ASPR TRACIE Webinar Transcript

Lessons Learned from the Signature Healthcare Brockton Hospital Fire

December 14, 2023

PowerPoint Presentation: https://files.asprtracie.hhs.gov/documents/signature-healthcare-february-2023-fire-amp--evacuation-webinar-final.pdf

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0:01
Rachel Lehman (RL): On behalf of the U.S. Department of Health and Human Services, Administration for Strategic Preparedness and Response (ASPR), I'd like to welcome you to ASPR's Technical Resources Assistance Center and Information Exchange webinar titled, Lessons Learned from the Signature Healthcare Brockton Hospital Fire.

0:16
Before we begin, we have a few housekeeping items to note.

0:20
First, the webinar is being recorded. To ensure a clear recording, everyone has been muted. However, we encourage you to ask questions throughout the webinar.

0:29
If you have a question, please type it into the question section of the GoToWebinar console and during the question-and-answer portion of the webinar we will ask the questions we receive through the console.

0:39
Questions were unable to answer due to time constraints will be followed up directly via e-mail after the webinar.

0:46
To help you see the presentation better, you can minimize the GoToWebinar console by clicking on the orange arrow.

0:52
Lastly, today's slides and speaker bios are provided in the handout section of the GoToWebinar console and will be posted along with the recording of this webinar within 24 hours on the ASPR TRACIE website.

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1:06
This presentation and the following slides by non-federal government employees are solely those of the presenter and not necessarily those of the US government. The accuracy or reliability of the information provided is the opinion of the individual organization or presenter represented.

1:22
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1:25
My name is Rachel Lehman, and I'm the Acting Director of ASPR TRACIE. Thank you so much for joining us today and thank you for what you do every day to enhance the preparedness, response, and recovery activities of your healthcare entities and communities.

1:38
During this busy time of year, your willingness to spend the next hour bus to further advance your knowledge is noteworthy.

1:45
I also want to convey my heartfelt thanks to the amazing presenters today from Signature Healthcare, your willingness to lend your precious time, share your story and your substantive expertise so others might benefit is commendable and greatly appreciated.

1:59
Lastly, many thanks to the wonderful ASPR TRACIE team for coordinating this session.

2:04
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2:08
To meet the nation's health and medical needs ASPR is focused on four key priorities. Prepare for future public health emergencies and disasters, manage the federal response to and recovery from public health emergencies and other disasters, improve and leverage partnerships with healthcare and public health stakeholders, and ensure workforce readiness through the development of innovative workplace practices.

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2:33
For new friends to ASPR TRACIE on the webinar today, this slide depicts the three domains of ASPR TRACIE: Technical Resources, Assistance Center, and Information Exchange.

2:43
If you need technical assistance, or you cannot find the resources you are looking for on our ASPR TRACIE website, please do not hesitate to reach out. Simply e-mail, call, or complete an online form and we'll respond to your inquiry.

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2:59
It is now my pleasure to turn it over to our moderator for today, ASPR TRACIE Senior Editor Dr. John Hick. Over to you Dr. Hick.

3:07
John Hick (JH): Thanks so much, Rachel.

3:09
Few situations present as many problems for a hospital as a facility-wide emergency evacuation. The risk to patient safety, as well as staff safety and the infrastructure of the building, combined with a prolonged recovery phase, make these incredibly challenging situations.

3:26
Further, fires and other causes of hospital evacuations often combine with cascading failures of other systems that may wind up additionally compromising the ability to evacuate safely.

3:38
Unfortunately, Signature Healthcare Brockton Hospital in Brockton, Massachusetts faced exactly this sort of situation.

3:44
We're grateful that we have three speakers to tell us about that day, and some of the lessons learned that your facility may be able to take away valuable lessons from.

3:53
I'd like to introduce first Claire Sears, who's the Emergency Management and Environmental Safety Program Manager at Signature Healthcare Brockton Hospital.

4:01
Claire, thank you so much for being with us today.

4:05
Claire Sears (CS): Thank you. We're very excited for the opportunity to speak.

4:08
So today, we'll be speaking about our lessons learned from the hospital fire that we had back in February of 2023.

4:15
And again, thanks so much to ASPR TRACIE for inviting us for this opportunity.

4:19
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4:23
These are a few disclaimers that we had to put in here. Essentially, if you could please refrain from copying any of this information, we would appreciate it. We're more than happy to speak directly to anyone with questions after the presentation and this is not meant to be a full after-action report, but simply a template for discussion and it's presented to the best of our ability and recollection. And we'd like to give photo credit to Richard Smith, who's a paramedic that provided the majority of the photos in this slideshow.

4:53
Next slide, please.

4:56
A quick agenda with a caveat.

4:59
So, first, we'll go through introductions for both myself and my two co-presenters We'll have a video that's actually about 3.5 minutes long, not the promised seven, and we'll go through some slides to discuss further the events of the day of the fire.

5:15
And then we'll get into a few personal stories from that day, concluding with the panel discussion, which we're looking at about 20 minutes for.

5:24
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5:27
And I'll let my co presenters introduce themselves beginning with Kim.

5:32
Kim Walsh (KW): Hi, good afternoon. Thank you very much. My name is Kim Walsh.

5:35
I am the Senior Vice President for Patient Services and Chief Nursing Officer at Brockton Hospital. I'm pleased to say that I have spent my entire career with the organization, and I'm very happy to be speaking to you today.

5:50
I'd also like to introduce my Vice President of Quality, Melissa DeMayo.

