UNIVERSITY OF TOLEDO HEALTH SCIENCE CAMPUS

SUBJECT: CODE YELLOW – MASS CASUALTY DISASTER PROCEDURE

Procedure No: EP-08-001

PROCEDURE STATEMENT

The Code Yellow Mass Casualty Disaster Procedure is an Annex of the University of Toledo Medical Center Emergency Operations Plan and will be activated by the Incident Commander when the potential exists for the Emergency Department to be overwhelmed by a sudden influx of patients.

PURPOSE OF PROCEDURE

Provide rapid treatment to incoming patients and a clear process to activate the Hospital Incident Command system and accomplish critical tasks.

INFORMATION

Requested staff, physicians and volunteers awaiting assignments during a Code Yellow are to report to the Hospital Lobby near the Information Desk. DO NOT REPORT DIRECTLY TO THE EMERGENCY DEPARTMENT OR COMMAND CENTER UNLESS REQUESTED BY THE INCIDENT COMMANDER OR DESIGNEE.

(NOTE: the incident command structure will be opened and implemented as widely as needed, depending on the nature of the disaster the hospital or community is facing).

ACTIVATION

The House Supervisor when the Emergency Event begins will act as the initial Incident Commander and may be delegated to another person as the Emergency Operations Plan is fully activated. A Code Yellow may be called in connection with other emergency situations on campus (i.e., Code Orange, Code Red, Loss of Electrical Power, etc.) if these situations require the activation of the Emergency Operations Plan and subsequently the Hospital Incident Command System (HICS).

Step #1:

- Call 419-383-2600 to contact the Hospital Security.
- If necessary, the Campus Security Levels and Lockdown policy will be activated for the appropriate locations.

Step #2:

- The HSC Security Director or senior security officer on duty will contact the Medical Director of the ED, Nursing Director of the ED or designee, Environmental Health and Radiation Staff and Hospital Administration who will be requested to meet in the command center in MLB 202, or virtually if needed. The decision whether to call a Code Yellow will be made at this time.
- The Command Center will evaluate the need to fully activate the Emergency Operations Plan, HICS and the complete Code Yellow Response Annex.

Step #3:

- Establish the command center in Room 202 (Board Room) on the second floor of Mulford Library Building. The Mulford Library Alumni Lounge in the basement is designated as the backup command center. (See instructions posted at each location.)

TRIAGE

Priority		Location	Color Code
I:	Immediate	Emergency Department (PACU Red Overflow)	Red
II:	Delayed	George Isaac Surgery Center	Yellow
III:	Minor	Heart & Vascular	Green
IV:	Expectant/Deceased	Expectant Clinics (BOP Room,2nd Floor), Deceased (HSB Basement) (see Mass Fatality Plan, EP-08-12.)	Black

LOCATION OF FUNCTIONS, ETC.

Command Center:	Room 202 on the second floor of Mulford Library, or in the Alumni Lounge in Mulford Library
Staging for Staff Assignments:	Hospital Lobby Adjacent to Information Desk
Discharged Disaster Victims:	Hospital Cafeteria
Communications Desk (News Media):	Ortho Clinic/Medical Pavilion
Discharged In-House Patients:	Hospital Cafeteria
Families, Friends of Disaster Victims:	MLB Basement (ICare Room)

TWO-WAY RADIO COMMUNICATIONS

- OPS Channel 1 is approved for Emergency Communications between Incident Commander, Liaison, Safety/Security, Public Information Officers and subordinate Section Chiefs. The radio emergency channel is to **ONLY** be used for special announcements to all radio groups from the Command Center.
- Post-Op Recovery Room, George Isaac Surgery Center, Ambulatory Clinic, O.R. and House Supervisor will be using radio OPS Channel 2.
- The Triage area, Emergency Department and Decon Team shall use OPS Channel 3 for communications and dedicated 2-way radios.
- Maintenance, Hospital Administration, Environmental Services, Transport and other departments will utilize their departmental channels and switch to OPS channels only when required.

DISASTER TELEPHONE LINES FOR CALLS INTO THE COMMAND CENTER, USE:

Additional lines available 419-383-5701; 419-383-5702; 419-383-5703; 419-383-5704
Main Communication Line (rear room counter) – 419-383-5488

FOR CALLS INTO TRIAGE AREA USE:

419-383-3888	ED	Priority I
419-383-3904	PACU	Priority I
419-383-4024	GIMI	Priority II
419-383-3963	1st Floor Clinics	Priority III

FREQUENTLY CALLED NUMBERS

419-530-5549	Office of Communications
419-383-3470	Lab
419-383-4123	Temporary Morgue in HSB Basement

ABBREVIATIONS

1. ED = Emergency Department
2. PACU = Post Anesthesia Care Unit
3. OPD = Outpatient Clinics
4. OR = Operating Room
5. OD = Laboratory Officer of the Day (Pathology)
6. RT = Respiratory Therapy

7. GIMI = George Isaac Minimally Invasive Surgery Center

SECTION 1. GOALS AND EMPLOYEE OBLIGATION

A. Goal

1. Provide an efficient operation to ensure maximum flexibility for the delivery of optimum care to victims of a mass casualty event/disaster, or unforeseen calamity, involving large numbers of people.

