

## ASPR TRACIE Technical Assistance

On March 28, 2018 ASPR TRACIE hosted the webinar [Healthcare Response to a No-Notice Incident: Las Vegas](#) with healthcare providers who responded to the October 2017 mass shooting incident in Las Vegas. The diverse panel covered topics such as surge management, triage, prioritization of surgical care, incorporating pediatric providers in adult response operations, and mortuary response. The [presentation, speaker bios, and recording](#) are now available.

Due to time constraints, speakers were not able to respond to all of the questions received during the Question and Answer (Q&A) portion of the webinar. ASPR TRACIE sent Remaining questions to panelists and their answers are provided below.

### Q&A

#### Communications

- 1. Regarding cell phones, does anyone at your facility use the GETS program, specifically WPS? If so, was it effective in improving your communication?**
  - Our Incident commander has GETS and WPC. There is further opportunity to expand use.
- 2. Can you explain to the group the use of iMobile/Internal Messaging system to help coordinate the response?**
  - iMobile is a WIFI based platform on hospital-provided iPhones that can communicate to pre-defined groups of nurses or clinical individuals within the hospital (it's called "Mobile Heartbeat" outside of Hospital Corporation of America [HCA]). It was set to speak with all nurses and clinical staff to give overall directions or to specific units or to specific individuals.
- 3. Would you please describe how you managed the media? Does each hospital have a public information officer (PIO)?**
  - Sunrise has a PIO and she was the point person for media requests. We set up a separate Media Command Center, near incident command but not in the same space. We captured requests and worked to provide updates as possible. This was a prolonged response so the regional and other HCA hospitals within the market provided support teams. We focused security on keeping media out of treatment areas and designated spaces on campus but away from the clinical care for media set up.
  - As one of the many physicians that that was asked to participate in interviews I can tell you first hand that Sunrise Hospital was respectful of our time and our needs. This was a balancing act that they handled beautifully.
- 4. How were hospitals notified and how quickly did the notifications occur (e.g., were the walk-ins a trigger)?**
  - In the case of Sunrise, we heard reports about the incident over the police radio before the walk-in patients arrived.

The ASPR TRACIE Topic Collections on [Communications Systems, Emergency Public Information and Warning/Risk Communications](#) and [Information Sharing](#) contain helpful resources.

## Community Partners

**5. How were hospitals in the Las Vegas area without emergency departments involved? Were they able to provide resources?**

- All our hospitals have Emergency Rooms. Hospitals in the area worked together well which we've done in our MCI planning and New Year's Eve (NYE) activities in the past. We also worked with other healthcare facilities (e.g., nursing homes, home health, etc.) to refer/ transfer patients as needed.

This Topic Collection can help healthcare facilities plan for [mass gatherings/special events](#).

**6. Did you utilize your Community Health Centers during this event?**

- Only as a referral site for outpatient follow-up if the patient qualified.

**7. Does the healthcare coalition in the area have a response capability? What is/ was the role/ responsibility of the coalition that night and following days?**

- They do/did not in this case. The health district and trauma system have the lead.

Check out these ASPR TRACIE resources for [Healthcare Coalitions](#).

**8. How were you coordinating with emergency management and public health?**

- We provided regular updates on patient numbers, names, illness and injury, and family status. We were queried on needs.

**9. Were the hospitals which decompressed able to emergently interact with nursing homes and home health agencies?**

- We reached out to the community nursing homes and home health agencies early in the morning after the event and they were accommodating. They altered some procedures to more aggressively take in patients.

**10. How do you interact with the large nightclubs and entertainment venues in the area in an event like this as wounded and other affected individuals sought shelter in those buildings?**

- Our MCI and NYE planning include strategies for handling these situations. The NYE planning includes these types of venues. The city emergency medical systems (EMS) has a response plan for this in the tourist areas.

**11. Does Nevada/Clark County have a Regional Healthcare Coordinator and was this person monitoring all events (e.g., with some sort of bed tracking software or WebEOC)?**

- They do but the reporting is intermittent (e.g., every 6 hours from Sunrise). They have more real-time scene information.

