Disaster: Nursing Homes Need to be Prepared

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David Dosa and his colleagues1 have shown us that, once again, in the absence of formal rules and regulations, nothing works better in an emergency than staying calm and using some common sense. Whether the emergency is a hurricane of unprecedented power or an ice storm that has caused widespread power outages, there are guidelines that administrators can and do use to determine the best course of action under the current circumstances. Saliba et al.2 reported that nursing facilities received limited post-disaster assistance following the Northridge earthquake. Problems included staff absenteeism, communication problems, and insufficient water and generator fuel.

Briefly put, the choices are to evacuate or to shelter in place. And, as was so publicly demonstrated in 2005 with both Hurricanes Katrina in the Gulf Region and Hurricane Rita in Texas, decisions to either evacuate or to shelter in place sometimes have to be reversed in light of new information.

The first lesson coming out of this paper is that you can never be overly prepared for an emergency. As we all realize, long-term care facilities house the frail,3,4 those with dementia,5 and often many persons with low-grade delirium.6 These persons are highly vulnerable and are at increased risk of death. Involuntary relocation of residents from nursing homes has been associated with increased falls.7 Emergencies are not times to be relying on either guardian angels or the kindness of strangers because both are rather busier than usual during an emergency. Most of the administrators who Dosa and his colleagues1 interviewed thought that they were prepared for emergencies and, at least superficially, they were. It was only as the emergency dragged on that flaws in the fabric of their preparedness became evident. They had generators, only to learn that fuel had to be pumped by electricity, which was not available in a wide-scale disaster. They had 3 days’ worth of diapers, bedding, and food, only to learn that they needed a week’s worth of those supplies. They had contracted for transportation, only to learn that bus drivers had already evacuated and that buses could be, and were, commandeered by state and federal officials to evacuate prisoners. They educated their staff members as to why they would be needed at work during a crisis, only to be reminded that blood is often thicker than water. Many staff members chose to evacuate with their families rather than to remain with and/or evacuate with the residents. Some administrators, anticipating that this might be true, either offered to let family shelter at the nursing home or to evacuate with the residents. Even those administrators experienced dangerously high levels of staff absenteeism during the hurricanes. During Hurricane Elena in Pinellas County, Florida, staff had problems passing through police checkpoints to get to work and there was a high rate of staff burnout.8

So what are administrators to do to become appropriately prepared for an emergency? Do they continue to learn through bitter experience over time and, as a result, become more and more prepared with each emergency? Do they try to find time to train staff about the special needs of the elderly residents in times of crisis, especially those with mental or sensory losses, and to practice evacuations with volunteers substituting for residents? Do they cause their facilities to become more island-like, more isolated and independent, incurring increasing costs in order to be ready for “anything”?

The answer to each of these questions is both yes and no. Experience is a great teacher but the learning curve is costly when the pupils are ill and frail, as most nursing home residents are. Practice evacuations are theoretically feasible and practically impossible given the shortages in staff and the other demands on their time. No nursing home can be an island, even though it should be prepared to subsist at least briefly until outside help can arrive. No matter how true all this may be, it helps neither the nursing homes nor the residents to limit the answers to emergency preparedness to these strategies. In fact, there are more things that an administrator and the staff can do. Those options were outlined both by Dosa et al.1 and in the articles that they cited. There has been no loss of lessons learned about how long-term care facilities can improve both decision making and procedures involving emergency preparedness. However, by concentrating on lessons learned about how to incorporate new strategies into future planning or by bemoaning how hard it is to retain critical staffing during an emergency or by reiterating the vulnerability of frail elders during the physically demanding and technically difficult evacuation, we are at risk of

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missing the most important lesson of all. Administrators felt abandoned by state and federal agencies. They were given to feel that nursing home facilities are not a priority for anyone but themselves in an emergency.

This is outrageous. This is ageism at its ugliest. This is a situation that has to be changed.

The first step towards change is to address the factors that contribute to that perception of abandonment. Dosa et al.1 give us a place to start in this campaign. They point out that, to date, there have not been articulated clear lines of responsibility of the public towards frail and vulnerable people living in private facilities. Although the federal government, in the form of reports from the Office of the Inspector General14 and the Government Accountability Office,15 has recommended strengthening of government oversight and the development of reporting relationships between state inspection agencies and emergency response agencies, no template for the footprint of such oversight has been provided, nor is there any apparent intention to provide any funding to facilitate the development of these relationships. It appears that the federal government has abdicated any responsibility it may have had towards the oldest and sickest of its citizens at the time of their greatest need. As Leonard et al.15 showed after Hurricane Marilyn, there is a need for outreach teams for the home-bound and nursing home residents who cannot commandeer supplies and equipment and to reset priorities. This secret to success here is to gather that information is best used by the staff. Staff members know intimately the needs of the residents and the limitations of the facility. They can identify the gaps in services that need to be filled. Then these needs must be catalogued and addressed. For this task, informal caregivers are invaluable partners in emergency preparedness. They can lead the grass-roots efforts needed to develop a regional or state-wide resource/training center dedicated to the public health and safety of nursing home residents during emergencies. This center would coordinate the training and certification of professionals, paraprofessionals, and informal caregivers in geriatric emergency preparedness.

This center would be responsible for the development of minimum standards of training of staff and volunteers, establish reasonable expectations for the care of residents during both an emergency and the recovery phase from that emergency, define the roles of caregivers during emergencies, and develop policies to minimize sensationalism and individual profit that often comes from disasters. The center could also work to modify Good Samaritan laws to protect rescuers who are assisting disaster victims who are removed from the disaster site. It can address how to get long-term care facilities recognized as providing essential services and therefore in need of priority restoration of public utility services following loss of power. Like most good ideas, the development of such a center would require volunteer labor and some funding. Modest funding would establish a public office, support the presence of dedicated personnel to organize those volunteers to represent the cause at critical meetings, and do fund-raising activities. This is a small price to pay for increased security of our most vulnerable elders. Indeed, several philanthropies have already shown an interest in supporting work on improving the care of the elderly in emergencies. These include the John A Hartford Foundation, Atlantic Philanthropies, the Robert Wood Foundation, Retirement Research Foundation, AARP Foundation, the Kaiser Family Fund, and the UJA-Federation of New York. Regional and local foundations can undoubtedly be convinced to join in this noble effort.

Emergency planning is everyone’s business and must address all three phases of the emergency: preparedness, response, and recovery.12 As long-term care facilities have developed their emergency plans, they have learned the value of sharing those plans with sister facilities and local school, fire, and police districts. A priority is the development of alternative housing for evacuees. In Hurricane Georges in Key West, the local jail was used to house more than 300 nursing home residents.13 It is essential that facilities develop a simple sheet providing essential information, including medication for all residents, that can be available during transitional care. This could be the same form as suggested by Terrell and Miller14 for use in transitional care between nursing homes and emergency departments. The development of electronic health care records would be an even better solution.15 Facilities have learned that they need to include staff and their families in the planning. What has not happened is their inclusion in the regional and state plans where the authority resides to commandeer supplies and equipment and to reset priorities. The development of a center to serve as the stakeholder that is invited to the table during regional planning sessions and to represent the interests of all vulnerable elders, whether community- or facility-based, is the proximal goal here. This center would also be responsible for coordinating plans for homebound elders and other persons in the community with special needs. It is my belief that this is an area that should be integral to the expanded role of the medical director.16 The ultimate goal is to ensure quality of life for all of us. And that is what this is all about: to do unto others as we would have them do unto us.

REFERENCES