Southwest Emergency Preparedness Team (SWEPT)

Full Scale Exercise

Operation: Team Spirit

After-Action Report / Improvement Plan 2014

June 30, 2014

Exercise or Incident Name	Operation: Team Spirit
Exercise or Incident Dates	May 29-May 30, 2014
Scope	This exercise/incident is a full scale exercise at Jackpot Junction Conference Center, Morton, MN. This exercise play / incident response evaluation is limited to medical surge and fatality management in a field environment.
Mission Area(s)	Response
Capabilities	• Emergency Operations Coordination • Medical Surge • Fatality Management • Information Sharing • Volunteer Management
Objectives	1. *Incident Command System (ICS)/Unified Command* Evaluate the on-site decision-making process, the capability to implement the ICS, coordination and integration of EMS Strike Teams (MNAST) and Mobile Medical Teams (MMTs) into the ICS structure, and the effective transition to a Unified Command in response to an explosion resulting in mass casualties and fatalities. ● Continue to practice assigning team resources to various medical care areas. ● Assure command and control decisions are consistent with National Incident Management System guidance. 2. *Medical Surge* Evaluate the ability to establish multiple mobile healthcare clinical treatment areas to receive and appropriately treat incident-specific casualties. Assess the ability to activate alternate medical surge plans, procedures, and protocols, to ensure medical treatment for patients requiring the specialized assistance when the community health care system is impacted.

	• Continue assessing clinical training needs for healthcare personnel drawn from private sectors to work as a team in each care area. • Establish and evaluate clinical team structures with liaison to EMS Strike teams. Evaluate patient collection, flow, and treatment decisions between Clinic, Triage, ACS and MCI buses ,SimLab, and Behavioral Health care areas. • Continue testing use of medical records (patient encounter) forms within and between each care area. 3. *Information Sharing/Communication* Assess the ability to establish and maintain multi-disciplinary communications network and flow throughout all aspects of patient evacuation and care during a response to an explosion incident resulting in mass casualty/mass fatalities, when the community health care system is impacted. Evaluate scene communication of resource needs, transport requests, and patient movement between various care areas. 4. *Mass Fatality* Demonstrate the ability to effectively manage decedents in excess of community morgue capacity.
Threat or Hazard	Natural gas explosion
Scenario or Incident Description	Natural gas explosion at local community hospital, impacting the entire hospital operational capability.
Sponsor	**Southwest Emergency Preparedness Team (SWEPT), using HSPP grant dollars.**
Participating Organizations	See Appendix B.
Point of Contact	Cathy Hockert, Exercise Director. 320-760-1954. cathy@disasterexperts.org

EXERCISE / INCIDENT SUMMARY

In the face of a disaster, the entire community is impacted. This impact can be readily felt especially in rural communities where resources to respond are limited. The destruction of the community's hospital can add to the stress upon other community medical providers and first responders. Providing field health and medical resources to replace the destroyed hospital's ability to care for victims and other medical needs is complex and requires significant coordination. In addition, managing fatalities in a small community can be extremely difficult without external support.

The success is dependent on the effectiveness of procedures, communications, relationships, community emergency responders and cooperation/coordination with all responding partners and assets. The focus of this particular exercise was to evaluate the operations of an austere field medical system that has been set up to provide care to the community that has been impacted. Participants were evaluated on emergency reporting activity, communications, patient tracking, and influx/surge coordination among care areas.

The full scale exercise provided an excellent opportunity to engage the participation of every member of the 16 county Southwest Minnesota region. The participants were able to see the results of the extensive planning, education, training, and data collection.

Every successful exercise identifies areas for improvement; this exercise was no exception. This After Action Report (AAR) is designed to analyze exercise results, identify strengths to be maintained and built upon, identify potential areas for further improvement, and support the development of corrective actions.

The exercise was conducted in three rounds, each approximately 75 minutes. Evaluators were placed in each of the care areas, and two evaluators roamed throughout the entire system. Role players/victims were asked to provide evaluation and feedback on their experience as they were sent to various care areas for treatment/assistance.

