THE ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI, NEW YORK STANDARD: POLICY/ PROCEDURE	SUBJECT NO.
DEPARTMENT: Internal Medicine Residency SUBJECT: Emergency Contingency Plan	

Inpatient Medicine at The Mount Sinai Hospital

- Establish Command Center for Medicine Residents
  - 9 West 180 preferentially
  - Establish times when all interns/residents will report here or at affiliate to:

    1) Check in at start of shifts

    2) Get periodic updates.
  - Hatch Auditorium is good initial meeting place for all house staff at Sinai for updates and planning, 9W-180 used thereafter for periodic check-in.
  - Establish best means of communication and disseminate (land line number for command center, chief resident cell phones, working email address, etc.)
- Internal Medicine Chief Resident On Call should attend hospital-wide command center meetings for updates
- All interns and residents should bring extra clothes, medications, etc. in case they need to stay in hospital overnight and work double shift as staff may not be able to travel to and from hospital
- Print out list of all intern/resident/attending contact info, ensure up to date, and distribute to interns/residents and post in 9 West 180 and 10 West Team Room
  - Include rotators' contact info (Anesthesiology, Elmhurst, Emergency Medicine, Psychiatry)
  - Include cell phone and pager numbers
- Determine Changes to Schedule if necessary: Have interns/residents arrive earlier than usual as needed, this is particularly true for night teams.

- Night teams can rest in the hospital during the day and be ready to work in evening
- If night teams cannot come in, day teams should assume cross cover and admissions based on geography and divide teams into shifts to allow for rest (Example: Red, Orange and Yellow teams will do cross cover and admissions from 4pm to midnight then Green, Blue and Purple teams will do cross cover and admissions midnight to 8am)
- Chief residents will need to make schedule to ensure that sufficient staffing is present in-hospital. Updated schedule should be posted in 9W-180 and disseminated to teams via contact list

- Sleeping Arrangements
    - Point person: Housekeeping 44443
    - Find out where they will be placing cots for extra areas to sleep and reserve as much as possible for medicine
    - Call rooms:
        - 9W team room: 1 couch
        - 10W team room: 1 couch
        - 11E team room: 1 couch
        - 11E Call Rooms: 4 beds (2 bunk-beds)
        - CCU Call Rooms: 2 beds
        - MICU Call Rooms: 4 beds
        - Preferentially give Guggenheim sleeping arrangements to PGY2/3s in charge of geographic teams in event of blackout
        - Keep list of which residents will be in which rooms and disseminate.
    - Alternate locations include FPA exam rooms, Ruttenberg, Morchand Center rooms in medical school
- Food and Water
    - Discuss with hospital command center, they make arrangements with food services
    - Contact housekeeping to pick up sets of linens, toiletries to distribute from command

center

- Establish a Blackout plan (see Appendix A for general plan)
    - In the event that power or pager system goes down, establish teams based on geography. A set team of attending, residents and interns will be assigned to cover designated floor(s).
    - These teams will be responsible for the care of all patients on the floor(s) and coordinating with primary teams for non-medicine patients
    - Print out list of attendings/residents/interns and distribute, post on each floor and in team rooms
    - Print out list of patients and patient sign-outs for each floor
    - Have each medicine team regularly print out sign-outs for their teams and give copies to chief residents
    - Ask for walkie talkies from hospital command center to facilitate communication
- Discuss with Hospital Medicine Division Chief which hospitalists can be assigned to floors and if MAPAs will be in house
    - Hospitalists will cover the ADS floors (KCC 4/5) and a hospitalist attending will be assigned as the attending for a specific teaching unit to oversee the house staff teams
- Contact each division chief (communicate with chair of medicine first) to find out their attending and fellow coverage and obtain contact information including cell phones in event paging system goes down (GI fellow, Cardiology fellow, etc.)
    - Chair of Medicine should request certain high priority fellows/attending stay in house
    - Distribute specialty contact lists to interns/residents
- Identify high risk patients and patients who need urgent procedures/imaging by geographic unit
    - Patients with oxygen requirements (ventilator, BiPAP, more than NC –2L/min)
    - Patients who receive dialysis and when last dialysis session was
    - Patients in abnormal vital signs on drips / vents
    - Patients who require lines (Line Service) or urgent imaging studies

- Indicate these patients on printed sign-outs for each unit (9W, 10W, 11E, 10C as well as off-service units with teaching patients)
- Provide copy of these patients sign-out and location to MPCU and MICU fellow/attending and renal fellows as appropriate
- Encourage teams to get important imaging, labs, etc. done as soon as possible

- Medical Consult Resident (MCR), Teaching Resident (TR) and Medical Admitting Resident (MAR) are considered overall go to PGY3 leaders and chief residents will distribute to each of them copies of the following:

  1) Contingency plan (Appendix 1)

  2) Patient sign-out per geographic unit with indicators for those on

  drips/vents/critically ill and

  3) Key phone numbers needed.

