HEALTH CARE EMERGENCY CODES

A GUIDE FOR CODE STANDARDIZATION

HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA®

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Hospital Council of Northern & Central California

CALIFORNIA HOSPITAL ASSOCIATION

HOSPITAL ASSOCIATION of San Diego and Imperial Counties

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

Page

INTRODUCTION

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:

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

In 2008, the codes were reviewed by members of the committee and updated to ensure compliance and conformity to the National Incident Management System (NIMS), the Hospital Incident Command System (HICS), the Joint Commission and other regulatory and accrediting agencies. Additionally, a new code was added (GREEN for Patient Elopement) and Code TRIAGE was expanded to include an ALERT.

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.

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Hospital Association of Southern California
March 2009
Los Angeles, California

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CODE RED: FIRE

I.   PURPOSE

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

II.   POLICY

A.   Due to the potentially devastating effects of a fire and the non-ambulatory nature of many patients, all employees have a responsibility to respond quickly to a suspected or actual fire.

B.   Code Red should be immediately initiated whenever any one of the following indications are 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 shall perform 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 must complete an annual safety training that includes appropriate fire/life safety procedures. The Code Red Task Force shall also receive appropriate annual training in accordance with their duties.

E.   Each department must develop individual protocols that support the organization's overall Code Red response.

III.   PROCEDURES

A.   Upon discovery of fire (suspected or actual)

1. At origin:

a. **R.A.C.E**.
Remove patients, visitors and personnel from the immediate fire 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**. – Fire extinguishing techniques:
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 assist, as needed. Do not automatically evacuate unless there is an immediate threat to life. Wait for instructions.
c. Nursing personnel are to return to their assigned units.

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 will assume the role of the team leader and will coordinate with a senior member of the department where the alarm is occurring, if applicable.
d. Each Task Force member shall perform specific functions, as assigned by the team leader, which support 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 will respond to the fire alarm location.

3. The Task Force will coordinate with a senior member of the department where the alarm is occurring and, if applicable, conduct 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 will declare an "all clear" and will document as appropriate.
   b. If an active fire is occurring, the team leader will initiate an appropriate response, such as notifying the house supervisor or administrator-on-call, or initiating a house-wide "Code Triage: Internal."

C.   Code Triage: Internal – Fire

   1. Incident Response:
      a. By policy, the administrator-in-charge will initiate a "Code Triage: Internal" and will assume the role of the incident commander.
      b. The incident commander will appoint the appropriate command and general staff positions.
      c. The incident commander will activate the Hospital Command Center (HCC), as appropriate.
         i.   If the incident commander is to work out of the Incident Command Post (ICP), consider appointing a deputy incident commander within the Hospital Command Center (HCC).
         ii. If the incident commander is to work out of the Hospital Command Center (HCC), ensure 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 should be undertaken only at the direction of the incident commander. This should be done 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. Ensure patient records and medications are transferred with the patient upon evacuation or transfer.
      f. Considerations for the shut off of oxygen should be made, as oxygen can promote the spread of fire and is found in most patient care areas. Ensure proper coordination with engineering, nursing, anesthesia, and pulmonary/ respiratory before shutting off medical gases to the affected area(s).
      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.
      h. Account for all on-duty staff and recall additional staff as necessary.
      i. Ensure the accurate tracking of patients and the appropriate notifications.
      j. Consider establishing a media staging area

   2. Recovery:
      a. Consider providing mental health support for staff.

b. Track all related incident costs and claims.

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

3. All Clear:

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

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

c. All employees are to 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 should be reviewed and retained. Reporting of the incident may be completed through an event report, security report, fire activation report, or other reporting method.

E.   Training and Education

1. All employees should 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 shall receive 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, accessible via the Internet at www.emsa.ca.gov/HICS.

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

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

The Joint Commission requirements, accessible via the Internet at www.jcrinc.com/Joint-Commission-Requirements.

CODE BLUE: MEDICAL EMERGENCY (ADULT)
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.

I. **PURPOSE**

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

II. **POLICY**

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

A. **Code Blue** is to be initiated immediately whenever an individual eight years of age or older 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. **Code White** is to be initiated immediately whenever an individual eight years of age or younger 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.

C. 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/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:

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. Assumes the role of Code Blue/Code White team leader.
   b. Initiates 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/Code White record.

