**Access the recorded webinar here:**
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**Speaker Bios:** https://asprtracie.s3.amazonaws.com/documents/healthcare-response-to-a-no-notice-incident-speaker-bios.pdf

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# Healthcare Response to a No-Notice Incident: Las Vegas

March 28, 2018

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# ASPR TRACIE: Three Domains


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- Unpublished and SME peer-reviewed materials highlighting real-life tools and experiences


- Personalized support and responses to requests for information and technical assistance
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- Area for password-protected discussion among vetted users in near real-time
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**John Hick, MD**

Hennepin County Medical Center & ASPR

Moderator

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# Background

- Route 91 Harvest music festival
  - 59 died, 527 injured
  - About 21,500 self-evacuated
- High velocity rifle / sniper attack
- Less than 20% transported by EMS
- 17 hospitals in area
  - “closest” vs. “trauma center”
  - >100 victims to nearby Level 3

# EMS Response

- Very robust EMS response
  - Clark County Fire
  - Las Vegas City support
  - AMR / other ambulances
- Multiple potential incidents / shooters
- Scene safety issues
- Difficulty directing people to triage points / treatment areas
- On-scene transports concluded early in event

# Hospital Distribution

- Sunrise – 215 official (likely 250+)
- University Medical Center – 104
- Desert Springs – 93
- 5 other hospitals saw 10-60 victims each
- EMS potential to re-distribute casualties between hospitals

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**Caleb Cage**

Chief and Homeland Security Advisor, Nevada Department of Public Safety, Division of Emergency Management

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# State Emergency Management Perspectives

- Use of Rescue Task Forces
- EMAC and Governor's Declaration/ Order
- HIPAA and external disclosures in an emergency

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# The Challenges to the Surgical Services

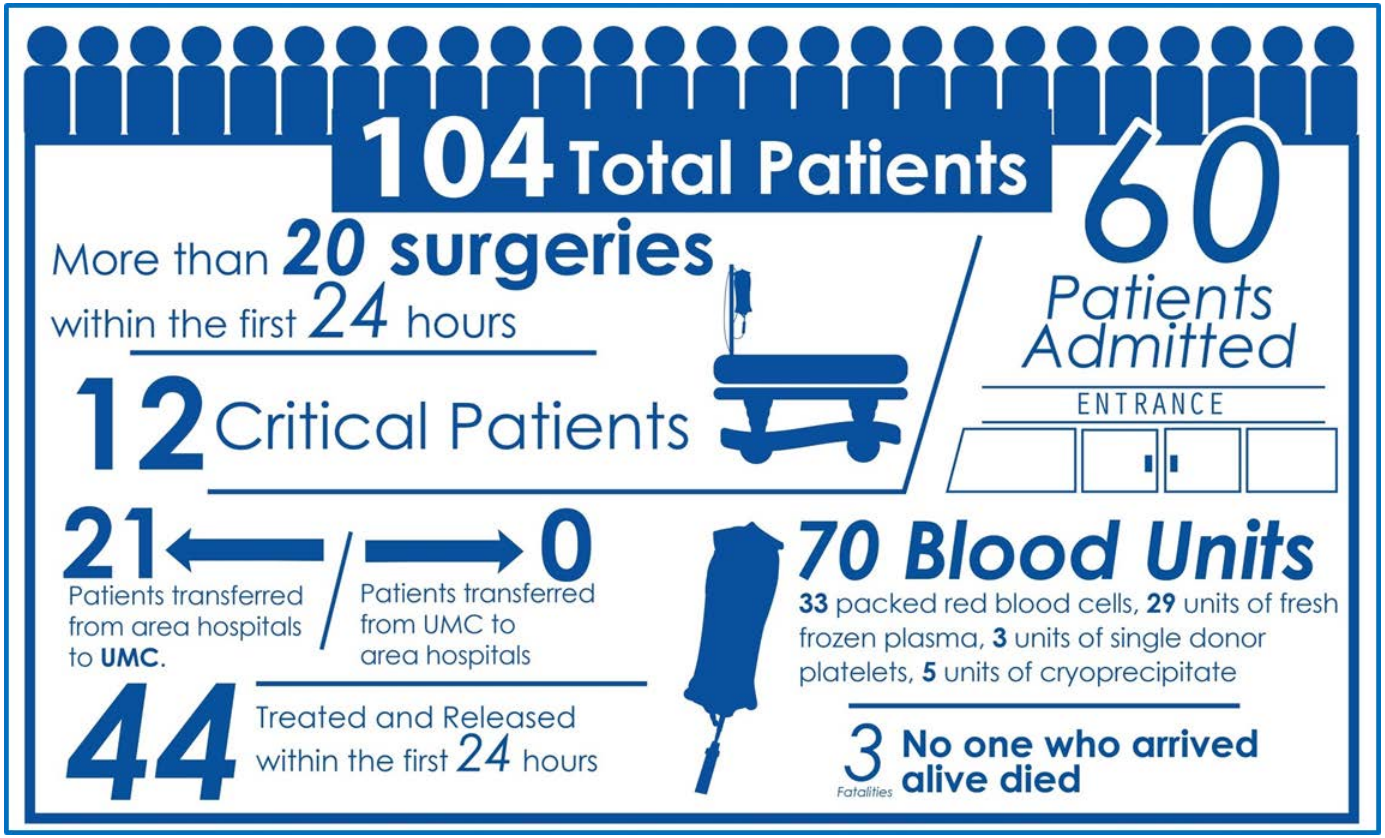
- No-notice event abruptly increased demand on surgical services
- Call in staff, a *technology solution* helps
- Be prepared to staff these services for 12/12 hours on/off for as long as it takes to care for these patients
- Immediately cancelled elective surgery for the next day