5:56
Melissa DeMayo (MD): Hi, I am Melissa DeMayo, Vice President of Quality and Chief Quality Officer at Signature Healthcare. I started my career here, at Signature, and just keep coming back, I'm going to end my career here as well. I was one of the individuals who was on-site and in a clinical, more clinical role the day of the fire. So I look forward to sharing that information with you and my experience.

6:18
CS: Thank you, Melissa. And as John mentioned, my name is Claire Sears, I'm the Emergency Manager for the hospital, and will probably be there for a lot longer than Kim and Melissa. But I'm very thankful for their expertise and knowledge that they'll share today.

6:32
And the day of the fire, I was in the role of Liaison Officer.

6:36
So a lot of the information that we speak to today will come from our three unique perspectives and sort of stories that we have to share there.

6:46
Next slide, please.

6:48
Thank you.

6:50
So as you can see, from the video, we are a community-based hospital in Brockton, Massachusetts, Southwest of Boston. This is a before photo of the hospital, it looks a little bit different now. And on February 7th, which was a Tuesday, it was about 37 degrees out. So for anyone in New England or, you know, the upper parts of the country understand that but a very typical Tuesday in the winter. And this is sort of the scene that was set for us coming into the facility that day. As was mentioned in the video the fire began around 7 o'clock in the morning so what we'll do here is get into a bit more detail of how the day progressed.

7:29
Next slide, please.

7:31
So as I was mentioning, the fire began around 7 o'clock and this hallway that you see used to be an old receiving hallway that goes into the ground floor of the hospital. The space on the left where you can see sparks emanating from the door is an electrical room that housed our transformers and switch gears and a variety of other electric equipment for which I don't know the specific names. And this entity is where the fire began. The sparks that you see here and in the video that you just saw continued to grow and the smoke began to come out of this space and into the rest of the hospital.

And ultimately, as you heard, the 911 call was made and we had very, very fast response from our local fire department, Brockton Fire. They were on site in less than five minutes and began the process of investigating the scene and ensuring it was safe for them to continue, at which point they recognized that the electricity was arcing it was not safe for the firefighters to enter the space until the power was cut for the street. So this is a little bit later in the day, but you'll see that this is the primary firefighting space where the firefighters set up and the incident command for the fire department was there.

8:56
So, as I was mentioning, this is the primary space where the firefighting was taking place. The incident commander within the fire department chief who you saw in the video established their command on the backside of the hospital to ensure that their firefighting was centrally located and as you'll notice in a few slides the evacuation ultimately will begin in the front of the hospital. But this was the primary location for all of the firefighting apparatus and for the firefighters that were actively involved in putting out the flames.

9:26
So, once this took place, as it was mentioned, it was right around change of shift. We were able to get out a page through our emergency notification system to inform staff that the code red alarm that they were hearing was indeed an active code red and not a drill, and that we were switching to generator power.

9:45
As you'll hear in a few slides, all of our systems ended up failing, so we were not able to communicate much further with staff. But that was the initial way that most of the staff that were on-site at the time were made aware of the event.

9:59
Next slide, please.

10:03
So as I mentioned, Chief Nardelli was the incident commander for the Fire Department and we ended up utilizing a unified command, essentially, where we integrated the Fire Department and the Hospital Incident Command or HIC to ensure that we were able to communicate throughout the event and establish who was in control and who was able to make decisions.

10:24
So you can see from the visual here that we had, we did have fire, police, and public health, along with dozens of other entities by the end of the day that were on-site.

10:34

But we were able to keep the same incident commander throughout the entire event, which made it very straightforward for staff and leadership who are looking for information to glean that from the fire department, and vice versa. We were able to establish the appropriate communication for the fire department to look to within our hospital organization. So, they knew who to reach out to once they were under the impression that we should evacuate based upon the safety of the scene.

11:04
Next slide, please.

11:09
And the figure on the right, shows a very basic outline of the hospital. On the bottom side, excuse me, the bottom, you'll see where the command post was set up, the green circle for C, that's the photo we just showed. And that's where the firefighting was taking place.

11:24
At the top, where it lists A, and the red, reddish orange circle is the EMS sector and triage. So, that ended up being where all the patients were evacuated out of. That is the main entrance of the hospital. What's not shown as the circular driveway we have out in front.

11:40
The blue circle is the mechanical space where the fire began.

11:45
So, we had to operating areas, they essentially split the hospital in half, front and back, and were able to ensure the firefighting was taking place on one side and focused on that while the first, excuse me, the front of the hospital was patient evacuation.

12:00
Next slide, please.

12:02
MD: So, Claire, it's Melissa.

12:04
CS: Yes, go ahead.

MD: I was wondering if you could go back just a little bit to when that fire broke out because that's when we were all at our various posts or trying to figure out what our role was in this fire, now that we knew it was active. And I recall that morning I was coming to the front of the hospital, which was unusual for me coming in for a lab draw. I had been fasting of all things and in new shoes, wondering why there were fire trucks that were coming up in front and wondering who had scheduled that fire drill at change of shift.

12:37
Um, and then I got a call from your director, Jeannette, who said, “This isn't a drill. The fire doors are shut. The smoke is everywhere, I'm going floor to floor to tell everyone, this is not a drill,” and my first call was to the CEO to tell him that there was a fire. I said, “Bob, hey,” and I never call him at seven o'clock in the morning for anything. And he said, “What's up Melissa?” And I said, “The hospital’s on fire.” He said, “What?” I said, “The hospital’s on fire.”

13:05

He's like, “OK, I'll be there in a couple of minutes. I'm in line at Dunkin' Donuts, and I can't get out.” And then I called Kim, my boss, and say, “Kim, the hospital's on fire.” She said, “What?” I said, “The hospital’s on fire,” “Where? Oh, it can't be that bad.” “It's OK.” I'm trying very much to keep things calm.

