St Vincent's Hospital is a major tertiary referral and teaching Hospital. The Emergency Department is a very busy, inner city trauma and emergency centre. Approximately 42,000 patients present each year, of these, 14,700 patients are brought by ambulance, and 46% of patients that present to the Emergency Department are admitted.

The Emergency Department sees and treats a variety of injuries, illnesses and other medical conditions and health concerns with a high proportion of high acuity presentations such as traumatic injury, severe cardiac conditions, respiratory illnesses and toxicological emergencies. Although the department will see and treat any immediately life threatening emergency they do not otherwise usually manage paediatrics or routine obstetrics.

**OBJECTIVE**

In the event of a Mass Casualty Incident (MCI) involving the activation of St Vincent's Hospital's External Emergency Response, the Emergency Department is responsible for the triage and treatment of all MCI patients arriving at the hospital.

## STAGES OF RESPONSE

**Alert** - *A Disaster situation is possible*

Preparations to clear ED

Review staffing and HICS allocation

**Standby** - *A Disaster situation is probable*

Clear ED of existing patients

Adequately stock Priority 1 and 2 areas with equipment

Allocate HICS positions

Don appropriate PPE and tabards with position titles

Allocate 2-way radios to designated staff

**Prepare to receive** - *A Disaster situation exists*

Deploy staff to allocated roles and locations

Treat and manage patients as per disaster care standards

**Stand down** - *A Disaster situation is contained*

No further MCI patients expected to arrive

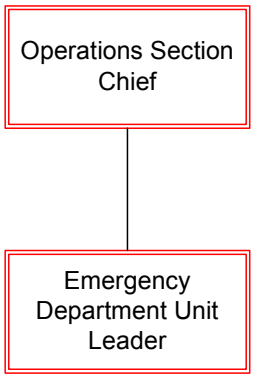
Complete management of MCI patients still in ED

Return to normal working arrangements

## HICS STRUCTURE

Emergency Department Unit Leader – ED Staff Specialist on duty

Report to Operations Section Chief




Triage Unit Leader – ED Staff Specialist

**Priority 1** "Immediate" Team Leader

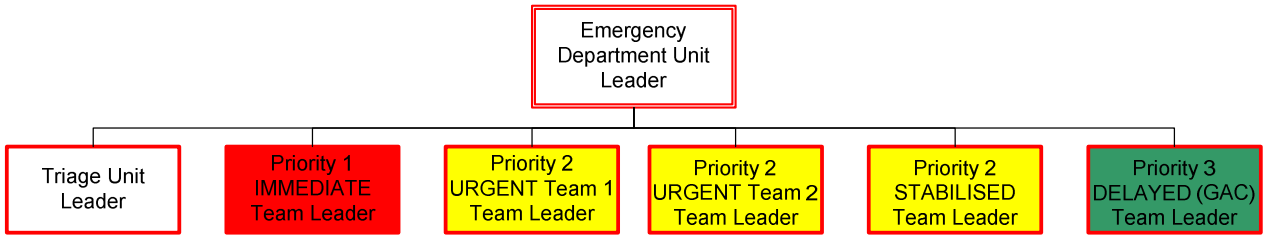
**Priority 2** Team 1 "Urgent" Team Leader

**Priority 2** Team 2 "Urgent" Team Leader

**Priority 2** Team 3 "Stabilised" Team Leader (EMU)

**Priority 3** "Delayed" Team Leader (General Ambulatory Care)

Report to Emergency Department Unit Leader



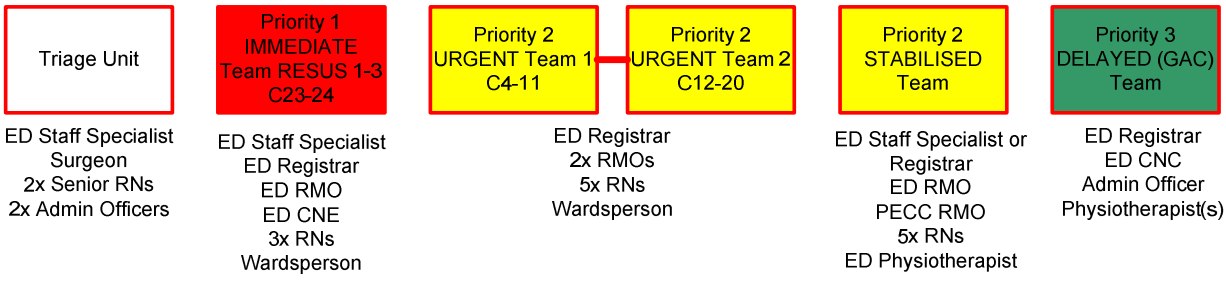
## STAFF ALLOCATION

On activation of a Code Brown External Emergency Response, all ED staff on duty, whether clinical or non-clinical, will be allocated to appropriate areas.
Staff allocation is based on staff availability during business hours. The ED Staff Specialist along with the Nurse Manager will allocate roles based on staff skill mix. Staff will be notified of their roles during the "Standby" phase of a Disaster Response.

ED staff will be allocated to roles in the Triage Unit, Priority 1 "Immediate" Team, Priority 2 "Urgent" Teams, as well as EMU and Transit Priority 2 "Stabilised" Team.

The Triage Unit Leader will be an Emergency Physician. A surgeon, allocated by the Operations Section Chief, will lead the second Triage Unit. The two Triage teams will perform surgical triage independently but will communicate with Hot Floor via Triage Unit Leader's 2-way radio.

Only on activation of the Surge Plan will a Priority 3 "Delayed" Team, consisting of an Emergency Registrar, ED Clinical Nurse Consultant and Administration Officer, be deployed to General Ambulatory Care to triage and coordinate the care of Priority 3 "Delayed" patients.




All Teams in ED will have a scribe allocated to them to assist with documentation and communication.

**STAFF ALLOCATION cont.**

Additional staffing will be available through Operations Section Chief, including scribes, an AIN to guard the Isolation Rooms if this becomes a temporary morgue, and runners to blood bank and for message delivery along chain of command.

The Physiotherapy Department will provide assistance with orthopaedic injury care in both ED/EMU and General Ambulatory Care.