B. Employee Obligation

1. Each employee must be familiar with the Plan, paying specific attention to his/her departmental plan, to allow for the best possible care when large and unexpected numbers of casualties arrive at UTMC.
2. Each employee must be ready to assume duties that may not fall into his/her particular area of employment as listed on the HICS job action sheets distributed during disaster. For example, an RN may be assigned to alternate duty assisting security in securing hospital entrance doors to prevent an uncontrolled influx of contaminated patients. An Environmental Services employee may be pressed into service as an escort for family members of victims as they are staged in the hospital cafeteria . Depending upon the nature of the disaster, employees may or may not perform regular duties.
3. The Staging Manager is ultimately responsible for assigning staff as needed and the situation dictates.

SECTION 2. ACTIVATION OF HOSPITAL INCIDENT COMMAND SYSTEM (HICS)

When the Emergency Department receives notification of an emergency resulting in mass casualties, the person receiving the information shall notify the nurse in charge of the Emergency Department (who shall notify the House Supervisor). The lead/charge nurse in the Emergency Department and or the House Supervisor have the authority to call a “Code Yellow.”

A. Communication

1. The ED lead/charge nurse or House Supervisor shall notify Hospital Security at 419-383-2600 of the Code Yellow.
2. The operator activates the emergency tone device and page the following, three times. "Attention all personnel, Code Yellow, Phase I, report to your department for further instructions
3. Operator will send out a UT Alert group message indicating “Code Yellow” and the Phase.
4. Disaster: Phase 0
    a. Phase 0 is a warning that the Emergency Department may have an influx of patients.
    b. Under Phase 0, all personnel should remain within their department unless otherwise instructed by their department head. Each department should prepare for implementing their disaster protocol.
    c. The Command Center may be opened at this time, if deemed necessary.
    d. No hospital personnel should call the Emergency Department during the Phase 0 to request further disaster information.
    e. Assessment of critical care and overall patient bed and stretcher availability should be made at this time from each patient care area and information should be transmitted, when requested, to the command center.

Disaster: Phase 1

a. Phase 1 occurs when the Emergency Department has exhausted its capabilities and a request will be made for additional resources.
b. A Phase 1 may be called based on an assessment of the event. The determination to move to a Phase 1 will be based on the need for additional resources which will be determined by the command staff. Should the need exist for additional resources, a staging area will be opened in the lobby.
c. The Staging Area will be established in the Hospital Lobby by the Operations Chief for the assignment of all additional persons involved in the emergency response. The Staging Manager, or designee, will be the initial point of contact to whom staff report in the incident command structure. Should the emergency event/disaster entail activation of the community area command structure, staff will report, as needed, to their department head. The department head shall report to the Planning Chief in the hospital's command structure. The Planning Chief allocates resources to the hospital or the community, wherever the need is greater.
d. Under Phase 1 individual departmental disaster procedures are activated (mainly the ED, Radiology, Trauma and possibly other departments).
e. The Command Center will be opened and staffed.
f. Communication lines will remain open between the Command Center and the Emergency Department.
g. Hospital transporters should assemble and prepare triage area to receive patients by retrieving stretchers from patient floors, taking them to the area north of ED.

3. Message all key personnel to "Report to the Command Center" via UT Alert for a Code Yellow. Phase 0 pages will include a smaller subset of the Phase 1 UT Alerts.

4. The Operator may contact by phone all on-duty residents, Respiratory Therapy, and EKG and Trauma pagers including the O.R. as directed by the Incident Commander.

B. Communication with Patient-Care Areas

Two-way radios will be made available from Transport. Maximum of 10 available.

1. These will be available Emergency Department, Triage area, Post-op Recovery, George Isaac Charge Staff, HICS Command Staff and Chiefs, Ambulatory Clinic, O.R. and House Supervisor for the purpose of communications between thesedepartments without interruption from other outside sources.

2. Staff will deliver additional two-way radios to the Emergency Department. Other available radios will be prestaged, or delivered to the Command Center (MLB 202) for use by selected personnel.

