

translate our class into an online course so their staff can be trained on disaster management.

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(A107) Victimbase: Disaster Victim Descriptions for Simulation, Training and Research

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Introduction: A 2006 survey showed that 27% of training institutions used computer-based training in disaster medicine and an additional 23% indicated that they will use it in the near future(1). Victim descriptions are an important element of simulation exercises. Currently, the victim data utilized in computerized simulation exercises cannot be used in an interchangeable way.

Methods: The European Master in Disaster Medicine (EMDM) Academy, recognizing the need for access to reliable disaster victim data, initiated the Victim Base project in order to improve the availability and quality of disaster victim profiles for use in simulation, training and research. A standardized victim template was developed through a review of primary and secondary survey requirements with consultation from an international consortium of training experts in disaster medical management during two workshops.

Results: The victim template is composed of a description of the victim profile, a set of clinical conditions and triggers (time and interventions) to move from one clinical state to another. The parameters of a casualty condition are organized in sub-templates and arranged in the way the victim would most likely be assessed. Victim profiles can be delivered in different output formats on request of the users.

Conclusion: In order to evaluate the effectiveness or outcome of disaster response exercises or test operational plans, victim data must be robust, reliable and of high quality. Moreover, the data must be interchangeable in order to make comparisons between different response systems, regions or countries. VictimBase as an online library of disaster victims will contribute to achieve these objectives. 1. Deloos H, Debacker M, Moens G, Johannik K. and the ISEE Partnership. European survey on training objectives in disaster medicine. *Eur J Emerg Med* 2007;14:25-31.

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(A108) Hospital Disaster Planning: The Structured Approach

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Background: Disasters and incidents with hundreds, thousands, or tens of thousands of casualties are not generally addressed in hospital disaster plans. Nevertheless, they may occur, and recent disasters around the globe suggest that it would be prudent for hospitals to improve their preparedness for a mass casualty incident. Disaster, large or small, natural or man-made can strike in many ways and can put the hospital services in danger. Hospitals, because of their emergency services and 24 hour a day operation,

will be seen by the public as a vital resource for diagnosis, treatment, and follow up for both physical and psychological care.

Objectives: Develop a hospital-based disaster and emergency preparedness plan. Consider how a disaster may pose various challenges to hospital disaster response. Formulate a disaster plan for different medical facility response. Assess the need for further changes in existing plans.

Methods: The author uses literature review and his own experience to develop step-by-step logistic approach to hospital disaster planning. The author presents a model for hospital disaster preparedness that produces a living document that contains guidelines for review, testing, education, training and update. The model provides the method to develop the base plan, functional annexes and hazard specific annexes.

References: 1. JCAHO standards as a starting point to prepare for an emergency 2. Australian Emergency Manual. Community Emergency Planning Guide, Second Edition. www.csu.edu.au/faculty/health/aemf/EMPlanning/PLANNING.doc 3. Developing practical emergency management education programs Joint Commission Perspectives, December 2001, Volume 21, Number 12 4. Guide for All-Hazard Emergency Operations Planning (FEMA). www.fema.gov/pte/slg101.pdf 5. EMERGENCY MANAGEMENT PLAN The University of Mississippi Medical Center The University Hospitals and Clinics Jackson, Mississippi August, 2002 6. Hospital Disaster Preparedness: Meeting a Requirement or Preparing for the Worst? By Paul V. Richter Risk Management Coordinator for Support Services South Carolina Hospital Association

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(A109) Health Workforce and Disaster Preparedness of Rural Hospitals

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Following the devastating March 2009 Victorian bushfire disaster in rural areas of Australia, authorities reviewed strategies designed to protect communities during periods of extreme fire risk. New policy and regulation were introduced and designed to ensure that small rural communities were protected and prepared to confront a wildfire emergency during days of extreme heat or bushfire risk weather. As a result on days of declared 'catastrophic' bushfire weather conditions government agencies in South Australia have implemented a policy for schools (including pre-schools) to be temporarily closed. On these days community members are advised to evacuate early to safe regional centres, and to limit travel on country roads. The WADDEM Guidelines for Disaster Evaluation and Research demonstrate that Basic Societal Functions (BSFs), such as education, health, transport and others, are interconnected and interdependent. For example in small rural communities in South Australia people may have a number of important roles including being parents, volunteers of emergency services while also being employed as staff of local hospitals. This project reviewed the impact of school closures and other protective measures on the availability of the rural nursing workforce and on rural hospitals. Rural hospitals in Australia are staffed, on average, by 2–8 nurses, service

very small communities and are separated by great distances. As a result, small changes in the absentee rate for nurses can have a significant impact on the operation of these hospitals. This paper will argue that policy changes in other sectors, such as education, can impact on societal activities such as childcare, volunteer emergency service work, and hospital staffing, in ways that may not be anticipated unless the impact on all Basic Societal Functions are considered by policymakers.

