



# Being part of a mass casualty incident is different.



We all train to be able to respond to a mass casualty incident in a calm professional manner. Being part of that incident and having to respond without our usual resources brings a whole new perspective. Jennie Woods, a consultant anaesthetist based at Derriord Hospital in Plymouth, was returning home from a long medical conference in London and was a passenger on the 5.35 Paddington to Plymouth on November 6<sup>th</sup> when it crashed into a car parked on the track.

Charmian Evans from the Daily Telegraph spoke to Woods a few days later and reports that even though she was hungry Woods never managed to eat

the carton of sushi she bought at Paddington railway station that Saturday afternoon. Half an hour into the journey, she felt the train run over gravel and lurch sideways.

"I felt myself falling and had nothing to hold on to," she says. "I landed squarely on top of other people and, as I managed to get up, the lights went out. As they did, I was aware that a teenager was trapped, kneeling with her head on the floor." In the darkness, there was a scream and calls for calm. Passengers who had been on their way to a fireworks display produced glowsticks and Woods realised the carriage was on its side.

"I climbed over the luggage rack and through the smashed door. It was very dark but I could see that our carriage, which was next to the buffet car, was on its own. Someone tried to smash open a window with an emergency hammer, but the handle broke off."

Woods realised the extent of the devastation and, instinctively, her medical training kicked in.

"My immediate response was to try to help other passengers," she says. "As a doctor, I receive regular training in mass disaster planning. I used to teach cardiac life support, too. It's imperative that, in disaster situations, one doesn't allow oneself to lose control. At work I have to lead a team, and falling apart would be counter-productive."

Although she had been trained to handle such medical emergencies, Woods had never attended one before. But she knew she had to help those who were seriously injured and she wasted no time considering her own welfare. "I didn't feel any panic or fear at any stage, and the fact that I'm used to seeing patients in surgery meant that I was not fazed by what I saw," she says. "I realised that all I could do was go through the process of assessment as quickly as I could."

"It was very difficult because I couldn't see much, but after about 15 minutes the firemen arrived. They broke down carriage doors, put up arc lights and brought oxygen masks. In the chaos, it was then a case of leaving those for whom there was no hope and attending to those who were critically injured."

Woods wasn't the only passenger who helped the emergency services to rescue those who were trapped or badly injured. "As well as the firemen, there was a priest, an osteopath, a

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**Besides Woods there was a priest, an osteopath, a nurse, two doctors and an anaesthetist. They quickly formed into a team**

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nurse, and two doctors, including Julie, an anaesthetist friend I'd been in London with," she says. "We quickly formed a team.



"A couple of Marines were brilliant, carrying people out of the carriages. One of them reassured a trapped passenger and held her hand while I took her pulse and checked, as well as I could, for other injuries. I was then asked to look at another passenger who needed resuscitating."

Usually, seriously injured patients should not be moved in case their neck or back is injured and there is a risk of exacerbating the damage. However, Woods had no choice but to adjust the position of one of the passengers she treated. "I realised she would die unless I cleared her airways by tilting her neck back," she says. "I knew it would risk further injuries, but I had no choice. The very hardest thing for me was having to stop trying to resuscitate another passenger because I knew there was no hope."

Woods and the other doctors and nurses struggled without medical kit. "I was frustrated at having no equipment," she says. "We used scarves for tourniquets, and I climbed back into the carriage to pull out as many coats as I could find, to wrap around those who were injured. We also worked with

***"The hardest thing for me was having to stop resuscitating another person because there was no hope"***

the walking wounded, trying to get them on the move and into ambulances as they arrived."

Woods was full of praise for the emergency services staff, who arrived quickly.

"They were all brilliant. And when I made myself known to them, I was given a yellow jacket and I worked with one of the accident and emergency doctors. Eventually, my colleagues and I were told that we were no longer needed, and we agreed readily. We had been through a lot and were glad to be able to get on the coach and go home to Plymouth.

"Julie's husband met us at the station and I got home at four in the morning. My teenage son gave me a huge hug, which was what I needed more than anything else in the world. I stood in the shower for ages, as I was covered in mud and blood, my fingernails were black and my hair was full of broken glass.