Departmental Managers will contact off duty staff if their assistance is required. Staff should not call Switchboard to notify their Managers of their availability. Staff preparing to come in for the next shift may be called to commence their shift earlier. Staff arriving for duty at SVH should assemble in the courtyard of the Staff Cafeteria for registration, briefing and deployment.

Deployment of a Health Response Team to the scene of the MCI or to another hospital that is overwhelmed by casualties is at the discretion of the Incident Commander after discussion with the Emergency Department Unit Leader.

**STAFF IDENTIFICATION**

St Vincent's Hospital staff identification tags shall be worn at all times.

Fluorescent yellow NSW Health tabards will be worn by:

- Emergency Department Unit Leader
- ED Nurse Manager
- Triage Unit (4 staff)

Green SVH tabards will be worn by:

- **Priority 1** IMMEDIATE Team Leader (R1-3 C23-24)
- **Priority 2** URGENT Team 1 Team Leader (C4-11)
- **Priority 2** URGENT Team 2 Team Leader (C12-20)
- **Priority 2** STABILISED Team Leader (EMU/Transit)
- **Priority 3** DELAYED Team Leader (GAC)

## EXISTING PATIENT ALLOCATION

During the ALERT phase of a Code Brown External Emergency Response (CBEER), the Emergency Department will be informed and shall begin preparations to clear the department.

The Emergency Department will:

- Discharge all appropriate patients to their homes. Patients unable to make their own way home will be transferred to the Discharge Lounge in HOAC (Xavier Level 4) pending transfer to their usual residence.
- Transfer all other patients to EMU and Transit areas pending admission and transfer to the ward.

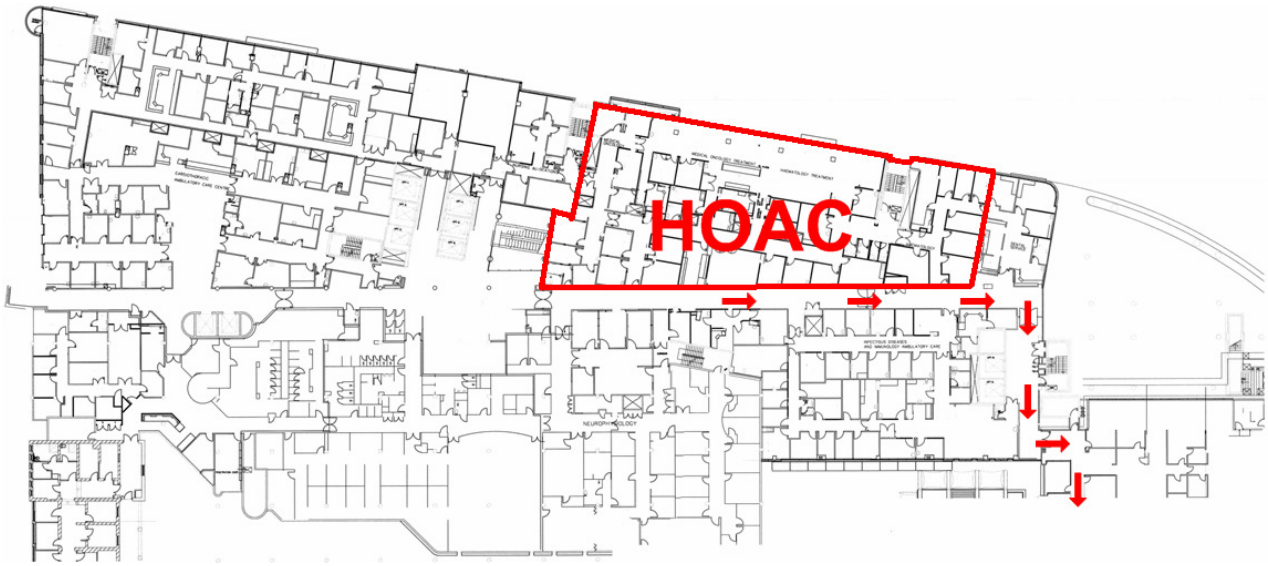
Assistance with clearing the ED will require communication with the Operations Section Chief through the appropriate chain of command. The Inpatient Unit Leader will respond when the Surge Plan enacted.
Patients appropriate for admission to SVPH or Sacred Heart Hospice will be coordinated by the Inpatient Unit Leader

During the STANDBY phase, ward nurse managers or team leaders will conduct an immediate ward round to identify patients suitable for early discharge. These patients will be transferred to HOAC to await discharge medications and transport home. This will allow admitted patients from ED to be sent to the wards.

## ALTERNATIVE PATIENT EGRESS

Once the main entrance of the hospital and the entrance of the Emergency Department have been closed, patients leaving the hospital will be directed along the Level 4 corridor to the SVPH lobby where they may exit through either the SVPH or SVC main entrances. Administration staff from other areas of SVH will be used to direct patients along this route.

As the St. Vincent's Darlinghurst Campus will have restricted access during a CBEER, it may prove difficult for patients to be collected from the hospital. SVH NEPT may be used to transfer patients to the Sydney Football Stadium car park or other central location where friends or family may collect them. This will prevent traffic congestion around the Darlinghurst Campus. This will only be available to those patients who have been able to direct their friends or family to this location. SVH NEPT may also be used to transfer patients directly to their place of residence if local to the hospital. This will be coordinated in the Discharge Lounge.



## TRIAGE AREA (AMBULANCE BAY)

The Ambulance entry is the ONLY entry into the ED. The ED Front Entrance will be closed off by Security at the time of activation of Surge Plan.
Access to the Ambulance Bay will be controlled by Security and/or Traffic Control Police to allow adequate time and space for ambulances to off-load and exit the area. Arriving ambulances will be lined up along Victoria Street outside the deLacy Building awaiting access to the Ambulance Bay.

Appropriately coloured flashing lights (red and orange) will indicate Priority 1 and Priority 2 areas in the Ambulance Bay (see **FIGURE 1**).

