

## No Room For Disaster - A Normal Day In E.R.

On a busy Wednesday last week, I was rushing around my ER as usual, trying to take care of all my patients and help my coworkers like we always do. It was an ordinary day. Patients were flowing into the crowded waiting room, and ambulance gurneys with patients were waiting at the Charge Nurse desk to report-off and get a bed assigned to put the patient in, so they could go back out and bring in some more. Just a normal Wednesday, busier than some, but nothing very unusual. The beds filled up early, as soon as they were vacated by the overnight patients. Then the waiting room filled up, and backed up; it was a normal busy day. Then I heard the main hospital overhead announcement system say "Attention Please! Attention Please! Code-Triage, Code-Triage." The overhead usually sounds like this when there is a Code-3 (life and death emergency) to call all the rest of the Code Team to the ER. But it wasn't a Code 3 this time. Code-Triage means mass-casualty disaster. What?!? "We don't have any room for a disaster!" somebody said. Everybody else that heard the announcement was also saying "WHAT?!" Then the announcer said it was a DRILL. Sure enough, it was a county-wide disaster drill, to practice disaster plans and policies, and see how well hospital, ambulance, police and fire disaster plans work. As soon as we heard it was a drill, we had to just continue working. There was no way we could take the time to play-act for a drill. We were loaded. We were drowning in patients, and more coming, with no letup. I never even heard exactly what the "disaster" scenario was, because we were much too overwhelmed with the real situation we already had. During the rest of the day, it got worse. Not only all the beds were full, we also had 4 patients who were being admitted to the hospital but there were no beds available in the hospital, so they had stayed in ER all night and were still here all day. We crammed as many beds as we could into the rest of the ER rooms. The ambulances kept pouring in, two and three at a time. Ambulance gurneys and Paramedics were lined up from the Charge Nurse desk all the way out into the main hall. I was sent upstairs to the nursing units to find extra transport gurneys, which we put into all the available halls and open spaces. They were immediately filled with more patients. All the less-serious patients (as well as could be determined by our ER nurses' triage assessments) had to be left in the waiting room. I don't know how long they waited. On a good day (less busy than usual) the wait is from one to four hours. On a bad day, considerably longer. It's not unusual for some patients to just give up and leave rather than wait. Of those who leave: Some are those who've come to ER with simple colds and sore throats, and decide they'd be better off at home in bed. Some are drug-seekers wanting narcotics, with no actual emergent medical problem. Some are homeless folks who, though not sick, are never really in very good health. They come to ER several times a week to get a sandwich and a bed. They know they can't get admitted for that, so they will declare some pain or condition, which might or might not be true. (Ethically and by law, we can never assume anything, even if dozens, or even hundreds, of other visits and workups have found nothing.) Every patient must get a full workup for their complaint, including EKGs, CAT scans, blood tests, as per medical protocols.) They tolerate this to get a bed and a meal or two. But if the waiting room is crowded and noisy, they will sometimes go somewhere else for a while. But some folks who leave, we always fear, might be people who actually needed to be seen by a doctor for something significant or even life-threatening. Perhaps something that they might have been unaware of, or whose symptoms didn't show up, or were vague, or otherwise got past the triage nurse's keen radar. They wait in the waiting room for hours while many beds are filled with the near-comatose alcoholics (yes, this is a true life-threatening condition) or drug addicts (same reason) who got here because someone saw them sleeping in the park or on the sidewalk and called 911. So the paramedics come, and bring them in again and again, with their plastic bags full of all their Stuff. We call those our "frequent flyers" and we all know them, we've known some of them for ten years or more. They can be very demanding, verbally and physically abusive, even assaultive to the staff. But their chosen lifestyle makes them chronically sick, so they are chronically here. Meanwhile in the waiting room, the couples with their kids who need stitches, and the folks with their elderly ill parents, get angrier and angrier as they wait and wait, and eventually they will write a raging letter of complaint to the hospital about the poor service they got. This is very disheartening to us. We would do anything, everything for them, and we do, 100% of the time. But we have no control over what comes through the door, and we are obligated by both ethics and law to serve the "worst first." Even though we have a separate "clinic" section for minor ailments and injuries, it fills up fast too. The rest simply have to wait their turn. By the end of my shift I was sweaty and exhausted, as I had been all day, pretty much. I was glad to be going home without overtime. The patients were still pouring in, and there was no place left to put them. Noplace. So finally, we got permission from the County Dispatch to go on "ambulance diversion" which means the ER is still open to walk-in patients or patients brought by private car, but the dispatcher must not send any more ambulances to our facility because it is overloaded and unable to take any more. This finally went into effect at about 3:15 in the afternoon. It should have happened at 10:00 a.m. Why didn't it? A couple of reasons: for one, there seems to be a sort of macho "Damn the torpedoes" Do-or-Die kind of pride thing among us, like it's somehow a weakness to ask to go on ambulance divert. And second, the other hospitals in our area always seem to go on diversion first, even though they have larger facilities and more staff than we do. Once they are on diversion, we can't go on diversion, because then there would be no hospital ER open to ambulances in this immediate area. The Bottom Line. The disaster drill in my opinion (and I want to be clear that this is only my personal opinion and other opinions may differ) was a total failure for us. Many of us didn't even have time to ask anybody what the scenario of the disaster was; it didn't matter; we were already overwhelmed. This is a problem, and the thought has occurred to me on so many of these busy ordinary days – "What if there was a disaster?" There is a hospital-wide Disaster Plan of course. But there would be relatively little we could do for it. We would be immediately overwhelmed of course, and in danger of injury to patients and staff alike from crowds of people pushing and shoving their way into the ER, where there will be no place for them to go anyway. The image of people trampling each other and us, as they fight each other just to get in ... God only knows... is a very disturbing possibility. And of course, there is also the possibility that the hospital itself may be damaged by earthquake, fire, or other disaster condition, and may have to be evacuated and shut down. A report produced by California's Office of Statewide Health Planning and Development offers a shocking look at the hospital industry's lack of readiness. For example, at the Alameda County Medical Center's Highland campus, four of the five buildings were given the lowest safety rating, indicating "significant risk of

