HARBOR-UCLA EMERGENCY DEPARTMENT

EMERGENCY OPERATIONS PLAN

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GUIDING PRINCIPLES

PURPOSE

This plan provides operational guidelines for the Emergency Department (ED) (and in its role as the ED/Casualty Care Unit when Hospital Code Triage is activated) to manage healthcare emergencies resulting in patient surges.

PRINCIPLES

The goal of this Harbor-UCLA ED Code Triage protocol is to quickly and efficiently meet the needs of incoming patients from an acute event while simultaneously caring for the existing patients in the Emergency Department. Many departments throughout the hospital play a critical role in this response, and understanding key principles will help staff make decisions during an MCI event.

- Rapid deployment of supplies and personnel is paramount to ensure effective response to an acute MCI event.
- Personnel need checklists of tasks to perform at the beginning of an MCI event and during demobilization to ensure this rapid deployment.

POLICY

The Emergency Department Emergency Operations Plan (EOP) is to be used as an all-hazards approach to manage healthcare emergencies affecting the Emergency Department (ED). The plan is to be implemented during a Multi-Casualty Incident (medical, trauma, or CBRNE), or an internal/external disaster. The EOP will remain in effect until the event has resolved and the department can be returned to normal operations.

DEFINITIONS

For the purposes of this document:

***Multi-Casualty Incident*:** an incident with 5 or more casualties expected to arrive to Harbor-UCLA, or < 5 casualties but expected to present challenges to standard ED operating procedures (e.g. security threats, decontamination needs, etc.).

Mass Casualty Incident: an incident in which regional/local emergency medical services resources are overwhelmed by the number and/or severity of casualties.

MCI patients may include both injured patients (either self-presenting or arriving by ambulance) as well as “worried well” seeking medical evaluation and/or reassurance after a disaster event.

Casualty Care Unit: Per standardized Incident Command System terminology, the Casualty Care Unit is where disaster casualties will first present. Hospital Command will refer to the ED as the Casualty Care Unit if the hospital initiates a Code Triage for a disaster scenario.

For the ease of use of this plan, we will henceforth refer to the Casualty Care Unit as the Emergency Department (ED), and have attempted to use common Harbor-UCLA ED Terminology for all roles.

REFERENCES:

Harbor-UCLA Hospital Policy No. 337: Surge Capacity Plan
Harbor-UCLA Hospital Policy No. 408: Emergency Management Plan
Harbor-UCLA Emergency Preparedness Plan Nos. 1-64

ACTIVATION

In most instances, notification of an MCI will be made to the hospital via EMS Medical Alert Center (MAC) contact to the Base. In such cases, the MICN is responsible for contacting ED Nurse Managers & Attending Physicians and requesting a decision from them on activation of the ED EOP. In rare cases, the MAC will notify an ED Attending physician directly. If this occurs, the Attending Physician shall request the MICN to gather key personnel.

When Harbor-UCLA ED is notified of an actual or potential Multi-Casualty Incident, the MICN shall contact the supervising nurses and physicians to brief them on the situation and to discuss whether to activate this ED EOP. Activation should be performed per the **Resource Tool: Activating the ED Emergency Operations Plan**. Briefing should cover the following information:

- Incident description (bombing, building collapse, Hazmat exposure, etc.)
- How many patients are estimated on scene?
- How many patients are estimated for transport to Harbor-UCLA?
- Is there any possibility of hazardous substances (chemicals, radiation, biologic)?
- Are there any known, or possible, security threats to the hospital?
- What is the estimated time to arrival of first patients at Harbor-UCLA?

ED Emergency Operations Plan should be activated for any incident expected to overwhelm normal ED staffing assignments due to incoming casualties. This would include multiple patients with time-sensitive conditions (Trauma or Medical).

Triggers for ED EOP Activation include the following (numbers refer to *potential* patients; the ED *should not wait* for any number of patients to arrive before activating ED EOP and/or the Hospital Code Triage Emergency Operations Plan):

- 5 or more critically injured (red triage or TTA1) patients expected to arrive within a 30 minute period (or 3 or more similarly injured pediatric patients). Patients may be arriving from a single incident or several separate incidents.
- 10 or more critical and/or urgent (red or yellow triage; TTA1, TTA2 or ED Trauma patients) total patients expected from a single incident.
- ED discretion - at the discretion of ED Leadership, it may be decided that additional resources are needed to respond to an incident (e.g. potential for extensive decontamination, or need to deploy HERT for extended period, leaving ED with decreased staffing). In this situation, ED Leadership may activate this plan to request additional personnel or resources.
- Hospital administration initiates Code Triage, either due to an external notification (i.e. from the EMS Agency Medical Alert Center (MAC)) or an internally detected event (e.g. after a hospital active shooter event).