13:23
But very, very quickly, I discovered that we were in a real situation, and we had patients who were arriving for the day to get blood drawn, to get prep for surgery, et cetera. And I found myself kind of caught up inside the hospital, redirecting patients and visitors who were entering the door, and had stationed myself down in a high traffic area, near the Emergency Department.

13:48
Um, and you were calling this for a woman who came in and said, “But no, I have to get upstairs to like prep for a colonoscopy,” and I had to turn her away. She said, “Can I reschedule?” I said, “Eventually, but not today. The hospital’s on fire,” which seemed to be a recurring theme that day, and ended up sort of getting swept up into the emergency room in a real critical clinical role that day that I hadn't anticipated. But I know you were running around with your emergency management hat on, and then I'm not quite sure, you know, where you were as things were being coordinated. Claire?

14:25
CS: Yes. Oh, go ahead Kim.

KW: This is Kim. I'll jump on. You know, from my perspective, again, Melissa had called, and with that, my phone started to blow up between texts and calls from my brand new nursing supervisor, who was saying that he'd like to go on Code Black, which in Massachusetts, you know, a condition where you want to stop all incoming traffic into the emergency department. And, again, because I've been here a long time and have seen a lot of lot of things. I couldn't imagine that this situation was, was that bad. We'll evaluate it and hold on.

15:02
But within a few short minutes and phone calls, they talked about the amount of smoke that was kind of being pulled from that first floor up through the ventilation system. And it was really getting rather noxious up on the fifth floor. And so they were starting to move some patients, and, you know, quickly realized that it was really going to be a challenge.

15:24
So, I'm about 40 minutes out from the hospital, by the time I got there, I had had a couple of phone calls and arrived to the back of the hospital where the Command Center, the Chief had, had kind of quickly setup, and we had talked about a couple of things. You know, the fact that arcing fire was going on, and they really couldn't do anything to address it until National Grid arrived and turned the electricity off.

15:52
The other concern was that our oxygen line and medical gasses were very, very close to the site of the fire, and there was a need to turn that, those gasses off. And, you know, obviously, the reality of this, you know, situation is escalating quickly, and we started to think about what we needed to do next.

16:12

So, I went over to the Emergency Department, where, away, from the, you know, the major event, to start to look at, where we could set up, and realized quickly, we had lost power, we had lost our IT, telephones, all of our capacity to get into electronic medical records.

16:33
As a matter of fact, we started to search and say, does anybody have a census printed? And fortunately, our Director of Patient Registration has a nightly census printed, and I think Claire was able to run across the street and make some copies, so that we actually knew who was in the building at that time.

16:54
So, I'll pause there, because, again, things were happening quickly.

16:57
And we started to recognize that we had handed over the facility, if you will, not the patients, or the staff, at the facility, to our firefighting team. And we were going to have to make some quick decisions.

17:14
CS: Yes, thank you both so much for those firsthand experiences.

17:17
And as each of them mentioned, this was beginning around seven o'clock in the morning. I personally had pulled into the hospital to see the smoke starting as I park across the street from the ramps that then caught on fire.

17:29
And was able to get in touch very quickly with our external, regional, HMCC group. Took a little bit of time, but we were able to connect eventually. Once we still had cell phones that were working, to just say that, you know, there's something happening. I probably won't be able to speak too much throughout the day but wanted to make you aware.

17:49
And then, kind of we're off and running.

17:51
As Kim mentioned, we did relinquish control fairly quickly, obviously, to the fire department, as they had multiple staff who were able to assess the safety of the building and the functionality of the building, which we were losing very rapidly as a result of the power being impacted.

18:08
And that really led us to make the decision in conjunction with the Fire Department to evacuate the building. The fire, and the smoke, it was uncertain as to how quickly they would move throughout the facility, and knowing that the medical gas and the oxygen were then being shut off, as well as our elevators, heat, phones, lights, et cetera.

18:29
That really snowballed into the decision that we were not going to be able to provide safe patient care for distinct period of time, and that really allowed us to make that decision fairly quickly with the information from the fire department, who related back, what they thought about the building, in conjunction with the clinical staff, who have a sense of who is in the building, and what their needs are, and if those needs could be provided for.

18:55
As this decision was made, we went to communicate it to staff, but were quickly stopped by the fact that our email was not functional, our paging system was not functional, and our in house phones were not functional. Our overhead paging was intermittent and at this point, no longer worked. So we had to essentially relay information by runners and people. We had a few two-way radios on-site that we utilized in the fire department and our security staff, and our maintenance staff had them, but most of our communication that day was from cell phone to cell phone or person to person running throughout the space.

19:31
As you can see in the photo on the left, we have a lot of stuff. This is not my favorite picture, because it usually looks better than that, but this is one of our emergency management storerooms within the hospital.

19:41
So we certainly have a lot of resources, equipment, and supplies that we can use during a system failure, or an evacuation or a fire.

19:51
But we were not able to access most of this because of where the fire was taking place. And due to the fact that there were no lights throughout the facility, with the exception of some emergency lighting.

20:01
So, just getting down to the storage space proved to be an issue. And is one of my personal lessons learned to ensure that we can maintain access as best possible in really any type of situation, have an all-hazards approach. On the right-hand side is an emergency notification system that we utilize called Alert Us. But this was no longer functional during the event, as well, due to our limitations within IT.

20:27
But it is something that we had in place; we just obviously did not expect such a catastrophic failure of our systems.

