Waukesha Christmas Parade Pediatric Mass Casualty Incident (MCI) Debrief

Maureen Luetje, DO

Assistant Professor of Pediatrics, Emergency Medicine

Children's Wisconsin

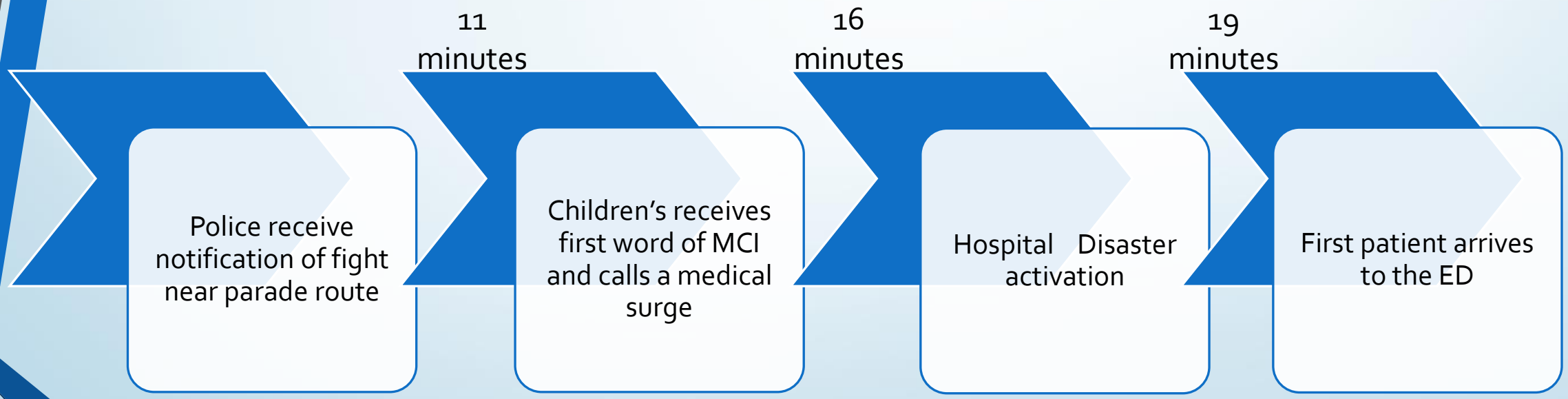
June 7th, 2022

Video Ad Feedback

Background

- Sunday early evening
- Typical Sunday evening increase in volume… weekend is winding down…. Covid rates were winding up…
- ED was full, waiting room also filling up
- Event occurred during shift change for the ED

Timeline of Events



1st Hour

- 9 patients came through the door

2nd Hour

- 5 more patients

3rd Hour

- 2 more patients

2 Level 1 medical emergencies, not related to the MCI

16 pediatric patients were seen in our ED, who were a part of the MCI

- 9 Level 1 traumas
- 7 ED-Alls (Not meeting trauma activation level, but requires immediate assessment)


LTE
16:47
75%
Messages
PCM
Details
Have you heard anything about a shooting in Waukesha with multiple injuries and dozens of kids?
Text Message

Preparation

Communication

Triage

Preparation:

How do you prepare for a mass casualty incident with little prep time?

Preparation:

How do you prepare for a mass casualty incident with little prep time?

STAFF

- Event occurred at shift change
- Timing- early Sunday evening, when people were heading home or were nearby
- Call-In Trees:
  - Nursing
  - ED Providers
  - PICU
  - Social work
  - Administration

SUPPLIES

- Consideration for increased need early on:
  - airway equipment
  - IV equipment
  - Extra beds
- Supply chain manager was looped in quickly to ensure availability of necessary resources

Space

- Reverse Triage – A system used to triage patients for early discharge from a hospital setting, in order to accommodate a surge of new critical patients.

