Practical Disaster Planning for Healthcare Facilities

Save to myBoK

by Jill Burrington-Brown, MS, RHIA

Disaster planning relies on imagining events that we hope and often believe will never happen. After the tragedies of September 11, however, imagining a large-scale disaster is no longer difficult and disaster planning has come to the fore. In this article, we look at several important lessons we can learn from healthcare professionals who have responded to recent disaster situations.

Disaster plans accompanied by serious practice drills are important. Most facilities have disaster plans and practice them, but don't expect to ever carry out the plan. However, it is important to know before a disaster strikes who is in charge in the facility during and after the incident, who in your area is in charge, and what responsibilities you and your staff will have. Even with planning and practice, most facilities are neither ready nor prepared for a large-scale disaster.

Remember that although orderly drills are helpful, the disaster itself will not be orderly. Control as much as you can ahead of time. Plan for more disaster victims than you think you'll ever receive. Plan that victims will arrive at all hospital entrances, and plan that collecting information will not be easy. Traditional admitting procedures will be impossible. Your facility should have a patient identification system that is simple and ready for use, enables tracking of the patients later by investigative authorities, and allows for the finding of the patients by relatives.

According to AHIMA's director of HIM products and services, Harry Rhodes, MBA, RHIA, after the Oklahoma City bombing in 1995, the disaster identification tags for patients were changed to include check boxes where appropriate (gender, hair and eye color, race, as well as child, adolescent, adult) to speed up the identification and check-in process. Also, pre-numbered stickers used to identify samples, records, and order sheets were attached to the back of the identification tags.

Internal and external communication will be complicated. Richard Westfal, MD, associate director of the Department of Emergency Medicine at St. Vincent's Catholic Medical Center in New York City, told Medscape that portable radios for communication were a big help during the aftermath of the September 11 disaster. Because telephones were tied up with calls from family members, doctors, volunteers, and others, having radios to communicate among all the key treatment areas and central supply was essential.

According to Sheryl McLain, MS, of the Oklahoma Hospital Association, the resources donated by wireless and local phone companies were essential for communications after the Oklahoma City bombing, and these companies must be included in community disaster planning. According to the American Hospital Association Web site, she also noted that working with the media will be a challenge, and that the facility should plan to have 24-hour coverage for the public relations department and determine ahead of time what the release of information policies will be during a disaster.

Plan for volunteers. People will come to your facility to volunteer during a disaster, and unless you are prepared for them, they can hinder your operations. Decide in advance if you will use non-employees and if so, designate a volunteer coordinator. Make plans for those who can help with administrative functions and volunteer clinicians who can treat patients. Further, determine if and how you will check credentials of healthcare practitioners. Have adhesive-backed name badges on hand to identify approved volunteers at a glance.

Plan for identification of and communication about victims. The rules for release of information are somewhat different in a disaster. The HIPAA regulations allow for disclosure of personal health information in a disaster for the purposes of notifying a family member of a patient's location, general condition, or death (Sec.164.510). Also, the state health department is allowed access to personal health information in a disaster.

Sharing patient information among hospitals is important, and a centralized computer linkage would save time and effort. Part of the communication plan should be how your facility will communicate with other facilities and centralize information about

location of victims.

One of the issues in New York was managing identification of victims. Facilities received many requests for patient health information from friends and families without any kind of release. The New York City Medical Examiner's Office told AHIMA that it was obtaining dental records or DNA mapping from next of kin or relying on their public health authority to obtain this information. Facilities should maintain the same level of concern for proper release of information.

Plan for debriefing and post-traumatic stress disorder counseling for staff. According to McLain, this step is not optional. Crisis intervention after the disaster will be a necessity. Emotional healing takes time, so counseling, both group and individual, should be planned. Project Heartland, a mental health clearinghouse formed after the Oklahoma City bombing, provided services to 190,000 individuals. In New York, services have been provided to more than 100,000 people to date: survivors, people who lost a loved one, rescue workers and first-hand witnesses, as well as those who lost jobs, homes, or businesses. The staff taking care of the victims and their families will be profoundly affected.

The terrorist attacks of September 11 remind us that we must take disaster planning seriously. While a disaster is statistically unlikely, each healthcare facility should take time to prepare as much as possible and use the lessons learned from those who have been there ahead of us. u

References

"Caring For Our Own." *Joint Commission Perspectives* 21, no. 1 (2001).

Hersche, B. and O.C. Wenker. "Principles of Hospital Disaster Planning." *The Internet Journal of Rescue and Disaster Medicine* 1, no. 2 (2000). Available at www.icaap.org/iuicode?86.1.2.19.

McLain, Sheryl L. "The Oklahoma City Bombing: Lessons Learned by Hospitals." Available on the American Hospital Association Web site (www.aha.org) under "Disaster Readiness."

Rhodes, Harry. "Disaster Plans: Lessons Learned." *Journal of AHIMA* 67, no. 4 (1996). Also available in the AHIMA Library in the Communities of Practice at www.ahima.org.

Saint-Jacques, Alfred J. "When Disaster Strikes: A Look at Emergency Response to the World Trade Center Disaster, An Interview with Richard Westfal, M.D." (2001). Available at www. medscape.com.

Jill Burrington-Brown *(jill.burrington-brown@ahima.org) is an HIM practice manager at AHIMA.*

Article citation:
Burrington-Brown, Jill. "Practical Disaster Planning for Healthcare Facilities." *Journal of AHIMA* 73, no.2 (2002): 56,58.