TITLE: PHYSICIANS RESPONSIBILITIES IN DISASTERS

Purpose: To assure that physicians at all levels are familiar with their roles during the activation of either Code ORANGE or Code TRIAGE.

Goal: Disaster medical operations have as their major goal the greatest good for the greatest number of patients. A spirit of extreme flexibility and cooperation is needed when catastrophic events occur.

BACKGROUND OF THE UCSD EMERGENCY PREPAREDNESS PLAN:

1. UC San Diego Health System (UCSDHS) uses the Hospital Incident Command System (HICS) to manage hospital-wide emergencies.
   A. Physician leadership roles under HICS may include the following:
      1) Incident Commander (IC)
      2) Medical Operations Section Chief
      3) Medical Area Officer (such as for Limited Treatment Area or the ED)
      4) Triage Officer
   B. During an activation of either Code Triage or Code Orange all physicians will abide by decisions of the Incident Commander with respect to:
      1) hospital evacuation,
      2) coverage, staffing,
      3) backfill, and
      4) level of services provided
   C. Safety of patients, visitors and employees is paramount.
   D. The senior-most physician will be the Hospital Command Center (HCC) Physician, and will advise the IC on issues related to medical care. This will either be, in descending order:
      1) Physician-In-Chief of UCSDHS (or his/her designee)
      2) Chief Medical Officer, UCSDHS (or his/her designee)
      3) Chief of Staff of the Health System (or his/her designee)
      4) Medical Director for Emergency Preparedness & Response (or his/her designee)
      5) This may alternate by shift, depending on the length of the Code activation

2. CODE ORANGE
   A. Code Orange is the emergency preparedness plan that can be activated by any employee in the facility when a sentinel event occurs that threatens, or that already has affected the ability of the facility to conduct patient care in a normal fashion. Examples of such internal hospital sentinel events may include, but are not limited to:
      1) Utility (power, water, or telephone service) or medical gas outages
      2) Fire or explosion within the hospital
      3) Infrastructure damage due to seismic or weather events
      4) Escaped prisoner or loose gunman within the facility
      5) Gang threats or invasions
6) Admission of a significant VIP that may generate heightened media attention and create significant security risk  
7) Any other such event that, in the opinion of a hospital employee, can affect the ability of the Medical Center to function  
8) Any event that may require evacuation of patients from the facility  

B. When Code ORANGE is activated, pre-designated Hospital HCC staff are notified and will open and activate the Hospital Command Center (HCC located in the Administrative Conference Room, 1st Floor in Hillcrest/Trout Room at Thornton). No other components of the emergency plan are activated unless there is a need for it identified by the Incident Commander.

3. Patient Safety and Evacuation  
A. If an event occurs that a physician believes should result in evacuation of a ward, Code ORANGE should be activated immediately.  
   1) Evacuations must be ordered by the Incident Commander and be coordinated for the safety of patients.  
   2) An Evacuation Plan exists which pre-identifies areas in the immediate surroundings of the Medical Centers, to where patients can be taken if necessary prior to the arrangement of transfer destinations, which would be done in advance if time permits.

4. Code TRIAGE is the activation of the hospital-wide emergency preparedness plan to:  
A. Manage a multiple casualty incident occurring in the community, that will result in a surge of patients and family members to the facility  
   1) Announcement of Code TRIAGE is an “all call” page and overhead page  
   2) Page goes out to all Medical Center employees in each affected facility  
B. When Code TRIAGE is activated, in addition to the set up of the HCC, other areas of the hospital are readied to receive multiple casualties including:  
   1) The TRIAGE area (circular driveway outside of ED  
   2) Manpower Reserve Center (Auditorium)  
   3) Limited Treatment Center (Outpatient Clinic/Ortho Suite, Cast Room, expandable to entire outpatient wing of the Medical Center)  
   4) Trauma Resuscitation Room  
   5) The Shock and Holding (S&H) area (PACU)

