

TRAUMA CENTER I
Best Preparedness Practice
Component: Overall Sustainability

1. Brief description of preparedness practice

Trauma Center I addresses disaster preparedness in a number of fashions. The preparedness initiatives start with the Emergency Preparedness committee, a subcommittee of the hospital's Safety Committee. The Hospital Emergency Incident Command system was modified to our facility in this committee, and an annual evaluation is conducted on best practice benchmarks and current threat analysis in this committee also.

Coordination between other agencies is crucial, and Trauma Center I attempts to address this. Planning is ongoing between the 7 hospitals and dozens of clinics in the health system, city, county, region, and state. Besides planning for coordination of assets and response, such interagency cooperation is also tested in multiple drills. Trauma Center I has active roles in the Local Emergency Planning Committee, City Medical Control Board Authority, Hospital Emergency Management System, Regional BioTerrorism Defense Network, and the National Disaster Medical System.

Staffing issues for prolonged crisis are modeled after a number of facilities in Florida, and it is called our 'Hurricane List.' Employees on the call lists of their units are marked with 2 different dots, red or green. If there is a disaster that will go on longer than a 24 hour period, the green employees are called 1st, and the red employees are called in 11 hours. Generally, green employees live within 30 miles of the hospital, and red employees live beyond that. There are a number of exceptions, but basically the closer employees are wanted for the 1st 12 hours. For epidemic issues, no one in the state is allowed to cross 2 county lines, so provisions are made for those employees to be housed on campus from the onset.

Food is stockpiled on-site, with protein stores for 72 hours and carbohydrates for 7 days of normal operations. Trauma Center I is a site for 2 levels of the Strategic National Stockpile, has both a ChemPak and a PushPak for drug supplies, in addition to extension drug caches developed by the facility for staff and staff dependent treatment and prophylaxis. Thirty thousand (30k) gallons of water and 20k gallons of gas are stockpiled on site, along with numerous other consumables that are critical to crisis management.

Dependent care is a significant concern here at Trauma Center I. It is broken down into 3 different areas. A PowerPoint™ is available to explain dependent care. If employees don't have a plan to watch their children, elderly dependents, or pets, Trauma Center I, will watch them on campus for the duration of the crisis. The plan for children addresses authority to pick up the child, contacts, and medical conditions of the child.

2. Need or motive that drove practice development

There was, within the hospital, active involvement in Disaster Preparedness going back 30 years, but activity was increased in this field post September 11th, 2001. Significant efforts and funds were increased in this area after a power outage in August 2003, and a full time Emergency Preparedness Coordinator was hired in August 2005.

3. Leadership involved in developing preparedness practice

The administrators owed the most debt of gratitude from the health system are **Joyce Farrer and William Schramm**. They had the task of inventing the wheel, and their initiatives and tenacity made most of the practices currently in place possible. Several dozen people have been involved in the health system, but the majority of the effort is produced in the Office of Safety. **Don Drabik, Jerry Matson, and Stephea Scheurer** have been instrumental in the hazardous materials response. **Nick Radu and John Weigle** completed the security protocols copied in so many other facilities as best practice. **Tom Mahony** developed a fire and evacuation plan for a facility of greater than 3 million square feet. **Dave Olejarz** has spearheaded an impressive public relations response plan. **Ed Szandik** has been crucial for development and maintenance of a drug cache for staff, the hospital, and the region. There are too many other people that have put a lot of work into the plan to name them all.

4. Resources involved or applied to practice development

The Infectious Disease department has an extensive epidemic plan that makes provisions for massive numbers of patients needing isolation within the facility. Capital outlays for negative pressure rooms were enthusiastically approved by administration.

Hazardous materials events within the facility will be managed by the Integrated Support Services Department and those outside the facility will be managed by the Emergency Department. The hospital conducts Operations and Awareness classes within the facility, and has gone so far as to cross train several hundred staff to help the ED in time of crisis. All ED techs and nurses are currently trained to Operations, as well as Security and Integrated Support Services. Cross-trained personnel come from a variety of units, including Critical Care, Physical Therapy, Employee Health, and Human Resources.

Materials for surge, decontamination and security have been acquired from a number of sources. Regional preparedness initiatives provide most of the funding from outside the facility; however some grants have been acquired through the Departments of Justice and Homeland Security.

HEICS training is currently provided by ED educators throughout the health system, and will be rolled into annual on-line competencies this year. Continuing education for hazardous materials education varies from unit to unit. Security undergoes quarterly training, and Nursing's training is rolled into annual competencies.

However, the best resource to test preparedness for a real disaster isn't training, lectures, or on-line classes. Other than a real disaster, the best training is drills. And Trauma Center I attempts to have many drills a year and attempts to make them as realistic as possible. Realism is almost achieved through the efforts of the local Medical Control Boards, nurses trained in moulage from the Department of Trauma Surgery, radiographs and other studies from radiology, and forgiving ambulance providers. Trauma Center I feels that it is important to stress all aspects of disaster response, and drills do not end in the ED. OR, ICUs, Admission/transfer, Radiology, Security, PR, HR... all units are tested in an effort to simulate realism and identify processes to be improved.

5. Evaluation of practice

Disaster Preparedness is difficult to measure quantitatively. A bus accident requiring 30 surgical ICU beds is significantly different from a lightning strike at the hospital's computer server, but some common themes exist in all disaster that allows us to measure progress. Whether our progress in this field has been due to good leadership, or a highly motivated staff isn't in question. But there is some data that exposure to disasters in the forms of drills and other trainings may have alleviated many staff members of fears that might have otherwise existed.

6. Outcome

Hospital administration has been very proactive at Trauma Center I in the disaster process. HEICS training, NIMS training, HazMat training have all been enthusiastically endorsed and attended by people in the system from the CEO to the newest grad nurse. The CEO has required HEICS and NIMS from his entire leadership cadre. The ED provides HazMat Operations training during orientation. Other units have been very proactive in sending staff for hospital paid elective classes in this field.

This has led to a measurable increase in many areas of drill evaluation. There is a far quicker discharge time from the Admission Transfer Management Office during drills, which open beds more quickly for patients from the event. Registration in the ED has streamlined the process of ID'ing patients. Nursing now very quickly provides additional personnel to the ED for surge staffing. There are many more examples.

7. Application to daily operations (If preparedness has been used in daily operations beyond MCIs describe how)

The benefit of Disaster Planning to daily operations is easy to identify in hazardous materials events. Staff is now trained frequently on what to expect and how to react, and we find a lot less anxiety now than we did several years ago.

But the more practical benefits aren't as visible. We've found that cross training, intra-agency and interagency, has produced good results in regards to cooperation. Friction between units has decreased (ICU/ED for example); between hospitals; and between hospitals and other agencies (Fire/PD) are all good examples of decreased tensions. Close proximities between different groups during times of crisis has caused many previously imagined rivalries to diminish or disappear.

Submitted by Emergency Preparedness Coordinator, Trauma Center I