# The Challenges to the Surgical Services

- Expand into ambulatory surgery for pre-op
- Expand into the PACU for post-op
- Concentrate the surgical patients by specialist
- Use abbreviated surgery and damage control when possible
- Triage and delay non-life threats until the next day

# The Challenges to the Surgical Services

- Control blood use
- Restock and resupply in real time
- *Create new capacity with faster through put*
  - You never know if you will get one surge or multiple surges
- And remember… appendicitis, free air, and C-sections keep coming!




UMC
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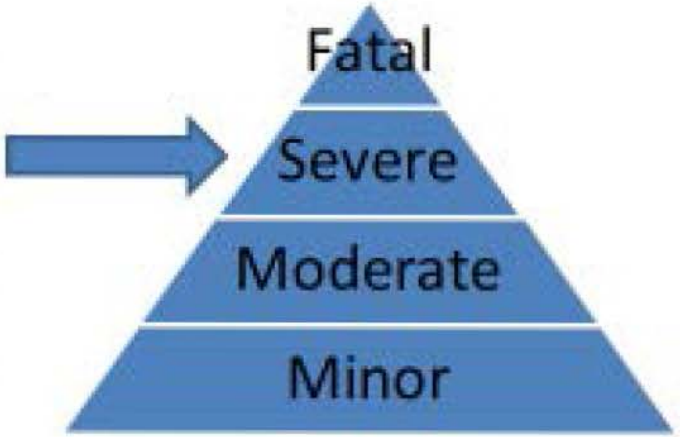
# Surgical Services in Non-Trauma Center Hospitals

- Treat what you can and shelter patients in place
- Stabilize and transfer patients you cannot treat
- Many surgical specialists do not do trauma surgery…
  - But all of them know how to *STOP BLEEDING* and *CONTROL CONTAMINATION*
- Seek an order from the Governor to allow all credentialed providers to exercise their privileges in all hospitals

# The Trauma Centers were Over Accessed

## The Trauma Center's Role

## The Injury Pyramid in an MCI



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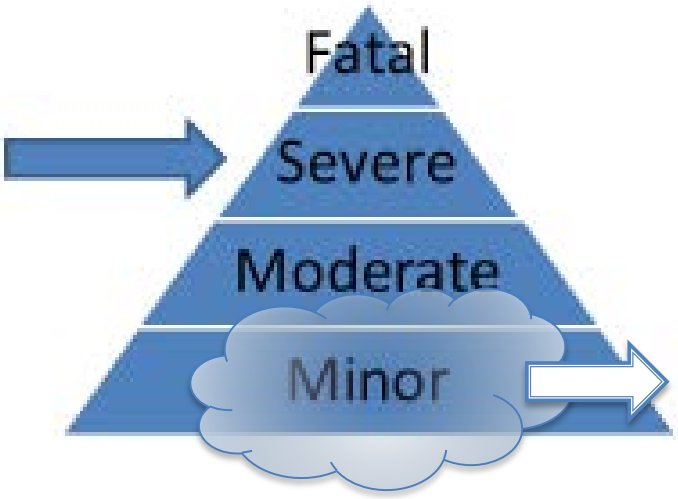


