HEALTH CARE EMERGENCY CODES

A GUIDE FOR CODE STANDARDIZATION

HOSPITAL ASSOCIATION
of Southern California

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INTRODUCTION

The HASC Security and Safety Committee completed a revision of the Health Care Emergency Codes in May 2014. We invite your updates and suggestions for this document at any time.

These guidelines offer a flexible plan in responding to emergencies, allowing only those functions or positions that are needed to be put into action. Additional customization of these guidelines must be made to make them applicable to a specific facility. All information being provided to facilities is for their private use. These guidelines can be used in many ways to assist healthcare facilities in the development of their own specific policies and procedures. The information contained in this document is offered solely as general information and is not intended as legal advice.

BACKGROUND

In December 1999, the Hospital Association of Southern California (HASC) established a Safety and Security Committee comprised of representatives from member hospitals with expertise in safety, security, licensing and accreditation. The committee's mission is to address issues related to safety and security at healthcare facilities. One major issue the committee has tackled concerns the lack of uniformity among emergency code systems utilized at different healthcare facilities.

Adopting code uniformity enables the numerous individuals who work across multiple facilities to respond appropriately to specific emergencies, enhancing their own safety, as well as the safety of patients and visitors. To facilitate code uniformity, the committee developed a standardized set of uniform codes and guidelines that can be adopted by all healthcare facilities.

In July 2000, the committee adopted the following standardized code names:

BLUE for adult medical emergency
GRAY for a combative person
GREEN for patient elopement
ORANGE for a hazardous material spill/release
PINK for infant abduction
PURPLE for child abduction
RED for fire
SILVER for a person with a weapon and/or active shooter and/or hostage situation
TRIAGE INTERNAL for internal disaster
TRIAGE EXTERNAL for external disaster
WHITE for pediatric medical emergency
YELLOW for bomb threat

The codes were previously reviewed in 2008, 2009, 2011 and 2014.

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CODE BLUE: MEDICAL EMERGENCY (ADULT)

Facilities should define the classification between adult (Code Blue) and pediatric (Code White) patients. Whatever definition is chosen should be clear to staff.

I. **PURPOSE**

To provide an appropriate response to a suspected or imminent cardiopulmonary arrest or a medical emergency for an adult or pediatric patient.

II. **POLICY**

Code Blue is called for patients who do not have an advance healthcare directive indicating otherwise.

A. **Code Blue** is initiated immediately whenever an adult is found in cardiac or respiratory arrest (per facility protocol). In areas where adult patients are routinely admitted there should be an adult crash cart available. If a Code Blue is called in an area without a crash cart, the designated response team will bring a crash cart.

B. If the patient's weight does not meet the expected developmental growth, consider a response based on the appropriate protocol (e.g., ACLS/PALS).

III. **PROCEDURES**

Code Blue teams should not enter an area where a Code Silver was called until the area has been determined by law enforcement to be safe.

Code Blue team members function within their respective scopes of practice and utilize guidelines set by the American Heart Association on Advanced Cardiac Life Support. The members perform functions that include, but are not limited to, the following:

A. Response

1. Person discovering an adult/child in cardiopulmonary arrest:

   a. Assesses patient's airway, breathing and circulation;
   b. Calls for help.
   c. Initiates CPR and notes time.
   d. Does not leave the patient.

2. First responding physician:

   a. Assume the role of Code Blue team leader.
   b. Initiate direct emergency orders, as appropriate.
   c. May transfer responsibility of team leader to attending physician or emergency department physician.
   d. Team leader signs the Code Blue record.

3. Personnel from department calling the Code Blue/Code White:

    a. Initiate Code Blue per facility protocol.
    b. Assess patient and begin procedures to open airway, begin rescue breathing and/or initiate CPR, as indicated.
    c. Obtain crash cart.
    d. Attach monitor leads.
    e. Assume compressions and/or ventilation until the Code Blue response team arrives.

4. Nurse assigned to patient:

    a. Provide most recent data on the patient, including the pertinent history and vital signs.
    b. Bring chart and Kardex to room and act as information source.
    c. Take responsibility for completion of the Code Blue record, other facility designated forms, and distribution of forms to appropriate departments.
    d. Mark and maintain monitor strips.
    e. Sign Code Blue record.

5. Designated nurse with appropriate training (e.g., ACLS/PALS), two (2) every shift, to be determined by policy:

    a. Respond to area/department where Code Blue is called.
    b. Ensure placement of cardiac monitor and assesses initial rhythm.
    c. Direct and delegates code responsibilities to nursing and other personnel.
    d. Direct Code Blue until physician arrives.
    e. Perform ongoing evaluation of patient status.
    f. Monitor and evaluate CPR procedures.
    g. Establish IV line and administer medications according to appropriate guidelines (e.g., ACLS/PALS or other approved protocol) or as ordered.
    h. Interpret EKG rhythm and defibrillate according to appropriate guidelines (e.g., ACLS).
    i. Sign Code Blue record.

6. Respiratory Therapy personnel:

    a. Assume ventilation responsibilities upon arrival.
    b. Assist with intubation and obtaining blood gases when needed.
    c. Stay with patient through transport.
    d. Sign Code Blue record.

7. Department clinical coordinator or charge nurse/ACLS (administrative supervisor, after hours):

    a. Record pertinent data on Code Blue record.
    b. Act as communication liaison to attending physician, family and pastoral care.

      c.   Support family members present during event.

      d.   Act as a resource and help coordinate Code Blue/Code White.

      e.   Coordinate and review interdisciplinary Code Blue team.

      f.   Assist staff in evaluation of performance during code event.

8. Pharmacist:

      a.   Exchange the used medication tray immediately after Code Blue to ensure readiness of the cart.

      b.   After hours, administrative supervisor is responsible for replacing the medication tray.

      c.   Mix medication, solutions and label medication during code.

      d.   Calculate drip rates and dosages.

      e.   Act as a resource.

      f.   Sign the Code Blue record.

9. Central Service or other responsible department staff member:

      a.   Respond to each Code Blue with replacement cart.

      b.   After hours, the administrative supervisor will replace cart.

10. Operator:

      a.   Voice page Code Blue and location three (3) times when notified.

      b.   Use pager system to notify appropriate interdisciplinary Code Blue team.

11. Chaplain/Social Worker (if requested):

      a.   Support the family.

      b.   Support the staff as needed.

12. Security:

      a.   Coordinate necessary movement of other patients and visitors.

      b.   Manage crowd control.

B.   Training and Education

1. All direct patient care personnel will re-certify in BCLS annually.

2. Specialized cardiac life support training (e.g., ACLS) is provided for physicians and nurses as required.

3. A program offering an interdisciplinary approach to managing Code Blue events provides opportunities for the purpose of enhancing clinical skills, including team training.

4. Training of personnel follows the guidelines of the American Heart Association on Advanced Cardiac Life Support.

5. Education includes review of all policies, procedures, and regulatory standards.

6. Verbal or written test.

IV. REFERENCES

Advanced Cardiac Life Support (ACLS) and Pediatric Advance Life Support (PALS) certification courses, American Heart Association.

California Code of Regulations, Title 22, § 70405(g), § 70743.

Consent Manual 2007, 27th Edition, Sacramento, CA, CH 3; The California Healthcare Association.

Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care, Emergency Cardiac Care Committee and Subcommittees, American Heart Association, Part IX; "Ensuring Effectiveness of Community-Wide Emergency Cardiac Care," 1992; JAMA, 28;268 (16), pp. 2289-95.

The Hospital Incident Command System (HICS) Guidebook, www.emsa.ca.gov/HICS.

The Joint Commission, ; www.jcrinc.com/JointCommission-Requirements.

CODE GRAY: COMBATIVE PERSON

I. PURPOSE

To provide an appropriate response to situations involving an aggressive, hostile, combative or potentially combative persons.

II. POLICY

Aggressive, combative or abusive behavior can be displayed by anyone: a patient or a patient's family member; staff or a member of the staff's family: acquaintances of patients and staff; vendors and contractors; or the general public. Aggressive, combative or abusive behavior may quickly escalate into a more violent episode.

A. Staff will take responsible and proactive measures to ensure the safety and security of all persons on hospital property by effectively responding to an event and minimizing the number of assault victims and their potential injuries.

B. When staff is concerned about their own safety and the safety of others due to abusive or assaultive behavior, they should initiate a Code Gray.

C. Any assault or battery that results in an injury to a staff member or patient must be reported to law enforcement within 72 hours.

D. Each department with a specific role in a Code Gray is to develop an emergency-specific plan.

E.   Any Code Gray response should be in accordance with this procedure and those developed by each department.

III.   **PROCEDURES**

A.   Prevention & Education

1.   A written policy makes clear the facility's commitment to promote workplace safety, prohibit threats and violence of any kind, require immediate reporting of any incident that causes a concern for safety, and require discipline of offenders.

2.   Recognizing early warning signs:

No single sign alone should cause concern, but a combination of any of the following signs should be cause for concern and action.

- Direct or verbal threats of harm.
- Intimidation of others by words and or actions.
- Refusal to follow policies.
- Carrying a concealed weapon or flashing a weapon to test reactions.
- Hypersensitivity or extreme suspiciousness.
- Extreme moral righteousness.
- Inability to take criticism regarding job performance.
- Holding a grudge, especially against a supervisor.
- Often verbalizing hopes that something will happen to the other person against whom the individual has the grudge.
- Expression of extreme desperation over recent problems.
- Intentional disregard for the safety of others.
- Destruction of property.

3.   Management of aggressive behavior training (MOAB). Only trained and certified personnel should be assigned to respond to minimize potential acts of aggressive behavior or violence.

B.   Response (Code Gray)

1.   Any staff member confronted with or witnessing a combative situation should initiate a Code Gray.

a.   Verbal Abuse – Personnel should provide assistance to the victim(s).

- Assist in attempts to verbally de-escalate the assailant.
- Call in a second person to take over.
- Add distance/barriers between victim and assailant.

b.   Physical Battery – Prepare to provide assistance to the victim(s) by:

- Protecting self and others by assisting victim to stop/deflect blows by the assailant.
- Creating a diversion by putting distance/barrier between victim and assailant.
- Getting medical assistance if needed.

c. Assault with a weapon – Refer to Code Silver: Person with a weapon /hostage situation policy.

2. Any employee who hears the request to initiate a Code Gray should contact the operator and state that a Code Gray is in progress by giving the location and nature of the incident.

3. The operator will contact the Code Gray Strike Team.

4. The Code Gray Strike Team is a pre-designated, security response team consisting of staff trained in the management of aggressive behavior.

   a. The Hospital Incident Command System (HICS) will be used as the incident's management structure.

   b. Strike Team members may include representatives from nursing, security, and other departments.

   c. The Strike Team leader shall be the assigned patient care nurse or designated charge nurse if patients are involved. If no patients are involved, the team leader may be the ranking security representative.

   d. The Strike Team shall perform as instructed by the Strike Team leader in support of the incident objectives.

   e. The incident action plan (IAP) objectives may include:

Initial Incident Objectives
☐ Identify potentially violent persons.
☐ Separate potentially violent persons to protect visitors, staff, and patients.
☐ De-escalate potentially violent behavior.
☐ Coordinate response with law enforcement, if appropriate.

5. The Code Gray Strike Team responds to the incident location.

6. The Strike Team leader briefs the strike team members and coordinates the response.

7. If the situation cannot be resolved using the Code Gray Strike Team, law enforcement is contacted for assistance.

8. When the Code Gray has been resolved, the Strike Team leader will call the operator to request an "all clear" message be broadcast

9. All personnel resume their normal duties.

C. Documentation of the incident should follow the facility's policy and procedure for documentation of such an event. Any assault or battery that results in an injury to a staff member or patient must be reported to law enforcement within 72 hours.

D. Management conducts a root cause analysis or similar review of the incident to identify areas for improvement and then implement those improvements.

E. Training and Education

Staff members and other personnel regularly assigned to departments with a known risk for violent behaviors from patients or others should, as appropriate to their job responsibilities and relative risk of violence, receive education and training on a continuing basis relating to at least the following:

   i. General safety measures.
   ii. Personal safety measures.
   iii. The assault cycle.
   iv. Aggression and violence predicting factors.
   v. Obtaining patient history from a patient with violent behavior.
   vi. Characteristics of aggressive and violent patients and victims.
   vii. Verbal and physical maneuvers to diffuse and avoid violent behavior.
   viii. Strategies to avoid physical harm.
   ix. Restraining techniques.
   x. Appropriate use of medications as chemical restraints.
   xi. Any resources available to employees for coping with incidents of violence, including, but not limited to, critical stress debriefing and/or employee assistance programs.

