HEMNZ Health Emergency Management New Zealand Bulletin

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Has Clinical Health Isolated Itself From The Public?

Bruce Parkes

Wame Baravilala , Dean of the Fiji School of Medicine, has no doubt that it has. His statement to the affirmative was offered in the context of a cautionary tale to participants of a scientific symposium held to mark the opening of Auckland School of Population Health on its Tamaki campus. Dr Baravilala was reminding his audience that to improve the health of a population, population health practitioners must work with and be responsive to the needs of the public. His statement is equally applicable to health emergency management so often locked within the body of hospital systems.

Dr Baravilala's argument is instinctively compelling. Hard working and caring clinicians, faced with an unending demand for the supply of increasingly expensive high tech service, are putting higher walls around those services. The message is clear, "we are very busy, there is no room in the inn, don't come near us unless you are very sick."

"Hospital urges patients to stay away unless really ill", shouts the headline in an article in the N.Z. Herald of June 3rd - so typical of the message consistently beamed to the public. Patients are being told to stay away from Tauranga Hospital's emergency department unless they are seriously unwell as it struggles to cope with an overflow of patients. The hospital is running an advertising campaign in community newspapers, on radio and in movie theatres encouraging people to visit their GP if they think their situation is not serious. Derek Sage, the hospital's director of emergency medicine, said the hospital was dealing with the issue and pressure on the emergency unit would ease after hospital development was finished in 2006. The cynic in me says that statement is a candidate for a Tui Beer "Yeah Right" ad.

Behind this message to visit your GP rather than ED is an implicit assumption that there is ample capacity in the primary sector to pick up this diverted demand. Access to GPs does not get the same media attention as crowded EDs but there is little doubt that they are also under pressure.

Typing 'crowded emergency departments' into Google gets 60,000 hits. While every reference talks about the problem, none offer a viable solution. GPs and Community Services are seen as both the cause of the problem (because they are not there and forcing the public to EDs by default) and the preferred alternative source of service for the public.

The Victorian Auditor General produced a report last month on managing emergency demand in public hospitals. Again a suggested solution is on a hospital - community provider partnership

Our basic strategy for providing health services in a major incident is to both rapid discharge and refer the less critical to primary and community providers. In other words, a continuation of what has become "business as usual" - a term so disliked by some. How realistic is our implicit assumption that those services have spare capacity, or can increase their capacity to cope? Have we entered into dialogue with those providers to test that assumption?

I continually hear civil defence practitioners and some health emergency planners equate a health response in a

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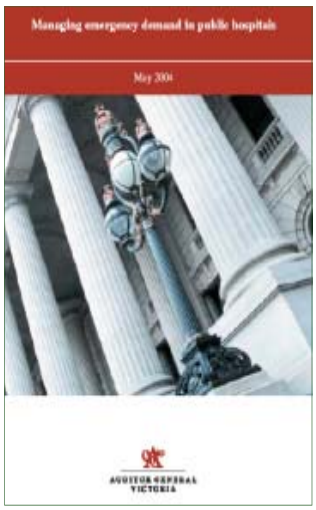

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"disaster" with a hospital response. Some DHB Major Incident Plans still base their planned response around hospital-based services. In an environment where hospitals are having trouble coping with "normal business" just how do they plan to do this? There is obviously little spare capacity in the system, despite vigorous triage strategies.

Current planning around a pandemic response is highlighting the probability of there only being a narrow window in which hospitals have a capacity to cope with those who are ill. As the number of those infected increases, community and/or home care will be the only option. It is sobering to discuss the need for reverse triage where we will concentrate our resources on keeping the healthy well.

In a Pandemic there will only be a narrow window where hospitals will have a capacity to treat those who are ill. Community care will be the norm. The focus will shift to keeping the healthy well.

Abandoning the population to its own devices is not unusual. Rationing of health services has always been an ethically appropriate strategy, used everyday to balance demand against available resource. Acute services do what they can with an expectation that less acute services will pick up the remainder. From a hospital perspective, planners have focussed on what they can do in the hospital setting without considering or testing how other health services will cope with those triaged for a lower level of care.