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

    a. Initiates Code Blue/Code White per facility protocol.

    b. Assesses patient and begins procedures to open airway, begins rescue breathing and/or initiates CPR, as indicated.

    c. Obtains crash cart.

    d. Attaches monitor leads.

    e. Assumes compressions and/or ventilation until the Code Blue/Code White response team arrives.

4. Nurse assigned to patient:

    a. Provides most recent data on the patient, including the pertinent history and vital signs.

    b. Brings chart and Kardex to room and acts as information source.

    c. Takes responsibility for completion of the Code Blue/Code White record, other facility designated forms, and distribution of forms to appropriate departments.

    d. Marks and maintains monitor strips.

    e. Signs Code Blue/Code White record.

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

    a. Responds to area/department where Code Blue/Code White is called.

    b. Ensures placement of cardiac monitor and assesses initial rhythm.

    c. Directs and delegates code responsibilities to nursing and other personnel.

    d. Directs Code Blue/Code White until physician arrives.

    e. Performs ongoing evaluation of patient status.

    f. Monitors and evaluates CPR procedures.

    g. Establishes IV line and administers medications according to appropriate guidelines (e.g., ACLS/PALS or other approved protocol) or as ordered.

    h. Interprets EKG rhythm and defibrillates according to appropriate guidelines (e.g., ACLS).

    i. Signs Code Blue/Code White record.

6. Respiratory therapy personnel:

    a. Assumes ventilation responsibilities upon arrival.

    b. Assists with intubation and obtains blood gases when needed.

    c. Stays with patient through transport.

    d. Signs Code Blue/Code White record.

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

    a. Records pertinent data on Code Blue/Code White record.

    b. Acts as communication liaison to attending physician, family and pastoral care.

    c. Supports family members present during event.

       d. Acts as a resource and helps coordinate Code Blue/Code White.

       e. Coordinates and reviews interdisciplinary Code Blue/Code White team.

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

8. Pharmacy:

       a. Exchanges the used medication tray immediately after Code Blue/Code White to ensure readiness of the cart.

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

       c. Mixes medication, solutions and labels medication during code.

       d. Calculate drip rates and dosages.

       e. Acts as a resource.

       f. Signs the Code Blue/Code White record.

9. Central Service or other responsible department:

       a. Responds to each Code Blue/Code White with replacement cart.

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

10. Communication Service/facility operator:

       a. Voice pages Code Blue/Code White and location three (3) times when notified.

       b. Sets off pager system to appropriate interdisciplinary Code Blue/Code White team.

11. Chaplain/Social Worker (if requested):

       a. Supports the family.

12. Security:

       a. Coordinates necessary movement of other patients and visitors.

       b. Manages 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) as required.

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

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

5. Review of all policies and procedures.

6. Review of regulatory standards.

7. 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, accessible via the Internet at www.emsa.ca.gov/HICS.

The Joint Commission requirements; accessible via the Internet at www.jcrinc.com/JointCommission-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 suspicious 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 incapable 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; and may also try to abduct from the home setting.

- Usually plans the abduction, but does not necessarily target a specific infant; frequently seizes on any 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 as follows: 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. All reasonable measures should be taken to prevent the abduction of an infant from the hospital.

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

C. Each department should develop 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. Every department should develop a written, critical-incident response plan in the event of a suspected or confirmed infant abduction, 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 on protecting infants from abduction (see: "Orientation and Education" below).
   g. 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.
   h. Establish an access-control policy for the maternal-child health nursing unit.

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 that indicates personnel that have direct contact with infants and children or authorized access to those areas.

3. Patient Education

   a. Distribute guidelines for parents on preventing healthcare facility abductions. Some 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 may cover all relevant healthcare facility identification procedures, and outline standard nursery procedures, visitation policies and the importance of never leaving the infant unattended.

   c. Hospital discharge parent education should include guidelines for prevention of infant abduction in the home and community.

   d. Parent(s)/guardian(s) should be 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, ensure that:
      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. Never leave an infant out of direct line-of-sight supervision.

   b. When in the mother's room:
      i. Bassinets should be placed near the mother and, when possible, the mother's bed should be 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. 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.

   e. 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.

f. Consider having the patient's nurse introduce each additional healthcare provider to the patient and during shift change.