**Redistribute to other EDs**

# Final Thoughts

- The science of disaster predicts that only 10–20% of the injured will require surgical services and/or critical care support
- EMS is required to transport GSWs to trauma centers
- The majority of the injured were “walking wounded”
  - Many could be treated in emergency departments
- Redistributing self-delivered patients is a new concept and challenge that must be met

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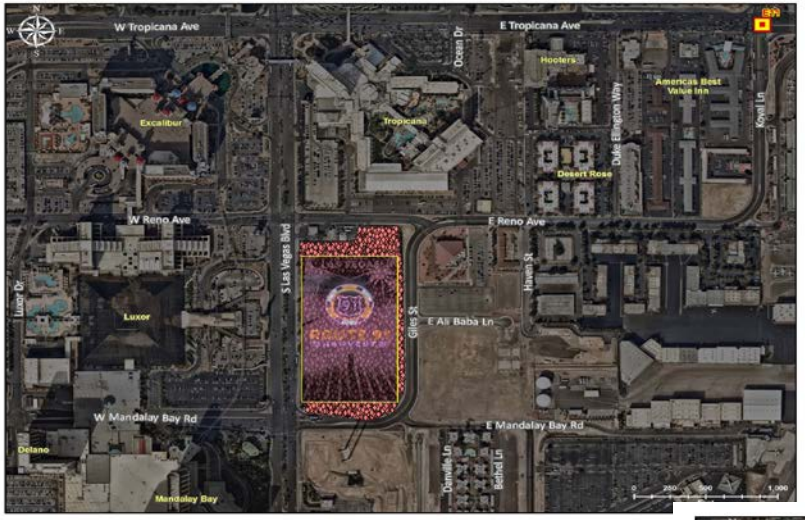
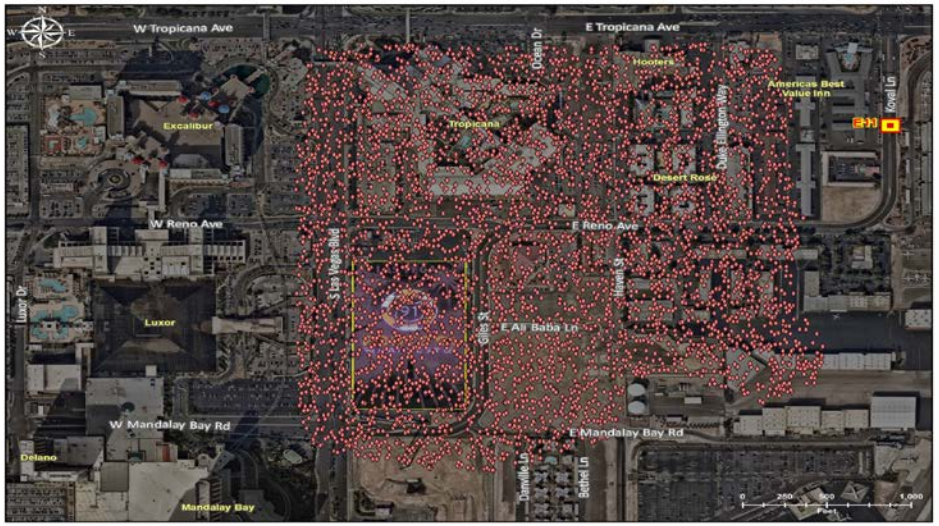
# EMS Arrival Process and Coordination




