A Night in the ED

By Todd Neff

At first glance, the fluorescent-lit corridors of University of Colorado Hospital’s Emergency Department impart a sense of order to a place that is, in fact, a warren of additions — a pharmacy hallway appropriated here, an outpatient clinic there. The color-coding of the ED’s halls — red for the most critical patients, then yellow, then green — has slowly lost meaning as patients of various statuses go wherever space can be found.

The newer annexes include “chartreuse,” a back hallway, and “MASH,” which starts at the ambulance vestibule and heads east toward radiology. Streams of patients have for years followed each small expansion.

So it was that as a typically busy Thursday night rolled into the morning of Friday, July 20, patients filled nearly all the ED’s 35 rooms as well as several of the 15 cots lining its many corridors. Fully 25 were inpatients being harbored in the ED until beds opened up in the tower above. A dozen more sat in the waiting room.

This was nothing out of the ordinary. The most striking thing about the night was that flu had swept among ED staff. Comilla Sasson, MD, had come on an off night to fill in, as had Justin Oeth, RN, the ED’s associate manager. He was there not as a manager, but rather as a nurse, having been unable to find a fill-in.

Sasson, who with Barbara Blok, MD, served as attending physicians that Friday morning, typically sees perhaps 35 patients during an 11 p.m.-to-7 a.m. overnight shift. Most are medical cases — infections, heart attacks, strokes — with maybe 10 to 20 percent being traumas. Working with Sasson and Blok were a pair of ED residents, an intern, and 14 nurses. The chief resident, Austin Johnson, MD, PhD, happened to be working a trauma case soon after he got in at 10:30 p.m. — a gunshot wound to the leg.

Serious, yes, but “not something we were worried about,” Johnson recalled.

Not long after that, the department’s emergency-management system radio — called simply “the box” — mentioned a shooting. Those within earshot figured it was related to the gunshot victim Johnson was taking care of.

“A lot of the time, when there’s one, there’s more,” Blok explained.

Then came chatter about gas masks, and then a phone call from EMS dispatch, telling the ED to be ready for five gunshot patients. At that point, Blok said, “we pretty much knew that there’s something big coming.”

Johnson and the ED intern started preparing the “star room,” the ED staff’s term for the big trauma/resuscitation room in the red zone. Others cleared patients out of hallways, set up infusion systems, called for blood. It was just after 1 a.m.

The first arrival. A bloodied woman came in through the waiting room. Her boyfriend had driven her in from the Century 16 cinemas at the Aurora Town Center. Blok assessed her, confirming that she had minor injuries, then asked what had happened. The young woman described the scene in theater 9 — the gas canisters, the black-clad gunman, the shooting, the screaming.

She had scarcely finished when three police cars pulled in, lights ablaze. Ambulances had been unable to get through to the worst-
hit victims because of all the cars and people in the cinema’s lot. Aurora police officers had just lifted victims into the backseats of their cruisers, pulling out with one, two, even three injured slumped in the backseat.

Becky Davis, RN, the charge nurse on duty, ran into the warm night through the ED ambulance bay. It smelled like burned rubber. People screamed in pain. She looked inside the cars and to those who had been lifted onto gurneys by nurses and police and security staff and others working far beyond the borders of their job descriptions. Davis then ran back inside and gave the physicians and other staff a rundown of what was about to hit the double doors. Three more police cars pulled in, then another three. With each wave, Davis did the same thing.

Oeth ran out to meet one of the first cruisers. His colleague Ryan Morissette, RN, wheeled in someone who had been shot in the head. Inside, Johnson pronounced the victim dead. There was no time to contemplate the loss: behind them, another gurney rolled in, then another three. With each wave, Davis did the same thing.

Johnson, Sasson or Blok took a close look at the patients as they rolled in and quickly decided the next step for each one. Who’s sickest? Who’s crashing? Who needs intubation to open an airway? Who needs a chest tube? Who needs a CT scan? Who needs a central line for a quick infusion of fluids, painkillers or medicines?

“What it became was essentially a massive logistics game,” Sasson said.

They handed critical patients off to small teams of at least one MD and nurse plus a respiratory therapist to keep patients breathing. The trauma room, designed for two patients, filled with three, even four gurneys, each surrounded by its own cluster of caregivers.

Another five critical cases lay in and near the ambulance vestibule’s “MASH” area, which on this night was living up to its name. Physicians gave handwritten orders to nurses – they could be reconciled with the electronic medical record later.