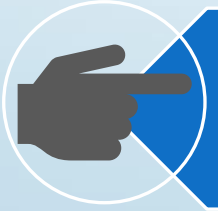
- Cleared out 8 critical care ED rooms within 15 minutes
  - Early and efficient discharge
  - Relocation to separate ED area and resumed care by incoming hospitalists, pediatric residents and ED advanced practice providers

Communication

OSH Direct Line

White Board

Mini-ED Teams



No Sign-out Transfers

OSH (Outside Hospital)→ Tertiary Hospital

- Prior to patient arrival, surge of phone activity in the ED
  - OSH unable to consistently connect to our team
- Direct phone line given to the main OSH that took in the most critical pediatric patients
- PEM provider took on communicator role
  - Feedback from OSH – Reassurance to talk through the patients, determine how much to resuscitate vs transfer and treatment plans and order of transfers
  - Feedback from our side- Better prepared for degree of injuries, knowledge for needed subspecialists and equipment and mini-ED team giving pre-arrival info to work from
  - This was a hospital that we interact with regularly. Physicians knew each other. Good communication and trust on both ends

White Board

- At entrance of ED, an ED physician and registration representative:
  - Pre-registered patients under disaster names → faster settling of patient into a room
  - Doorway triage by ED physician
    - Ability to divert to trauma bay for escalation in care and entire mini-ED team moves to that room, if actively decompensating patient
- Patient basic info and disaster name placed on white board for identification and flow and used as main form of organization:
  - Bed assignment
  - OR vs admit
  - Need for imaging and prioritizing imaging

Mini-ED Teams

- Enough staff in the ED to accomplish this
- Each room staffed with:
  - PEM/ICU doctor, nurse x2, advanced practice provider, respiratory therapist
- Anesthesiologists grouped in the arena and called to a room, as needed
- Each mini-ED team assigned with a patient with pre-arrival information from the PEM communicator
- Each team was only responsible for 1 patient at any given time and was not given a second patient, until first patient had left the ED or stabilized. No team saw more than 1-3 patients by the end of the night.

No Sign-Out Admissions

- ICU attending in the ED throughout the event
- Hospital bed manager in the ED throughout the event
- Once patient was initially evaluated- decision made for OR vs ICU vs floor
- ICU attending directly communicated with ICU team for incoming patients.
- Bed assignment and ED transfer occurred within minutes
  - This allowed us to keep the flow going and mini-ED teams to reset for next patient coming through.

Triage

- Triage and re-triage was embedded into every transition in care throughout this event.

- This is basic disaster training, but performing it repetitively helped ensure that patient decompensation was captured at multiple points throughout an otherwise chaotic event.

~ Lessons Learned ~

Preparation

Communication

Triage

Preparation

- Disaster plans are necessary for a hospital to have in place
  - Exhaustive protocols are not feasible during the disaster, but are essential for preparation, exercising and testing during training
- Cheat sheets:
    - reverse triage sign-out of partially worked up patients
    - Identification forms for patients coming in under disaster pseudonyms
    - Reunification checklists for social work
    - Mini ED forms for incoming patient info, exam findings, treatment plan, disposition
- Reunification Plan
  - Was developed but had never been tested. This is a facet of disaster preparedness we now incorporate into our exercises with much more emphasis

Communication

- Prior established relationships with community hospitals.
  - Reaching out before disaster happens, making sure there are direct lines of communication, providing community hospitals with education, resources and live feedback helps everyone achieve best patient care.
- Visual communication for staff, acknowledging role, title and name
  - Rudimentary name tag on tape with your name and your role- large enough to be read from across a room.
- Technology Barriers
  - We continue to work on better solutions if we have a future event without access to our daily technology for access and care.

Triage

- Post-it notes handed to each mini-ED team for pre-arrival information
  - Provided each team with valuable information on age, weight and specific injuries, which helped with preparation for incoming patient.
  - Working on formally structuring this communication into future disaster plans.
- ICU attending triaging for ICU placement
  - Working on formally structuring this into future disaster plans.

Final Thoughts

- Approach to confirming rumors of an MCI from a disaster response standpoint?
  - Benefits vs difficulties with technology and with social media
  - When to call it vs wait for more information
- Staff needs during ongoing care
  - Food, drinks, and breaks
- Mental Health for Health Care Teams after mass casualty incidents
  - Informal Check-ins
  - Debriefs
  - After Action Reports
  - Individual Counseling and Therapy
  - Group Therapy

Questions?