"I couldn't sleep at all that night.

On Sunday morning, news of the crash spread around my friends and family, and my phone and doorbell didn't stop. "The train company called to ask if I needed to see a counsellor, but going over the experience with friends was all the counselling I needed. On Sunday night I slept like a log and on Monday I was back in the operating theatre as usual. But I am not sure when I will get on a train again."

***"The train company called to see if I needed a counsellor, but going over the experience with friends was all the counselling I needed"***



A couple went on holiday to Lake Taupo. While the husband likes to fish at sunrise his wife prefers to read. One morning the husband returned after several hours of fishing and decided to take a nap and his wife, although not familiar with the lake, decided to take the boat out. She motored out a short distance, anchored, and continued to read her book.

A fishing inspector came along in his boat, pulled up alongside the woman and said, "Good morning ma'am. What are you doing?" "Reading a book," she replied (thinking "isn't that obvious?!").

"You're in a restricted fishing area," he informed her.

"I'm sorry officer but I'm not fishing, I'm reading".

"Yes, but you have all the equipment. For all I know you could start at any moment. I'll have to take you in and make a report."

"If you do that, I'll have to charge you with sexual assault" said the woman.

"But I haven't touched you!!!!" said the man.

"That's true, but you have all the equipment. For all I know, you could start at any moment."

"Have a nice day ma'am" he said and left.

**MORAL: Never argue with a woman who reads. It's likely she can also think.**

## Smuggled birds raise fears of avian flu spread

Avian flu continues to receive media attention in the northern hemisphere as winter and the normal "influenza season" approaches. This, coupled with almost alarmed concern over a shortage of regular flu vaccine, helps to keep the public informed and interested. "Normal events" are now being given an avian flu spin. Witness the syndicated story carried by many newspapers in early December. "**Smuggled birds raise fears of avian flu spread**". The small suitcase being carried through the Brussels airport by the traveller from Thailand looked unremarkable. But when customs officials opened it they found a surprise: 2 rare small eagles, weak but healthy-looking, taped inside lengths of PVC pipe. Their surprise turned to horror when tests on the eagles came back 4 days later: the smuggled birds were infected with avian influenza H5N1; the virus that health authorities fear could blow up into a pandemic and kill millions.

The finding launched a frantic hunt for the man who carried the eagles, the officials who inspected them, and the 135 passengers who shared the man's 2 flights. Twenty three people were tested; 652 birds that had been in the airport, including the eagles, were destroyed. The episode did not spark an outbreak, but it shook international health authorities. It demonstrated that trade in smuggled wildlife could become an inadvertent and efficient ally in moving a lethal disease around the world.

Underscoring that fear, 3 weeks later, customs officials in Taipei found 28 parrots packed into PVC pipe in a piece of hand luggage that had been carried from Indonesia. "Those are the ones that were caught, there are almost certainly others that have not been caught," said Dr Peter Daszak, executive director of the Consortium for Conservation Medicine in New York. So far in 2004 avian influenza H5N1 has not moved beyond 8 countries in South East Asia.

The ability of smuggled wildlife to cause wildlife disease has long

been recognized: In 1971, a batch of parrots infected with a strain of Newcastle disease and brought illegally from Mexico, killed millions of poultry in California, causing \$65 million in damage. But the need to block animal diseases because they threaten humans is a new problem, spurred by the 1999 U.S. arrival of West Nile virus — primarily a disease of birds and horses — and reinforced by last year's outbreak of monkey-pox, transmitted by Gambian giant rats

On November 29<sup>th</sup> a World Health Organization official warned that, if avian flu gains the genetic ability to move easily from person to person, it could cause up to 100 million deaths around the world. The WHO summoned vaccine manufacturers to its Geneva headquarters for an emergency summit, warning that the world's capacity for making pandemic flu vaccine stands at only 330 million doses and that vaccine production will take at least 6 months.