IV. REFERENCES

California Code of Regulations, Title 22, §70743, §70746.

California Health and Safety Code, Chapter 2, Article 1, § 1257.7, § 1257.8, http://leginfo.ca.gov.

The Hospital Incident Command System (HICS) Guidebook, www.emsa.ca.gov/HICS.

The Joint Commission, www.jcrinc.com/Joint-Commission-Requirements.

CODE GREEN: PATIENT ELOPEMENT

I.   PURPOSE

To provide an appropriate response in the event of a missing or eloping patient who is determined to be a danger to himself, herself others or who is identified a safety risk.

II.   DEFINITIONS

High-Risk Patient for Elopement / Patient Elopement: A patient who fits the following criteria or who leaves the patient care unit without permission who is:

1. On a legal hold (danger to themselves or others).
2. Having active suicidal/homicidal ideation and may be on a voluntary status.
3. Gravely disabled – unable to provide food, shelter or clothing.
4. On a "patient watch" or has a safety attendant/sitter.
5. Confused, disoriented or otherwise appearing to lack mental capacity.
6. On Lanterman Petris-Short (LPS) conservatorship.

III.   POLICY

A.   All reasonable measures are taken to prevent the elopement of high-risk patients from the hospital.

B.   The hospital take all reasonable steps necessary to safely retrieve or locate an eloped patient as quickly as possible.

C.   At no time during an elopement anyone without a valid need to know is informed of the incident.

D.   No hospital employee or volunteer is authorized to make a public statement concerning this incident or communicate with the news media or any other public agency.

E.   The hospital's response is limited to the hospital campus as defined by policy. Law enforcement is notified for assistance beyond the hospital campus.

F.   Patients, other than those that are involuntary patients, have the right to leave the hospital against medical advice. Theorganization ensure the patient is safely discharged.

IV.   PROCEDURES

A.   Upon discovery of a patient who is missing or suspected of elopement:

1. Staff notify the operator immediately and provide the following information:

   a. Patient care unit where the patient was assigned.

   b. Description of the eloped patient.

   c. Time and location the patient was last seen.

2. The operator will announce a Code Green via the overhead paging system and ensure notifications are made to the administrator-in-charge, security and risk management.

3. If a patient is missing from the patient care area and does not meet the criteria of a missing or eloping patient, the charge nurse and security services are notified to assist with locating the patient.

B.   Code Green Response

   1. Code Green Task Force

      a. The Hospital Incident Command System (HICS) is used as the incident's management team structure.

      b. By policy the administrator-in-charge assumes the role of the incident commander or delegates the responsibility to the most qualified individual.

      c. A pre-designated, multi-disciplinary patient elopement response team (Code Green Task Force) receives a patient elopement notification via overhead page.

      d. Task Force members may include security, risk management and nursing.

      e. The most qualified member of the Task Force will assume the role of the team leader and will coordinate with the senior member of the patient care unit from which the patient eloped and the incident commander.

      f. Each Task Force member performs specific functions assigned by the team leader in support the incident objectives.

      g. The incident action plan objectives may include:

Initial Incident Objectives
☐   Conduct a facility-wide search.
☐   Make appropriate notifications.
☐   Locate the eloped patient.

      h. The Code Green Task Force conducts a campus-wide search for the missing patient. Law enforcement is notified for assistance beyond the hospital campus.

2. Security

   a. Secure hospital perimeter utilizing access control system, if applicable.

   b. Secure video, if applicable.

   c. Initiate continuous searches of campus [name all locations/adjoining buildings or facilities within campus jurisdiction] until missing/eloping patient is located. Officers may be required to leave property in order to facilitate patient retrieval.

   d. Provide further information regarding the incident including detailed description of patient clothing, medical conditions relevant to their safety or safety of others, other parties involved, and any other pertinent information.

   e. Announce the missing/eloping patient description to the checkpoint screeners and hospital staff.

   f. All surrounding entrances and exits to the hospital are monitored until the situation has been resolved or unless otherwise directed by incident commander and/or law enforcement.

   g. Notify law enforcement, if applicable.

3. Risk Management

   a. Risk Manager serves to advise, coordinate, and act as a liaison with administration as well as regulatory agencies.

   b. Notify family in collaboration with incident commander and patient care staff.

4. Patient Care Staff

   a. All relevant medical information pertaining to the subject(s) is made available to appropriate persons at the command post or as authorization allows.

   b. The patient care staff notifies the attending physician of the incident.

5. Public Information Officer

   a. Draft a press release for approval by the incident commander and chief operating officer.

   b. Establish a media briefing area and briefing time, if appropriate.

   c. Coordinate with law enforcement regarding the type of information that can be released to the news media, and when it is appropriate to do so.

6. All Personnel

a. Upon hearing Code Green, monitor all points of exit and surrounding area in their vicinity for persons appearing to be a patient from another unit leaving the facility.

b. Communicate any suspicious activity to security immediately.

C. Recovery

1. The Risk Manager/security and law enforcement (if applicable) determine when the Code Green event is concluded and then release the site to resume normal operations.

2. The Incident Command Center will notify the operator to page, "Code Green, all clear" three (3) times.

3. Management will conduct a root cause analysis or similar review of the incident to identify areas for improvement and then implement those improvements

D. Training and Education

1. Patient care staff receive appropriate orientation and training relative to working with high-risk elopement patients.

2. The Code Green Task Force members also receive training specific to their respective roles in a Code Green response.

V. REFERENCES

The Hospital Incident Command System (HICS) Guidebook, www.emsa.ca.gov/HICS.

The Joint Commission, www.jcrinc.com/Joint-Commission-Requirements.

CODE ORANGE: HAZARDOUS MATERIAL SPILL/RELEASE

I. PURPOSE

To provide an appropriate response to an actual or suspected hazardous material spill or release in a manner that is safe for staff, patients and visitors.

II. DEFINITION OF TERMS:

Hazardous Material Spill or Release: A spill or release of a substance that is likely to cause injury or illness, may result in exposure that exceeds federal or state limits, or may harm the environment.

III.   **POLICY**

A.   Employees are familiar with the products they are using, know how to use the product and know the spill precautions taken.

B.   Each department will maintain appropriate Material Safety Data Sheets (MSDS) in an easily accessible location for all products used within the department. This may include access by computer.

C.   The clean-up of a hazardous material spill is only conducted by knowledgeable and experienced personnel who have received proper training (e.g., spill response team, fire department HAZMAT team).

D.   Each department develops individual protocols that support the organization's overall Code Orange response.

E.   In coordination with the hospital safety officer, the department management assures the department has the proper clean-up and personal protective equipment available for use in a response to a hazardous spill/release, including spill kits with instructions, absorbents, reactants and protective equipment.

F.   In coordination with the hospital safety officer, the department managers determine the appropriate level of response to decontaminate the spill/release.

1.   Level I – The department is capable of decontaminating the spill/release themselves.

2.   Level II – The department requires assistance from the Code Orange Task Force to adequately respond.

3.   Level III – The Code Orange Task Force requires assistance from outside resources to adequately respond.

IV.   **PROCEDURES**

A.   Discovery of a Hazardous Material Spill/Release

1.   If an employee spills, releases or discovers the spill or release of a potentially hazardous substance, he/she notifies their supervisor immediately. In coordination with the hospital safety officer, the department manager will determine the appropriate level of response based on the identification of the substance and information available in the MSDS.

a.   **Level I**: In coordination with the hospital safety officer, the department controls and removes the product using existing spill containment supplies. This response includes contacting environmental services

to remove the product using a mop and rinse water as long as the product is legally permissible to be discarded through the sewer system.

i. Follow departmental procedures.
ii. Notify the department manager, designee, or supervisor.
iii. Alert people in the immediate area of the spill and advise them to keep away.
iv. Do not touch the material nor walk into it.
v. Isolate the area or make the area inaccessible.
vi. Confine the spill in a safe manner to minimize its spread.
vii. Determine if available staff can safely clean up the spill or if emergency personnel should be notified.
viii. Engineering controls are implemented as appropriate (e.g., increase ventilation).
ix. Read the Material Safety Data Sheet (MSDS) for precautions.
x. Work with a partner, and use spill kit to clean up.
xi. As appropriate, exposed staff will utilize eye wash stations, showers, etc., to clean the chemical from eyes, skin and clothing
xii. Call engineering or environmental services for disposal of chemical and all contaminated material
xiii. Document all actions.

b. **Level II**: In coordination with the hospital safety officer, the department needs assistance from the Code Orange Task Force for spill control due to the volume of the product spilled, the need for a large spill kit, or because the product requires special attention due to its hazards.

i. Activate a Code Orange and notify the administrator-in-charge and the safety officer.
ii. Code Orange Task Force or qualified individual conducts an internal assessment of the type and scope of the spill.
iii. Follow departmental procedures.
iv. Alert people to evacuate the area if necessary and secure the area.
v. If the person is contaminated with toxic materials, they should stay in place to be assessed by a HAZMAT Response Team. Follow Decontamination Policy & Procedure.
vi. ONLY if personal exposure is unlikely, attend to injured or contaminated victims and remove them from exposure,
vii. Engineering controls are implemented as appropriate (e.g., increase ventilation).
viii. Use the MSDS to assist with remedial actions.
ix. Assist the HAZMAT Response Team as directed.
x. Complete an incident report and document all actions.

c. **Level III**: The Code Orange Task Force needs assistance from an outside agency or company to assist with the hazardous spill.

     i.   Notify the administrator-on-call/Safety Officer and activate a Code Orange, if not already completed.

    ii.   Conduct internal assessment by HAZMAT team or qualified individual. Call the fire department or contracted HAZMAT company.

   iii. Coordinate spill clean-up with appropriately licensed and trained third party agency. (It is recommended that this arrangement be coordinated in advance.)

   iv. Follow departmental procedures.

    v. Alert people to evacuate the area if necessary and secure the area.

   vi. If a person is contaminated with toxic materials, they should stay in place to be assessed by a HAZMAT Response Team. Follow Decontamination Policy & Procedure.

  vii. ONLY if personal exposure is unlikely, attend to the injured or contaminated persons and remove them from exposure,

  viii. Engineering controls will be implemented as appropriate (e.g., increase ventilation).

   ix. Use the MSDS to assist with remedial actions.

    x. Assist the HAZMAT team as directed.

   xi. Complete an incident report and document all actions.

B.   Code Orange Task Force

1. The pre-designated, multi-disciplinary hazard materials response team (Code Orange Task Force) receives a hazardous spill notification via the overhead page.

   a. The Hospital Incident Command System (HICS) is used as the incident's management team structure.

   b. Task Force members may include security, engineering, environmental services, respiratory and nursing.

   c. The most qualified member of the Task Force will assume the role of the team leader and will coordinate with a senior member of the department where the response is occurring, if applicable.

   d. Each Task Force member shall perform specific functions assigned by the team leader and in support the incident objectives.

   e. The Task Force Leader will report to the administrator-in-charge (incident commander) until directed otherwise.

   f. The incident action plan objectives may include:

Initial Incident Objectives
☐   Isolate the contaminated area(s).
☐   Identify the hazardous material(s).

☐	Provide patient triage and medical management, if needed.
☐	Protect patients, staff and visitors.

2. The Code Orange Task Force responds to the hazardous material location.

3. The Task Force will conduct an assessment of the spill to determine whether an actual hazardous material spill has occurred or is occurring.

    a. If no spill of hazardous material has occurred and it is deemed a "false alarm," or if a hazardous material spill has occurred, but has been appropriately cleaned up, the team leader will declare an "all clear" and will document as appropriate.

    b. If an active hazardous material spill is occurring, the team leader initiates an appropriate response, such as notifying the administrator-in-charge or house supervisor.