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

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

i. Conduct a Code Pink drill – 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. Alarms on stairwells and exit doors on the perimeter of the maternity, nursery, neonatal intensive care and pediatric units.

b. Whenever an alarm is sounded, an immediate investigation to determine the cause of the alarm should be conducted, and, 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. Ensure all nursery doors have self-closing hardware and remain locked at all times.

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

e. Consider installation of a security-camera system that continuously records all activities.

f. If you have cameras, 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. Establish protocols for system maintenance of quality and reliability.

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

c. The facility operator shall provide the responding personnel with the relevant supporting information (e.g., the abductor's description, the location of unit where the child was last seen) as determined.

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) will be 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 shall be the assigned patient care nurse or designated charge nurse of the department where the alarm is occurring, if applicable. If no patients are involved, the team leader may be the ranking security representative.

   v.   Each Task Force member shall perform specific functions, as assigned by the team leader, which support the incident objectives.

   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 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 rest rooms, public rest rooms, waiting rooms, and empty rooms on unit, and report back with results of searches to charge nurse (team leader for Infant Abduction Task Force).

<blockquote>
iii. Communication between nursing staff, security and others via hand-held radios facilitates transmission of information and coordination of the response effort.
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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 will contact the administrator in-charge and report the actual abduction of an infant. The following procedures will be implemented in order to provide a systematic response to an infant abduction.

a. Incident Commander

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

    ii. The incident commander will appoint the appropriate command and general staff.

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

    iv. Call NCMEC at 1-800-THE-LOST (1-800-843-5678) for additional assistance in handling ongoing crisis management.

    v. The Public Information Officer (PIO) will ensure 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.

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 report it to the incident commander.

    ii. 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.)

    iii. Notify the involved pediatrician and obstetrician.

    iv. Have the nurse assigned to the mother and infant continue to accompany the parents at all times.

    v. Secure all records/charts of the mother and infant.

    vi. Notify the lab and place STAT hold on infant's cord blood or other blood samples.

    vii. Consider designating 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. Social services and pastoral services have their own response plans.

    ix. Team leader to brief all staff on the unit, and to reinforce confidentiality of incident.

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

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

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

    xiii. 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.

c. Security

    i. Immediately call the local police department. 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 or 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 facility operator announces "Code Pink, all clear" three (3) times.

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

C. Training and Education

    1. Staff members who deliver care to infants need to be 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, such as NCMEC literature.

        a. Infant security videos.

        b. Review of all policies and procedures.

        c. Review of regulatory standards.

        d. Review of case studies and any possible attempts.

        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 should receive the appropriate training and should 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, accessible via the Internet at www.emsa.ca.gov/HICS.

The Joint Commission requirements, accessible via the Internet at 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.   A state custody dispute may result in the taking of a child by an official of the Department of Family Services while the child is in the healthcare facility, perhaps for treatment of suspected child abuse.

D.   Children can often verbally let someone know when they face a threatening situation. However, some factors, such as domestic situations, state custody, and "wandering," create a need for an expansion of the infant monitoring system into the pediatric unit.

III.   **POLICY**

A.   All reasonable measures will be 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 shall be implemented.

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

D.   Each department must develop 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. Every department should develop a written, critical-incident response plan in the event of a suspected or confirmed child abduction, in support of the facility's Code Purple response plan.
   e. Proactive interaction with the child's legal guardian to determine if any threats (domestic situations, etc.) exist which could create a security problem for the child.
   f. Train staff on protecting children from abduction (see: Orientation and Education below).
   g. 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.
   h. Establish an access-control policy for the pediatric nursing unit.
   i. Instruct healthcare facility personnel to ask visitors which child they are visiting.

2. Patient Education

   a. Distribute guidelines for parents in preventing healthcare facility abductions.
   b. Information may cover all relevant healthcare facility identification procedures, visitation policies, and the importance of never leaving the child unattended.
   c. Hospital discharge parent education should include guidelines for prevention of child abduction in the home and community.
   d. Parent(s)/guardian(s) should be 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 a Code Purple drill, 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, and, 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.

f. Ensure all pediatric unit exit doors have self-closing hardware and remain locked at all times.

g. All doors to lounges or locker rooms where staff members change/leave clothing must have self-closing hardware and be 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. Consider installation of a security camera system that continuously records all activities.

j. If you have cameras, position them so they will capture the faces of all persons entering all entrances and exits of the pediatric unit.

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

l. Establish protocols for system maintenance of quality and reliability.