3. If necessary, the Logistics Chief will retrieve any additional two-way radios from designated departments, returning the radios to the Command Center for distribution.

C. Communication with the Employees.

1. Current information may be dessiminated via overhead announcements, UT Alert, EMTrack and email/web.

2. The Planning Chief may recall employees to the Staging Area unless otherwise instructed.

3. If telephone communications are interrupted, the Logistics Chief will institute the Emergency Communication System Plan (EP-08-011).

4. When all communications are interrupted, the hospital will rely on personnel on duty.

a. Any nursing personnel, volunteers, and other staff reporting for duty must report to the Staging Area location adjacent to the Information Desk in the Main Lobby via the east entrance to the hospital (Mulford Library side) and park in Lot #44.

D. Communication with the Medical Staff and Residents:

1. Overhead announcements, and email/web can be used by all staff to obtain current information.

2. All in-house physicians including residents - with the exception of anesthesiologists as mentioned below - should report to the Hospital lobby to the Staging Area once they hear the "Code Yellow" alert on their beeper or on the overhead system.

3. Anesthesiologists - all anesthesiologists should respond as follows:

   a. The senior member of the Division of Anesthesiology, should report to the Surgical Control Desk, 2nd Floor, hospital, to assume control of PACU patient disposition as well as continued triage and treatment of victims referred to the PACU.

   b. Additional anesthesiologists should report to the Main Surgical Control Desk, or to the George Isaac Desk for directions from the senior attending anesthesiologist.

4. Outpatient Clinic - Physician in charge of the emergency will appoint physicians to outpatient area. Senior medical resident or designee will assume control of the department. Also, a surgical resident will be assigned to this area for minor surgical procedures.

E. Activation of Departments and Modification of Services

1. All department heads or designees contacted by the operator shall inform the Planning Chief of their notification and report to the General Nursing Care Unit Leader on the readiness of their departments. Discussions will focus on what hospital services to temporarily discontinue or modify (such as elective surgeries).

2. Lead/charge nurses from clinical units will assess bed availability and initiate immediate discharge of patients able to be sent home, if necessary to accommodate casualties through coordination with the Discharge Unit Leader.

3. Patient Tracking Manager (Admitting Department) will call for status of bed availability, and will take part in discussions involving the scheduling of hospital services as needed in response to the unique circumstances of the disaster (for example, little surgery needed, but significant decontamination follow-up care needed).

4. For extended patient-surge events the UTMC Infectious Disease Agent Plan and Max-Surge Plan will be activated.

F. Activation of Community-Wide Response

In the event of a disaster that involves the entire community and/or a response that requires the resources of multiple hospitals, community-wide efforts of disaster response will be implemented as follows:

1. Upon receiving notification of a major community-wide disaster, the Incident Commander, or Liaison Officer will initiate contact with the EMS Command Center located in the EMS Building near downtown Toledo, in order to integrate UTMC into the community-wide area command structure.

SECTION 3. TRIAGE

A. Code Yellow

The switchboard operator will announce the appropriate code as instructed by the Incident Commander in conjunction with the House Supervisor or Associate Hospital Administrator/Chief Nursing Officer. To provide optimal care, a phased disaster program has been adopted.

1. Code Yellow, Phase 0: High probability of disaster with multiple victims.

   a. Warning only

   b. All hospital personnel should remain in assigned department until further notice, unless instructed otherwise by department head/supervisor.

   c. Announcement of Code Yellow Phase I or termination/cancellation will be forthcoming.

B. Triage Procedure

1. Primary Triage Area (Initially in Cold Zone under Ambulance Canopy)

   a. Later it will be relocated to outside of the north side of the Emergency Department. Maintenance will assemble blue curtains from basement of ED and proceed to enclose the old ED canopy area.

   b. If the weather is cold, Maintenance personnel will place the portable heater from the basement of the ED in the assembled canopy area.

   c. Public Safety personnel will be responsible for crowd control.

   d. Persons assigned to the Primary Triage Area are directed by the Treatment Area Supervisor and/or Triage Unit Leader and at a minimum will be staffed by the Emergency Department physician or designee, a Clerical Specialist, an emergency nurse, and multiple transporters.

      1. All other persons are to remain away from this area, unless they are specifically assigned by the Triage Unit Leader.

      2. Transport personnel will be responsible for bringing all available stretchers, backboards, and supplies to the triage area for exchange and rapid patient transfer with EMS personnel.

