

C. Transfer Trauma

Minimizing the Impact on Community Based and Institutionalized Elders

(This section was written for hurricane response, but can be used for many kinds of disaster situations.

The impact of natural disasters on individuals has been studied, but few studies have focused on the frail elderly. The fact that the United States continues to age at unprecedented rates warrants a closer examination of the capabilities and the challenges inherent when reaching and serving an older population. The difficulties encountered during and after the mass evacuation of one thousand eight-hundred sixty nursing home residents in response to the threat from Hurricane Elena in 1985, which stalled off the west coast of Florida, served as one of the first documented incidents in which large numbers of frail elders were transferred to alternate sites for care. Experience from this activity indicated that the time required to transfer residents was dramatically underestimated as was the type of shelter and the skill levels of personnel needed for this specialized type of mass care.

Unlike the general public, elders face a unique problem that experts have termed "transfer trauma." In this context, this condition affects elders impacted by a disaster that results in being uprooted from routines and familiar surroundings. This type of change can lead to aggravation, depression, serious illness and even death among the elderly.

It is improper and impractical to perform stringently controlled randomized studies on the needs of the elderly in the atmosphere of fear and panic surrounding a catastrophe such as a hurricane. The alternative is to rely on anecdotal information regarding this population and the first hand experience of trained observers when we design disaster plans for the care of the elderly. Each new disaster seems to uncover unanticipated problems that need to be addressed. The insights for this discussion are drawn largely from the experiences of Hurricane Andrew and specifically from the response to those demands by the Miami Jewish Home and Hospital for the Aged (MJHHA).

The MJHHA is a community teaching, long term care facility in Miami, Florida that provides housing and nursing care units that meets the needs of the independent ambulatory to the acutely ill feeble elderly. The other dimension of the Jewish Home is that of a provider of "nursing home-like" community based care to thousands of home and bed bound elders annually. It is important to emphasize frail elders being cared for in the community in that, at any given point in time no more than 5% of the 34 million elders in the country are residents in a nursing home.

During the hurricane watch, a number of elderly were admitted to the Jewish Home for shelter. In addition, some staff's families were evacuated to the facility. Thus, MJHHA was entrusted with providing support for more than 1,000 elderly clients, staff and their families. Documentation of problems evident at time of admission was made by Administration, Nursing, Dietary Services, Medical Services and the Department of Social Work. Though the campus was structurally spared, as the storm passed through, both water and electrical service was disrupted. Post-storm ambient temperatures were in the 90 degrees Fahrenheit range with humidity being at 90%. Water for drinking, bathing, and for flushing toilets had to be carried manually from levels of one to eight floors in five gallon containers. Without air conditioning, most residents required constant monitoring and increased fluid intake orally, by tube feedings, or by intravenous administration when oral intake lagged. Ice was placed in tubs in the hallway as were the patients. Fans powered by emergency generators were used to circulate cool air. Patient temperatures were closely monitored. The staff toiled under extreme duress in the heat and chaos to keep up with the patients' loss of fluids. If the air conditioning had not been restored within 72 hours as it was, heat related injuries would have been severe and the necessity of transferring the residents much more likely. Although electricity and water were restored, chaotic conditions continued for weeks in the aftermath of the storm.

Extremely ill community based patients, some languishing in evacuation shelters or fabricated tent cities, were admitted to the Miami Jewish Home and Hospital requiring medication and treatment, but without transfer data. The patients' families and their physicians were unavailable for information. Medical regimens and care plans were implemented by a nursing staff trained in the complexities of geriatric care and able to fill the blanks. The absence of a cadre of knowledgeable geriatric nurses would have presented a dangerous nursing care environment. This is a point that warrants further emphasis in that is not commonly recognized within emergency management that paramedics who are often called upon to fill the gap are neither trained nor versed in the medical management of a chronic and frail population.

Staffing was a major problem immediately preceding the hurricane and immediately following. Most nurses and nursing aides scheduled for duty were unable to reach work because of personal difficulties or lack of reliable transportation. Delivery of care (treatments, medications and providing fluid and feeding) responsibilities were left to a small group available in dietary and administration, nurse practitioners, nursing supervisors and other employees and volunteers.

The staff endured long, emotionally draining hours with an arduous work load, sleep deprivation, and limited privacy. The stress was also related to both personal property losses and disruption of one's interpersonal network, in a surrounding of devastation. Many staff were counted among the new population of homeless.

Nutritionally balanced hot meals were not available for one week. Transporting meals in hot carts was a logistical problem with the loss of power for elevators. Much of the nutritional support of difficult patients, many with feeding-swallowing disorders, became the responsibility of the dietary department due to diminished nursing support.

Perhaps the single issue that most traumatized the patients transferred and the staff that received them was the inadequate patient identification. In a number of instances, the caregivers "disappeared" leaving helpless, demented people with no information, as to medication, medical problems and other patient information. Other shelters received large numbers of residents, virtually "dumped" from nursing homes, for their day to day care. Many incontinent elderly were brought to shelters with no medications, diapers, or other supplies.