Hospital Code Triage, may be activated for any situation occurrence – naturally occurring disaster, human-induced emergency, or technology failure – expected to exceed Harbor's ability to respond using standard operating procedures. Per Hospital Policy 408, any expected arrival of 10 or more patients from a single incident should prompt Hospital Code Triage consideration by hospital administration.

ESTABLISHING COMMAND & ASSIGNING ROLES

The ED Command Post will be established at the AED Acute Side A Nursing Station. The Command Staff for the ED is structured per the ED EOP Organizational Chart.

The most senior ED Nurse Manager on duty should take the role of ED Nurse Leader. In communicating with hospital command, this person is termed the "Casualty Care Unit Leader". He/She may delegate this position to another supervising nurse, up to and until the Overall Charge Nurse.
Once the ED Nurse Leader has been established, all other actions in this EOP will occur under his/her command until the Emergency has been declared resolved and demobilization procedures have been completed.

Communication between the ED and Hospital Command Center occurs through the ED Nurse Leader to the Medical Branch Director (if appointed) or Operations Section Chief. If neither of these have been established, the ED Nurse Leader should communicate with the Hospital Incident Commander.

Specific steps for activation of this ED EOP, establishment of command, and assigning roles should be followed per the **Resource Tool: Activating the ED Emergency Operations Plan.**

The ED Nurse Leader shall refer to his/her ED Nurse Leader Job Action Sheet (JAS) to assign roles and distribute Job Action Sheets, Vests and Clipboards to designated individuals as appropriate. These supplies are found in the shelves next to the AED Clerk's desk. Additional vests and clipboards are in the Supply Closet (NA7 key) located in the pedestrian spine near the Greeter desk.

The ED Nurse Leader (or their Staff Assistant) should complete the Branch Assignment List (HICS-DEM Form 204) with names and phone numbers of all assigned personnel and photocopies of this shall be distributed to ED Command Staff. This information should also be written on the White Board next to the AED Nursing Station/Doc Box.

All briefings/meetings during the Emergency Period will be held at the AED Nursing Station.

SECURITY

Immediately after decision is made to activate this Emergency Operations Plan, the MICN shall call ED Security via the Securitas Supervisor cell phone (213) 281-3028 and LASD (x64450 or (310) 222-3311) and request restricted access to the Emergency Department and participation of LASD and Security supervisors at the ED incident briefing.

In the event of decontamination needs or security threats to the Emergency Department, all access to the hospital shall be limited so that all arriving individuals (including patients, community members, and hospital staff) shall be immediately redirected to the ED Triage area by the Helipad.

Wording for these requests is included in the **Resource Tool: Activating the ED Emergency Operations Plan.**

The ED Nurse Leader and Treatment Area Manager (TAM) will remind nurses to close and secure all doors to hallways (e.g. between AED and Gold unit). The Treatment Area Manager will inform the Ambulance Bay security officer of security precautions in place (Decon, Lockdown, etc).

DECOMPRESSING THE ED

Decompression should be initiated prior to arrival of victims. The Treatment Area Manager (TAM) should request that each Area Leader (Minor, Delayed, Immediate) and/or Attending Physician repeat the Decompression evaluation every 2 to 4 hours until demobilization is complete.

Attending Physicians in the ED and the Hospitalists assigned to Gold Unit will review their current team lists with Residents and designate each patient as:

- ***Chair*** – patient may be seated in a chair to anticipate discharge if bed is required emergently
- ***Admit*** – patient requires admission and can be moved to an inpatient bed as soon as available
- ***Stay*** – patient must remain in a monitored bed and is not sufficiently stabilized/evaluated to be admitted

Physicians caring for the patients should write patient designations in the "MD Comments" section of the Cerner Tracking Board. Designations may be altered as patient condition/evaluation progresses; but should be evaluated by the Attending physician or Senior Resident at a minimum of every 2 to 4 hours until demobilization is complete.