2. Triage Personnel

   a. The Triage Unit Leader can be the Emergency Department attending physician or designee. For a Phase II disaster (greater than 15 patients) a second triage officer will be assigned by the Triage Unit Leader to assist in patient evaluation in the triage process.

   b. The Immediate Treatment Unit Leader can be the Nursing Director or emergency lead/charge nurse or designee on duty at the time of the activation of the plan. Overflow Red (Priority I) patients will be sent to the PACU for management by recovery and O.R. staff.

   c. The Delayed Treatment Unit Leader in George Isaac Surgery Center (Priority II) can be the Nursing Director, or in his/her absence, a House Supervisor or an experienced critical care nurse as assigned by the House Supervisor.

   d. The Minor Treatment Unit Leader in the Outpatient Clinic (Priority III) can be the Nursing Director, or in his/her absence, either a House Supervisor, or designee.

3. Triage Rating System and Treatment Areas**

		Arm Tags
Priority I:	Emergency Department (Overflow to PACU)- Immediate	Red
Priority II:	George Isaac Min. Invas. Surg. Center - Delayed	Yellow
Priority III:	Outpatient Clinic 1B - Minor	Green
Priority IV:	2nd Floor Clinics - Expectant	Black

PRIORITY I: IMMEDIATE (RED)

1. Asphyxia
2. Respiratory obstruction
3. Sucking chest wounds
4. Tension pneumothorax
5. Shock
6. Hemorrhage
7. Cardiac injuries
8. Severe burns
9. Major fractures
10. Major medical problems
11. Cerebral injuries
12. Spinal cord injuries
13. Other as applicable

PRIORITY II: DELAYED (YELLOW)

1. Vascular Injuries
2. Wounds of the genitourinary tract
3. Thoracic injuries
4. Burns
5. Fractures
6. Eye injuries
7. Others as applicable

PRIORITY III: MINOR (GREEN)

1. Ambulatory
2. Non-critical
3. First-aid measures
4. Others as applicable

PRIORITY IV: EXPECTANT (BLACK)

1. Unsalvageable patients with lethal injuries
2. Deceased

a. Any Priority I victim may be taken to the Priority I area of PACU if the Emergency Department should become overloaded. Facilities are such that the same type of intensive care and treatment could be managed without delay or difficulty.

b. In a situation when the hospital is full or damaged, the victims to be admitted will remain in the treatment areas or holding area until beds are available (the Discharge Unit Leader by discharging other patients or opening new beds) in the hospital and/or arrangements made to transfer the patients to other area hospitals. Activation of the Patient Surge Procedure should be initiated by the Incident Commander to free up additional space for treatment of patients.

   In a situation where one of the treatment areas (Emergency Department, PACU, 1st Floor Clinics) is damaged then victims will be taken to the next highest functioning priority treatment area (not damaged) at that time until they are stabilized and admitted or go to operating room or are discharged.

c. All patients transferred to 1st Floor Clinics (low priority/green) should be transferred through the back hallway entrance located on the west side of the main lobby.

d. The Collier Building has been tested as an Alternate Care Facility (ACF) and will be used when the Hospital has extensive damage.

C. Information and Paper Flow

1. Papers and Forms Used

   a. Color-coded folder for each of the Treatment Areas

      1. Contains form for Nursing Notes, Assessment form, Physician's Orders and Treatment, x-ray form, Lab form

      2. Colors Are:
         a) Red = Emergency Department / Post Anesthesia Care Unit

b) Yellow = George Isaac Minimally Invasive Surgery Center
c) Green = Clinic
d) Black = Expectant/Deceased

3. Armbands are the same color as the folders.

b. Victim Flow Log (EMTrack)

1. One is used for each Treatment Area and maintained by the Patient Tracking Manager which can be clerical personnel.

2. Should be turned in to the Planning Chief in the Hospital lobby at the conclusion of the disaster.

3. Purpose is to keep accurate account of all the disaster victims.

c. Disaster Chart

1. Affixed to the clipboard for each patient in each treatment area.

2. To be filled in by a Clerical Specialist, or a nurse, time permitting. A physician will fill out his or her part.

3. Last two copies of the Disaster Chart are to be sent to the Command Center.

4. First, or hard copy, of the Disaster Chart is to remain with the patient.

5. The number that is written on the Arm Band is to be transferred to the Disaster Chart and to all the papers that belong to the victim.

d. Armbands and Triage Tags

1. Identification number and name, if possible, are written on the Armband. Colors are color-coded appropriately.
   a. Transfer this number to the Disaster Chart and to all appropriate papers belonging to the victim.
   b. This number must be placed on all requisition forms, i.e., lab, x-ray, etc.

2. If victim is unidentified, this number is used for identification of all lab specimens and x-rays, etc. A photo ID will be taken in the Triage area and remain with the patient in the Emergency Department for purposes of future identification. Disaster ID number should be placed on this photograph.