Priority 3 walking wounded will be redirected to Main Entrance of Hospital down main driveway, (green arrows) by Staging personnel
If patients are up-triaged in GAC and need to return to Acute Care areas, they will enter Ambulance Bay through the side gate on trolley or wheelchair to be re-triaged and gain entry to the ED (see **FIGURE 1**). Patients shall NOT be transferred from GAC to the ED via any other entrance.

Trolleys (20) will be delivered to the Triage Staging Area (arranged by Staging Manager). Porters (arranged by Staging Manager) will be organised to transport patients to appropriate treatment areas in the ED.

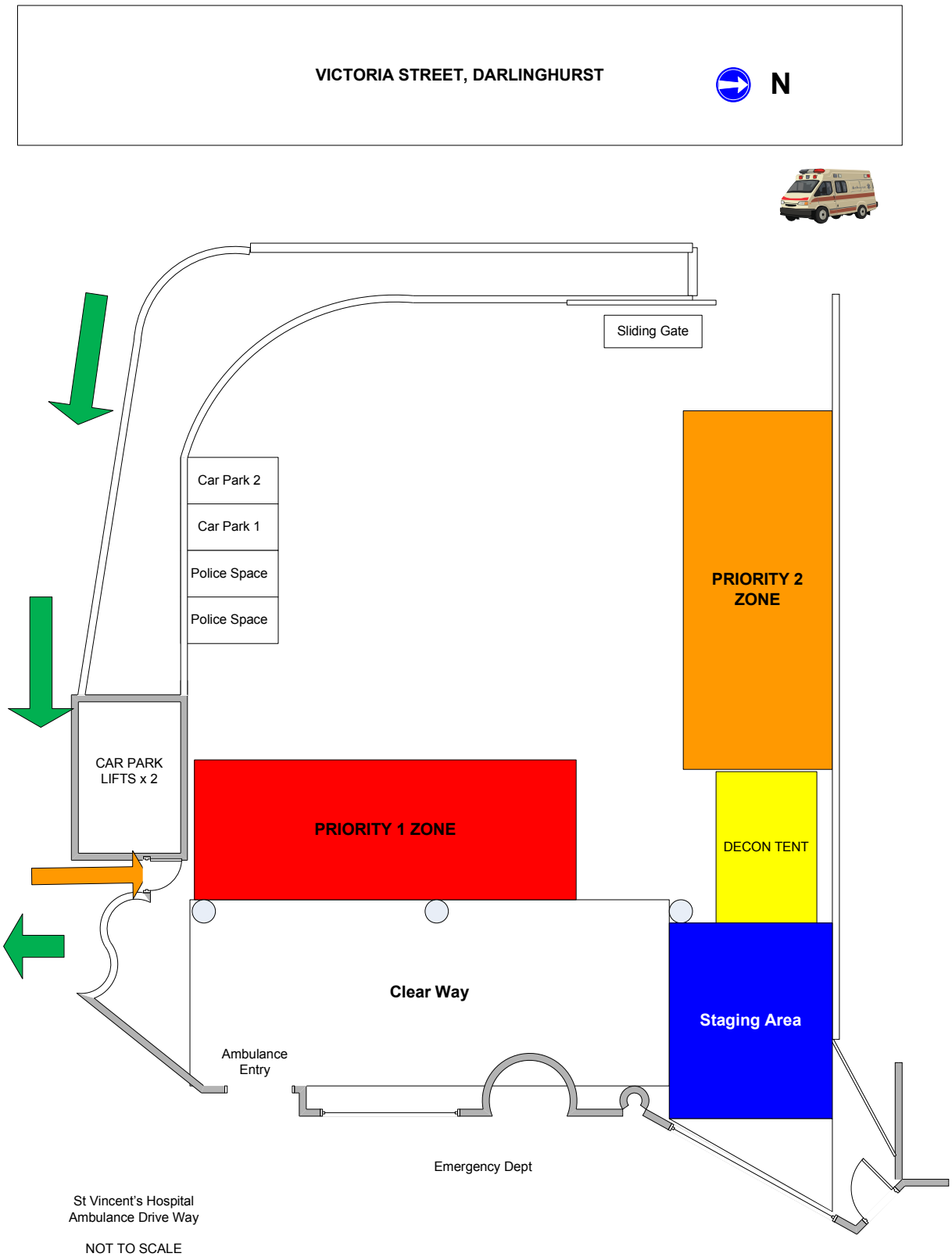

VICTORIA STREET, DARLINGHURST
N
Sliding Gate
Car Park 2
Car Park 1
Police Space
Police Space
PRIORITY 2 ZONE
CAR PARK LIFTS x 2
PRIORITY 1 ZONE
DECON TENT
Clear Way
Staging Area
Ambulance Entry
Emergency Dept
St Vincent's Hospital Ambulance Drive Way
NOT TO SCALE

**FIGURE 1**

## TRIAGE

Disaster triage involves the rapid assessment and sorting of patients so that the greatest good can be done for the greatest number of casualties. It is a continuous process and frequent reassessment is essential.

Colour coded SMART Triage Tags will be attached to the casualties at the scene of the MCI (Primary Triage). The SMART Triage Tag is an interchangeable triage tag with a documentation field which is useful for dynamic triage. The tag is durable, waterproof and can be written when the tag is wet. It has a prominent priority numbering and matching colour system on the tag (Red, Yellow and Green). A separate Black colour triage tag is used for the deceased person.

All casualties arriving at St Vincent's will be re-triaged (Secondary Triage) in the Ambulance Bay by the two Triage Units located there. Secondary Triage involves sorting patients based on physiologic parameters as well as location and severity of injury. Triage is only to assess and prioritise arriving casualties – NOT to commence treatment.

The two Triage Units will operate independently and communicate with the Emergency Department Unit Leader regarding patients requiring management within the ED and directly with the Hot Floor Priority 1Unit Leader and Hot Floor Priority 2 Team Leader (by 2 way radio) regarding patients appropriate for the Hot Floor.

If patients are reassessed and their triage code is changed, the triage tag is re-folded to display the appropriate code. No triage tags are to be removed. The tags are retained as part of the patient's medical record. A Triage time should be documented on the tag.