Attending Physicians should immediately review existing admissions with the Overall Charge Nurse. The Overall Charge will call Patient Flow (weekdays) or the House Supervisor (nights and weekends) to request expedited location of appropriate inpatient beds to facilitate ED decompression. In addition, the CORE/Gold Unit Hospitalist should prioritize patients for admission. Admissions should focus on the most acute patients (those expected to need significant nursing attention/resources). However, it should be anticipated that all Gold patients will be moved to inpatient units to enable overflow treatment in the Gold Unit. Refer to the section on **Admitting Patients to the Hospital** for further information on the rapid admission process for disaster surge.

The Overall Charge Nurse will maintain a log [Resource Tool: Tracking of ED Patients Moved to Inpatient Units] of all patients who are moved out of the ED to inpatient wards precipitously to enable later/delayed completion of charting.

If the Overall Charge Nurse has been designated the ED Nurse Leader for the Emergency incident, inpatient bed assignments should be performed by the Treatment Area Manager together with the ED Nurse Leader and/or his/her Staff Assistant.

The Treatment Area Manager should contact EVS (x29014/ Supervisor at x29026) to request immediate ED bed preparation and dedicated staff in the ED for rapid turnover of ED beds and room cleaning between patients. Spectra phone numbers for EVS staff stationed in ED (x29014/ Supervisor at x29026) should be written on the White board at the AED Command Post.

TRIAGE

For Multiple Casualty MCI events in which the majority of victims are anticipated to arrive by ambulance, the most senior Attending and/or Senior Resident physician will stand at the ambulance bay and coordinate victim placement in Trauma Bays and AED together with the Treatment Area Manager. For Mass Casualty Incidents, in which regional EMS resources are overwhelmed and many patients arrive by alternative means, Simple Triage and Rapid Treatment (START) may be utilized for hospital triage per the discretion of the ED Nurse Leader, Purple Attending, or Medical Director for Disaster Preparedness (if on scene) [See **Resource Tools: START & JumpSTART Algorithms**].

Triage area equipment includes:
Vests for personnel
Triage bracelets for noting patients as "Immediate", "Delayed", or "Minor"
Triage Tags for HAZMAT/CBRNE or other events requiring decontamination
Disaster packets with pre-registration Labels/Stickers for "Immediate" patients
HICS 254 forms for patient arrivals tracking
Safety cones (located in the Pedestrian Spine closet)
Disaster gurneys (located in the DRC trailers)
Wheelchairs (from adult waiting area)
Geiger counters (Charge Nurse Office) if indicated for suspected CBRNE events
Spectra link phone for push-to-talk communication with other ED staff

Staff at each Triage Area will include:
Physician (ambulance bay) and/or Senior Nurse (walk-in area) – to perform triage
Nurse – to perform patient assessment and communicate bed needs to Treatment area Manager
Transporters/Runners
Registration personnel (2) – to complete HICS 254, apply Triage bracelets

In a Mass Casualty Incident not requiring decontamination or ED Lockdown, "walk-in" patients will be triaged at the walk-in entrance to the Pedestrian spine. Patients arriving by ambulance will be triaged inside the sliding glass doors of the ambulance bay (Ambulance Triage). The Triage Unit Leader will maintain control of the Ambulance Triage Area and will assign nurses to other Triage areas as appropriate. The Triage Unit Leader will designate a leader for the Walk-In Triage Area. Resident physicians may also be assigned to Triage based on staffing needs. Each designated Triage Area Leader shall have a Spectra phone and/or handheld radio. The Triage Unit Leader is responsible for documentation and coordination of both Triage areas, and will communicate with the Treatment Area Manager regarding patient placement in the treatment areas. If internal capacity has been reached, such that there are no beds rapidly available, Immediate or Delayed patients will be placed in designated overflow areas to initiate care pending bed/OR availability [See Treatment Tools: ED Treatment Area Map].

Patients triaged as Immediate/Delayed/Minor will be routed to internal treatment areas Trauma/AED/RME respectively. If internal surge capacity is reached, triaged patients will be routed to Triage overflow areas in Pedestrian Spine (Delayed) and Adult Waiting Room (Minor).

Pediatric victims will be primarily routed to the Pediatric ED. If internal capacity of the Pediatric ED is reached, additional triaged patients will be routed to the Pediatric ED waiting room. However, in the case of a surge event comprised of majority Pediatric patients, the Treatment Area Manager and ED Nurse

Leader/CCUL, along with the Pediatric Unit Leader may decide to route patients primarily to other treatment areas as appropriate to their Triage category.