3. Number will also be placed on the house chart of any victim that is admitted.

4. Any clinical information and ancillary tests or needed referrals ordered will also be placed on armband.

e. Emergency Situation Report

1. Maintained at the Telemetry Unit.

2. Filled in by personnel handling the calls.

3. Forwarded to the Treatment Areas Supervisor and Treatment Areas as indicated.

D. <u>Supplies</u>

1. Disaster Supplies

a. Stores/Linen Department

1. Stores will maintain carts containing dressings, trays, suction catheters, towels, IV Trays. Linen staff will maintain ready carts of most commonly used linen items, such as bedsheets and pillow cases, and take them to the locations specified as directed based upon the developing disaster.

2. A cart will be taken to the post-op recovery room (PACU), George Isaac Center, or ambulatory clinic immediately with back up cart transported to Emergency Department.
3. In addition a reserve cart of supplies will then be available upon request through the Finance Chief and Procurement Unit Leader from Central Stores.
4. Additional disaster supplies and medical caches are available in the ED basement and can be requested by the Incident Commander. A listing of these supplies is available for placement in the Command Center as needed.

b. Respiratory Care Cardiopulmonary Unit Leader

1. Maintain cart containing Ambu bags, oxygen tubing, extension tubing, endotracheal tubes, masks, etc.
2. Respond with cart to PACU and George Isaac Center immediately.
3. Unused ventilators are kept in the RT department (setup and always ready to go). If we have a high vent pt population, Fitzsimmons (1-800-648-1015) is called to deliver vents (approx. 1 hour to do so).

c. Pharmacy (Pharmacy Unit Leader)

1. Shall maintain a cart containing most commonly used medications and pharmaceuticals, IV solutions, IV tubing, etc.
2. Respond immediately with cart to the PACU and George Isaac Center.

d. The Food & Nutrition Department will assess its supply of food to determine its capability to handle a large influx of unexpected victims (generally, Food & Nutrition maintains at least a three-day supply of food for normal operations, along with sufficient food to handle a three-day period in which no food was delivered to the campus, or a sudden influx of victims).

e. The Maintenance Department has clear protocols in place to handle any interruption in domestic water supplies, and has a specific policy dedicated to that contingency. The policy identifies the name and telephone numbers of companies capable of supplying large quantities in the event of a loss of water. Also, Northwest Ohio has a cache of pharmaceuticals available for use during a community-wide disaster.

f. Transport Team as directed by Logistics Chief and Transportation Unit Leader (Transporters, Environmental Services, Facilities Maintenance)

1. At the Phase 0 (disaster warning stage) Transport Team will begin to move all available stretchers and wheelchairs to the triage area. If there is an inadequate number of stretchers and wheelchairs available to receive the number of patients expected to be transferred to our facility, a member of the transport team should be sent to the Command Center to assess the availability of additional stretchers reported by nursing units. During a Code Orange stretchers and wheelchairs should be supplied to the members of the decon team in the area just north of George Isaac Surgery Center glass enclosed canopy.
2. Take supply boxes to triage area for pick up and exchange with EMS personnel, i.e., IV fluids, tubing, angiocaths, meds, etc.

SECTION 4. MEDICAL DIRECTION

A. Medical Personnel

1. The Attending Physician of the Emergency Department will serve as the Medical Branch Director in the Incident Command System.

2. Until the arrival of the Medical Director of the Emergency Department, a physician designated by the physician in charge of the Emergency Department will serve as Immediate Treatment Supervisor

    a. The Medical Director of the Emergency Department may designate, after his/her arrival that the designated doctor remains at the Command Center as the Medical Branch Director.

3. The Medical Branch Director shall assess current resources and assign appropriate personnel to treatment areas as needed with the assistance of the Planning Chief.

4. PACU and George Isaac Center Director will be the most senior Anesthesiologists (Secondary Immediate Treatment Unit Leader and Delayed Treatment Unit Leader respectively).

5. First Floor Clinics will be directed by senior medical resident or Medicine attending Minor Treatment Unit Leader.

B. Medical Staff Personnel

1. Physician staff (except anesthesiologists as mentioned above in Section 2.D.3.a.) and residents shall report to the Hospital Lobby and check in with the Medical Staff Unit Leader for assignments in the Staging Area.

2. The Medical Staff Unit Leader has the primary responsibility for granting privileges to physicians and other medical staff in the event of a disaster. This process is outlined in Medical Staff By Laws, Credentials Policy Manual, Section J.

C. Transport Personnel

1. All medical students will report to the Hospital Lobby and receive direction from the Transportation Unit Leader and will be assigned primarily as transport personnel, and may be assigned to act as escorts and take victims to x-ray, treatment rooms, etc.