## Electronic Health Records

**12. Did you attempt EHR charting in the beginning or just go directly to paper charting? How was this determined?**

- Right to paper, and it is part of our MCI plan.
- One, two, or three emergencies shouldn't throw off the regular system. An EHR that is in regular use should be used in an emergency. At Sunrise Hospital, our first two emergency cases that went back were charted in our EHR. Our trauma doctors treated this as any emergency, and they did what they always do. Our EHR, Medaxion, is a hand held personal iPad, not a laptop based system.

The ASPR TRACIE Topic collection on [Electronic Health Records](#) contains helpful resources.

- As providers arrived we had rapid succession of cases going back to operating rooms (ORs). Multiple duplicate trauma names at this point and no time to load any information left a couple of our providers no choice but to use our paper record. Many charts were back filled as time went by or another provider came into the room. We have our original paper charts that we had access to. I think no matter which EHR system your hospital uses, there must always be a paper supply to pull from.
- Education to all providers on booting up your hospitals EHR system in case of an emergency is very important. Some of this was decided by the provider personally. As the morning became day and more cases went to the OR, more cases were handled through our EHR. We had minimal use of paper.

**13. Please discuss limitations of the electronic medical record and ordering in this sort of event. What were your solutions?**

- We used verbal orders in the mass response and nurses double assigned to get this done. We overrode the dispensing machines to improve turn time. Some trauma order sets are on paper and were used.
- The chart itself is not the limitation. For systems like Cerner and Epic, the limitation would be to have the case loaded or the provider knowing how to create a case, and having the 30 seconds available to associate the monitor. With our personal iPads the option is much easier. We can start a chart by putting any two letters in the first and last name spot. Almost any anesthesiologist will tell you they've started an emergency or big case without having the chance to begin charting anything for the first 10-30 minutes. We rely on our monitors for this history and our own intellect to treat the patients as we go. For ordering medications outside the OR, usually as different doctors walked the various areas they gave orders.

### Equipment/ Supplies

**14. What equipment or supplies would the emergency department now place on their "wish list" as a result of working through this incident and the lessons learned?**

- More rapid transfusers, Bair Huggers, and chest tube trays.

**15. Did you have enough ventilators?**

- Yes, but we got assistance from sister hospitals with extra ventilators within 6 hours.

**16. Sounds like you had no issue with fluid resuscitation and access to fluids despite the national shortage or did you have to improvise that as well?**

**17. As a trauma center we took maintaining a stock very seriously. Also in the following days we had support from sister hospitals and our purchasing group to replenish. How do hospital staff handle supply/drug shortages and restocks during/ following an incident? Is there an emergency stock of medical supplies that are available for use?**

- For some supplies there is an emergency cache, for medications it was a pre-planned group that pharmacy provided.

**18. Question for the hospital that received the most patients - how did you manage patient transport devices?**

The [ASPR TRACIE Drug Shortages and Scarce Resources page](#) contains helpful resources, such as a fact sheets, links to applicable Topic Collections, and a webinar recording with SMEs on solutions for medication shortages.

You can also try out our [Hospital Disaster Pharmacy Calculator](#) to help estimate the adequate supplies of medications you may need for a disaster in your hospital stock.

- We reused as efficiently as possible and had a team of people dedicated just to gurney and wheelchair turn around. Occasionally this was a limiting factor but once the need was articulated we used it. We often don't have enough gurneys on a normal day, and have to hunt the house for them.
- 19. What coordination was done to identify and maintain any potential organ donors in the midst of other priorities?**
- We had only 1 patient with an isolated head injury that could have been a donor candidate and those discussion were held 24 hours after admission.
- 20. How much emergency release blood was dispensed? How quickly were patients moved into type-specific blood? How was this tracked?**
- Blood bank used O negative and then O positive for initial. All patients were quickly typed and crossed and by the time when were transported out of initial ED, patients were transitioned. We were able to get excellent support from the regional blood bank with extra O neg.

### Family Assistance/ Reunification

- 21. How were relatives able to get to the hospital to transport the discharges home?**
- Most traveled normally, as Sunrise was off lockdown within 6 hours.
- 22. How successful was any sort of family reunification process?**
- This is very case specific. Some were more challenging than others. ASPR TRACIE's [Family Reunification and Support Topic Collection](#) includes some lessons learned from other incidents and planning resources.