The Triage Unit Leader is responsible for maintaining the Patient Tracking Form (HICS 254) together with the Registration Supervisor. A copy of this form should be provided to each Triage Area Leader, and should be collected by the Triage Unit Leader once filled, or every hour until the Emergency is over. The Triage Unit Leader is responsible for ensuring that these forms are complete and returned to the ED Nurse Leader during the demobilization period.

Triage/Acuity category of patients will be marked by placement of a colored bracelet on the bracelet of each patient.

In the case of events requiring mass decontamination for patient and staff safety, hospital triage tags will be used (to enable rapid identification of decontaminated patients). Different hospital triage tags will be used for Adult and Pediatric patients. Triage Unit personnel shall remove unused parts of the hospital disaster triage tag to designate the patient's initial appropriate triage category (Minor, Delayed, Immediate, Expectant).

DECONTAMINATION

If hazardous materials exposure is suspected, or for any blast events, decontamination procedures should be engaged. The MICN, along with the ED Nurse Leader shall consider likely volume of patients requiring decontamination.

MICN should page overhead for Decon-trained staff, per the **Resource Tool: Activating the ED Emergency Operations Plan.**

A list of Decon-trained staff is also maintained in the Prehospital Section of the Harbor UCLA ED Intranet webpage. From reporting staff, the ED Nurse Leader or Decon Unit Leader (if designated) shall select 2 personnel for operation of the Decon Shower outside Ambulance Ramp and provide keys (NA7 key) to these individuals (personnel should consist of at least 1 nurse and 1 nursing-assistant if possible). If greater than 20 patients requiring decontamination are anticipated, or if the incident is anticipated to have a prolonged duration with ongoing need for decontamination, the ED Nurse Leader shall contact the Power Plant to request set up of the Decontamination Trailers. The ED Nurse Leader shall further alert the Hospital Command Center to request additional staffing for Decontamination. It shall be noted that a minimum of 1 hour is required for set up of the Decontamination Trailers.

PATIENT CARE AREAS & ED BED ASSIGNMENTS

The following areas are designated for Patient Care and Patient Overflow [see Resource Tool: Triage & Treatment Areas Map]

Triage [See Resource Tool: Triage Areas Map]

CBRNE, Hazmat or events involving security threat to hospital:
All Triage will occur behind the Emergency Department Ambulance Parking area, in the parking lot normally reserved for law enforcement and County Transport vehicles.

All other Mass Casualty Events:
Walk-In: Pedestrian Spine, just inside of Security Screening area
Ambulance: Hallway by Ambulance entrance, inside security double-doors

Initial Treatment Areas [See Resource Tool: Treatment Areas Map]

Immediate Unit
Trauma Bays

Delayed Unit
AED Rooms 1 – 23

Minor Unit
RME Rooms 1 – 20

Pediatric Unit
Pediatric ED Rooms 1-16
Trauma Bays 6 – 7

Expectant Unit
Gold Unit (per nursing)

Note: It is *highly unlikely* that patients will be triaged "Expectant" in the initial phases of a disaster.

OVERFLOW AREAS (for staging and initiating treatment if necessary)

Immediate Overflow Area
Behind Triage Station until bed available
Delayed Unit Beds if all Immediate Unit beds full

Delayed Overflow Area
Gold Unit
Pedestrian Spine

Minor Overflow Area
Urgent Care Clinic (when open)
Adult ED Waiting Room

Pediatric Overflow Area
Pediatric Waiting Room

The hospital owns a surge tent that may be used as an alternate care site. Contact Facilities for set-up

The Treatment Area Manager (TAM) is responsible for assigning beds in all areas of the ED, and for maintaining the census of available beds in the ED. Treatment Area Leaders shall contact the TAM any time a patient is taken to the OR. The TAM will contact EVS to request bed/room cleaning. If rapid bed turnover is needed it will be performed by area staff (including nurses and physicians) to avoid care delays.

PATIENT TRACKING/REGISTRATION/RECORD KEEPING

In a Mass Casualty event requiring rapid movement of large numbers of critical patients, the HICS 254 form is the initial method for ED patient tracking and charting will be performed on paper charts with Disaster Packets. Longer duration and/or slower-influx disaster events (i.e. Hospital Code Triage) may use regular charting processes via Cerner, or some combination of paper and Cerner charting.