C.   Code Triage: Internal – Hazard Spill/Release

    1. Incident Response

        a. By policy the administrator-in-charge initiates a Code Triage: Internal and assumes the role of the incident commander or delegates the responsibility to the most qualified individual.

        b. The incident commander appoints the appropriate command and general staff positions.

        c. The incident commander activates the Hospital Command Center (HCC), as appropriate.

            i. If the incident commander works outside of the Incident Command Post (ICP), a deputy incident commander is appointed within the Hospital Command Center (HCC).

            ii. If the incident commander works inside the Hospital Command Center (HCC), a liaison officer is posted at the fire department's Incident Command Post (ICP).

        d. A "unified command" with the responding agencies is established.

        e. The need for additional evacuation is considered.

            i. Evacuation and relocation of staff, patients, and/or visitors is undertaken only at the direction of the incident commander.

            ii. Patient records and medications are transferred with the patient upon evacuation or transfer.

        f. Account for all on-duty staff and recall additional staff as necessary.

        g. Ensure the accurate tracking of patients and the appropriate notifications.

        h. Consider establishing a media staging area.

  2. All Clear

       a. The incident commander issues an "all clear" notification to the operator to initiate the termination of response operations when appropriate.

       b. The operator shall announce, "Code Orange, all clear" three (3) times via overhead page system.

       c. All employees are to return to normal work duties.

  3. Recovery

       a. Notify all responding agencies and personnel of the termination of the response and demobilize as appropriate.

       b. Any recovery activities should be coordinated through engineering/facilities and the department(s) affected.

       c. Track all related incident costs and claims

       d. Management will conduct a root cause analysis or similar review of the incident to identify areas for improvement and then implement those improvements

  4. Refer to the Hospital Incident Command System (HICS) planning and response guides for additional guidance.

D.   Documentation and Reporting

Documentation should be reviewed and retained indicating information about the activation. This may be completed through an event or incident report, security report, or other reporting method.

E.   Training and Education

  1. All staff that may use or otherwise come into contact with hazardous materials should be trained annually. Training should include the following safe handling procedures for hazardous materials:

       a. Personal protective equipment training.

       b. Hazardous communication procedures.

       c. Material Safety Data Sheets (MSDS).

       d. Spill clean-up procedures.

       e. Review of all policies, procedures, and regulatory standards.

       f. Verbal or written test.

2. The Code Orange Task Force receives annual training specific to their response procedures, including additional training for the potential team leaders.

V.   REFERENCES

California Code of Regulations, Title 22, § 70743, §70746.

California Code of Regulations, Title 19, § 4.

California Code of Regulations, Title 26, 19.1.

California Code of Regulations, Title 27, § 27.1-4.

The Hospital Incident Command System (HICS) Guidebook, www.emsa.ca.gov/HICS.

The Joint Commission, www.jcrinc.com/Joint-Commission-Requirements.

CODE PINK: INFANT ABDUCTION

Facilities should define the classification between Code Pink and Code Purple. Some facilities choose to define by age (e.g. Code Pink for infants up to six months of age, and Code Purple for infants/children from six months to 13 years of age), by location of abduction (e.g., newborn nursery versus pediatrics unit), or by some other characteristic (e.g., Code Pink for babies that cannot walk and Code Purple for any child that is able to walk). Whatever definition is chosen should be clear to staff.

I.   PURPOSE

To provide an appropriate response in the event an infant is abducted from the facility.

II.   DEFINITIONS

Typical Abductor: The following are characteristics of a typical abductor as identified by the National Center for Missing and Exploited Children (NCMEC). However, there is no guarantee an infant abductor will fit this description and anyone acting suspiciously in areas of risk for abductions should be reported immediately.

- Female of "childbearing" age (range from 12-50), often overweight.

- Most likely compulsive; most often relies on manipulation, lying, and deception.

- Frequently indicates that she has lost a baby or is not capable of having one.

- Often married or cohabitating; companion's desire for a child or the abductor's desire to provide her companion with "his" child may be the motivation for the abduction.

- Usually lives in the community where the abduction takes place.

- Frequently initially visits the nursery and maternity units at more than one healthcare facility prior to the abduction; asks detailed questions about procedures and the maternity floor layout; frequently uses a fire exit stairwell for escape. May also try to abduct from the home setting.

- Usually plans the abduction, but does not necessarily target a specific infant; frequently seizes on a target of opportunity present.

- Frequently impersonates a nurse or other allied healthcare personnel.

- Often becomes familiar with healthcare staff, staff work routines, and the victim's parents.

- Demonstrates a capability to provide "good" care to the baby once the abduction occurs.

- May remove the newborn by carrying the infant, carrying a bag large enough to hold an infant, covering the infant with coat/baby blanket, or may be in healthcare uniform/scrubs carrying the infant.

III.   POLICY

A.   Reasonable measures are taken to prevent the abduction of an infant from the hospital.

B.   Employees receive appropriate education and training relative to their response roles.

C.   Each department develops individual protocols that support the organization's overall Code Pink response.

IV.   PROCEDURES

A.   Safeguarding Infants

Safeguarding infants requires a comprehensive program that involves extensive staff and physician education and collaboration, and often requires the use of physical and/or electronic security measures based on ongoing risk assessments completed by the facility.

1. General Responsibilities

   a. Ensure that this or similar written proactive prevention plans are further   customized, developed and augmented by the facility.
   b. Develop a written assessment of the risk potential for infant abduction, and update annually as needed.
   c. Annually review the prevention and response plan.
   d. Have every department develop a written, response plan in support of the facility's Code Pink response plan.

e. Ensure proactive interaction with the mother (and/or the infant's legal guardian) to determine if any threats (domestic situations, etc.) exist that could create a security problem for the infant.
f. Train staff to protect infants from abduction (see: "Orientation and Education" below).
g. Establish an access-control policy for the maternal-child health nursing unit.

h. In situations involving a legal guardian or child protective services, routine pediatric procedures should be carried out, and, based upon maternal/child assessment, supervised parental visits may be recommended.

2. Infant Identification

a. Immediately after the birth of an infant, ensure there is a defined process to identify and/or band infants and their parents/guardians.
b. As soon as possible after the birth:
    i. Footprint the baby.
    ii. Take color photograph of the baby.
    iii. Perform and record full physical assessment of baby.
    iv. Ensure that cord blood is kept in lab for two weeks.
    v. Note all items in the chart.
c. Require the parent(s)/guardian(s) taking the infant home from the healthcare facility to show their ID wristband(s), and match their band(s) to the bands on the wrist and ankle of the infant.
d. Require all healthcare personnel to wear up-to-date, conspicuous color photo ID badges.
e. Facilities may utilize an identifier or special access badge that indicates personnel that have direct contact with infants and children are authorized to access those areas.

3. Patient Education

a. Distribute guidelines for parents on preventing healthcare facility abductions. Common means of distribution can be through childbirth classes, pre-natal classes, during pre-admission tours, upon admission, and at postpartum instruction.
b. Guideline information covers all relevant healthcare facility identification procedures, and outlines standard nursery procedures, visitation policies and the importance of never leaving the infant unattended.
c. Hospital discharge parent education includes guidelines for prevention of infant abduction in the home and community.
d. Parent(s)/guardian(s) are encouraged to ask questions when their infants are taken from them while in the healthcare facility.

4. Staff Procedures and Education

a. When infants are transported within the facility;

    i.   Only authorized staff members are allowed to transport the infant.

    ii.   The only authorized non-staff individuals allowed to transport the baby out of the room are the "banded" parent or guardian.

    iii.   Infants are taken to mothers one at a time.

    iv.   Infants are never carried, but instead are always pushed in a bassinet.

    v.   An infant is never left out of direct line-of-sight supervision.

b. When in the mother's room:

    i.   Bassinets are placed near the mother and, when possible, the mother's bed is between the bassinet and the doorway.

    ii.   Instruct the mother to alert nurses if/when she is unable to supervise the infant, such as when she is in the shower or attending to other personal needs.

c. Do not post the mother's or infant's full name or identify the sex of the infant where it will be visible to visitors.

d. Establish an access-control policy for the nursing unit (nursery, maternity, neonatal-intensive care, and pediatrics). This may include check-in for visitors at a lobby or entrance.

e. Have the patient's nurse introduce each additional healthcare provider to the patient.

f. No home address or other unique information that could put the infant and family at risk after discharge is divulged to the public in birth announcements. All departments (e.g., medical records, information systems, baby photography) are included in this policy.

g. In situations involving a legal guardian or child protective services, routine nursery procedures are carried out, and, based upon maternal/neonatal assessment, supervised parental visits may be recommended.

h. If/when providing home visitation services, personnel entering patients' homes need to wear a unique form of ID used only by them which is strictly controlled by the facility and known to the parents.

i. Conduct Code Pink drills – facility-wide and in the MCH units – per facility recommendations.

5. Physical Security / Infant Security Systems

Below are potential physical and electronic security safeguards that facilities may consider as part of their plan for prevention of infant abductions. A documented infant security assessment should be completed.

a. An alarm system with alarms on stairwells and exit doors on the perimeter of the maternity, nursery, neonatal intensive care and pediatric units should be in place.

b. Whenever an alarm is sounded, an immediate investigation to determine the cause of the alarm is conducted. If it is verified that no infant was taken, then a charge nurse or one of the security personnel (or as per facility policy) may silence and reset/rearm the system. Call an "All Clear."

c. All nursery doors have self-closing hardware and remain locked to prevent unauthorized access at all times. Alarmed "panic bars" should allow egress in the event of an emergency.

d. All doors to lounges or locker rooms where staff members change/leave clothing has self-closing hardware and are under strict access control.

e. Installation of a security-camera system that continuously records all activities should be considered.

f. If there are cameras in the units, position them so that they will capture the faces of all persons entering the maternal-child-care unit.

g. Camera video recordings should be archived for a minimum of 30 days before being re-used or purged.

h. Protocols for maintenance of quality and reliability of the system are established.

B. Response

1. Code Pink Alarm

   a. Upon receipt of an infant abduction alarm or the confirmation of a missing infant, the nurse will notify the operator and state the location of the patient care unit, the description of the missing infant, and the place and time the infant was last seen.

   b. The operator will announce a "Code Pink" for the missing infant via the overhead paging system.

   c. The operator provides the responding personnel with the relevant supporting information (e.g., the infant's description, the abductor's description, the location or unit where the child was last seen) as it becomes available.

2. Code Pink Alarm Response

   a. Code Pink Task Force

      i. The pre-designated, multi-disciplinary response team (a.k.a. Code Pink Task Force) receives a Code Pink alarm notification (via overhead page).

      ii. The Hospital Incident Command System (HICS) is used as the incident's management team structure.

iii. Task Force members may include personnel from maternal-child health, security, engineering, environmental services, respiratory and nursing.
iv. The Task Force team leader is the assigned patient care nurse or designated charge nurse of the department where the alarm is occurring, if applicable. If no patients are involved (ie.,the infant is a visitor), the team leader is the ranking security representative.
v. Each Task Force member performs specific functions supporting the incident objectives and assigned by the team leader.
vi. The initial Incident Action Plan (IAP) objectives may include:

Initial Incident Objectives
☐ Establish a security perimeter around the alarm area.
☐ Determine if abduction has actually occurred.
☐ Identify the infant and abductor, if applicable.
☐ Recover the infant, if applicable.
☐ Communicate situation to staff/patients as necessary.
☐ Investigate and document incident details.

b. Maternal-Child Health Patient Care Staff

i. Immediately search the entire unit.
ii. Staff members are assigned to search staff locker room, examination and equipment rooms, staff restrooms, public restrooms, waiting rooms, and empty rooms on unit, and report back with results of searches to charge nurse or team leader for Infant Abduction Task Force.
iii. Communication between nursing staff, security and others via hand-held radios facilitates transmission of information and coordination of the response effort.

c. Security Staff

i. Immediately and simultaneously activate a search of the entire healthcare facility, both interior and exterior.
ii. If possible, close exits to parking lots (e.g., gate arms, doors) and record the license plate numbers of any vehicles leaving the premises.
iii. Assist nursing staff in establishing and maintaining security in the unit.

        iv.   Establish a security perimeter around the facility until the possible abduction can be confirmed.

        v.   Contact local law enforcement.

  d. All personnel

        i.   Upon hearing that a Code Pink has been called, all healthcare facility personnel are to immediately stop all non-critical work.

        ii.   Cover all interior stairwell doors, elevator areas and doors that exit anywhere near their area.

        iii.   Staff members who are outside their own department area are to go to the nearest exit way.

        iv.   When a second person reaches an exterior door, one of them is to exit the facility to watch for suspects leaving the facility grounds or entering a car.