collapse and danger to the public." Eleven of the twelve buildings on Kaiser's Oakland campus got the same low rating, as did six of ten buildings that make up Eden Medical Center in Castro Valley and four of the seventeen buildings at the Mount Diablo Medical Center in Concord. Of the 163 buildings that make up the major hospital facilities in Alameda and Contra Costa counties, only 21 were deemed "reasonably capable" of providing services to the public after a large quake. "Most of the major hospitals in the East Bay seem to be within a mile of the Hayward Fault, so we're very concerned about how they would survive," says Susan Tubbesing, executive director of the Earthquake Engineering Research Institute in Oakland. So if there's an earthquake, a hospital may not be the best choice. (Unless it's within walking distance and you can get there in less than 5 or 10 minutes and be first in line.) All hospitals will be jammed, and freeways and streets will be damaged or blocked with cars all trying to get home, or to a hospital. Instead, the most effective plan of action would probably be: (1) Do a Disaster Triage of the injured people at your location (see S.T.A.R.T. rapid triage at: [www.disasterfirstaid.com/rapidtriage.html](http://www.disasterfirstaid.com/rapidtriage.html)) and then (2) Send a runner or messenger to the nearest Fire Station with your request for help and the number and kind of injured you have. That's the fastest and most reliable way to get your fair share of the help. It will not be all you need, so be ready to help yourselves and each other as best you can. Then (3) Follow the rest of the Action Outline. ([www.disasterfirstaid.com/actionoutline.html](http://www.disasterfirstaid.com/actionoutline.html)). Print it out and keep it in your First Aid kit. Give a copy to a friend or neighbor. In the meantime, don't wait. Don't leave your life and health in the hands of others unless you really have to. Those hands will be very full. Take some disaster preparedness courses or CERT from your city or county Fire Department now, so you'll know how the bigger picture works, what's available, and where you fit into the plan. If you are a teacher, an EMT, a Paramedic, or know someone who is, consider teaching Disaster First Aid and S.T.A.R.T. Rapid Triage to your group. The first step is to gather with the people on your block, or in your apartment building, or your office. Talk to your neighbors and coworkers - Decide to help each other now, before it's too late to prepare. When the Big One hits (and there's no "if" just when) all of us will be on our own for the first hours and days, maybe even up to 3 weeks, and that's an inescapable fact. You can make the best of it, or you can make it harder for yourselves and for those who try to help you. Making the best of it will require some degree of effort and initiative on your part, but there's nothing that's hard, and nothing you can't do. Now is the time; while it's still do-able. It doesn't take a band of heroes, all it takes is a team of regular people who know what to do, and have each other to do it with. You (yes, I really do mean you) can make a big difference. DECIDE to do it. Do it for yourself, do it for your family, or do it for your community, but make up your mind, and start. Now is the best time there'll ever be.

## About the Author

Doctors at major hospitals are spending more time to discuss failed cases, a trend that could eventually help healthcare institutions receive.

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