All patients entering the hospital during a Hospital Code Triage should receive a triage bracelet (red, yellow, green). Triage bracelets are located with other disaster supplies on the shelf next the AED Clerk desk.

The Triage Unit Leader is responsible for initiating and maintaining the Patient Tracking Form (HICS 254). The ED Clerks, Registration personnel, and assigned nurses shall assist in this process. The Registration Supervisor will assign Registration staff to Triage and Treatment areas to complete Tracking via the HICS 254 form and to perform modified Registration in Cerner.

No patient financial screening will be done in Disaster Triage or Treatment Areas during periods of surge.

Disaster Registration Procedure

In the Triage Area, Triage Unit personnel, including Registration staff, will enter initial patient information into HICS 254, including name (or HAR name if victim not identified), Prehospital Triage Tag Number (if patient arrives with this), Sex, DOB (or approximate age if victim not identified), and initial Triage Category (Minor, Delayed, Immediate, Expectant)

On arrival to a treatment bed, quick registration will be performed by Nursing. If additional staff are needed to assist with Quick Registration due to patient volume and/or lack of available nursing staff, and on request of the TAM, the ED Nurse Leader may assign registration personnel to assist in the treatment areas. The Registration Supervisor will assign Registration staff to each of: Trauma bays, AED, and RME as necessary.

Instructions for QuickReg and for entering data into the Cerner system are found in the **Resource Tool: Registration and Tracking of Disaster Patients.**

Avoid removing prehospital triage tags or triage bracelets. The triage tags and bracelets are waterproof and should be kept on patient until the removing personnel have verified ALL of the following:

1) Patient is being moved out of the ED to their definitive disposition (OR, Inpatient Unit, Morgue) or is being Discharged
2) Patient has received a Hospital Identification bracelet with their MRUN number, and
3) The Prehospital/EMS Triage Tag # has been entered into Cerner correctly.

If removing Triage Tags, personnel should place a patient sticker on each of the patient's Triage Tags (prehospital and hospital) and return the sticker-labeled Triage Tags to the Triage Unit Leader. Triage Tags are part of the patient's permanent medical record and must be submitted to medical records during demobilization to be scanned into the electronic health record.

ADMITTING PATIENTS TO THE HOSPITAL

During a Hospital "Code Triage" activation

1. The ED Nurse Leader or his/her Staff Assistant will contact Hospital Command (if activated), Patient Flow (weekdays) or House Supervisor (nights and weekends) to obtain the name of the Inpatient (weekdays) or ED Hospitalist (nights/weekends), the Trauma Attending, Pediatric Hosptilist on-call, and the in-house OB/GYN Attending. Hospital command will provide a Spectra phone from disaster cache to each of these individuals if they do not already possess one, and shall provide the phone number to the ED Nurse Leader for dissemination to treatment teams.
2. Once the need for hospital admission has been determined by the ED Attending, the ED Physician will enter a "Request for admit" order, and will contact the service Attending to give report as possible.
    a. Medical Patients will be admitted under the Inpatient Medicine Hospitalist's name (weekdays) or ED Hospitalist (nights/weekends). The Hospitalist will assign admitted patients to Medicine teams per his/her judgement.
    b. Surgical patients will be admitted to Trauma Surgery with the name of the Trauma Attending.
    c. OB/GYN patients will be admitted under the On-Call OB/Gyn Attending. Call 310-222-3900 x29762 to reach the Attending on-call
    d. Pediatric patients (<21 years old) will be admitted under the Pediatric Hospitalist

During a Surge event without hospital "Code Triage" activation

The treating physicians will be responsible for entering "Request for Admit" orders for patients admitted to the hospital. Patients with traumatic injuries will be admitted under the name of the Trauma Attending on-call and/or present in the ED. If rapid decompression/admission of patients with medical complaints/conditions is requested, the Green Attending (Delayed Unit Leader) will contact the Inpatient/ED Hospitalist at pager (310) 501-1325 to request "Code Triage admission" procedures. Alternatively, if surge patients are primarily pediatric in nature, the Pediatric Hospitalist should be paged to request "Code Triage admission" procedures, as described above.