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

c. The facility operator shall provide 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 determined.

2. Code Purple Alarm Response

a. Code Purple Task Force

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

ii. The Hospital Incident Command System (HICS) will be 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 shall be the assigned patient care nurse or designated charge nurse of the department where the alarm is occurring, if applicable. If no patients are involved, the team leader may be the ranking security representative.

v. Each Task Force member shall perform specific functions, as assigned by the team leader, which support the incident objectives.

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 rest rooms, public rest rooms, 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 will contact the administrator in-charge and report the actual abduction of the child. The following procedures will be implemented in order to provide a systematic response to a child abduction.

a. Incident Commander

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

ii. The Task Force 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.

iii. 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.

iv. The Public Information Officer (PIO) will ensure 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.

v. Protect the crime scene.

b. Pediatric Staff

i. Move the parents of the abducted child 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.

ii. Notify the involved pediatrician.

iii. Have the nurse assigned to the child accompany the parents at all times.

iv. Secure all records/charts of the child.

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

vi. Contact social services and/or pastoral services to assist as needed.

vii. Nurse manager/supervisor to brief all staff on the unit, and to reinforce confidentiality of the incident.

viii. Nurses should then explain the situation to all of the other mothers on the unit, preferably while the mother and her child are together.

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

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

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

c. Security

   i. Immediately call the local police department. Consider calling the local FBI office requesting the Crimes against Children (CAC) coordinator.
   ii. Control and protect the crime scene until law enforcement arrives.
   iii. Notify newborn nurseries, postpartum and pediatric units, emergency rooms, and outpatient clinics, or 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.
b. The facility operator shall announce, "Code Purple, all clear" three (3) times via the overhead paging system.
c. All employees are to return to normal operations.

C. Training and Education

1. Staff members who deliver care to infants/children need to be 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, such as the following:

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

2. Members of the Code Purple Task Force should receive the appropriate training and should 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, accessible via the Internet at www.emsa.ca.gov/HICS.

The Joint Commission requirements, accessible via the Internet at www.jcrinc.com/Joint-Commission-Requirements.

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

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.

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: A known or suspected explosive device (e.g., bomb).

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 minimize the loss of life.

A.   The director of security and the administrator-in-charge shall 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 well informed on bomb threat procedures.

C.   Should a suspected device be found, the decision to evacuate must be resolved through consultation between the police department and administrators of the healthcare facility to balance the risk of a potential explosive versus the risk of moving patients.

D.   At no time should the healthcare staff try to touch a bomb or suspected bomb.

IV.   PROCEDURES

A.   The Threat

1. Any location may receive anonymous calls regarding the presence of an explosive device within the facility. It is also possible that a potential explosive device may be discovered on the premises without the facility receiving a previous call or warning. This may include the receipt of a suspicious package or letter. 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, complete the *Bomb Threat Checklist* or similar documentation immediately.

e. Notify your supervisor and security immediately.

f. 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 of 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, our 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 result 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. Category I – Non-specific Threats: 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. Category II – General Threats: 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. Category III – Specific Threats: 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 will notify the security director and the administrator- in-charge and inform 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 the police department 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 & 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 page 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 police. 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. The police department 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 the police department'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 use crime scene tape to prevent access to the danger area. Police 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/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. Police 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 hospital operator to announce, "Code Yellow, all clear," three (3) times.
   2. All personnel will return to their normal duties.

F.   Other Important Considerations:

1.   If a known or suspected device is in a vehicle: do not attempt to search for it.
2.   Do not use two-way radios during search for explosive device.
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, accessible via the Internet at www.emsa.ca.gov/HICS.

The Joint Commission requirements, accessible via the Internet at www.jcrinc.com/Joint-Commission-Requirements.

CODE GRAY: COMBATIVE PERSON

I.   **PURPOSE**

To provide an appropriate response to situations involving an aggressive/hostile/ combative or potentially combative person.

II.   **POLICY**

Aggressive, combative or abusive behavior can be displayed by anyone; a patient, a patient's family member, staff, staff family members, or acquaintances of employees and patients. Aggressive, combative or abusive behavior can escalate into a more violent episode.

