proclamations; nor when the act or omission
2563 involved is required in order to comply with any regulation, directive, or order of the Governor
2564 promulgated under the California Emergency Services Act. No person shall be prosecuted for a violation
2565 of any statute or ordinance when violation of such statute or ordinance is required in order to comply with

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2566 an order or proclamation of any military commander who is authorized to issue such orders or
2567 proclamations; nor shall any person be prosecuted for a violation of any statute or ordinance when
2568 violation of such statute or ordinance is required in order to comply with any regulation, directive, or order
2569 of the Governor promulgated under the California Emergency Services Act. The provisions of this section
2570 shall apply to such acts or omissions whether occurring prior to or after the effective date of this section.
2571

2572 **Civil Code 1714.2**

2573 (a) In order to encourage citizens to participate in emergency medical services training programs and to
2574 render emergency medical services to fellow citizens, no person who has completed a basic
2575 cardiopulmonary resuscitation course which complies with the standards adopted by the American Heart
2576 Association or the American Red Cross for cardiopulmonary resuscitation and emergency cardiac care,
2577 and who, in good faith, renders emergency cardiopulmonary resuscitation at the scene of an emergency
2578 shall be liable for any civil damages as a result of any acts or omissions by such person rendering the
2579 emergency care. (b) This section shall not be construed to grant immunity from civil damages to any
2580 person whose conduct in rendering such emergency care constitutes gross negligence. (c) In order to
2581 encourage local agencies and other organizations to train citizens in cardiopulmonary resuscitation
2582 techniques, no local agency, entity of state or local government, or other public or private organization
2583 which sponsors, authorizes, supports, finances, or supervises the training of citizens in cardiopulmonary
2584 resuscitation shall be liable for any civil damages alleged to result from such training programs. (d) In
2585 order to encourage qualified individuals to instruct citizens in cardiopulmonary resuscitation, no person
2586 who is certified to instruct in cardiopulmonary resuscitation by either the American Heart Association or
2587 the American Red Cross shall be liable for any civil damages alleged to result from the acts or omissions
2588 of an individual who received instruction on cardiopulmonary resuscitation by that certified instructor. (e)
2589 This section shall not be construed to grant immunity from civil damages to any person who renders such
2590 emergency care to an individual with the expectation of receiving compensation from the individual for
2591 providing the emergency care.
2592

2593 **Civil Code 1714.21**

2594 (a) For purposes of this section, the following definitions shall apply: (1) "AED" or "defibrillator" means an
2595 automated or automatic external defibrillator. (2) "CPR" means cardiopulmonary resuscitation. (b) Any
2596 person who, in good faith and not for compensation, renders emergency care or treatment by the use of
2597 an AED at the scene of an emergency is not liable for any civil damages resulting from any acts or
2598 omissions in rendering the emergency care. (c) A person or entity who provides CPR and AED training
2599 to a person who renders emergency care pursuant to subdivision (b) is not liable for any civil damages
2600 resulting from any acts or omissions of the person rendering the emergency care. (d) A person or entity
2601 that acquires an AED for emergency use pursuant to this section is not liable for any civil damages
2602 resulting from any acts or omissions in the rendering of the emergency care by use of an AED, if that
2603 person or entity has complied with subdivision (b) of Section 1797.196 of the Health and Safety Code.
2604 (e) A physician who is involved with the placement of an AED and any person or entity responsible for the
2605 site where an AED is located is not liable for any civil damages resulting from any acts or omissions of a
2606 person who renders emergency care pursuant to subdivision (b), if that physician, person, or entity has
2607 complied with all of the requirements of Section 1797.196 of the Health and Safety Code that apply to that
2608 physician, person, or entity. (f) The protections specified in this section do not apply in the case of
2609 personal injury or wrongful death that results from the gross negligence or willful or wanton misconduct of
2610 the person who renders emergency care or treatment by the use of an AED. (g) Nothing in this section
2611 shall relieve a manufacturer, designer, developer, distributor, installer, or supplier of an AED or
2612 defibrillator of any liability under any applicable statute or rule of law.
2613

2614 **Civil Code 1797.196**

2615 (a) For purposes of this section, "AED" or "defibrillator" means an automated or automatic external
2616 defibrillator. (b) In order to ensure public safety, any person who acquires an AED shall do all of the
2617 following: (1) Comply with all regulations governing the training, use, and placement of an AED. (2)
2618 Notify an agent of the local EMS agency of the existence, location, and type of AED acquired. (3)
2619 Ensure all of the following: (A) That expected AED users complete a training course in cardiopulmonary
2620 resuscitation and AED use that complies with regulations adopted by the Emergency Medical Services
2621 (EMS) Authority and the standards of the American Heart Association or the American Red Cross. (B)

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2622 That the defibrillator is maintained and regularly tested according to the operation and maintenance
2623 guidelines set forth by the manufacturer, the American Heart Association, and the American Red Cross,
2624 and according to any applicable rules and regulations set forth by the governmental authority under the
2625 federal Food and Drug Administration and any other applicable state and federal authority. (C) That the
2626 AED is checked for readiness after each use and at least once every 30 days if the AED has not been
2627 used in the preceding 30 days. Records of these periodic checks shall be maintained. (D) That any
2628 person who renders emergency care or treatment on a person in cardiac arrest by using an AED
2629 activates the emergency medical services system as soon as possible, and reports any use of the AED to
2630 the licensed physician and to the local EMS agency. (E) That there is involvement of a licensed
2631 physician in developing a program to ensure compliance with regulations and requirements for training,
2632 notification, and maintenance. (c) A violation of this provision is not subject to penalties pursuant to
2633 Section 1798.206. (d) This section shall become operative on January 1, 2013.
2634