Initial EMS Call Distribution

Delayed Call Distribution

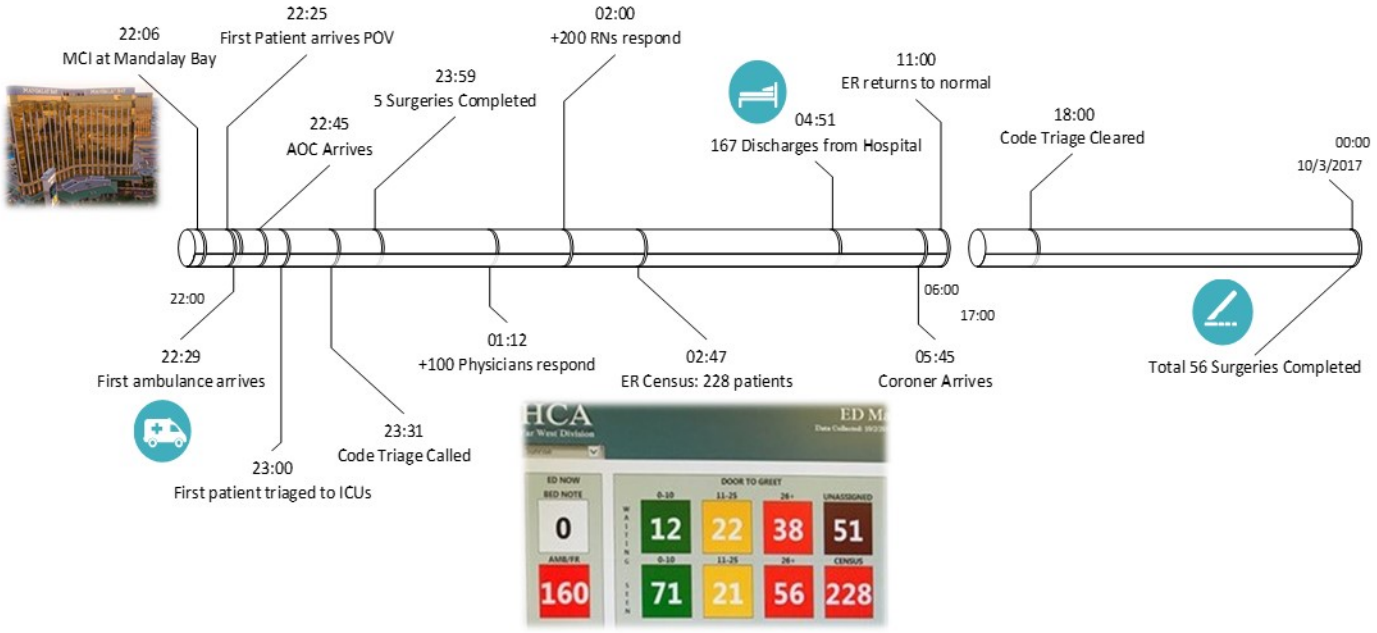


# Emergency Department Intake Lessons

- Triage of Patients at Front Door Process
- Unidentified Patient Process
  - Prior practice: single list of trauma, name for alias
  - Current practice: NOAA hurricane naming list year to each registrar
- Lead Staging Sections and Initial Treatment
  - Coordinated hospital staff to pair one RN to one patient until handoff to OR, ICU or floor
  - Dedicated RT for intubation support and supply pack creation in ED
  - Dedicated ED pharmacy resources to ensure adequate medication supplies
  - Management of over 125 crash carts in first three hours
  - Assignment of Surge ED Providers

# Hospital Throughput Coordination Requirements

- Mobilized Hospitalists and Intensivists to ensure open ICU beds (184 discharges in 15 hours)
- Partnered with Incident Command to expand capacity
  - Doubled Single Bed Unit (2 existing headwalls)

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# Intake Processes Adapted for Space

Walk In Entry

Ambulance Entry

Trauma Bays

Emergency Room

Operating Suites and Department

# Trauma Surgery-Driven Adaptations and Lessons

- Emergency Room areas dedicated to specific treatments
  - Major injuries to Trauma Space (RED)
  - Overflow into ED care areas, avoided spaces with poor line of sight
  - Minor injuries to Pediatric Space (GREEN)
  - Moderate injuries shifted into main ED Spaces (Yellow)

