Getting Started - What A Disaster!

By Dave Swift, RRT
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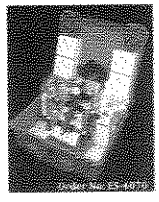

In the mid 20th century, disaster preparedness meant developing a response plan to deal with mass casualties from a local fire, flood, industrial accident or similar event. At the time, it seemed as if we were ready for anything.

And then came the beginning of the 21st century. In its first decade, the scale of mass casualty incidents (MCI) expanded to include previously unthinkable acts of terrorism, novel virus epidemics, and natural disasters of unprecedented scope.

Yet, many facilities still rely solely on the response plans they developed in the late 1990s. These are useful for dealing with small to midsize internal and local external disasters, but they are quickly overwhelmed when faced with large scale disasters. A new and updated approach is needed to develop a multi-tiered approach to dealing with MCI.

These "new" MCI have two very different characteristics - speed and duration. We must be prepared to effectively respond to three types of scenarios:

- sudden, short-lived small to midsize local MCI events
- sudden, intense short-lived local or regional MCI events (bombing, chemical spills, etc.)
- sudden, rapidly building but long-lived state or national MCI events (H1N1, H2N5, similar pandemic)

Sudden, short-lived small to midsize local events

Each health care facility is an integral part of the local and regional response to a MCI. These facilities are expected to utilize their own internal physical and staffing resources for up to 72 hours. Beyond 72 hours, assistance with physical and staffing resources from local, regional, and state resources would be expected.

Unfortunately, one of the biggest issues will be insufficient staffing resources. Staffing shortages are a day-to-day reality, and this poses a challenge to successful MCI response. Most U.S. facilities routinely operate on an 80 percent to 85 percent occupancy level, and Canadian facilities operate on a 90 percent to100 percent occupancy level. Addressing this difficulty realistically and building it into your MCI planning and response is essential. Think about how you could creatively shuffle staffing resources to allow for continuity of care.

Sudden, intense short-lived local or regional events

The "you're on your own for 72 hours" philosophy would apply during the initial stages of this type of MCI. Although many levels of government have encouraged health-care facilities to expand their on-hand supplies to at least a 90-day maximum activity level, the reality is that the financial implications result in varying levels of success.

In addition to staffing challenges, the second bottleneck is the limitation of physical resources. For example, demand for your ventilator fleet is likely to be significant. High consumption items such as resuscitation equipment, ventilator circuits, and blood products will be quickly depleted and need urgent replacement. In the recovery phase, the demand for resources will continue to be high.

Supplier and vendor response to these demands is a significant part of your facility's rapid recovery and normalization of operations. A priority for your MCI planning is to establish an emergency purchasing agreement with vendors. Also, negotiate an inter-facility resource sharing agreement with health care facilities close to your region. Be sure to consider the financial implications of both the response and recovery phases.