Dear Dr. Jeff:

Reading the papers or watching television lately has been a reminder of the numerous natural and manmade disasters that can occur. Our facility has a committee to create a “disaster plan,” which is required by our state, but the process lacks any sense of reality and the state seems to want us to prepare for a hurricane even though we are a thousand miles from the ocean. What do you suggest?

Dr. Jeff responds: Even without hurricanes, there is no shortage of disasters in our world. The plans are at risk of tornadoes. Mountainous areas have blizzards and landslides. The North and West can be ravaged by forest fires. The electric grid has yielded blackouts extending over vast regions. Flash floods, ice storms, terrorist attacks, plane crashes – the list seems endless.

Every facility should have at least two disaster plans. One should address what the facility would do if a disaster occurred outside and, as a health care institution, the facility needed to aid the survivors. The other should address how the facility would deal with an internal disaster or a larger one that enveloped it.

Of course, no one can prepare for every unexpected event, but certain elements of preparation remain the same. In the case of an external disaster, we should consider where and how we could care for the sudden influx of a large group of unscreened refugees, some or all of whom might be injured. Most facilities identify a large space where triage could be established and the disaster victims could be safe and separate from the nursing home residents: an auditorium, a large dayroom, or even the lobby or chapel.

A reserve supply of cots or mattresses is desirable, along with privacy screens and some basic first aid supplies and an ample supply of fluids. Key staff who would need to be involved should be identified with necessary contact information, and there should be a list of appropriate relief agencies, both public and private, to call. Local emergency rooms might be overwhelmed, so people should be screened on site and serious trauma cases referred to the hospital. State “Good Samaritan” laws protect health care workers who in good faith provide assistance in these situations. You should assess the approximate number of residents that you could safely shelter. And remember the potential risks for your current residents. Families could come in laden with all the classic childhood illnesses, for instance.

Many facilities have mutual agreements to shelter residents from nearby nursing homes in the event that one or the other facility has to be evacuated. These agreements allow you to review how your facility could deal with a familiar but inflated population. How would extra meals be prepared? Are there sufficient toilet facilities? How would the emergency area be staffed, or would these residents be scattered into existing units? What documentation would be done regarding the health status of these new guests? Unfortunately, agreements like these can fail because large-scale disasters often affect both the receiving and sending facilities.

When Sandy Struck

The recent devastation from Hurricane Sandy in the greater New York area forced many nursing homes to pull out their disaster plans. The two nursing homes where I am medical director are both within 100 yards of the ocean. One evacuated totally while the other evacuated some residents from the flooding first floor and did an “evacuation in place” on upper floors.

However, as soon as we finished bringing our residents back, we had to turn around and accept people from other facilities. They originally had been evacuated to hospitals, which then became overcrowded. We also took in home care and hospice patients who could not stay in houses or apartments without heat or electricity.

Thus, we used both our evacuation and “surge” plans within a week. Similar situations may occur in any disaster associated with prolonged loss of electric power, as the emergency generators at many facilities are designed to run for only 36 hours, forcing otherwise undamaged facilities to evacuate.

The Centers for Medicare & Medicaid Services has a number of useful materials on its website. One is a link to a five-page PDF file reviewing essential and desirable elements of a disaster plan. Although nominally addressed to long-term care ombudspersons, it is a very useful review for any facility preparing its own plan. Another document answers a set of frequently asked questions regarding waivers of regulations that can be granted during public health emergencies (called 1135 waivers after the relevant section in the code) and other special considerations, including reimbursement issues, that might arise during an emergency. While it is probably premature to review these waivers prior to an emergency, it is worth recording this site and various other significant contact numbers as part of your plan.

As the care needs of nursing home residents have become increasingly complex, the planning required to meet those needs becomes more and more difficult. For example, many facilities now routinely accept residents requiring hemodialysis at nearby dialysis centers several times per week. Any catastrophic even in a small facility – even a gasoline shortage – could place these residents at risk. Other outside vendors could be prevented from providing tube-feeding solutions, laboratory and radiology services, oxygen tanks, pharmaceuticals, wound-care products, linen and laundry, telephones, faxes, internet access, and waste disposal. Realistic backup plans may be needed for any or all of these services. This would be in addition to the basic supplies of food, water, paper goods, and flashlight batteries.

Electric power deserves special consideration. All nursing homes are required to have emergency generators and to test their function at least monthly. Aside from the time limitations discussed above (and it may be significantly less than 36 hours if the tester doesn’t check that the fuel tank is full) emergency generators have limited power capacity. This means that not all of the ever-multiplying electrical devices in the facility can be maintained off the emergency generator.

It is important to review periodically the list of what is attached to the emergency generator, to ensure that what is NOT on the list is truly nonessential. Low-air-loss mattresses or pumps to control intravenous flow rates may need to be on the generator. Many facilities may not realize that when they convert to electronic medical records they will lose access to patient charts and vital information unless significant portions of the computer system have back-up power as well as backed-up data. The paperless world of the future will be totally dependent on reliable sources of power.

People Come First

Another important yet frequently overlooked factor is facility staffing. In the end, we are more dependent on people than on any piece of equipment. But natural disasters also destroy staff homes, disrupt their access to transportation, and put their families at risk. One major factor that complicated the attempts to evacuate nursing homes during Katrina was that many key patient-transport personnel, such as bus drivers, were busy transporting their own families to safety.

When New York City closed the subway system prior to Hurricane Sandy (an action without which people would have drowned in the tunnels) it also meant that many health care personnel could not get to where they worked. Facilities should consider planning car pools and preparing space in the building where staff can sleep and have access to food, showers, etc. I have always been amazed at the commitment that our staffs exhibit to the care of their residents, but good planning can make that easier.

Perhaps the single most important piece of any disaster plan is the identification of the key decision makers, their substitutes if necessary, and multiple ways to contact both. If the facility is to evacuate, how is that decision made and by whom? An evacuation requires the coordinated efforts of a management team, as does the call that it’s safe for the residents to come back. Decisions should not be made by self-appointed, take-charge types or, worse yet, multiple individuals barking contradictory orders to bewildered staff.

Disaster planning always feels somewhat pro forma. At its worst, it is like the 1950s air raid drills, when we were told to put our heads under our desks in case of a nuclear attack. At its best, it feels like a great deal of preparation for something that will never happen. Resources for a comprehensive plan may simply not be available, and the exact nature and extent of any disaster is unpredictable. Some facilities prepared frantically for the Y2K computer meltdown, which never happened.

But crises are a part of life. They will happen, and when they do you will be happy to have a blueprint to guide your actions. And if they don’t happen, and you rue the time you wasted in creating various scenarios of doom and destruction? No problem at all. Just take a moment more and count your blessings.

Dr. Nichols is the medical director of Our Lady of Consolation and Good Samaritan Nursing Homes in Suffolk County, N.Y., and senior vice president for clinical effectiveness of the Catholic Health Care System of Long Island. He invites your questions for possible discussion in this column, at caring@elsevier.com. You can also comment on this and other columns at www.caringfortheages.com, under “Views.”

Preventing for Disaster Doesn’t Have to Be a Calamity