20:35
One thing that we did need, and Kim was kind to mention, was the facility maps. We do have a set in each of the boxes, which is a resource we have at the front and rear entrance to the facility. It includes badge access cards, keys, facility maps, and a few other resources for responding first responders. Excuse me. But we needed additional copies. And because nothing was functional within the main hospital building, several people had to run across the street to other offsite buildings to utilize the copiers, the printers, the fax machines, et cetera. This is part of the evacuation command post that we'll speak to in just a moment, this photo here.

21:15
Next slide, please.

21:18
So meanwhile, this is what that mechanical space was beginning to look like. And we, I apologize, we don't have a lot of photos of the scene itself for a variety of reasons. The primary one, being, that this was not a safe space for anyone to be going into during the fire itself.

21:35

A lot of our mechanical items and electrical items are housed in a vaulted area within the hospital sort of halfway underground, and this is one of the photos from that space. So, as you can see, there was a lot of impact from that fire that began and began to spread.

21:52
One thing that really helped us, we got very lucky throughout the day, as you'll hear, but one of the best things was really the fire doors that we had in place were functional and did what they needed to do, and prevented the fire from spreading outward from that space. We did have some smoke, and some fire that went up, but it did not go out, which really would have impacted the rest of the hospital a lot more than we experienced.

22:16
Next slide, please.

22:20
Another photo of the after, this is our hospital cafeteria, which is above the mechanical space where the fire started, and you'll notice that there's a lot of ceiling tiles coming out. Our sprinklers did deploy in this space. But we had a lot of damage from the smoke and the fire that went through the electrical conduit. So that's what you can see in the back side of those walls there.

22:43
Next slide.

22:47
And just a bit further into the damage. Pardon me. This is also the cafeteria, which is sort of a half or above that mechanical space. Thankfully, at this point in time, there were very few people in this area, and they were moved to safety, but this was one of the worst impacted spaces within the hospital.

23:05
Next slide, please.

23:08
And as you've alluded to multiple times throughout this, we had a cascading failure of all our systems, and as an organization that prides itself on training well, and drilling well and ensuring our staff are capable of making decisions and having gone through exercises, we really did not expect to have everything down at the same time.

23:29
So it was certainly an adjustment throughout the day to ensure our response was efficient, but it just took a little longer for us to make some communications.

23:40
And we had to circumvent some normal kind of processes, but as you'll see here, we had none of these items by probably about an hour into the event.

23:51
And that includes normal power, lighting, water, generator power, emergency lighting, and elevators. And really, the elevators being down, they were down for quite some time after the fact. So that was one of our more longstanding impacts. So as we're trying to move things from the hospital to make more spaces available, that really kind of impacted us even further.

24:14
And then, medical systems, I'm going to turn this over to the more clinically inclined to discuss the impacts here.

24:23
Sure. The clinical systems, there were, there were a number of things that obviously, were concerning. I had mentioned just briefly oxygen, and our oxygen storage room was also located very, very close to the site of the fire. So, we have, we put calls out to local hospitals and had some oxygen delivered from various other sites, just to shore up the oxygen that we had.

24:52
One of the most concerning issues was the fact that in our ICU patients were intubated and sedated were starting to wake up, and needed medication, and our, all of our Omnicells were locked down.

25:06
Our systems and, I think opportunities for improvement looking at who can override and who has keys to these Omnicells in an effort to get access to medications as needed. So, certainly something we're looking at for the future.

25:22
Kinda moving down, I think we talked a little bit about knowing who was in the hospital. We mentioned our fortune, which was change of shift.

25:31
The weather was good, and we had an oncoming shift that that helped while we held over people that were on site.

25:41
It was early enough that none of our OR cases had started, So no one was in the middle of surgery, we had two patients in labor, and we identified them quickly, and they were the first patients transferred out. We had a number of patients receiving dialysis, that had started at 6:30, and those patients were prioritized. And then we spent, you know, probably the first effort, identifying patients who would be transferred out first, and those were our most critical patients in our ICU and calls were being made from our intensivists and hospitalists, looking for replacements at that point. One of the conversations we had about things that you would do different, and lessons learned. My first lesson learned was always carry a cell phone charger.

26:26
My cell phone was fully charged when I arrived that day, but by about noon time, things were starting to change. So I now carry a couple of those around, in my bag, but those were the, you know, kind of, the top priorities, right. At this point, as we were trying to organize staff, and people wanted to help, they didn't know what to do. We get, kind of took a group of people, moved them over to the School of Nursing, for deployment. We were trying to identify how we were going to evacuate all of these patients. And certainly when the firefighters arrived, we recognized that they would be handling that situation, as they have the appropriate gear to kind of work in the, this environment where the smoke obviously was really filling up.

27:10
And they were having to go in and, and really make assessments of the toxicity and really how safe it was for people to be occupying these areas. So, I will pause there.

27:25
MD: Alright, thanks. It's Melissa. I'll jump in a little bit because as things unfolded, I was in the emergency room which has no windows in the clinical area and when the power went down and when I walked in there, the nurses said, "Should we prepare for downtime?"

27:40
I said absolutely, and I pulled up on my laptop the census of patients that we had right there at the time, which was fortuitous because we went on generator power then in what seemed like a minute or two, no more generator power and we lost all of our ability to access those patient records. We were able to build a board very quickly, by hand and whiteboard by hand and marker, of who was in house, etcetera. I ended up going in the very back of the Emergency Department where our behavioral health patients are cared for. And when those lights go out and you are caring for patients on suicide precautions in the dark, a whole different sense of reality and isolation starts to hit.