5. Hazardous Materials (HAZMAT) Events:  
A. HAZMAT events involving few patients, Code Triage or Code Orange will generally NOT be activated. Larger numbers of exposed or potentially exposed patients, Code Triage will be activated.  
   1) Contaminated patients are to be decontaminated prior to entry into the hospital.  
   2) One or two contaminated patients can currently be showered off outside the ED immediately with an existing fixed shower, at Hillcrest.  
   3) UCSD Medical Center, Hillcrest can activate a decontamination trailer located at 112 Arbor St. Set-up time is approximately 30 minutes and will accommodate ambulatory and non-ambulatory patients.  
   4) UCSD’s two Hospital sites have the ability to set up, within 20-30 minutes, one or two decontamination tents as needed, at each site, for performing warm water decon on either ambulatory or gurney-transported conscious or unconscious patients.
6. **Physician Roles for Code Orange**
   A. Activation
      1) Dial x36111
      2) State “Activate Code Orange” and give details of the incident
      3) In the event of an incident within the facility that generates a number of injured individuals within the facility who are either employees or visitors, a triage area may need to be set up within the facility.
   B. Triage
      1) Initiated by a senior physician experienced in triage and treatment of emergency patients, or by the senior-most physician available.
      2) Injured inpatients: Immediate consultation from the appropriate service, such as the Trauma Consult, rather than transporting to the ER (they are already registered and have an ongoing record.)
      3) Injured visitors or employees. Triaged to the ED or to the Trauma Resuscitation Room.
      4) Available physicians should investigate the incident; involve the Nursing House Supervisor (Pager (619) 290-2616) who will contact the Administrator on Call (AOC). The IC will activate additional physicians and areas, depending upon the incident.

7. **Physician Roles for Code Triage**
   A. Activation
      1) Code Triage event that is not an exercise:
         a) All physicians at the UCSD Medical Center and UCSD Healthcare Clinics are to remain on-site until the incident has been assessed and it is clear that they will not be needed to assist in response (i.e., Code Triage ALL CLEAR has been signaled by pager or overhead).
         b) Physicians who receive announcement of a Code Triage on their pagers (“not an exercise”) should NOT call the operator for details.
         c) Call the Code Triage Message Line (619) 543-6555 Hillcrest or (858) 657-6767 Thornton for updated message(s):
            1. about the incident,
            2. status of the activation,
            3. details of the incident,
            4. any special requests for off-call MDs to report
         d) The initial message may take several minutes to be recorded by the operator. Call back periodically for updates.
   B. Assignments
      1) Preparation for Patient Surge
         a) All physicians (residents, fellows and attendings) assigned to ward or specialty clinic unit rotations report to wards and units IMMEDIATELY to determine if:
            1. Patients can be safely discharged immediately or within 2-6 hrs
            2. Prepare paperwork and discharge prescriptions
            3. Order quick and safe discharge to create open beds for an influx of acutely afflicted patients
         b) Medical students report to their resident for assignments.
         c) All residents, fellows and attendings on service in the ICU, SICU, Burn ICU, IMUs or CCU report to their units to assess the ability of patients within their intensive care areas:
            1. To be transferred to a lower level of care (such as IMU or floor bed)
            2. Prepare for an influx of new patients that may require Intensivist level care and, elective Special Procedures
   C. Elective Surgery Cases
      1) All elective surgery cases will be canceled, unless they represent:
D. Assignment of Physicians via the Emergency Department

1) Faculty or residents, who are not rotating on a clinical service or have completed their discharges on their wards, report to the Emergency Department. At the ED each available physician:
   a) Will be assigned a patient to be responsible for.
   b) Will accompany that patient to the destination to which the patient is triaged
   c) Will manage that patient until such time as a transfer of care to an inpatient physician has been made.

2) No physician will take a patient into the hospital that has not been formally triaged and assigned a Triage Medical Record number by a Triage Team. Without the Triage Medical Record number, it will be impossible to order labs or blood transfusions, or obtain X-Rays.

3) Physician will remain with that patient at all times and will be responsible for ordering test and procedures and applies even if the patient is triaged to the ED.

4) Only when the patient’s care has been taken over by an inpatient physician, and agreement has been specifically, verbally reached between the physician accompanying the patient and the inpatient physician, will the accompanying physician leave that patient. Documentation of all interactions and interventions for each patient should be made ASAP.

5) If identification has not been made of the patient on the disaster medical record (name, age, date of birth, SSN if obtainable), this should be done at this time by the physician before leaving the patient’s side.

6) If there are no immediate patients to be assigned to each physician:
   a) The MD must register their name, pager number and specialty in the ED, so that they may be called when there are patients to assign.

E. Assignments to Hospital Location

1) Physicians may be assigned to specific medical care areas and not to their own specialty area. Possible assignments include:
   a) Limited Treatment,
   b) PACU (Shock and Holding),
   c) Ward unit or special care area,
   d) Any area that is set up to manage the catastrophic event.

