KENTUCKY HOSPITAL ASSOCIATION
OVERHEAD EMERGENCY CODES
FREQUENTLY ASKED QUESTIONS

Question - Why have standard overhead emergency codes?

Answer – Lessons learned from previous disasters show that the resources and talent of our healthcare system may have to be shared, and could potentially be sent to other hospitals, communities and regions of the Commonwealth or nation. Some facilities are already sharing staff from PRN agencies and physician groups. As these people move from facility to facility, it appears logical that the codes which trigger emergency protective and response steps should be standardized as much as possible to help insure quick action, and minimize misunderstanding. *From a Risk Management standpoint, this makes sense!*

Question – What is the change in this version from the previous KHA endorsed recommendations?

Answer – Over the past few years there have been increasing situations within healthcare facilities involving workplace violence, to include what law enforcement refers to as "Active Shooter" situations. These are most commonly being referred to as "Code Silver" scenarios. The only change that the KHA Emergency Preparedness Committee and the Hospital Preparedness Program regional leadership group is recommending at this time is to add "Code Silver" to the existing board recommended standard codes.

Question – Do I have to use the KHA recommended overhead codes?

Answer – No. These are recommendations.

Question – Can I add local codes specific to our organization?

Answer – Yes. The intent of the KHA Emergency Preparedness Committee was to recommend a base-level of standardized codes. The committee recognizes that there may be a need to have facility, community or region specific codes. *For example*, a facility that offers pediatric services may want to consider something like "Code Adam" for an infant or child abduction. A geriatric center may want to adopt something like "Code Brown" for a missing adult patient. Both of these examples are taken from standard codes that had been recommended in Ohio, but not included by the KHA committee in the original or the 2011 update.

Question – I am in an area that borders Ohio, and we have patients and staff who frequently commute across the border. How do the Kentucky codes compare to those, say, in Cincinnati?

Answer – Ohio appeared in the committee's research at the time to be the only neighboring state with a system endorsed by their hospital association as a recommendation for their facilities.

The six color codes included in the KHA chart are all the same as the codes previously recommended by Ohio, with two minor exceptions:

1.) The KHA scheme uses CODE BLUE to refer to any Medical Emergency (adult or pediatric); Ohio has a Code Pink to differentiate a Pediatric Medical Emergency.

2.) The KHA recommended CODE SILVER definition has been expanded from that used in Ohio to include the current "Active Shooter" term. Ohio is currently working on a potential modification to include this in a future update.

Ohio does have some additional color codes. The KHA committee decided through a deliberate consensus building process to stay with a basic set of minimum recommendations, and then allow local facilities and regions to consider variation beyond that as they deemed appropriate.

Question – Do I have to use the names and colors of the codes as written?

Answer – Yes. The intent of the color and names are to standardize codes across our health care systems. If you change the color or the name of the code it defeats the purpose.

Question - Can other organization/agencies utilize the codes (nursing homes, EMS etc)?

Answer – Absolutely. In keeping with the spirit of the National Incident Management System (NIMS), the intent is to use a common vocabulary where we can. The more health care institutions that adopt the codes the better.

Question – Will my institution be provided with any educational materials?

Answer – The document with the KHA recommended Overhead Emergency Codes will be placed on the KHA website in the Emergency Preparedness section, along with these Frequently Asked Questions (FAQs).

Included with the FAQ are a set of guidance statements that the organization's emergency preparedness team can consider when looking at possible modification of internal policies, procedures and/or guidelines. These are *suggestions* put forth to stimulate discussion and planning. The FAQs have been very generally adapted from similar guidance issued by other associations. Please adapt them to fit your institution's unique operation.

Question – Will my institution have to absorb the costs of implementing the Kentucky Hospital Association Emergency Codes?

Answer – The reasonable costs associated with adopting standardized emergency overhead codes can be submitted through the regional hospital preparedness program planning coalition for consideration as a reimbursement expense. Work through your organization's representative to the HPP group in your planning region.