A.   Staff will take responsible, proactive measures to ensure the safety and security of all persons on hospital property by effectively responding to and minimizing the number of assault victims and 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 staff 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 needs to make clear the facility's commitment to promote workplace safety, prohibit threats and violence of any kind, and require immediate reporting of any incident that causes a concern for safety, as well as requiring 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.
- Refusing 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. Managing aggressive behavior training. 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 facility operator and state that a Code Gray is in progress by giving the location and nature of the incident.

3. The facility 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, or, 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 potential 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 will respond to the incident location.

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

7. If the situation cannot be resolved using the Code Gray Strike Team, the local police department should be contacted for assistance.

8. When the Code Gray has been resolved, the Strike Team leader will call the facility operator and inform them to broadcast an "all clear."

9. All personnel will resume their normal duties.

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

D. Training and Education

Staff members and other personnel regularly assigned to the emergency department and staff members assigned to other departments should, as appropriate to their job responsibilities and relative risk to 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, by way of example, 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, accessible via the Internet at http://leginfo.ca.gov.

The Hospital Incident Command System (HICS) Guidebook, accessible via the Internet at www.emsa.ca.gov/HICS.

The Joint Commission requirements, accessible via the Internet at www.jcrinc.com/Joint-Commission-Requirements.

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

I.   PURPOSE

To provide an appropriate response in the event of an incident involving a person with a weapon or who has taken hostages within the facility (including an active shooter incident).

II.   DEFINITIONS

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

III.   POLICY

The hospital will take all reasonable measures to minimize the negative impacts of a situation involving a person with a weapon or a hostage situation.

IV.   PROCEDURES

A.   Discovery

1.   Anyone encountering a person brandishing a weapon should:

   a.   Seek cover and warn others of the situation.
   b.   Notify the facility operator of the incident with all known information.
      i.   Location – building, area, floor and room number.
      ii.   Abductor(s) – the number of suspect(s) and any physical descriptions.
      iii.   Any known hostages or victims.
      iv.   Any other relevant information (e.g., weapons, demands).

2.   The facility operator will:

   a.   Immediately initiate Code Silver specifying the location within the facility.
   b.   The facility operator will notify the administrator-in-charge and the security department of the incident.

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

B.   Response (Code Silver)

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

   a.   Evacuate if possible.
   b.   Seek cover/protection and warn others of the situation.
   c.   Do not panic and stay alert.

2.   Any staff members in an area distant from the area stated in Code Silver should:

a. Upon hearing Code Silver, stay away from the area specified in 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.

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

a. The Hospital Incident Command System (HICS) will be used as the incident's management structure.
b. Strike Team members may include representatives from security, administration, nursing, and other departments.
c. The Strike Team leader shall 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 Strike Team leader will report to the administrator-in-charge (incident commander) until directed otherwise.
f. 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.

4. The Code Gray Strike Team will respond to the incident location.

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

6. The Code Silver Strike Team will, if it is safe to do so:

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 do not allow anyone to enter or exit until the situation has been resolved or until directed by law enforcement authorities.

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.

7. 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.

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

C. Hospital Command Center (HCC)

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

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

   a. If the incident commander is to work outside of the Incident Command Post (CP), consider appointing a deputy incident commander within the HCC.
   b. If the incident commander is to work outside of the HCC, ensure a liaison officer is assigned to the police department's Command Post (CP).
   c. Consider establishing a "Unified Command" with the police department's incident commander.

3. The incident commander will appoint the appropriate command staff 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 to other nearby healthcare facilities. These facilities should be notified about the situation.

D. Police Arrive

1. When police arrive, it becomes a police incident and they will assume full responsibility of managing the situation. The police will request and expect cooperation and assistance from the staff.

2. The police will need a copy of the facility's layout, indicating rooms, exits, windows and utility access.

3. The police department will establish incident command post outside the facility, but away from the incident.

E. Media

1. The public relations department will contact families of identified hostages and serve as a liaison with the media.

2. All media coverage is to be directed by the public relations office. 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, and protection of privacy is extremely important. The police will request that any and all official

statements of the facility be discussed with the designated police representative before being released.

F.   All Clear

1. The incident commander, after consultation with law enforcement, shall issue an "all clear" notification to the facility operator to indicate the termination of response operations.

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

3. All employees are to return to normal operations.

G.   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.

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 requirements, accessible via the Internet at 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/Release: A spill or release of a substance that is likely to cause injury or illness, and may result in exposure that exceeds federal or state limits, or may harm the environment.