**War zone.** Some of the wounds seemed more like blast damage than the product of small arms. The gunman had shot patrons of this midnight showing of “The Dark Knight Rises” with a high-powered rifle, its muzzle velocity topping 2,200 mph – more than double that of the shotgun or the .40-caliber handgun he had also turned on movie patrons.

The ED filled up fast, with patients in rooms, halls, even the ambulance vestibule. Staff squeezed four patients into a trauma room designed for two. Because so many had been hustled over by quick-thinking Aurora police, there had been no triage. Usually, the work of EMTs keeps blood under bandages, in control, out of sight. Now, blood covered patients, caregivers, gurneys, beds, and floors.

The unorthodox transport had also left emergency managers and scrambling ED leaders in the dark about the number of patients, how badly they were wounded, and to which hospital they were headed. And there was no sense of when the flood of patients might stop. This doesn’t usually happen. Plane crashes and terrorist attacks – the mass-casualty events the ED focuses its training on – are surprises, too, said ED Senior Medical Director Bruce Evans, MD. But emergency rooms usually know what’s coming well before the first victims arrive.

At 1:19 a.m., the first – and only – ambulance from the Century 16 arrived with three patients. They would be the last of the big wave. In the span of less than 20 minutes, the ED had received 23 patients, including the one who was dead on arrival. Nine were critically injured. A typical night had transformed into the largest mass-casualty event University of Colorado Hospital had ever seen.

ED leaders knew they needed help. Between treating patients and consulting with the residents, interns and nurses, Sasson and Block were on the phone with the operating room, trauma surgery, neurosurgery, cardiothoracic surgery, neurology, cardiology, anesthesiology, orthopedics, radiology, critical care, respiratory therapy, pharmacy and other areas. Please clear space, they said. Get the ORs ready. Send down docs and residents and nurses.

Upstairs, throughout the house, nurse after nurse took on another three or five patients for a colleague headed into the cauldron. Four
O'Farrill seemed pale.

“Are you okay?” Davis asked.

“I feel bad right now,” O'Farrill offered weakly.

His blood pressure had plummeted. Davis connected an IV, waited for his blood pressure to reassert itself, then moved on to the next patient, assisting with a chest tube here, talking to a patient while a doctor performed a procedure there, running lines, checking vital signs.

“I thought to myself, my God, what it must have been like for these people – what they went through and who they just saw die and how many friends they've lost,” Davis said. “But I was thinking: ‘Let’s save as many lives as fast as we can.’”

For most, there was no reflecting – just doing.

“You had to get through these patients, make sure they were okay, and make sure they had the resources they needed,” Blok said. “You didn’t have time to think.”

Help from without. The patients and accompanying families and friends – in the treatment areas and the waiting room and the hallways outside the ED, as well as those who came to the Anschutz Inpatient Pavilion lobby in increasing numbers as the night wore on – grasped the gravity of the moment. There seemed to be a universal impulse to subjugate one's own needs to those on the precipice who needed help simply to get through the night.

It's not always that way, more than one ED staffer noted.

Help arrived from outside the walls of the hospital, too. Awoken by a page shortly after 1 a.m., ED Nurse Manager April Koehler, RN, had hurried in from Stapleton. By 1:30 a.m., she was checking patients. The wounded were moving in and out of rooms, making the tracking boards unreliable. Koehler stuck a preprinted sticker identifying each patient to sheets of paper. On each one she wrote “what was wrong with this patient, is he stable or not stable, and what the disposition was – to the OR, to the ICU, to the floors, or to discharge,” as she described it. Then she taped the paper to the patient's IV pole.

Koehler kept in close contact with the incident command center, set up on the first floor of the AIP, via radio. Rob Leeret, RN, UCH’s director of Emergency and Trauma Services, alternated between the ED and the command center. Koehler communicated needs, the command center met them. Leeret called in five additional ORs were readied within 30 minutes. Specialists and surgeons arrived quickly, asked how they could help, and jumped in. They diagnosed, stabilized, and whisked patients to CT scanners and ORs.

The cavalry. Some of the arrivals took over the inpatients who had already been in the ED. Two came to help ED nurse Kari Grodin, RN, who had found herself watching over about 15 patients in an ED back hallway in addition to caring for a gunshot wound patient. Meanwhile, the ED never closed for business.

Even as those with gunshot wounds worked through the system, a seizure patient was wheeled straight to an ICU. In a hallway in the yellow zone, Oeth resuscitated another dangerously ill new arrival, pouring oxygen from four tanks into the man.