Business & Professions Code §1627.5

2636 No person licensed under this chapter, who in good faith renders emergency care at the scene of an
2637 emergency occurring outside the place of that person's practice, or who, upon the request of another
2638 person so licensed, renders emergency care to a person for a complication arising from prior care of
2639 another person so licensed, shall be liable for any civil damages as a result of any acts or omissions by
2640 that person in rendering the emergency care.
2641

Business & Professions Code §2727.5

2643 **2727.5.** A person licensed under this chapter who in good faith renders emergency care at the scene of
2644 an emergency which occurs outside both the place and the course of that person's employment shall not
2645 be liable for any **civil** damages as the result of acts or omissions by that person in rendering the
2646 emergency care. This section shall not grant immunity from **civil** damages when the person is grossly
2647 negligent.
2648

Business & Professions Code §2861.5

2649 A person licensed under this chapter who in good faith renders emergency care at the scene of an
2650 emergency which occurs outside both the place and the course of his employment shall not be liable for
2651 any **civil** damages as the result of acts or omissions in rendering the emergency care. This section shall
2652 not be construed to grant immunity from **civil** damage to any person whose conduct in rendering
2653 emergency care is grossly negligent.
2654

Business & Professions Code §3503.5

2655 (a) A person licensed under this chapter who in good faith renders emergency care at the scene of an
2656 emergency that occurs outside both the place and course of that person's employment shall not be liable
2657 for any **civil** damage as a result of any acts or omissions by that person in rendering the emergency care.
2658 (b) This section shall not be construed to grant immunity from **civil** damages to any person whose
2659 conduct in rendering emergency care is grossly negligent. (c) In addition to the immunity specified in
2660 subdivision (a), the provisions of Article 17 (commencing with Section 2395) of Chapter 5 shall apply to a
2661 person licensed under this chapter when acting pursuant to delegated authority from an approved
2662 supervising physician.
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2665

Endnotes

¹ California Emergency Services Authority. Hospital Incident Command System (HICS) Frequently Asked Questions. <http://www.emsa.ca.gov/hics/faq.doc>

² California Emergency Services Authority. Hospital Incident Command System (HICS) Guidebook. August 2006. http://www.emsa.ca.gov/hics/hics_guidebook_and_glossary.pdf

³ Hospital Council of Northern & Central California. Sacramento County Hospital Mutual Aid Memorandum of Understanding.

⁴ Fernandez, Lauren, and Joseph Barbera. *Strategies for Managing Volunteers during Incident Response: A Systems Approach*. 2006

⁵ CCR 22 §71215(e) Acute Psych Hospitals, §72329 Skilled Nursing Facilities, §73319 Intermediate Care Facilities, §75028 Primary Care Clinics. §76355, Intermediate Care Facilities – Developmentally Disabled, §76878 Intermediate Care Facilities – Developmentally Disabled/Habilitative, §77061 Psychiatric Health Facilities, §78313 Adult Day Health Centers, §79631 Correctional Treatment Centers

⁶ CCR 22 §70129 General Acute Care Hospitals, §71127 Acute Psychiatric Hospitals, §72213 – Skilled Nursing Facilities, §73227 – Intermediate Care Facilities, §74689 – Home Health Agencies, §76227 – Intermediate Care Facilities – Developmental Disabled, §76852 – Intermediate Care Facilities – Developmental Disabled – Habilitative, §77049 – Psychiatric Health Facility, §78217 – Adult Day Health Center, and §79593 – Correctional Treatment Center

⁷ Agency for Healthcare Research and Quality *Reopening Shuttered Hospitals to Expand Surge Capacity*. AHRQ Publication No. 06-0029, Rockville, MD: February 2006. <http://www.ahrq.gov/research/shuttered/shuthosp.htm>

⁸ State of Wisconsin. Guidelines for Managing Inpatient and Outpatient Surge Capacity, Recommendations of the State Expert Panel on Inpatient and Outpatient Surge Capacity. November 2005.

⁹ Scripps Mercy Hospital. July 2006.

¹⁰ Sutter Health System

¹¹ The Joint Commission. *Comprehensive Accreditation Manual for Hospitals*. Oakbrook Terrace: Joint Commission Resources. 2007

¹² Health Resources and Services Administration. Emergency System for the Advanced Registration of Volunteer Health Professionals – Interim Technical and Policy Guidelines, Standards and Definitions Version 2 June 2005. Appendix 1: State and Institutional Approaches to Training. http://www.hrsa.gov/esarvhp/guidelines/guide_app1.htm

¹³ Sutter Medical Center, Sacramento – Medical Staff Rules

¹⁴ American Academy of Physician Assistants. *Guidelines for Amending Hospital Staff Bylaws*. Alexandria, VA: October 2005. <http://www.aapa.org/policy/hospital-staff-bylaws.htm>

¹⁵ Sutter Health Affiliate – Circumstances for Granting Emergency Privileges in a Disaster

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¹⁶ California Emergency Medical Services Authority. Hospital Incident Command System Guidebook. 2006. <http://www.emsa.ca.gov/hics/hics%20guidebook%20and%20glossary.pdf>

¹⁷ California Governor's Office of Emergency Services. *Disaster Service Worker Volunteer Program (DSWVP) Guidance*. April 2001.