

Disaster Preparedness Should Represent an Augmentation of the Everyday Trauma System – But Are We Prepared?

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Abstract

Introduction

Mass casualty incidents (MCI) range from natural disasters to terrorist attacks. The increased frequency, geographical spread and the heterogeneity in type of terror incidents, challenge healthcare systems all over the world. Trauma systems constitute the base upon which disaster preparedness is being built. The largest MCI in Norway took place 22 July 2011 and several lessons were learnt including the importance of having designed the everyday trauma infrastructure to be able to increase activity and adjust according to needs. Norway is sparsely populated, with a national trauma system consisting of four regional trauma centers (TCs) and 35 acute care hospitals treating trauma (non-trauma centers; NTCs). We wanted to assess how well hospitals fill the national trauma system requirements for competence, and the degree of awareness of existing MCI plans.

Methods

We conducted a cross-sectional survey of the on-call trauma team in all 39 Norwegian hospitals during two time periods: July-August (HS; holiday season) and September – June (NHS; non-holiday season). A standardized questionnaire was used to evaluate the MCI preparedness.

Results

A total of 347 trauma team members participated with 173 during HS and 174 during NHS. Over 95% of the team members were aware of the hospital MCI plan, only half had read the plan during the last 6 months, whereas 63% at the TCs and 74% at NTCs were confident with their designated role in the event of an MCI. Trauma team exercises were conducted regularly and 86% had ever participated, primarily residents and nurses. Only 63% at the TCs and 53% at the NTCs had participated in an MCI exercise. The proportion of resident surgeons and anesthetists with >4 years clinical experience was significantly higher in TCs (88% and 63%) than in NTCs (27% and 17%). At NTCs 38% of the resident surgeons were on call from home after working hours. All the on-call consultant surgeons were at home after working hours, leaving interns in charge at several of the hospitals. All resident surgeons at the TCs were ATLS providers compared to 64% at the NTCs and almost 90% of the consultant surgeons had participated in advanced trauma surgical courses.

Conclusion

Despite increased focus on disaster preparedness at a national level after the 2011 attacks, we identified limited compliance with trauma system requirements concerning competency and training. Strict guidelines to secure immediate notification and early presence of consultants whenever a situation that might turn into an MCI occurs should be a prerequisite. The awareness and content of existing MCI plans should be continuously improved to be able to meet the challenges of future MCIs.

Background

Mass casualty incidents (MCIs) are occurring frequently worldwide ranging from terrorist attacks to natural disasters. On that background, healthcare systems need to be prepared for the next possible event. Four aspects of trauma care have been identified being valuable for MCI preparedness and response: communication, triage, transport and training.(1)

Accurate prehospital triage is essential to ensure optimal patient flow, in order to avoid that the closest facilities get a disproportionally high number of patients.(2) Hospitals play a critical role in the system. The hospital MCI definition will vary with available local resources and capacity as well as trauma patient volumes meanwhile the outcome to a large extent will depend on trauma experience and competence.(3) Hospital MCI plans have been developed in an effort to prepare the hospitals for situations when their surge capacity becomes challenged.(4) In order to be functional, a well-designed MCI plan should be based on the everyday trauma organization, adjusted for the specific needs of multiple patients.

In addition to implementing and maintaining a trauma system, MCI plans should mandate regular training and testing of the different elements of the plan including tabletop exercises for core personnel. (5) The individual task of the hospital staff on the other hand is to fill the competency requirements and to know their own role in an MCI.

In Norway, the initial national trauma plan was designed in 2007, a first version was implemented in the South East health region in 2010. The plan describes 2 levels of care: regional trauma center (TC) and non-trauma center (NTC). The NTCs have general surgical capabilities 24/7 and should be able to provide initial care, including damage control resuscitation, before transfer of severely injured patients to the regional TC. Based on these concrete recommendations and the lessons learned after the largest terrorist attack in Norway on July 22, 2011,(6–9) the national trauma plan was revised in 2017. The plan describes all aspects of trauma care including individual competencies, course requirements and team training.(10)

In this study we wanted to investigate the individual awareness of the MCI plan and adherence to defined trauma team requirements in all hospitals receiving trauma patients in Norway through a telephone interview of the on-call trauma team key personnel at 2 different time points.

