Introduction: The past three years have included multiple Public Health Emergencies of International Concern (PHEIC) and dramatically impacted all facets of Emergency Medical Response. During this time, simultaneous crises have demonstrated the value of the non-traditional responder in mitigating complex incidents. Current geopolitical climate has proliferated nuclear power and increases the necessity for readiness and awareness for radiological incidents. These are complex incidents a responder may face and requires even the lowest skilled practitioner to be fully engaged before special operations intervention.

Limited research exists to determine whether current emergency medical services (EMS) training supplies the competency necessary to ensure safety of the prehospital provider during a radiological incident. Forthcoming research will investigate the effectiveness of this current training within the United States.

Method: Survey data will be collected from multiple providers across the United States to evaluate their confidence level on two primary objectives during a radiological incident: competency of personal protective equipment donning and doffing, and management of contaminated patients.

Data analyses of survey responses help drive future proposed educational activities that will be compliant with best practices set forth by organizations such as the United States Department of Health and Human Services Radiation Emergency Medical Management (REMM), the National Fire Protection Agency (NFPA), and Radiation Emergency Assistance Center/Training Site (REAC/TS).

Results: Data will be collected by survey responses to evaluate a diverse range of EMS services. Details such as skill level, type of EMS service, catchment of communities served, and their impressions upon the training will be analyzed.

Conclusion: This is an ongoing project that will embrace the perspectives of the diverse group of delegates of WADEM throughout and become enriched through the organization's wealth of knowledge. Gaps highlighted during roll-out of this research can also be used to address logistics, doctrine, and policy shortfalls.

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EMS and Bioterrorism Response

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Introduction: Previous studies have found that public health systems within the United States are inadequately prepared for an act of biological terrorism. As the COVID-19 pandemic continues, few studies have evaluated bioterrorism preparedness of Emergency Medical Services (EMS), even in the accelerating environment of biothreats.

Method: This study utilized an Internet-based survey to assess the level of preparedness and willingness to respond to a bioterrorism attack and identify factors that predict preparedness and willingness among Nebraska EMS providers. The survey was available for 1 month in 2021 during which 190 EMS providers responded to the survey.

Results: Only 56.8% of providers were able to recognize an illness or injury as potentially resulting from exposure to a biological agent. Provider Clinical Competency levels ranged from a low of 13.6% (ability to initiate patient care within his/her professional scope of practice and arrange for prompt referral appropriate to the identified condition(s)) to a high of 74% (the ability to respond to an emergency within the emergency management system of his/her practice, institution, and community). Only 10% of the respondents were both willing and able to effectively function in a bioterror environment.

Conclusion: To effectively prepare for and respond to a bioterrorist attack, all levels of the healthcare system need to have the clinical skills, knowledge, and abilities necessary to treat patients exposed to biological agents. Policy changes and increased focus on training and drills are needed to ensure a prepared EMS system, which is crucial to a resilient state. EMS entities need to be aware of the extent of their available workforce so that the country can be prepared for the increasing threat of bioterrorism or other novel emerging infectious disease outbreaks. A resilient nation relies on a prepared set of EMS providers who are willing to respond to biological terrorism events.

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The National Israeli Field Hospital in Ukraine - Innovative Adaptation to a Unique Scenario

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Introduction: Following the outbreak of hostilities in Ukraine and the resultant humanitarian crisis, the State of Israel deployed a field hospital inside Ukraine. Challenges included a large refugee population, disruption of routine medical services to the local population, first-time deployment of a civilian field hospital, and deployment to a country at war.

Method: The activity of the field hospital during a deployment in Ukraine is described along with lessons learned for future deployments.

Results: A Rapid Assessment Team (RAT) performed needs assessment and coordination with local authorities. The main necessity encountered was delivery of primary care to both the refugee and local population. During the 6 weeks of deployment, 6,161 patients were treated in the hospital. 65 patients were hospitalized and 59 underwent surgery. The hospital was completely digitalized. 103 remote consultations were performed using telemedicine techniques. Capacity building of local teams was given high priority and 796 Ukrainian health professionals underwent training.

