Disaster Plans: Lessons Learned

Save to myBoK

by Harry Rhodes, MBA, RRA

Shortly after I accepted my first position as director of medical records, I began to develop time management skills and created a "to do" list. One item on my list that got very little attention was my department's disaster plan. Working in a 55-bed hospital in a peaceful eastern Texas community, I was lulled into a false sense of security. Because the facility was small, I had the opportunity to serve as safety director. Yes, we had the regular disaster drills as required, but those drills seemed more like good-natured fun and socialization as opposed to preparation for the ugly reality of an actual disaster.

It has been my experience that disasters occur in the nicest weather. Such was the case the day we were notified that we would be receiving 30 to 40 victims of a school bus/church bus accident. We thought we were prepared. We were not. Everything was difficult. There were problems with organization. My staff was unfamiliar with the forms and the distribution of copies. I hadn't considered that my staff would be unprepared for what they had to see and do.

We made it through that awful day, and we told ourselves that we did the best we could under the circumstances. We felt grateful that these kinds of events do not occur on a regular basis. Our next disaster drill was deadly serious. Little did I realize that my experience with disaster response was not a one-time experience, worthy of "a good story" status. That bus wreck experience was just the beginning of my personal journey.

April 19, 1995, would have qualified as another of those nice days. It was spring in Oklahoma City, warm and sunny. I was at work, in the hospital auditorium, participating in an in-service program. We were all comfortable, relaxed, and totally unprepared for what happened next.

What occurred in the auditorium reminded me of the way I felt when, years ago, I was rear-ended in my car while waiting at a stop light. The entire auditorium rocked as though it had been rear-ended. The violent motion was followed by a loud roar that rushed over the building. For a moment, all of the directors in the auditorium stood frozen. Then slowly, silently, we began to move toward the doors. As if in a dream, I moved to-ward my office to find my telephone ringing. It was my wife: "Harry, thank God you are all right! There has been an explosion downtown. They say it's really bad. You'd better get your staff ready."

Hanging up the phone, I went to the main room of the department and began to inform my staff of the situation. Having learned from my previous experience, I had spent more time preparing my staff for a possible disaster. This time we knew where the disaster tags were, how to complete them, and who got what copies. We were able to locate the clipboards and pre-prepared disaster records quickly. Before the first victims had arrived, we were standing at the door of the emergency room.

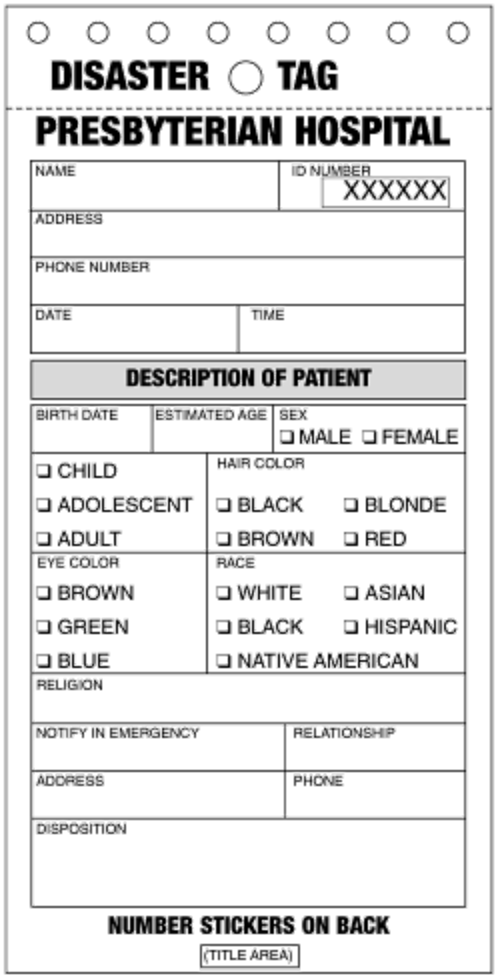
We were ready, but there were still lessons to be learned.

We received 77 victims of the bombing that day. In the drill, we told ourselves that we didn't need more than 25 pre-prepared tags and records. We rationalized that in a real disaster, the victims would be dispersed among many city hospitals; therefore, we wouldn't get too many. During the drill, we were in control. In reality, the disaster controlled the situation.

In the drill, victims arrived by ambulance in an orderly fashion. But shortly after the explosion, things were anything but orderly. Citizen rescuers loaded victims into their vehicles and drove them to the hospital. The emergency room parking lot became congested with ambulances and private vehicles. In the drill, all the victims came to the emergency room entrance. In this disaster, victims came in from different entrances. At one point I found a victim standing in the center of a hallway. Because her injuries were minor, she had driven herself to the hospital. Once inside she became distraught and was unable to move from the hallway. The rescuers, covered with blood and dirt, looked like victims themselves, which added to the

confusion. Members of a Russian ice skating team were among the victims. They couldn't speak English, and we couldn't speak Russian.