Materials And Methods

Norway has 5.3 million inhabitants and is organized in four health care regions (population range 400.000 to 3.2 million), each with a regional TC similar to a US level-I or level-II trauma center.(11) Each region has 4–14 NTCs admitting trauma patients. These hospitals will have general surgical capabilities 24/7, and the ability to stabilize and transfer patients to the TC according to predefined transfer criteria. Hospital patient population vary greatly(12) and the hospitals will have different thresholds for MCIs ranging from 2–12 critically injured patients. The only equivalent to a level 1 trauma center (11) in

Norway is Oslo University Hospital (OUH-U) in the southeastern health region covering 3,2 million inhabitants.

We conducted a cross-sectional survey during the period August 2017 to June 2018 at all 39 hospitals admitting trauma patients in Norway, focusing on relevant trauma system requirements and degree of MCI plan awareness. Personnel in the four TCs and 35 NTCs were interviewed in July/August (holiday season; HS) and September-June (non-holiday season; NHS). The telephone interview consisted of standardized questions presented to the on-call emergency room (ER) nurse, senior resident surgeon, senior resident anesthetist, consultant surgeon and consultant anesthetist (Table 1). These health care workers would be essential in the early stage of an MCI. The interviews were based on voluntary participation and were conducted by two consultant trauma surgeons at OUH on weekdays between 8 am and 4 pm.

Table 1

Translated version of the topics in the survey

Years of experience
ATLS / Trauma nursing course*
DSTC**
Knowledge of the hospital's MCI plan
Read MCI plan within last 6 months
Familiar with own role during an MCI
Would feel competent during an MCI
Confident with own hospital's competency during an MCI
Increased focus on MCI preparedness after July 22, 2011
Number of trauma team simulations per year
Last participation in trauma team simulation***
Hospital MCI exercises per year
Last participation in MCI alertness exercise***
Hospital triage tabletop exercises per year
Last participation in triage tabletop exercise***
Hospital ER evacuation exercises per year
Last participation in hospital ER evacuation exercise***
Hospital ICU evacuation exercises per year
Last participation in hospital ICU exercise***
Hospital MCI exercises per year
Last participation on hospital MCI exercise***
ATLS, advanced trauma life support; *TNCC (trauma nursing care course), ATCN (advanced trauma care for nurses) or KITS (Norwegian trauma care course); DSTC, definitive surgical trauma care; **or equivalent; MCI, mass casualty incident; ***time given in months; ER, emergency room; ICU, intensive care unit

Statistical analyses comparing the two time periods and TCs compared to NTCs were done with SPSS version 25 (SPSS, Chicago, IL, USA). Kolmogorov-Smirnov/Shapiro Wilk histograms and normal-quartile plots were used to test for normality. Numerical data are reported as median with interquartile range (IQR)

and categorical data as frequencies (n) and percentages (%). Mann-Whitney U-test was used to compare numerical data and Fisher's test or chi-squared test was used to compare categorical data. Statistical significance was set as a two tailed p-value of < 0.05.

The institutional Data Protection Officer at OUH had no objections to this study.

Results

Of the interviewed trauma team members, 347 participated with 173 in HS and 174 in NHS. Two persons opted out leaving 155 consultants, 114 residents and 78 nurses participating in the survey (Table 2). Fourteen NTCs had an attending consultant anesthetist as the only anesthetist on call.

Table 2
Number of personnel in different categories

		TC	NTC
Anesthesia	Consultant, in-house	5	27
	Consultant, standby*	3	43
	Resident, in-house	8	33
	Resident, standby*	0	2
Surgery	Consultant, in-house	0	0
	Consultant, standby*	8	69
	Resident, in-house	8	39
	Resident, standby*	0	24
Nurse		8	70
TC, Trauma center; NTC, Non-trauma center. *30 min standby-time			

There were no statistical differences between the two time periods.

