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# Burn Surge Annex
# Tabletop Exercise
# TEMPLATE

## Situation Manual

Template developed by: ASPR TRACIE

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

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# PREFACE

This Burn Surge Annex Tabletop Exercise (TTX) Toolkit Template has been developed by the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE). It can be used by healthcare coalitions (HCCs) to enhance operational area awareness and capabilities in order to effectively address the needs of burn patients as part of a whole community emergency response framework. It can also be utilized to satisfy Funding Opportunity Announcement (FOA) requirements for the Hospital Preparedness Program (HPP) Cooperative Agreement.

HCCs are not required to use this template and may conduct a burn surge annex exercise using any acceptable Homeland Security Exercise and Evaluation Program (HSEEP) compliant format.

This template is intended to be edited and modified by the HCC Exercise Planning Team to satisfy the concepts and objectives each HCC intends to test. Blue text boxes and bracketed sections are included throughout the document and serve as notes to planners and prompts to enter your own text. Please delete those boxes and bracketed areas once final planning decisions are made and text has been crafted.

The complete toolkit template includes the following supporting materials for conducting a Burn Surge Annex TTX:

1. Step-by-Step Guide to Implementing the Burn Surge Annex Tabletop Exercise Template (compliant PDF, DOC)
2. Situation Manual (this document) (compliant PDF, DOC)
3. Burn Surge Annex Tabletop Exercise Presentation (compliant PDF, PowerPoint)
4. Participant Feedback Form (compliant PDF, DOC)
5. Sign-in Form (compliant PDF, DOC)

ASPR TRACIE developed a HCC Burn Surge Annex Template and has many additional resources for HCCs and burn mass casualty planners. For more information, visit www.asprtracie.hhs.gov or contact our Assistance Center at 1-844-5-TRACIE or askasprtracie@hhs.gov.

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# HANDLING INSTRUCTIONS

1. The title of this document is *Burn Surge Annex Tabletop Exercise (TTX) Situation Manual (SitMan).*
2. This template is a publicly available document, however once downloaded and completed by any jurisdiction, this document is FOR OFFICIAL USE ONLY (FOUO). It contains information that may be exempt from public release under the Freedom of Information Act (5 U.S.G. 552) and State and local statutes. It is to be controlled, stored, handled, transmitted, distributed, and disposed of in accordance with jurisdictional policy relating to FOUO information.
3. [Insert any local statutes or regulations with regard to document handling.]
4. For more information or questions regarding this exercise, please contact:

   [Insert Contact Information]

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# INTRODUCTION

## Background

[May include additional background information specific to the coalition, member organizations, and threats/hazards as identified in the jurisdiction's risk assessment/ hazard vulnerability assessment and resource gap analysis.].

## Purpose

The Burn Surge Annex TTX provides HCC members and leadership with a useful exercise planning template to address mass casualty events with large numbers of burn patients. The exercise allows participants to address key issues through a series of facilitated discussions.

## Scope

This toolkit is an interactive, discussion-based exercise focusing on impacts to HCCs and healthcare facilities caused by mass casualty events with large numbers of burn patients.

The exercise is planned for a half day, and the scenario consists of three modules in chronological order and portrays an incident and its aftermath causing mass casualty.

## Health Care Preparedness and Response Capabilities

[These are suggested related existing HPP program capabilities. Grantees will determine their current burn medical resources in the community under normal conditions and define how they work together to determine relevant capabilities, objectives, and activities that need to be addressed during the Initial Planning Meeting.]