28:29
It was extremely frightening, not being able to even call for help with flashlights or any kind of redundant service to that area. So those cell phones tended to be a real lifeline within the hospital and outside of it. The fact that there were so many people coming on fresh with charged cell phones was really fantastic. And, you know, if you were lucky enough to have someone's number, that was great, too. I had gotten a call from a colleague at the state level who had been at a conference with me a couple of weeks before. She said, "Melissa, it's all over the news. What's happening down there? What can I do to help?" And I said, "Please, you know, I need the Holy Grail, I need two beds for two teenagers who are acutely psychotic." I know we have to evacuate, but I had no idea what was going on in the parking lot and outside. I didn't know that we had command of the fire in the back of the building and evacuation at the front. There was no way to get that information to me. So, I felt like I was on an island in a behavioral health unit trying to make sure everyone stayed safe. And as we lost things, the cascade of the power, the normal power, the generator power, the Omnicell access was huge for us down in the ED. The oxygen, and you know, all of that it's like, it's the worst-case scenario, and I don't know that we'd ever prepared for something as basic as losing the ability to communicate.

30:03
CS: So, speaking of islands, we are in Region 5, which here is the purple section. And it includes 13 hospitals 2 of which are located on Islands, Martha's Vineyard and Nantucket.

30:14
And as such, we have a great relationship with the other facilities in our region and within our health and medical coordinating coalition. And luckily, we were the only hospital on fire that day, so we were able to receive an incredible amount of resources and primarily staff, power and manpower from external entities.

30:37
So after, we reached out initially, to our regional coordinator, and after we were on Code Black, which is a big heads up for the area, we began to be inundated with requests for information on what we would need, and where patients would be going.

30:53
But we were unable to communicate through many of our normal methods. And luckily, for us, the Fire Department has an incredible statewide program that allows them to call in for resources

in a phased approach, which took place alongside our efforts. So it was a huge burden off of our shoulders to be looking for people to move these patients, as it was part of the fire and EMS plan.

31:18
So, again, this is just a quick snapshot of the State of Massachusetts. We do not operate on a county system, which is not common throughout the country, but we are very much our own towns and cities.

31:31
So there's 351 within the Commonwealth, and over 50 of them came to our aid that day. So we can go to the next slide, please. We'll take a look at the external resources that came to our aid.

31:44
This is a photo of the front of the hospital. That's Center Street, for anyone familiar with Brockton. And it was very full of firefighting apparatus that were coming to not only fight the fire but also ended up helping us to evacuate.

31:59
And I know, as Melissa mentioned, being in the emergency department, you really couldn't see any of this that was taking place, necessarily.

32:07
And how many people were really on-site to kind of heed the call and respond to the event.

32:13
But, because of the escalating nature of the event, which went up to 10 alarms, the fire itself, eventually would get knocked down, but the remaining alarms were so that we had enough people to evacuate the facility.

32:25
Next slide please.

32:28
And, these are just a few photos that we'll quickly go through to keep an eye on the time to ensure that we can get to questions.

32:36
But, if we could go to the next slide, these are just a few more showing us the incredible resources that came to our aid. Ironically, we were supposed to be doing an exercise on Thursday. This took place on a Tuesday with Brockton Fire.

32:50
So, there are entire new recruit classes on-site. Next slide, please.

32:58
These are the ambulances staged in front of the hospitals. So, like you mentioned, the evacuation took place on the front side.

33:04
Next slide, please.

33:08

And some more ambulances, and the next slide, please, we'll give a list of all the entities that responded.

33:14
So these are all different cities and towns within the state that sent aid to us, for those not familiar with the geography of Massachusetts, anything coming from the Cape is almost two hours. So we had a huge expanse of assistance.

33:29
Next slide, please.

33:31
This one here is just the visual, so all of these towns sent resources to us.

33:37
Next slide.

33:39
Which brings us to, getting the patients, into set ambulances. This is our evacuation command post. You can see, Kim, there front and center in the tan, as well as our CEO, Bob Haffey. We also had our EMS, our Regional EMS, Deputy Director, who was allocating the facilities for excuse me, for patients to go to.

33:59
Next slide.

34:03
And there was a fire chief, though, specifically in charge of evacuation, so, Chief Nardelli, who was the incident commander, had a chief allocated to each operating area within the facility, that could then report back to him, so they were placed in the evacuation command post.

34:19
And, Kim, if you'd like to just kind of touch on a little bit more on the patient movement that we looked at.

KW: So, yeah, we were, we were looking obviously at our highest acuity patients and then working with the region to find spots and make connections. And, again, we were very limited, because we did not, obviously, have paper records. We had no demographic information. We were really just working off of, obviously, our master list of patients and name badge. We set up a couple of our case managers at the doors to start to track and take names and where the destinations were.

35:03
And as you can imagine, this, this took a tremendous amount of time, as hours were now going by, we were fortunate that the fire had been put down, but the, you know, the residual smoke, and then just the timing of how long it took, you know, we were, we were certainly stressing the region. Who, if you remember at this time, you know, COVID was still in play in terms of inpatients that we have a lot of behavioral health patients. And in the community we're a safety net hospital we're managing a lot of patients with the challenges we were waiting for disposition.

35:40

So all of these things are being taken into consideration, and the other thing is, you know, our concern around communication to families. We have, you know, people who are not able to get to the hospital to find out about loved ones.

35:52
So working with the state on setting up a line for families to be able to call in.

35:58
And basically doing what we could do to safely place patients, get the appropriate handoff, and then give the information that we needed to, to the receiving facilities. Many people arrived into emergency departments without notice, due to the stress in the system. And that was a little bit later in the day. We had to work through all of those issues.

36:18
We had a team that night that went to our medical records site at another location, printing records, getting information to facilities, so that we could do whatever we could do to provide them with the appropriate treatment plans.

36:33
And it just was a tremendous amount of work for many people late into that night.

