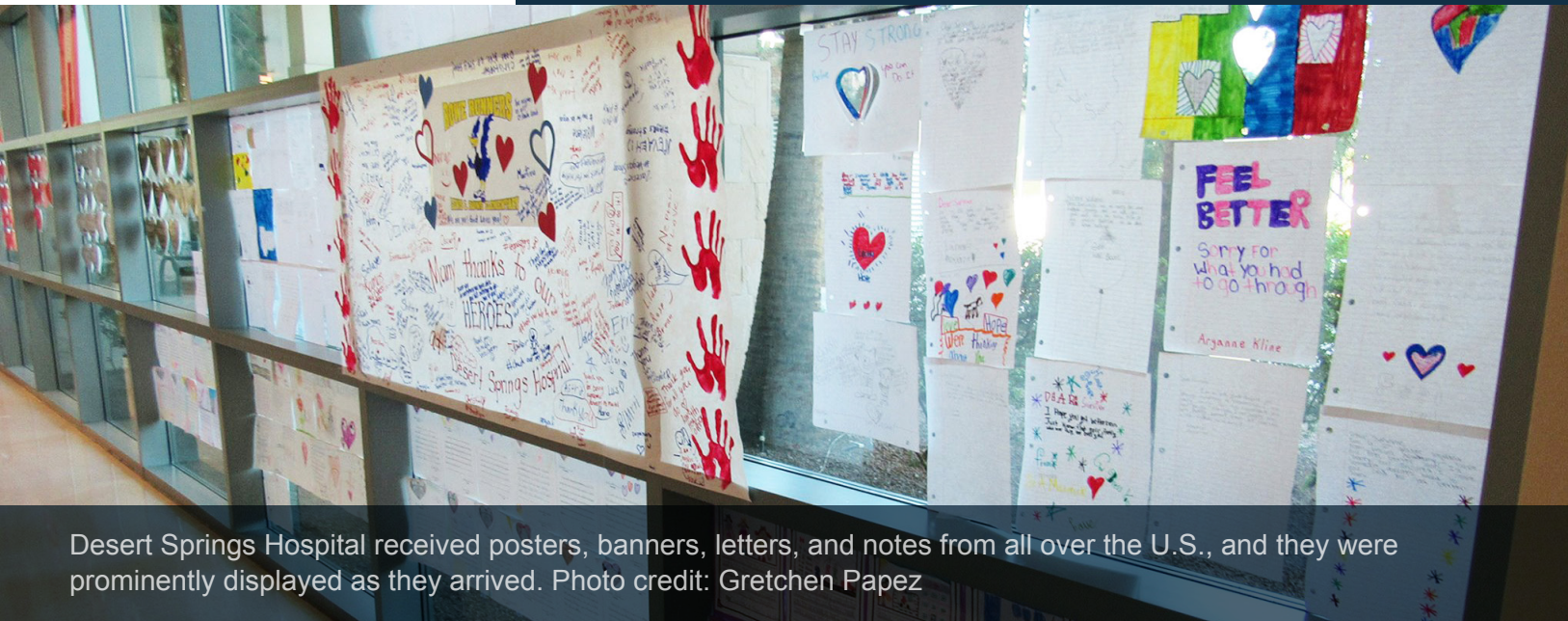




**TRACIE**  
HEALTHCARE EMERGENCY PREPAREDNESS  
INFORMATION GATEWAY

# THE ROLE OF NON-TRAUMA HOSPITALS IN NO-NOTICE INCIDENTS



Desert Springs Hospital received posters, banners, letters, and notes from all over the U.S., and they were prominently displayed as they arrived. Photo credit: Gretchen Papez

*Though they treat patients who arrive directly from the Las Vegas Strip, very few trauma cases are handled by the healthcare providers at Desert Springs Hospital Medical Center. That changed quickly on the night of October 1, 2017 when a surge of more than 100 patients with varying degrees of injuries appeared after the Harvest Festival mass shooting. ASPR TRACIE interviewed Dr. Don Reisch (former Emergency Department Medical Director and currently an emergency medicine physician on the medical staff), Ryan Jensen (Chief Executive Officer), Dr. Dan McBride (Chief Medical Officer of The Valley Health System), and Karen Donnahie (Emergency Room [ER] Registered Nurse [RN] and Emergency Preparedness Coordinator) to learn more about how non-trauma hospitals can prepare for similar mass casualty incidents.*  
(Originally published in 2018)

