EMERGENCY PLANNING & MANAGEMENT AT DEEP CHAND BANDHU HOSPITAL- A STUDY

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ABSTRACT

Hospitals play a critical role in providing communities with essential medical care during all types of disaster. Depending on their scope and nature, disasters can lead to a rapidly increasing service demand that can overwhelm the functional capacity and safety of hospitals and the health-care system at large. The World Health Organization Regional Office for Europe has developed the Hospital emergency response checklist to assist hospital administrators and emergency managers in responding effectively to the most likely disaster scenarios. This tool comprises current hospital-based emergency management principles and best practices and integrates priority action required for rapid, Effective response to a critical event based on an all-hazards approach. **Healthcare** System Preparedness The preparedness cycle is outlined in detail as it relates to healthcare preparedness. In the preparedness cycle, the required steps for planning, equipping, training, exercising, and evaluation activities are defined and by the objectives (tasks) and supporting resources that are needed to be prepared. Preparedness is defined as "a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action in an effort to ensure effective coordination during incident response."

KEY WORDS: organizing, training, equipping, exercising, evaluating.

Emergency Operations Plan (EOP)

Hospitals are required to have an Emergency Operations Plan (EOP) which describes how a facility will respond to and recover from all hazards. It is inclusive of the six critical elements within the Joint Commission's Emergency Management Standards

- Communications
- Resources and assets
- Safety and security
- Staff responsibilities
- Utilities and clinical
- Support activities

The "all hazards" approach allows ability to respond to a range of emergencies varying in scale, duration, and cause. The EOP addresses response procedures, capabilities and procedures when the hospital can not be supported by the community, recovery strategies, initiating and terminating response and recovery phases, activating authority and identifies alternate sites for care, treatment and services.

The Emergency Operations Plan (EOP) provides the structure and processes that the organization utilizes to respond to and initially recover from an event. The EOP is therefore the response and recovery component of the EMP.

MATERIALS AND METHODS

The data was collected using both by primary data collection methods as well as secondary sources.

PRIMARY DATA

Most of the information was gathered through primary sources. The methods that were used to collect primary data are

- Questionnaire
- Interview

SECONDARY DATA

Secondary data was collected through

- Text Books, Magazines, Journals, Websites

Data Analysis & Interpretation – Classification & tabulation transforms the raw data collected through questionnaire in to useful information by organizing and compiling the bits of data contained in each questionnaire i.e., observation and responses are converted in to understandable and orderly statistics are used to organize and analyze the data: Graphical analysis by means of pie charts bar graphs etc.

NUMBER OF RESPONDENTS

Total samples of 100 respondents were contact who respond to the questionnaires.

SAMPLING TECHNIQUE

The technique was used for conducting the study were convenience sampling technique as sample of respondents will be chosen according to convenience.

STASTICAL TOOLS

The tools uses in this study will MS-EXCEL, MS-WORD. MS-EXCEL use to prepare pie-charts and graphs. MS-WORD was used to prepare or write the whole project report.

RESULTS

Appointing a disaster recovery officer responsible for overseeing hospital recovery operations.

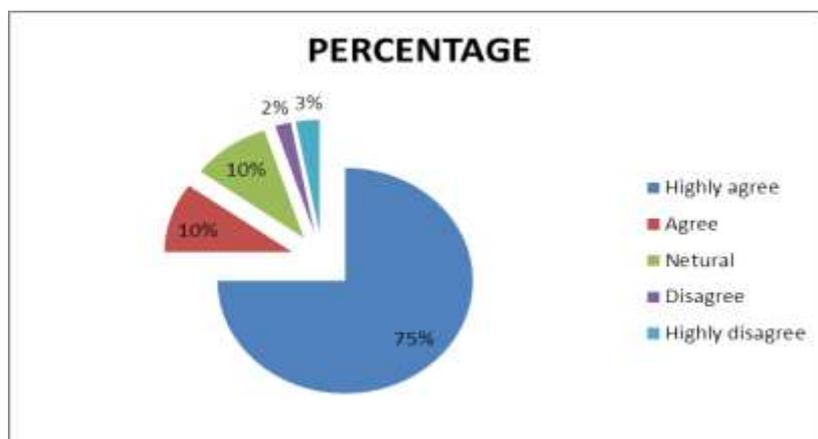| Criteria	Frequency	Percentage
Highly agree	25	25%
Agree	35	35%
Neutral	20	20%
Disagree	10	10%
Highly disagree	10	10%
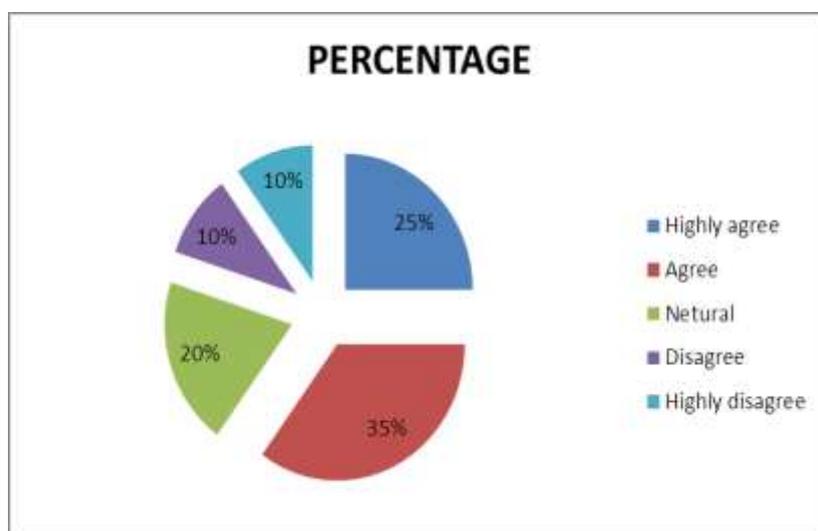
Analysis

