


**driving readiness in
dynamic times**

Disaster Planning for California Hospitals



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**“Shots Fired”
A National Perspective on
Responding to Terrorist Actions**

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The world has changed.

**And so has the nature of the
threat.**



Objectives

- Describe the paradigm shift that governs the law enforcement approach to 'active shooter'
- Appreciate the continuum of care that extends from field management to hospital care
- Review steps for ensuring trauma/burn surge capability



April 20, 1999



Columbine — Paradigm Shifter

- Both had self-inflicted fatal wounds
- Occurred within 45 minutes from start of incident
- No significant law enforcement entry for 1 hour
- No medical operations inside for 4 hours
- 12 students & 1 teacher killed; 24 wounded
- Teacher bled for > 2 hours before dying



Paradigm Shift

EMS/fire/rescue must be involved earlier in the care of the victims

- **T**hreat suppression
- **H**emorrhage control
- **R**apid **E**xtrication to safety
- **A**ssessment by medical providers
- **T**ransport to definitive care



Hartford Consensus, Jacobs, 2014



Shared responsibility between law enforcement, fire/rescue and EMS

- Optimal outcome depends on communication between all public safety responders
- The response requires coordination between law enforcement and the medical/evacuation providers
- Such coordination includes jointly developed protocols for an integrated response to these events



Rescue Task Force

First arriving EMS personnel (NOT tactical medics) team up with two patrol officers (NOT SWAT) and move quickly into the “warm” zone along cleared areas to initiate treatment and evacuation of victims



Discussion Paper

Health and Medical Response to Active Shooter and Bombing Events

John L. Hick, Dan Hanfling, Bruce Evans, Sheldon Greenberg, Roy Alson, Suzet McKinney, and Matthew Minson

June 17, 2016



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<https://nam.edu/wp-content/uploads/2016/06/Health-and-Medical-Response-to-Active-Shooter-and-Bombing-Events.pdf>



Key Points

- Prepare for acts of mass violence
- Medical support for/with law enforcement
- Broaden “citizen first responder” training/education (e.g., public access tourniquets)



Initial Hospital Actions and Priorities

- Ensure perimeter security
- Initiate triage of wounded
- Implement surge response plan

Focus on surge “capability” planning and response (e.g., trauma and burn surge; management of cases in non-trauma/burn facilities)



HEALTH

Orlando Injuries Were Severe, but Trauma Care Was Nearby

By DENISE GRADY JUNE 14, 2016

“Initially, we had four operating rooms going,” Dr. Bullard said. “Then they opened a fifth, and after 3 a.m. they may have opened more.”

The hospital is well stocked, but with so many patients, supplies dwindled and hospital officials went across the street to a children’s hospital to restock. So many people were shot in the chest that one item in short supply was special tubing needed to help reinflate the lungs.

Key Points

Augment Hospital Plans

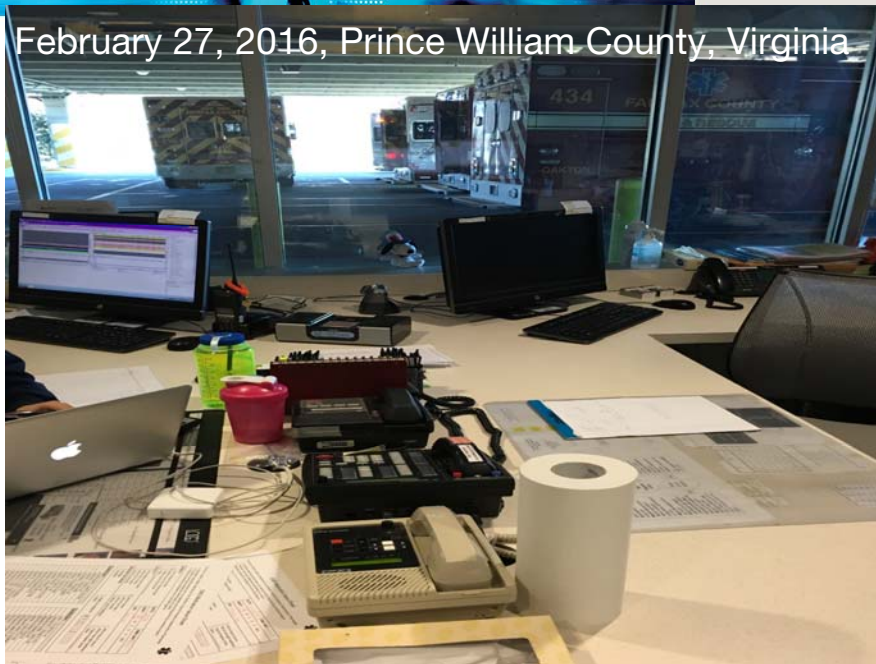
- Increased security posture and “crowd control”
- Rapid screening of victims, triage and hemorrhage control
 - Tourniquet application; tourniquet takedown
 - Tranexamic acid (TXA) protocol
- Surgical triage and decision making process — damage control surgery; vascular surgical set-ups; massive transfusion protocol implementation
- Mental health support for responders (e.g., PSYStart)

Medical Surge Response

- Tourniquet use
 - Put on
 - Take down
- Key resources — Considerations given to **Crisis Standards of Care** planning:
 - Substitution; Adaptation; Re-use
 - Massive transfusion protocol (blood products availability)
 - Damage control surgery
 - Chest tubes
 - Vascular trays



February 27, 2016, Prince William County, Virginia





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Key Challenges

- Minimal alert time for receiving hospitals
- Communications difficulties
- Security and crowd control at hospitals
- Providing Situational Awareness and mobilizing all hospital departments to provide clinical services for the influx of severely injured patients



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