2. All available Environmental Services/Facilities Maintenance personnel will form the Transport Team and report to the Hospital Lobby and receive direction from the Transportation Unit Leader and will serve as transports unless needed by their own department.

3. Volunteers may also be required as transporters if necessary, and will be assigned by the Transportation Unit Leader located in the Hospital Lobby.

4. The head of Transport Services or Environmental Services (night/evenings), in-house or on-call, will serve as Transportation Unit Leader of the transport team. He/she will serve as a supervisor of all transport personnel and help coordinate and facilitate the transfer of patients to various treatment areas: triage area, surgery, etc. per role card.

5. Transport personnel will be responsible for taking the available stretchers and backboards to the triage area for the availability of incoming EMS vehicles for rapid patient transfer. Also, they will be responsible for taking additional supplies to the triage areas for exchange with EMS personnel, i.e., IV fluids, tubing, angiocaths, meds, etc.

6. When assigned to any treatment area, report to the Treatment Unit Leader and identify yourself.

7. The Command Staff may appoint a runner to transfer information between the Command Center and the Emergency Department, if necessary using the Emergency Incident Message Form.

8. Any treatment area requiring additional personnel should notify the Planning Chief of such on two-way radios on OPS Channel 2, or through the Command Center if the radio is inoperable.

SECTION 5. COMMAND CENTER

The Command Center shall be established as soon as is possible, after the announcement of a Code Yellow, Phase 0 or I (A formal Command Center may be established during Phase 0 if necessary). As soon as possible the

Command Center will be located in Room #202 Mulford Library Building. The Command Center shall be staffed by the following individuals (or designates):

- House Supervisor, Administrator-on-call, EHRS Staff, or ED staff in the role of **Incident Commander**
- Hospital Security Director or EHRS Staffer in the role of **Safety Officer**
- Senior Hospital Administrator/Chief Nursing Officer, or EHRS Staff in the role of **Liaison Officer**
- Director of the Office of Communication, or designee in the role of **Public Information Officer**
- As assigned Operations, Planning, Logistics, and Finance **Section Chiefs**

***Various other HICS positions will be filled as needed by the Incident Commander and his/her General Staff**

Function of the Command Center

1. Appraise the disaster situation both administratively and medically and maintain clear communication with the other members of the Incident Command System through two-way radios.
2. Maintain constant contact with the Office of Communication representatives through the Public Information Officer.
3. Direct the assignment of extra personnel and supplies to needed areas through the Planning Chief and the written Incident Action Plan.
4. Receive a copy of the disaster patient charts from the treatment areas and log names from the Patient Tracking Manager.
5. Direct the expansion of hospital facilities as needed. Determine the need for discharging patients and, if necessary, the Inpatient Areas Supervisor will coordinate with the Admitting Department the discharge of in-house patients.
6. The Liaison Officer will maintain contact with other area hospitals and public support agencies, including fire and police.
7. The Labor Pool Unit Leader will release personnel as they are no longer needed or call in additional personnel as may be needed. In the event of an extended emergency situation, establish emergency scheduling of all employees to provide necessary coverage for the period of the disaster.
8. The Support Branch Director will coordinate support of family/etc., in the Cafeteria a role normally assumed by patient representative or Director of Pastoral Care Department. Support programs and activities will be based on the demands of the specific emergency.

   Contingency plans for specific needs that can be anticipated have been established and tested during drills or actual plan implementations. These include, but are not limited to:

   - Emergency child care
   - Emergency transportation
   - Staff/family lodging and meals
   - Psychological and bereavement counseling (provided jointly through Department of Psychiatry and Pastoral Care)
   - Staff/family prophylaxis,immunization, or other pharmaceutical needs
   - Initiating Emergency Response and Notifying Staff
   - Fatality Management
   - Volunteer Management Plan

9. The Incident Commander will terminate disaster response upon notification that all victims have been triaged to the appropriate treatment areas.

SECTION 6. ACTIVITY CENTERS

A. Morgue (Morgue Unit Leader)

1. Located on the ground floor of the hospital in the Pathology Department.
2. The basement of the HSB will be used for temporary overflow (this room will be used for "morgue victims" in a drill/actual event).
3. The Morgue Unit Leader is responsible for identification of the victims as well as cataloging personal effects and clothing. The Mass Fatality Plan may be activated when a large number of casualties are expected.
4. Command Center is notified by the Patient Tracking Manager of the identity of the victims and will then notify the Situation Unit Leader.