The ED ran out of essential supplies like heart monitors, chest tubes, IV fluids and portable suction machines. Certified nursing assistant Sherri Acevido fetched boxes full of IV bags, put them on a cart and rounded with them. ICU nurses appeared with monitors and medications. Central Supply rounded up other equipment and consumables like bandages and oxygen and brought them all to the ED.

There were no exclamations points to requests, no raised voices, no sharp demands like “I need this now,” several who were there remarked. The scene combined intense activity and relative quiet, at least beyond the sounds of suction, the snapping on and off of rubber gloves, the beeping of monitors, and the succinct exchanges among those helping patients. “Focused chaos” would become the shorthand.

There were more procedures needed than hands to do them, despite the influx of clinical help from the inpatient floors. Patients with gunshot wounds to a hand or an arm or a leg don’t normally hang out in waiting rooms. On this night, there was no other way.

Pierce O’Farrill, 28, said that, despite having been shot twice in the foot and once in the upper arm, leaving his humerus shattered. Well into the night, O’Farrill moved from a gurney in an ED hallway. To Jenny Davis, RN, who had checked on him repeatedly,
nurses, but then felt that, with the influx from the inpatient floors, they had enough, leaving many others on standby.

A pressing need was to clear out a half dozen inpatients boarding in the ED to make space for shooting victims (see accompanying story in this issue). Those patients soon went to the Post-Anesthesia Care Unit (PACU). Hospital President and CEO John Harney and colleagues knew early on that they would need ICU space, too, so the ICU team moved seven critical patients to the PACU, whose staff was bolstered by a call for several nurses.

The work in the ED continued for hours. As the most critical patients moved on, those a rung down moved in. Finally, by about 6 a.m., the patient mix had returned to normal.

For the staff who were in the ED that night, returning to normalcy will take much longer.

**Processing it all.** None had ever seen anything like it.

Sasson said she had some “hellish nights” at the Grady Health System ED in downtown Atlanta where she trained. But, she said, “Nothing compares or can begin to prepare you for what I’ve seen here.”

The combination of having had no time to prepare mentally for such a huge number of patients and having no idea, once they started coming in, when the flood would stop engendered a combination of horror and disbelief, she said.

“One critical patient on a given night would shut down the ED. They just kept pouring in,” Sasson said. “Even our walking wounded – not that critically injured – were going to the operating room. The sheer number of people and how bad their injuries were is just something that’s so hard for us to fathom.”

Blok, having trained at Johns Hopkins in east Baltimore, is no stranger to trauma, either.

“You’d think, ‘It’s just another gunshot wound. You’ve managed hundreds of those.’ But there was really something there that was really personal and intense,” Blok said. “We can put ourselves in their shoes and listen to their stories.”

Eight days later, Johnson, the chief resident, said the night was on his and his colleagues’ minds when they fell asleep and, sometimes, when they woke up.

“I think this night made me grow up a lot,” he said. “Obviously we see really terrible things all the time – but this was a night where everything I’ve spent years and years learning came into play simultaneously.”

Everyone from Johnson to UCH CEO Harney was struck by the ED’s – indeed the entire hospital’s – performance in the early morning hours of July 20. Somehow, despite it all, “everyone that came in with a pulse left with a pulse,” as Leeret put it.

Leeret believes that, with time, the humanity of the response will drown out the horror of the act. A nurse with years of trauma experience at Denver Health, Leeret is a big man, with shaven head and goatee. He had to gather himself more than once, though, when he related how Koehler, who had been moving from gunshot wound to gunshot wound, had settled a screaming child in the ED hallway at perhaps 3 a.m. Her mother had been shot in the leg and had been taken for X-rays. Her father, holding his three-month-old baby, just needed a moment to go to the bathroom.

“Can I hold you?” Koehler asked the child. “I’m a mommy, too.”

The child quieted and raised her arms.

In the succeeding days, Sasson and others from the ED ventured upstairs to ICUs to see patients, to talk to families, to try to replace the images of physical destruction with those of recovery and healing. In one case, a half dozen ED staff went together.

“I think most of us just lost it – seeing that person with their family,” Sasson said. The patient, wanting to comfort her, asked Sasson to come over for a hug.

“The child quieted and raised her arms.

In the succeeding days, Sasson and others from the ED ventured upstairs to ICUs to see patients, to talk to families, to try to replace the images of physical destruction with those of recovery and healing. In one case, a half dozen ED staff went together.

“I think most of us just lost it – seeing that person with their family,” Sasson said. The patient, wanting to comfort her, asked Sasson to come over for a hug.

“Such a role reversal. Usually, we take care of people. And here was this patient taking care of us – of our souls, anyway,” Sasson said.