Created staging area for resupplying treatment areas

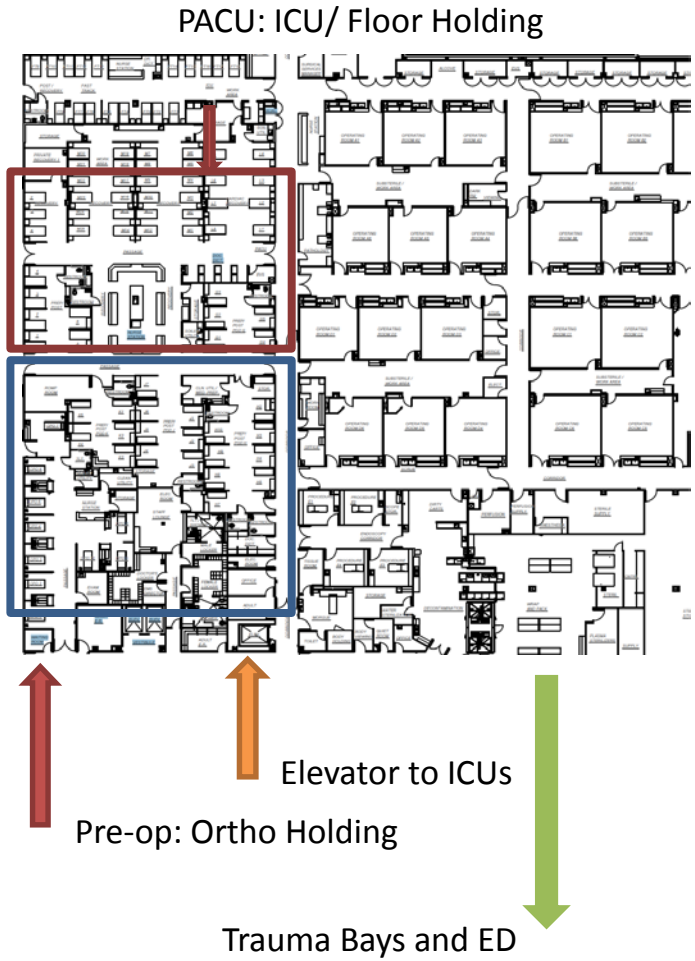
Blood Bank

# Trauma Surgery-Driven Adaptations

- Clear Decision on Prioritization of Patients by Team
  - Front end receiving by ED staff
  - Focused care delivery in trauma bays prior to OR / ICU
  - Dedicated trauma resources in ED areas
  - Appropriate use of consultants in operating suites and PeriOp
  - Re-evaluation done in cycles during immediate influx
- Importance of Support to Trauma Surgeons
  - Blood Bank
  - Respiratory
  - Pharmacy
  - Nursing
  - Environmental
  - Supply Services

# Trauma Surgery Driven Adaptations

- XABCDE
- ICU utilized to complete evaluations and expand triage capabilities
  - Trauma Surgeon, Anesthesiologist, Intensivist and support team in each ICU
  - Moved as soon as hemodynamically stable
  - Disease-specific assignments (CV, neuro, trauma, medical ICU's)
- Pre- and Post-Operative Care Unit assigned team to ensure management of immediate post-op recovery while assigning ICU bed

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# Role of Anesthesia in a Mass Casualty Incident

- Management of the Intraoperative Patient
  - Traditional roles
  - Non-traditional roles (Nursing Extender and leader, transport)
- Review and Assessment of Patients
  - Pre-operatively after ED/trauma review
  - Reassessments in post-operative recovery
  - Communication of change in status from initial assessment

# Role of Anesthesia in a Mass Casualty Incident

- Communication Between Locations
  - Act as a physician bridge between ED (triage) and OR
  - Improve handoffs between OR and ICU
- Critical Care Extender
  - Provide critical care services to augment trauma and ED providers
  - Expand ICU intensive care medicine service
  - Address pain management issues

# Learnings and Advice

- Engage Anesthesiologists in Your MCI Planning Activities
- Highly Flexible Providers Improve Quality Within All Locations- ED/OR/ICU
  - Provides leadership for enhanced OR turnaround time
  - Improves pain management effectiveness and quality
  - Extends surgical and ED capabilities
  - Addresses in real-time nursing skill gaps
  - Improves safety in patient transport

# Learnings and Advice

- Able to Re-evaluate and Reassign Triage Levels as Patient Conditions Evolve
  - Accelerates re-evaluation timeliness during initial surge
  - Improves post-operative re-evaluation during surge
- Critical Role in Patient Identification
- Bridge for Family Management
- Critical Role in Staff Post-Crisis Debriefings