As per the above pie chart 25% of respondents are highly agree to appoint a disaster recovery officer responsible for overseeing hospital recovery operations, 35% of respondents are agree with the same.

Q 2. Provide a post-action report to hospital administration, emergency managers and appropriate stakeholders that includes an incident summary, a response assessment, and an expenses report.

Criteria	Frequency	Percentage
Highly agree	75	75%
Agree	10	10%
Neutral	10	10%
Disagree	2	2%
Highly disagree	3	3%

Analysis: As per the above pie chart 75% of respondents are highly agree that a post-action report should be provided to hospital administration, emergency managers and appropriate stakeholders that includes an incident summary, a response assessment, and an expenses report, 10% of respondents are agree with the same.
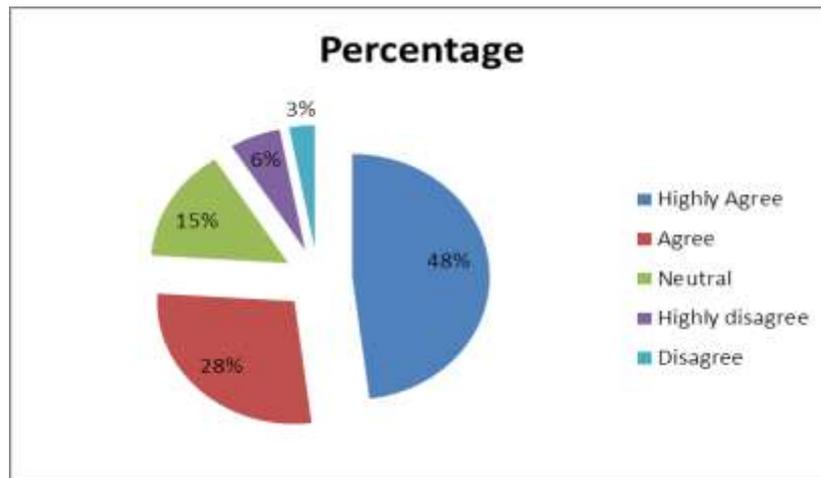
Q3 Ensure that all members have been adequately trained on the structure and functions of incident command system (ICS) and that other hospital staff and community network are aware of their roles within the ICS.

Criteria	Frequency	Percentage
Highly Agree	48	48%
Agree	28	28%
Neutral	15	15%
Highly disagree	6	6%
Disagree	3	3%

Analysis: As per the above pie chart 48% of respondents highly agree that all members should be adequately trained on the structure and functions of incident command system (ICS) and that other hospital staff and community network should be aware of their roles within the ICS, 28% of respondents are agree with the same.

• Most of the respondents agree that a specific location i.e.hospital command center should be prepared to convene and coordinate hospital-wide emergency response activities and equipped with effective means of communication in Deep chand bandhu hospital.

• 66% of the respondents said yes that if the command center need to be extruded ,then Deepchand Bandhu Hospital has determined an alternate, 23% of the respondents disagreed that if the command center need to be extruded, then the Deepchand Bandhu Hospitalhas not determined an alternate.