The number of personnel in the different categories is shown in Table 2. A total of 40 staff was interviewed at TCs and 307 at NTCs. As shown in Table 3 the TCs had more experienced residents compared to NTCs. The proportion of surgical residents with > 4 years' experience was 88% in TCs and 27% in NTCs ($p < 0.05$). For anesthesiology residents, the trend was similar with 63% in the TCs and 17% in NTCs ($p < 0.05$). All on-call consultant surgeons (100%) and more than half of the consultant anesthetists (38% at TCs, 61% at NTC) had to be called in from home after working hours. There was no difference between the experiences of ER nurses at TCs compared to NTCs.

Table 3
Experience and provider status in different personnel categories

		TC	NTC
Anesthesia	Consultant experience in years	20 (15–29)	20 (12–29)
	Consultant ATLS provider, n (%)	7 (88)	57 (81)
	Resident experience in years	4 (3–11)	3 (2–3)*
	Resident over 4 years' experience, n (%)	5 (63)	6 (17)*
	Resident ATLS provider, n (%)	6 (75)	19 (54)*
Surgery	Consultant experience in years	16 (14–31)	23 (14–28)
	Consultant ATLS provider, n (%)	5 (63)	60 (87)*
	Consultant DSTC provider, n (%)	7 (88)	62 (90)
	Resident experience in years	6 (5–8)	2 (1–4)*
	Resident over 4 years' experience, n (%)	7 (88)	17 (27)*
	Resident ATLS provider, n (%)	8 (100)	40 (64)*
	Resident DSTC provider, n (%)	8 (100)	20 (32)*
Nurse	Experience in years	10 (5–29)	12 (5–20)
	Trauma nursing course provider, n (%)	6 (75)	63 (90)
Values are in median IQR (interquartile range) unless stated otherwise; TC, trauma center; NTC, non-trauma center; ATLS, advanced trauma life support; DSTC, definitive surgical trauma care; * denotes P-value < 0,05			

Advanced Trauma Life Support (ATLS) is a course for doctors focusing on the initial assessment and management meanwhile Definitive Surgical Trauma Care (DSTC) is a course for surgical teams focusing on surgical decision-making. All surgical residents at the TCs were ATLS and DSTC providers compared to 64% and 32% at the NTCs, respectively. A higher proportion of resident anesthetists were ATLS providers at the TCs compared to NTCs (75% vs 54%, $p < 0,05$). Almost 90% of the consultant surgeons were DSTC providers meanwhile significantly fewer consultant surgeons were ATLS providers at the TCs compared to the NTCs (63% vs 87%, $p < 0,05$).

Over 95% of the study population was aware of the hospital MCI plan but only half had read the plan during the last 6 months with no difference between the personnel in TCs and the NTCs (Table 4). More than 85% of all the interviewed persons were familiar with their MCI role meanwhile fewer felt confident in fulfilling the role (63% in TCs vs 74% in NTCs, NS). The majority were confident with their hospital's level

of competence and more staff at TCs compared to NTCs reported an increased MCI awareness in their institution after July 22, 2011 (78% vs 56%, $p < 0.05$) (Table 4).

Table 4
Reported MCI preparedness

	TC	NTC
Knowledge of the hospital's MCI plan	37 (93)	294 (96)
Read MCI plan within last 6 months	19 (48)	160 (52)
Familiar with own role during an MCI	33 (83)	271 (88)
Would feel competent during an MCI	25 (63)	226 (74)
Confident with own hospital's competency during an MCI	34 (85)	249 (81)
Increased focus on MCI preparedness after July 22, 2011	31 (78)	171 (56)*
Values are in n (%); TC, trauma center; NTC, non-trauma center; MCI, mass casualty incident; * denotes P-value < 0,05		

Regular simulated training was conducted in all hospitals. The vast majority of personnel (86%, 299/347) had participated in a trauma team exercise with significantly more in NTCs compared to TCs (89% vs 68%) (Table 5). Median time in months since the last trauma team training participation was 3 for staff at NTCs compared to 6 at TCs with the majority performed by residents.