### Patient Tracking/ Management/Transfer

- 23. What was the main intervention that you felt was necessary at the outset that other facilities should address?**
- An effective triage system to sort the patients at arrival and teams to determine the first actions.
- 24. Regarding the prehospital side for emergency medical technicians and medics, are trauma alias names something we could assign or assist in assigning to expedite this process and provide better clarity and continuity?**
- It is something we could consider but our regional trauma group is exploring further.
- 25. Do you think a centralized patient tracking system/software would have helped in this incident? (All hospitals could access, phone app, etc.)**
- Anything that improves communication is helpful, however I don't know if it would have changed outcomes.
- 26. Curious to know how you could transfer, and to where did you transfer patients, since everyone nearby was inundated?**
- Neither Sunrise nor University Medical Center transferred out, we just flexed to create capacity. However, both facilities have plans to move low acuity patients to hospitals not impacted if the event was larger or continued longer.
- 27. Is the NOAA naming list a single name or dual name?**
- The [NOAA list](#) is first names and trauma is the last name. Creates a single entry with duplication.

**28. How was patient tracking accomplished?**

- Each hospital had a master list of patients and our health district coordinated the overall list. As we shared the updated list the recovery center was able to match individuals.

For additional resources, see the [ASPR TRACIE Patient Movement and Tracking Topic Collection](#).

**29. How was information regarding identification of these patients and their locations coordinated amongst the facilities? Who was responsible for collecting this data? If they are not medical - what amount of data was shared to ensure HIPAA compliance?**

- The recovery center was the central point, if a family looked for a patient, descriptions were provided to all the hospitals.
- Our command center and the health district are responsible for collecting the data.
- All the info that was shared was with law enforcement (given they are crime victims) and healthcare providers. Please refer to the comments from Caleb Cage (Chief and Homeland Security Advisor, Nevada Department of Public Safety, Division of Emergency Management) during the webinar for additional information on data sharing. Also access ASPR TRACIE's [HIPAA and Disasters Fact Sheet](#).

Patient Triage

**30. How do you suggest redistribution of "minor" patients in a system with limited EMS units? All of the EMS units will likely be transporting from the scene.**

- Hospitals need to keep an open mind as to how to transfer "minor" patients during a surge. Given most of these injuries are not unstable or life threatening, we considered transfer but opted to triage and use alternate spaces instead of moving the patient. Had the event been sustained we would have worked with the regional trauma system to coordinate transport options, such as military resources (there is a military base here) and potential public transport availabilities.

The ASPR TRACIE Topic Collections on [On-Scene Mass Casualty Triage and Trauma Care](#), [Pre Hospital](#), and [Hospital Surge Capacity and Immediate Bed Availability](#) contain helpful resources.

**31. We have discussed the redistribution of casualties by EMS after they arrive to a particular healthcare facility for years. This is of course to try to diminish the impact of the geographic phenomenon. We also suspect that most of that cohort of people are of lower acuity. Experience has demonstrated that most refuse such relocation for a number of reasons. I know it is sacrilegious to suggest this, but what about using EMS to redistribute resources and personnel where the casualties are rather than the reverse? I suggest this because experience has repeatedly demonstrated that casualty redistribution rarely has any impact during mass casualty disaster incidents.**

- We have scene response teams but given the Hot and Warm Zone size, guaranteeing patient safety while we moved them was our primary concern.

**32. Does your everyday triage system differ from START triage? Was there any use of triage tags in field or hospital?**

- Given the fact that most presented as walk-in or by privately owned vehicle (POV) we saw less triage tags though they were used. We typically use the Emergency Severity Index ([ESI](#)); [START](#) is part of our MCI plan at Sunrise.

**33. Was there any form of ESI triage done on patient arrival or simply paper chart only as the patient was moved to next staging/secondary triage area?**

- Given the nature of the bolus, most were only paper charting though on the lower acuity, and ESI was done after the initial sorting.
- 34. Do they see a place for the standard triage treatment areas or will they amend their plans to incorporate cohorting and running normal ED ops at speed?**
- Given the size we had to dedicate all space to the MCI, we used ED at high speed for the moderately injured. Standard triage is too slow to address the volume per time.
- 35. Did EMS help with external triage next to ER? Would it have helped if fire or EMS had sent resources to the front doors to help the hospital triage outside of the hospital?**
- Available EMS did assist our physicians at front door screening. Adding this resource is part of our MCI evaluation.
- 36. What criteria was used to quickly offload post-anesthesia care unit (PACU) patients? Are floor/unit nurses comfortable with the types of patients they received sooner than expected on a typical day?**
- To address this we shifted any patients from our surgery floors to the medical floors and therefore were able to more comfortably send up surgical patients. Also additional staff that arrived were spread out to ensure competencies were covered.
- 37. How were the floors able to absorb the influx? Was there a lean-forward mentality or was it a push process from the ED/Trauma/OR?**
- Once the call went out about the need it was a clear lean forward. Floors pulled up patients and used hallways to improve bed turn times.