3. Actual Infant Abduction

Upon the discovery of a missing infant, the Code Pink team leader contacts the administrator-in-charge and reports the actual abduction of an infant. The following procedures are implemented in order to provide a systematic response to an infant abduction.

  a. Incident Commander

        i.   The administrator-in-charge, by policy, assumes the role of incident commander or delegates the responsibility to the most qualified individual.

        ii.   The incident commander appoints the appropriate command and general staff.

        iii.   The incident commander activates the Hospital Command Center (HCC), as appropriate.

        iv.   Call National Center for Missing and Exploited Children (NCMEC) at 1-800-THE-LOST (1-800-843-5678) for additional assistance in handling ongoing crisis management.

        v.   The Public Information Officer (PIO) ensures all information about the abduction is cleared by the incident commander and law-enforcement authorities before being released to staff members, family, friends and the media.

        vi.   Protect the crime scene

  b. Maternal Child-Health Staff

        i.   Team leader obtains all pertinent information regarding the description of the alleged kidnapper and infant and the situation in the unit at the time of the kidnapping and reports it to the incident commander.

        ii.   A facility-developed infant abduction form should include the following documentation: a description of the infant, the kidnapper, and any person(s) with the kidnapper. It should also

document all information from witnesses regarding the occurrence.

iii. The parents of the abducted infant are moved to a private room off the maternity floor (but not their belongings, as they are part of the crime scene and must be protected throughout the investigation.)

iv. Notify the involved pediatrician and obstetrician.

v. The nurse assigned to the mother and infant continues to accompany the parents at all times.

vi. All records/charts of the mother and infant are secured.

vii. The lab is notified to place STAT hold on infant's cord blood or other blood samples.

viii. Designate a room where other family members can wait and have easy access to any updates in the case, while offering the parents some privacy.

ix. Contact social services and/or pastoral services to assist as needed by activating their own response plans.

x. Team leader briefs all staff on the unit and reinforces confidentiality of incident.

xi. Nurses should explain the situation to all of the other mothers on the unit, preferably while each mother and her infant are together.

xii. After the mother is discharged from the facility assign one staff person to be the single liaison (i.e., social services, risk management or nursing) between the parents and the facility.

xiii. Hold a group debriefing/discussion session(s) as soon as possible, requiring all personnel affected by the abduction to attend.

c. Security

i. Immediately call local law enforcement. Consider calling the local FBI office requesting the Crimes against Children (CAC) coordinator.

ii. Assume control and protect the crime scene until law enforcement arrives.

iii. Notify newborn nurseries, postpartum and pediatric units, emergency rooms, and outpatient clinics at other local healthcare facilities about the incident, and provide a full description of the baby and the suspected abductor (if known).

4. Demobilization & Recovery

a. When the Code Pink incident has been resolved, the incident commander shall issue an "all clear" notification to staff to terminate the response operations. To do so, the operator announces "Code Pink, all clear" three (3) times.

b. All employees are to return to their normal work duties.

     c. Management will conduct a root cause analysis or similar review of the incident to identify areas for improvement and then implement those improvements

C.   Training and Education

     1.   Staff members who deliver care to infants are educated regarding infant security issues upon their initial orientation to the unit and on a quarterly basis. This can be achieved through a number of different methods, including but not limited to:

     a. NCMEC literature.

     b. Infant security videos.

     c. Review of all policies, procedures, and regulatory standards.

     d. Review of case studies and any possible attempt scenarios.

     e. Verbal or written test.

     f. Additionally, ancillary staff members should be in-serviced upon initial orientation and as needed. It is recommended that the following departments be included: security, housekeeping, laboratory, radiology, and auxiliary staff.

     2.   Members of the Code Pink Task Force receive appropriate training and conduct periodic response exercises to ensure a coordinated response.

V.   REFERENCES

An Analysis of Infant Abductions, July 2003; National Center for Missing and Exploited Children.

California Code of Regulations, Title 22, § 70547(b)(21), § 70717(g)(h), § 70737(d), § 70738, §70743(b).

California Health and Safety Code, Section 1276, § 208(a), §1275.

For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions. Eighth Edition, 2005; National Center for Missing and Exploited Children.

The Hospital Incident Command System (HICS) Guidebook, www.emsa.ca.gov/HICS.

The Joint Commission, www.jcrinc.com/Joint-Commission-Requirements.

Preventing and Responding to Infant Abductions, 1996; Emergency Care Research Institute (ECRI).

CODE PURPLE: CHILD ABDUCTION

Facilities should define the classification between Code Pink and Code Purple. Some facilities choose to define by age (e.g., Code Pink as up to six months of age, and Code Purple as six months to 13 years of age), by location of abduction (e.g., newborn nursery versus pediatrics unit), or by some other characteristic (e.g., Code Pink for babies that cannot walk and Code Purple for any child that is able to walk). Whatever definition is chosen should be clear to staff.

I.   PURPOSE

To provide an appropriate response in the event of the abduction of a child from the facility.

II.   DEFINITIONS

The following are characteristics of a possible child abductor that should be considered. However, it is important to note that abductor characteristics are not limited to this list, and anyone acting suspicious in areas of risk for abductions should be reported immediately.

A.   The abductor can be a stranger to the child, or a family member, such as a non-custodial parent.

B.   Children can often verbally let someone know when they face a threatening
situation, however, some factors, such as domestic situations and "wandering," create a need for an expansion of the infant monitoring system into the pediatric unit. Staff should not rely on the child to verbally indicate that they are in a threatening situation.

III.   POLICY

A.   All reasonable measures are taken to prevent the abduction of a child from the hospital.

B.   In the event of a missing child or child abduction, the following Code Purple response procedures are implemented.

C.   All employees receive appropriate education and training relative to their response roles.

D.   Each department develops individual protocols that support the organization's overall Code Purple response.

IV. PROCEDURES

A. Safeguarding Children

Safeguarding children requires a comprehensive program involving extensive staff and physician education and collaboration, and often requires the use of physical and/or electronic security measures based on ongoing risk assessments completed by the facility.

1. General Responsibilities

    a. Ensure that this or similar written proactive prevention plans are further   customized, developed and augmented by the facility.
    b. Develop a written assessment of the risk potential for child abduction, and update annually as needed.
    c. Annually review the prevention and response plan.
    d. Have every department develop a written response plan in support of the facility's Code Purple response plan.
    e. Establish a defined process to identify and/or band children and their parents/guardians, i.e., color photographs of both child and parents and full physical assessment of the child.
    f. Ensure proactive interaction with the child's parents or legal guardian to determine if any threats (domestic situations, etc.) exist which could create a security problem for the child.
    g. Train staff to protect children from abduction (see: Orientation and Education below).
    h. Establish an access-control policy for the pediatric nursing unit.
    i. Instruct healthcare facility personnel to ask visitors which child they are visiting.
    j. In situations involving a legal guardian or child protective services, routine pediatric procedures are carried out, and, based upon maternal/child assessment, supervised parental visits may be recommended.

2. Patient Education

    a. Distribute guidelines for parents on preventing healthcare facility abductions.
    b. Information covers relevant healthcare facility identification procedures, visitation policies, and the importance of never leaving the child unattended without notifying staff.
    c. Hospital discharge parent education includes guidelines for prevention of child abduction in the home and community.
    d. Parent(s)/guardian(s) are encouraged to ask questions when their children are taken from them while in the healthcare facility.

3. Physical Security Safeguards

a. Develop written assessment of the risk potential for child abduction and update annually or as needed.

b. Conduct annual self-assessment reviews within each department on the prevention and response plan.

c. Conduct Code Purple drills, facility-wide and in the pediatric units, per facility recommendations.

d. Install alarms on all stairwell and exit doors on the perimeter of the pediatric unit.

e. Whenever an alarm is sounded, an immediate investigation is done to determine the cause of the alarm. If it can be verified that no child was taken, then a charge nurse or one of the security personnel can silence and reset/rearm the system and call an "All Clear".

f. All pediatric unit doors have self-closing hardware and remain locked to prevent unauthorized access at all times. Alarmed "panic bars" should allow egress in the event of an emergency.

g. All doors to lounges or locker rooms where staff members change/leave clothing have self-closing hardware and are under strict access control.

h. Document an assessment of the need for an electronic-asset-surveillance (EAS) detection system tied to video recording of the incident and alarm activation.

i. Installation of a security camera system that continuously records all activities should be considered.

j. If there are cameras in the units, position them so they will capture the faces of all persons utilizing all entrances and exits of the pediatric unit.

k. Camera video recordings should be archived for a minimum of 30 days.

l. Protocols for maintenance of quality and reliability of the system are established.

B. Response

1. Code Purple Alarm

   a. Upon receipt of a child abduction alarm or the confirmation of a missing child, the nurse will notify the operator and state the location of the patient care unit, the description of the missing child, and the place and time the child was last seen.

   b. The operator will announce a "Code Purple" for the missing child via the overhead paging system.

   c. The operator provides the responding personnel with the relevant supporting information (i.e., the child's description, the abductor's description, the location of unit where the child was last seen, etc.) as it becomes available.

2. Code Purple Alarm Response

   a. Code Purple Task Force

i. The pre-designated, multi-disciplinary response team (Code Purple task force) receives a Code Purple alarm notification (via overhead page).

ii. The Hospital Incident Command System (HICS) is used as the incident's management team structure.

iii. Task force members may include personnel from pediatrics, maternal-child health, security, engineering, environmental services, respiratory and nursing.

iv. The Task Force team leader is the assigned patient care nurse or designated charge nurse of the department where the alarm is occurring, if applicable. If no patients are involved (i.e., the child is a visitor), the team leader is the ranking security representative.

v. Each Task Force member performs specific functions supporting the incident objectives and assigned by the team leader,.

vi. The initial Incident Action Plan (IAP) objectives may include:

Initial Incident Objectives
☐ Establish a security perimeter around the alarm area.
☐ Determine if an abduction has actually occurred.
☐ Identify the child and abductor, if applicable.
☐ Recover the child, if applicable.
☐ Communicate situation to staff/patients as necessary.
☐ Investigate and document incident details.

b. Pediatric Staff

i. Immediately search the entire unit.
ii. Staff members are assigned to search staff locker room, examination and equipment rooms, staff restrooms, public restrooms, waiting rooms, empty rooms on unit, and report back with search results to the Code Purple Task Force team leader.
iii. Communication between nursing staff, security and others via hand-held radios facilitates transmission of information and coordination of the response effort.

c. Security Staff

i. Immediately and simultaneously activate a search of the entire healthcare facility, interior and exterior.

  ii. If possible, close exits to parking lots (i.e., gate arms, doors) and record the license number of any vehicles leaving the premises.

  iii. Assist nursing staff in establishing and maintaining security in the unit.

  iv. Establish a security perimeter around the facility until the possible abduction can be confirmed.

  v. Notify local law enforcement.

d. All personnel

  i. Upon hearing that a Code Purple has been called, all healthcare facility personnel are to immediately stop all non-critical work.

  ii. Cover all interior stairwell doors, elevator areas and doors that exit anywhere near their area.

  iii. Staff members who are outside their own departments are to go to the nearest exit way.

  iv. When a second person reaches an exterior door, one of them is to exit the facility to watch for suspects leaving the facility grounds or entering a car.