KENTUCKY HOSPITAL ASSOCIATION
OVERHEAD EMERGENCY CODES
Guidance for Policy or Operating Procedure Modification
(Suggested potential language for consideration. This is generally adapted from materials originally developed by the Ohio Hospital Association.)

CODE BLACK: BOMB or BOMB THREAT (Including suspicious packages)

PURPOSE
To establish a method for coordinating an appropriate facility response to ensure immediate protection of life, property and the continuation of vital patient care services in the event of a bomb threat or discovery of a bomb or suspicious package.

SUPPORTING INFORMATION
Bomb threats do occur in healthcare facilities; however, it is unlikely that an actual bomb is placed. The facility will usually make a thorough search when a bomb threat is received. Personnel who normally work in an area are more likely to notice when something is wrong or out of place. IF A BOMB OR SUSPICIOUS DEVICE IS FOUND IT SHOULD NOT BE TOUCHED. *Report the device to your supervisor or building manager.* The handling of bombs and bombing investigations is solely an official police function. At no time should the healthcare facility security staff try to touch or move a bomb, suspected device or package. The role of the facility security staff is to help the police find the bomb, and to evacuate patients, visitors and facility personnel.

When the police enter the healthcare facility they will need personnel who are familiar with the facility to direct them quickly to a potentially suspicious device or package, and to assist them in searching for a possible bomb. Facility personnel assisting law enforcement with the search should have master keys, and should also be familiar with all areas of the building, including closets, restrooms, storage areas, trash bins, etc.

The facility may choose not to evacuate, especially if a suspicious device has NOT been identified. This decision not to evacuate should normally be made by the House Supervisor or facility administrator, and is typically done after consultation with the local law enforcement or fire service. Safety procedures take precedence over all other activities by healthcare facility employees, except for the provision of immediate medical assistance to patients in life-threatening circumstances.

It is important to remember that a bomb can be placed anywhere, therefore a complete search should be made. Depending on available time, make as complete a search as possible.

General Search Guidelines for Bomb Threats
1. Launch search promptly.
    a. Initiate simultaneous assessment and search.
    b. The depth and nature of the search can vary based upon the threat assessment and information updates as applicable, working with local law enforcement.
    c. If something is found, ***do not touch it***. Secure the area and notify a supervisor.
2. The question of evacuation is a challenge that is best resolved by consultation between the police department and the healthcare facility administration.

CODE YELLOW: DISASTER/DISASTER PLAN ACTIVATION
(Internal or External)

PURPOSE
To meet the response needs for incidents that could require significant support from throughout the organization to assist with emergency needs, or while addressing the emergency medical and healthcare needs of the community.

SUPPORTING INFORMATION (INTERNAL DISASTER)
Internal disasters can happen anywhere within the facility. Departments affected should deal with the disaster as necessary to protect the safety of staff and patients, and to mitigate the problem (that is, reduce chances of a situation getting worse by taking preventative or defensive actions). As much as reasonably possible, this should be addressed in the departmental specific disaster plan. An example might be to include shutting off power or water to a system in the department to prevent damage from unattended operation.

The various levels of an internal disaster alert serve as a general guide only to provide a sense of the internal working departments' involvement in the situation. The actual situation and response may require variations to this guide, and will be coordinated with and through the organization's Incident Command System (ICS). An organization's *Hospital Coordination Center* (HCC) may need to be opened to coordinate the flow of information and resources. The administrator on-duty or on-call will make the determination based on the best available information at the time.

Examples of what might constitute an **internal disaster** are:
- Total power outage or utility disruption from an internal system failure.
- Plumbing outage and or problems.
- Flooding for water line break.
- Explosion without fire (with fire would be **CODE RED**).

Each department within the healthcare facility is to develop a departmental specific incident action plan to support the overall internal disaster plan. Departments unaffected by the disaster should stand-by for further information and instructions.

