Ontario Critical Care Clinical Practice Rounds (OC3PR): COVID-19

Hosted by CCSO | SMPCO

April 7 2022

Mass Casualty Planning and a Sudden Increase of Critically Ill Patients

Chaired by Dr. Dave Neilipovitz
Presented by Dr. Paul Bradford
& Diane Bradford

Meeting Etiquette

- Attendees can submit questions to Q&A in the Zoom menu.
- Please note, reproduction in part or in full of any of this presentation requires express permission from CCSO.

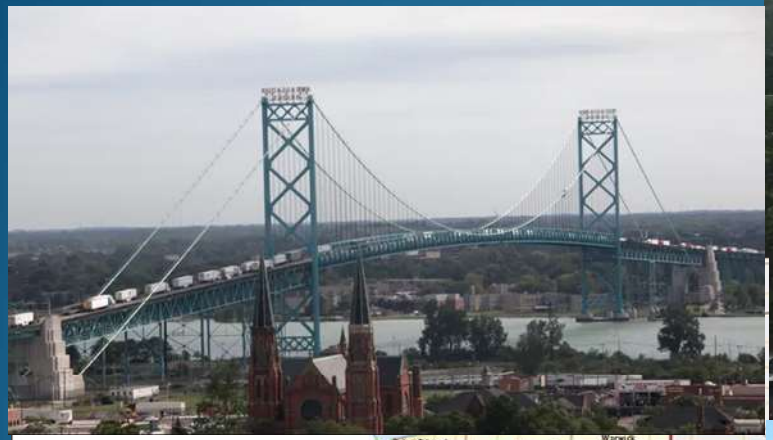
Mass Casualty Planning: to drill or not to drill

April 7, 2022

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

Regional Trauma Program

Where in the World is Windsor?



WINDSOR REGIONAL HOSPITAL

OUTSTANDING CARE – NO EXCEPTIONS!

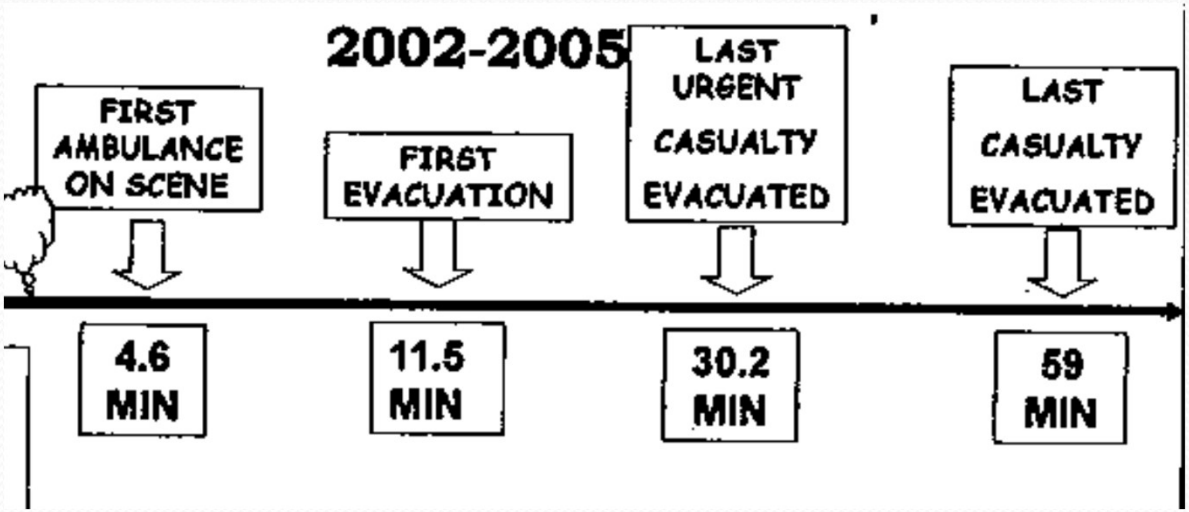
Mass Casualty Trigger

- What ever overwhelms your hospital/ clinical area
- 5 multisystem traumas? Or 3 multisystem traumas with 2 critical care patients, Code STEMI, Code Stroke simultaneously, (or sick calls effect)

