

Not Everyone Can be a Chief

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Introduction: In 2014, the residency program adopted a new chief resident model. Multiple other programs had adopted a similar style of having all final-year residents have a “chief” role. Chief residents are meant to be leaders in the residency, have a direct influence on the program, and serve as liaisons with other department chiefs.

Method: Prior to 2014, the program had three chief residents a year: one Admin, one Academic, and one Recruitment. They were chosen using a vote amongst residents/faculty, with the ultimate decision made by the residency leadership. Many other residents were interested, and often qualified, but were ultimately not chosen. In 2014, the all-chief model was adopted. Each PGY-3 would have a responsibility. The goal was to give each a leadership opportunity, and a tangible product as they transition to fellowships or new jobs. The residents were allowed to pick their position, with some influence by residency leadership. Residents were encouraged to create new roles which aligned with their personal interests or career goals. Examples included Medical Director Chief, U/S chief, PEM chief and Wellness Chief.

Results: Some residents thrived when given responsibility, while others did not. Some could not manage more responsibility: there was a clear disparity in the effort. At the start of this, all residents’ total shifts/month decreased equally. This created some controversy when the workload was not equal. The alteration of details, requirements, and expectations occurred every year in an attempt to correct the failures.

Conclusion: Ultimately, the all-chief model was a failure. The program reverted to a traditional chief model, allowing only those the residency leadership felt could manage chief responsibilities to have a role. Those not doing a chief role were given additional shifts and those with less added work were given only a partial shift reduction.

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Organizational Resilience Among Health Organizations in Israel

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Introduction: Health Organizations (HOs) worldwide are vital to any nation’s capacity to withstand crises. The COVID-19 pandemic increased the HOs’ awareness of the importance of Organizational Resilience to ensure Operational Continuity during crises.

This study aimed to identify the main elements affecting HOs’ resilience, to enable their application in long-term processes of capacity building.

Method: A cross-sectional study examining the level of organizational resilience in HOs was performed, in a general hospital (group A) and one region of Emergency Medical Services–EMS (group B). A structured questionnaire, consisting of 29

items, was developed, validated, and subsequently used to assess organizational resilience. The questionnaire encompassed: ethos, organizational culture, leadership and human capital, situational awareness, adaptability, organizational performance, and learning ability.

Results: The respondents included 225 participants from the hospital and 214 from the EMS. Both HOs presented a high level of organizational resilience (average score among hospital and EMS personnel was 3.79 versus 3.91 respectively).

In a multivariate linear regression test, the factors found to predict the organizational resilience (in both organizations) were education (academic/non-academic), gender (male/female), and two age groups (20-30 & 31-40).

These factors explained 11% of the organizational resilience. Other factors such as profession or seniority at work, were found to be non-significant.

Conclusion: As the operational continuity of health organizations is vital during crises, the developed evaluation tool contributes to the capacity of managers and policymakers to continuously monitor the level of organizational resilience. In line with the factors identified as predictors of organizational resilience, health managers should focus on educational interventions to increase their organization’s resilience. It is recommended that follow-up studies be initiated to examine additional variables that may predict the level of organizational resilience.

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Evidence Mapping Survey on Professional Development Programs and Courses in Health Emergency and Disaster Risk Management

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Introduction: A prepared and well-trained workforce is essential to reducing the loss of lives from health emergencies. However, it is uncertain what should be included in the common set of core competencies for the health emergency and disaster risk management (Health EDRM) workforce. The objective of the study is to provide evidence mapping for the competencies in existing professional development programs and courses in Health EDRM.

Method: A survey conducted using an online platform (Survey Monkey) was conducted from October to November 2021. Experts in the Health EDRM Research Network including experts identified for the Delphi studies were invited to join the study. Participants should be ≥ 18 years of age, and had relevant experience in Health EDRM and in disaster education and training programs. A self designed questionnaire containing 28 questions in four domains including competencies; curriculum; evidence gaps; work and personal details were used.