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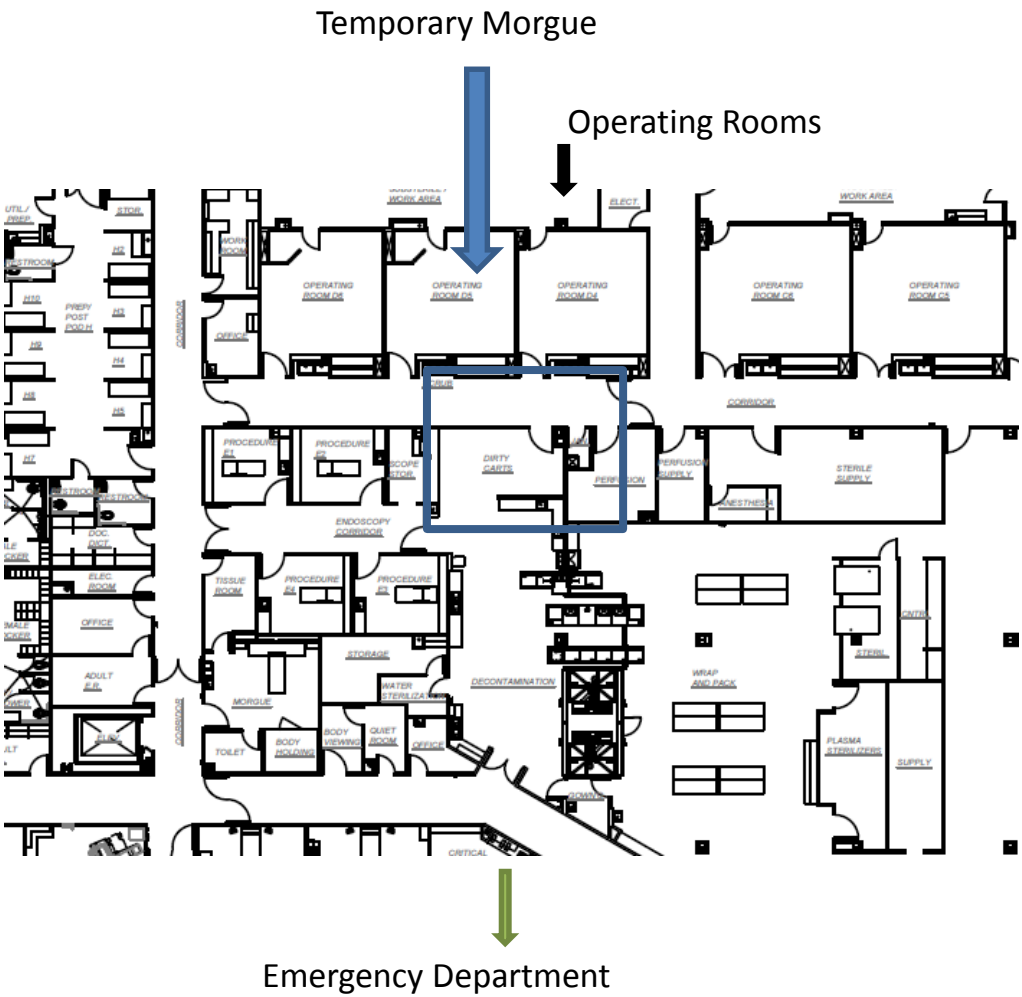
# Fatality and Family Management

- Created Temporary Morgue in Endoscopy
  - Adaption of plan as mortuary under construction and volume surge
  - Plan for appropriate management and preservation of evidence
  - Assigned staff to assist with coordination with Coroner's Office and family notification
- Ensure that staff appropriate
- High risk for post-incident stress



# Family Support and Coordination

- Created separate family space away from treatment areas
- Identification of the unknown
- Comfort supports
  - Clothes, food, chargers
- Mental Health Support
  - Social work
  - Clerical
  - Case management

# Staff Crisis Support During and Post Incident

- Immediate Need for Crisis De-Briefing and Counseling
  - Patients
  - Staff
- Partnered with Department of Veterans Affairs for 24/7 On-Site Services
  - Allowed for staff to engage on their schedules
  - Focused hospital resources on patients and families
- Developed Immediate and Long-Term Plans for Support
  - 24/7 on-site counseling center for staff offering grief and stress debriefing
  - Address medical staff wellness in partnership with employer
  - Hospital Town Halls for effective communication
  - Employee assistance programs for ongoing needs
  - Captured these to add to MCI Recovery Period plans

# Question & Answer

# Contact Us

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