- **Capability 2: Health Care and Medical Response Coordination**

  ***Objective 1:*** Develop and Coordinate Health Care Organization and Health Care Coalition Response Plans

- **Capability 4: Medical Surge**

  ***Objective 1:*** Plan for a Medical Surge

  ***Objective 2:*** Respond to a Medical Surge

## Exercise Objectives

The following exercise design objectives are focused on understanding the concept of operations of the HCC Burn Surge Annex and developing recommended actions and procedural adjustments to address potential gaps or problem areas:

1. Review existing burn care assets and identify gaps that may occur in a burn-related mass casualty incident.

2. Review agency/facility role in a burn mass casualty incident.
3. Validate assumptions in the HCC Burn Surge Annex.
4. Identify changes that need to be made in the HCC Burn Surge Annex based on the roles and capabilities of the involved partners.
5. [Other objectives identified by the Exercise Planning Team.]

## Roles

- *Players* respond to the situation presented based on their current roles in their facility or HCC; expert knowledge of incident management procedures; current plans and procedures in place in their agency, jurisdiction, or organization; and insights derived from previous experience.
- *Observers* view all or selected portions of exercise play and support the group in developing responses to the situation during the discussion.
- The *Facilitator* provides situation updates and moderates discussions. They also provide additional information or resolve questions as required.
- *Data Collectors* observe and record the discussions during the exercise, participate in the data analysis, and assist with drafting the After Action Report (AAR) that will be used to suggest improvements within the burn annex itself and future exercises.

## Exercise Structure

The exercise will be a half day event. The TTX has three modules consisting of an initial incident and then the subsequent aftermath. Players in this exercise will participate in the following exercise module elements:

- Module 1 – Initial Incident Period – Emergency Medical Services (EMS) and Healthcare Facility Response
- Module 2 – Community Coordination
- Module 3 – Transfer/Transport Coordination

Each module begins with a scenario update that summarizes the key events occurring within that time period. A series of questions following the scenario summary will guide the facilitated discussion of critical issues in each of the modules.

**Planning Note:** The coalition may add, delete, or modify questions based on their local plans and resources. Based on exercise priorities, time dedicated to each module will be managed by the facilitator.

The following is an approximate schedule:

- 8:00-8:30 AM – Introductions and opening remarks
- 8:30-9:00 AM – Overview of the HCC Burn Surge Annex / process during a mass burn event
- 9:00-9:20 AM – Table discussion Module 1
- 9:20-9:40 AM – Report out and discussion
- 9:40-10:00 AM – Table discussion Module 2
- 10:00-10:10 AM – Break
- 10:10-10:30 AM – Report out and discussion
- 10:30-10:50 AM – Table discussion Module 3
- 10:50-11:10 AM – Report out and discussion
- 11:10-11:50 AM – Wrap up and Hotwash

**Planning Note: The Exercise Planning Team should use this information for planning purposes and delete this text box once decisions have been made.**

This exercise could also be facilitated with a large group and no table discussion breakouts, based on Exercise Planning Team and Facilitator preference. If less than 20 people are participating in the exercise, full group facilitation is likely most effective. Facilitation will need to be adjusted if this is a virtually conducted exercise.

Attendees should sit together by facility and discipline. If there are few attendees from a specific discipline (e.g., emergency management) they should be assigned to a table which the planners feel would be most valuable from a contributions, learning, and relationship standpoint. Ideally, if there is a healthcare system participating in the TTX, the hospitals for that system should be seated together so that they can discuss any system responses to this incident as well as facility and coalition-level. Planners should avoid having tables with fewer than six members if possible.

## Exercise Guidelines

- Open, low-stress, no-fault environment.
- Comments will be non-attributable.
- Be professional and respect other's opinions based on their knowledge.
- Responses should be based on knowledge of current plans and capabilities – you do not have to have all the answers.
- Exercise-based decisions are not precedent setting.
- Problem-solving efforts should be the focus; it is expected that more questions than answers may be generated.

- The situation updates, written material, and resources provided are the basis for discussion; it is not expected that participants will need to do additional research or review other materials prior to participation in this exercise.
- Participants are encouraged to use the SitMan as a reference and to fill out the Participant Feedback Form as you go; feedback is welcome!
- Use the notes pages available in the SitMan.