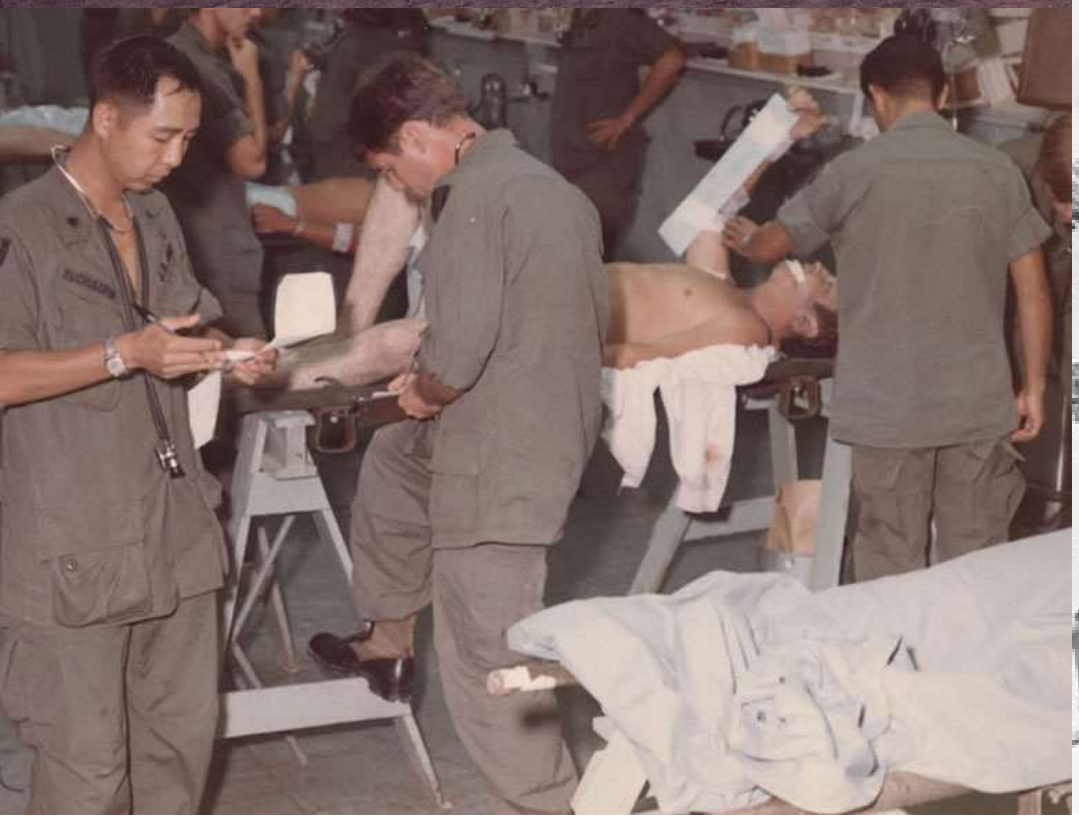
Mass Casualty Trigger

- What would help you immediately!!
- Decision execution at local leadership level with defined initial responses: e.g.
  - OR stops new cases
  - Radiology stops new cases, add Rads for more reads
  - ICU sends two nurses
  - Floors pull patients (porters/ in-patient staff)
  - Decant ER
- **Who are the experts!**

Isreal Bus Bombing Time Intervals



Military Experiences “Thousands of Years of Creating Mass Casualties”



Mass Casualty Trigger

- Know **your** organization time line/ situational awareness
- Begin situation evaluation with dispatch 911 "**pre-alert**" of event? Create Space, and people, pull supports, consider "**system pre-alert**"
- Confirmation patches from dispatch: roll into **Code Orange**
  - Use the lull time to decant/ discharge prior to 3rd and 4th case arrival
  - D/C patients from floors, ICU plans on creating space executes surge plans with PACU
  - Careful with TTL prioritizing resources, works in literature and military context but not so good with septic shock, and strokes in the middle of mass casualty, with physician more comfortable with OR environment than ER.
  - Prioritize CT scanner/ OR (don't wait for all of the patients)
  - Plan for walking wounded, (bus/ alternate destination/ clinic space)

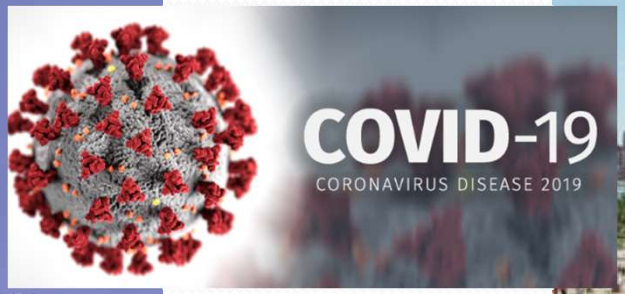
Mass Casualty Time Line

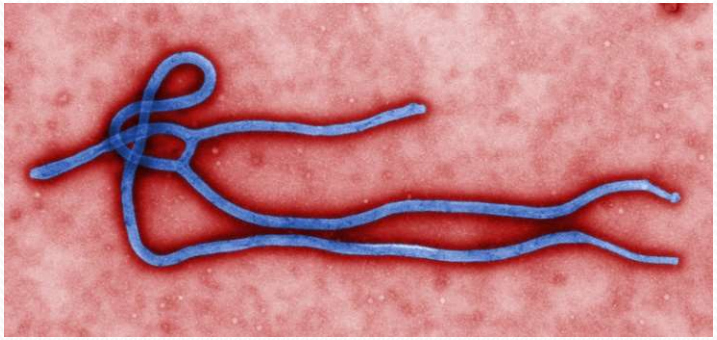
- More instant responses (operational consequences)
  - Surge in ER for 2 to 3 hours
  - Surge in Radiology +_ interventional for 4 to 6 hours
  - (need extra trained immediate staff, and plan)
- More delayed and longer responses (operational consequences)
  - Surge in OR for up to 48 hours possibly longer
  - Surge in ICU delayed, but up to a week possibly longer
  - (need immediate response to ER, and increased work/ cancellations for a while, worth transferring people out)
- **How do we Prepare ??**