Table 5
MCI maintenance

	TC	NTC
Participated in TT simulation, n (%)	27 (68)	272 (89)*
Last participation in trauma team simulation	6 (2–36)	3 (2–8)*
Participated in MCI alertness exercise, n (%)	31 (78)	208 (68)
Last participation in MCI alertness exercise	2 (1–6)	2 (1–6)
Participated in triage exercise, n (%)	12 (30)	70 (23)
Last participation in triage tabletop exercise	7 (2–24)	11 (4–20)
Participated in hospital ER evacuation exercise, n (%)	7 (18)	44 (14)
Last participation in hospital ER evacuation exercise	18 (9–24)	15 (7–36)
Participated in hospital ICU exercise, n (%)	1 (3)	31 (10)
Last participation in hospital ICU exercise	18 (18–18)	12 (6–24)
Participated in hospital MCI exercise, n (%)	25 (63)	164 (53)
Last participation on hospital MCI exercise	18 (9–30)	12 (6–24)
Values are months, median IQR (interquartile range) unless stated otherwise; TC, trauma center; NTC, non-trauma center; MCI, mass casualty incident; TT, trauma team; * denotes P-value < 0,05		

MCI alertness exercises were conducted with a median of every second month for both TCs and NTCs, and the majority reported having participated in such (78% in TCs and 68% in NTCs, respectively (NS)). Less than 25% had participated in a triage exercise and less than 15% had participated in ER and/or ICU evacuation exercises. Far more had participated in a full-scale hospital MCI exercise (63% at TCs vs 53% at NTCs, NS) (Table 5).

Discussion

We performed a national survey assessing awareness and knowledge of MCI plans and adherence to relevant trauma system criteria. Although more than 95% of the interviewed trauma team members were aware of their hospital's MCI plan, limited compliance with trauma system requirements concerning competency and training was identified both in TCs and NTCs.

Recent studies, including the experience gained in Norway on July 22, 2011,(7) have demonstrated that the closest hospital in the event of an MCI will receive the highest number of patients indicating the need for MCI preparedness at all hospitals receiving trauma victims.(13–15)

Most Norwegian hospitals have limited exposure to trauma, i.e. receive very few severely injured on an annual basis, and have limited surgical trauma competency.(12) However, due to the settlement pattern in Norway including a lot of small communities with long transportation distances to the regional TC, the NTCs have to be prepared to take care of severely injured patients under normal circumstances as well as under an MCI.(12, 16, 17)

Obviously, regular training, both theoretical and practical, becomes even more important in the NTCs if adequate trauma care in daily practice and in an MCI situation is to be delivered.(18) Only 27% of the surgical residents in NTCs reported at least 4 years of surgical training which is a minimum to fulfill the role as team leader during a regular trauma team activation according to the criteria in the national trauma plan. On that background, the consultant surgeon on call will have to take on the role as trauma team leader in almost every Norwegian NTC and almost 90% of the interviewed consultant surgeons working in NTCs reported to be ATLS trained which is another prerequisite to fulfill that role. Moreover, as severely injured patients might need damage control surgery as part of initial care, surgeons need to be specifically trained for this. Advanced surgical course participation (like DSTC) is another criterion to be met and 90% of consultant surgeons at NTCs were DSTC trained and represents a major improvement compared to the situation before July 22, 2011.(19)

As only 32% of resident surgeons at NTCs were DSTC trained, the need for early consultant surgeon presence is evident. Even though most consultant surgeons were DSTC providers, their real MCI and trauma surgery experience is limited.(6–9, 20) Frequent, goal directed training is therefore a prerequisite to achieve acceptable preparedness in all Norwegian hospitals. Training for MCIs results in improved skills, knowledge and attitudes,(21) and the outcome of an MCI is largely dependent on preparedness.(3)

Trauma team training is especially important in low volume centers and in our study almost 90% of the interviewed health care workers at NTCs had participated within the last 3 months. Fewer (68%) had participated in trauma team training at TCs probably reflecting that the frequency of trauma team training is not proportional to the number of staff. That the physician-based roles in the team training in TCs were mainly covered by residents might be attributed to the fact that they are more experienced compared to the interviewed residents at NTCs. However, senior staff should be present to supervise and interfere both during training and real situations to improve performance and outcomes.(22, 23) The interviewed nursing staff reported high levels of experience and competence both in NTCs and TCs. Their important role in the trauma team cannot be overestimated including their roles as continuity carriers.