3. Actual Child Abduction

Upon the discovery of a missing child, the team leader contacts the administrator in-charge and reports the actual abduction of the child. The following procedures are implemented in order to provide a systematic response to child abduction.

a. Incident Commander

  i. The administrator-in-charge, by policy, assumes the role of incident commander or delegates the responsibility to the most qualified individual.

  ii. The incident commander appoints the appropriate command and general staff.

  iii. The incident commander activates the Hospital Command Center (HCC), as appropriate.

  iv. Call the National Center for Missing and Exploited Children (NCMEC) at 1-800-THE-LOST (1-800-843-5678) for additional assistance in handling ongoing crisis management.

  v. The Public Information Officer (PIO) ensures all information about the abduction is cleared by the incident commander and law enforcement authorities before being released to staff members, family, friends and the media.

  vi. Protect the crime scene.

b. Pediatric Staff

  i. Team leader obtains all pertinent information regarding the description of the alleged kidnapper and child, and the situation in the unit at the time of the kidnapping and reports it to the incident commander

ii. A facility-developed child abduction form should include the following documentation: a description of the child, the kidnapper, and any person(s) with the kidnapper. It should also document all information from witnesses regarding the occurrence.

iii. The parents of the abducted child are moved to a private room off the pediatric unit (but not their belongings, as they are part of the crime scene and must be protected throughout the investigation).

iv. Notify the involved pediatrician.

v. The nurse assigned to the child accompanies the parents at all times.

vi. All records/charts of the child are secured.

vii. Designate a room where other family members can wait and have easy access to any updates in the case, while offering the parents some privacy.

viii. Contact social services and/or pastoral services to assist as needed by activating their own response plan.

ix. Nurse manager/supervisor briefs all staff on the unit and reinforces confidentiality of the incident.

x. Nurses should then explain the situation to all of the other parents/guardians on the unit, preferably while the parent/guardian and child are together.

xi. Assign one staff person to be the single liaison (i.e. social services, risk management or nursing) between the parents/guardian and the healthcare facility.

xii. Hold a group debriefing/discussion session(s) as soon as possible, requiring all personnel affected by the abduction to attend.

c. Security

i. Immediately call local law enforcement. Consider calling the local FBI office requesting the Crimes against Children (CAC) coordinator.

ii. Assume control and protect the crime scene until law enforcement arrives.

iii. Notify pediatric units, emergency rooms, and outpatient clinics, and other local healthcare facilities about the incident, and provide a full description of the child and the suspected abductor (if known).

4. Demobilization & Recovery

a. When the Code Purple incident has been resolved, the incident commander shall issue an "all clear" notification to staff to terminate the response operations. To do so, the operator shall announce, "Code Purple, all clear" three (3) times via the overhead paging system.

b. All employees are to return to normal operations.

c. Management will conduct a root cause analysis or similar review of the incident to identify areas for improvement and then implement those improvements

C. Training and Education

2. Staff members who deliver care to infants/children are educated regarding infant/child security issues upon their initial orientation to the unit and on a quarterly basis. This can be achieved through a number of different methods, including but not limited to:

   i. NCMEC literature.
   ii. Infant security videos.
   iii. Review of all policies, procedures, and regulatory standards.
   iv. Review of case studies and any possible attempt scenarios.
   v. Verbal or written test.
   vi. Additionally, all staff members should be in-serviced upon initial orientation and as needed.

3. Members of the Code Purple Task Force receive the appropriate training and conduct periodic response exercises to ensure a coordinated response.

V. REFERENCES

An Analysis of Infant Abductions, July 2003; National Center for Missing and Exploited Children.

California Code of Regulations, Title 22, § 70547(b) (21), § 70717(g) (h), § 70737(d), § 70738, §70743(b).

California Health and Safety Code, Section 1276, § 208(a), §1275.

For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions. Eighth Edition, 2005; National Center for Missing and Exploited Children.

The Hospital Incident Command System (HICS) Guidebook, www.emsa.ca.gov/HICS.

The Joint Commission, www.jcrinc.com/Joint-Commission-Requirements.

Preventing and Responding to Infant Abductions, 1996; Emergency Care Research Institute (ECRI).

CODE RED: FIRE

I.   PURPOSE

To provide an appropriate response in the event of a suspected or actual smoke condition or fire in order to protect life, property and vital services.

II.   POLICY

A.   All employees have a responsibility to respond quickly to a suspected or actual fire.

B.   Code Red are immediately initiated whenever the following is observed:
1.   Seeing smoke, sparks or a fire.
2.   Smelling smoke or other burning material.
3.   Feeling unusual heat on a wall, door or other surface.
4.   In response to any fire/life safety system alarm.

C.   The Code Red Task Force performs only basic fire response operations for beginning stage fires that can be controlled or extinguished by portable fire extinguishers without the need for protective clothing or self-contained breathing apparatus.

D.   All employees complete an annual safety training that includes appropriate fire life safety procedures.

E.   The Code Red Task Force completes appropriate annual training in accordance with their duties.

F.   Each department develops individual protocols that support the organization's overall Code Red response.

III.   PROCEDURES

A.   Upon discovery of smoke condition or fire (suspected or actual)

1.   At origin:
a. **R.A.C.E**.
Remove patients, visitors and personnel from the immediately affected area. Consider removing patients and staff from the adjoining rooms/floors. Disconnect exposed oxygen lines from wall outlets.
Activate the fire alarm and notify others in the affected area to obtain assistance. Follow your organization's emergency reporting instructions.
Contain the fire and smoke by closing all doors
Extinguish the fire if it is safe to do so. (*see* P.A.S.S.)

b. **S.A.F.E**.
Safety of life

Activate the alarm
Fight fire (if it is safe to do so)
Evacuate (as necessary or instructed)

    c. **P.A.S.S**. – Proper use of the fire extinguisher:
Pull the pin
Aim the nozzle of the extinguisher at the base of the fire
Squeeze the trigger
Sweep the extinguisher's contents from side to side

2. Away from origin:

    a. Listen to overhead paging system.
    b. Prepare to implement Code Red response plan for your department or location, as needed. Do not automatically evacuate unless there is an immediate threat to life. Wait for instructions.
    c. Nursing personnel return to their assigned units if safe to do so.

B.   Code Red Task Force

1. The pre-designated, multi-disciplinary fire response team (a.k.a.: Code Red Task Force) receives a fire alarm notification (either via overhead page or directly from the fire system).

    a. The Hospital Incident Command System (HICS) will be used as the incident's management team structure.
    b. Task Force members may include security, engineering, environmental services, respiratory and nursing.
    c. The most qualified member of the Task Force assumes the role of the team leader and, if possible, coordinates with a senior member of the department where the alarm is occurring.
    d. Each Task Force member performs specific functions as assigned by the team leader in support of the incident objectives.
    e. The incident action plan objectives may include:

Initial Incident Objectives
☐   Determine if fire is an actual fire or a false alarm.
☐   Rescue and protect patients and staff.
☐   Confine the fire/reduce the spread of the fire.
☐   Implement partial/full evacuation.
☐   Communicate situation to staff, patients, and the public.
☐   Investigate and document incident details.

2. The Code Red Task Force responds to the fire alarm location.

3. The Task Force coordinates with a senior member of the department where the alarm is occurring and conducts an assessment of the alarm to determine whether an actual fire has occurred or is occurring.

   a. If no fire has occurred and it is deemed a "false alarm" – or if a fire has occurred, but has been extinguished – the team leader declares an "all clear" if it is safe to do so and documents as appropriate.
   b. If an active fire is occurring, the team leader initiates an appropriate response, such as notifying the house supervisor or administrator-on-call, or initiating a house-wide "Code Triage: Internal." The Task Force members address the fire situation as per their training and communicates situation to team leader and responding Fire Department personnel.

C.   Code Triage: Internal – Fire

   1. Incident Response:
      a. By policy, the administrator-in-charge initiates a "Code Triage: Internal" and assumes the role of the incident commander.
      b. The incident commander appoints the necessary command and general staff positions.
      c. The incident commander activates the Hospital Command Center (HCC), as appropriate.
         i. If the incident commander works out of the Incident Command Post (ICP), appointing a deputy incident commander within the Hospital Command Center (HCC) should be considered.
         ii. If the incident commander works out of the Hospital Command Center (HCC), a liaison officer is posted at the Fire Department's Incident Command Post (ICP).
      d. Consider establishing a "Unified Command" with the responding agencies.
      e. Consider the need for additional evacuation.
         i. Evacuation and relocation of staff, patients, and/or visitors is undertaken only at the direction of the incident commander and only when in agreement with the Fire Department's incident commander.
         ii. Horizontal evacuation of patients and staff to surrounding smoke compartments is preferred in most cases. Vertical evacuation of patients and staff is completed if necessary.
         iii. Patient records and medications are transferred with the patient upon evacuation or transfer if it is safe to do so. If waiting for patient records or medications will jeopardize patient or staff safety, they should evacuate to safety first. Medical records and medications will follow the patient when it is safe.
      f. As oxygen can promote the spread of fire and is found in most patient care areas, consider shutting off medical gases to the affected area(s) after proper coordination with engineering, nursing, anesthesia, and pulmonary/ respiratory.

g. Do not use elevators in areas near a Code Red event; use the stairs instead. Elevators can increase the spread of smoke from floor to floor. Utilize evacuation equipment to move non ambulatory patients down stairs.

h. Account for all on-duty staff and recall additional staff as necessary.

i. Ensure accurate tracking of patients and appropriate notification to families and other agencies if needed.

j. Consider establishing a media staging area.

2. Recovery:

a. Notify all responding agencies and personnel of the termination of the response and demobilize as appropriate

b. Consider providing mental health support for staff.

c. Track all related incident costs and claims.

3. All Clear:

a The incident commander – after consultation with the fire department, if
   applicable – issues an "all clear" notification to the operator to indicate the
   termination of response operations.

b. The operator shall announce "Code Red, all clear" three (3) times via the
   overhead paging system.

c. All employees return to normal operations.

4. Refer to the Hospital Incident Command System (HICS) planning and response guides for additional guidance.

D. Documentation and Reporting

Documentation containing information about the activation is reviewed and retained. Reporting of the incident may be completed through an event report, security report, fire activation report, or other reporting method.

Management will conduct a root cause analysis or similar review of the incident to identify areas for improvement and then implement those improvements

E. Training and Education

1. All employees are expected to be familiar with the basic Code Red response plan and know the location(s) of the nearest fire alarm pull stations and fire extinguishers. Employees working in areas with specialized extinguishers or extinguishing systems (e.g., Halon, FM-200, non-magnetic) should receive specific training for those devices.

2. The Code Red Task Force receives annual training specific to their response procedures, including additional training for the potential team leaders.

IV.   REFERENCES

California Code of Regulations, Title 22.

The Hospital Incident Command System (HICS) Guidebook, www.emsa.ca.gov/HICS.

National Fire Protection Association (NFPA) 101 and 99, www.NFPA.org.

Occupational Health and Safety Administration, (OSHA) 29 CFR 1510, 1910, 1915

The Joint Commission, www.jcrinc.com/Joint-Commission-Requirements.

CODE SILVER: PERSON WITH A WEAPON, ACTIVE SHOOTER AND/OR HOSTAGE SITUATION

I.   PURPOSE

To provide an appropriate response in the event of an incident involving a person with a weapon, an active shooter or a hostage situation within the facility.

II.   DEFINITIONS

Weapon: Any firearm, knife or instrument that can cause bodily harm or injury

Active Shooter: Person discharging a weapon

Hostage: Any person being threatened or held against their will

III.   POLICY

The hospital will take all reasonable measures to minimize the negative impact of a situation involving a person with a weapon, an active shooter or a hostage.

IV.   PROCEDURES

A. Discovery

1. Anyone encountering a person brandishing a weapon should:
   a. Seek cover and warn others of the situation.
   b. Clear immediate danger area of all personnel and patients, if it is safe to do so.
   c. Notify the operator of the incident with all known information.
      i.   Location - building, area, floor and room number.

  ii. Suspects - number and any physical descriptions.

  iii. Any known hostages or victims.

  iv.Any other relevant information (e.g., weapons, demands).

  v. Law enforcement personnel authorized to carry a weapon should be identified if they are not in a distinctive uniform.

2. The operator will:

 a. Notify the hospital via a public announcement of "Code Silver" or "Code Silver – Active Shooter" with location.

 b. Notify the administrator-in-charge and the Security department of the incident.

 c. Notify staff of the event via pager, e mail, mass notification system other communication methods available to the facility.

3. Due to the nature of this incident, the operator will generally initiate a Code Silver and notify law enforcement via 9-1-1 without first seeking approval from the administrator-in-charge.

B. Response (Code Silver)

Code Blue and Code White teams should not enter an area where a Code Silver was called until the area has been determined by law enforcement to be safe.

1. Any staff members in the area specified by a Code Silver should:

 a. Warn others of the situation

 b. Evacuate if it is safe to do so.

 c. Seek cover/protection,

 d. Assist patients in seeking shelter/protection, if it is safe to do so

 e. Remain calm and stay alert.

 f. If at all possible, don't make contact with the perpetrators.