Classic Mass casualty Exercises

- “We are not ready”, admin reluctance
- Hundreds of people
- Thousands of dollars in staff FTE
- Almost always off site
- Time line is often entire day, most people standing around waiting
- Does not activate the real IMS, or include actual leaders
- Depends on many volunteers and schedules
- Usually one goal to show how it feels to be “notionally” overwhelmed

Threat Assessment Essex County





Start with a Table Top

- Dive into the issue
- Hopefully some familiarity of IMS
- Threat assessment, what's happened before, previous work
- Develop a plan that works 24 hours a day with leaders who are reliably in house.
- **Then Revise** with other agencies and **front line input**
- Work through issues that will need drills to finalize
- Updating of contact information/ positions
- Value of networking with other agencies

Value of Using Drills for Disaster Preparedness

- Can be applied to any scenario
- Take less than 1 hour (30 to 45 min interruption)
- Can do them in the real environment
- Almost no cost
- Flexible with scheduling
- Multidisciplinary
- Also, an educational intervention

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

Pick a Date, and Have an Exercise

- Pick small exercise with small achievable goals
- Pick a time when volume and intensity of work generally lower
- Be flexible on exercise day, assign a safety officer
- Scribe to record issues/findings for later discussion/ policy/ education

Suggested 1st exercise

- Quick win
- Register 20 notional patients in 40 minutes
- 10 ambulances 10 “walk-ins/ driving in from scene”
- 6 CTAS 1, 8 CTAS 2, 6 CTAS 3
- **Develop work around for EMR, so people exist in the system**
- Choose a working threshold to trigger
- Get local IT, medical records experts to facilitate the plan. Think of twists
- 5 have the same last name, 5 are unidentified (John/ Jane Doe)
- Same thing with computers down
- Entire drill can be done without effecting work flow

Take Drill Beyond the ED

- Staffing resources/ create standard work
- ICU/ floor discharge status
- Include OR/ ICU (code Omega drill)
- Acute care staffing and capabilities
- Shift change?
- In house courses (source of more staff)
- Transferring location opportunities-where can you send outside of your facility? Can you pull trained staff from your other site

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

Local Area Support

- Make a leadership checklist (sick charge nurse)
- Leverage partnerships with other hospitals for transfer of stable ICU patients not requiring regional programs
- Postpone more elective OR cases possibly needing Post Op ICU support
- Postpone IR and Cardiac elective Caths for CCU bed space
- Leverage relationship with chronic care and Rehab to open up in patient beds with patients waiting

Incorporate Disaster preparedness in the Strategic Plan of the Hospital

- In the next contract negotiations with all suppliers ensure that they will have at least 3 days and surge supply on hand i.e., linen, diesel fuel, drugs, ET tubes
- Just in time delivery, could mean no surge supplies
- Consider rotating supplies on **disaster carts**, watch expiry dates. (Barrie Tornado)
- Include inspection, battery care in assigned regular job roles

Provincial Resources

- Immediate Support
  - Critical
  - ORNGE
- Emergency Management Branch Ontario
  - EMAT (24 hours)

Federal Resources

- Immediate Support
  - Military SAR
  - Local Reserve units/ Bases
  - RCMP
  - Coast Guard
- Follow on Support (through County EOC)
  - Aid to Civil Power
  - Logistics, Fuel, Lift, Security, Planning
  - DART

Debrief Everyone

- Cleaners (critical issue with Ebola)
- Physical Plant (power, heat, light, water, air)
- Patient Advocate, guest services leaders, pastoral care-very unique perspective (should be part of the response/ family support)
- Registration, finance
- Media relations/ public relations (can bring order to the press issue, and can be key for public messaging communications, **have a media plan**)
- Most of the critical findings are not medical but logistics and service support

Mental Health Debrief for Staff

- Check in with staff
- Have a resource plan
- Peer support
- Coffee and food
- Be prepared to hold a debrief if needed
- May need to replace some staff
- Moral injury, “overwhelmed do not have resources you needed” , Critical Incident Stress

Communication

- Are **text groups** on your Code Orange contacts? Most phone lists are totally inaccurate (3 to 4 small drills a year should fix this)

OSPITAL
CEPTIONS!

Wheatley Explosion Aug 26, 2021

Border Protests

COVID Changes

- High staff attrition-border town, retirements, inexperience
- Lots of staff turn over
- Not familiar with code orange policy
- Age and condition of CBRNE equipment
- Need system solutions to maintain readiness and consolidate findings, such as scheduled inspections

Loss of Power

“Train as you Fight”
all we have is each other

Hosted by
CCSO | SMPCO

Thank you for joining us today

Feedback?
Suggestions for the next topic?

Submit ideas in our evaluation survey (Link in chat)

Subscribe — **Critical Care Services Ontario**

Follow — **@CriticalCareON**

Join — Eventbrite

Questions? **info@ccso.ca**