## ■ John Hick (JH)

**Please give us an overview of that night before the incident occurred, and your hospital in general.**

## ■ Don Reisch (DR)

Desert Springs Hospital is a 257-bed community hospital that typically sees about 149 patients in the emergency room (ER) on a Sunday; that number may increase or decrease depending upon what's happening on the Las Vegas Strip or elsewhere in town. The hospital focuses on cardiac and surgical services. If needed, we stabilize and transfer neurosurgery, OB/ GYN, and pediatric patients. A Level 2 trauma center is located about two miles away, and our community emergency medical services (EMS) protocols indicate all trauma patients must be transported to a trauma center.

The night of October 1, I found out about the incident from my son. His roommate was listening to the police radio and heard gunfire over the radio. He told my son, who called me, and I reported to the hospital within 30 minutes of the first shot being fired.

We already had two emergency medicine physicians and two Advanced Practice Providers (APPs) on duty. Another 29 providers arrived to support them.

As soon as I arrived, three nurses took me to see patients. I became the Medical Incident Commander, and focused on triaging patients,

directing their movement to appropriate areas or requesting transfers, and contacting more physicians.

We called in four operating room (OR) teams. We had a vascular surgeon, general surgeon, and orthopedic surgeon come in, and were able to operate the ORs simultaneously.

Four patients were dead on arrival to us, and five patients arrived with significant chest, abdominal, and closed head injuries and needed to be moved immediately. We had them transported to a Level 3 trauma center and sister hospitals that were not as inundated by the incident or had capabilities that we do not.

Desert Springs Hospital is part of The Valley Health System (VHS), a six-hospital system in Las Vegas. VHS operates its own transfer center, handling transfers to and from our own hospitals and to hospitals outside our system. They were extremely helpful. I could tell them, “I have two abdomens, two chests, and a head wound—what can you do?” and they arranged patient transfers to other facilities based upon their capabilities.

■ JH

**How many patients did you end up transferring, and how did the process go?**

■ DR

We transferred seven critically injured patients to other facilities because we didn't have the subspecialty surgeons available (i.e., neurosurgical, gynecological).

The second group of patients who were transferred had minimal injuries and may or may not have been seen or triaged in the waiting room. EMS arrived in their ambulances, went to the waiting room, triaged and pulled 2-3 patients each, and transferred them to hospitals that had providers standing by.

I also learned about a new resource we have in Las Vegas, an ambulance bus (AMBUS), that could hold multiple patients, and we used that to transfer out the less serious patients, too.

■ JH

**How did patients arrive to the hospital?**

■ DR

People either self-evacuated or arrived by car.

■ Ryan Jensen (RJ)

We even had a city bus drop off patients at our main entrance.

■ Karen Donnahie (KD)

Of the over 100 patients that came to Desert Springs, only 11 came by ambulance.

Check out this ASPR TRACIE tip sheet on the [Emergency Medical Treatment and Labor Act \(EMTALA\) and Disasters](#).

■ JH

**How long did it take you to activate your disaster plan?**

■ RJ

The official time we called our disaster code was 2318. I came in around the same time. Our Incident Command Center is located on the other side of the hospital, so we had a mobile command center and met in the ER breakroom on a regular basis for incident updates and to discuss pressing needs.

■ JH

**Were any activations or notifications made or codes called?**

■ KD

We initially called a Code Lockdown shortly after the first patient with a gunshot wound (GSW) appeared. This means Security locks down all hospital entrances except the ER; this is a standard safety procedure when a patient with a GSW or knife wound arrives at our ER by private vehicle.

■ RJ

Phone trees were activated, leadership was texted, and as staff heard about it on social media, the news or through coworkers, they just came in to help, even if they weren't called or scheduled.

■ JH

**This poses particular challenges for staff in the ER— you've got a lot of patients coming in who need triage, and at the same time, you're prioritizing who needs surgery versus who needs to be transferred— how did you go about making these decisions?**

■ DR

We don't see GSW patients unless they walk in, but when we do, we typically throw all our resources to stabilize and transfer them to a trauma center. On October 1, we had four people arrive DOA. We had to redirect our resources to all the survivors.