SUPPORTING INFORMATION (EXTERNAL DISASTER)
External disasters are things that occur outside the facility, but can have an adverse impact on the facility or its operations (short-term or long-term). The various levels of an external disaster alert serve as a general guide to identify the facility's involvement in the external situation, or perhaps how the facility will respond to and/or cope with the external situation which caused the disaster alert.

External disasters may be accompanied by an area, community, region or national alert. They can be caused by natural or man-made events, or the impending threat of an event. The actual situation and response may require variations to this guide, and will be coordinated with and through the organization's Incident Command System (ICS). It is likely an organization's HCC will be opened to coordinate the flow of information and resources. The administrator on-duty or on-call will make the determination based on the best available information at the time.

Examples of what might constitute an **external disaster** are:
- Community power grid failure or major utility system disruption.
- Severe storm damage to a segment of the community.
- Flooding caused by rising or moving water.
- Chemical release with fumes/plume spreading.
- Explosion causing a large number of casualties.

Each department within the healthcare facility is to develop a disaster specific plan to support the overall external plan. This could include potentially assisting another department that is overwhelmed with non-traditional tasks (things a person is not normally assigned or responsible to do).

General Guidance:

Each department within the facility is required to have their own emergency Incident Response Plan. There are a number of common specific internal and external planning scenarios with suggested Incident Action Plans and response guides contained the HICS program manual. Each of these scenarios is discussed in detail, and includes suggested ICS staffing for response, sustained operations at that level, and recovery phases. Included are suggested Incident Action and Response Plans to help with planning. Here are some other planning considerations:

- The overall goal of the various institutional emergency plans are to ensure the facility can adequately respond to, sustain or maintain an acceptable level of operations during and immediately following an emergency or disaster, and can speed the organization's recovery and return to normal operation. All employees should be briefed on **Code Yellow**, and their potential immediate actions to protect fellow staff, the patients, visitors, and the facility.
- Facility and department emergency plans shall include at least two evacuation routes for staff and patients. The plans should recognize that some patients, especially those who are NOT ambulatory, may need special assistance and transport devices.
- The facility may need to have a plan for the potential operation of the key services or operations of the organization at an ALTERNATE location. This plan should consider things like:
    - Moving staff, patients and key equipment to the alternate site;
    - Relocation of patient records; and
    - Obtaining needed items and services.
- Emergency incident action plans should identify general responsibilities per job title during different types of disasters (such as fire, flood, earthquake, and so forth). The HICS program manual has a large collection of suggested JOB ACTION sheets that can be adapted to help define/clarify roles and responsibilities during an emergency. Tese are useful, especially when an individual may need to temporarily assume a different job role for a period of time.
- Each facility, and departments within the facility, should pre-define who is in-charge, and who is next in-charge. It may be necessary to have some level of distinction going down several levels so that (for example) at 3 PM Saturday afternoon whomever is on-duty knows the person who will be in the lead role for that department or function should an emergency occur. For example, in this scenario there may not an X-Ray Department Supervisor on-duty, so the most senior technician would be designated at the team lead.
- It may be useful in disaster planning to cross-train some personnel within the department on key functions that must be accomplished to sustain operation even if the primary person is not available. For example, are there a number of people who can operate the facility switchboard?
- When resources are needed from the community to support or sustain the organization in a disaster the normal process under NIMS is to coordinate with the local Emergency Management Agency (EMA). If the organization has opened its internal Hospital Coordination Center (HCC) then the hospital department in need would go through the facility HCC. If they are unable to fill the need by shifting internal resources, the request will be forwarded by the HCC to the community EOC or Emergency Management (EM). If they can fill the need from community assets it will be handled locally. If not, the community EOC will forward it to a state EOC or regional resource allocation center.

CODE RED: FIRE

PURPOSE
To provide the procedures to be followed to protect patients, visitors, staff and property in the event of a real or suspected fire.