## SMART TRIAGE TAGS


**SECONDARY TRIAGE**

## TRIAGE REVISED TRAUMA SCORE (TRTS)

| SYSTOLIC BP | Coded Value |
|---|---|
| >89 | 4 |
| 76 - 89 | 3 |
| 50 - 75 | 2 |
| 1 – 49 | 1 |
| 0 | 0 |

| RESPIRATORY RATE | |
|---|---|
| 10 -29 | 4 |
| >29 | 3 |
| 6 - 9 | 2 |
| 1 - 5 | 1 |
| 0 | 0 |

| GLASGOW COMA SCORE | |
|---|---|
| 13 - 15 | 4 |
| 9 - 12 | 3 |
| 6 - 8 | 2 |
| 4 - 5 | 1 |
| 3 | 0 |

| IMMEDIATE PRIORITY 1 Score = 1 – 10 | URGENT PRIORITY 2 Score = 11 | DELAYED PRIORITY 3 Score = 12 |
|---|---|---|

**Priority 1 IMMEDIATE** - patients who require immediate, life-saving interventions.

**Priority 2 URGENT** - patients who require surgical or other interventions within 4 to 6 hours.

**Priority 3 DELAYED** - patients whose treatment may be safely delayed for more than 6 hours.

## PATIENT ALLOCATION AND UNIDIRECTIONAL FLOW

The Ambulance Bay Triage area is the only patient entrance to the Emergency Department. Patients will be transferred from Triage to the ED, Hot Floor or General Ambulatory Care. Only patients who deteriorate in GAC are to be transferred back to Triage (see FIGURE 2). Patients SHALL NOT be transferred in to the ED via any other route.