ANALYSIS OF CAPABILITIES

Aligning exercise objectives and capabilities provides a consistent taxonomy for evaluation that transcends individual exercises to support preparedness reporting and trend analysis. Table 1 includes the exercise objectives, aligned capabilities, and performance ratings for each capability as observed during the exercise and determined by the evaluation team.

Table 1 Summary of Capability Performance

The following sections provide an overview of the performance related to each exercise or incident objective and the associated HPP, PHEP, or Core Capability, highlighting strengths and areas for improvement.

Objective	Capability	Performed without Challenges (P)	Performed with Some Challenges (S)	Performed with Major Challenges (M)	Unable to be Performed (U)
Evaluate the on-site decision-making process, the capability to implement the ICS, coordination and integration of EMS Strike Teams (MNAST) and Mobile Medical Teams (MMTs) into the ICS structure, and the effective transition to a Unified Command in response to an explosion resulting in mass casualties and fatalities.	EOC Coordination		S		
Evaluate the ability to establish multiple mobile healthcare clinical treatment areas to receive and appropriately treat incident-specific casualties. Assess the ability to activate	Medical Surge		S		

Objective	Capability	Performed without Challenges (P)	Performed with Some Challenges (S)	Performed with Major Challenges (M)	Unable to be Performed (U)
alternate medical surge plans, procedures, and protocols, to ensure medical treatment for patients requiring the specialized assistance when the community health care system is impacted.					
Assess the ability to establish and maintain multi-disciplinary communications network and flow throughout all aspects of patient evacuation and care during a response to an explosion incident resulting in mass casualty/mass fatalities, when the community health care system is impacted. Evaluate scene communication of resource needs, transport requests, and patient movement between various care areas.	Information Sharing		S		

Objective	Capability	Performed without Challenges (P)	Performed with Some Challenges (S)	Performed with Major Challenges (M)	Unable to be Performed (U)

Ratings Definitions:

- Performed without Challenges (P): The targets and critical tasks associated with the capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws.
- Performed with Some Challenges (S): The targets and critical tasks associated with the capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws. However, opportunities to enhance effectiveness and/or efficiency were identified.
- Performed with Major Challenges (M): The targets and critical tasks associated with the capability were completed in a manner that achieved the objective(s), but some or all of the following were observed: demonstrated performance had a negative impact on the performance of other activities; contributed to additional health and/or safety risks for the public or for emergency workers; and/or was not conducted in accordance with applicable plans, policies, procedures, regulations, and laws.
- Unable to be Performed (U): The targets and critical tasks associated with the capability were not performed in a manner that achieved the objective(s).

Capability 1 Emergency Operations Center Coordination

Objective 1: Evaluate the on-site decision-making process, the capability to implement the ICS, coordination and integration of EMS Strike Teams (MNAST) and Mobile Medical Teams (MMTs) into the ICS structure, and the effective transition to a Unified Command in response to an explosion resulting in mass casualties and fatalities.

Gap Addressed: Gas explosion hazards are a higher hazard ranked within the SW region of Minnesota. The ability to respond to such an event that incapacitates a rural community hospital and overwhelms the local morgue has been addressed in previous exercises. This is the last of the series in dealing with mass casualty/mass fatality response in SW Minnesota.

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Strengths

The partial capability level can be attributed to the following strengths:

Strength 1: Because this is the 3rd exercise in the series that SWEPT has conducted, discussions have taken place around incident command roles and integration of medial resources into the local IC structure. In addition, this is the 4th exercise the state has been involved with similar in response actions and scope--each time the ICS structure is practiced, more is learned. This has helped to clarify how a response structure might function for this type of response.

Strength 2: MMT and Strike Team Leaders understood their role within their care areas.

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: It took a while for the ICS Structure to be pulled together based on the assets available for this response.

Reference: Previous exercises such as Operation Full DECC, and Operation Sandbox

Analysis: The ICS Structure that was practiced in the past exercises was not readily available to the current Incident Commander and Staff.