**At** the same time French press sources in Alsace reported that the 69-year old male who returned home in early December with respiratory difficulties after a 15 day vacation visit to Viet Nam and Cambodia does not appear to have contracted avian influenza A (H5N1) virus infection as first suspected.

Because of heightened concern over a possible pandemic from this virus, the patient was isolated in an intensive care unit at the Central University Hospital in Nancy, pending diagnostic tests. Blood and tissue samples were sent to the Pasteur Institute in Paris where it was determined that avian influenza A (H5N1) virus was not present. The cause of his current illness is still not determined.



## Chocolate is the best medicine

Summer has failed to kick in and influenza remains a common malady so, although this story has had recent exposure in the newspapers it deserves repeating in this our traditional season of overindulgence. Eating chocolate could be a better way of stopping persistent coughing than anything available from the chemist's, according to new research

Theobromine, an ingredient of cocoa, was found to be almost a third more effective in preventing coughing than codeine - considered the best available cough medicine.

Researchers also found that it did not cause any of the potential side-effects of cough treatments, such as drowsiness, headaches or insomnia. Ten healthy volunteers were given theobromine, codeine or a placebo pill, not knowing which they were taking. They then took capsaicin, used to stimulate coughing.



Those given theobromine needed around a third more capsaicin to make them cough compared with the placebo group. When they were given codeine they needed only marginally higher levels of capsaicin to cause a cough than with the placebo.

Prof Peter Barnes, the head of respiratory medicine at Imperial College London, said: "We have very poor cough medicines. There is a need for new treatments."

The researchers, writing in the online journal of the Federation of American Societies for Experimental Biology, said theobromine suppressed the activity of the vagus nerve which is responsible for causing coughing.

Prof Maria Belvisi, of Imperial College London and Royal Brompton Hospital, said: "With theobromine having no demonstrated side-effects it may be possible to give far bigger doses, further increasing its effectiveness."

Dame Helena Shovelton, the chief executive of the British Lung Foundation, said: "The results of this research sound very promising."

## U.S. Has Contingency Plans to Draft Health Professionals

Those who attended the Ministry workshop on emergency management this month will have no illusions about the limited capacity of our Defence Force medical corps. With many major deployments, the US Military is similarly stretched. So much so that contingency plans for drafting civilians are being updated. The New York Times of October 19 reports the Selective Service has been updating its contingency plans for a draft of doctors, nurses and other health care workers in case of a national emergency that overwhelms the military's medical corps.

In a confidential report a contractor hired by the agency described how such a draft might work, how to secure compliance and how to mould public opinion and communicate with health care professionals, whose lives could be disrupted.

On the one hand, the report said, the Selective Service System should establish contacts in advance with medical societies, hospitals, schools of medicine and nursing, managed care organizations, rural health care providers and the editors of medical journals and trade publications. On the other hand, it said, such contacts must be limited, low key and discreet because "overtures from Selective Service to the medical community will be seen as precursors to a draft," and that could alarm the public.

President Bush, re-elected since this report was published, has flatly declared that there will be no draft, but Richard S. Flahavan, a spokesman for the Selective Service System, said "We have been routinely updating the entire plan for a health care draft. The plan is on the shelf and will remain there unless Congress and the president decide that it's needed and direct us to carry it out."

The Selective Service does not decide whether a draft will occur. It would carry out the mechanics only if the president and Congress authorized a draft. The chief Pentagon spokesman, Lawrence T. Di Rita, said "It is the policy of this administration to oppose a military draft for any purpose whatsoever. A return to the draft is unthinkable. There will be no draft." Mr. Di Rita said the armed forces could offer bonus pay and other incentives to attract and retain medical specialists.

In 1987, Congress enacted a law requiring the Selective Service to develop a plan for "registration and classification" of health care professionals essential to the armed forces.

Under the plan, Mr. Flahavan said, about 3.4 million male and female health care workers ages 18 to 44 would be expected to register with the Selective Service. From this pool, he said, the agency could select tens of thousands of health care professionals practicing in 62 health care specialties.

"The Selective Service System plans on delivering about 36,000 health care specialists to the Defence Department if and when a special skills draft was activated," Mr. Flahavan said.