The disaster tags we purchased could be tied to wrists or ankles. We were confronted with two problems. First, most victims were in shock and covered with blankets, so there was no easy way to find a wrist or ankle. Second, many of the victims reacted to the image of a "toe tag" (most likely reinforced by Hollywood) and vehemently objected to having a tag placed on their wrist or ankle. Our Post-Disaster Quality Improvement Process (QIP) Team decided to redo the tags with a combination alligator clip and elastic attachment that could either be clipped or tied to the victims.


DISASTER ◯ TAG

PRESBYTERIAN HOSPITAL

NAME | ID NUMBER XXXXXX

ADDRESS

PHONE NUMBER

DATE | TIME

DESCRIPTION OF PATIENT

BIRTH DATE | ESTIMATED AGE | SEX ❑ MALE ❑ FEMALE

❑ CHILD
❑ ADOLESCENT
❑ ADULT

HAIR COLOR
❑ BLACK ❑ BLONDE
❑ BROWN ❑ RED

EYE COLOR
❑ BROWN
❑ GREEN
❑ BLUE

RACE
❑ WHITE ❑ ASIAN
❑ BLACK ❑ HISPANIC
❑ NATIVE AMERICAN

RELIGION

NOTIFY IN EMERGENCY | RELATIONSHIP

ADDRESS | PHONE

DISPOSITION

NUMBER STICKERS ON BACK

(TITLE AREA)

The Post-Disaster QIP Team also suggested the following changes to the disaster tag:

- The amount of information on the tags was reduced because it was more than could be quickly captured.
- The spaces for gender, hair color, race, and eye color were changed from blanks to check boxes.
- In addition to a space for age, spaces for estimated age and date of birth were added. The date of birth proved to be useful in identification. We also added check boxes for "child," "adolescent," and "adult."
- All blank spaces on the form were enlarged to make recording information easier.
- The prenumbered stickers used to identify samples, records, and order sheets were attached to the back of the tag. Previously they had been located in the pre-prepared disaster charts. They were loose and often were misplaced and forgotten.
- The tags would be prenumbered during printing, so they would be easier to read.

Originally, the pre-prepared disaster chart was housed in a two-pocket paper folder. After the patient information was obtained and the patient was tagged, the folder was handed to the nurse or placed on the gurney. When the patient arrived in the treatment area, often the folder would be overlooked. The Post-Disaster QIP Team recommended that brightly colored ring binders be purchased. The ring binders were also to be clearly labeled "disaster patient record."

In a disaster drill, once patient actors are transported to the treatment area and the drill is over, they are allowed to leave. The truth is that admitting staff members need to be on hand to formally discharge minor-injury patients and to assist with room assignments for patients who need to be admitted.

In a drill, you don't have to deal with anxious friends and family. Our job became more difficult as many people called the HIM department looking for victims. Many individuals were wandering in the triage area or in the halls searching for injured friends or family. It is a good idea to set up open lines to other healthcare facilities so that victim lists can be compared. Telephone circuits may become overwhelmed during the height of the disaster, so designating certain telephone circuits to the disaster team in advance will improve the team's responsiveness. Allowing family and friends to gather in a central location, where they can get information from all local facilities, is an important service. Consider forwarding incoming calls to a central location. Because of concerns regarding release of confidential information, it would be beneficial to assign an HIM employee to answer the telephone.

When rooms that are not normally used for treatment become treatment rooms, signs are crucial for staff and nonstaff members. Large signs could be made up in advance, or a plan to quickly create signs should be in place.

In a disaster, there is no shortage of volunteers. However, because these well-meaning individuals are not familiar with the established procedure, they may do more harm than good. Consider appointing a volunteer coordinator to control volunteers.

One suggestion was to have special adhesive-backed name badges for authorized staff. The volunteer coordinator would control the issuing of these badges.

Be kind to your staff. Schedule some time as soon as possible after the disaster to allow your staff to deal with their emotions. We made time the very next morning, calling it a Post-Disaster Critique. It was much more than just a quality improvement exercise; it was an opportunity to come to terms with what had happened. During the weeks and months that followed, we created numerous opportunities for the staff to express their feelings.

During the disaster, we asked ourselves (and were asked by others) whether the health information management staff should have been in the triage area helping to identify victims. At the time, what we were doing seemed minor when compared to the heroic acts of the doctors and nurses. In time, we got our answer. Information had to be clarified and reconstructed. Often we had to personally contact patients to obtain needed information. We worked closely with our business office in an effort to construct billing statements from chart documentation.

The number and variety of requests for information astonished us. The list of requesters included the state and local health departments, police and fire departments, the Centers for Disease Control, the FBI, the state attorney general's office, the medical school faculty and students, the media, and the victims' personal physicians. After all of the patients had been cared for, the information became invaluable.

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