

UNC Health Wayne

The evolution and growth of hospital disaster response



Abstract

Lessons learned from hospital-based disaster response

- Active shooter/Accidental discharge
- Mass Decontamination/Radiological event
- Mass casualty/trauma events

How these events have changed and forced UNC Health Wayne to evolve

Objectives

- Hospital disaster response at front line level
- Hospital disaster response at leadership level
- Strategic communication and regional coordination
- Operational changes in response to lessons learned

Reactive Focus – historical approach

For decades, hospital EM focused on responding to immediate crisis as they arose

Limited emphasis on prevention or preparedness

Why?

Lack of funding/comprehensive program

C-suite support

Staffing/resources/time/effort

“It’ll never happen to us”

Just look around the room at the collective experiences we have all endured

Nothing fosters growth faster than when the “it’ll never happen to us”... happens

Unfortunately, at the expense of someone or something

Hospitals quickly become the focal point of the disaster/response

Creates a bottleneck and threatens normal operations

This is why JCAHO and CMS have pushed their standards towards proactive

Proactive Focus

Recognize the importance of planning and preparation

Mitigation efforts build resilience to potential emergencies

Emergencies can be qualified as any threat to normal daily operations

Not all potential emergencies are external

Joint Commission and CMS requirements

HVA

Emergency and Continuity plans

PACE plan

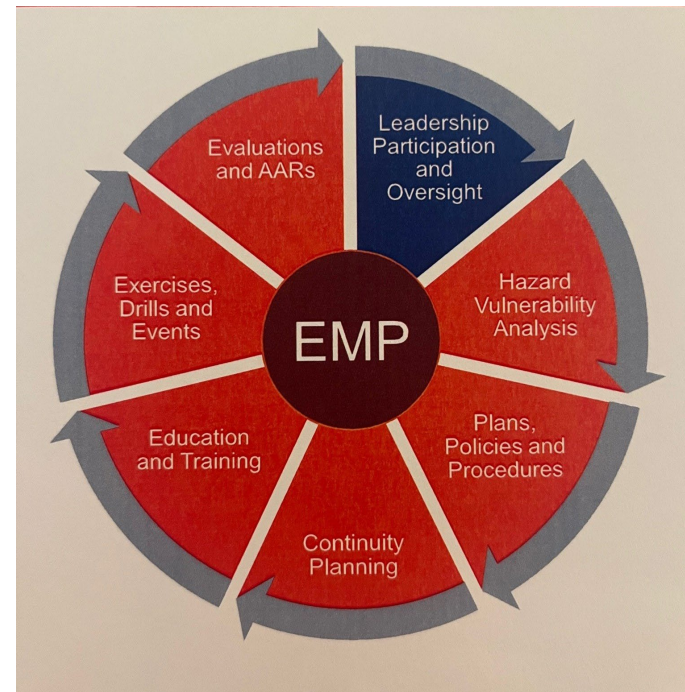
Education and training

All hazards approach

Response and Recovery

Pitfalls and challenges

emergency credentialling



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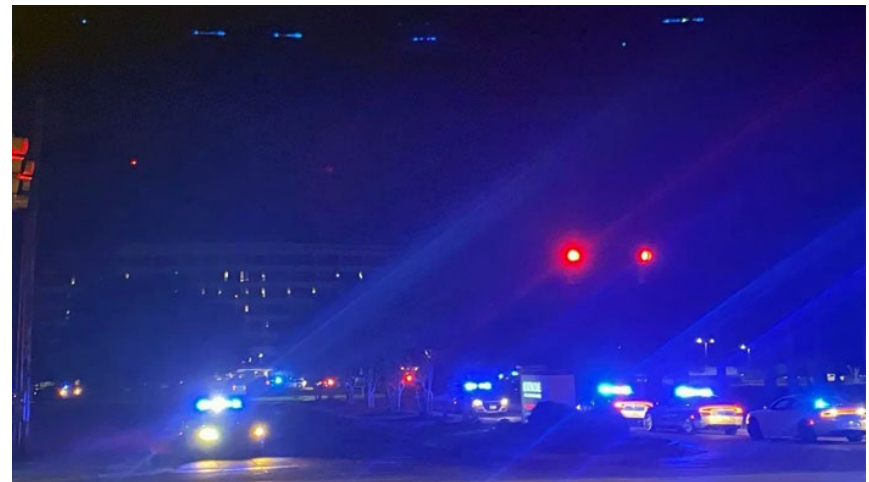
June 5, 2022

What we knew in the first several minutes

- overhead announcement - shooting
- hospital police – active shooter
- me – a nurse was shot on 6th floor
- risk – found out on social media

Timeline of events

- 20:04 – shot is fired
- 20:06 – overhead page is made
- 20:07 – hospital police arrive on the unit
- 20:20 – external law enforcement arrive on scene and facility is locked down



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Reactive response –

- Staff could not reach the switchboard operators

- Nobody was answering the emergency line

- Hospital police didn't answer the emergency line rollover

So... what did staff do?