Conclusion: Deployment of a national civilian field hospital in a country of war is possible through coordination with local authorities while undertaking the necessary security measures.

The change in caseload from expected war trauma to predominantly primary care necessitated agility in planning and operation with subsequent adaptation of hospital and staff structure.

The use of telemedicine enhanced capabilities, allowing access to consultation with the most experienced specialists in Israel.

Capacity building of local teams should be given a high priority. This was implemented by combining clinical training and the inclusion of a medical simulation unit in the hospital.

Dispatching a team delivering medical care and extending a helping hand in time of need, especially when done by a national entity, contributes greatly to building the people's faith, hope, and resilience during the crisis, and has a critical role in the recovery effort.

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No One Should Die Alone: Preparing for the Next Pandemic

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Introduction: As health care professionals and family members, we *know* that many patients died alone in healthcare settings during the first six months of the COVID-19 pandemic. An extensive literature review confirms this as well, and concludes that visiting restrictions during the pandemic had negative impacts on patients and their loved ones.

There is a right to not die alone contained in the Dying Patient's Bill of Rights; however, it happened time and time again during the early months of this pandemic when countless people in long-term care settings and hospitals were reported to be isolated during their final hours of life. *No one should die alone!* What can we learn from this experience to try to minimize this from happening during the next pandemic?

Method: This study will explore the state of the literature on the status and impact of visitor restrictions during the COVID-19 pandemic, in conjunction with a survey of a defined sample of practicing registered nurses in the United States. This study seeks to respond to the primary research question of *how* patients'/family members' end-of-life needs can be met in a pandemic when hospital visitation is severely limited or nonexistent? There are for (4) related sub-questions concerning effective direct and indirect methods of family presence.

Results: The literature concludes that countless people were isolated without family presence during their final hours of life during the first six months of COVID-19. The initial survey process is currently underway, with the identification and analysis of recommendations for improvement in early 2023.

Conclusion: The goal of this study is to develop best practices for meeting the end-of-life needs of hospitalized patients and their loved ones during a pandemic, so that to the extent possible, *no one dies alone*.

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Review of Psychiatric Patient Transfer Times in an Emergency Department with Limited Psychiatric Services

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Introduction: The National Ambulance Service (NAS) must transport patients with acute psychiatric needs to their nearest emergency department for assessment. Wexford General Hospital (WGH) does not have on-site medical psychiatric services after hours, in-patient psychiatric beds, or dedicated psychiatric doctors. Patients requiring formal acute psychiatric assessment and/or admission after ED review need to be transferred 60-80 km to other healthcare facilities.

Aimed to assess average ED stays of psychiatric patients and determine what degree transfer time contributed to their total time would help to determine what delay there was to providing acute psychiatric care due to the lack of after hours/on-site services.

Method: Data was collected from the iPMS system. A total of 125 patients presented with primary psychiatric complaints between January 1, 2021 and December 31, 2021 and required onward transfer for acute psychiatric assessment or admission. Patients were excluded if less than 18 years or had been admitted to another WGH service before transfer. There are no existing guidelines in the National Clinical Program for Psychiatry or NICE guidelines for acute psychiatric patient transfer times or ED stays.

Results: The average WGH ED attendance time was 15h 27min (range 0h08min and 19h22min). The longest interval contributing to overall time was Transfer Booked to Transfer Time (average 3h 27min). The time from Psychiatric Referral to Transfer accounted for 30% (on average) of patients' attendance time.

Conclusion: There are significant delays in accessing acute psychiatric care due to the absence of Ambulance Service Bypass Protocols to transport patients to the most appropriate rather than the nearest ED. Proposed Trauma bypass system changes offer unique opportunities to review such inequity of access to acute psychiatric services.

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