The Treatment Area Manager and/or ED Nurse Leader will communicate with hospital bed control to request beds and communicate inpatient bed assignments to the Treatment Teams. The Treatment Area Manager will post inpatient bed assignments in the Nurse Comments column of the Cerner Tracking Board as per usual, and shall announce the bed assignment via overhead page as "[ED Bed Number] Inpatient bed has been assigned". In the case of computer/Cerner malfunction, the Treatment Area Manager will write Bed Assignments on the White boards in the ED, and also announce via overhead page.

In the case that beds are not being assigned in a timely fashion, the ED Nurse Leader will contact Bed Control, House Supervisor, and/or AOD to escalate concerns.

Patient Report

Once bed assignments have been designated, physician and nursing hand-off report shall be made per protocol as resources allow. If need for ED beds is pressing and inpatient beds are available, patients may be sent to designated inpatient beds without formal report. In these cases, the transporter shall be instructed by the patient's nurse to inform the receiving team of the ED nurse's Spectra link number and/or that no formal hand-off report was performed between physicians.

During disaster processes it may not be possible to provide hand-off reports with the normal level of detail. For standardization of communication, when providing report to the inpatient receiving nurse, the ED nurse will provide the following information:

- Known injuries/diagnoses
- Treatments provided in the ED prior to admission
- Last known GCS/Level of Orientation on leaving the ED
- Any abnormal vital signs that were present at time of admission

SUPPLIES & STAFFING

The ED Logistics officer, as designated by the ED Nurse Leader, will be responsible for attaining, stocking, and setting up resources and assets from within the department (i.e. supplies, equipment, gurneys etc.) and from outside departments through the Hospital Command Center if appropriate, or via standard processes. Initial disaster resources for the ED are available as described below.

Disaster supplies stocked in the ED are accessed with the ED Disaster Key (AA-49) available in the AED Pyxis at SE-1J25. Copies of this key are located in Nursing Operations (Rm 1-M-3A, x65620), the LASD Office (call x3311), and with the Emergency Preparedness Nurse Coordinator (pgr. (310) 501-0810, cell (562) 572-7803)

The ED Nurse Leader will obtain the Disaster Key from the Pyxis in SE-1J25 via the following steps:

1. Click 'inventory'
2. Click 'select by med' and type 'keys'
3. Select '*Keys, ER disaster keys kit'
4. Click 'inventory selections' and remove keys

Resource locations / contacts:

1. Triage supplies are located in the Pedestrian Spine storage closet next to the greeter desk. (NA-7 Key)
2. Decon equipment is located in the Decon equipment shed under the Helipad. (Disaster Key AA-49); additional boots may be found in the "Decon Supplies" closet in the ambulance bay.
3. On-site Disaster Supplies:
    a. DRC supplies are located in the disaster trailers 1-5 on the decon lot next to the helipad. See attached list of supplies. (Disaster Key)
    b. Gurneys are located in the DRC trailers #1 and 3; and should be requested from EVS
    c. Wheelchairs are located in the Helipad storage area (Disaster key AA-49)
    d. Geiger counter – 3 Geiger Counters are located in the ED Charge Nurse Office. Additional Geiger Counters are located in the Radiation Safety Office in the main Hospital basement (accessible during daytime hours).
    e. Additional ED Linens and Med Surg Supply carts for disaster use should be requested by the ED Logistics Officer (or the ED Nurse Leader if no Logistics Officer is appointed) from central supply (SE BASEMENT, Room 1B09, x65370)
    f. If additional supplies are required for a Mass Casualty Incident where the hospital's Command Center has been established (i.e. during a Code Triage event), the ED Logistics Officer will inform the ED Nurse Leader of the resources requested. The ED Nurse Leader may authorize the ED Logistics Officer to contact the Hospital Command Logistics Officer directly to process internal resource requests for additional items from the Hospital Command Center via phone at x68401 or x68402, email humccodetriage@dhs.lacounty.gov or fax (310)212-0171

If additional space is needed to care for patients, or to expand the patient waiting area, the ED Nurse Leader may contact EVS (x68373 or x68370; or Spectra x29026) to request set-up of additional Disaster Gurneys and/or may contact Facilities (x68501) to request set-up of the Disaster Surge Tent.

Redistribution of on-shift staff will be performed the ED Nurse Leader and Purple Attending. The ED Nurse Leader, or the ED Logistics Officer if designated, will submit staffing requests to the labor pool if activated

by the hospital Command Center. It is suggested that 5 – 10 staff be immediately requested from labor pool to assist with patient transport, restocking, bed cleaning and other unanticipated needs.