Dr. Reich is interviewed by the media. Photo credit: Gretchen Papez

Our other challenge was triage. With so many walk-in patients, we had to look at everyone as quickly as possible. For me, one of the hardest things was moving patients into either critical or non-critical areas. We did rounds and talked to every patient in the hospital. We found some who had gotten lost, and some who were stoic or were losing consciousness. We didn't know how seriously they had been injured until we spoke with them and re-triaged them. We admitted 19, and 11 of those were critical. They were admitted to either ICU or a medical/surgical unit.

■ JH

**How many patients did you send to an OR that night?**

■ DR

Three. Other patients had orthopedic injuries and we could safely wait on them until the next day.

■ JH

**How did you track patients in the ER? Did you have any challenges?**

■ DR

Our greatest challenge was handling the volume, and we didn't have trauma tags immediately available in the ER. We now have paperwork with pre-registered Cerner numbers so when we need to, we can pull the paperwork and the records will work with our electronic medical record (EMR) system.

■ JH

**Did you have any issues with supplies in the ER or OR?**

■ RJ

We are a "just-in-time" facility. We receive supplies daily, and we're looking at updating this in our facility master plan right now. Because of the volume and types of injuries, we didn't have some of the necessary trauma supplies on hand. However, we were able to call other hospitals in our system for additional supplies (e.g., bandages, gauze, and chest tubes).

■ KD

When we ran low on lidocaine, we switched to marcaine. It was easier for us to replenish supplies because of our sister hospitals.

■ JH

**What other lessons from the ED would you like to share with our readers?**

■ KD

In the future, providers will have a bundle of colored armbands they can snap onto patients to indicate who had been seen and by whom.

After the incident, a reporter asked me what the "typical" injury was for this event. After the Boston Marathon bombing, for example, the "typical" injury was perforated eardrums. In this case, patients had a lot of bullet shrapnel injuries because the attacker was shooting from so high. The bullets shattered when they hit the pavement and ricocheted before hitting people.

*Don Reisch, MD, former  
Emergency Department  
Medical Director (current  
emergency medicine  
physician)*

## ■ DR

During disaster preparedness training, you have an opportunity to connect with key partners in your community, like the fire departments, county management, city management, police and EMS. A key takeaway is that everyone remembers to ask one another: “What can we do to help you right now?” That night, I needed someone to send me empty ambulances that could transport patients to other facilities. That’s when I learned about the AMBUS.

Having the transfer center was so helpful. When you have an Incident Command center, one of the actions is call around quickly to determine where we can start sending patients. A good question to ask is “do we have the infrastructure in place to quickly transfer multiple people, and if so, who is going to handle?”

## ■ JH

**Karen, tell us more about your role and how you think events went from a systems standpoint.**

## ■ KD

I am the Emergency Preparedness Coordinator for Desert Springs Hospital and Henderson Hospital. The entire staff of Desert Springs Hospital, from the housekeepers to the IT Director, to the CEO, to security guards, were beyond phenomenal. In our debriefing, we identified some important communication opportunities. For example, staff came in, but didn’t tell anyone they were there. Some staff were hurt that they weren’t called in, but we explained that we needed people who were fresh and ready to take over at 7 a.m. instead of being physically and emotionally exhausted. We also focused on re-educating our staff on using the county-wide triage system.

## ■ JH

**Was the response a challenge for your OR staff?**

## ■ RJ

While we aren’t a designated trauma center, we have a very strong open heart program, along with orthopedic and general surgery. The physicians were available, and we had multiple OR teams running that night. I think the OR teams and surgeons did a great job.

## ■ JH

Let’s talk about any issues you might have had with communication—internally and with the media.

## ■ KD

On the night of the event, I issued two-way radios to all physicians and myself, but no one used them for anything. We’d like to increase staff familiarity with using the radio—they work well throughout the hospital. Another communications challenge involved our cell service going down for a period of time. Everyone was trying to communicate with their loved ones and it was difficult to make outgoing calls.

■ RJ

People looking for loved ones was a challenge until the community-wide Missing Persons number was set up. Our main switchboard was overwhelmed. Fortunately, our operators could check if a person was at any of our six hospitals. Our social media channels were also overwhelmed. UHS (our parent company) assigned remote staff to answer questions that came in via social media and post updated information.

Our public relations and media director (Gretchen Papez) and the marketing team worked with the media and took the calls. I would say a lot of the public relations efforts really occurred Monday through Thursday since the incident occurred Sunday night.