- The PGY3 floor leadership (MAR, MCR, TR) should keep in close contact with the chief residents and may be asked to fill-in as needed in case of shortages.
- If anticipated emergency, teams should expedite any potential discharges that day prior to free up as many beds as possible
- Email out coverage schemes to medhs@mssm.edu including expected arrival/departure times and what they should bring to hospital with program director and chair cc'd
- If hospital determines it will need to expand patient capacity, hospital command center will likely open an additional patient care area (in past has been GP 1/Ruttenberg, though construction has made this unlikely to be the future location)
  - Should only be for low-acuity patients (stable patients awaiting disposition, etc.)
  - Chief resident and other member(s) of medicine leadership (Hospitalist, Vice Chair, etc.) should contact teaching and ADS teams to identify patients potentially appropriate for transfer then round on patients with nursing leadership to decide if transfer should be approved
  - Below is operations manual for GP 1 which opened during Hurricane Sandy

(see Appendix 2 for Hurricane Sandy-specific plan)

- Residents should not leave the hospital prior to checking in with chief residents or other

designated senior resident/faculty

- Back up residents: residents on OP and elective (depending on specific situation, may need them to come into hospital in case of need). Chief residents should contact them and verify their availability.

- **Establish an Evacuation Plan to receive patients from hospitals that need to evacuate: HURRICANE SANDY Plan**

  - For Hurricane Sandy, the command center was in charge of converting the geriatrics emergency room into the NYU/Bellevue triage area; bed management physically assigned someone to efficiently assign beds as patients arrived

  - Chief residents mobilized 2 extra PGY3 residents from elective/outpatient to facilitate triage and transfer to the floor as well as 3-6 additional PGY2 residents to perform admissions for these patients; note: we only received patients from OB and psychiatry from Bellevue and these teams were not needed ultimately but it was better to have them come into the hospital (See Appendix 4)

  - For the NYU Langone intensive care unit evacuation, patients were transferred from the combined ICU (surgical, medical, cardiac, etc.) to Sinai's PACU in Guggenheim. They were transferred with NYU nursing staff and attending as well as residents and with the help of PACU staff were transitioned to Sinai's care over the course of 8-12 hours

  - Chief resident role: Call in 2-3 PGY3s to create a medicine PACU team – responsibilities included making a list of all patients transferred (See Appendix 4) and determining disposition (service and bed needs), entering relevant sign-out information into EPIC once virtual unit / medical records created, being contact person for bed management to list patients for beds, assigning teams once beds ready, providing verbal sign-out to admitting teams, corresponding with medicine chiefs and key people listed above, who then correspond with Command Center with updates

<u>Affiliate Hospitals (Elmhurst and Bronx VA)</u>:

- Establish command center for residents

  - Where to go for updates, check-in, etc.

  - VA: ICU team room

  - EHC: 6th floor conference room

- Coordinate with department chair/GME head (Dr. Masci for EHC and Dr. Rosendorff for VA)
    - Determine attending coverage: at a minimum each floor should be assigned one attending
    - Determine resident sleeping arrangements
    - Determine how hospital will provide food/water
    - Request that high priority subspecialty fellows/attendings stay in house
- Transportation to affiliates
    - Contact security office to determine if and how long shuttles will be running
    - Emergency vehicles may be available to transport residents to affiliates if needed, check with MSH command center and command centers at affiliate sites
    - If transportation not available, on-call residents may need to remain in-hospital
- Determine deployment strategy
    - Determine whether to send residents to affiliates before scheduled shifts based on anticipated start of emergency/disaster
        - Example: Residents/interns who are slated to work night shifts should go to affiliates in AM if anticipated difficulty traveling
- Instruct residents to bring extra clothes, medications, food, etc. in case they need to stay in hospital overnight and work double shift as staff may not be able to travel to and from hospital
- In conjunction with GME at affiliates, will need to create geographic system. Potential examples:
    - EHC: Maintain strict geography (i.e. B5 takes care of all B5 patients) with plan needed for A3 patients.
- Have all teams print out updated copies of their sign-out periodically and give copies to chief residents
- Residents should not leave the hospital prior to checking in with chief residents or other designated senior resident/faculty
- Back up residents: residents on OP and elective. May not be feasible for them to make it to affiliates depending on type of emergency, so on-call teams will need to be prepared to stay at

affiliates until emergency is over.

IMA

- Contact IMA leadership and determine time that last patient will be checked in
- IMA should be closed
- IMA residents should be explicitly told to be on stand-by for extra help at Sinai and/or affiliates and called in as necessary

Appendix 1 – Blackout Contingency Plan - Sinai

General Medicine and Specialty Medicine

Unless explicitly told otherwise by the command center, the geographic teams should assume care of all patients on their floors, with the exception of the non-geographic overflow team ("Off-Service Team") and the specialty teams. The chief residents will need to discuss this plan with the hospitalists (10W, 9W, 10C). Additionally, they will need to discuss this with Liver Medicine (9C/9E teams), Oncology Medicine (11E/11C), and Cardiology Medicine (7C/7E) about their coverage plans for the non-teaching patients on these floors.