#### Personnel-Related

- 38. As a hospital emergency manager, getting doctors involved in exercises is extremely tough. They say, "Include Us" but when it comes time to actually do exercises and go through procedures they are always busy. So what actions and steps are they taking to be included?**
- An actual event is a great motivator. Physician-to-physician communication is best. A champion or leaders (our Chief Medical Officer and Trauma Medical Director) are getting good traction. We focus on keeping the exercises relevant and short as possible to value everyone time and are creative on when (early in the morning).
- 39. Are they reaching out to their hospital emergency managers (or appropriate facility equivalent) to be included and actually follow through?**
- We have to work directly to reach out to them. As busy providers with their own practices, we have to balance the needs but when a physician reaches out it is more successful.
  - As the quality chair for our anesthesiologist group, US Anesthesia Partners, you need to find champions that will help you get to the people that are difficult to reach. Set up continuing medical education (CME) since we all always need CME's. Have your group, hospital set up Mortality and Morbidity (M&M) meetings, provide a webinar that is mandatory to watch (yes sometimes somethings need to be mandatory!).
- 40. How was the local Medical Reserve Corps or other medical volunteers utilized during this incident? If utilized, how were they managed?**
- Given the speed of the incident, we did not use the Medical Reserve Corps. As mentioned in the webinar, we did get the Emergency Order from the Governor of

Check out the [ASPR TRACIE Volunteer Management Topic Collection](#) and [tip sheet for Retaining and Caring for Staff after a Disaster](#).

Nevada to allow physicians to cross between all hospitals.

- 41. How often would you recommend a level one trauma center do mass casualty incident drills to keep staff knowledge of procedure as fresh as possible?**
- The American College of Surgeons (ACS) has recommendations and I would recommend to follow those as a minimum.
- 42. How many physicians do they typically have on at night?**
- At Sunrise we have 4 ED physicians, 2 Trauma providers and in-house anesthesia as well as 2 surgery residents.
- 43. Were behavioral and mental health issues considered and were these professionals brought in during the initial response at these hospitals? Both for the patients and staff?**
- This was an immediate consideration and we encouraged use of the crisis counseling services from the Department of Veterans Affairs and we coordinated with the physician practices to ensure they had access to services. We needed all services for patients, staff and families. We had these available within 24 hours and 24/7 for 2 weeks.
- 44. What kind of turnover in staff has there been since the event (if applicable)?**
- It was lower in the immediate post-event period and after 3 months returned to usual levels. There was no turnover from anesthesiologists.
- 45. Were the hospitals competing for resources (I am assuming docs and nurses may be affiliated with multiple hospitals)?**
- Given the limited scope of the event, resources were cohorted at the impacted facilities. There was some strain on the outer hospitals the following day but not impact on nursing. Had this event been ongoing, issues would have been encountered with anesthesia. The provider group now has a plan to address this. Also some subspecialties were self-organized to cover all impacted hospitals.
- 46. Have you thought of creating an essential personnel ID (For those times, when law enforcement has roads closed)?**
- It is something being raised to the local health district. However, in this situation, law enforcement recognized our hospital identification and let us move freely.

## Planning

- 47. Were plans in place ahead of time to address medical insurance issues and/or how was that addressed during the event? Specifically, those patients without proof of insurance, and those situations where patients had no insurance, ultimately, or where insurance wouldn't pay for treatment.**
- At the initial phase there was no concern given to insurance status. It wasn't considered in any treatment decisions.
- 48. Do the Clark County Hospitals have a Regional Response Plan?**
- Yes
- 49. Did any of the hospitals activate their COOP Plans?**
- Not sunrise, we returned to mostly normal too quickly.

