

Addendum to submission by Dr Alexander Donald. 11th April 2013

The week-end after I made my submission, Bundaberg Hospital was evacuated due to flooding. Some of the critical comparisons with the evacuation of Cairns:

Like Cairns, Bundaberg had no evacuation plan. Fortunately Cairns emailed theirs. Plan – and sent experienced staff involved in the Cairns evacuation.

Managers in Cairns found out about the decision to evacuate through the media, managers in Bundaberg made the decision.

The decision to evacuate Cairns was almost certainly based on a misinterpretation of advice (but not necessarily incorrect). The decision to evacuate Bundaberg appears to have been based on a reasonable assessment of an imminent threat.

Communication with staff in Cairns was reasonably regular by email, and through line managers after meetings with senior management (there were some critical omissions). There was virtually no communication with staff in Bundaberg, other than “forums” in the Staff Dining Room for those who were aware and able to attend. Many staff appear to have found out about the evacuation through the media.

Decisions on releasing staff prior to Yasi were poor and inconsistent. It is unclear what decisions were made in Bundaberg, by whom, or when.

Timing of the evacuation decision in both cases allowed complete evacuation of the hospitals.

In Cairns the alternative facility was the FEC (Fretwell Emergency Centre), which demonstrated in great detail why prior planning is so critical. In Bundaberg there was an existing hospital above flood level. Major problems in Bundaberg with evacuation centres, and in particular with evacuees from Nursing Homes.

Following Yasi there was a “debrief”, consisting of a small number of meetings spread around the Health Service. Many staff feel they never had an opportunity to offer their experience and opinion, or that they were ignored. Bundaberg has had a “debrief” apparently involving only management. Future plans are unknown.

During and after Yasi there were problems with communications between various sites. In Bundaberg the problems appear to have been worse, and in particular some smaller hospitals were isolated by flooding and had no communication for 24 – 72 hours.

Phones: In Yasi mobile communications were hampered primarily by wind damage to mobile phone towers, and by failure of those exchanges without generator backup once their batteries were exhausted. In the Bundaberg floods most of Northern Queensland lost some or all phone services for 24 hours due to failure of the telecommunications backbone.

Finally I attach a “Surge Management Card” developed by the Disaster Medicine Subcommittee of the Australian College for Emergency Medicine. This concept of concise, evidence-based, operational advice for a specific circumstance could be applied to the many aspects of responding to extreme weather events, and is desperately needed in the Health system.

Surge Strategy Working Group Recommendations Event Priority Actions

SPACE

- Maximize cohort care and minimize one-on-one care

SUPPLIES & EQUIPMENT

- Have a team member dedicated to restocking supplies in main cohort areas allowing staff in these areas to maintain clinical roles.

STAFFING

- Request surgical and critical care liaison points in ED
- Engage non-clinical staff (e.g. medical students) as runners, scribes, and patient transporters.

SYSTEM OPERATIONS (Flow)

- Delegate extensively. Your job is to make decisions, not gather data.
- Make frequent rounds to geographic areas of cohort care.
- Pursue an appropriate disposition even without a clear diagnosis.
- Consider the use of Focused Abdominal Sonogram in Trauma (FAST) to assist early disposition
- Limit contrast studies. ED staff read films but insist on real time reporting of studies as driven by patient instability or provider uncertainty.
- Minimize return of patients to the ED. A patient sent out of the ED for a special study goes with a provisional diagnosis and a disposition plan.

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Surge Strategy Working Group Recommendations Pre-Event Priority Actions



SPACE

- Clear the ED of all admitted patients with cooperation of inpatient units as feasible and the hospital executive as needed.
- Send admitted patients without a bed to a pre determined holding area (e.g. outpatients, short stay unit) to allow immediate decant and have inpatient units pick patients up rather than ED staff perform transfer.
- Identify intra-ED expansible areas—corridors, transit lounge, short stay, fast track—for care of stretcher and sitting patients who can be cohorted.
- Identify and set up an extra-ED diversion area for stable, ambulatory, non-emergency patients.
- Clear the waiting room of all patients fit for disposition to alternative providers.

SUPPLIES & EQUIPMENT

- Distribute pre-made “disaster” IDs, chart packs, X-ray and lab slips.
- Distribute tools for redundant communications—cell (mobile) phones, 2 way radios, white boards, runners.
- Call for extra trolleys and chairs so every patient has a place to lie or sit.
- Call for extra portable suction, ventilators, monitors.
- Create at least one portable disaster trolley appropriate for each cohort area. Stock with items such as fluids, dressings, IVs, analgesia, antibiotics.