2. Patients in the area specified by a Code Silver should be instructed:

 a. to remain calm and stay alert.

 b. not to make contact with the shooter.

 c. evacuate, if possible and safe to do so, at the direction of area staff members.

 d. if unable to evacuate and safe to do so, staff will close doors and turn lights off in the patient's room.

3. Any staff members in an area distant from the Code Silver location should:

 a. Stay away from the location specified in the Code Silver. *This is an extremely dangerous and sensitive situation that should only be handled by trained authorities.*

 b. Close all patient and unit exit doors.

 c. Take cover behind locked doors if possible.

d. Provide assistance as requested by an authorized person.

4. The Code Silver Strike Team is a pre-designated security response team consisting of staff trained in the response to violent situations.

   a. It is important to remember that a Code Silver is primarily a law enforcement event, and should be addressed by trained law enforcement officials. Hospital staff should take direction from local responding law enforcement officers
   b. The Hospital Incident Command System (HICS) is used as the incident's management structure.
   c. Strike Team members may include representatives from security, administration, nursing, and other departments.
   d. The Strike Team leader is the ranking security representative.
   e. The Strike Team shall perform as instructed by the Strike Team leader in support of the incident objectives.
   f. The Strike Team leader reports to the incident commander until directed otherwise.
   g. The incident action plan (IAP) objectives may include:

Initial Incident Objectives
☐ Identify the location of the incident.
☐ Establish a perimeter.
☐ Clear the area of all possible bystanders.
☐ Gather intelligence from witnesses.
☐ Coordinate the response with law enforcement.

5. The Code Silver Strike Team respond to the general area of the incident location.

6. The Strike Team leader will brief the team and coordinate the response.

7. If it is safe to do so, the Code Silver Strike Team will:

   a. Establish a perimeter around the affected area.
   b. Clear the area of bystanders from the surrounding area to protect them from danger.
   c. Close and secure the entrances and exits to the facility, and not allow anyone to enter or exit until the situation has been resolved or until directed by law enforcement.
   d. Interview witnesses to determine the exact location, number and identities of the hostages, and the number of perpetrators/abductors, including how they are armed, their apparent motivation and any demands made.
   e. Maintain communications with the HCC and or responding law enforcement.

8. The Code Silver Strike Team <u>will not:</u>

   a. Bargain with or make any promises to the person(s) with a weapon or hostage taker(s).

   b. Engage in any rescue attempts.

C. Triage Response

   1. Wait for law enforcement to declare the scene "safe for triage" before any clinical personnel enter to triage patients/victims.

   2. If staff or physicians MUST enter or leave the building or a patient has an emergency that requires movement of the patient (e.g., Code Blue), law enforcement must be notified. If appropriate, an armed escort by law enforcement should be provided

D. Hospital Command Center (HCC)

   1. The administrator-in-charge, by policy, assumes the role of the incident commander or delegates the responsibility to the most qualified individual.

   2. The incident commander activates the Hospital Command Center (HCC) in a location not affected by the incident.

      g. If the incident commander works outside of the Incident Command Post (ICP), a deputy incident commander is appointed within the HCC.

      h. If the incident commander works inside of the HCC, a liaison officer is assigned to the Law Enforcement's Incident Command Post (ICP).

      i. A "Unified Command" with the law enforcement incident commander is established.

   3. The incident commander appoints the appropriate command and general staff, who will, in turn, assign appropriate personnel to HICS positions needed to accomplish the incident's objectives.

   4. All incoming patients should be routed other appropriate areas within the hospital or to other nearby healthcare facilities for medical care until the Code Silver event has been cleared. These facilities should be notified about the situation.

E. Law Enforcement Arrival

   1. When law enforcement arrives, the Code Silver becomes a law enforcement incident and they assume full responsibility for managing the situation. Law enforcement will request and expect cooperation and assistance from the staff.

   2. Law enforcement will need a copy of the facility's layout, indicating rooms, exits, windows, utility access, keys and access cards and a

hospital 2-way radio, if such communications are utilized by security within the hospital.

3. Law enforcement will establish an incident command post in a location of their choosing, most likely outside the facility and away from the incident.

4. Response:

    j. It is important for anyone in the affected area to show their hands at all times when law enforcement is on scene. This helps law enforcement officers to identify who may or may not be armed with a weapon.

    k. Follow law enforcement instructions as they are given. Understand that law enforcement officers may be yelling and may seem aggressive.

    l. Verbally identify yourself.

    m. If you are injured, tell law enforcement you are injured and state whether or not you require immediate medical attention.

    n. Leave all personal belongings during the evacuation process. It is more important to get to safety first

F. Media

1. The Public Information Officer (PIO) will contact families of identified hostages, in conjunction with Law Enforcement, and serve as a liaison with the media.

2. Law enforcement will request that any and all official statements of the facility be discussed with the designated law enforcement representative before being released.

3. All media coverage is directed by the PIO. Staff must avoid giving out any information to the media. Media representatives may be quite assertive and some may not display official identification. The incident should not be discussed openly among the staff. Protection of privacy is extremely important.

G. All Clear

1. After consultation with law enforcement the incident commander authorizes an "all clear" notification to the operator indicating the termination of response operations.

2. The operator announces "Code Silver, all clear" three (3) times via the overhead paging system, mass notification system or other approved notification system.

3. All employees are to return to normal operations.

H. After Action Report

1. Be prepared to spend time with the law enforcement authorities to review the incident in detail.

2. Provide details of the perpetrators, victims, incident scene and events leading up to the initial trigger point of the incident.

3. Facility administrators, staff and public safety first responder groups must meet within a 24-48 hour time frame after the conclusion of the incident to review the incident from start to finish. The goal of the debriefing is to determine what actions, policies and procedures could be enhanced to better respond to a future Code Silver incident. This debriefing is to determine the how and why, not to assign blame. The goal is to understand what happened and how to be better prepared to respond to any future event.

4. Management conducts a root cause analysis or similar review of the incident to identify areas for improvement and then implement those action items

I. Mental Health Considerations

Mental health evaluations for employee & non-employee victims: Post Traumatic Stress Disorder (PTSD) is a significant and debilitating disorder that affects victims of and responders to violent events such as an active shooter or hostage event. It is strongly recommended that all affected persons be required to complete an initial PTSD evaluation by a mental health professional to determine if continued therapy is required and for what duration of time the therapy is to continue. The evaluation will also include a physical component to determine what effect if any the stress is having on the person's physical well-being. All persons involved in the event should be provided a written evaluation with the mental health professional's recommendation for a return to duty date.

J. Education and Training

1. Training and education ensure that all staff is aware of potential security hazards and how to protect themselves and their co-workers through established policies and procedures.

2. Specific training should be provided to the Code Silver Strike Team members as to their specific roles and responsibilities during a variety of scenarios.

3. Training for staff includes what to do when they become a hostage or victim such as the following:

- **Remain calm and be patient.** Time is on your side. Avoid drastic action. The captors in all probability do not want to harm persons held

by them, however such direct challenges may cause the captor to escalate his actions.

- **The initial 45 minutes are the most dangerous.** Follow instructions, be alert. Your focus is on staying alive. Don't make mistakes that could hazard your well-being.
- **Don't speak unless spoken to and only when necessary.** If it is necessary to speak with the captors, avoid appearing hostile, avoid arguments and don't talk down to him or her. Maintain eye contact with the captor but do not stare. If medications, first aid or restroom privileges are needed by anyone, say so.
- **Be Compliant.** Treat the captor like royalty. Comply with instructions the best you can. Expect the unexpected. Displaying a certain amount of fear can possibly work to your advantage.
- **Be Observant.** When you are released, or when you escape, the personal safety of others may depend on what you remember about the situation.

V. REFERENCES

California Code of Regulations, Title 22, §70743 (a)(b)(c)(d). §70746.

Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, 3148 (1998); U.S. Department of Labor, Occupational Safety and Health Administration (OSHA).

The Hospital Incident Command System (HICS) Guidebook, accessible via the Internet

at www.emsa.ca.gov/HICS.

The Joint Commission, www.jcrinc.com/Joint-Commission-Requirements.

Department of Homeland Security (DHS) Independent Study Course: *Active Shooter, What can you do (*IS*907),* accessible via the Internet at
 http://training.fema.gov/EMIWeb/IS/IS907.asp

CODE TRIAGE
ALERT, INTERNAL and EXTERNAL

I. PURPOSE

To provide an appropriate response to all hazards and events that may potentially have a significant impact on the normal operation of the facility.

II. DEFINITIONS

"All-hazards plan" basic framework for response to a wide variety of events

Code Triage: Alert informs appropriate staff that an event has occurred, or may occur, that could potentially impact the facility.

Code Triage: Internal is the activation of the organization's Emergency Operations Plan (EOP) to respond to an event that has occurred within the facility.

Code Triage: External is the activation of the organization's Emergency Operations Plan (EOP) to respond to an external event that has disrupted, or may disrupt, the facility's normal operations.

III.   **POLICY**

A.   The organization has an established Emergency Operations Plan (EOP) that addresses "all hazards" emergencies in accordance with state and federal laws, the National Incident Management System (NIMS), the California Standardized Emergency Management System (SEMS), The Joint Commission accreditation standards, the Occupational Safety and Health Administration (OSHA), and/or other regulatory agencies.

B.   The Hospital Incident Command System (HICS) is used as the structure for the organization's incident management system.

C.   Each department develops individual protocols that support the organization's overall Code Triage response.

D.   A Code Triage is implemented when an incident occurs, or is anticipated or imminent to occur, that may significantly impact normal operations and/or require resources not readily available to appropriately respond to the incident.

E.   It is assumed that a Code Triage: Internal is automatically activated during an obvious incident that might impede communications, such as a large earthquake where power has been lost.

IV.   **PROCEDURES**

A.   Incident Recognition

1.   The facility may receive a warning or pre-incident intelligence that an incident that can significantly impact normal business operations is likely to occur is occurring, or has occurred without warning

2.   The administrator-in-charge is informed of any incident that is determined to be potentially disruptive to normal hospital functions.

B. Response

1. Code Triage Alert

   a. A *Code Triage: Alert* is given when a response is likely or imminent and should prompt an elevated level of preparedness.

   b. The administrator-in-charge, by policy, assumes the role of incident commander or assigns the duties to a qualified individual.

   c. The incident commander will notify key personnel by contacting the operator to initiate a Code Triage: Alert. The operator will announce the code via multiple communication systems (e.g., overhead page, mass notification system, telephone, pagers, radio, runners).

   d. The activation of a Code Triage: Alert should result in the following:

      i. The response of pre-designated key personnel to respond to the Hospital Command Center (HCC) for an incident briefing and planning meeting.
      ii. The nature and severity of the incident will determine if the Hospital Command Center (HCC) will be partially or fully activated.

2. Code Triage Internal or External

   a. A *Code Triage: Internal / External* activation is initiated when an organizational response is required.

   b. The administrator-in-charge or the most qualified person assumes the role of incident commander or assigns the duties to a qualified individual.

   c. The incident commander notifies all personnel that the Emergency Operations Plan (EOP) has been activated by contacting the operator to initiate a Code Triage: Internal or External. The operator will announce the code via multiple communication systems (e.g., overhead page, mass notification system, telephone, pagers, radio, runners).

   d. The activation of a Code Triage: Internal or External should result in the following actions:

      i. The incident commander assigns the initial incident management positions needed to develop the initial

Incident Action Plan (IAP) based on the incident objectives.

    ii.   An assessment of the operational status and resources of all departments is reported to the HCC (usually on a standardized form or checklist).

    iii.   The incident commander or his/her designee immediately opens the Hospital Command Center (HCC).

3.   Incident Action Plan (IAP)

    a.   As soon as possible after the Code Triage activation, the incident commander conducts a briefing and planning meeting with the initial incident management team to develop the Incident Action Plan (IAP) based on the incident objectives.

        i.   The incident commander establishes an *operational period* based on the incident, usually set in terms of hours, to accomplish a given set of tactical actions. The IAP should be updated for each operational period.

        ii.   The incident commander establishes the incident's *control objectives* to define where the organization wants to be at the end of the response. These broad objectives are foundational and will not change over the course of the incident.

        iii.   The incident commander establishes *operational objectives* to achieve the control objectives. These are steps or actions to be accomplished during the defined operational period.

    b.   The operational objectives are simple, measurable, achievable and realistic and time sensitive.

    c.   The IAP identifies the needed resources to meet the objectives, including personnel, equipment, supplies, pharmaceuticals and vehicles.

    d.   The IAP should be formally documented on the appropriate HICS forms.