III.   POLICY

A.   Employees will be familiar with the products they are using, know how to use the product, and know the spill precautions they should take.

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

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

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

E.   Each department will ensure their 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.   The department will determine the appropriate level of response to decontaminate the spill/release.

1. Level I – The department will decontaminate 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 or releases a product, or discovers a spilled or released product, they must notify their supervisor immediately. The department will determine the appropriate level of response based on the identification.

a. **Level I**: The department can control and remove the product using existing spill containment supplies. This response can include contacting environmental services to remove the product using a mop and rinse water, as long as the product can be discarded through the sewer system.

   i. Follow departmental procedures.
   ii. Notify the department's management.
   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. Isolate spill area; deny entry to others.
   ix. Engineering controls will be implemented as appropriate (e.g., increase ventilation).
   x. Read the Material Safety Data Sheet (MSDS) for precautions, work with a partner, and use spill kit to clean up.
   xi. As appropriate, staff exposed will utilize eye wash stations, showers, etc., to clean the chemical off.
   xii. Call engineering or environmental services for disposal of chemical and material used to clean up.
   xiii. Document all actions.

b. **Level II**: 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. Conduct internal assessment by Code Orange Task Force or qualified individual.
   iii. Follow departmental procedures.
   iv. Alert people to evacuate the area if necessary and secure the areas
   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. Attend to injured or contaminated victims and remove them from exposure, ONLY if self contamination is unlikely.
   vii. Engineering controls will be implemented as appropriate (e.g., increase ventilation).
   viii. Obtain 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. Follow departmental procedures.

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

  v. 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.

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

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

  viii. Obtain the MSDS to assist with remedial actions.

  ix. Assist the HAZMAT team as directed.

  x. Complete an incident report and document all actions.

B. Code Orange Task Force

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

 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 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, as assigned by the team leader, which 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).
☐ Patient triage and medical management.
☐ Protection of patients, staff and visitors.

2. The Code Orange Task Force will respond 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 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 will initiate an appropriate response, such as notifying the administrator-on-call (AOC) or house supervisor.

C.   Code Triage: Internal – Hazard Spill/Release

1. Incident Response

a. The administrator-in-charge, by policy, will initiate a Code Triage: Internal and will assume the role of the incident commander or delegate the responsibility to the most qualified individual.

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

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

i. If the incident commander is to work outside of the Incident Command Post (ICP), consider appointing a deputy incident commander within the Hospital Command Center (HCC).
ii. If the incident commander is to work outside of the Hospital Command Center (HCC), ensure 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 should be undertaken only at the direction of the incident commander.
ii. Horizontal evacuation of patients and staff to surrounding smoke compartments is preferred in the most cases. Vertical evacuation of patients and staff is completed if necessary.
iii. Ensure patient records and medications are transferred with the patient upon evacuation or transfer.

f. Considerations for the shut off of oxygen should be made, as oxygen can promote the spread of fire, and is found in most patient care areas. Ensure proper coordination with engineering, nursing, anesthesia, and pulmonary/ respiratory before shutting off medical gases to the affected area.

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

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

i. Consider establishing a media staging area.

2. All Clear

    a. The incident commander, after consultation with the fire department, if applicable, shall issue an "all clear" notification to the facility operator to initiate the termination of response operations.

    b. The facility 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. Consider providing mental health support for staff.

    b. Track all related incident costs and claims.

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

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

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 report, security report, fire activation 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 and procedures.
    f. Review of regulatory standards.
    g. Verbal or written test.

2. The Code Orange Task Force shall receive 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.

The Hospital Incident Command System (HICS) Guidebook, accessible via the Internet at www.emsa.ca.gov/HICS.

The Joint Commission requirements, accessible via the Internet at www.jcrinc.com/Joint-Commission-Requirements.

CODE GREEN: PATIENT ELOPEMENT

I. **PURPOSE**

To provide an appropriate response in the event of a missing/eloping patient who is determined to be a danger to himself/herself, or who is identified as 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 will be taken to prevent the elopement of high-risk patients from the hospital.

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

C. At no time during an elopement should anyone without a valid need to know be 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 will be limited to the hospital campus as defined by policy. The police will be notified for assistance beyond the hospital campus.

F. Patients have the right to leave the hospital against medical advice and the organization must ensure patient safety and therefore a safe discharge.