SUPPORTING INFORMATION
CODE RED should be immediately initiated whenever any one of the following indications of a real or suspected fire are observed:

- Seeing smoke or a fire.
- Smelling smoke or other burning material.
- Feeling unusual heat on a wall, door or other surface.
- Other indications as identified by the facility
- A **CODE RED** alarm may also be initiated automatically by electronic fire detection equipment, heat and smoke sensors, ventilation equipment and water pressure sensors.
- Fire response procedures must be implemented upon suspicion of a fire. Notification of coworkers for a timely, effective and efficient response is critical.

CODE ORANGE: HAZARDOUS MATERIAL SPILL/RELEASE

PURPOSE

To identify unsafe exposure conditions, safely evacuate an area, and/or protect others from exposure within the healthcare facility or on its grounds, due to a hazardous materials spill/release.

A hazardous material spill/release is an unexpected release into the environment (internal or external to the facility), either accidental or deliberate, that has the potential to cause injury or illness, may result in further risks such as an explosion, and may result in exposure to a potentially toxic substance which exceeds state or federal exposure limits, or may harm the environment. Some substances and situations can create potentially dangerous or deadly circumstances very quickly, and may require immediate activation of Incident Response Plans.

SUPPORTING INFORMATION

It is recommended that each facility define procedures to be taken in response to a minor and a major spill, either EXTERNAL or INTERNAL. It should be considered in planning that in either scenario the facility or organization may need to both react in a defensive manner to protect staff, patients, visitors and/or the facility, AND prepare to receive, decontaminate, triage and treat potential victims of the incident.

Planning for potential decontamination operations shall be consistent with the OSHA *Best Practices for Hospital First Receiver Operations* guidance.

In the event of a release that may EXTERNALLY impact on the facility, a decision may need to be made to either evacuate portions of a building (horizontally or vertically), the entire building, or to "shelter-in-place". Plans should address all three of these potential scenarios. The decision to take one of these actions should be coordinated with Fire Department on-scene Incident Command.

It would be appropriate to have a good working relationship with the community's emergency management and response agencies, and include them in planning and drills.

In the event of a spill or release that may occur INTERNALLY, the personnel in the affected area or department should be aware of the immediate actions they are to take to alert others and the 9-1-1 system, protect fellow staff, patients, visitors, and the facility.

Some potential mitigation actions could include, but are limited to:

- Shutting off power or control valves to critical systems;
- Starting, shutting off, or reversing ventilation fans; and
- Evacuating the impacted area and closing fire doors.

These types of plans are best developed at the specific department or section level where the hazard is likely to occur. The staff is likely to be most knowledgeable about the materials they work with, the risks involved, and the safety systems available.

OSHA requires that to protect the health and safety of all employees, they shall be informed about potential hazardous substances within the workplace. That includes providing them with unrestricted access to information on these hazards normally contained in Material Safety Data Sheets (MSDS) that must be readily available at all times.

Further, OSHA requires that employers train employees in the proper procedures they must follow to protect themselves from the risks of hazardous materials. Often this includes information on the appropriate level of PERSONAL PROTECTIVE EQUIPMENT to use, how to wear or use it, and where to get it (which should be at no cost to the employee). This is considered AWARENESS-LEVEL training.

CODE BLUE: MEDICAL EMERGENCY (Adult or Pediatric)

PURPOSE

To facilitate the arrival of equipment (crash/code cart) and specialized personnel to the location of an individual in cardiopulmonary or respiratory arrest. ***If there is any doubt*** about the existence of a valid DNR order or an advanced healthcare directive, then the response should be towards an immediate decision to call a **CODE BLUE** and initiate Cardiopulmonary Resuscitation (CPR) at the level appropriate to the training of the responder.

SUPPORTING INFORMATION

CODE BLUE is called for patients who **do not** have a physician's Do Not Resuscitate (DNR) Order, or an advance healthcare directive indicating otherwise.

CODE BLUE is to be initiated immediately whenever a person 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. In areas where pediatric patients are routinely admitted there should be a pediatric crash cart available with pediatric-sized supplies and equipment.

If a **CODE BLUE** is called in a non-treatment area, or one that is not normally assigned a crash cart, it may be appropriate to request a **CODE BLUE PEDIATRIC** so that an appropriately equipped cart can be sent from the closest designated area.