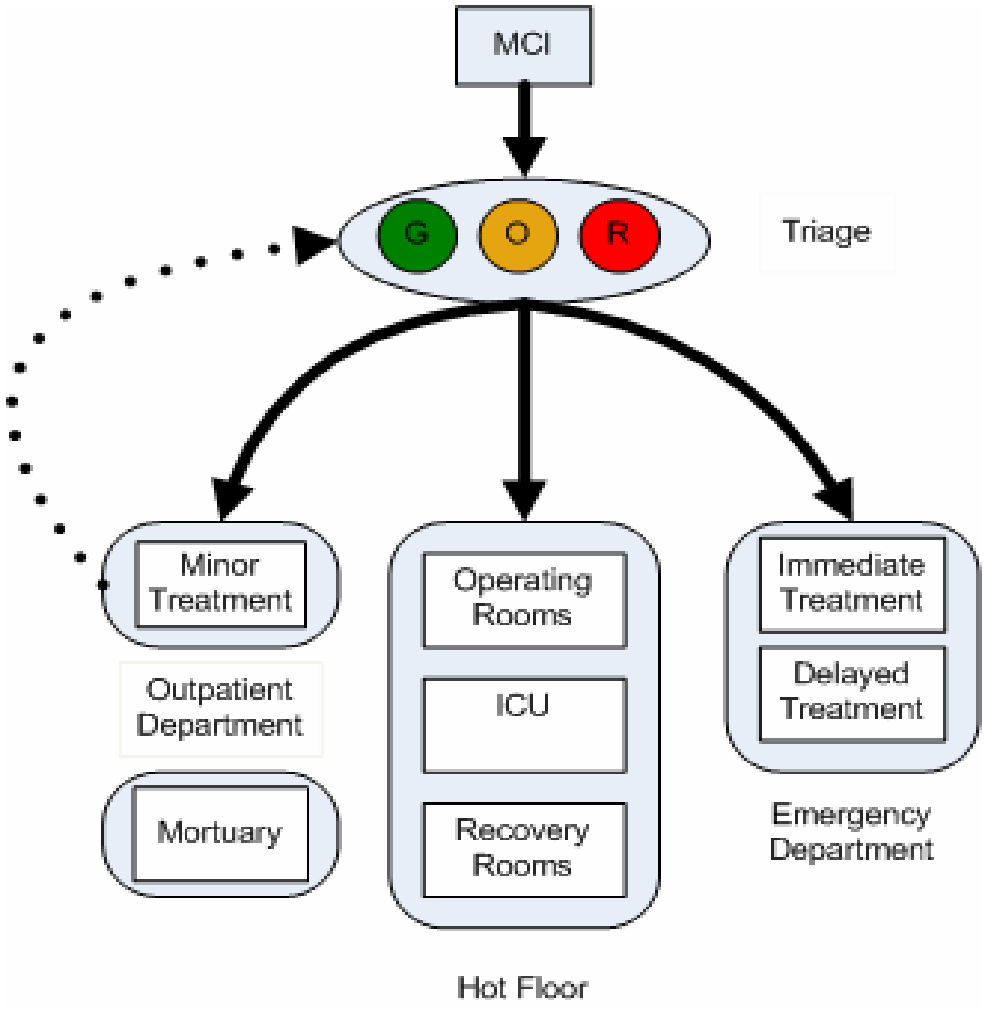



**FIGURE 2**

## PATIENT ALLOCATION IN THE EMERGENCY DEPARTMENT

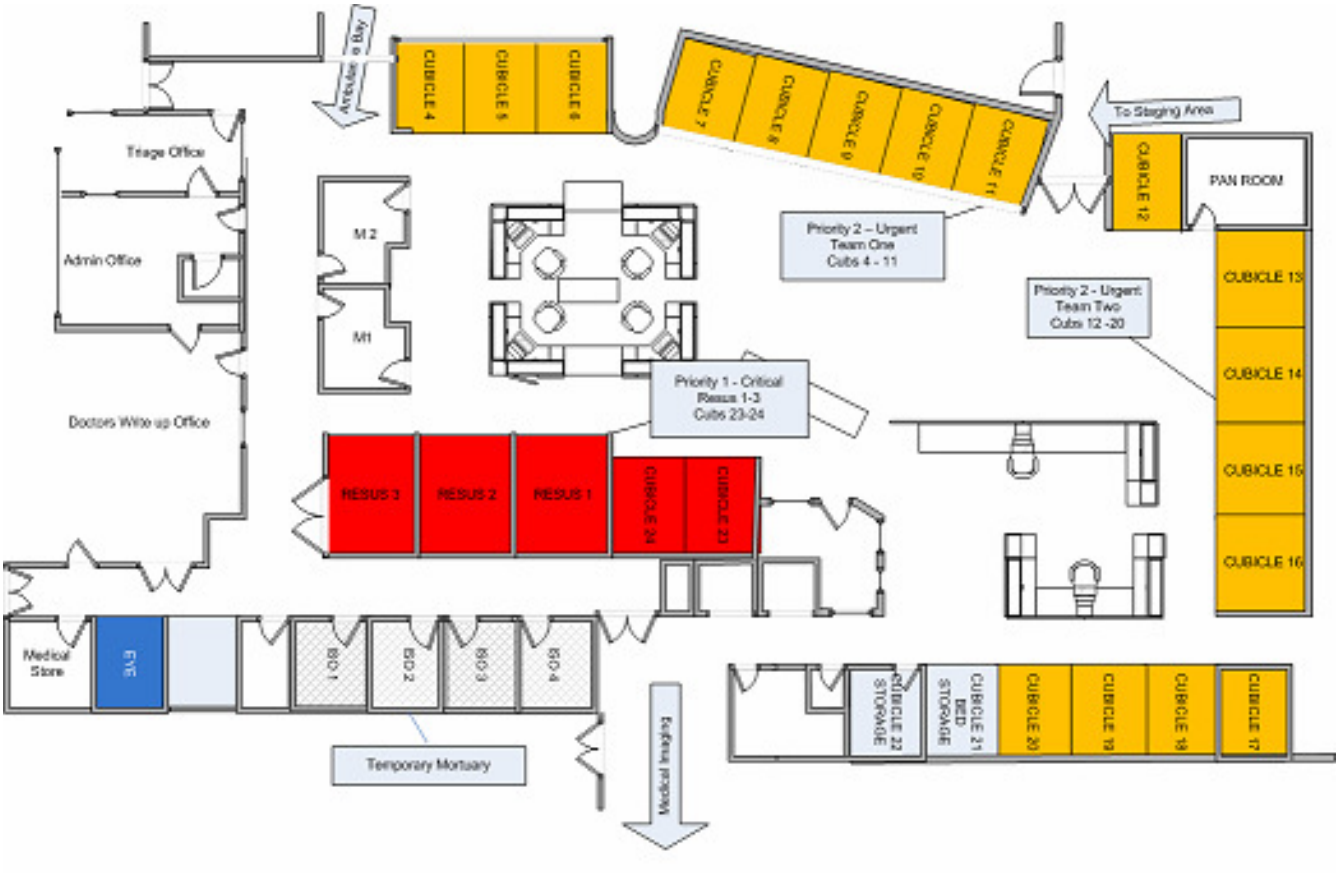



**FIGURE 3**

**Priority 1 IMMEDIATE** patients will be transferred from Triage to Resuscitation Bays 1-3 and Cubicles 23-24.

**Priority 2 URGENT** patients will be allocated to Cubicles 4-11 and 12-20.

**Priority 2 STABILISED** patients will be transferred from the main ED (C4-20) to EMU and Transit.

## PATIENT ALLOCATION

**Priority 2 STABILISED** staff will manage EMU and Transit areas during the Surge Plan activation. An Emergency Staff Specialist, SRMO and 5 Emergency RNs will primarily manage these patients. The ASET Nurse will also assist here. The ED Unit Leader may need to assist in clearing this area by coordinating with the Inpatient Unit Leader.

Initially these areas will hold patients being cleared from the main ED and waiting transfer to a ward or the Discharge Lounge.

Once the pre-existing patients are cleared, the staff will manage Priority 2 *stabilised* patients from the MCI awaiting transfer to OT and wards.

MCI patients appropriate for this area include:

- Long bone fractures
- Blunt trauma – haemodynamically stable
- Multiple lacerations

Patients who deteriorate once transferred to these areas will be managed by Team 3 staff and transferred for appropriate definitive care in OT/ angiography suite/ ICU. This will need coordination with the Emergency Department Unit Leader and Operations Section Chief.

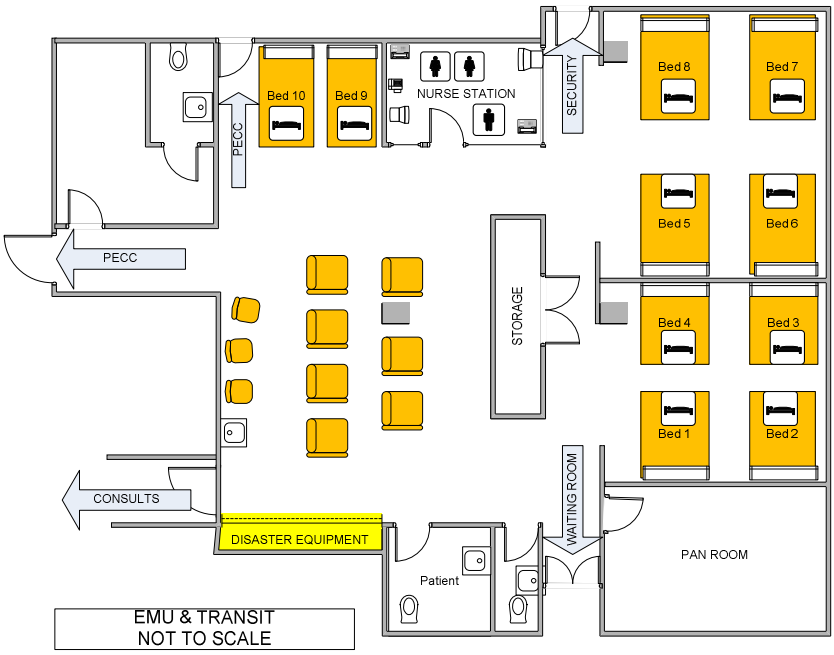



**FIGURE 4**

## PATIENT ALLOCATION GENERAL AMBULATORY CARE

**Priority 3 DELAYED** patients will be transferred directly to General Ambulatory Care from the Ambulance Bay via the Main Entrance.