Capability 2 Medical Surge

Objective 1: Evaluate the ability to establish multiple mobile healthcare clinical treatment areas to receive and appropriately treat incident-specific casualties. Assess the ability to activate alternate medical surge plans, procedures, and protocols, to ensure medical treatment for patients requiring the specialized assistance when the community health care system is impacted.

Gap Addressed: Medical surge and the ability for a local community to respond has been discussed for the last 3 exercises in the SWEPT region, as well as for the state of Minnesota. This exercise continued to explore the strengths and gaps for this capability.

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Strengths

The partial capability level can be attributed to the following strengths:

Strength 1: The simulated clinic was the first of it's kind for an exercise relating to medical surge in a rural community. This provided the opportunity for clinical personnel who normally don't get to participate in exercises, to take on an active role in responding to a surge of patients/walking wounded.

Strength 2: Each time the field medical system is set up and operationalized during an exercise, the teams continue to refine their techniques and understanding of coordination with all care areas.

Strength 3: There was an active engagement and participation from many disciplines within the SWEPT region, including clinical staff, funeral services, behavioral health professionals, and physicians.

Strength 4: The exercise provided the participants a sound foundation in which to evaluate their actions and thought process to prepare for an influx of patients/surge within a field medical system.

Strength 5: Participants utilized patient tracking sheets, and communication channels to transmit patient information and notification of the safe acceptance of patients. All of the mock patients were able to be tracked and found when requested.

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: It took a while for clinical teams to find their "battle rhythm"

Reference: N/A

Analysis: Not all clinic personnel were familiar with Incident Command, nor were they accustomed to working with unfamiliar staff.

Area for Improvement 2: Patient tracking form utilized for event was not integrated/standardized for use by all potential responding medical providers/mobile medical system.

Reference: N/A

Analysis: Although a draft tracking form was utilized for this event, there were missing elements on the form that would be helpful for all care areas to complete as needed. However, this was the first full scale exercise incorporating a simulated clinic using field patient tracking forms.

Area for Improvement 3: Behavioral Health Team members from Local Public Health were unsure of their specific roles and responsibilities and felt overwhelmed at times, especially caring for the type of patients that were seen in this care area.

Reference: N/A

Analysis: Most Public Health professionals are trained to provide basic psychological first aid and some of the patients seen in the behavioral health center needed more in depth behavioral health assistance.

Capability 3 Information Sharing

Objective 1: Assess the ability to establish and maintain multi-disciplinary communications network and flow throughout all aspects of patient evacuation and care during a response to an explosion incident resulting in mass casualty/mass fatalities, when the community health care system is impacted. Evaluate scene communication of resource needs, transport requests, and patient movement between various care areas.

Gap Addressed:

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Strengths

The partial capability level can be attributed to the following strengths:

Strength 1: The use of 800 MHz system for all care areas and Command was essential for sharing of patient and response information.

Strength 2: Each time the field medical system is set up and operationalized during an exercise, the communication plan continues to be refined.

Strength 3: Although the Mass Fatality Disaster Portable Morgue Unit did not receive "victims" from the exercise, they did provide excellent information and hands on experience to those participating in that area on processing decedents and information necessary for that part of a response/recovery operation.

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: During the exercise, it was noted that communication challenges existed between the care areas. This included the process of notifications of patient movement (simulated transfer or transit by EMS) from one care area to another. There were care areas that had patients arrive at their area and had no notification that they were leaving the previous care areas. Additionally, there was confusion over who was making the notifications that the mock patients were "en-route".

Reference: Operation Sandbox

Analysis: Strike Team Leads were not always assigned as the dedicated communication link.

Capability 4 Volunteer Management

Although this was not a formal capability measured by the HSPP grant, it was a capability measured by Local Public Health and Tribal partners within the SWEPT region for their PHEP grant. Information below lists their objectives and results are attached at the end of this report:

Objectives:

79% of the registered MRC volunteers in the SW region will review, updated, and complete their profile within the MN Responds System by May 25, 2014.