Conclusion and Recommendations

Indications are that because of legal and staffing constraints even more of the burden of patient care will fall upon nursing homes to provide even greater assistance during the next disaster. General public shelters are not designed, equipped or staffed to manage the care of great numbers of chronic patients. Be it the frail in the community, or those congregated in institutions, the recommendation, and at times the requirement, on institutions is to shelter in place or transfer their population to a "like facility" well outside the probable impact area. It's obvious, in order to ensure adequate staffing, facilities must provide for employees, as well as their families and pets, including everything from food and bedding to legal assistance. The comfort needs of patients and staff alike, along with their psychological needs, under the most adverse conditions must be considered.

Strict command and control measures during the critical hours must be adopted. Monitored points of entry to the facility with proper pre-prepared identification badges should be issued by security, and logs meticulously maintained for all "new residents" for accurate tracking. The time dedicated to this process is both logical and humane. In both instances loved ones that have abdicated the care of an older family member, as well as the older resident him/herself, will be much less anxious and far more reassured if contact with loved ones is not lost through the process of being moved from one shelter or one care setting to another.

Further steps that can be taken to minimize the trauma that might be inflicted on the older adult whether they remain where they experienced the disaster or must be transferred due to the circumstances of the disaster. An understanding and appreciation of the high risk in the elderly is also paramount. Particular attention to vision deficit, hearing loss, cognitive changes, and acute illness is required, as well as keen attention to prevent injury from falls during this critical period. New surroundings, poor lighting and hazards from fallen debris must also be taken into consideration to minimize the incidents of risk or injury.

Specific attention to the psychiatric needs of the nursing home population need to be addressed as well. Studies have found that without the added impact of a disaster 91% of nursing home residents had at least one psychiatric diagnosis and/or at least one behavioral problem. When any circumstances warrant a change in their living environment, behavioral problems and even mood disorders will occur more frequently. Furthermore, the elderly and those with pre-existing medical problems and/or some cognitive impairment may also be more susceptible to developing post-traumatic stress disorder. The temptation to restrain these individuals either physically or by pharmacologic techniques will likely lead to further complicating the resident's pre-existing illnesses. An adequately staffed locked unit would enable residents to ambulate freely and safely under proper supervision.

During crises the demand on resources can be so extreme that it may overwhelm the staff that has been able to report to duty. To prepare for these contingencies a viable recommendation would be ongoing training and exercises as a means of ensuring maximum access to staff's capabilities and availability. The ideal would be that staff who customarily deliver community based services would be cross-trained to provide patient care in a nursing home; similarly, nursing home staff would have been crossed trained to deliver basic care and assistance in the community.

In conclusion, as we all prepare for the next disaster, the question that must have an answer before the earth shakes, the wind builds, the water rises, the mud slides, the rain falls or the fire rages, is when these frail elderly must be transferred from their present dwellings, where do we send them? Extensive literature details complicated medical pathology on the possible risks whenever frail elderly are displaced, especially to hospitals, even in the best of times. It is illogical to think that the elderly with special needs can adequately be cared for and monitored in hastily prepared shelters. As this country continues to age at unprecedented rates there will simply not be one set of actions that will satisfy all unmet needs. A partial solution requires nursing homes to prepare themselves to be as self-sufficient as possible, for as long as possible, while fortifying mutual aid agreements with multiple facilities creating plentiful options and humane response.

Institutional Action Steps to Minimize Transfer Trauma

1. Each nursing home department or section should ***prepare a specific hurricane preparedness plan and*** conduct a detailed ***review yearly***.
2. ***Designate all critical staff*** who can be relied on to be present for the disaster.
3. ***Make a detailed contingency evacuation plan***, including pre-arrangements such as scheduling and transportation by bus companies.
4. Each institutional department or section should ***designate key personnel*** who will be available in case of emergency.
5. ***Confirm third party support agreements*** with outside vendors.
6. ***Prepare for employees and their families*** to obtain shelter and assistance in personal needs.
7. ***Establish and coordinate chain of command*** with wire-diagrams placed at key areas.
8. ***Make provisions for pets*** (outside kennel agreements).
9. ***Prepare a required task list*** of all assignments that must be completed before storm strikes (everything from water heaters, to closing shutters and water proofing computers).
10. ***Develop a command center*** for control of all activities and obtain battery powered computers available to allow daily update flyers for all personnel.
11. ***Develop interdisciplinary teams*** to provide care to individuals in each building during any storm. They should include a nurse, social worker, security guard, aide, etc.
12. ***Develop security***, with single monitored door for entry, and proper I.D. badges for all persons on campus. Have badges available before hand.
13. ***Plan on using hand-held radios*** for communication since telephone service may be inoperable. Prior training in their use is necessary.