■ JH

**From a Hospital Command Center and administrative standpoint, what were the primary roles of the CEO and CMO? Were they more command or support in nature?**

■ RJ

When I arrived, the hospital looked like a MASH (Mobile Army Surgical Hospital) unit. I let the staff continue doing the great job they were doing. I spent a lot of time with law enforcement and families of the four deceased victims that came in, making sure they had what they needed, including a place where they could have some peace and quiet and wait for additional family members to arrive. I also tried to provide support to staff wherever I could.

■ JH

**The next day, what pieces did you have to put together?**

■ RJ

First, everyone needed some rest. I went home, hoping to get at least 2 hours of sleep. I'm from NJ originally, so the news was breaking there as soon as I got home. I got a lot of calls and texts from my contacts on the east coast.



"Comfort Dogs" consoled Desert Springs Hospital patients, visitors, and staff. Photo credit: Gretchen Papez

Organizing all of these resources that people were so willing to give was amazing, but also time consuming.

*Ryan Jensen, CEO*

I live about 30 minutes away from the hospital. By the time I returned to work (about two hours after I went home), most of the ER had been cleared; I was amazed. Staff did a great job cleaning up and getting patients up to their rooms.

My next steps were finding out how our critical patients were doing, meeting with media, and updating family members. I spent a lot of time over the next two weeks with critical patients' loved ones.

We also began receiving tons of donations and worked to manage the kindness and graciousness of the people of Las Vegas. People brought our staff food, donated food trucks for family members. The Veterans Administration sent mental health professionals. Organizing all of these resources that people were so willing to give was amazing, but also time consuming.

### ■ Dan McBride (DM)

Once I became aware of the event, I immediately visited each of the hospitals, starting with Spring Valley Hospital. One thing that was remarkable to me was how quiet things were at seven in the morning. CEOs, CNOs, and administrative staff did a fantastic job supporting and taking care of family members and loved ones over the next two weeks. Valley Hospital had a number of patients in the ICU who were critically injured. The destruction caused by these high-caliber bullets was far greater than a typical gunshot wound. When the bullets struck bone, they shattered it; rather than a single GSW and its trajectory, you'd have a scattering of bullet fragments. Several patients had shrapnel-related injuries that became more apparent in the following days. One patient had an unrecognized lung injury—she was shot in the liver, but the bullet ricocheted into her lung. She went into respiratory distress, and the lung injury became apparent several days later. Another patient was shot in the lower pelvic area and that bullet shattered. It became apparent a couple of days later that the shrapnel also caused an injury to his rectum.

The response from the surgical team was truly remarkable. Many had not performed trauma surgery for some time—these are very well-trained general surgeons who came in voluntarily. The rest of the staff, who worked with families and dealt with media attention and inquiries over the next couple of weeks, displayed remarkable stamina and made a great effort.

Dr. Jeff Davidson, the ER Medical Director at Valley Hospital, works closely with EMS. He made a number of personal calls to surgeons with certain specialties to perform surgeries on patients with iliac artery injuries, facial wounds, and a through-and-through GSW involving both lungs.

I've never been through something like this, and the coordination was something to see. This includes all of the facilities involved—the response was truly amazing.

### ■ JH

**Do you have any recommendations for facilities of your type/size?**

## ■ KD

Continued training is essential. We also have to prepare for things that are beyond our imagination. The biggest thing that happened from October 1 is a paradigm shift. In all of our professional mass casualty incident (MCI) trainings, we've been told that EMS will evenly distribute patients, they will all come via ambulance, in a neat package, with clearly marked triage tags.

On October 1, we learned that Siri, Google maps, and Uber came before EMS. People will not wait patiently on the green tarp, so hospitals—regardless of their location and size—need to be prepared for a medical surge event.

## ■ DM

Continued resources need to be placed throughout the community – maybe additional Level 3 trauma centers. We might not know where the next MCI will take place, but we want to have a greater level of training for all of our nursing, ED, support staff, surgeons, and administration. We need to explain to others the importance of preparing hospitals for things that may happen in the future. We need to maintain that level of training and broaden it to the medical community.

## ■ KD

At Desert Springs Hospital, we now have full-time ED staff attending the Trauma Nursing Core Course (TNCC). Even though we aren't a trauma center, we will be trained at this level. Education makes all the difference in the world.

People go where they know,  
or where their phone tells  
them they should go.

*Karen Donnahie, RN,  
Emergency Preparedness  
Coordinator*