B. Information Desk (Adjacent Area used normally for Patient Check-in)

1. Will serve as a receiving area for all arriving staff/doctors reassigned from in-house, and those staff/doctors/volunteers who have been called in arriving through the east entrance of the hospital lobby. These individuals will be assigned by the Labor Pool Unit Leader and the Medical Staff Unit Leader. The Medical Staff Unit Leader is responsible for emergency credentialing of physicians and other medical staff.

C. Main Hospital Cafeteria

1. Holding area for discharged in-house patients and discharged disaster victims.
2. This will function as an overflow area for discharged in-house and discharged disaster victims, if the capacity of the admitting lobby is exceeded.
3. Designated area for families and friends of the victims.
4. At least one Security Officer will be assigned there.
5. A member of Administrative Staff, designated by the Operations Section Chief, will be assigned with authority to disclose information to the families from the Public Information Officer.
6. The Support Branch Director and designate will be assigned here.
   a. Information for patients seen in Emergency Department will be available through the Patient Tracking Manager and will work in conjunction with the Public Information Officer.
7. It will also serve as an overflow area for ambulatory patients if other clinic areas have exceeded their capacity to handle patient care activities or a critical treatment area has been damaged and this area will need to be used as an alternative treatment for the low-priority ambulatory patients.

D. Communications Center (Room 100 Hospital Lobby)

1. Designated for Office of Communication staff and news media. This area will be selected on a case-by-case basis depending on type of incident.

SECTION 7. HOSPITAL DEPARTMENT RESPONSIBILITIES

A. General Responsibility

1. It is the responsibility of each department head to have a detailed knowledge of all aspects of this plan and serve as an advisor to his/her department.
2. Each non-physician department head involved in disaster response, also bears the responsibility for formulating a disaster plan in writing for his/her department. This plan would cover such subjects as departmental disaster authority, functions, assignments, communications and responsibilities of personnel.

This plan must be submitted and approved by the Emergency Preparedness Task Force, which has the responsibility to coordinate the maintenance of this plan. Each department shall maintain a copy of their individual plan, and can be submitted for review by Emergency Preparedness Task Force.

3. In an actual disaster or during a disaster drill, department heads (specifically: Emergency Department, Nursing Services [PACU/Operating Room/Patient Transport], Ambulatory Services [Outpatient Clinic], Admitting, University Police, Patient Relations, Central Service, Respiratory Care, and Pharmacy) will inform the Command Center of the readiness of their departments.

4. Department heads involved in disaster response must provide Telephone Services with a call-in schedule (telephone tree) with back-up contacts if the Department Head is unavailable. These must be updated at least annually.

SECTION 8. OFFICE OF COMMUNICATION

A. Office of Communication *(Public Information Officer)*

1. Responsibilities

   a. To manage and provide information concerning the victims of a mass disaster to news media and other concerned persons, both internal and external.

   b. To manage and monitor the activities of on-site media reporters and photographers.

   c. To coordinate with the Patient Tracking Manager to provide assistance with the timely notification of victims and their family members.

2. Location

   a. A Communications Center will be set up by the Office of Communication near the main lobby of the Hospital, where telephone lines are available. Communication personnel will staff the Communications Desks, and one staff member (Public Information Officer) will be assigned to the Command Center in Room 202, Mulford Library Building or in the alternate location, the Alumni Lounge in the basement of Mulford Library. Telephone numbers are listed on page 2 of this policy.

   b. If necessary staff members from the Department of Communications will be assigned to manage a Communication Center in the Emergency Department.

   c. Additionally, the Radiology Academic Conference Room will potentially be used for media interviews.

3. Communication

   a. The Triage Unit Leader appointed to the Emergency Department will provide timely update information on patients triaged to the Emergency Department to the Patient Tracking Manager.

   b. All calls and inquiries from the news media and others regarding the status of victims or disaster information should be referred to the Communications Centers.

   c. The Office of Communications will also be responsible for keeping employees informed using tools such as e-mail, Web sites, letters, voicemail messages and/or flyers.

4. Media Information

   a. Information regarding disaster victims will be released to the news media following current and regular hospital protocol.

      1) The name, condition and injuries of disaster victims will be released only if the next of kin have officially been notified by the Patient Tracking Manager (per HIPAA regulations).

      2) The names of any deceased victims will be released under the same conditions.

b. News media reporters and photographers will be directed to the Communications Center located near the main lobby of the Hospital.

1. Reporters and photographers are not permitted to visit treatment areas unless accompanied by Office of Communication personnel.

2. Office of Communication may restrict media to one representative from each news agency if necessary.

3. If a victim agrees to talk with the media, a consent form will need to be signed prior to an interview. A copy of the consent form must also be given to the patient.