10 West Team

Hospitalist: TBD by Chief of Hospital Medicine

Resident: Red/Orange/ Resident

Interns: All West Red/Orange Interns (including rotators)

9 West Team

Hospitalist: TBD by Chief of Hospital Medicine

Resident: Yellow/Green

Interns: Yellow/Green Interns (including rotators)

10 Center Team

Hospitalist: TBD by Chief of Hospital Medicine

Resident: Blue/Purple

Interns: Blue/Purple Interns (including rotators)

11 East/11Center Team: Oncology Teaching Team

Attending: Will need to coordinate with Oncology division chief (Dr. Oh). Most likely to be current service attending.

Residents: Oncology A and B Residents

Interns: Oncology A and B Interns

9 Center/9 East Team: Liver Teaching Team

Attending: Will need to coordinate with Liver division chief (Dr. Friedman). Most likely to be current service attending.

Residents: Liver A and B Residents

Interns: Liver A and B Interns

7 Center / 7 East Team: Cardiology Teaching Team

Attending: Will need to coordinate with 7C team (currently Dr. Miller and Dr. Barman). If unable to come to conclusion with them, there will be initiation of discussions with Dr. Fuster.

Residents: Cardiology A and B Residents

Interns: Cardiology A and B Interns

Off-Service Team – Chief resident will make a list of all non 9W/9C/10W/10C/7C/7E/11C/11E patients. This team will take care of all off-floor medicine teaching patients including those on 8C, 8W, and 6W.

Hospitalist: TBD by Chief of Hospital Medicine

Resident: ID A & B Residents

Interns: All ID A &B Interns (including rotators)

Medical Consult Resident / Medical Admitting Resident / Teaching Resident: Should assume leadership role to assist in oversight of all teams. The MAR/MCR should be in close communication with chief residents as above. May be required to help with sick patients, organizational tasks, provide coverage in case of staffing shortages, etc.

Appendix 2 – Overflow Clinic Operations Manual (overflow emergency medical unit)

HURRICANCE SANDY GP 1C OPERATIONS MANUAL EXAMPLE

Capacity: 14 beds

Non-teaching Medicine

No telemetry capability

Can accommodate isolation patients

Patients who need dialysis must go to B1 to have it done

Phone: x 41021

Patient Identification / Flow

Criteria

- Stable non-teaching Medicine patients. Unstable patients or patients with severe behavioral issues (e.g., wandering, requiring 1:1, severe agitation) are excluded.

- Patients may be identified in the ED or sent to GP1Center from the wards if stable and have no major behavioral issues (wandering, etc.).

Process

- Triage of potential ED patients is done by:
    - Medical Admitting PA (MAPA) [9am-9pm Mon-Fri, Sun]
    - Medical Admitting Resident (MAR) [Mon-Fri nights, Saturday]

- When the MAPA/MAR identifies an appropriate GP 1C candidate from the ED they will list the patient for ADS Medicine and contact a designated Nursing leader.
    - Monday through Friday days designated clinical nurse manager
    - Evenings and nights and weekends the covering Nursing Administrator
    -
- The Nursing leader will assess and if appropriate will inform BedBoard that the patient will be assigned to GP 1C.
- Transfers - Stable Medicine patients may also be identified on the Medicine wards and transferred to GP 1C.
    - May be identified by SW or the Medicine teams
    - If a teaching patient is transferred, the patient is considered transferred to ADS Medicine
    - The Medicine team must be aware of all transfers as they can confirm that the patient is stable/
- No patient can be sent to the GP 1C unit without explicit approval from the designated Nursing leader.

Input into Cerner: Need to be in close contact with bed management (Linda Fausto). The BA (may need to have one assigned) will input patient into Cerner upon arrival to unit.

Clinician Staffing

Monday-Friday Daytime Hours

- A hospitalist will be assigned to cover GP 1C on a daily basis. This MD may also be assigned ADS patients on other GP wards.
- Patients may also be assigned to other medical physicians, including private medical physicians and the Geriatrics Service.
- No other departments (e.g., Surgery) will admit to GP 1C.
- An NP will be assigned to provide coverage for the unit.

Nights

- Night cross-coverage will be by the night NP assigned to cover ADS patients in GP.
- A hospitalist attending is in-house and will back-up the NP at all times for medical emergencies.

Weekends

- A hospitalist will be assigned to round on all Hospitalist Service patients.
- Other physicians and services will similarly ensure attending coverage over the weekend.

Team 7000

- A crash cart is on-site

- Both the ED and the Medicine teams will respond
- If the distinction is necessary, the ED is primarily responsible for running the code.