IV. **PROCEDURES**

A. Upon Discovery of an Eloped Patient

1. Staff discovers an eloped patient.

2. Staff will notify the facility operator immediately and provide the following information:

a. Patient care unit where the patient eloped from.

b. Description of the eloped patient.

c. Time and location the patient was last seen.

3. The facility 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.

4. If a patient is missing from the patient care area, and does not meet the criteria, notify the charge nurse and call security services to assist with retrieving the patient.

B. Code Green Response

1. Code Green Task Force

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

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

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

d. 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 where the patient eloped and the administrator-in-charge (incident commander).

e. Each Task Force member shall perform specific functions, as assigned by the team leader, which support the incident objectives.

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

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

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

h. The Code Green Task Force will conduct a facility-wide search for the missing patient.

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 situation 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 should be monitored until the situation has been resolved or unless otherwise directed by incident commander and/or law enforcement.

    g. Notify local police department, if applicable.

3. Risk Management

    a. The risk manager is to advise, coordinate, and serve 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) should be made available to appropriate persons at the command post or as authorization allows.

    b. The patient care staff will notify the attending physician of the incident.

5. Public Information Officer

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

    b. Establish a new media briefing area and briefing time.

    c. Coordinate with police 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 police department (if applicable) will determine when the Code Green is concluded and will release the site to resume normal operations.

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

D.   Training and Education

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

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

V.   REFERENCES

The Hospital Incident Command System (HICS) Guidebook, accessible via the Internet at www.emsa.ca.gov/HICS.

The Joint Commission requirements, accessible via the Internet at www.jcrinc.com/Joint-Commission-Requirements.

CODE TRIAGE: EMERGENCY ALERT
INTERNAL EMERGENCY
EXTERNAL EMERGENCY

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**

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 must have 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), Joint Commission accreditation standards, the Occupational Safety and Health Administration (OSHA), and other regulatory agencies.

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

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

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

E. It should be 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 is likely to occur, or an incident may occur without warning, that can significantly impact normal business operations.

2. The administrator-in-charge, by policy, will be 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, will assume the role of incident commander or will assign the duties to a qualified individual.

   c. The incident commander will notify key personnel by:

      i. By contacting the facility operator to initiate a Code Triage: Alert.
      ii. The facility operator will announce over 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 / 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, by policy, will assume the role of incident commander or will assign the duties to a qualified individual.

   c. The incident commander will notify all personnel that the Emergency Operations Plan (EOP) has been activated as follows:

      i. By contacting the facility operator to initiate a Code Triage: Internal or External.

ii. The facility operator will announce over 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 should assign 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 to be reported to the HCC (usually on a standardized form or checklist).

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

3. Incident Action Plan (IAP)

a. As soon as possible after the Code Triage activation, the incident commander should conduct 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. Establish 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. Establish *operational objectives* to achieve the control objectives. These are steps or actions to be accomplished during the defined operational period.

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

c. The IAP should identify the needed resources to meet the objectives. They may include 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 have been 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 should be appointed to command positions.

5. Hospital Command Center (HCC)

a. The location of the HCC should be away from the areas impacted by the incident and easily accessible. A nearby location is identified for briefings.

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

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

6. Hospital Command Center (HCC) Activities

a. The incident commander should conduct 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 should brief the administration and/or the Board of Directors ("Agency Executive") as appropriate.

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

7. Demobilization

    a. Demobilization planning should begin at the outset of the incident and be included as part of the Incident Action Plan.

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

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

    d. Manage the public's perception throughout the demobilization to protect the facility's reputation, and to publicize the facility's recovery and return to normal business operations.

C. Recovery

1. All Clear

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

    b. The facility 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. Ensure staffing levels, functions, activities and resources to 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. Address any other personnel issues, such as:

      i. Those who wore PPE should complete medical surveillance forms.

      ii. Receive an appropriate health debriefing covering signs and symptoms to watch for.

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    iii.   Address financial, psychological and medical care issues of any staff member who became ill or injured during the response.

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

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D.   Training and Education

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

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

    3.   Annual functional exercises should be 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 should ensure the planning section gathers and consolidates all relevant incident documentation and evaluations to publish an After-Action Report (ARR).

        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 Actions

        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, accessible via the Internet at www.emsa.ca.gov/HICS.

The Joint Commission requirements, accessible via the Internet at www.jcrinc.com/Joint-Commission-Requirements.