4.   Building the Incident Management Team

    a.   Once the incident objectives and needed resources are identified, the incident management team positions are assigned to accomplish those objectives.

    b.   The incident commander is responsible for assigning the command and general staff positions, while the general staff

section chiefs are responsible for assigning the needed positions within their respective sections.

c.   Only those personnel who have completed the required incident command training specified by the National Incident Management System (NIMS) and other hospital or corporate requirements are appointed to command positions.

5.   Hospital Command Center (HCC)

a.   An area should be established where HCC materials and supplies are readily available.

b.   The HCC is located away from the areas impacted by the incident and is easily accessible. A nearby location is identified for briefings. A secondary HCC location is ready to be utilized in case the primary location has been impacted and is not usable.

c.   The HCC has available all possible lines of communication, such as telephone with fax, cell phone, hand-held radio, and HAM radio reception.

6.   Hospital Command Center (HCC) Activities

a.   The incident commander conducts a planning meeting with the initial incident management team to confirm/develop the strategy/tactics.

b.   The IAP is prepared and approved.

c.   The incident commander conducts an operations briefing to brief the operational leaders on the action plan.

d.   The operational leaders then implement the action plan.

e.   Periodic management meetings are held to evaluate and revise the incident objectives, as needed.

f.   The incident commander briefs Administration and/or the Board of Directors ("Agency Executives") as appropriate.

g.   Documentation of all incident planning, interventions, response activities, resource requests, and outcomes are completed in accordance with HICS Guidelines.

7.   Demobilization

a.   Demobilization planning begins at the outset of the incident and is included as part of the Incident Action Plan.

b.   Demobilization of positions/roles and resources occurs as incident objectives are met.

c.   When the decision to demobilize has been made, it is communicated in a timely and effective manner to the hospital staff and appropriate external agencies.

d.   Management of the public's perception throughout the demobilization protects the facility's reputation and informs the public of the facility's recovery and return to normal business operations.

C.   Recovery

1.   All Clear

a.   The incident commander shall issue an "all clear" notification to the operator to indicate the termination of the response operations after consultation with appropriate agencies and staff

b.   The operator shall announce, "Code Triage, all clear" three (3) times via the overhead paging system and via any other communication mediums used.

c.   All employees are to return to normal operations.

C.   System Recovery

d.   The transition from response to recovery operations is rarely obvious.

e.   Staffing levels, functions, activities and resources return to their normal or new normal levels.

f.   Recovery operations may continue for weeks or even years after incident response operations have terminated.

g.   The recovery phase may be managed by utilizing incident management concepts. The command and general staff positions may be fulfilled by different hospital staff than those during the response phase

h.   Address any other personnel issues, such as:

i. Those who wore PPE complete medical surveillance forms and receive an appropriate health debriefing which covers signs and symptoms of potential after affects.

        ii.   Financial, psychological and medical care issues of any staff member who became ill or injured during the response are addressed.

        iii.   Formal and informal recognition of individuals and hospital unit.

D.   Training and Education

    1.   All personnel receive an initial orientation to the facility's Emergency Operations Plan (EOP) and annual refresher training as appropriate.

    2.   Specific training (e.g., NIMS, HICS, TJC, OSHA) may be required for individual positions and responsibilities.

    3.   Annual functional exercises are conducted based on requirements and standards to test the facility's response to an all-hazards incident.

    4.   Refer to the Hospital Incident Command System (HICS) Guidebook for more information.

E.   Documentation & Reporting

    1.   After Action Report (AAR)

        a.   Immediately following any incident, including field and tabletop exercises, the incident commander ensures the planning section gathers and consolidates all relevant incident documentation and evaluations to publish an After Action Report (AAR).

        b.   The AAR is a record of what worked well and what needs improvement. The draft AAR should be submitted to the appropriate authority (e.g., emergency management or safety committee) with recommendations for improvement.

    2.   Corrective Action Plan (CAP)

        a.   The appropriate authority (e.g., emergency management or safety committee) should approve relevant recommendations and track the implementation of the approved corrective actions.

        b.   Make changes to the Emergency Operations Plan (EOP) in accordance with the approved recommendations.

V. REFERENCES

The Hospital Incident Command System (HICS) Guidebook, www.emsa.ca.gov/HICS.

The Joint Commission, www.jcrinc.com/Joint-Commission-Requirements.

CODE WHITE: MEDICAL EMERGENCY (PEDIATRIC)

Facilities should define the classification between adult (Code Blue) and pediatric (Code White) patients. Whatever definition is chosen should be clear to staff.

V. PURPOSE

To provide an appropriate response to a suspected or imminent cardiopulmonary arrest or a medical emergency for an adult or pediatric patient.

VI. POLICY

Code White is called for patients who do not have an advance healthcare directive indicating otherwise.

C. **Code White** is to be initiated immediately whenever a patient fitting the criteria for a pediatric patient is found in cardiac or respiratory arrest (per facility protocol). In areas where pediatric patients are routinely admitted there should be a pediatric crash cart available. If a Code White is called in an area without a pediatric crash cart, the designated response team will bring a crash cart with pediatric equipment.

D. If the patient's weight does not meet the expected developmental growth, consider a response based on the appropriate protocol (e.g., ACLS/PALS).

VII. PROCEDURES

Code White teams should not enter an area where a Code Silver was called until the area has been determined by law enforcement to be safe.

Code White team members function within their respective scopes of practice and utilize guidelines set by the American Heart Association on Advanced Cardiac Life Support. The members perform functions that include, but are not limited to, the following:

C.   Response

13. Person discovering an adult/child in cardiopulmonary arrest:

a. Assesses patient's airway, breathing and circulation;
b. Calls for help.
c. Initiates CPR and notes time.
d. Does not leave the patient.

14. First responding physician:

    a. Assume the role of Code White team leader.
    b. Initiate direct emergency orders, as appropriate.
    c. May transfer responsibility of team leader to attending physician or emergency department physician.
    d. Team leader signs the Code White record.

15. Personnel from department calling the Code White:

    a. Initiate Code White per facility protocol.
    b. Assess patient and begin procedures to open airway, begin rescue breathing and/or initiate CPR, as indicated.
    c. Obtain crash cart.
    d. Attach monitor leads.
    e. Assume compressions and/or ventilation until the Code White response team arrives.

16. Nurse assigned to patient:

    f. Provide most recent data on the patient, including the pertinent history and vital signs.
    g. Bring chart and Kardex to room and act as information source.
    h. Take responsibility for completion of the Code White record, other facility designated forms, and distribution of forms to appropriate departments.
    i. Mark and maintain monitor strips.
    j. Sign Code White record.

17. Designated nurse with appropriate training (e.g., ACLS/PALS), two (2) every shift, to be determined by policy:

    j. Respond to area/department where Code White is called.
    k. Ensure placement of cardiac monitor and assesses initial rhythm.
    l. Direct and delegates code responsibilities to nursing and other personnel.
    m. Direct Code White until physician arrives.
    n. Perform ongoing evaluation of patient status.
    o. Monitor and evaluate CPR procedures.
    p. Establish IV line and administer medications according to appropriate guidelines (e.g., ACLS/PALS or other approved protocol) or as ordered.
    q. Interpret EKG rhythm and defibrillate according to appropriate guidelines (e.g., ACLS).
    r. Sign Code White record.

18. Respiratory Therapy personnel:

    e. Assume ventilation responsibilities upon arrival.
    f. Assist with intubation and obtaining blood gases when needed.
    g. Stay with patient through transport.

h. Sign Code White record.

19. Department clinical coordinator or charge nurse/ACLS (administrative supervisor, after hours):

   g. Record pertinent data on Code White record.
   h. Act as communication liaison to attending physician, family and pastoral care.
   i. Support family members present during event.
   j. Act as a resource and help coordinate Code White.
   k. Coordinate and review interdisciplinary Code White team.
   l. Assist staff in evaluation of performance during code event.

20. Pharmacist:

   g. Exchange the used medication tray immediately after Code White to ensure readiness of the cart.
   h. After hours, administrative supervisor is responsible for replacing the medication tray.
   i. Mix medication, solutions and label medication during code.
   j. Calculate drip rates and dosages.
   k. Act as a resource.
   l. Sign the Code White record.

21. Central Service or other responsible department staff member:

   c. Respond to each Code White with replacement cart.
   d. After hours, the administrative supervisor will replace cart.

22. Operator:

   c. Voice page Code White and location three (3) times when notified.
   d. Use pager system to notify appropriate interdisciplinary Code White team.

23. Chaplain/Social Worker (if requested):

   c. Support the family.

   d. Support the staff as needed.

24. Security:

   c. Coordinate necessary movement of other patients and visitors.
   d. Manage crowd control.

D.   Training and Education

   1. All direct patient care personnel will re-certify in BCLS annually.

   2. Specialized cardiac life support training (e.g., ACLS) is provided for physicians and nurses as required.

3. A program offering an interdisciplinary approach to managing Code White events provides opportunities for the purpose of enhancing clinical skills, including team training.

4. Training of personnel follows the guidelines of the American Heart Association on Advanced Cardiac Life Support.

5. Education includes review of all policies, procedures, and regulatory standards.

6. Verbal or written test.

VIII. REFERENCES

Advanced Cardiac Life Support (ACLS) and Pediatric Advance Life Support (PALS) certification courses, American Heart Association.

California Code of Regulations, Title 22, § 70405(g), § 70743.

Consent Manual 2007, 27th Edition, Sacramento, CA, CH 3; The California Healthcare Association.

Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care, Emergency Cardiac Care Committee and Subcommittees, American Heart Association, Part IX; "Ensuring Effectiveness of Community-Wide Emergency Cardiac Care," 1992; JAMA, 28; 268 (16), pp. 2289-95.

The Hospital Incident Command System (HICS) Guidebook, www.emsa.ca.gov/HICS.

The Joint Commission, www.jcrinc.com/JointCommission-Requirements.

CODE YELLOW: BOMB THREAT

I. PURPOSE

To provide an appropriate response in the event of a bomb threat or the discovery of a suspicious device or item.

II. DEFINITIONS

Bomb Threat: A bomb threat exists when any communication is received that a bomb or other explosive device has been placed or secreted in any public or private place.

Device/Package: A known or suspected explosive device/package (e.g., bomb, backpack).

III. POLICY

Bomb threats do occur in healthcare facilities; however, the motive for making a bomb threat is primarily to disrupt business operations or to threaten harm or the loss of life.

A. The director of security and the administrator-in-charge coordinate the bomb threat response procedures.

B. Department managers are responsible for thoroughly acquainting themselves with the plan and using their own judgment regarding the personnel in their departments who need to be informed on bomb threat procedures.

C. The decision to evacuate is resolved through consultation between law enforcement and the administrators of the healthcare facility to balance the risk of a potential explosive versus the risk of moving patients.

D. Do not touch or move a bomb or suspicious item.

IV. PROCEDURES

A. The Threat

1. Threats may be communicated verbally, in writing or as a package. Any location within the facility may receive the threat. It is also possible that a potential explosive device may be discovered on the premises without the facility receiving a previous call or warning. While the majority of bomb threats received are usually hoaxes – made in an attempt to disrupt normal business operation – it is important to take every threat seriously and never disregard a bomb threat.

2. *If you receive a bomb threat by telephone*:
   a. Remain calm. Do not hang up.
   b. Take note of the caller's exact words. Try to prolong the conversation and get as much information as possible. Use a *Bomb Threat Checklist* as a guide to record the details of the threat.
   c. Attempt to ascertain when the bomb will detonate, where the device is located, what it looks like, and why it was placed at this location.
   d. When the call is over, notify your supervisor and security immediately and complete the *Bomb Threat Checklist* or similar documentation immediately.
   e. Stand by for further instructions. If it is deemed necessary to search your area or to evacuate, you will be notified by your supervisor or via the overhead paging system.

3. *If you receive a written threat*:
   a. Gather all materials as evidence, including any envelopes or containers.
   b. Avoid further handling to prevent the contamination of evidence.

c. Notify your supervisor or security immediately.