It is anticipated that staffing assignments of nurses and physicians/NPs in the department will need to be adjusted several times over the course of the Emergency period.

ANCILLARY SERVICES AND NON-EMERGENCY DEPARTMENTS

Trauma Service

The Trauma Attending on duty will serve as a member of the Command Staff for the ED, and will be primarily responsible for deciding priority for movement of patients to the Operating Room (OR). The Trauma Attending may designate a Senior Resident to this position if his/her presence is required in the OR. The Trauma Attending or his/her designee shall attend all briefings at the ED Command Post and will be responsible for disseminating the information to their Trauma Division Residents and Attending physicians.

Perioperative Services/ Operating Room

Operating Room (OR) Triage will be coordinated by the Trauma Attending, or his/her representative, stationed in the Emergency Department. It will be the responsibility of this individual to communicate with the OR front desk to prepare ORs and/or to assess delays to OR.

Pharmacy

The ED Nurse Leader will contact the ED Pharmacist as part of the initial EOP activation. The ED Pharmacist will request an additional hospital pharmacist to assist with medication retrievals and preparation in the ED.

For events with 5 or more Delayed or Immediate patients anticipate, the role of the pharmacist will be to resupply the ED with critical medications as necessary for patient care. The ED pharmacist maintains 10-12 pre-packed RSI kits in the ED for rapid access. Anticipated need for additional resuscitation medications (e.g. TXA, Ketamine, etc.) should be communicated to the ED Pharmacist as early as possible.

ED Radiology

On activation of this EOP, the Treatment Area Manager shall contact CT and Xray technicians to inform them of disaster operations. The Treatment Area Manager will request one or more portable Xray teams to be stationed in the Trauma Bays continuously until demobilization.

CT Techs will maintain both ED CT scanners available for ED imaging throughout the emergency/surge period. No inpatient or elective scans should be performed until demobilization is complete.

Respiratory Services

The Treatment Area Manager will contact the Respiratory Therapist (RT) Supervisor to request two RTs be sent immediately to the ED.
RTs should be asked to arrive with ventilators and BiPAP machines for the anticipated patients
RTs will assist with set-up and return of airway equipment and ventilators.

If at any time the number of traditional ventilators available is insufficient for the estimated number of patients expected, RT should inform the ED Logistics Officer of imminent need and request retrieval of portable ventilators from the disaster surge supply cache.

Psychological & Social Services

Social Workers will be responsible for implementation of PsySTART mental health first aid screening, and for review and completion of the Family Reunification Module on ReddiNet. For victims who arrive to the ED unidentified, social workers will make every attempt to enter identifying characteristics (hair color, eye color, tattoos, and other identifying marks) into the Reddinet Family Reunification module.

EVS/Facilities

EVS/Facilities shall station no less than 2 staff members in the Trauma and AED areas of the ED for rapid turnover of rooms. In addition, EVS/Facilities will be tasked with assembly of gurneys/stretchers, and restocking of linens.

Urgent Care Clinic

In the event of ongoing patient surge, the Urgent Care Clinic (UCC) shall be utilized for definitive treatment of patients triaged Minor and having undergone secondary screening confirming no more than minimal injuries. UCC will also receive patients arriving to the ED with minor and intermediate medical complaints not related to the Disaster situation.

Morgue

Morgue surge will be coordinated by the Hospital Command Center.

If multiple deceased are anticipated early in the response, the DEM Communications Officer (MICN) shall contact Morgue Services to request expedited removal of bodies from the DEM. Bodies shall not be maintained in treatment rooms, or family/viewing rooms for viewing.

DEMOBILIZATION

Demobilization shall be considered when the number of arriving patients decreases to < 5 per hour. Coordination of demobilization in the ED and alternate/surge care locations shall be the responsibility of the ED Nurse Leader, on the decision of the Hospital Incident Commander if Hospital Code Triage has been activated, or by coordinated decision of the ED Nurse Leader, Treatment Area Manager and Immediate and Delayed Unit Leaders.

Demobilization tasks shall include:

- Collection & inventory of supplies by unit leaders
- Return of all forms to Emergency Coordinator (Essence Wilson) via her mailbox in the Nursing Office (1M6)
- Return of signed JAS checklists to Emergency Coordinator (Essence Wilson) via her mailbox in the Nursing Office (1M6)