Results: There were 65 respondents from 20 countries participating in the survey. Most of the respondents worked in academic institutions (60%), followed by government employees (19%), and non-governmental organizations (7%). These organizations have roles throughout the disaster cycle with 95% in the preparedness phase. For management skills, EDRM managers should be competent in planning, organizing, applying management processes, establishing effective communication systems and providing effective leadership. For technical competencies, emergency communications, hazard specific knowledge, communicable diseases were essential for frontline workers. In terms of designing the competency matrix, WHO resources were frequently used for the competencies and the curriculum design.

Conclusion: Health EDRM managers are expected to master a large number of managerial and technical skills, including the increasingly recognized leadership and decision-making skills for effective planning and implementation. These competencies need to be established for the development of a Health EDRM workforce.

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Trauma Skill Stations to Improve ED Staff Confidence and Engagement

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Introduction: Particular skills are critical when participating in trauma response. Engagement and practice with these skills can help build staff confidence, however, ensuring competency across all staff can prove challenging. Establishing a training utilizing skill stations can positively affect staff experience and confidence measures on predetermined dates to capture all team members is a way to ensure confidence in skills vital for patient care in ED settings. Execution of the “skill station” exercises at measured intervals demonstrated improved confidence in trauma skills by ED staff. Exercises with specific skill-oriented practicum offer low-cost, dynamic training opportunities. Improving confidence and competence in critical trauma-related clinical skills directly improves patient outcomes.

Method: Six trauma skill stations were created, aimed at specific skill-based practices. These measured skill competencies include arterial line setup, rapid blood infuser use, defibrillator use, chest tube management, pelvic binder application, and tourniquet application. Competency was reached when participants could effectively perform the skills through teach-back technique.

Results: Qualitative feedback demonstrated that nurses felt more confident responding to a patient needing trauma interventions in an ED setting. Nursing staff were more engaged with trauma skills in their scope. All participants were able to appropriately and adequately teach-back the skill with 100% accuracy. Improved knowledge retention will be measured in future training sessions.

Pre and post-tests could be utilized to demonstrate more dynamic results. This measurement tool will be utilized in the formal training process moving forward to capture baseline and improvement data more objectively.

Conclusion: This low-cost and highly efficient method of strengthening novice nurses’ trauma skills competency and confidence can be utilized across various skills and departments. More confident nurses show improved readiness to respond to a patient in need of trauma interventions.

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Global Burden of SARS-CoV-2 on Health Care Workers’ Mortality and Morbidity

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Introduction: Unfortunately, before SARS-CoV-2, a global workforce crisis in health care had already been flagged internationally and is only expected to grow. Health care workers are the critical driving force underpinning all health systems. A skilled workforce takes years to develop, and staff shortages have enduring negative impacts on patients, patient safety, and the ability to deliver Universal Health Coverage.

Method: A scoping literature review on health care worker mortality and morbidity resulting from SARS-CoV-2 was undertaken and included reviewing the peer-reviewed and grey literature.

Results: Four opportunities for improving the protection of health care workers during a pandemic were identified:

- 1) Strengthening data collection and reporting standards of health care worker mortality and morbidity due to SARS-CoV-2
- 2) Improving the protection of health care workers
- 3) Accelerating the vaccination of health care workers against SARS-CoV-2, and
- 4) Addressing gender inequities in health care

These four approaches provide opportunities for improvement and are only preliminary steps in addressing the ‘perfect storm’ that the shortage of global health care workers and the ongoing SARS-CoV-2 pandemic have created.

Conclusion: The global community has a unique opportunity to protect health care workers and improve pandemic preparedness and response. The health and socioeconomic impact of SARS-CoV-2 has been unprecedented, and health care workers have borne the brunt of this pandemic. We owe our health care workers more. Without a well-trained and adequately resourced health care workforce that is prepared to face the next pandemic, we as a global community will not be able to deliver global health care or global security at the level that is required.

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