## Other

- 50. Was security and issue? What extra steps were taken to ensure safety and security? What did lockdown look like at your facilities?**
- At Sunrise, we had additional security staff activated and entry to campus was controlled to one employee entrance with badge check and one patient and visitor entrance through the ED. Security also did bicycle rounds on campus to manage media.
- 51. Would you be willing to share the anesthesia form you recommend going with the emergency downtime paperwork?**
- Use a paper anesthesia record your physicians are familiar with.
  - Absolutely, this actually brings up an interesting point on if we should consider creating MCI anesthesia records or perhaps our devices have a mode to be able to chart during an MCI. Contact [ASPR TRACIE](#) if you'd like a copy of this form.
- 52. What were other major policy-level decisions that needed to be made?**
- Decisions to double rooms with double headwalls and using pediatric nurses as support staff.
- 53. How did environmental services handle room cleaning?**
- They assigned a team to each geographic area that functioned independently. They were rotated out every 6 hours or so. This allowed some continuity but also did not overlap dependencies. If any team needed assistance, the Operations Chief would address.
- 54. Was an 1135 wavier filed due to the declared disaster? If so, who initiated the wavier?**
- No 1135 waiver was requested or issued for this incident. 1135 waivers require both a presidential declaration and a public health emergency declaration by the HHS secretary in order to request the waiver and neither of those declarations were made. Please see the [ASPR TRACIE EMTALA and Disasters Fact Sheet](#) for additional information.
- 55. EMTALA- related questions: Was there a Governor order to bypass EMTALA when moving "Green Tag" patients out to alternate care sites/non-trauma facilities? Was the state of emergency used to support moving less injured patients to another hospital to avoid EMTALA violations? The first speaker suggested that future plans might have EMS redistribute casualties between hospitals to help lighten the load. What considerations for EMTALA need to be made with regard to this plan?**
- This particular incident did not meet the requirements for a waiver, as there was no Presidential emergency declaration and no HHS declaration of a public health emergency. Both criteria must be met for application for EMTALA waivers. Below is information on waivers to Section 1135 of the Social Security Act.
  - Under certain circumstances, sanctions for violations of EMTALA obligations may be waived for a hospital. The EMTALA medical screening exam (MSE) and stabilization sanctions can be waived under the following circumstances:
    - The President declares an emergency or disaster under the Stafford Act or the National Emergencies Act; AND
    - The Secretary of Health and Human Services declares that a Public Health Emergency (PHE) exists and also authorizes EMTALA waivers under section 1135 of the Social Security Act. Notice of EMTALA waivers will be provided through CMS to covered entities; AND
    - Unless EMTALA waivers are granted for an entire geographic area, the hospital applies for a waiver; AND

- The hospital must have activated its emergency operations plan; AND
- The State must have activated its emergency operations plan or pandemic plan for an area that covers the affected hospital.
- The waiver generally lasts for 72 hours after the emergency is declared and the facility's emergency plan is activated (in case of a pandemic the waiver will last until the termination of the PHE declaration). Even in the case of a waiver, however, the hospital is still responsible for ensuring the safety of the patients in its care.
- Local or state declarations or waivers cannot alter, waive, or otherwise address EMTALA, as EMTALA is a federal law.
- Please see the [ASPR TRACIE EMTALA and Disasters Fact Sheet](#) for additional information.

Additional helpful ASPR TRACIE resources:

- [Continuity of Operations \(COOP\)/Failure Plan Topic Collection](#)
- [Explosives \(e.g., bomb, blast\) and Mass Shooting](#)
- [Fatality Management](#)
- [Incident Management Topic Collection](#)
- [Recovery Planning Topic Collection](#)
- [Responder Safety and Health](#)
- [Select Mass Violence Resources](#)

As a follow-up to this webinar, ASPR TRACIE also developed eight tip sheets based on healthcare system lessons learned (listed alphabetically):

- [Community Response and Media Management](#)
- [Expanding Traditional Roles to Address Patient Surge](#)
- [Family Assistance](#)
- [Fatality Management](#)
- [Hospital Triage, Intake, and Throughput](#)
- [Non-Trauma Hospital Considerations](#)
- [Trauma Surgery Adaptations and Lessons](#)
- [Trauma System Considerations](#)