5. Personnel

a. Personnel to carry out the responsibilities of the Public Information /Office of Communication will be called at the discretion of the Director of Communication, who will determine staffing requirements.

b. One representative from the Pastoral Care will be assigned to the Communications Center if needed, for the purpose of contacting the families of disaster victims. This assignment will be made by the Patient Tracking Manager.

c. The Triage Unit Leader from the Emergency Department along with Treatment Areas Supervisor will provide updated information to the Public Information Officer through the Patient Tracking Manager.

SECTION 9. FACILITY ACCESS

A. University Public Safety

1. University Public Safety personnel and designees will assume assigned positions at entrances to the hospital and will place designated directional signs identifying treatment areas at hospital as outlined in the Campus Security Threat Levels/Lockdown Procedure (SM-08-003). Anyone without identification as an employee and/or a physician shall be prevented from entering the building. Press will be directed to the main Hospital lobby, and visitors will be directed to the Hospital Cafeteria.

2. Police will direcet traffic in and around the hospital entrances and parking lots to alleviate congestion and provide ready access to the hospital for emergency vehicles.

3. Hospital Security personnel will be responsible for unlocking the back-up CT scan area and also the clinic area including the hallway access to the clinic, on weekends and evenings, for use during a disaster.

4. During a disaster drill, hospital security will place signs in appropriate locations identifying a drill is taking place and retrieve signs at the conclusion of the drill.

B. Identification of Employees

1. Proper personal identification must be presented to the Hospital Security Officer to enter the hospital. This identification is your ID card with your photo on it.

2. Armbands and incident command vests will be provided to medical and technical personnel to better delineate their function in patient care.

SECTION 10. MEDICAL RECORD, CLOTHING AND VALUABLE CONTROL

A. Medical Record - Disaster Chart

1. During the early stages of caring for disaster casualties, a disaster chart will constitute the basic medical record. These will be stored in the Emergency Department and be available for immediate use. As soon as possible, a hospital admission number will be provided by the Admitting Department.

2. The Medical Record team will utilize a disaster chart to record each casualty's initial diagnosis, treatment rendered, medical classification and destination. Identifying information which can be obtained readily will also be recorded on the chart.

   The disaster chart will serve as the patient's medical record until such time that his/her regular chart may be assembled. The disaster chart will then be incorporated with (and become part of) the permanent Medical Record. (The number that is written on the armband is to be transferred to the disaster chart and to all the papers that belong to the victim.)

B. Clothing and Valuables

1. Valuables will not be removed from the victim during the emergency situation unless absolutely necessary.
2. When absolutely necessary, valuables should be placed in special Valuable Envelopes and be taken to the Admitting Department for safe keeping.
3. Clothing should be placed in plastic bags available in the Emergency Department. The bags will be numbered to correspond with the disaster chart number and/or the hospital admission number. The bags will accompany the patient.

SECTION 11. DISASTER TERMINATION

A. Primary Triage Area

1. The Treatment Area Supervisor and Triage Unit Leader must notify the Incident Commander in the Command Center that all victims have been received and transported to treatment areas.

B. Command Center

1. After receiving above notification from triage area, the Command Center will notify each treatment area.
2. If adequate resources are available in each treatment area to manage patients, hospital operators will be notified of Code Yellow disaster termination.
3. Disaster termination/cancellation will be announced by telephone operators.

SECTION 12. RECOVERY FROM DISASTER

A. Documentation

1. All materials and written information generated during the disaster (excluding medical records) will be collected and delivered to the Command Center for review by disaster team.
2. All HICS clipboards, charts, memos, etc., will be returned to the Command Center.
5. All expenditures will be forwarded to the Finance Chief for compilation for possible third party reimbursement and a report will be submitted to the Incident Commander.

B. Reports/Incident Critique

1. The Liaison, Public Information and Safety Officer will make short presentations based on information collected and received from the divisional chiefs in the Logistic, Operations, Finance and Planning Sections.
2. The Incident Commander will go over the reports and evaluate the institutions response to the disaster.
6. The Incident Commander will then compile a final report for submission to Hospital Administration, Emergency Preparedness Task Force and the Safety Committee discussing the incident, issues/problems, financial information and planned changes for future disasters.

SECTION 13. EVALUATION

After each activation of this procedure, a detailed critique should be made and the report sent to the Safety & Health Committee as soon as is feasible. This critique should include those people who were involved in decision-making and implementation of the procedure, along with verification of all applicable telephone numbers and the contents of the policy.

Source: Safety & Health Committee
Emergency Preparedness Task Force

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5/10/01
5/1/02
5/15/03
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2/9/07
2/26/08
1/17/11
1/10/14
6/25/14
7/20/15
2/6/2017
2/5/2018
2/4/2019
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