

Conclusions: Survivors emphasized immediate emergency response that address primary needs. Communities showed resilience that can be bolstered by working through local structures. Early adjustment of key survivor-helpers can facilitate societal recovery. The role of organizations (school) and faith in adjustment should be recognized.

Keywords: cohesion; earthquake; qualitative; resilience; spirituality; survivor

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(H66) Capacity Building in Emergency Medicine—An Initiative following the Tsunami in Sri Lanka

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The 2004 tsunami devastated 15 districts in Sri Lanka. Nearly 50,000 lives were lost and about 10,000 are missing. More than two million people were displaced. Many survivors of the tsunami suffered serious mental and physical damages, and lost their hope for the future.

In this context, the Institute of Human Development and Training (IHDT) started a pilot project called the Public Health Education and Emergency Preparedness Initiative in Kahawa. Kahawa is below sea level, and the major source of income for the community was coral mining. The project covers all the stakeholders in the community including the local authority, schools, beach hotels, community-based organizations (CBOs), etc. A lecture series was held to educate the community on how to cope with disasters and manage the responses. Workshops on disaster management and first aid also were held for community leaders. Participants were trained on how to use emergency medical facilities during a disaster. The community is better prepared in emergency health care to face future disasters.

This paper analyzes the post-tsunami scenario in southern Sri Lanka and the initiative taken to prepare vulnerable communities. It describes the challenges of extending this project to a national level and provides conclusions and recommendations based on the experience.

Keywords: capacity building; community; disaster; education; preparedness; response

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(H67) Emergency Response Plan for a Teaching Hospital in Sri Lanka

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Introduction: From a medical point of view, *disasters* can be defined as incidents that generate a large number of casualties that exceeds the medical response capacity. Emergency response planning is a key element in disaster preparedness and mitigation.

The teaching hospital (Anuradhapura) manages a large number of external emergencies. It is one of the hospitals in Sri Lanka that receives the highest number of patients per unit time. From December 2006 to November 2007, there were 16 occasions during which clusters of >15 patients

were admitted to the emergency surgical unit. The Working Emergency Response Plan (WERP) of the hospital was initiated in early 2006.

Objective: The objective of this project was to evaluate the existing plan and design a more efficient and flexible working plan by analyzing the responses of emergency team members and studying other emergency plans currently in practice.

Methods: A total of 45 members using the current emergency plan were asked to complete a questionnaire, and two other emergency response plans currently in place were reviewed.

Results: The existing WERP is not adequate to maintain communication and coordination or to use human resources and infrastructure optimally during the management of a mass-casualty incident.

Conclusions: Considering the weaknesses of the existing plan and using the essentials from the other plans reviewed, a new, flexible, revisable plan was designed. The new plan is in the process of implementation. A second study is needed once the new WERP is established to assess its effectiveness.

Keywords: emergency plan; emergency response; hospital; plan; preparedness

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(H68) “We Don’t Have a Backup Plan”: An Exploration of Family Emergency Preparedness Plans following Stroke

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Introduction: Family preparedness planning is one strategy to mitigate the negative impact of disasters. High-risk populations, such as families coping with debilitating illness, require special consideration depending on the functional limitations imposed by the illness.

Methods: In a qualitative study of family caregiving experiences following a stroke, family caregivers were recruited through rehabilitation centers at the point of patient discharge. Within the first month after the stroke survivor was discharged from hospital/rehabilitation center, family caregivers were asked about their “back-up plan”, should they become unable to provide care for the family member who is ill, or in the event of a natural disaster.

Results: Using grounded theory, with the family as the unit of analysis, the findings from these semi-structured interviews with family caregivers (n = 12) showed that the majority of these families did not have a back-up plan in the event the primary caregiver was unable to provide care. Most families would have to rely on the city’s emergency respite care programs, because there is no one else to provide the care, or other family members are unable to provide respite. For natural disasters, rural families reported having more supplies, such as generators, extra water, and food.

Conclusions: Families providing daily care for a family member recovering from stroke are at high-risk of being caught off-guard

during a disaster, particularly during a bio-event where the primary caregiver may become sick and unable to provide care. Emergency management sectors should anticipate high demands for respite care in community disaster planning.

Keywords: caregivers; family; emergency preparedness plans; recovery; stroke

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(H69) Compliance with Statutory Major Incident Exercise Schedules in the Hospitals of North West England

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Introduction: Since 2004, there has been a statutory duty, under the Civil Contingencies Act, for designated receiving hospitals (those with emergency departments) to demonstrate fitness for and be able to respond to a major incident. National Emergency Planning guidance defines what is considered a sufficient exercise schedule for this purpose; a staff incident communication cascade test every six months, a hospital tabletop exercise every 12 months, and a live-casualty exercise every three years.

Methods: All receiving hospitals in the North West region of England were identified and their emergency preparedness leads approached during summer 2008 enquiring about the frequency and extent of their recent exercise schedule, the lessons that were learned and changes made as a result.

Results: A total of 18 of 23 identified organizations (78%) were willing to report. When exercises had occurred, most issues for improvement related to inadequate communication. Not surprisingly, these were centered on links between the emergency department and the hospital management team, but also between the management team and outside supporting agencies.

	Time interval	Compliance	% compliance
Communication test	6 months	12/18	66
Tabletop exercise	1 year	11/18	61
Live exercise	3 years	13/18	72

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Conclusions: In the event of a hospital in North West England failing to mount a sufficient response to a major incident, a significant proportion would be unable to show that they had taken all reasonable steps to ensure that their facility was capable of mounting that response. The hospital management potentially would be criminally liable for this failure.

Keywords: compliance; England; exercise; incident response; preparedness

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(H70) Surge Capacity Preparation for a Major Incident in the Hospitals of North West England

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Introduction: English National Health Service (NHS) hospitals work close to full capacity but have a statutory duty to cope with unexpected incidents and surges in admissions. This might be a Big Bang major incident or a Rising Tide infectious disease outbreak. The Civil Contingencies Act requires the NHS to prepare for such events, recognizing that the surge response must be dynamic, reflecting more than simply a count of empty hospital beds.

Methods: Using the Emergency Planning Guidance, an outline of essential capacity information to manage a patient surge was created. All designated hospitals in the North West of England were approached and asked to provide information on their anticipated surge plan; focus was on initial receiving capacity and accelerated discharge planning.

Results: A total of 18 of 23 organizations (78%) responded. Capacity also typically included consideration of patient triage categories. Accelerated discharge plans for current in-patients were present for all hospitals. A total of 15 of 18 (83%) had plans to increase the discharge rate by providing additional community nursing care. Fourteen of 18 (78%) had plans to increase discharge to residential and nursing facilities within the community. Only seven (39%) had exercised these processes.

	Capacity known	% Capacity known
Initial capacity to receive identified	14/18	78
Estimated hourly rate following initial load stated	7/18	39
Maximum capacity defined	8/18	44

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Conclusions: The planning guidance recommends that an ambulance service should know the real receiving capacity of its hospitals. While the data suggest some good practice, the lack of exercising raises the possibility that the numbers are aspirational.

Keywords: civil defense; disasters; England; preparedness; surge capacity

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(H71) Managing Surge Capacity—Lessons Learned from a National Mass-Casualty Simulation Exercise

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Introduction: Managing surge capacity is a challenge all emergency departments face during a mass-casualty incident. A full-scale, mass-casualty simulation exercise at Singapore General Hospital and the lessons learned will be reported. The experience of creating temporary intensive care unit beds and the presence of a forward anesthesia and surgical command at the emergency department also will be shared.