



## Managing Surge Needs for Injuries: Administration Response

### PURPOSE

Within four hours, operationalize additional administrative-related resources related to treat 300 patients injured from an explosion and sustain care for 72 hours.

### BACKGROUND

The experiences of the Madrid terrorist bombings were used as a model to help develop solutions for managing rapid surge problems during a mass casualty event.

On March 11, 2004, 10 terrorist explosions occurred almost simultaneously on commuter trains in Madrid killing 177 people instantly and injuring more than 2,000. That day, 966 patients were taken to 15 public community hospitals. More than 270 patients arrived at the closest facility between 0800 and 1030 hours.

Federal resources should not be expected to arrive sooner than 72 hours from the time of explosion. Resources can be delayed by the time taken to deploy them and by responding to multiple communities.

Emergency Medical  
Service Response

Emergency Department

Surgical and Intensive  
Care Unit Response

Radiology Response

Blood Bank Response

Hospitalists' Response

#### Administration Response

Drugs and Pharmaceutical  
Supplies

Nursing Care

### GOAL

To organize and support response to influx of 300 patients injured from an explosion for a 72-hour period.

### RESOURCES REQUIRED

The workload associated with an administrative response will require access to multiple facilities to support the needs of patients, staff, and general public. Administrators will manage communications, acquire political support, work with and respond to media, handle public inquiries, manage internal systems and departments

*This document is a resource guide. Local needs, preferences, and capabilities of the affected communities may vary.*

### ASSUMPTIONS

- Health care systems and hospitals should function as an integrated system for the best use of resources.
- A medical response to a mass casualty event must be comprehensive, community based, and coordinated.
- Legal and regulatory issues need to be included in the hospital emergency preparedness plan: Emergency Medical Treatment and Active Labor Act (EMTALA), Health Insurance Portability and Accountability Act (HIPAA), Federal Volunteer Protection Act, Good Samaritan Laws, labor laws, OSHA, and Facility codes.

- Activating the community Emergency Operations Center (EOC) and hospital's command center are critical to success.
- Communication among hospitals, health systems, EMS, EOC, and public health cannot be lost or interrupted.
- Hospitals use the incident command system and have staff who can implement it.
- Hospitals, long-term care facilities, offices, and clinics have Memoranda of Understanding (MOU) to share resources.
- The EOC includes health care representatives to coordinate medical resources.
- Patients who do not need acute care services should be treated at alternate care facilities.
- The institution must:
  - Establish a response plan based on the Incident Management System (e.g., Hospital Incident Command System (HICS) model).
  - Include clinics and offices with emergency preparedness plans consistent with the hospital.
  - Include medical, nursing, dental, and pharmacy staff; respiratory students; and house staff and fellows, if available.
  - Determine the location of the command center (not in the ED) and backup sites.
  - Establish written plans to secure the perimeter of the facility and access points.
  - Identify a spokesperson for the hospital (public information officer).
- The preparedness plan should include mechanisms for modifying admission, discharge, and procedure schedules.
  - Defers admissions that are not emergent (develop criteria and put into policy).
  - Notify operating room manager to defer or cancel inpatient and outpatient non-emergency surgeries
- Incorporate intensivist, hospitalist, or Chief of Staff's designee into plan for discharging patients during emergency operations. (See template on Hospitalist Response) Set up MOUs with hospitals.

Additional staffing issues for consideration:

- Have staff available to address the mental health of victims, families, and staff (e.g., psychiatrists, psychologists, licensed mental health practitioners, and volunteers).
- Employ workers trained by the American Red Cross, especially those who can provide mental health services.
- Provide child care services so that staff are free to attend to patients.
- Compile a list of qualified translators for the disaster.

## **ACTION STEPS**

The solutions listed below include estimated number of hours for each task.

### **1. Control of the External Environment**

The external environment will change rapidly during a large-scale, mass casualty event. The hospital must be secured and campus traffic must be controlled. Such control of the external environment includes clearing beds to accommodate incoming casualties, redirecting non-emergency patients to other resources, and managing the comings and goings of staff. Managing media relations can be challenging when trying to provide safe and effective care. The institution's security and public affairs offices must work together and be in place before the media arrives.

### **2. Activation of Hospital Incident Command System (HICS)**

HICS, a widely used emergency management system, is known for providing a chain of command with the ability to effectively manage an incident, provide accountability of position functions, allow for a flexible response to specific emergencies, improve documentation of facility actions, provide a common language to facilitate outside assistance, and develop prioritized response checklists for senior leadership. Identifying the appropriate people to make decisions is pivotal in a fast-paced disaster, such as in the Madrid bombings. There is little time for meetings and discussion about the appropriate use of support functions and personnel. Staff should be trained and drilled regularly to ingrain the difference between incident structure and normal operations.

### **3. Logistics and Supplies**

Coordination with key suppliers and maintaining current inventories throughout the health system will make stocking efforts easier. When resources are limited, providers must be prepared to respond to care needs with whatever is available.

Logistics include, but are not limited to, patient transportation. For example, housing evacuees and the walking wounded and their families is a function of the emergency management program. Knowing the locations of designated shelters throughout the vicinity and transportation resources for low-acuity patients and their families will hasten discharge planning and patient flow in acute care facilities.

### **4. Alternate Care Sites**

A hospital's ability to mobilize emergency care units and extend care to the city's walking wounded adds to its effectiveness. Triage systems are used to prioritize patients so that low-priority patients can be directed from the main hospital, allowing ambulances and hospital staff to focus on high-priority trauma patients in need of medical assistance. Alternate sites, like the ones used during Hurricanes Katrina and Rita, allow large health systems to facilitate triage and direct patients to appropriate sources of care.

## **5. Credentialing**

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) emergency credentialing system must be tested within an organization before it is really needed. State Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP) reflect JCAHO requirements and provide a standardized set of verified credentials for volunteers who may be called to assist hospitals during emergency situations.

## **6. Patient Tracking**

Successful patient tracking begins as soon as they enter the health care system. When more time is spent identifying and tracking patients, the prospect of reimbursement for related costs is better. The ability to track patients, identify their supply consumption, and monitor bed use enables senior management to proactively meet the needs of health care providers on the frontline. Patient tracking systems must be flexible enough to accommodate such needs.

## **7. Identify gaps**

- Ensure coordination between on-scene management and available community resources so that specific facilities are not overloaded.
- Communication among facilities at clinical and administrative levels is essential.

## **8. Identify additional sources of community support**

Additional sources of support can include local shelters, locally developed stockpiles, community pharmacies, drug wholesalers/warehouses, public health authorities, etc. Access to these resources will be important if the event displaces many residents due to contamination, property damage, utility failure, etc.

## **9. Establish communication and relationships**

- Develop communications with local emergency management
- Establish communications with local, regional, and state hospitals.

## **10. Exercise plans**

- Establish regular schedules to drill every aspect of a response to ensure all staff understand their roles.
- Evaluate the drills, and modify plans based on after-action reports.
- Drill the new plan.

## **EVALUATION**

1. Plan, conduct, and evaluate facility-wide drills. The evaluation should identify stressors on clinical and administrative activities.
2. Plan, conduct, and evaluate community-wide drills. The evaluation should identify stressors on clinical and administrative activities.