F. Response Phase

1) Record Keeping and Documentation
   a) Despite being a disaster, there is a minimum amount of information that must be obtained regarding each patient, including, but not limited to:
      1. Name
      2. DOB (Date of Birth)
      3. Allergies
      4. Medications
      5. Underlying illnesses that would directly affect their care
      6. Any treatments and interventions done on the patient
   b) Each MD should legibly sign the medical record and record their PID.
   c) Document orders on an order sheet.
   d) Record keeping requirements as standards of care should be filled out as best as possible considering the circumstances.
Policy: MSP - 003

TITLE: PHYSICIANS RESPONSIBILITIES IN DISASTERS

e) If the Medical Center computerized record system remains functional, care documentation should be switched over as soon as possible, after the patient has been entered into the computer.

G. Department Responsibilities
1) Emergency preparedness (disaster) plans are maintained by each department, to facilitate specific assignments within that department and maintain updated call back phone numbers, both home and cell.
2) The Chair (or his/her designee) and Clinical Chief of the Department shall:
   a) Semi-annually review the assignments
   b) Assure that all physician members of the department are given and understand their roles
   c) Roles may also be assigned to medical students rotating on that service.
3) All MD contact information should be confirmed every 4-6 months
4) MDs should immediately report any change in address, home and cell phone numbers, and pager numbers to Medical Staff Administration. Changes will be put online by Medical Staff Administration under PCIS and will be forward to Telecommunications
5) Off hours or weekends, physicians should call Telecommunications directly.

H. Code Triage Issues
1) It is impossible to know in advance the mix of clinical problems that will occur for catastrophic events, nor where the greatest need of physician manpower may be. Accordingly, all physicians should be prepared to respond to requests that are outside normal operating procedures.
2) Should a physician find themselves in a clinical situation outside of their specialty that they do not feel capable of handling, immediately request assistance.
3) Surgical and Trauma
   a) During a Code Triage, “OR Resus” is not used. Patients requiring surgery should be triaged to the Trauma Resuscitation Room
   b) If the Trauma Resuscitation Room is full, triage the patient to the Shock & Holding Area in the PACU
4) Surgical Subspecialties
   a) Surgical sub-specialists have been assigned by the Trauma Director to the Shock and Holding Area (PACU) and Trauma Resuscitation areas of the hospital.
   b) Upon request by the ED Attending:
      1. Surgical staff will be requested to augment the ED when bedside surgical procedures are required that do not merit Trauma Resuscitation Room support.
5) Medical Subspecialties
   a) Report to the ED and be prepared to assume primary care responsibilities or consultant activities, as needed.
6) Anesthesiology
   a) Support the ED staff as needed, defined by the lead ED Attending for patients requiring Rapid Sequence Intubation (RSI), Moderate or Deep Sedation.
7) Orthopedics
   a) Orthopedic residents will cover both Trauma Resuscitation and the ED.
   b) Only X-Rays that are deemed vital to the care of a patient should be ordered.
   c) Simple presumed extremity fractures should be splinted and discharged to follow-up on a later day, as X-Ray services may be needed continuously for life-saving procedures via interventional studies.
8) Ambulatory Clinic Physicians
   a) When requested to do so by the HCC:
      1. Outpatient physicians shall discontinue their clinics, and reschedule patients.
2. If outpatient clinics are cancelled, physicians report to Manpower Reserve Center for potential assignment to Limited Treatment Area and other areas depending on need.
3. Patients from those clinics should not be referred to the ED for routine prescription refills or for regular office care, unless a true emergency has been identified.

I. Recovery and Debriefing
   1) All personnel involved in a community disaster will be exposed to some degree of Critical Incident Stress (CIS); and having symptoms identified with CIS is normal.
   2) Referrals for Criteria Incident Management Services are available through the HCC from the UCSD Critical Incident Management Team developed and supported by the UCSD Department of Psychiatry and Social Work or by contacting the Faculty and Staff Assistance Program (858) 534-5523.
   3) Family issues often arise in a stricken community. Medical staff may have conflicting issues related to members of their families being affected by the same incident staff are responding for, and these issues need to be shared with the HCC.
   4) Some problems may be solvable by the Medical Center, such as day care for dependent children and seniors, and provision for sheltering in some circumstances.
   5) Observations and ideas for improvement of the Code Orange and Code Triage Plans should be referred to the Emergency Preparedness Advisory Committee (EPAC).

J. Abbreviations Used
   CIS – Critical Incident Stress
   DECON – Decontamination
   EPAC – Emergency Preparedness Advisory Committee
   HAZMAT – Hazardous Materials
   HICS – Hospital Incident Command Systems
   HCC – Hospital Command Center
   IC – Incident Commander
   PACU – Post – Anesthesia Care Unit
   PIN – Physician Identification Number
   RSI – Rapid Sequence Intubation
   S & H – Shock and Holding
   SSN – Social Security Number