36:39
MD: So, you know, Kim was talking about how we were sending folks out without a lot of clinical information to the region. And what became apparent in the days following or weeks following, even, is that the receiving hospitals had really felt like we hadn't done a good job communicating with them, which was true. But what they hadn't realized, even though it was an evacuation, um, technically, what it really was, was like a mass casualty event.

37:10
We didn't have that information to give them, and sort of people's ideas about what had happened that day kind of flipped when they started to realize, oh, you didn't have communication. It took a while. It's very difficult to realize, in this day and age, what it feels like to be shut down from everything, and not even be able to fax or copy anything to send. So, that was interesting. I did want to share, I know we're getting short on time, but this is my favorite story of the day, and it has to do with this area of the hospital where you have the EMS folks coming in, to pick up, patients, kind of like an a carousel fashion, who are coming down from the floors, with the firefighters, and being loaded into their ambulances for transport.

37:56
And there was a call that came in the day after the fire to our AVP of Nursing from a woman who did not know Barbie. And she said, “You don't know me, you have no idea who I am, but I am a nursing instructor, and I have to tell you about this patient that I had. We had a clinical team on this floor and this patient in room seven needed her Foley catheter discontinued. So I brought the students in there. Because that's a great opportunity. And of course, we started talking to the patient, and I asked the patient where she was from. And she said, I came from the Brockton Fire. And then she wanted, proceeded to tell her story that she had not had any bit of fear the entire time that the nurses and the staff made her feel completely safe, that the fire fighter who brought her downstairs made her feel safe, that she wasn't scared in the least bit. And when she got done, got put on the stretcher and the fire fighter who was putting her on and wheeling her out, gave her a kiss and said, ‘Good luck grandma.’ And it was her grandson, who was on his first day as a recruit on the Brockton Fire Department had happened to have been that

day.” And then in all the chaos to have them have aligned like that just at that moment at the front of the building was pretty amazing. And probably something I'll never, never forget.

39:19
Next slide, please.

39:23
We can keep going on the slides till the next subsection. We talked about patient evacuation.

39:30
Next slide, These are some of the media shots that were around. Next slide.

JH: Can we back up to that slide three slides ago now that shows an intensive care patient being evacuated.

MD: Sure.

39:45
JH: Just on oxygen and the monitors, and whether or not your ventilators had battery backup, that sort of thing. Thank you.

39:55
KW: Yes, and we relied on the transport team and the equipment that they brought with them. So, everything we had were on battery. We lost a lot of that battery power, and over time, we were probably able to get the ICU completely transferred out within two hours, based on acuity, but we really did rely on those transport teams.

40:21
MD: Something else that I recall too, that was, what happened right away. Our respiratory department was really fantastic. They were bringing in oxygen, portable oxygen tanks up to the ICU immediately and we were getting oxygen tanks, my understanding is from other area hospitals to bring up there, because those ventilators that were on battery power were sucking the oxygen tanks dry and empty within minutes. When I went into the hospital the next day on rounds for the Department of Public Health, I saw a big stack of these cylinders, these green cylinders just laying on their sides like cannon balls, you know, heavy artillery, and I couldn't imagine what had happened up there. But things were moving so quickly that they had laid down, the cylinders as they emptied so that they wouldn't unintentionally grab an empty cylinder and hook it up to a patient. So that's what that, that was, and it was just stacks and stacks and stacks high, but they did an incredible job focusing on the patients. And our intensivist too, using, again, his cell phone and the connections he had in the community. I can't stress that enough. Those connections that you have with the surrounding facilities and organizations to be able to find the appropriate placement for the acuity of the patient, despite what was happening downstairs. He knew that if he didn't get his patients out, the ones that were waking up because we couldn't get any medications out of the machines to sedate them, he knew that that patient had to go and was really pressing and advocating. So, thanks for asking that question, Dr. Hick.

CS: As Melissa was mentioning, I think we can skip pretty well down towards the end. We'll skip over the hazmat concerns right now except for the quick mentioned that the State Hazmat Team was deployed and they were incredibly helpful in that day. Tested for a multitude of, yeah, concerns within the facility and also interfaced extremely well with our department and others that have to do with hazardous materials and those concerns. They also were incredibly

respectful and helpful with the patients that were in our morgue and ensuring that they got safely transferred out within the event and that day. So, we'll just keep on going to the next slide, please, but I'd like to give them a personal shout out because they made our jobs a lot easier that day.

42:39
Kim, if you'd like to speak to the media briefly, I think maybe we can wrap it up with this slide, and then a quick note on recovery.

42:46
KW: Sure. Obviously, you know, getting the message out public relations was involved at the outset, and the media was, was quite anxious to get updates. So, they did set up a small area behind the hospital where the CEO and the Chief briefed the community with our, our VP of Marketing and Public Relations.

43:08
So always a very important point to consider as you're communicating to the public and to families.

MD: How things get spread very quickly, like wildfire, whether they're truth or not, kind of unbelievable, how quickly that works on social media.

43:27
CS: And if we could just progress a few slides down, I think our recovery process is worthy of a whole additional presentation because it is ongoing at this point.

43:37
And honestly, probably the most difficult piece of this event response in my opinion, having responded to a lot of different types of events, the response for this was very chaotic and draining and a lot of work.

43:50
But, I think, in a sense, you're trained for it. You understand what the priority is, ensuring safety for patients, the first responders, the staff. But then to come back to an empty facility the next day, and look to get back open, I think has been a really incredible learning experience for all of us, and we appreciate all of the assistance that we've got from the community, in the state, in this process. So, I don't know that we have a ton more time, but if we have questions or anything specific you'd like us to touch on within recovery, we would be happy to speak to that.