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(A110) A Survey of Health Professions Students Attitudes towards and Knowledge of Emergency Preparedness

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Introduction: The possibility of natural disasters and public health emergencies coupled with the possibility of terrorism support the need to incorporate emergency preparedness into the curricula for every health professional school. **Methods:** A survey methodology was employed to assess both attitudes towards and knowledge of emergency preparedness amongst health professions students which included the schools of medicine, nursing, dentistry and public health. The survey was piloted to graduating students and then administered prior to institution of an emergency preparedness curriculum and then repeated as an annual survey.

Results: The survey found that 51.8% had been present at a disaster as non-responder while only 12.1% had ever been present as a responder. With regard to baseline class room exposure over 50% reported no exposure to such key concepts as incident command, triage, all-hazards planning, surge and aspects of terrorism. In addition at baseline most students felt they had no competency in emergency preparedness. As an example only 10% of students felt competent with personal protective equipment. While exposure both as a responder and student was low, 82.5% of students felt that emergency preparedness should be a mandatory topic in their education. Lastly, with a minimal curriculum change students showed statistically significant increases on knowledge testing.

Conclusions: While exposure was low for emergency preparedness topics and most did not recognize how information they had been taught might be applicable to emergency preparedness, there was a strong desire for additional training. In addition simple curricular adjustments can lead to significant improvements in knowledge.

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(A111) Role, Resources, and Clinical and Educational Backgrounds of Nurses Who Participated in the Prehospital Response to the 2009 Bushfires in Victoria, Australia

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The bushfires of February 2009 in Victoria, Australia resulted in the deaths of 173 people and caused injuries to 414. Furthermore,

> 2,030 houses and 3,500 structures were destroyed. The role and experience of nurses in this environment are not well understood, and little is known about the clinical and education background of nurses in this setting. This presentation will provide an overview of the bushfires and report on two research projects. The aims of these projects were to explore participant demographics and various aspects of nursing activities in the prehospital environment. These projects used volunteer nursing members of St John Ambulance Australia who responded to the Victorian fires. The first project used a retrospective, descriptive postal survey, and the second was descriptive and exploratory, using semi-structured interviews as a means of data collection. The survey highlighted that nurses had varying clinical and educational backgrounds. Males were overrepresented when compared to the national average of nurses. Most participants had taken disaster-related education, however, this varied in type and duration. Similarly, most had participated in training or mock disasters; however this usually was not related to bushfire emergencies. The qualitative findings identified two main themes having expansive roles and being prepared. These highlighted that nurses maintained a variety of roles, such as clinicians, emotional supporters, coordinators and problem solvers, and they were well prepared for these roles. This research provided insight into the characteristics and level of preparedness of nurses who responded to the 2009 Victorian bushfires in the prehospital environment. Additionally, it highlights the need for more structured education and training for nurse that is aligned with their role and deployment environment.

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(A112) Development of Model Medical Care Protocols for Alternate Care Sites during Pandemics and Public Health Emergencies

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Introduction: Developing alternative systems to deliver emergency health services during a pandemic or public health emergency is essential to preserving the operation of acute care hospitals and the overall health care infrastructure. Alternate care sites which can serve as areas for primary screening and triage or short-term medical treatment, can assist in diverting non-acute patients from hospital emergency departments and manage non-life threatening illnesses in a systematic and efficient manner. Maintaining consistent standards of care in these settings is essential to a uniform approach to the medical management of a public health emergency.

Methods: Subject matter experts in emergency and disaster medicine, public health, pediatrics, and various other medical specialties were convened at regular intervals over an 18-month period. Through a consensus-based process this working group created a universal standard of care along with model clinical protocols to manage patients in an out-of-hospital setting using medical and non-medical personnel.

Results: These protocols were designed to allow the mild to moderately ill patient to be managed in a non-acute care