• Most of the respondents said Designate prospective replacements for medical administrator and focal points to guarantee continuity of the command-and-control structure and function of the deepchand bandhu hospital.

• 51% of the respondents highly agree that mechanisms should be established for the appropriate and timely collection processing and reporting of information to supervisory stakeholders' and through them to neighboring hospital practitioners and prehospital networks of different government hospital and 25% of the respondents agree to the same.

• 52% respondents said that the rules for engagement in crowd control are clearly defined for proper functioning of emergency ward functioning at Deep chand Bandhu Hospital.

• 55% of the respondents highly agree to consult internal and external documents related to hospital emergency management to ensure application of the basic principles and accepted strategies related to planning and implementing a hospital incident action plan at Deepchand Bandhu Hospital and 25% of the respondents agree with the same.

• Most of the respodents said mechanisms of information exchange between hospital adminsitation department/unit heads and facility staff of Deep chand Bandhu Hospital should be established.

• 50% respodents highly agree that an hospital security team should be appointed for all hospital safety and security activities to tackle the any incident in the hospital, 24% of respondents are agree with the same.

52% respondents highly agree that security needs should be prioritized and areas where increased vulnerability is anticipated should be identified, 27% of respondents are agree with the same.

DISCUSSION

Health-care emergency planning aims to protect the public's health and maintain services to treat people's illnesses. Therefore the communities to be served should be central to such planning. Yet it would appear that not enough is known about communities and how to support them, and the potential for active partnership between communities and services has not been fully realised (Ahmed *et al*, 2012).

Despite the existence of national guidance on recovery (National Recovery Working Group, 2007), which makes reference to people's health needs, recovery often seems to be the poor cousin of emergency planning and response. Yet unless recovery processes swing into action as the emergency is being dealt with, there is evidence that long-term problems can be created (Levine *etal*,2007).The U.K. research studies (Anathallee *et al*, 2007; Williams *et al*, 2007; Fell, 2008; Day *et al*, 2010) typically indicate shortfalls in the emergency preparedness of health-care services. Training and exercises are a major component of developing preparedness, but knowledge is lacking. Organisations need senior managers who have the abilities to take effective command and control decisions during emergencies. Yet decision-making processes during crises are not fully understood (Rake, 2003; Sementelli, 2007) due to the dynamic complexity of incidents and the nature of the evolving and unknown risks that

are present. **Debra J. Levin** has worked for The Center for Health Design in various roles since 1989 and is currently president and CEO. Under her direction The Center has grown exponentially, expanding its impact both in the United States and internationally through research, education, and advocacy efforts. The purpose of this publication is to help health care organization leaders, environment of care professionals, and other health care organization staff members successfully navigate the complex aspects of planning, design, and construction. This concept of health design, or evidence-based design, is emphasized throughout this publication in all issues related to planning, design, and construction. In 2005, its World Health Assembly (WHA) passed a resolution calling on the Organization to provide technical guidance and support to countries building their emergency response capacities, stressing a multisectoral and comprehensive approach. The following year, another resolution called on Member States to further strengthen and integrate their response programmes, especially at the community level, and emphasized interagency cooperation at the international level. WHO Regional Committees have also passed resolutions . The World Conference on Disaster Reduction, held in January 2005 in Kobe, Japan, adopted the Framework for Action 2005–2015: Building Resilience of Nations and Communities to Disasters and provided and promoted a strategic and systematic approach to reducing vulnerabilities and risks to hazards. WHO will partner the United Nations International Strategy for Disaster Reduction (ISDR) and other UN and non-UN agencies in the 2008–2009 Safe Hospitals Initiative, which aims at building the resilience of hospitals and other health facilities to disasters, both structural and functional, so that they would still be functional under emergency situations. Under the aegis of international policies, including WHA resolutions, and as part of its mandate as the international health lead agency and the IASC global health cluster leader, WHO intensified its work during 2006 in the field of emergency preparedness and response. Beginning with the definition of its global strategy and moving gradually into the implementation of the main directions highlighted in the strategy. After the 2004 Indian Ocean tsunami, in Sri Lanka alone the health physical infrastructure losses included at least 92 partially or fully damaged health institutions. These included hospitals, drug stores, cold rooms, preventive health care offices, health staff accommodation facilities and district health offices. In addition, a large number of vehicles (ambulances, lorries, vans, motorbikes) and most of the medical equipment and office equipment in the affected areas were totally destroyed. The loss of health personnel included medical officers, nurses, midwives and support staff. Furthermore, a large number of health staff were injured, traumatized or displaced by the event, hence unable to assist the affected.

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