4. *If a suspicious letter/package is received by mail*:

a. Do not accept unsolicited packages. If a package is delivered under unusual circumstances, or is unexpected, the authenticity of the delivery should be verified with the sender, delivery person or service. If any doubts exist about a letter or package, treat it as a suspicious package.

b. Mail bombs have been contained in letters, books, and parcels of varying sizes, shapes, and colors. When examining suspicious packages, look for the following characteristics of a letter bomb:

- No return address – sender is unknown.
- Restrictive markings such as Confidential, Personal, Private, etc.
- Endorsed with "Fragile – Handle with Care" or "Rush – Do Not Delay."
- Excessive postage.
- Foreign mail, air mail or special delivery.
- Misspelled words.
- Handwritten or poorly typed addresses.
- Addressed to title only, without specific names.
- Incorrect titles with name.
- Oily stains, discoloration, or crystallization on wrapper.
- Excessive weight.
- Rigid or bulky envelope.
- Lopsided or uneven envelope.
- Protruding wires or tinfoil.
- Visual distractions.
- Excessive securing material, such as masking tape, string, etc.
- Strange odor.
- Package makes a buzzing, ticking, or sloshing sound.

c. If you have a *suspicious package* as described above and are unable to verify the contents:

i. Handle the item with care. Do not shake or bump.
ii. Do not open, smell or taste the article.
iii. Isolate the mailing and secure the immediate area.
iv. Do not put in water or in a confined space, such as a desk drawer or filing cabinet.
v. If possible, open windows in the immediate area to assist in venting potential explosive gasses.
vi. Contact security immediately.

d. If you receive a *suspicious package* containing an unidentified substance:

   i. Do not handle the item.
   ii. Do not open, smell or taste the article.
   iii. Isolate the mailing and secure the immediate area.
   iv. Call security immediately.
   v. Ensure that all persons who have touched the item wash their hands with soap and water.
   vi. List all persons who have come into contact with the item. Include contact information and provide the list to authorities.
   vii. Place all items worn when in contact with the suspected item in plastic bags and have them available for authorities.
   viii. As soon as practical, shower with soap and water.

e. If a letter or package is received that is not expected by the addressee and whose origin cannot be identified, but otherwise does not meet the characteristics of a suspicious package, the item should be referred to as "*Mystery Mail*." Once you identify mystery mail:

   i. Isolate the item(s) from the building, its air supply, and critical areas.
   ii. Carefully open the item(s) and based on the mail contents; throw away, deliver, or treat as suspicious.

B. The Evaluation of the Threat

1. Most bomb threat calls are hoaxes, and, in most cases, the objective of the person who calls in a bomb threat is to disrupt business activity. Consequently, the philosophy in dealing with a threat is aimed at analyzing the threat rather than reacting to it. Aside from the disruption, loss of productivity and safety issues involved in the evacuation of patients/employees/visitors, a hasty evacuation almost always results in a rash of subsequent threats.

2. There are generally only two reasonable explanations for reporting that a bomb will off at a particular location:

   a. The caller has definite knowledge or believes that an explosive or incendiary device has been or will be placed and wants to minimize personal injury or property damage.

   b. The caller wants to create an atmosphere of anxiety and panic, which, in turn, possibly results in the disruption of normal activities at the location where the device is purportedly located.

3. The following threat categories have been established to assist management in assessing the risk of the threat based on the information received. These threat categories should be used only as a guide, and not as a steadfast rule:

a. <u>Category I – Non-specific Threats</u>: Category I threats are non-specific (e.g., "I'm going to blow you up!"). This corresponds to a caller who wishes to disrupt normal business rather than one who wants to minimize injury or damage. Recommendation: Don't evacuate – conduct a discreet search.

b. <u>Category II – General Threats</u>: Category II threats are general in nature (e.g., "I'm going to blow up your facility next week!"). These types of threats are also intended to disrupt normal business operations. Recommendation: Don't evacuate – conduct a discreet search.

c. <u>Category III – Specific Threats</u>: Category III threats are specific (e.g., "A bomb is going to go off in your Emergency Room today at 12:00 noon."). This type of bomb threat may be indicative of a suspect who wishes to minimize the loss of life by giving a warning. Recommendation: Initiate a Code Yellow and conduct a thorough search. Consider evacuation based on the information available.

4. The security supervisor notifies the security director and the administrator-in-charge and informs them of the threat.

5. The security director will evaluate the threat based on all of the information available and recommend a course of action to the administrator-in-charge. Should the security director be unavailable, the administrator-in-charge will direct the operator to contact law enforcement and request immediate assistance.

6. If the threat analysis results in a decision to search the premises or to evacuate, a Code Yellow may be declared.

C. Code Yellow

1. Alerting and Notification

a. Should a search of the premises be warranted, or if a suspected explosive device is found, the administrator-in-charge or security director will instruct the operator to announce "Code Yellow" three (3) times over the page system and through the department notification procedure. The page will be repeated every three (3) to five (5) minutes.

b. The administrator-in-charge will initiate the facility's Emergency Operations Plan (EOP) and establish the Hospital Command Center (HCC). Ensure the HCC location is searched before setting up operations.

c. The administrator-in-charge, by policy, will assume the role of incident commander or will delegate the responsibility to the most qualified individual.

d. Each department will report in to the HCC and accept duties as delegated by the incident commander.

e. The incident action plan (IAP) objectives may include:

Initial Incident Objectives
☐   Evaluate the threat.
☐   Determine if an actual device is present.
☐   Protect all staff, patients and visitors.

f. All personnel are to be on alert for persons acting in a suspicious manner and for any suspicious objects and report them to security immediately.

2. Searches

a. During the search for a potential explosive device, it is recommended that a low profile be maintained because it can be potentially dangerous to unnecessarily alarm people. A discreet search can be accomplished by management without evacuating the facility.

b. If a Code Yellow was declared, or if the facility was evacuated prior to the search, the building should be systematically and cautiously searched beginning with exterior and public areas. When possible, persons familiar with the area should conduct the search accompanied by security or law enforcement. Search teams will vary in size depending on the number appropriate for the area being searched. (Two [2] person teams minimum).

c. If the security department has a trained explosives detection K-9 team on staff, they should be used in the search process. If the K-9 team is used, the K-9 handler must give direction regarding the mechanics of the search.

d. Department management is responsible for searching their entire area as well as any areas assigned. Available security officers and other personnel will be assigned to help search public access areas and any other areas as assigned.

e. The incident commander may request that security restrict building entry points with additional personnel posted to screen anyone entering with a package. If a suspected device is located, the incident commander may request a complete hospital lockdown until the device is rendered safe.

f. Teams entering areas to be searched should stop, look and listen. By remaining quiet and listening for audible sounds, they may hear a timing device. All machinery which could create extraneous sounds should be shut off (computers, copy machines, electric typewriters, etc.). A visual examination can also reveal any items that are foreign to a particular area which should be considered suspect.

g. The room should be mentally divided for search purposes. Search the room one level at a time. The first level should include the floor, rug, furniture, etc., to a level reaching the waist of the searcher. The next level of the search should be any area or item that is present in the room from the waist of the searcher to the top of their head. The next level of the search should be any area or item on a level from the top of the head of the searcher to the ceiling and above. The ceiling panels should be checked to ensure no false ceiling is present and that no foreign item has been hidden in the ceiling space.

h. The search should begin at one side of the room and work toward the center. Inspect furniture, cabinets, closets, clocks and wall fixtures, sinks and other lavatory facilities, loose clothing, light fixtures, water coolers, trash receptacles, refreshment canteen machines, public telephone booths, and window coverings, such as venetian blinds and drapery fixtures.

i. Anyone involved in the search must be admonished NOT to handle, move, or disturb objects suspected of being bombs, or activate light switches, thermostats or other mechanisms that might trigger an explosive device. This includes any unfamiliar or out-of-place objects.

3. *If Nothing Out Of The Ordinary Was Found*:

a. If NO device is located, all parties who are aware of the search should be notified that a device was NOT found, especially the incident commander. Appropriate hospital management should tell the parties involved that "NOTHING OUT OF THE ORDINARY WAS FOUND." *Do not tell the parties that the location is safe*. An incident report should also be completed to document the event. If the area is clear, contact the Hospital Command Center (HCC) immediately, and inform the incident commander that the area is <u>clear</u>.

b. The appropriate security authority and the incident commander will assess the situation and make a decision about whether to evacuate.

4. *If A Suspicious Device is Located*:

a. If a device or suspect device is located – <u>do not touch it!</u> Note its location, description and proximity to utilities, gas lines, water pipes and electrical panels.

b. Report this information to the Hospital Command Center (HCC) then clear and secure area.

c. Call 911.

d. Law enforcement will take charge of the area and direct any needed evacuation. The decision to evacuate should be made through a unified command consisting of the hospital's incident commander and law enforcement's incident commander.

e. A discovery of one suspected device does not end the search. More devices may be present and search efforts should continue until the entire facility has been checked.

V. EVACUATION

A. The most serious decision management must make in the event of a bomb threat is whether or not to evacuate the building. Evacuating when the threat is a hoax can result in serious implications to patient care and can be very costly – especially if employees learn that they can leave early every Friday afternoon if they call in a bomb threat. Choosing not to evacuate the building then learning that a device was present could be even more costly.

B. An evacuation decision should be made only if an actual device has been located or substantiated through clear and reliable information provided by the caller based on the threat criteria.

C. Prior to evacuating, employees should check their immediate work area for suspicious packages or items that do not appear to belong. If a suspicious item is located, they should not touch the item and contact the appropriate authority immediately.

1. Make emergency notifications and call 911 (do not use radios or cellular telephones).

2. Post a temporary sentry near the device to protect it from inadvertent contact by employees until the area can be successfully vacated.

3. Evacuate the building (including the temporary sentry).

4. Check to see that all doors and windows are open to minimize damage from a blast and secondary damage from fragmentation.

5. Establish a minimum 300-foot cordon around, above and below the object. Secure the area until authorities arrive by posting sentries and/or using crime scene tape to prevent access to the danger area. Law enforcement may choose to evacuate to a greater distance depending on the location or size of the suspected device.

6. Do not permit re-entry into the area until the device has been removed or disarmed and the building has been declared safe for re-entry.

7. Report the location and an accurate description of the object to the appropriate authorities.

8. Reentry into the facility, relocation to another facility, and a decision to send employees home should be made according to existing policy.

D. Explosion

1. If an explosion occurs, initiate Code Triage – Internal.
2. Evacuate the facility immediately – secondary devices may exist.

3. Call 911.
4. Establish a 1,000-foot cordon around, above and below the blast area. Secure the area until authorities arrive by posting sentries and/or use crime scene tape to prevent access to the blast site. Law enforcement may choose to evacuate to a greater distance depending on the location or size of the device.
5. Treat injured in an area away from the blast site.
6. Record the names and contact numbers of potential witnesses.
7. Support law enforcement efforts as requested.

E.   All Clear

1. When it has been determined that there is no evidence of a device in the facility, or the suspected device has been rendered safe, the incident commander will notify the operator to announce, "Code Yellow, all clear," three (3) times.
2. All personnel will return to their normal duties.

3. Management will conduct a root cause analysis or similar review of the incident to identify areas for improvement and then implement those improvements

F.   Other Important Considerations:

1. If a known or suspected device is in a vehicle: do not attempt to search for it.
2. Upon notification of a Bomb Threat all wireless devices are to be turned off immediately.
3. Should press or other news media be present, take firm position not to allow use of satellite dish for transmitting or reporting purposes. This is a possible source of detonation.
4. Be prepared to conduct crowd control should the "bomb squad" arrive.
5. Avoid use of the term "bomb" – use the term "device."
6. Have available supplies such as flashlights, mirrors, knives, screwdrivers, tape, ladders, etc., to assist in search efforts.

VI.   REFERENCES

Bomb Threat and Physical Security Planning, Department of the Treasury, Bureau of Alcohol, Tobacco and Firearms, 7/87.

California Code of Regulations, Title 22, §70743, §70746.

The Hospital Incident Command System (HICS) Guidebook, www.emsa.ca.gov/HICS.

The Joint Commission, www.jcrinc.com/Joint-Commission-Requirements.