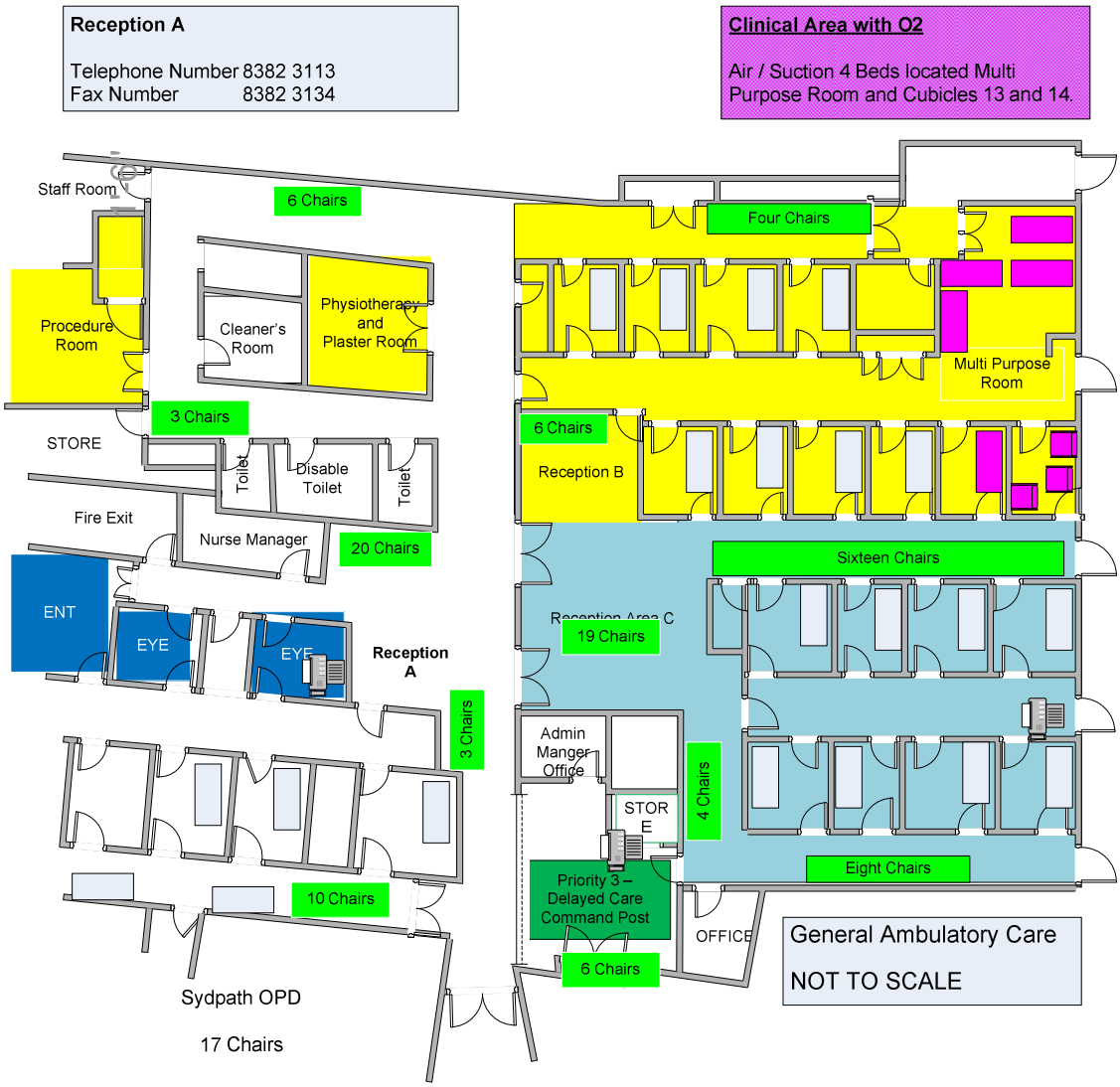



FIGURE 5

MCI patients meeting **Priority 3 DELAYED** criteria include:

- Walking wounded (no major burns or lacerations; no long bone fractures of lower limbs)
- Minor lacerations – including scalp lacerations (minor head injuries with GCS 15)
- Facial injuries including eye and ENT injuries
- Fractures of upper limbs
- Minor burns <10% TBSA (not involving critical areas such as face, airway or circumferential)

## PATIENT ALLOCATION GENERAL AMBULATORY CARE

The Priority 3 DELAYED Triage Team will consist of an Emergency Registrar, ED RN (preferable MIMMS trained) and Administration officer. The Priority 3 DELAYED Team Leader will carry 2-way radio to communicate with the Triage Unit Leader and the Emergency Department Unit Leader as necessary.

Secondary Triage will occur at General Ambulatory Care Reception area (Delayed Care Command Post - **FIGURE 5**) for all patients arriving at GAC. All Priority 3 patients will be entered onto Web DeLacy at GAC Reception by the ED Administration officer.
Any patients that do not fit the criteria for Priority 3 DELAYED must be transferred to the Ambulance Bay for re-triage and admission through the ED acute care areas (see orange arrow **FIGURE 1**). Staging Manager will provide trolleys to GAC for transfer of unstable patients to the Ambulance Bay.

GAC Priority 3 DELAYED Area will be divided into 3 treatment areas, as colour coded in **FIGURE 5**:

- Area A (dark blue) – facial injuries, eye and ENT examinations
- Area B (yellow) – more severe injuries; suturing in Multi Purpose Room; Procedure Room for reduction of fractures
- Area C (light blue) – minor injuries requiring wound cleaning and dressings

GAC nursing staff will be allocated to appropriate treatment areas within GAC to manage MCI patients.

Social workers and the PECC ED Liaison Nurse will be deployed to GAC to counsel and assist distressed patients. They may also provide support for clinical staff. Quiet rooms are available near Reception and Treatment Area A (**FIGURE 5**).

Exit doors to the staff cafeteria courtyard shall be closed off to avoid patient egress.

## PATIENT ALLOCATION - DECEASED

**DECEASED** patients will be transferred to St Vincent's Mortuary, Xavier Level 2 (**FIGURE 6**) or to the Isolation Rooms if these are commissioned as a temporary mortuary (**FIGURE 3**).

