

University of Kentucky's football field and subsequently deconstructed two months later before ever being used, costing the hospital \$6.7 million dollars. Lack of tests and knowledge about the disease in combination with over ordering labs and CT scans in an attempt to risk stratify. There was no reliable way to obtain COVID-19 testing or deliver the results and this led to increased non-sick patients presenting to the ED just for information.

Conclusion: The COVID-19 pandemic highlighted many shortcomings of our hospital system and its preparedness for a pandemic or mass disaster. The silver lining of these failures was the implementation of system wide improvements in throughput and preparation within our emergency department.

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Mapping Nurses' Advanced Roles in Emergency Departments Globally

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Introduction: It is widely recognized that there is an increasing demand for healthcare in emergency departments (ED) around the world as well as a global shortage of healthcare workers (HCWs). This has led to ED overcrowding, which increases risks of avoidable complications and suboptimal care provision. Since ED overcrowding impacts patients, staff and quality of care, new strategies are needed for optimizing patient throughput and reducing waiting times. One such strategy is to reconsider the specific roles and professional duties of different cadres of HCWs. Empowering nurses to take on some of the tasks historically performed by physicians is a promising solution for improving ED healthcare provision. However, nurses' professional responsibilities and competencies differ significantly from country to country. There are few studies about best practices and how to effectively implement such task-shifting strategies. The aim of this study is to map the evidence published in the scholarly literature on nurses' advanced roles in ED as a strategy for reducing overcrowding, facilitating ED throughput, and, ultimately, improving quality of care.

Method: A mapping review was performed by searching the following databases: PubMed, Embase, Scopus and Web of Science.

Results: A total of 168 studies were analyzed and the data were grouped according to the countries where advanced tasks were implemented. The type of tasks that were carried out were: autonomous management of patients with minor injuries, triage-based ordering of exams and administration of therapy and management of patient flow.

Conclusion: In some high-income countries having nurses take on advanced roles is well-established, and it contributes to reducing overcrowding in ED. Further evidence is needed to assess the barriers and facilitating factors to implementing this strategy in other contexts.

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Critical Decision-making in Medical Command and Control During Early Covid-19: An Interview Study

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Introduction: A resilient health care system is expected to withstand disruptive events and consistently deliver high quality care by continually adapting, learning, and improving. To achieve these expectations, medical command and control teams are responsible for making relevant strategic decisions, reallocating resources, and initiating cooperation. Early during Covid-19, medical command and control teams were faced with an unforeseen increase in number of patients, as well as unknown disease mechanisms and treatment regimes. Timely and adequate decision-making to become a resilient healthcare system and maintain high quality care was necessary. The aim of the present study was to describe the challenges and strategies in a medical command and control team during the early phase of the Covid-19 pandemic.

Method: A semi-structured retrospective in-depth interview study with phenomenological approach and inductive design was used. Thirteen experienced decision makers serving in a regional medical command and control team were interviewed using the Critical Decision Method. The interviews were analyzed using manifest conventional content analyses.

Results: The respondents described twelve separate episodes during the Covid-19 management. The analysis resulted in five themes: organization, adaptation, common operational picture, assumptions, and analysis. Organization described how organizational challenges affected the decision-making process. Adaptation described the strategies to overcome the obstructive organizational factors. Common operational picture described how challenges in lack of available information affected decision-making and strategies used in creating situational awareness. Assumptions offered descriptions of strategies used to make decisions. Analysis emphasized descriptions and strategies affecting the decision-making process.

Conclusion: This study enables a better understanding of how medical command and control teams can be organized and structured, while also highlighting challenges in maintaining high-quality care during unexpected events. The findings obtained in the present study provide further knowledge about

disaster resilience and can be utilized in educational and training settings for medical command and control.

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Integrating Response Plans for Burn Mass Casualty Incidents

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Introduction: Across the United States (US), there are approximately 2,000 burn beds in 133 burn centers, only 72 of which are verified by the American Burn Association (ABA). As such, many areas in the US are hundreds of miles from the closest burn center. Eight states do not have a burn center, and another 11 do not have an ABA-verified center. Further, the average center has 15 beds, and, on average, there are 90 available beds across the US. Therefore, in addition to patient care complexities, the broader infrastructure for burn patients is severely limited. These constraints suggest the burn healthcare system is particularly vulnerable to disasters, where the needs will exceed the resources available.

Method: A literature review was conducted of available burn mass casualty incident (BMCI) plans from stakeholders in each level of a response. These response partners included prehospital agencies, hospitals (those with and without trauma center designations), emergency management agencies (local, state, and federal), healthcare coalitions, public health (district, state, and federal), regional coordinating burn centers, and the ABA.

Results: The amalgamation of the BMCI plans yields a tripartite infrastructure not unfamiliar to emergency management professionals. The burn care agencies integrate into a response, similar to the way in which public health integrates into the emergency management infrastructure. The local to state to federal escalation of assets is reflected by an escalation from the local burn center to the regional coordinating burn center to the ABA. However, gaps remain in the communication between response partners. Few plans, particularly at the local level, reflect the integration of the burn system response.

Conclusion: The burn healthcare infrastructure in the US is constrained and therefore is particularly vulnerable to a BMCI. Emergency responders should preemptively examine their plans and systems to specifically integrate the burn care and response infrastructure.

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Role of General Practice Led Observation Ward to Support Emergency Ward to Improve Health Outcomes at a Major Kathmandu Hospital in Nepal

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Introduction: Tribhuvan University Teaching Hospital (TUTH) is a tertiary care hospital in Kathmandu. The emergency department sees between 130 to 140 cases per day.

These patients get initial evaluation and basic investigation for acute emergency management and treatment. Those requiring further treatment are then admitted to the department of General Practice for post emergency care which acts as an observation ward. This step allows for the patients to be observed on a short-term basis and permits patient monitoring and/or treatment for an initial 24–48 hour period and up to a maximum of five days. These steps allow for focused follow up, improved efficiency and minimizes inappropriate admissions to other hospital inpatient wards. This paper evaluates functionality, admission criteria, patient categorization and subspecialty referral to specialty patient care, discharge criteria and cost effectiveness.

Method: A descriptive observational study was carried out of the patients admitted to the observational ward between 2020–2021.

Results: Most articles suggest these wards improve patient satisfaction and clinical care, decrease length of stay, reduce unnecessary inpatient hospital admissions and are useful in fever under evaluations, COPD, poisoning, pneumonia, mild head injuries, high sugar, hypertension, gastroenteritis etc. Around 14% of patients were sent to the observation ward after acute emergency care. 84% were discharged from observation ward with a mean stay of three days and were followed up in community care or GP OPD. Nine percent were admitted to hospital wards, and 7% transferred to yellow/red area emergencies for derange vitals.

Conclusion: Observation wards seem to have advantages, excluding those who will inevitably need longer treatment, reduces cost savings and unnecessary burden of hospital admission.

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Quality Improvement Project: Optimizing Compliance with NICE CG176 Head Injury CT Time Standards at Wexford General Hospital Emergency Department

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Introduction: Head trauma is a high-risk presentation to the emergency department (ED). Preventing secondary brain injury through earlier diagnosis and intervention relies on timely access to head CT. Wexford General Hospital (WGH) ED uses NICE guidelines, which recommend specific timeframes for acquiring CT in head trauma. Following an audit demonstrating low compliance to NICE CG176 time standards in