100% of the MRC units in the SW Region will test the Mn Responds System by calling up registered volunteers by May 28, 2014.

Agencies participating included: Countryside Public Health, SWHHS, Nobles County Public Health, Kandiyohi-Renville Public Health, Cottonwood-Jackson Public Health, Upper Sioux and Lower Sioux Tribal Communities.

Health Coalition partners included Lower Sioux Community in the planning process. The Lower Sioux Community was instrumental in obtaining the Midewakanton Communications unit to add to the many assets deployed for this exercise.

Upper and Lower Sioux Community members participated in the trainings/meetings that were held in January/February prior to the Full Scale Exercise.

During the two-day event, Upper and Lower Sioux Community members participated in the educational sessions and the full scale exercise, as players. The exercise helped identify what their role and/or responsibility may be during a mass casualty/mass fatality event within the counties they reside.

MRC call-up

At this time Upper Sioux and Lower Sioux Communities do not have MRC Units. However, both Tribes have MN Responds member accounts which enables them to participate in the MRC call down exercise. In the coming months, both communities will be looking at ways to enhance volunteer management within their communities.

Other agency results, see Appendix C: AAR/IP for Local Public Health

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APPENDIX A: IMPROVEMENT PLAN

This Improvement Plan (IP) has been developed for Southwest Emergency Preparedness Team as a result of Operation Team Spirit occurring on May 28-30, 2014.

Capability	Issue/Area for Improvement	Corrective Action	Capability Element[1]	Primary Responsible Organization	Organization Point of Contact	Start Date	Completion Date
Capability 1: Emergency Operations Center Coordination	1.1 It took a while for the ICS Structure to be pulled together based on the assets available for this response.	1.1.1 Provide Function Specific Incident Command Training for Medical Surge events having multiple assets responding. 1.1.2 For any incident, an Incident Action Plan (IAP) should be developed at the onset. An IAP is an oral or written plan that contains general objectives that identify a strategy for managing an incident within an operational period	T T				
Capability 2: Medical Surge	2.1. It took a while for clinical teams to find their "battle rhythm"	2.1.1 Continue to include and engage clinical staff in training and exercises.	T, E				
	2.2. Patient tracking form utilized for event should be more integrated/standardized for use in any event and	2.2.1 Consider workgroup to create standardized patient tracking form, or enhance current form to include the elements missing for clinical	P				

[1] Capability Elements are : Planning, Organization, Equipment, Training or Exercise

	by all potential responding medical providers/mobile medical system throughout the State of MN.	involvement.					
	2.3. Behavioral Health Team members from Local Public Health were unsure of their specific roles and responsibilities and felt overwhelmed at times, especially caring for the type of patients that were seen in this care area.	2.3.1 If Local Public Health is to be utilized for a BH response with patients needing more assistance, they should be provided with more in depth education/training, or working with a BH lead that can assist them, or having the patients triaged to ascertain those who are requiring more BH assistance than basic Psychological First Aid.	T				
Capability 3: Information Sharing	3.1. Communication challenges existed between the care areas. This included the process of notifications of patient movement (simulated transfer or transit by EMS) from one care area to another. There were care areas that had patients arrive at their area and had no notification that they were leaving the previous care areas.	3.1.1 There was minimal initial communication between the care areas and dispatch/transportation. There needs to be a better process for quick, efficient communication, specifically in the beginning of the incident. The Strike Team Leads/Transport Leads from all care areas should have a direct line of communication established together at the beginning of the incident and establish regular briefing	P, T				

	Additionally, there was confusion over who was making the notifications that the mock patients were “en-route”.	periods.					

Draft After Action Report submitted by: Name_____Cathy Hockert_____ Date_June 30, 2014_____

AAR/IP approved by designated agency representative: Name_____ Date_____

APPENDIX B: EXERCISE PARTICIPANTS

Participating Organization	Type of Organization
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APPENDIX C: LOCAL PUBLIC HEALTH AAR/IP