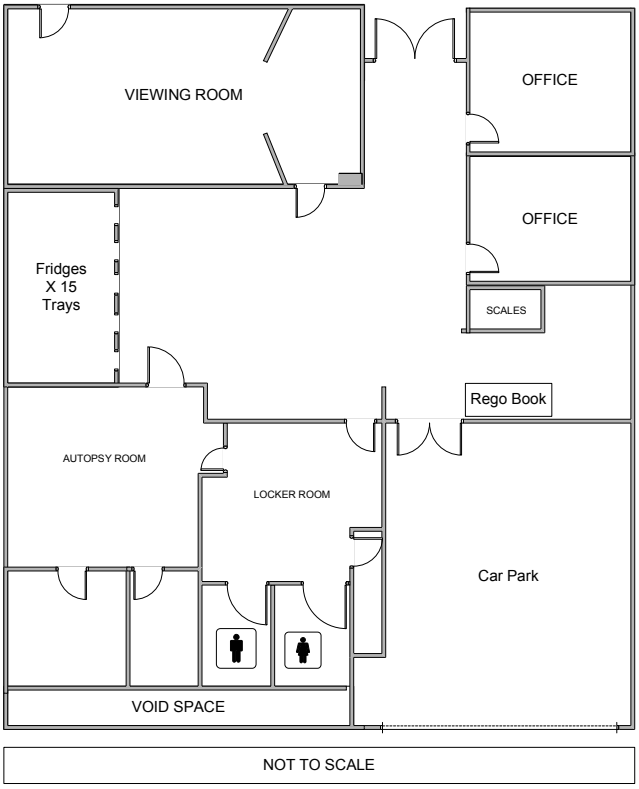



**FIGURE 6**

## UNINJURED PERSONS

Any uninjured persons who present to SVH from the scene of a MCI shall be directed to the Survivor Reception at the Wintergarden Café in SVC where they will be registered by NSW Police. These persons shall not be registered as patients. Social workers shall be deployed to Survivor Reception to support these persons prior to the arrival of NSW Police.

## SURGICAL TRIAGE AND UNIDIRECTIONAL FLOW

Unique to St Vincent's Hospital's CBEER Surge Plan is the surgical triage of casualties from Triage to the Operating Theatres and Intensive Care Unit BYPASSING the ED. Xavier Level 5 will be known as the Hot Floor during the activation of the Surge Plan. This area encompasses ICU North and South and the entire Peri Operative and Interventional Services (PAIS) Department - Operating Theatres (OT), Day Procedure Centre (DPC), Medical Surgical Transit Unit (MSTU), Recovery (1, 2 and 3), and Cardiac Catheter Unit. The Hot Floor is designed to receive Priority 1 immediate patients directly from the Triage Area for active resuscitation and stabilisation.

Hot Floor OT patients must meet the following criteria:

- Priority 1 IMMEDIATE
- Penetrating abdominal injuries
- Penetrating chest injuries
- Partial or complete amputations
- Uncontrolled massive haemorrhage

Hot Floor ICU patients must meet the following criteria:

- Priority 1 IMMEDIATE
- Casualties intubated at the scene
- All serious burns: >20% TBSA, airway burns, circumferential burns

Close communication between the Triage Unit Leader and Hot Floor Unit Leader is essential to ensure OT/ Recovery/ ICU have not reached maximum capacity. Adequate time must be allowed for the Hot Floor team leaders to respond to requests.

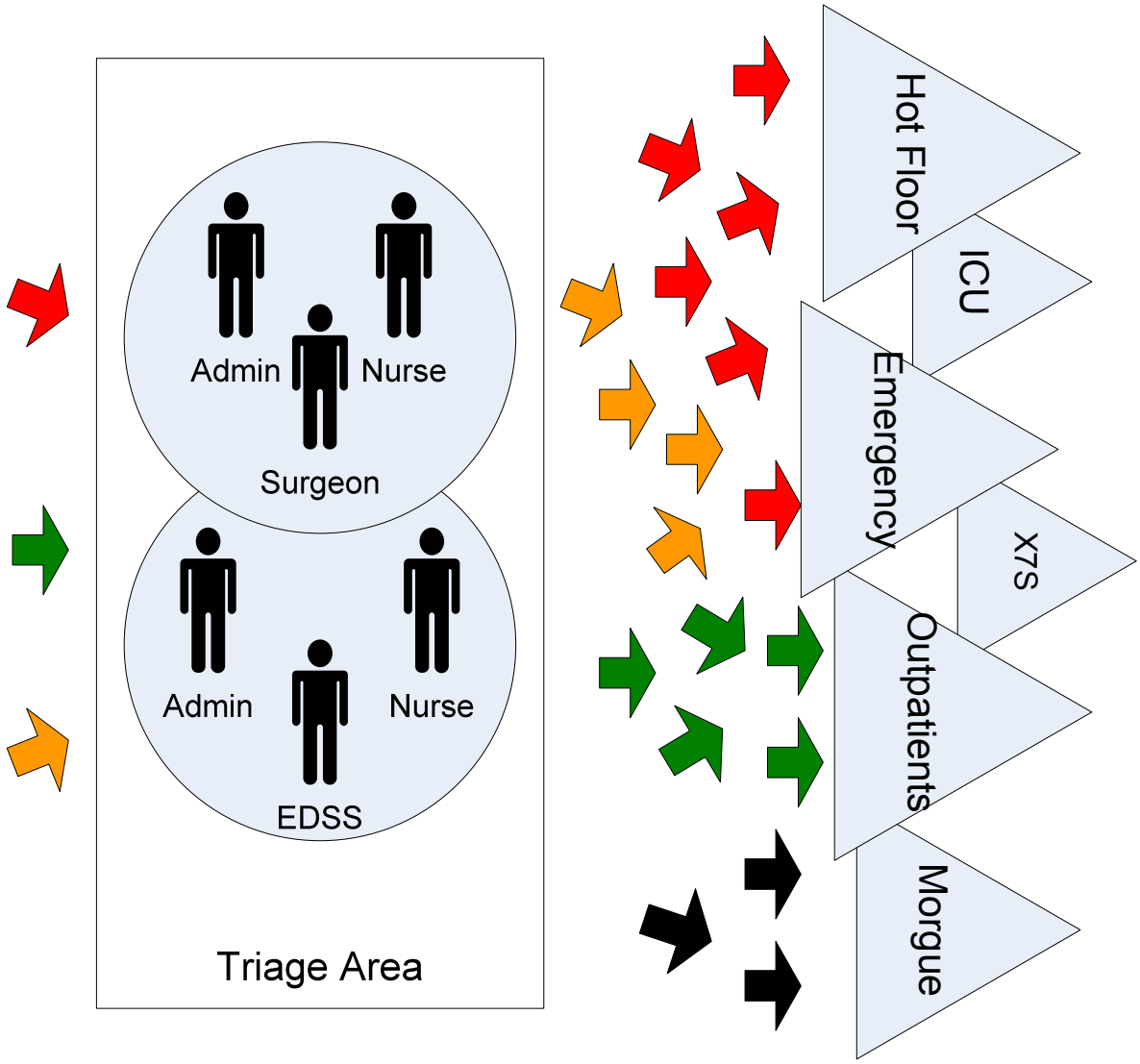
Personnel (medical and nursing) required for transporting patients to the Hot Floor are to be provided by OT and ICU. This must be discussed with the Hot Floor Unit Leader and the Operations Section Chief.