44:25
JH: Oh, there's lots of questions, which is good, and there's good ones. So can you just comment on the current status of Brockton Hospital? And then I know you all made some early efforts to try to open Urgent Cares and other things to support the community's health care needs, if you can just speak to that very briefly, that would be great.

44:46
MD: No. Go ahead, Kim, you got it.

44:48
KW: OK, sorry, or we're stepping on each other here, you know, obviously the moment, it's kind of the end of the, the day on February 7th. There was a thought that this rebuild, could take a year, if not more, and it was, it was really just a stunning, you know, blow. Because we really

just didn't get up in the morning thinking that would be the case. What people have to realize, and I think many people in hospital communities realize is that this is an old buildings, so this the newest part of our building was built in 1980, the rest, the infrastructure in the fifties. We've been around for over 100 years on this site. So, to rebuild and get 250,000 square feet of wiring up to code, it's going to take some time with, you know, our partners in the community. People have been very supportive because we are a safety net hospital. The community has lost an ED that saw about 160-170 patients a day. You know, we do 1400 deliveries.

45:53
It's a really an essential part of the community care model, so we had to get some Urgent Cares open. The teams did a tremendous job that within weeks had a site open. We had a second site, we now are running. We opened our third Urgent Care, but we're seeing over 110 patients a day, in two sites. One of our onsite urgent cares is seeing over 100 patients daily. So we're doing what we can to get access available. We deployed our staff. We were very, we are very concerned that while we're rebuilding that, our staff will, will move into other positions. So, we set up a small agency, if you will, a deployment, we reached out to local organizations and asked if they would like to lease our staff and, you know, certainly not at an increased rate, but just kind of a rate that would help to keep our employees employed and also help our partners, who are seeing more patients than they normally would. And we've had a number of staff do that.

46:59
We've also opened up our Endo Program, our Wound and Infusion Program and a limited number of OR cases that we can do in our main support hospital.

47:10
The last remaining, kind of bit of the building that has power, while we rework and rebuild the rest of the organization, and we're hoping to see success through the winter, and then an opening in the late spring, early summer of 2024.

47:29
So a lot of work ongoing, and a lot of challenges, as I said, in an old building, with an infrastructure that, like many hospitals, when you're making strategic plans for upgrading systems, you don't always go to anything that's broken. You kind of go to the technology, and you have to leave your HVAC and other things at the mercy of time, and we're looking at rebuilding that as well. So a lot of plans in place for rebuilding, but a very strong commitment to get back into the community.

48:02
JH: Great, thank you so much. We'll try to hit some of these rapid fire, and we may go just a couple minutes over if that's OK. But can you comment, it sounds like the generators failed early on, was that because their transfer switches were in the area with this major electrical fire occurred, is that the reason?

MD: Correct.

JH: OK, then the oxygen, the main line and I'm guessing that your backup system for oxygen was affected because the main oxygen line ran directly through that room in the vicinity of the fires, is that right?

KW: Too dangerous. That's correct. Yes.

48:37
JH: How much notification did you have that the oxygen was going down? And it sounds like staff reacted, you know, very quickly, you know, to that happening, you know, moving to portable tanks and things. Can you comment on anything that you kind of wish you'd had, as far as resources or training for that?

48:54
CS: I can speak to this. We had actually had a few medical gas shutdowns previously in which we included our respiratory staff, during the events. So, they were actually quite used to going through the process of checking for which patients were on oxygen, ensuring they had enough, for the foreseeable future, and then, going through the process of turning off the medical gas. So, they were ready, as soon as they heard it was a real fire, they were pre-deploying oxygen for patients who needed it. And that really helped us make a fast decision to turn off the oxygen once it was recommended by the fire department, in conjunction with the additional clinicians that were caring for those patients. It was a very quick situation.

49:34
JH: That's wonderful. You were quite lucky. It sounds like you had some connections with the healthcare coalition very early on, but because of the lack of comms, there really wasn't a lot of opportunity to engage them in patient placement and other coordination activities. Is that fair?

49:52
CS: Yes. We have had a lot of exercises and tabletops and drills that we've done as a coalition and we're in constant communication on a normal day just to ensure that we maintain situational awareness of each other and, you know, go through best practices together. But we were very much cut off from the rest of the world with the exception of text messages. And that was really not the best way to share patient information, certainly, but also updates real-time, because we were scattered to the winds, and ensuring that the immediate response was being taken care of.

50:27
KW: If I can jump in, Dr. Hick, one of the biggest reasons for our success was the fact that we had those established relationships, and that our senior team was willing to hand the building over, and the whole operation of the evacuation to hand it over to the state and to the local fire department. They didn't buck anything. They didn't try and direct where our patients went. And it was identified pretty early on post fire that that was a big plus in our favor. And if I can give a takeaway for this at all, it's to develop those relationships with your area organizations and who potentially could respond, and who would be potentially responding, too, and make sure that they are tight, tight enough that you have cell phone numbers for people so you can text them.

51:16
JH: You bet. It sounds like the vast majority of the patient movement was by EMS backboards down the stairs to a stretcher at the bottom of the stairwell. Is that a fair assessment?

51:27
KW: Correct.

51:29
JH: Did you, did you have any med sleds or anything like that, or, or was that equipment all unavailable, because it was in the store room?

51:37

CS: We do have med sleds, but with the way that the evacuation was being run and the fact that we have a five story building that we're bringing patients out of, the safer route was going to be utilizing EMS and fire to transport, because there was smoke in the stairwell as well.

51:55
JH: OK, very good. Did you, prior to the evacuation, did you use any evacuation, triaging, tagging system or no?

