Hospital Emergency Preparedness

Andrew McCallum, MD FRCPC

Objectives

- Introduce hospital emergency planning
- Discuss differences in hospital capability and response to emergencies
- Discuss specifics of anticipated civil disorder response
- Contrast 1995 with 2004 hospital emergency preparedness

Planning for an Emergency

- Multiple casualty incidents
- Hospital capability
  - Primary care hospitals
  - Secondary care hospitals
  - Tertiary/quaternary care hospitals

No hospital fits these categories exactly!

Primary Care Hospitals

- Found in smaller communities e.g. Strathroy
- Typically run by family physicians who provide ER, labour and delivery and GP anesthesia services plus in-patient care
- May have certain specialists, most often internists and general surgeons, also OB-GYN; rarely have complete coverage

Secondary and Tertiary Hospitals

- Larger communities e.g. Kitchener-Waterloo and teaching centres e.g. London
- Have full specialty services including ICU
- Trauma centres are mainly linked to teaching centres
- Not the focus of this presentation except for trauma system

Preparing for a “Disaster”

- Defined as temporary overwhelming of resources; institution and location dependent
  - Trauma disasters e.g. major road traffic accidents
  - Natural disasters e.g. hurricanes, earthquakes and floods
  - Public health disasters e.g. water contamination or the outbreak of a virulent disease
  - War and civil disorder
- Prior planning necessary (accreditation requirement)
- Plan sets out policy and procedure to be followed in a disaster

Components of a Disaster Plan

- Identification of event
- Key personnel including authority to commence plan (Administrator, Chief of Staff, CNO)
- Procedures to follow
  - Physical plant
  - Personnel esp. RN and MD assignments
- Communication procedures
  - From and to scene
  - With NOK and media
- Patient movement
  - Within hospital
  - To other hospitals
- Materiel and supplies
- Liaison with other agencies

Anticipated Civil Disorder

- Communication between Enforcement Agency and Hospital essential (if foreseeable incident)
- Consideration of worst case scenario
- Assessment of proximate resources (personnel, skills, beds, ER, ICU, OR, diagnostics)
- Liaison with referral centres esp. Trauma Centres
- Principles of Military Medicine

Military Principles of Casualty Care

- First Aid (on the battlefield)
- Forward Aid (the Unit Aid Station)
- Triage and Stabilization (the “MASH” unit)
- Definitive Care (the Hospital)
- Rehabilitation and/or Return to Action

These principles apply equally in peacetime multiple casualty incidents.

Military Principles of Casualty Care

- First Aid (at the scene)
- Forward Aid (at the scene perimeter)
- Triage and Stabilization (at the local hospital)
- Definitive Care (at the referral trauma centre)
- Rehabilitation and/or Return to Action

These principles apply equally in peacetime multiple casualty incidents.

Differences between 1995 and 2004

- 9/11and experience of NYC hospitals
- Consideration of CBRN disasters in context of terrorism → new resolve in planning
- Adoption of International Codes (Orange = disaster, Red = fire, Blue = Cardio-Respiratory Arrest, Pink = Neonatal Resuscitation, Black = Bomb threat, White = Aggressive/Agitated Patient