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The Integration of the Regional Hospital in Belgian Disaster Planning: Some Practical Aspects

De Pauw C
H Hartliniek-Eeklo Medical Fire Brigade
Zomergem, Belgium

The role of the regional hospital consists not only of adequate diagnosis and treatment of trauma patients, but also of stabilization and preparation for transport of those who need more specialized help such as neuro- and cardiac surgery.

A practical analysis is made for the H Hartkliniek-Eeklo, which is a medium-size (214 beds) regional hospital situated in the north of Flanders (Belgium). Seven fire brigades protect a rather rural population of 150,000 people. They provide support in three private and four public ambulances. During 1991, 2,422 trauma patients were brought to the emergency service of the hospital with a maximum during autumn. The geographical origin and temporary distribution of these patients and also the dedication of the private ambulance services are described. A scheme is given for the hospital disaster plan. The relationship between the hospital disaster plan and work of fire-brigades, Red Cross, Government, Army, Police, and other emergency services, and their impact on its activation are also described.

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Guidelines for Hospital Disaster Plans

Kai T, Pretto EA, The Disaster Reanimatology Study Group
International Resuscitation Research Center
University of Pittsburgh
Pittsburgh, Pennsylvania, USA

Currently, hospitals in the United States are required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to have internal and external disaster plans. However, JCAHO does not make detailed recommendations concerning disaster preparedness plans. Therefore, there might be a wide variability in the level of preparedness from one institution to another. In a survey of hospitals in Osaka, Japan,[1] this was found to be the case. A similar study in the United States currently is in progress. The following are general guidelines for external hospital disaster preparedness based upon the experiences observed by studying medical response to disaster.[2] It is suggested that hospitals focus on three important areas that frequently fail in disaster events:

1) hospital organization;
2) lifeline vulnerability (electrical, gas, and water supply); and
3) food and medical supplies. These three categories will be discussed in detail.

References:

1. Kai T, et al: Hospital disaster preparedness in Osaka, Japan. *Prehospital and Disaster Medicine,* 1993 submitted for publication.
2. Ricci E, et al: Assessment of prehospital and hospital response in disaster. *Critical Care Clinics* 1991;7:471–487.

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Fire Department Assistance in Development of a Hospital Disaster Plan

Yarritu LF, Munoz T, Gallardo S, Areitio I
Intensive Care Unit
Hospital de Galacano
Euskadi, Spain

Objective: To describe the results of the first inspection carried out by the fire department of this hospital. It is the newest in this community, having been open for only five years.
Methods: The hospital security committee includes a special group for internal disaster prevention which began its work by asking members of the fire department to conduct a detailed inspection of the hospital relative to security systems. After three unannounced visits, conclusions were reported to the fire chief and to the hospital administrator. This report will present the main problems detected, with descriptive photographs.
Results: The fire department reported 21 deficiencies; five safety problems required additional work toward achieving resolution. The remaining deficiencies involved cleaning, safety, or storage problems. A summary of these deficiencies classified by affinity groups includes: inadequate firestairs at psychiatric areas; cleaning deficiencies at laundry area; non-existent emergency exit at the patient's clinical record area; inadequate storage, conduction, and use of propane both in the laboratory area and kitchen; irregular dust placement; smoking outside of permitted areas; lack of emergency designation and non-existent alarm system in closed and deserted areas (clinical records, hospital store); others—blockade in parking access, insufficient pressure for water pumps, blockade of fire extinguishers, non-existent plan to stop medical gas supply in the event of a disaster, and lack of a general disaster plan.
Conclusion: The fire department should conduct at least one annual visit to every hospital for the purpose of reporting deficiencies related to disaster prevention.

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Comparative Analysis of Physician's Work of the Specialized Emergency Teams

Tchuev, PN, Belijakov AV, Basenko IL, Brusnitsina MA, Larionov VM, Ksovreli EA
Odessa Medical Institute
Odessa, Ukraine

Evaluation of complex professional knowledge and theoretical skills has been achieved through the use of computerized scoring among 126 physicians engaged in the following specialized emergency teams: cardioresuscitology emergency team (CR), toxicology team, pediatric team, intensive team, midwifery team, and the general emergency team.

Among a total of 150 monthly calls registered with the CR team, the average time required for a patient's treatment was 80 min; the general emergency team recorded 400 calls, each averaging 25 minutes. However, the number of deaths registered by the CR team was 3.2 times greater than those registered by the general emergency teams. General emergency