

BRONX FIRE DISCUSSION: GROUP A

GROUP A/PART 1: PRE-HOSPITAL TO HOSPITAL COORDINATION AND NOTIFICATION

Official Notification & Agency Information Sharing (FDNY, NYCEM)

- **Level A** notifications were sent to hospitals early in the incident (first to two hospitals). One hour later, **Level B** notifications were sent. There was no routine change in operations of emergency departments (ED) until Level B notifications triggered activation of the emergency operations plan of the facilities first notified of the mass casualty incident (MCI). **Level C** notifications to additional hospitals happened still later in the incident. Several hospital personnel received notifications of the incident via their personal Citizen app.
 - Clarification: The difference in notification times was to be expected as the New York City Fire Department (FDNY) and Emergency Medical Services (EMS) escalated the incident from Level A to B to C as more patients were discovered on scene.
- New York City Office of Emergency Management (NYCEM) was notified of the incident through its Watch Command when the incident was a second alarm. NYCEM response unit went to the scene to coordinate with incident command. NYCEM initial outreach to hospitals was through the Emergency Management Network. NYCEM used limited messaging via Microsoft Teams, then continued to liaise with Watch Command responders on the scene.
- One hospital with a 24-hour communications center with a team that monitors citywide frequency from an EMS perspective was dialed into the event early on and notified its emergency management partners.
- The MCI was primarily a smoke-inhalation event. Cyanide antidote (hydroxocobalamin) was administered at the scene to red-tag patients (patients who require the most urgent treatment as they have suffered a life-threatening injury), which was helpful to the EDs.

Takeaway from Group A/Part 1

- Timely Level C notification: include messaging of incident specifics (location, type, potential patient counts)
- Timely Sit Stat notification: include location, type of event, updates
- Open-source apps (e.g., Citizen) were helpful in supplementing EMS field reporting to obtain situational awareness
- There is a need to receive Level C notifications as a radio call, as per protocol
- 10-60/Level C did not trigger a citywide radio notification to hospitals to prepare as per protocol. This appears to be due to miscommunication between FDNY and NYCEM.

GROUP A/PART 2: EMERGENCY DEPARTMENT & WHOLE-OF-HOSPITAL RESPONSE

Internal Activation & Notification (Hospitals)

- Internal hospital activation varied: One ED made calls internally after receiving notifications via Citizen app but did not activate the Hospital Incident Command System (HICS). One hospital ED didn't activate until it started receiving red-tag patients. One hospital ED activated the HICS as situational awareness evolved. Level C notification was received by this facility. No additional personnel were called in as it was believed that the additional personnel would have been disruptive to the ED operation at that time. Other hospital Eds activated the HICS virtually.
- One member of senior leadership was in the ED when notification of an MCI arrived via a phone call (secretary who received call did not know what an MCI was). Senior leadership of one hospital was notified by personnel in their network who received notification via the system's e-mail.
- One ED used a virtual command center approach between the administrator and offsite senior leadership.



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- One facility activated its internal and external disaster plan after being inundated with red-tag patients about 25 minutes into the event.

ED Activation

- After receiving notification by phone of an MCI, some EDs, with cooperation from other departments, cleared beds in the ED.
- Decanting of the emergency room was done by one ED that had 50 COVID-19-positive admissions in the department, some of whom were intubated. Some patients were sent to upper floors, and others were relocated out of critical areas when it was believed there would be a need for resuscitations. Bed space was created in the Isolation and Medical/Surgical units so the ED could accommodate 15 to 20 incoming patients.

Rest of Hospital Activation

- Additional staff at one transfer center was mobilized to take calls. No shortage of emergency staff was reported in any ED during the incident.
- Senior leadership at one health system (a Burn Center) notified the Patient Placement Operation Center to mobilize patients out of the Burn Unit anticipating it would be receiving critical burn victims. The health system paired up a nurse with an individual hospital, then connected the hospital to the Burn Unit.
- The Office of Chief Medical Examiner (OCME) responded directly to one of the hospitals and worked with decedents from a wing within that facility.
- Only one Hyperbaric Center operates 24/7 in New York City. The use of a 24/7 Hyperbaric Center during an incident of this magnitude, with so many casualties, requires assistance from additional personnel.

Interfacility Coordination

- One hospital that had previous arrangements within its health system in the event of an MCI used level loading to transfer a handful of patients.
- Pediatric and adult patients were transferred from varying hospital EDs to another hospital with a Hyperbaric Center. Pediatric and adult patients were transferred from varying EDs to Burn Centers in other hospitals.

Most Effective Aspect of Facility's Response

- Having available staff resources present in the ED or the ability to have them.
- Some hospital EDs reported cyanide antidote (hydroxocobalamin)—which was administered at the scene to red-tag patients—was in short supply in the ED or that stocks were depleted. FDNY provided hydroxocobalamin to EDs requiring a supply.
- Maintaining situational awareness by obtaining critical information via different sources such as Citizen app, etc.

Priority Areas for Improvement

- More designated Hyperbaric Centers that are operational 24/7
- Transfer center notifications, particularly to those with specialized beds and specialized resources like Hyperbaric Centers, require early notification. When a Level C notification is called, a radio notification should be sent to all hospitals.
- There is a critical need for OCME to have a private location when there are many decedents.
- How to provide a feedback loop to FDNY about ED capacity, particularly with walk-ins, so that FDNY can adjust patient transport decisions accordingly.