Hospital overload is a worldwide problem and comes at a time where there are major paradigm shifts in Western culture. We have been through phases of health gain through better hygiene and prevention; increasing professionalism in healthcare; and technological development. Health gain in the 21st Century will come through greater and more responsibility for one's own health and wellbeing. The population is increasingly turning to alternative treatments. At least fifty percent of the Australasian population currently utilise complementary approaches toward their health. These treatments are often employed along with early preventative approaches when conventional medicine fails, or as an adjunct to its use. Some of these modalities are also used as first-line treatment alternatives.

Nearly one in four New Zealanders are visiting complementary and alternative medicine (CAM) practitioners each year – and this doesn't include people who are buying CAM products from pharmacies and health food stores. Some herbal medicines, such as Echinacea for colds and flu, are now in common use. Will the public abandon these alternative approaches when a "disaster" disrupts their lives? Can we rely on self care and alternative remedies be used to ease the demand on stretched clinical services?

Public sector personal health services are overloaded, the population is being asked to take more responsibility for their own health, how can we equip the population to take that personal responsibility? If we health emergency planners are expecting our communities to be resilient in the face of adversity I suggest we have an obligation to help them to build that resilience. The promotion of first aid courses and the preparation of information sheets on how to treat those with common illnesses are but two of the strategies that might be employed.

Because it is hard to know what CAM information is reliable the Ministry of Health has launched a website at www.cam.org.nz to enable consumers to make better informed choices about their health care options. The site provides evidence-based information on the safety and effectiveness of a range of CAM treatments.. From this information people can draw their own conclusions and make their own decisions.

The website is aimed at a wide audience, including consumers and health practitioners of all disciplines and is still in its establishment phase. The number of topics on the website will be built up over time. The site does not provide medical advice. Medical advice is available from the free Healthline telephone advice service, successful in 4 pilot areas and soon to be rolled out across the whole country.

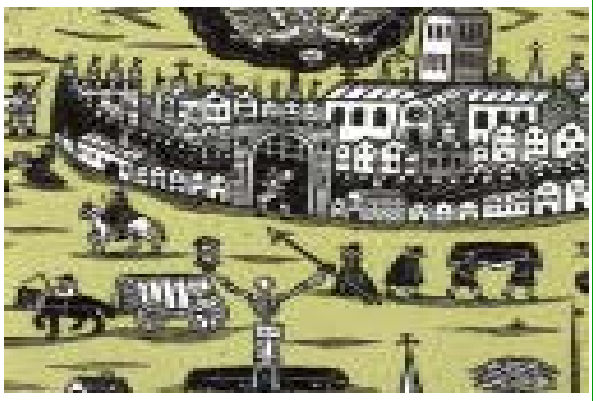
This week Gore Health won a highly commended award at the Health Innovation Awards for its Community and Wellness Programme. Centred at Gore Hospital, the programme began in September 2003 with seminars and wellness clinics covering all facets of a healthy lifestyle for old and young, male and female. It is based on 13 areas identified by the Primary Health Care Strategy as having potential for substantial improvement. The community immediately embraced the programme and was soon offering suggestions for more topics.

The first wellness clinic was a pharmaceutical brown bag check in which people brought along their drugs and supplements for review by local pharmacists. This was a great success. In one case, a woman's bag full of drugs was found to include three primary and very expensive medications; two to start kidney function and one to stop it. After a $50 blood test, one medication was retracted with a better result for the patient and a saving of $200 a month.

Gore's programme was not put together for emergency management reasons but perhaps it shows the way forward. While the rest of us are rushing around setting up very necessary CIMS structures and high tech treatment options, Gore has worked out that actually talking with the public and responding to their needs can help keep all but the most ill away from a clinicians door.

While the detail of what works well in the Mataura Valley might not fit well in Mornington, Merrilands, Mana or Meadowbank the principle of working with a community to keep it healthy surely will. There are certainly other programmes funded by DHBs or delivered by their community service arms. Lets not just pull up the hospital drawbridge. There is much we can do to make our communities more resilient and self sustaining.