**SURGICAL TRIAGE AND UNIDIRECTIONAL FLOW cont.**

The maximum numbers of patients that can be accepted to the Hot Floor are as follows:

- 5x casualties to OT
- 5x casualties to Anaesthetic Bays
- Recovery Stage 2 may have capacity for 2-10 casualties
- The capacity of ICU will be dependent upon the bed status of the unit prior to the activation of the Surge Plan.

Capacity will need close co-ordination between the Hot Floor Unit Leader and the Operations Section Chief.



## ORTHOPAEDIC WARD X7S

In the event of a MCI, X7S may be commissioned to become a pre- and post-operative orthopaedic ward. This is to allow earlier movement of orthopaedic casualties from GAC and EMU/Transit to reduce the burden on resources in these areas.

During the STANDBY phase, the X7S NUM will identify all patients suitable for early discharge. These patients will be transferred to the HOAC Discharge Lounge. All other patients not requiring high level orthopaedic care will be transferred to other wards. This will be coordinated by the Inpatient Unit Leader.

Priority 2 STABILISED and Priority 3 DELAYED patients who have orthopaedic injuries requiring surgical interventions at a later time will be transferred promptly from EMU/Transit and GAC. These patients must be haemodynamically stable.

Priority 2 STABILISED and Priority 3 DELAYED patients who have undergone surgical repair for primarily orthopaedic injuries may be transferred to X7S post-operatively. Any patients who are haemodynamically unstable or whose injuries are not primarily orthopaedic shall not be transferred to X7S.

The primary care aims of X7S shall be to monitor patients awaiting surgical orthopaedic interventions and to provide immobilisation of fractures and analgesia. Physiotherapists will be deployed to this ward to assist nursing staff with splinting and traction of fractures. Pharmacy will supply additional S4 and S8 analgesia as required in a timely manner.

## DOCUMENTATION

- HICS Forms are attached to each Job Action Sheet
- Operational Log (Form 214)
- Incident Message (Form 213)
- Branch Assignment List (Form 204) – with Casualty Care Unit Leader JAS
- Incident Management Team Chart (Form 207)
- Scribes will be available where possible to assist treating teams with documentation
- All triage tags on MCI patients are retained as documentation of the patient journey

## JOB ACTION SHEETS

- Job Action Sheets will be held in a folder in the Disaster Cupboard for ED personnel
- JAS are available for Team Leaders including:
    - Emergency Department Unit Leader
    - Triage Unit Leader
    - Priority 1 IMMEDIATE Care Team Leader
    - Priority 2 URGENT Care Team Leaders
    - Priority 2 STABILISED
    - Priority 3 DELAYED Care Team Leader
    - Nursing ED NM and Triage RN – all other roles emulate medical roles (Priority 1-3)
- Each JAS will be in a plastic sleeve along with necessary HICS forms (see Documentation):
    - Branch Assignment List (**Form 204**)
    - Incident Management Team Chart (**Form 207**)
    - Incident Message Form (**Form 213**)
    - Operational Log (**Form 214**)

## COMMUNICATION

- Adherence to HICS Command structure is imperative for effective operation of the Surge Plan. Team members must know their chain of command for requesting resources, equipment and staff.
- 2-way Radio communication will be available to Team Leaders including:
    - Emergency Department Unit Leader
    - Triage Unit Leader
    - Priority 3 DELAYED Team Leader – due to distance of GAC from main ED
- Communication within the ED must go through Team Leaders to minimise duplication.
- Scribes and communication officers may be used as runners if necessary.
- Communication with Sydpath and Medical Imaging will be by the usual means (i.e. page or phone).
- Communication with staff outside hospital:
    - Department managers will contact necessary staff using current personal details.
    - All Emergency Registrars can expect to be contacted by the Duty Staff Specialist.

## EQUIPMENT

- The Disaster Cupboard located in Transit Area of ED contains Disaster overalls and tabards for Team Leaders in each treatment area.
- Keys to access to Disaster cupboard are held by Security, Nursing Manager of ED, ED Nursing Coordinator, ED Administration Office and Emergency Response Coordinator. A spare key is also held in key cupboard in ED Drug Room.
- Additional equipment and resources to treat, transport and manage arriving casualties may be obtained through the Staging Manager via Medical Operations Section Chief.

## SECURITY

- Security will be required to control particular areas in and around ED.
- Security will be available on 2-way radio system as well as on usual extension x2519.
- Front door access to ED will be closed or controlled with adequate security to prevent disruption of patient flow from Ambulance Bay to ED and from ED into EMU.
- Walking wounded need to be directed to GAC down driveway to Main Entrance.

## DEBRIEFING

All staff will be invited to a formal debrief as soon as possible after the incident**.** Further counselling and support will be available to individuals on request through their usual supervisors