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

PURPOSE

To ensure a safe and secure environment for patients, visitors and staff, and provide guidance to staff that specified immediate actions should be initiated. The assumption is that staff members and/or visitors are confronted by an individual who is actively shooting a firearm, brandishing a weapon, or who has taken hostages within the healthcare facility or within its property.

- For purposes of this protocol, the definition of a weapon is any firearm, knife, or instrument that can cause bodily harm or injury.
- Weapons are not permitted on the healthcare facility's property, except for persons who are professionally exempted or authorized by law to carry a weapon in the performance of their duties, such as:
  - ✓ City, county, state or federal law enforcement officers.
  - ✓ Staff of contract services companies (i.e., Brinks, Wells Fargo Armored Car, etc.).
- The facility reserves the right to inspect the contents of all packages or articles entering or being removed from the facility.
- Weapons, dangerous devices and illegal or unsafe items will be retained by facility management, security personnel and/or local law enforcement authorities.

These are dangerous situations which must be approached calmly, carefully and thoughtfully in order to reduce the risk to patients, staff and visitors. The situations will typically require an emergency response from security and law enforcement, certain immediate staff actions to lock-down or secure areas of the facility, and pre-planned defensive steps to protect staff, patients and visitors.

SUPPORTING INFORMATION

CODE SILVER will is to be immediately activated when a person (patient, staff or visitor) produces a **firearm** and either **threatens to shoot**, or **begins to shoot**, inside the facility, outside but aimed at the facility, or at things/people immediately adjacent to the facility.

In this situation, **immediately notify security and law enforcement**, initiate lockdown procedures and protective actions throughout the facility since it won't initially be known if the individual is acting alone, or with others.

CODE SILVER is to be initiated immediately when a patient, visitor or staff member is discovered to have a **weapon**, and *is potentially threatening staff*, visitors and other patients.

In this situation, **immediately notify security and law enforcement**. Unless there is some indication that this more than an isolated incident, initiate lockdown procedures and protective actions *in the affected unit*.

CODE SILVER *may not* apply in situations where a weapon is found in the clothing or belongings of a person, but there is NO apparent or intended threat. In this situation, it is recommended that the device be rendered safe, then bagged and tagged (as to the owner, location of the weapon, circumstances of its discovery, and who handled the device), and turned over to security for safekeeping. It may be surrendered to law enforcement if there is subsequent indication that the person or weapon may have been involved in a crime. If staff is not familiar with how to render a device safe, security should be summoned to handle this task.

CODE SILVER is to be initiated immediately whenever one or more persons is being held **hostage** by a patient, visitor or staff member, with or without a weapon being visible. *The assumption should initially be made that the person holding others hostage is armed until proven otherwise* by security or law enforcement personnel. *If such a situation arises, staff members should not attempt to intervene or negotiate.*

In this situation, **immediately notify security and law enforcement**. Unless there is some indication that this more than an isolated incident, initiate lockdown procedures and protective actions *in the affected unit*.

PRE-PLANNED DEFENSIVE STEPS

These are examples of some pre-planned defensive actions that can be taken:

- Lock doors into the unit or section of the facility. If doors don't lock, close them and place heavy obstacles behind the door to make entry difficult;
- Move patients, visitors and co-workers into an area that can be secured (locked or barricaded);
    - If in a unit, move patients into a patient room, close the door, turn out lights, and pull the curtains.
- Turn out unit lights and close shades/blinds;
- Turn off cell phone ringers, radios and televisions;
- If you are going to call 9-1-1 or a security number to report do so from a cell phone or telephone that does NOT have an extension indicator in another area which might light or flash to tell the threatening person that someone is in the area;
- When law enforcement arrives in your area of the building follow their directions *exactly*. Don't try to touch, hug or distract the law enforcement officer. Remember that at this point they may not know who or where the perpetrators are, *or if you are a "hostile" person*.