Canadian Hospitals battling outbreak more deadly than SARS



Get used to the term clostridium difficile, or C diff for short. In Montreal and Calgary more people have died after contracting a virulent strain of this bug than were killed by SARS, reports the Canadian Medical Association Journal. For 18 months at least 12 hospitals in Montreal have been battling an outbreak of C difficile, an organism that is naturally resistant to most of the broad spectrum antibiotics that are being used on hospital wards these days. While many hospitals are loath to release data, in 2003 more than 1400 patients at 6 Montreal hospitals tested positive for the infection. 79 deaths are reported, although some clinicians claim some patients die with C difficile rather than from it. By comparison, in all of Canada 44 people died of SARS in last year's outbreak

The outbreaks are not yet under control in Montreal or in Calgary, where a not so virulent strain of the organism has resurfaced after hospitals there were able to rout it during an earlier outbreak in 2000 – 2001.

The infection occurs in some patients after they have taken prescribed antibiotics. Once established in the intestine, the organism produces a toxin (cytoxin B) that damages the colon. Patients suffer diarrhoea, which can be mild or severe and can be accompanied by haemorrhage if further infections have done more damage to the colon. In these cases, a total colostomy may be necessary.

The outbreak is not yet under control.
79 deaths have been reported.
More than the 44 who died from SARS

The organism forms spores that can survive for long periods outside the body and are resistant to common hospital disinfectants. C difficile is spread through hand-to-hand contact, often by patients sharing rooms and bathrooms, or inadvertently by staff caring for multiple patients. The infection is believed to occur when antibiotics reduce the normal bacterial population of the small intestine, allowing the organism to thrive. Patients, often elderly and immunocompromised, have usually been admitted for other illnesses then contract the infection in the hospital. While healthy hospital staff are not at high risk, at one hospital at least, a doctor, a volunteer and some health care workers have also been admitted with C difficile.

Despite the epidemic, hospitals have not warned either the general public considering elective hospital admissions or patients entering hospital. C difficile is not a reportable disease, in part because nosocomial infections have been viewed as confined to hospitals and thus not posing a risk to the general public. Yet doctors are seeing patients from the community who have never been hospitalised testing positive for C difficile. The patients are young – in their 20s, 30s and 40s and are presenting with bloody diarrhoea and diarrhoea. Cases of death and colostomies have been reported.

The Montreal Public Health Authority does not have an opinion on whether the general public should be informed. Dr John Carsley, the head of the Authorities infectious disease unit said, " right now it's an institutional decision about what kind of information they give out about infection control and the extent of the infection." Other clinicians believe that the lack of a public statement is keeping patients from making the choice of delaying elective procedures or being admitted to hospitals with lower infection rates. The problem is that no hospital in Montreal wants to be labelled a C difficile hospital.

To protect hospitals, the public has not been informed about this outbreak

Dr Michael Libman, an assistant professor at McGill University and an authority on C difficile offers a "doctor knows best - hospital view" "I think the outbreak is a serious problem, but generally it is a concern within hospitals to specific types of patients," says Libman. "In any given day or month things are going on in the hospital that affects patient risk. I don't know why we should be picking C difficile out of the multitude of risks to put emphasis on," he says. "It would be more frightening than anything else to take low risk elective patients and frighten them with the numbers that probably have very little impact statistically on their cases."

Infection control, as always, is the key to beating C difficile. Montreal hospitals have had problems through the physical set up of their bathrooms and wards and the cutting back on household services. The organism sticks around. "We're finding it days and weeks after we thought a room was thoroughly sterilised with bleach. You have to treat the whole hospital environment as contaminated," says Ken Flegel, a professor of Medicine at McGill University.

C diff infections pop up all around the world. Lets hope this particularly nasty strain does not make it here. With so many New Zealanders visiting and transiting the northern hemisphere through our winter we can never assume distance is an effective barrier. If it does make its way into our hospitals our public will be outraged if they are not advised of the risks they may be facing.

Taking D for Death out of Hospital Demolitions

Robert Patton

Natural gas from a ruptured underground line ignited with a roar near George Washington University Hospital, covering part of a street with towering flames and forcing the evacuation of patients and medical staff. Authorities said the gas leak appeared to originate on the site of the old George Washington hospital building, now being demolished. (Washington Post 3 October 2003)

In 1997 the Royal Canberra Hospital was demolished using a technique known as 'implosion'. A 12-year-old girl, standing 430 metres from the demolition site, well beyond the exclusion zone perimeter of 200 metres, was struck and killed by a 1kg fragment of steel.