Widmeyer Communications, the contractor hired by Selective Service, said that local government operations would be affected by a call-up of emergency medical technicians, so it advised the Selective Service to contact groups like the United States Conference of Mayors and the National Association of Counties.

Doctors and nurses would be eligible for deferments if they could show that they were providing essential health care services to civilians in their communities. But the contractor said: "There is no getting around the fact that a medical draft would disrupt lives. Many familial, business and community responsibilities will be impacted." Moreover, Widmeyer said, "if medical professionals are singled out and other professionals are not called, many will find the process unfair," and health care workers will ask, "Why us?"

In a recent article in The Wisconsin Medical Journal, published by the state medical society, Col. Roger A. Lalich, a senior physician in the Army National Guard, said: "It appears that a general draft is not likely to occur. A physician draft is the most likely conscription into the military in the near future." Since 2003, the Selective Service has said it is shifting its preparations for a draft in a national crisis toward narrow sectors of specialists, including medical personnel.

Colonel Lalich, citing Selective Service memorandums on the subject, said the Defence Department had indicated that "a conventional draft of untrained manpower is not necessary for the war on terrorism." But, he said, "the Department of Defence has stated that what most likely will be needed is a 'special skills draft,' " including care workers in particular.

That view was echoed in a newsletter circulated recently by the Selective Service System, which said the all-volunteer force had "critical shortages of individuals with special skills" that might be needed in a crisis.

The Selective Service and Widmeyer held focus groups this summer to sample public opinion toward registration and a possible draft including medical personnel. People from a variety of professions, including doctors and nurses, were questioned. A report summarized the findings this way:

- \* There was substantial resistance to the notion of a call-up of civilian professionals that would send draftees to foreign soil.
- \* A draft of civilian professionals was seen as unworkable because "training would be inadequate to transform groups of people who had never worked together into cohesive units.
- \* People are apprehensive about the length of service that might be required. Members of the National Guard are "serving tours of duty far longer than many ever anticipated.
- \* People believe the government has the ability to "find whomever it needs" in a crisis, by using a "master database" if necessary.

**Physicians are split almost 50-50 on the draft. Nurses strongly oppose it**

An on-line poll conducted by Medscape produced an interesting split of views. Physicians were split, 49% in favour and 51% against a draft. On the other hand, nurses were strongly opposed – 33% for and 67% against a draft.

## Children, not the elderly, should get flu vaccines

New research showing that the influenza virus spreads fastest in schools advocates that to control an influenza epidemic and protect the rest of the population it would be better to target school-aged children, because they are the ones who trigger an epidemic. Those who are normally the top priority for vaccinations would be pushed further down the queue in a reversal of current policy which directs that the flu shot should be given to protect people who are most likely to have serious health problems if they get the flu. Those people, as listed by the CDC are:

- \* Children ages 6 months to 23 months.
- \* People who are 65 years of age and older.
- \* People 2 years old or older who have an underlying, long-term illness (heart or lung disease, metabolic disease [like diabetes], kidney disease, a blood disorder, or a weakened immune system including people with HIV/AIDS)).
- \* Women who will be pregnant this season.
- \* People who live in nursing homes or other chronic-care places.
- \* People who are 6 months to 18 years of age, and take aspirin daily.
- \* Health-care workers who take care of patients.
- \* People who have or take care of a baby under 6 months old.

A pilot scheme to vaccinate thousands of children in Texas found that when just a quarter of them were given the vaccine it led to a drop of up to 18 per cent in flu cases among unvaccinated adults. Computer models suggest that vaccinating half the child population would reduce the chances of an epidemic among adults by two-thirds. Vaccinating 90 per cent of children reduces the probability of an epidemic to just 4 per cent. Scientists involved in the study believe that vaccinating even a minority of school-aged children against flu would lead to a significant decline in outbreaks among the very old and the very young, who are at the greatest risk of serious complications, such as pneumonia.