## Exercise Assumptions and Artificialities

In any exercise, a number of assumptions and artificialities may be necessary to complete the exercises play in the time allotted. During this exercise, the following apply:

- The scenario for this exercise is artificial, however, it is plausible, and events occur as they are presented.
- There is no "hidden agenda" or any "trick questions."
- All players receive information at the same time.
- Assume cooperation and support from other responders, agencies, and organizational entities.

**Planning Note:** Planners may change the event or the scope as needed to fit local considerations. Scenarios should still follow the modular approach in this sample. Planners should consider adjusting patient numbers and providing any other demographic or geographic information specific to your community and designed to exceed day-to-day capabilities to test and/or "break" the system. It is important that the burn casualty volumes overwhelm area capabilities without being so extreme that they are unrealistic and cause participants to lose focus or focus on issues that do not contribute to functional planning. The Facilitator should have license to adjust patient volumes during the exercise to move the exercise forward.

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# MODULE 1: INITIAL INCIDENT AND FACILITY RESPONSE

## Monday afternoon, May 10, 3:00 pm.

Your hospital is at normal staffing and supply levels. Your hospital is at your average daily occupancy.

You receive a notification from your local EMS agency that there is a large fire at your community / convention center.

You are told there were two conferences being held in the center with up to 4000 attendees. (Note: small / rural coalitions may adjust this number down to 100-200 depending on appropriate scale and can select a different venue, based on what is available locally.)

Hundreds of people have been injured, including burns, smoke inhalation, and minor and major traumas.

The first wave of patients from EMS is expected in 15 minutes, but patients are beginning to arrive by private vehicle.

**Planning Note:**

- This module focuses on the hospital response to this incident and not the pre-hospital response. Exercise Planners can choose to create sub modules or adjust this scenario if they would prefer a more detailed discussion of pre-hospital operations.
- Determine whether to add any at-risk populations to your patient mix, such as pediatric patients or those with access or functional needs.
- Supply those who will report out with a note pad and pen/ pencil at the beginning of the exercise and assign a scribe for each report out team, preferably someone whose handwriting is legible for later review.

## Module 1 Discussion Questions

1. What is the EMS plan for local distribution of burn casualties? (For example, what patients go to which hospitals if there are multiple potential receiving hospitals?) What role does your facility play in a burn mass casualty?

2. What are your initial actions upon notification of this incident? What do you need to do to activate your disaster plan? Do you have a burn surge plan? If yes, how is it activated?

3. How could your facility access real-time expert assistance via consultation with a Burn Center Physician, either through a nearby Burn Center or through a state or regional Burn Coordination Center, Medical Operations Coordination Center, etc.? Are the other hospitals in the area using these same resources?

4. Does your facility have telehealth / telemedicine agreements with a Burn Center (or trauma center if there is no regional burn center) for additional assistance?

5. Does your facility have Burn Triage cards or other quick reference resources?

6. How many burn patients is your facility prepared to handle?
    a. Do you provide burn inpatient care?
    b. What supplies do you have on-hand to manage burn patients?
    c. What staff do you have on-hand to manage a surge of burn patients?
    d. What burn care training does your hospital emergency department and inpatient staff have?
    e. Do you have a plan to provide just-in-time burn care training?

7. What changes to your facility disaster plan are needed to accommodate a burn surge?

8. In the event that your facility's burn capacity is exceeded, or you do not provide burn services, how would you address referring these cases to a larger and/or burn specialty hospital?
    a. What is the current referral process for a critically ill patient and how would this change in this incident?
    b. How would you prioritize/triage multiple burn referrals *from* your facility?
    c. Does your facility have written agreements with burn referral centers to expedite patient transfer?
    d. What patient transportation resources would you need?

# MODULE 1 NOTE PAGE



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# MODULE 2: COMMUNITY COORDINATION

**Planning Note:** The questions may need to be changed based on coalition resources. The key issue for this module is defining what activities occur where (e.g., does transfer coordination occur at the hospital [particularly if a single/few hospitals in the coalition], jurisdictional Emergency Operations Center [[EOC]], coalition physical or virtual coordination center, or receiving burn center).

