Asiana Airlines Flight 214 Response
Lessons Learned

December 6, 2013
Objectives

• Review overall scenario – From plane crash to “All Clear”
• Look at types of injuries seen
• Review lessons learned from response
Timeline of Events

• 11:28 a.m. – Asiana Airlines Flight 214 crashes upon landing at San Francisco International Airport (SFO)
  – Debris field covered an area greater than 9 football fields from the sea wall to resting area
Timeline of Events
Timeline of Events

• Field Response
  – 307 people were dispersed along the crash site
    • 291 passengers and 16 crew members
  – 178 victims were transported from SFO within 5 hours
Timeline of Events

- 11:49 a.m. – First news reports seen by Emergency Department nurse
Timeline of Events

• 12:06 p.m. – Stanford Hospital and Clinics’ “Code Triage Standby” activated

**Code Triage Standby:** Report of MCI with potential of >10 Immediate patients  
**Code Triage Minor:** MCI with 10-20 Critical or Immediate Patients  
**Code Triage Major:** MCI with >20 Critical or Immediate Patients or Chemical, Biological, Radiological, Nuclear Event
Timeline of Events

• 12:40 p.m. – First two patients arrive at SHC via US Coast Guard helicopter
• 12:42 p.m. – First EMS notifications of a mass casualty incident, “Fire Department triaging 290 casualties”
• 12:43 p.m. – “Code Triage Major” notification
Timeline of Events

• 12:46 p.m. – First ambulance arrives at SHC with four patients
• 6:27 p.m. – Last busload of patients arrive
• 8:12 p.m. – Code Triage All Clear made
• Throughout the night – Visits from DHS, DOJ, Immigration & Customs, Korean and Chinese Consulates
Types of Injuries

- Burns and inhalation injuries
- Head trauma (traumatic brain injuries)
- Spine fractures
- Chest trauma (collapsed lung and rib fractures)
- Extremity fractures
- Lacerations
- Bruises
- Seat belt injuries to spine and abdomen
Overall Success Stories

- Hospital Command Center activated in a timely manner following initial notification
- Rapid Admission Plan in the Emergency Department
- Seamless coordination and cooperation between staff
Overall Success Stories

• Treated 55 patients from Asiana Airlines Flight 214
• 18 patients admitted to SHC
• 7 pediatric patients admitted to LPCH
• 150 hospital personnel responded to incident
• Hospital maintained business and service continuity through entire incident
Primary Areas for Improvement

• Initial notification page source of confusion
  – Lack of messaging to off-site staff members on their next steps
• Patient identification and tracking patient movement throughout hospital
  – “Girl with blue socks”
• Patient did not receive registration / medical record numbers until after initial evaluation was complete
  – Medical services could not be provided until registration was completed
• Uncertainty on what information could be provided to the media
The Joint Commission Critical Elements

1. Communication
2. Resources and Assets
3. Safety and Security
4. Staff Responsibilities
5. Utilities Management
6. Patient Clinical and Support Activities
Communication

• Positives
  – Only 27 minutes for the Hospital Command Center to be fully activated and operational following notification of activation
  – Updates posted in HCC allowed for constant visibility on latest situational awareness
  – Information flow traveled through appropriate HICS channels
Communication

• Areas for Improvement
  – Hospital Incident Management Team was unclear on what could be said to the media regarding patient information
  – Confusion regarding triage vocabulary
  – AlertSU was not used for this response
Resources and Assets

• Positives
  – Turnaround time between Code Triage notification and triage area being established
Triage Area
Resources and Assets

• Areas for Improvement
  – Old disaster information found in multiple locations
  – Underutilization of Epic and Webtracker in Hospital Command Center
Safety and Security

• Positives
  – Vehicular traffic to Emergency Department was well-controlled
Safety and Security

• Areas for Improvement
  – More security desired to control access to Emergency Department
Staff Responsibilities

• Positives
  – Rapid Admission Plan worked in the Emergency Department with the support of the Administrative Nursing Supervisor
  – Recent training empowered staff
  – Seamless coordination and cooperation across the organization
Staff Responsibilities

• Areas for Improvement
  – Roles and skills of certain functions have not been properly finalized
    • Chaplaincy, Interpreter Services
Patient Clinical and Support Activities

• Areas for Improvement
  – Slow patient registration delayed care
  – Trauma names were confusing
  – Patient Identification was difficult
  – Lack of a mobile registration system hindered process
Thank You

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