- Called a rapid response for help

- Called 911



We had no plan for when people panic and forget every policy and procedure

Radio comms were a mess – internal vs external

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Reactive response –

- Executives drove to the hospital

- HICS was not considered initially, but was eventually established virtually

- ED and facility lockdown

 - Directives for teammates for security purposes via smartnotice

 - WRAL / media control

- Continuity of operations during lockdown

 - Sunday night

- Need clarity and direction on all levels of the organization

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So... what actually happened?

The first story is never true or fully accurate

Accidental discharge at 20:04 – can't make this up

Family lied to CEO and police

Shooter out in 90 seconds

Lockdown

Active sweep

Security camera review

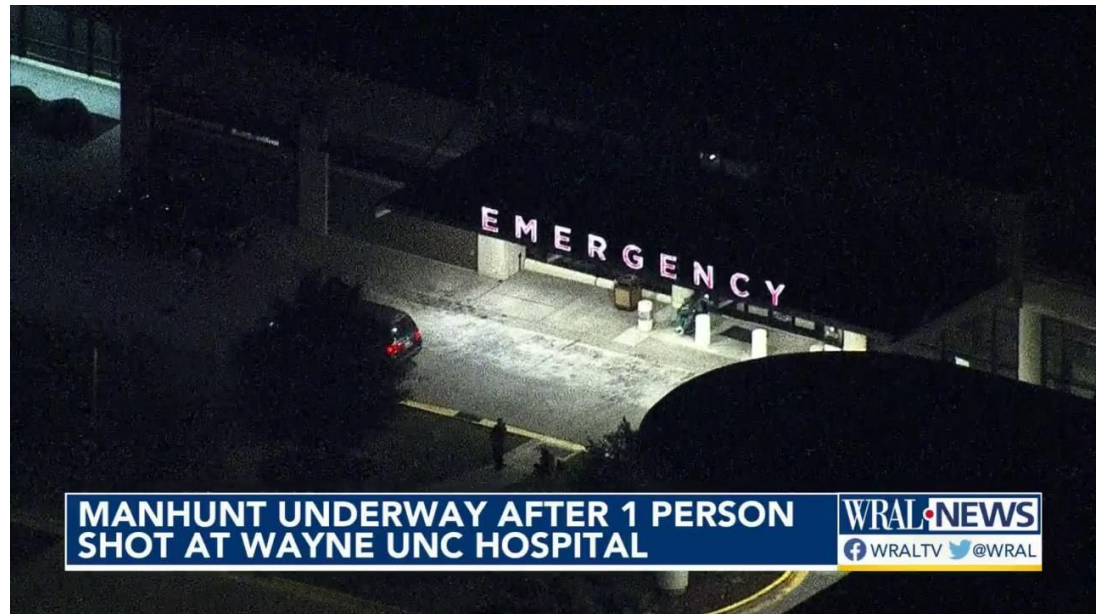
Lockdown lifted at 21:10

Arrested in 48 hours

Clean up

Media... media... media...

Joint Commission visit



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Shifting to proactive and what we've done since –

- Formed an interdisciplinary EM team

- Overhauled the EOP, COOP, HICS and emergency response plans

- Established relationships with community and regional partners

- Worked to get the hospital off the island we had put ourselves on

- Security

- Weapons detection

- Badging system

- Cameras

- Comms control board

- VIPER compatible with BDA infrastructure

- Staging areas – media and labor reinforcements

- Education, orientation and leadership training

- Directors and Execs are FEMA ICS trained (100, 200 and 700)

- Teammate support, human resource programs and employee health

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Radiological exposure

- Bird strike during a night op

- Ground crew responded

- Presented to ED with nausea, vomiting and intractable stomach pain

 - 11 in total

- Mass decontamination

- Just revamped our high consequence pathogen policy and procedures

Early morning hours

- ED was not full

- Able to decon presenting victims and bag belongings

- Able to quarantine quickly and add HEPPA filters

- Thankfully, our ED manager at the time was diligent and asked questions

- Used our resources – EHPC pulled together a team of radiological experts

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Turned out to be a false alarm

Able to validate and verify

Internal lessons –

Decon plan is slow especially at 2am

Communication is key

Validate information

Couldn't find anyone to empty the decon tank

Relationships are important

Make sure you know the contacts in your region

This was validated more than ever

We were in a position to decide on shutting down (at least ½) the ED

Able to avoid this due in part to those relationships

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Real world experiences continue to push us forward

Education and training blend with real world scenarios

Literally – real world and simulation at the same time

Lessons learned

Always communication

Structured HICS

Be honest (this is hard for organizations)

Identify gaps in emergency plans

Ask questions

Learn from dept SME's

Understand the plans

Ask for help



Additional threats and hazards

Hurricanes and inclement weather

Wind, flooding, ice

Comms/IT failures and attacks

Utility failures

Infrastructure failures

Workplace violence

Mass casualties/traumas

Pandemic/Respiratory

High consequence pathogens

Supply shortages

Combinations of these

... threats are daily



In conclusion

No emergency plan is perfect

Communication is critical

Building relationships internally, locally, regionally – helps build a strong foundation

Strive for a culture of learning and continuous improvement

The goal is to preserve life and property

Be proactive

Plan, mitigate, respond, recover

Be resilient

Thank you