Paul Glezen, professor of virology and epidemiology at Baylor College of Medicine in Houston, Texas, said there was little doubt that flu epidemics were spread mainly by schoolchildren and that targeting them with a vaccine was the best way to avoid a wider death toll. "There's a lot of evidence that children have the highest infection rates and that the virus then spreads from these children to their older and younger contacts," he said. "The elderly and the very young are at the end of the transmission chain so inoculating them won't have any effect on the rate of spread of an epidemic."

Even if only a proportion of children is vaccinated against flu, this could lead to wider "herd immunity" within the population at large, said Pedro Piedra, a member of the Baylor research team. "There have been studies demonstrating that



Vaccinating school age children may protect their parents and their parent's work colleagues, but would the benefit spread to the elderly who have little contact with children? Epidemiologists are confident that it will.

children contribute to the spread of flu in families and communities. By reducing influenza in children, hopefully we can reduce the spread of influenza in the community," Dr Piedra said. "With the current policy of vaccinating the elderly, you only try to control mortality. If you want to control flu, our hypothesis is to focus on children."

The Baylor researchers vaccinated 20,000 eligible children in the Texas towns of Temple and Belton in 1998-99. The vaccine was delivered as a nasal spray rather than injection. Cases of flu in adults over the age of 35 in the two towns fell by between 8 and 18 per cent compared with similar communities where there was no significant childhood vaccination. Professor Glezen said this meant that there were thousands of people who did not catch flu who otherwise would have succumbed to the infection, and some would have developed more serious respiratory illnesses.

John Watson, head of respiratory diseases at the British Government's Health Protection Agency, said that any changes to Britain's vaccination policy would have to be decided by the Department of Health. "This is an interesting study that the Health Protection Agency will be keen to look at in more detail. It is well recognised that children play an important role in the transmission of the influenza virus in closed environments such as households, schools and nurseries," he said. Japan imposed widespread flu vaccination of schoolchildren but the policy was abandoned in 1987 before epidemiologists realised it had saved at least 10,000 elderly Japanese from respiratory diseases.

Professor Glezen said that in the US the number of people needing hospital treatment as a result of flu had increased in recent years despite an increase in the proportion of people over 65 who had been vaccinated. "I don't think we can say we have an effective vaccination policy ... but it doesn't mean that the vaccine is ineffective. We need to target schoolchildren instead," he said.

# Attitudes to risk

Why do so many emergency managers find it consistently difficult to engage key stakeholders in the systematic management of operational risk? From senior management to stores staff, from clinicians to cleaners, acceptance and buy-in to what is clearly a commonsense business practice is often patchy and at worst rejected. This is all the more startling when you consider the high proportion of serious business interruptions caused or permitted by the actions or inactions of people from within organisations, as opposed to hazards with natural or external origins.

Foresight alone is of limited use; like peering into the fog from the bow of a ship, scanning for things that could send it to the bottom. But searching for what? Clearly, we need the ability to recognise hazards far enough in advance to allow us to respond before they strike. We need the ability to communicate every sighting accurately back to the ship's captain in terms he can understand, assess and act upon. And to maximise our chances we need these basic skills to be widespread amongst the crew.

Most stakeholders in an organisation will probably share a general knowledge of the probable disaster scenarios faced by a vessel; bluntly, the ship may sink with the loss of crew and cargo. However, any detailed knowledge of how one or other causal threats may be realised is generally confined to the captain, a core of officers and specialist crew members whose roles include dealing with those hazards. Everyone else is left to develop their opinion of the risks they face based on what they see and hear, and on their own experience.

Because of this, and in the absence of consistent education, pockets of belief form, subtly altering behaviour and causing individuals and groups to become either more gung-ho or blasé, or more conservative than is appropriate for the greater good. Either extreme is potentially damaging; with those in the former category in some cases actually welcoming risk as 'character-forming' or more likely causing risk management to be sidelined as weak, unnecessary or wasteful; the latter embracing it so tightly that adherents threaten to strangle the activity they are supposed to protect, attracting potential ridicule.

