



“A bus just went off the road!”



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Dealing with a disaster

You are the doctor on weekend call for a small community hospital. Your pager suddenly goes off; it is emergency medical services dispatch calling to inform you that a bus has just rolled into a ditch at highway speed about 15 kilometres from your hospital. There are reports of numerous casualties lying around the bus, as well as others still trapped inside.

Read on for what to do...

Questions & Answers

1. *What is the first thing that I should do?*

Mass-casualty incidents involve a volume of medical or surgical casualties that will overwhelm your hospital's usual resources. The first thing you should do is to get as many details as possible from the emergency medical services (EMS) dispatch, such as:

- How many casualties are there?
- What type of injuries (*i.e.*, burns vs. blunt trauma)?
- Are they contaminated with diesel or any other hazardous material?
- What is the estimated time of arrival of the first casualties at your hospital?
- Have they notified the regional and provincial disaster management organizations?
- Before you let the dispatcher off the line, get their name and phone number

Your next action should be to immediately page the duty administrator on call for your hospital or district. Tell them what you know, and ask them to declare a disaster (frequently referred to as a “Code Orange”) and to activate the disaster plan.

2. *What do I do when I arrive at the hospital?*

You need to take on the role of leader until reinforcements arrive. Delegate responsibilities as clearly as possible, since it is much more efficient for subsequent tasks to proceed in parallel, not in series.

- Identify an experienced nurse as the Triage nurse: their responsibility is to be there when the first

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Take-home message

Disasters are very stressful, but also bring out the best in staff and physicians. With some basic organization and an understanding of the necessary roles and requirements, everyone's natural inclination to pitch in and help can make a disaster a surprisingly positive experience in the life of your ED.

- ambulance arrives (which could occur at any time)
- Call the hospital operator to ensure staff are being called in
- Identify where patient treatment will occur. This often means expanding into non-traditional areas (*i.e.*, outpatient clinics and waiting areas). Have someone gather supplies (IV sets, suture kits, dressings—there is often a special “disaster cart”) and place them where patient care will occur. You may want to identify separate “major” (“reds” and “yellows”) and “minor” (“greens”) treatment areas
- Clear as many emergency and inpatient beds as possible for the expected casualties. This involves taking a census of the current patients and identifying those who can be discharged or immediately transferred. Clear the waiting room of any patient willing to return later
- Delegate someone to gather and organize staff who have been called in
- Task security with controlling vehicular access to the ED so that cars do not prevent ambulances from efficiently dropping casualties off and going back to the scene. Likewise, they should control the access of family members to the patient care areas. Most hospitals institute a “lock down” as part of their disaster plan

3. *What do I do once the casualties start coming through the door?*

As other physicians arrive to help, assign them to attend to “major” or “minor” treatment areas. As long as you are the overall clinical leader, you should try to remain free from individual patient care so that you can direct medical and support staff, solve logistic problems, anticipate bottlenecks and continually re-evaluate your current situation.

The Triage nurse should rapidly (*i.e.*, about thirty seconds) evaluate each casualty based on their respirations, pulse and whether they are able to follow commands. “Reds” typically need intubation, significant volume resuscitation and often surgery. “Yellows” are non-ambulatory and have significant, possibly life-

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threatening injuries, but are currently stable. “Greens” may have fractures, large lacerations and other significant injuries, but if they can walk and talk, they can sit in chairs and wait until there are no more “reds” or “yellows” to be seen.


Following their ED evaluation and treatment, patients should be moved from their ED bed as soon as you have reached a disposition decision (either the operating room, ICU, medical or surgical inpatient ward, or transfer for definitive care elsewhere). This may mean temporarily parking them in a hallway.

Anticipate that the large majority of walk-ins to your ED will be anxious and worried, but may not have any real medical problems. These patients can be screened out with a brief history and by assessing their vital signs and re-evaluated more thoroughly once all non-ambulatory casualties have been transported from the field scene.

Family members will quickly fill the ED and other waiting areas; they need to be directed by security to an area distant from the patient care areas (often in a separate but nearby building) while information is obtained about their loved ones. Failure to anticipate this can shut down your ED due to the overwhelming crowd and can prevent legitimate ambulatory patients from reaching the normal triage desk.

4. *What support do I have?*

A lot of resources will suddenly appear during disasters that are not normally available:

- Nearby hospitals will likely be not as busy and can send staff and supplies, both of which you might run out of otherwise. The EMS communication centre can also direct casualties to other EDs
- Your hospital, the regional trauma centre, the municipality and likely the province will all set up Emergency Operating Centres (EOCs) during a disaster. Each EOC consists of senior decision-makers who have the authority (and the credit cards) to make things happen quickly. Recognize when you are up against a resource or logistical issue and call on your EOC to resolve it for you
- Within 48 hours of the end of the disaster response, your hospital should provide a “debrief” as well as initiating stress counselling for any staff or physicians who were traumatized by their experience 

OMNARIS is indicated for the treatment of seasonal allergic rhinitis, including hayfever, and perennial allergic rhinitis in adults and adolescents 12 years of age and older.

OMNARIS is contraindicated in patients with a hypersensitivity to any of the ingredients. OMNARIS should be used with caution, if at all, in patients with active or quiescent tuberculosis infections of the respiratory tract.

The most common adverse reactions with OMNARIS reported in short-term clinical trials of SAR and PAR in patients 12 years of age and older were epistaxis (2.7% vs. 2.1% placebo), nasal passage irritation (2.4% vs. 2.2% placebo) and headache (1.3% vs. 0.7% placebo).

The most common adverse reactions with OMNARIS reported in a 52-week clinical trial of PAR in patients 12 years of age and older were epistaxis (8.4% vs. 6.3% placebo), nasal passage irritation (4.3% vs. 3.6% placebo) and headache (1.6% vs. 0.5% placebo).

OMNARIS should be used with caution, if at all, in patients with untreated local or systemic fungal or bacterial infections; systemic viral or parasitic infections; or ocular herpes simplex. Patients who are on drugs that suppress the immune system are more susceptible to infections than healthy individuals. Because of the inhibitory effect of corticosteroids on wound healing, patients who have experienced recent nasal septal ulcers, nasal surgery, or nasal trauma should not use a nasal corticosteroid until healing has occurred. Rarely, immediate hypersensitivity reactions or contact dermatitis may occur after the administration of intranasal corticosteroids. Rare instances of wheezing, nasal septum perforation, cataracts, glaucoma, and increased intraocular pressure have been reported following the intranasal application of corticosteroids. To minimize the systemic effects of intranasal corticosteroids each patient should be titrated to his/her lowest effective dose. In patients who have asthma or other clinical conditions requiring long-term systemic corticosteroid treatment, rapid decreases in systemic corticosteroid dosages may cause severe exacerbation of their symptoms. There are no adequate studies with OMNARIS in pregnant women. It is unknown if ciclesonide is excreted in human milk.

Product monograph available upon request.

*Mean change in average reflective AM and PM total nasal symptom score: after 2 weeks in SAR – OMNARIS -2.40 vs. -1.50 placebo, $p < 0.001$; after 6 weeks in PAR – OMNARIS -2.51 vs. -1.89 placebo, $p < 0.001$.