In hospitals in Ireland, Britain, Italy and the United States, there is an increased mortality rate of patients in acute, high dependency areas, due to respiratory complications caused by Aspergillus Fumigatas. Aspergillus is a fungal genus found in soil and decaying plant life. Hospital acquired outbreaks of aspergillosis have become a well-recognised complication of hospital renovation and demolition. At risk are cancer patients receiving chemotherapy, transplant patients receiving immunosuppressive therapy and patients who have undergone major surgery.

The above incidents highlight the very real risks present during the demolition and renovation of hospital buildings and during the construction of new buildings. Problems associated with hospital construction, renovation and demolition reported at a meeting I attended recently drew a chorus of "us to" from other attendees. Thankfully, none of the reported incidents were as dramatic as those given above.

A risk assessment should be completed before any construction-type work is undertaken and a risk management plan developed based on this assessment. A useful tool to assist with the assessment is an *Infection Control Risk Assessment Matrix of Precautions for Construction and Renovation.* Available at www.abatement.com/healthcare/pdf/icra_matrix.pdf

Although this matrix is primarily targeted at infection control, a number of aspects of the tool and process can be applied for a general risk assessment prior to construction and renovation. Another useful document available at www.utmb.edu/policy/hcepidem/search/01-38.pdf is *Infection control guidelines for hospital construction, renovation and demolition*. These guidelines highlight important aspects for which a risk assessment ought to be completed and identifies education of construction workers as being necessary.

The key components of a risk assessment are identifying what can happen and how it can happen. An excellent source of information to help with this is learning from what has happened elsewhere. Some of the more common causes of problems I hear about include:

- Utility and system lines such as electricity cables, water and gas pipes, security and fire wires, for other buildings and areas, often run through buildings to be demolished or renovated
- Unidentified hazards such as asbestos being found in buildings being renovated or demolished
- Altered egress routes and evacuation points due to construction, renovation or demolition activities.

The Risk Assessment Matrix mentioned earlier identifies the need to assess the departments, offices or buildings either side, back and front, or above and below the building or space to be renovated or constructed. Of special note, in case water pipes were to be cut or damaged are adjacent areas that contain medical records or critical or expensive electrical equipment. Consideration must also be given to kitchen and food handling areas or walkways that food trolleys pass along that are adjacent to areas where dust may be produced. Clinical areas, especially those with at-risk patients will need to be carefully and thoroughly assessed and involve the input of clinicians involved with the patient's care. Dust and noise are the greatest potential irritants to patients.

All construction, renovation and demolition activities will generate new and additional traffic flow, which may include heavy machinery and large sized construction items. Usual traffic flow, both pedestrian and vehicular will be disrupted. The impact of this should be carefully assessed, taking into account that many people within the hospital environment have some form of disability. Impact on parking space, always at a premium on hospital sites will need to be included in the assessment.

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Cell Phones and Mechanical Ventilators

Common belief has it that electro magnetic fields generated by cell phones will interfere with the operation of medical equipment and many hospitals have policies banning the use of cell phones in intensive and critical care areas. Cheryl I. Shaw; Robert M. Kacmarek; Rickey L. Hampton; Vincent Riggi; Ashraf El Masry; Jeffrey B. Cooper; William E. Hurford set out to determine whether a cellular phone would interfere with the operation of mechanical ventilators. Their research is reported in Critical Care Medicine 32 (4) – available at www.ccmjournal.com

Wireless technology is commonplace in today's intensive care units (ICUs). Many physiologic monitors transmit information to central monitors using wireless technology. These systems are designed to operate in the environment of the ICU and generally do not emit radio frequency (RF) signals of sufficient strength to cause electromagnetic interference (EMI) that affects the function of other medical equipment. Other electronic devices, however, can be found in the ICU that are not specifically designed to operate in hospital environments. Both staff and visitors entering the ICU often carry cell phones, wireless personal digital assistants, two-way pagers, or radios. These wireless devices permit easy communication and exchange of data but might also emit sufficient radio frequency energy to interfere with the function of mechanical ventilators.