52:03
CS: We did, we have pace kits, so we were able to utilize those somewhat for patients. Although, it got to be a little bit slow, as we didn't have an extensive amount of people trained on how to utilize them. So it ended up kind of being a just in time adjustment, but we were able to utilize some of the preexisting evacuation resources that we had onsite.

JH: OK, But it sounds like you prioritized your laboring and ICU and, you know, psychiatric and other folks, you know first, and then, those with lesser degrees of need, you know came later, so very good. Can you help me understand a little bit more about the patient records. You lost your access to EHR. And just, basically, it sounds like, kept a line list of what patients were going to what hospitals. And then how are you able to start to reconstitute the record to them forward to that hospital?

52:54
KW: With that, yeah. We have, we have off site redundancy in our medical records, so we were able to get down to another location and download that patient information once we had the master list available and that was done later that evening.
53:11
CS: And they were also able to, DPH, was able to put out an alert to all of the receiving facilities asking for them to submit the patients they had received in order for us to further reconcile.

JH: OK. Very good. How cold did it get inside the facility, since your heating, and other systems were out, and you've had a lot of open doors for the evacuation?

53:34
CS: I was outside, I'm not sure.

53:40
KW: Yeah, in Massachusetts, the weekend before this, we had had a tremendous cold snap way below zero. So I think, you know, for us, it was in the thirties and forties, we felt it was a manageable day. It really didn't play a play, a factor, in the management of patients.

53:59
JH: Good. Was pharmacy able to bring critical medications to ICU and in other places, as needed, you know, despite a lack of comms? How did that work, or was central pharmacy affected in different ways?

54:13
KW: Central pharmacy was, was very, very close to the fire site. So, once the director was able to get keys that were needed to open the Omnicells, we were, it took some time, but that's, we kind of broke into those system and we were able to access the needed medication.

54:32

MD: We utilized, too, our code carts in the emergency department because those are easy, easily accessible. So, I know that a lot of the code carts had been opened, as well.

54:45
JH: I can imagine there's quite a consumption needed. What do you think really helped your staff to get through this from a training standpoint? So, if I was going to emphasize, you know, some areas of training for my staff going forward to prepare them for, you know, these sort of situations, where would you advise that we spend our time?

55:07
CS: I think, from an emergency management perspective, we really try to keep everything all hazards, which I realize is such a kind of key phrase that's thrown around. But, in this sense, a lot of our COVID response translated well to this event, which you wouldn't necessarily assume, but just being aware of the patients and ensuring that their safety comes first and whether we'd have to move them to a different space.

55:30
We did a lot of finagling during the pandemic to ensure that we still had appropriate patient care and I think that mentality, coupled with empowering staff to make decisions and act, really benefited us. I mean, we got incredibly lucky, but we also had staff that prioritized their safety and their patient safety and made decisions, and that came together to ensure that we were able to safely move everyone.

55:55
MD: Something else that, um, if I could jump in, it's Melissa. I had been scheduled for a few weeks ago to Anniston for FEMA training after this and decided it wasn't a good time to go, and we had had our own experience here. But many of our leaders had gone in the past and for years, just the drills that we have in the environment of care events and the focus on that and how Claire and her team with Jeannette McGillicuddy, our director, really kind of drilling it into it.

56:27
It becomes part of the fabric of how we do business and how we trained. So I'm really thankful for all of that. The fire drills and the importance of keeping fire doors closed and race and everything that we get in our annual training and beyond.

56:46
JH: You bet. I think this will be our last question since we already have kept you a few minutes over, but it sounds like you have a fairly robust healthcare coalition, would they have helped coordinate destination to hospitals had you had better communications, and in this case, was it more the EMS agencies that worked on that aside from, it sounds like you're psychiatric and ICU patients, there were some arrangements directly made by the physicians or the personnel on those units, is that fair?

57:15
CS: Yes. So, in previous exercises, within the coalition and across the state, we have acted in such a way where a central entity would be determining where each of the patients would go, including an event that we or an exercise, rather, that we did about them two months after this real life event. But it just was not effective because of our lack of communication, and because of how quickly patients needed to be moved. So luckily, we had a representative from Southeastern Mass EMS onsite, and she was able to collect information from a variety of different hospital representatives who were sending information and all sorts of methods, and we

were trying to collate that information in order to ensure that, this spaces, that we were looking to send patients to did exist. And we quickly realized, originally that patients were, excuse me, hospitals were applying with their availability based upon a red, yellow, green system, when in reality it was a lot more effective to submit, essentially COVID numbers with, you know, availability based on more acute needs, you know, whether you had a bed, an ICU bed, et cetera. So it transitioned from a coalition-based approach. Also, we were over, not just one region, so it kind of spread, not just in Region five, but into two or three other regions. So, it kind of surpassed our coalition capability in a sense. Not, they're not capable, but I think it was just a bigger event because we hadn't anticipated having to move 162 people.

58:48

I, again, I want to thank all three of you, for sharing this with us. What an incredible story, and what an incredible challenge, not only during the event and also in the aftermath. And I'm sure, both from a, you know, recovery, and staff, and regulatory, and other standpoint, and this has been a really difficult year. So we're really grateful. I'm afraid that's all the time we have today, but we do have some other questions we will be forwarding along and getting some answers back in written form. Again, this webinar will be archived and available. If you do have any suggestions, questions, or further queries, please don't hesitate to get in touch with us at asprtracie.hhs.gov. Give us a call and for sure, visit us on our website, and continue to keep an eye on the Express and the Exchange for great information on other upcoming topics. So, thank you so much for joining us today. Be safe, be well, and happy holidays to all of you.