## Monday afternoon, May 10, 5:00 pm (Incident + 2 hours)

- Your facility has now received significant numbers of patients and your surge capacity has been exceeded.
- Your usual burn referral center is 100 miles away.
- You must stabilize and treat the burn patients at the local hospitals for now, in addition to others who are not burned and have also sustained critical injuries.

## Module 2 Discussion Questions

1. What alerts and notification mechanisms are in place to ensure that the coalition members and partners are aware of the incident?

2. How does the HCC support this response?
    a. If the coalition has an operations center, how is this activated, staffed, and what functions does it serve? How does it interface with the EOC?
    b. If the coalition functions are conducted by/at the jurisdictional EOC, how rapid is the activation? Who provides coordination and supports the healthcare needs?
    c. How will the HCC support resource allocation decisions in a scarce resource environment (e.g., transportation, staff, supplies)?

3. What type of assistance (staff, space, resources, systems) could the HCC and its members provide? Are there other partners that you should coordinate with? Is this different from Emergency Support Function (ESF)8 support?

4. When would you notify and request assistance from emergency management and what would you need?

5. What EMS transport resources are available (both public safety and private services including local, mutual aid, state resources / ambulance strike teams)? (Note: encourage EMS to discuss considerations related to both ground and air assets.)

6. Where would you obtain guidance or clinical advice for burn patient care prior to and during an event? What types of burn or other experts might be needed that are not yet included? How do you communicate with them (e.g., telephone/telemedicine)? Is there a role for bringing a burn provider and supplies to the community to assist / support? How would that be managed?



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# MODULE 2 NOTE PAGE



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# MODULE 3: TRANSFER/TRANSPORT COORDINATION

**Planning Note:** This section requires coalition partners to have situational awareness about their current resources as informed by a gap analysis and risk assessment. The following should be considered when shaping this module:

1) Who are the usual burn inpatient providers in your area?
2) How would burn referrals be prioritized, particularly across multiple facilities (e.g., by burn and trauma combination injuries, more severely injured, or those with other trauma injuries)?
3) What other regional resources for care and clinical advice are there and how would they be accessed?
4) How would patient information, tracking, and accountability be handled?

## Monday afternoon, May 10, 7:00 pm and beyond (Incident + 4 hours)

- Multiple burn patients have been stabilized at area hospitals and they now require secondary transfer for ongoing care. Some patients will be accommodated at trauma centers or will need to be cared for locally until transport / inpatient burn capacity catches up to demand.
- Specialty transportation resources may be needed for patient movement.

## Module 3 Discussion Questions

1. How does the HCC Burn Surge Annex address this kind of scenario?

2. How will the team coordinate sharing patient information across multiple facilities for patient tracking and family re-unification?

3. How can the coalition ensure patient load balancing among hospitals or play a role in transfer decisions locally if relevant (e.g., movement to trauma center if burn center is overwhelmed)? How will hospitals and EMS coordinate this decision making?

4. If the coalition does not serve in this role, do you know how to notify state or substate Medical Operations Coordination Centers or Regional Burn Centers? What role would they play?

5. Who will be responsible for prioritizing patient transfers to the burn center and what criteria will be used to make that determination (i.e., which patients will benefit most from burn center care)? How will the receiving burn center participate in those decisions?

6. How will transportation be coordinated for these patients?

7. What is the mechanism for tracking these patients through the referral process?

8. What resources does your facility have onsite if you need to provide ongoing care instead of transferring a critical burn patient or patients with smaller burns? If on-site staff would be



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required to care for these patients, is there a staff sharing mechanism or agreement(s) to support this? Are telemedicine capabilities available? Has a common point of contact been identified for clinical advice?

# MODULE 3 NOTE PAGE



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