## Perception

So how does an individuals' perceptions of risk affect emergency management? Perceptions become ingrained in the demeanour of employees, giving rise to a distinctive and unique 'risk culture', which translates as 'the way we do things around here'. In the absence of a strong risk culture offered by the organisation, the treatment of operational risk becomes a matter of personal interpretation and influence. There are three parameters that help characterise this tendency:

**Risk awareness.** The risks individuals perceive that they face. This is a reflection of ability to channel undiluted and accurate risk information, from top-to-bottom and from side-to-side within an organisation. There have been few incidents in health facilities that have either degraded build-



ings or equipment on a long term basis, or threatened the safety of a large number of staff, so for many, risk awareness is low. By startling contrast, the risk of SARS infection caused acute risk awareness amongst clinical staff and there was a shared language between clinicians and management to communicate that risk. Once the risk of SARS diminished, risk awareness again became an unfashionable, unnecessary commodity unable to compete with pressing operational matters for management attention. It is not that those in healthcare do not care. Healthcare is a very caring profession. Risk awareness has to compete with the many other financial and operational imperatives demanding attention.

**Risk appetite.** The decision to act on or accept a risk is based partly on an individual's tolerance of that risk. In the absence of a clear mandate or policy setting out what is and is not acceptable, risk tolerance information is collected and conveyed personally. We make up our own minds according to our views, opinions and agendas; our views are then modified by other local factors. An example of this is how managers react when told of a risk condition by staff. If the information is well received by the manager then the donor feels encouraged and continues to pass information, and vice versa.

Our willingness to tolerate or accept a level of risk is called risk appetite. It works hand-in-glove with risk awareness, since an individual can only judge the acceptability of a risk based on his/her knowledge of that risk. The risk appetite of those working in public hospitals is increased by knowing that the hospitals are "government owned" and the government, despite statements to the contrary, can be expected to bail out any DHB hospital that gets into financial trouble or loses its facilities. Similarly, hospitals are there to treat those who are injured or become ill elsewhere. The loss or degrading of hospital facilities is perceived as a risk to those seeking treatment, not those working there. Hospital staff take important risk decisions affecting key stakeholders, based on their own view of acceptability. Yet strong risk appetites – a willingness or desire to gamble – are usually inappropriate in a health care setting.

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**Risk Ownership:** This is a measure of an individual's perceived acceptance of responsibility, the willingness and the ability to act on available risk information by others in the organisation and is inextricably linked to risk appetite and awareness. Although we are getting better, healthcare still works in silos. While willing to own the risk in our own silos, we often do not see organisational wide risk as our concern.

Whilst far from defining an organisation's risk culture absolutely, the three parameters described here offer a basis for comparison and improvement. For example, if we can measure a person's awareness of the operational risks facing the organisation we can determine how well informed their risk decision-making is likely to be. Similarly, if we can measure a person's risk appetite, we may be able to infer how well they are suited to making consistent risk-decisions in the organisation's interest. Thirdly, if we can measure their perception of risk ownership, we can begin to judge the pervasiveness of risk culture via the risk management activities they see taking place around them.

An individual's risk behaviour may be typed by other attributes, such as membership of function or department, seniority, experience, motivation and 'stake' in the enterprise. Being able to demonstrate group tendencies based on these and other relevant criteria allow us to predict and then focus more ably on the origins of risk cultural strengths, weaknesses, opportunities and threats within already well-defined areas of the organisation. For example, a department exhibiting poor awareness of the actual risks and a strong risk appetite might be offered very specific training to help comply with risk standards, thereby improving risk culture. Similarly, we can benchmark a department's performance against a standard response or against the behaviour of another group. This allows changes in attitude to be tracked and consistently compared, applying carrot-and-stick measures

to guide participants into an acceptable cultural and behavioural zone.

### Conclusion

This article invites more questions than the answers it provides. For example "What is our risk culture? How do we compare against other organisations? Is our risk culture improving or getting worse? Is change possible and how do we achieve it?" The answers to these are both specific and subjective, requiring local investigation.