Our study revealed that in the NTCs no consultant surgeons and less than 40% of the consultant anesthetists on call are in-house after normal working hours. Hence, simple and written guidelines to secure immediate notification and early presence of the consultants under ordinary trauma team activations as in a possible MCI situation should be mandatory.

An MCI plan is the core of a hospital's MCI preparedness.(4, 5, 24) Trauma care in the event of an MCI should be based on a trauma system's everyday practice.(1, 5, 20) MCI plans should be readily available and healthcare workers need to be familiar with their role and confident with their function during an MCI.

In our study over 95% were aware of the MCI plan but only 50% had read the plan within the last 6 months. One can argue that knowledge of the plan is enough. In our study, on the other hand, more than 25% were not sure whether they could fulfill their designated role during an MCI, possibly reflecting the lack of regular training. Moreover, only 54% of the interviewed personnel had ever participated in a hospital MCI exercise, possibly reflecting an ever-increasing demand for hospital effectiveness. However, Norwegian law mandates all hospitals to have an MCI plan, conduct exercises and train all relevant personnel.(25, 26) As full-scale MCI exercises and evacuating hospital units has an economic cost and might affect outcome in ordinary patients negatively, cheaper alternatives have to be sought. Although small scale exercises, such as tabletop triage training, are valuable options,(5, 27) in our study less than 25% reported such an experience. The need to evacuate the ED is a challenging task but described recently by Hojman and coworkers after the Boston marathon bombing.(28) Although only 14% had ever participated in an ED evacuation exercise in our study, preparation and training at OUH-U lead to a successful evacuation of the ED in 45 minutes during the twin terrorist attack in 2011.(6)

Limitations

This cross-sectional study was performed by telephone interviews of the on-call trauma team members. Team members were asked to respond to a predefined set of relevant questions (Table 1). This might lead to communication difficulties including unpredicted unclarities in some of the questions.(19, 29) A pilot test of the questionnaire might have reduced the uncertainty the interviewed personnel experienced. However, sufficient time was set aside for clarification if needed during the interviews.

Competence and experience among the personnel on call will vary in every hospital on a daily basis. The design of the study might lead to bias since it reflects the competence at a given time point. Performing interviews at two different time periods was done to reduce such effects.

Some of the questions were related to the respondents' memory of the last time different categories of exercises were performed. Since some exercises had more relevance to one personnel group than to others, that might influence the responses. The reported frequency of training is likely due to recall bias or simply describes the respondent's own participation in team training. Finally, self-assessment is subjective and introduces a bias per definition.

Conclusion

Despite increased focus on disaster preparedness at a national level after the 2011 attacks, we identified limited compliance with trauma system requirements concerning competency and training with reference to daily trauma care as well to MCI situations. Strict guidelines to secure immediate notification and early presence of consultants whenever a situation that might turn into an MCI occurs should be a prerequisite. The awareness and content of existing MCI plans should be continuously improved to be able to meet the challenges of future MCIs.

Declarations

- Ethical approval and consent to participate: The institutional Data Protection Officer at OUH had no objections to this study
- Consent for publication: Not applicable
- Availability of data and material: The datasets during and/or analysed during the current study is available from the corresponding author on reasonable request
- Competing interests: None reported
- Funding: None of the authors have any financial and personal relationships with other people or organizations that could inappropriately influence their work. There are no financial or non-financial competing interests
- Authors' contributions: All authors have made contributions to the design of the study, analysis and interpretation of data, and drafting and revising the manuscript. They have all given final approval of the version to be submitted and have given permission for their names to be included as co-authors
- Acknowledgements: Not applicable

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