Managing Surge Needs for Injuries:
Administration Response

PURPOSE

Within 4 hours, mobilize additional administrative-related resources needed to treat 300 patients injured from an explosion and sustain care for 72 hours.

BACKGROUND

The Madrid, Spain, 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 explosions occurred almost simultaneously on commuter trains in Madrid, killing 177 people instantly and injuring more than 2,000. On that day, 966 patients were taken to 15 public community hospitals. More than 270 patients arrived at the closest facility between 8:00 a.m. and 10:30 a.m.

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

GOAL

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

REQUIRED RESOURCES

- Staff: To support the needs of patients, staff, and the general public, administrators will need to manage communications, acquire political support, interact with the media, address public inquiries, and manage internal systems and departments.
- Disaster response plans for the hospital should outline a disaster call schedule for administrators to ensure that appropriate numbers of administrative staff can be accessed.
- Transportation arrangements should be addressed as part of the disaster response plan to ensure that administrative staff can arrive at the hospital.

- Emergency communications plan for administrators should include amateur radio and/or satellite phone.

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

ASSUMPTIONS

- Hospitals have a Hospital Incident Command System (HICS)-based emergency operations plan with appropriate staff training and resources.
- A medical response to a mass casualty event is comprehensive, community based, and coordinated.
- Legal and regulatory issues will 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, Occupational Safety and Health Administration (OSHA) regulations, and facility codes.
- Activation of the community emergency operations center (EOC and incident command system), including the hospital's command center, is critical to success.
- Communication among hospitals, health systems, emergency medical services (EMS), EOC, and public health cannot be lost or interrupted.
- Hospitals, long-term care facilities, offices, and clinics have memoranda of understanding (MOU) to share resources.
- The community's EOC includes health care representatives.
- Patients who do not need acute care services should be treated at alternate care facilities.
- The hospital's preparedness plan will include mechanisms for modifying admission, discharge, and procedure schedules.
- Admissions that are not emergent will be deferred (develop criteria and put into policy).
- Operating room manager will be notified to defer or cancel inpatient and outpatient nonemergency surgeries.
- Intensive care specialist, hospitalist, or chief of staff's designee will be incorporated into plan for discharging patients during emergency operations. (See template on Hospitalist Response.) Set up MOUs with receiving hospitals.
- Administrative staff will be familiar with the hospital disaster plan, their individual roles and responsibilities, and the roles and responsibilities of all essential departments.

Additional staffing issues that should be considered:

- Have staff available to address the mental health of victims, families, and staff (i.e., 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

1. When an incident management system such as HICS is used, certain issues need careful consideration:

- Identification of all appropriate key stakeholders,
- Communication and coordination with local government,
- Mental health needs of the staff,
- Special needs population, and
- Security.

2. Control of the environment

- Consider the following about the external environment:
  1. The external environment will change rapidly during a large-scale mass casualty event. The hospital must be secured, and campus traffic must be controlled. Controlling the external environment includes clearing beds to accommodate incoming casualties, redirecting nonemergency patients to other resources, and managing the comings and goings of staff. The facility should have pre-identified locations for all emergency functions with appropriate signage.
  2. 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 arrive.
- Consider the following regarding the internal environment:
  1. Develop a plan that identifies all physical beds available for care, including those in storage and those that can be rented on short notice.
  2. Ensure placement of cots in rooms or hallways as required.
  3. Make sure each department has a procedure for mass casualty care. The procedures need to be reviewed and accessible in the hospital command center.
  4. Departments need to determine procedures for what will be done immediately (0 to 120 minutes), intermediately (2 to 4 hours), and long term (4 to 24 hours).
  5. Every department should have a current call list that identifies staff by their proximity to the hospital.
  6. Make staff aware of where to park, where to report, how to respond, etc.
  7. Ensure that plans apply staff to tasks with which they are most familiar and perform daily; do not change routine procedures.
  8. Policies should be approved by a centralized committee that oversees the emergency operations and plans.

3. Activation of an incident management system

HICS, a widely used incident management system for health care facilities, 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 like the bombings in Madrid. Little time is available 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.

4. Logistics and supplies

Coordinating with key suppliers and maintaining current inventories throughout the health system will make ramping up the level of effort easier. When resources are limited, providers must be prepared to respond to care needs with the resources at hand.

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

5. Alternate care sites

A hospital's ability to mobilize emergency care units and extend care to the community's walking wounded enhances 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.

6. Credentialing and privileges

The Joint Commission [TJC] 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 TJC requirements and provide a standardized set of verified credentials for volunteers who may be called to assist hospitals during emergency situations.

Coordinating with key suppliers and maintaining current inventories throughout the health system will make ramping up the level of effort easier.

7. Patient tracking

Successful patient tracking begins at the point a patient enters 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 front line. Patient tracking systems must be flexible enough to track patients through the health care system.

8. Identification of 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.

9. Identification of 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 a large number of residents due to contamination, property damage, utility failure, etc.

10. Establishment of communication and relationships

- Develop communications with local emergency management.
- Establish communications with local, regional, and state hospitals.
- Establish regular schedules to drill every aspect of a response to ensure that all staff understand their roles.
- Evaluate the drills, and modify plans based on after-action reports.
- Drill the new plan.

14. An ethics panel should be convened as necessary to develop disaster policies, especially regarding alterations to standards of care in disasters.

EVALUATION

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

For more information, visit **http://emergency.cdc.gov/masscasualties**.