14. ***Order critical supplies*** (see attached) (water, ice, medical, emergency) through pre-arranged vendors during hurricane watch.
15. ***Order dietary orders*** including milk, groceries etc., during watch from pre-arranged vendors. A pre-planned seven day menu can be made available ***for residents, employees and employees' families (including provisions for infants)***.
16. ***Internal Disaster Plan*** (for injuries during storm, since EMS may not be operable).
17. ***Staff Pharmacy*** with extra personnel and common medications for contingencies.
18. ***Physical plant must have generators in working order*** and adequate fuel supplies for a week.
19. ***Fuel all vehicles*** during watch phase.
20. ***Include chainsaws***, for cleaning debris, and repair of damage after storm.
21. ***Photograph and document all property damage*** for adequate insurance reimbursement.
22. ***Develop a person transfer log*** to assure tracking of all regular residents as well as those recently displaced and brought for shelter.
23. ***Have protected cash on hand***. All purchases after the storm will need to be carried out through cash transaction.
24. ***Routinely follow infection control procedures*** to prevent sanitary related problems.
25. ***Secure battery operated radios*** to obtain information.
26. ***Coordinate with county and state disaster plans***.
27. ***Ensure services are available*** (possible by Department of Social Work) for emotional support of staff as well as residents.
28. ***Provide disaster education to all staff on a continuing basis***.
29. ***Conduct disaster alert simulations*** on a routine basis.

INVENTORY OF CRITICAL SUPPLIES AND EQUIPMENT

MEDICAL SUPPLIES

Underpads	Diapers	Disposable Wash cloths
Water pitchers	Exam gloves	Gauze bandages
Syringes V 100	Eggcrate mattress	Nutritional Supplement
Picture Bands	Patient ID Bracelets	

EMERGENCY EQUIPMENT

Batteries "D"	Batteries 6 Volt	Chainsaws
Water - 2 1/2 Gal.	Duct Tape	Flashlights
Lanterns 2x6	Lanterns 4x6	Masking Tape

* Quantities of items will be based on the size of the facility.

* Any inventory of supplies and equipment must include consideration that the patients' caregivers might also be sheltered at the facility.

ACTION STEPS TO MINIMIZE TRAUMA FOR HOME BASED ELDER

DISASTER PLANNING WORKSHEET

BEFORE DISASTER STRIKES:

EACH INDIVIDUAL SHOULD PREPARE BY PACKING A WATERPROOF EMERGENCY SUITCASE.

- flashlights
- fresh batteries
- battery operated radio
- bug repellent and sunscreen
- personal hygiene items
 - toothpaste and brush
 - dentures and glasses
 - deodorant and soap
 - shaving equipment
- wash cloth and hand towel
- tissues, premoistened towelettes and toilet paper
- change of clothes
- disposable incontinency supplies and other supplies if you will be providing care to a frail family member or friend.
- list of numbers of important papers
 - insurance policies
 - mortgages, bank and savings accounts
- list phone numbers - family, friends, physician, pharmacy, caregiver, business contacts
- copy of all prescriptions
- extra pair of glasses
- plastic bag with water purification tablets
- matches in plastic bag
- manual can opener
- plastic garbage bags
- map of the area

STORE TWO-WEEK SUPPLY OF FOOD AND LIQUID

- special dietary needs
- small containers of canned meats and fish
- small cans of canned fruits
- crackers, dry cereal, granola bars, bread
- canned or bottled juice
- nuts, peanut butter
- dry milk
- paper plates and napkins
- water bottles (at least two quarts of water per person per day for at least seven days)

GENERAL

- pre-arranged care of pets
- home construction inspection
- notify friends, family and senior services of your plans
- provide family in another city copies of important papers
- tell family, neighbors, service agencies where you would go to stay in an emergency and give each of them phone numbers in order to check on you after the disaster
- have a transportation plan for emergencies
- install shutters and storm doors

SPECIAL NEEDS

If necessary (and available in your area), register with your county's Special Needs Registry.

DURING THE DISASTER WATCH PERIOD

- check medication supply
- fill prescriptions
- move car to a safe area
- double check emergency suitcase
- clean and fill bathtub with water
- pick up loose objects outside
- move furniture away from windows
- make hotel reservation and get reservation numbers
- replenish batteries
- fill gas tank
- cash a check
- pack dentures, glasses
- fill containers with clean water
- pull curtains, blinds and shutters
- call family/friends, tell your plans

EVACUATION PERIOD:

THINGS TO TAKE

- emergency suitcase
- be sure to have identification on your person
- meet your buddy
- move car to a safe area
- post your name, phone and location on a visible inside wall of your home
- plastic bag with towels, blanket, pillow, change of clothes
- adjustable lawn chair
- pack in plastic pail tissue, paper towels, trash bags, liquid detergent, disinfectant
- turn off electricity at main circuit breaker
- unplug appliances
- Medicare, Medicaid cards
- driver's license and identification
- checkbook and credit cards