Following the unexplained failures of several Puritan Bennett (PB) 840 mechanical ventilators Shaw et al questioned if these failures might be caused by the EMI from personal cell phones carried by staff and visitors in the ICU. They hypothesized that the current international standard governing electromagnetic compatibility (EMC) for medical equipment was insufficient to safeguard mechanical ventilator function from the maximum EMI created by cellular phones.

Their study evaluated the change in operation and malfunction of fourteen mechanical ventilators when a Nokia 6120i cell phone was placed at various distances from the devices. Six of the 14 ventilators tested malfunctioned when a cell phone at maximum power output was placed </=15 cm from the device. None of these responses were considered immediately life threatening except for the response of a Puritan Bennett 840, which stopped ventilating when the cell phone at maximum power output was placed </=30 cm from the ventilator.

One ventilator doubled the ventilatory rate and another increased the displayed tidal volume from 350 to 1033 mL. In one of the infant ventilators, displayed tidal volume increased from 21 to 100 mL. In another ventilator, the high respiratory rate alarm sounded but the rate had not changed.

Their conclusion was that in a controlled laboratory setting, cell phones placed in close proximity to some commercially available intensive care ventilators could cause malfunctions, including irrecoverable cessation of ventilation. This is most likely to occur if the cellular phone is <30 cm from the device and ringing. Based on their data and the available literature, they believe it is reasonably safe to permit the use of cell phones in the intensive care unit, as long as they are kept >/=3 feet from all medical devices. The current electromagnetic compatibility standards for mechanical ventilators are inadequate to prevent malfunction. Manufacturers should ensure that their products are not affected by wireless technology even when placed immediately next to the device.

Other types of wireless technology, Blackberry devices (two-way pagers), and personal digital assistants operate at the same frequencies and the same or slightly higher power outputs as cellular phones. Although these devices were not evaluated, based on their frequencies and power outputs, there is an expectation that ventilators would be as susceptible to EMI from these devices as cellular phones.

Since the use of wireless technologies is rapidly increasing in hospitals and in daily life, Shaw et al believe that strategies that attempt to ban or limit the use of wireless devices in patient care areas are unlikely to be successful or desirable. However, it is necessary for healthcare facilities to carefully consider and minimize the impact of EMI in their environment. For example, in addition to staff education, micro-cell and distributed antenna systems that require minimal power output from wireless devices may be installed in patient care areas.

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There are often hazards contained within buildings that are not easily seen or detected until after work commences. These may include lead, mercury, halon and asbestos. If underground tanks are part of the removal or upgrade programme consider the likelihood of leaching of tank contents into the surrounding ground.

An extremely important component in the process of constructing or renovating is the commissioning of the new facility or building. Commissioning is a systematic and documented process of ensuring that building systems perform according to the design intent and the operational needs of the facility. Commissioning should be done when all construction work has been completed and before staff and patients begin to use the area. Done correctly and thoroughly, it will ensure a safer environment for staff and patients and reduce the likelihood of having to call back contractors.

Applying the principles of risk management to all construction, renovation and demolition projects, regardless of their size, will ensure that the likelihood of a dramatic and possibly life-threatening situation will be averted.

Building Your Own Personal Best Practices

In addition to all the books, publications (including this one), seminars, and advice from others, it's a good idea to build your own set of "personal best practices." Contingency Planning offers such a list in its June issue. While the list is not exhaustive and contains elements not applicable to health emergency managers, it's a good start and provides food for thought as you build your own. Do you:

- ☑ Work with a well-defined project plan using Microsoft Project 2000 or an Excel spreadsheet;
- ☑ Regularly plan updates on a weekly or bi-weekly basis;
- ☑ Record minutes of all meetings for future review/audit;
- ☑ Use PowerPoint presentations when discussing emergency management with a unit manager or organisational representative;
- ☑ Use e-mail in an awareness program; send out regular blasts promoting the program, and its value to the organization;
- ☑ Produce laminated wallet-sized cards with critical phone numbers, emergency response activities; review and update them periodically;
- ☑ Integrate emergency management activities with other corporate and operational change management functions;
- ☑ Get sign-offs for delivery of reports or other documentation;
- ☑ Check fire extinguishers for proper charging, location in clear view, overhead signage to evacuation locations;
- ☑ Have clearly written emergency evacuation details on every floor, not only at elevators but also at stairwells, within work areas, and common areas;
- ☑ Analyse equipment area layout to identify and minimize critical equipment, e.g., servers, routers, located within same area;
- ☑ Analyse wiring infrastructures to identify single points of convergence (failure) that can be rewired;
- ☑ Quarterly review of power protection equipment to ensure that devices are correctly rated for the equipment they serve;
- ☑ Weekly review of fuel levels in emergency generators to ensure they are topped up;
- ☑ Obtain brochures on emergency preparedness from civil defence offices and emergency services, set up display rack in common area;
- ☑ Periodically meet with local emergency services and civil defence; have them review your plans, physical sites, procedures;
- ☑ Schedule and conduct at least two annual organisation-level exercises; schedule and conduct system-level exercises quarterly;
- ☑ Have procedures to manage the major incident AND to manage the business;
- ☑ Develop and use checklists for risk assessments, business impact analyses, health and safety, fire risk, environmental risk, insurance coverage;
- ☑ For risk assessments and business impact analyses, use available data, such as project cost benefit/analyses, audit reports;
- ☑ Temper your expectations, as a physical emergency to your facility could cripple even the best plans, at least temporarily; be realistic in your expectations of people;
- ☑ People are your most valuable – and your most fragile – asset; don't overestimate technology or underestimate the need for human resources; while technology may function flawlessly in a crisis, people may not; physical and psychological effects of a disaster can devastate people; prepare to care for "damaged" staff and have a plan to keep fresh troops at the ready;
- ☑ Keep out of the tunnel and away from the fire; don't let the crisis cause tunnel vision, such that you ignore what is going on around you; this can lead to management and staff burnout; be mindful of letting managers take complete ownership of a crisis or process; initiate relief and shift work ASAP;
- ☑ Choose your crisis teams carefully; team members must be flexible and adaptable, and can be away from home for more than 48 hours if necessary; good crisis managers have good family preparedness plans at home;

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Outcomes from the 3rd Conference of the Pacific Community

The theme of the 3rd Conference of the Pacific Community convened in November 2003, was "The Pacific Islands Response to Infectious Disease". The Conference noted that infectious diseases continue to result in significant ill health and death. Diseases such as cholera, typhoid, malaria, dengue fever, influenza, tuberculosis, leptospirosis and HIV/AIDS occur right across the region. Increases in non- communicable diseases will also increase the vulnerability of Pacific Island people to a number of infectious diseases and those infectious diseases will continue to result in a significant disease burden for the foreseeable future.

The Conference acknowledged that for effective action against infectious diseases, strong partnerships between Pacific Island countries and territories (PICTs), regional organisations and donors, and between PICT governments, NGOs, the private sector and communities are especially important. HIV/AIDS is on the increase in many PICTs, and has already reached epidemic proportions in Papua New Guinea. The Pacific region is probably the only region in the world today where there may be a realistic chance of achieving a target of halting and ultimately reversing the increasing trend of HIV infections. Political will, commitment and leadership are key to addressing the HIV/AIDS challenge in PICTs, to prevent it becoming a regional epidemic.

Central to achieving this goal is the mobilisation of financial and other resources through donor partnership initiatives such as the France/Australia and France/New Zealand initiatives in HIV/AIDS and disease surveillance.

The Conference acknowledged that a range of regional organisations are actively involved in particular in relation to HIV/AIDS and agreed that SPC should take on this coordination role for HIV/AIDS activities. Other infectious diseases, activities should continue to be discussed and informally coordinated as necessary through the PPHSN and regional tuberculosis programmes. Most of the responsibility for infectious disease surveillance and control rests with individual governments and administrations. Effective activities at the national level are essential if the health of Pacific people is to be adequately protected.

Being prepared for possible future outbreaks is essential for prompt and effective public health responses.