STAFFING

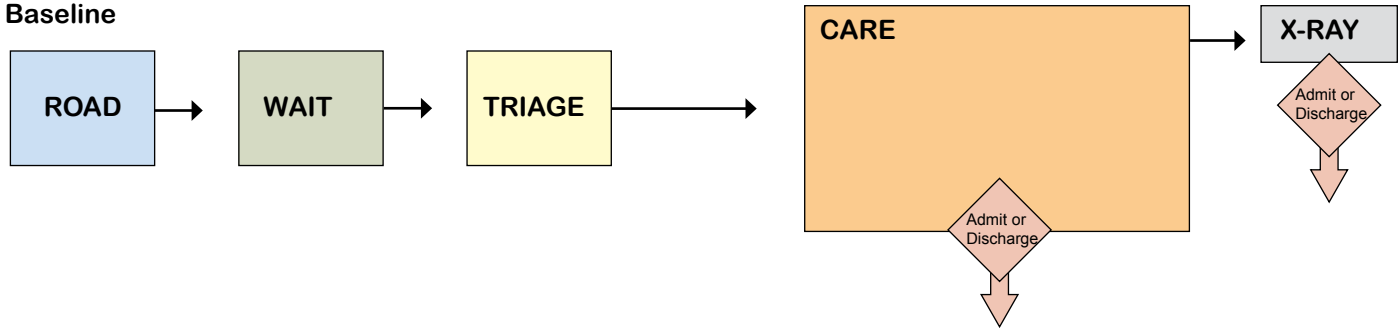
- Allocate roles and distribute appropriate job action cards.
- Determine meeting points for new staff to arrive and staff updates to occur.
- Decide if/how the ED must modify its staffing model.

SYSTEM OPERATIONS (Flow)

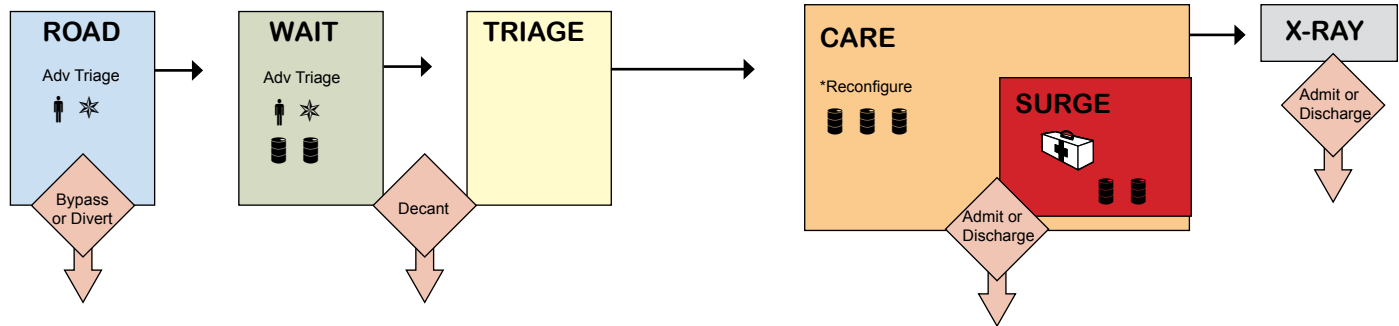
- Notify EMS to arrange bypass of individual patients unrelated to the surge event.
- Co-locate triage and security staff to create triage-security surge team(s).
- Preposition a surge team to the waiting room entrance.
- Use rounds to force clinical decision-making.
- Announce surge induced goals of care with truncated investigation and treatment processes.
- Place security at all entry and exit points to ensure access exclusively to patients and properly badged staff
- Announce intent to delegate extensively to free up the senior clinician(s) for decision-making purposes.
- Bring in early use of disaster patient tracking system and have a dedicated staff member keep this updated.
- If recognized by the local system, invoke pre-established methods of utilizing alternative sites for patient disposition.

PRIORITIES IN SURGE AUGMENTATION

Baseline



Surge/MCI



Physical spaces/places are depicted with CAPITALS.

Recommended priorities for the ED supervising consultant and senior colleagues are depicted in lower case.

CARE = patient care area/treatment cubicles and resuscitation areas

ROAD = Roadside

SURGE = surge areas (eg. Short stay unit, fast track area, corridor)

TRIAGE = triage area

Adv Triage = advance triage

WAIT = waiting room

X-RAY = radiology services

👤 = Re-deployed senior ED staff member

⚡ = Security personnel

🛌 = Extra trolleys/stretchers

🏥 = Medical supplies and equipment

➔ = Usual patient flow

*Reconfigure = Re-organise staff and cohort patients