*However, we can propose some general tenets:*

- A strong risk culture reduces unplanned loss and benefits stakeholders
- Risk culture flourishes untended, but rarely in the direction our organisation would choose. It needs constant attention, management and leadership
- Formal and informal groups exist in every organisation. Each has a potentially different attitude to the risks they face, and together they set the risk culture
- Incomprehensibility, jargon and vagueness damage risk culture. For effective buy-in, use languages that even risk sceptics can understand
- Awareness has to be nurtured. If no-one knows, nothing happens
- Appetite is personal. Shape it through policy but ignore it at your peril

As a final point, it is clear that we need information to make sense of our own and others' conditions. Only then can we detect the potential for 'bad behaviour' and improve. Such information can be obtained by experience, by guesswork or through the collection of genuine business intelligence.

[This article is based on an article by John Robinson published in the Business Continuity Journal](#)

## Accessing Personal Genius

Those who attended HEMNZ2004 will remember Colin Cox's keynote presentation. Colin is running 3 day workshops in Auckland, Wellington, Hamilton, Gisborne and Napier on accessing your personal genius.

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Articles and comment on emergency management issues are welcomed

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Check out our Web site at  
[www.hemnznz.org.nz](http://www.hemnznz.org.nz)

## Up coming Conferences

16 - 17 February 2005  
**4th Annual Emergency Management Conference**  
Wellington Town Hall  
Cost \$1795 +GST. More information from  
[www.conferenz.co.nz](http://www.conferenz.co.nz)

## Editor's soapbox

The emergency management workshop at Wellington earlier this month showed that at long last we are starting to close the yawning gap between public and personal health services.

But the gap is still there and we need to do a lot more work before we are all comfortable with the way we are being asked to work together.

Two themes seemed to run through the workshop First, there were the "high tech" IT projects and second, there were projects aimed at engaging our key stakeholders.

The IT projects were impressive, have specialised application and required intensive training in their use and application. The stakeholder engagement projects on the other hand were low tech, required commitment and had wide adaptability.

For me, low tech won the day. Although high tech has the potential to make our work more efficient, unless we successfully engage with our primary and community providers and other key stakeholders we will not be effective in our emergency management planning and response.

All those who undertook projects are to be congratulated. Without innovation we will not progress. To them and to all Bulletin readers, thank you for all you have done during the year. Enjoy any break you get this summer. You have earned it.

*Bruce Parkes*



## Race on to end RACE

Fire Safety Officers are currently in the process of writing the content for the NZ Fire Service National Fire Safety Manual on Care Facilities, including Facilities for the Disabled. They are intent on 'writing out' the Fire Evacuation acronym 'RACE' without developing an alternative acronym that succinctly summarises action staff should take on discovering a fire.

The New Zealand Fire Service has the responsibility for approving Evacuation Scheme protocols & practices. Health-CERT at the Ministry of Health Clinical Services Directorate certifies long term care facilities and works closely with Fire Safety Officers.

RACE has been used in hospitals for over thirty years, is easily remembered and has survived because it works.

RACE stands for:

**R**emove all persons/residents/patients that are in danger to safety.

**A**ctivate the alarm

**C**ontain the fire

**E**xtinguish the fire.

Now that almost all healthcare facilities are sprinklered these Fire Safety



Officers believe that the risk of injury from fire evacuation drills or real emergencies is greater than the risk from any fire. They are concerned that a staff member could at times spend several minutes attempting to move/remove a disabled person whilst no one else in the complex is aware that a fire emergency is in progress.

For them, activation is the first action required and with modern sprinkler systems, removing patients, containing or extinguishing the fire should not be necessary. This view overlooks the probability that smoke will kill before heat activates a sprinkler system.

While such a view has some validity, a regional hospital recently failed an ACC accreditation audit because there was no evidence of fire evacuation drills having been carried out. Yet another example of two agencies with different policy and different agendas. Who are we to follow? The ACC with the power of financial sanctions or rewards can be very persuasive and the Fire Service has the power to decline to approve an evacuation scheme.

While primarily intended for fire, RACE is also valid for hazardous chemical spills. When taught as a basic instruction to be used and altered to fit the situation it still has a future.