The conference recommended that PICTs pay more attention to preparedness, including: the development and adoption of national plans to guide future responses to outbreaks of priority communicable diseases, the regular updating of these plans informed by periodic exercises, and the identification of necessary resources that could be accessed quickly.

The Conference acknowledged the important contributions from a number of donors under their bilateral, regional or multilateral programmes to support these activities in PICTs and noted with appreciation the new France-New Zealand project in infectious disease surveillance, and the new France-Australia project in HIV/AIDS/STI. Donor support for infectious disease surveillance and control needs to continue into the foreseeable future.

A full report on the conference is published in the Inform'ACTION #17 available at www.spc.int/phs/ENGLISH/Publications/InformACTION/IA17-contents.htm

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- ☑ Make crisis management processes part of daily routines and activities; for example, the process for reporting sick should be the same as “reporting in” post-crisis and utilize the same numbers, website, etc.;
- ☑ Include on-call crisis teams as part of a daily e-mail or check-in process;
- ☑ Have crisis teams meet regularly (once or twice monthly for no more than one hour); encourage team leaders to read newspapers for example of crisis events and discuss how their team might handle the situation at the meeting;
- ☑ Don’t overlook logistics and finance/administration activities in a crisis; someone has to coordinate the movement of people and resources; someone has to pay the bills, make the reservations, purchase food and office supplies and track expenses; include these in your crisis teams.

HEMNZ Health Emergency Management New Zealand

The HEMNZ Bulletin is published monthly by the Risk Management Unit of St John Northern Region for all those interested in emergency management in health care settings

Articles and comment on emergency management issues are welcomed

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Check out our Web site at www.hemnz.org.nz

Up coming Conferences

24-25 June 2004: Auckland
28–29 June 2004: Wellington
Evolved Methodologies in Business Continuity Planning
Fee $1595+GST
More information from **www.brightstar.co.nz**

12-13 July 2004
Recovery Symposium
Napier War Memorial Conference Centre
More information from
www.civildefence.govt.nz

29 September -1 October 2004
New Zealand Institute of Health Management Conference:
Showcasing New Zealand—innovation from isolation
Rotorua Conference Centre
More information from **www.nzihm.org.nz**

The Natural Hazards Centre Course Programme 2004

National Hazards Management Conference, Tauranga 10-11 August
Managing Extreme Weather and Flooding, Christchurch 26-27 August;
Planning for a Volcano Crisis, Wairakei 14-15 October
More information from
www.naturalhazards.net.nz

Editor's soapbox

Turangi, at the foot of Lake Taupo is a fair step from any centre of civilisation yet 44 health emergency managers and colleagues from the other emergency agencies in the area braved the threat of snow closed roads and a disruption to their Queen's Birthday holiday weekend to meet there recently. Our purpose was to test our ability to work together in responding to an event where the interests of five DHBs converge.

The scenario was a weather bomb travelling down the country disrupting communications, roading and people's lives. Relatively minor norovirus and lahar "niche emergencies" were added in just to keep participants on their toes. One of the successes of the exercise was the opportunity for health planners to see how well an EOC can operate when it is staffed by Police, Army and Ambulance who have regularly trained in this activity.

Despite the headlines devoted to potential big bang tectonic or volcanic events, adverse climatic events are the source of almost all emergencies in this country. Disrupted or destroyed communication links, in all its forms, is the inevitable consequence.

Our exercise confirmed that our achilles heel is a lack of robust communications. The good news is that we know about it and at least the Central DHBs have the will fix the problem. The not so good news is that an ability to communicate across DHB borders and particularly across regional borders, is common across the country.

Here is a simple self test. Do you have the numbers for emergency managers in each of the DHBs adjourning yours programmed into your cell phone and/or PDA?

A recent simple if flawed test of a national capability to contact DHB's "one points of contact" supports the finding from the Turangi exercise that communication across health providers, let alone with supporting organisations, is a major gap in our preparedness for the unexpected. It is something we all have an ability and responsibility to fix.

Bruce Parkes

The Lakes team were in the best room but a long walk in the rain from the other groups

A little excess water is old hat for Whanganui and Mid-Central

Perhaps inevitably the Army, Ambulance and Police got to work in the Restaurant/Bar area