

Aim: The aim of this study was to evaluate the effect of various educational tools and personnel characteristics on personnel skills, views, and compliance to participate in the management of UBEs.

Methods: As part of the preparations for an institutional drill in the Tel Aviv Medical Center, several educational methods were employed. These included e-mail notifications, computer-based self learning, publication of an institutional protocol, tabletop drills, personal briefings, and finally, a large scale exercise. Questionnaires regarding personnel characteristics, participation in pre-drill education, personal views, compliance, and familiarity of institutional protocols and selected diseases were distributed.

Results: Age, family status, and years of experience had no significant influence on personal views. Confidence in the health system increased with experience. Intensity of training had significant positive effect on personal confidence and compliance to attend work during a UBE, however it did not appear to significantly influence personal views or medical knowledge.

Conclusions: Comprehensive education and exercise of personnel is beneficial effect in terms of personal confidence and work attendance during UBEs. Specific educational tools, such as self-learning software, increase proficiency.

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(A30) Risking It All on Risk Assessment – Why Risk Assessment is broken in Disaster Medicine and How We Can Fix it

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Why did we predict Y2K, but not 911? Why did we predict dirty bombs for much of the past decade, but failed to predict the Asian Tsunami, Hurricane Katrina, and the Haiti Earthquake? Rational disaster preparedness depends on rational risk assessment – but does this really occur? This presentation will explore why risk assessment in disaster medicine is broken, including (1) type I and type II errors in risk assessment; (2) limitations of human neurophysiology; (3) cognitive biases in risk assessment; (4) impact of the media; (5) lack of harmonization of the language of risk; (6) deference to so-called risk experts; (7) risk innumeracy; (8) flaws in risk assessment matrices; (9) black swan events; and (10) managing risk based on extreme events. Concomitantly, this presentation will explore how we can fix risk assessment in disaster medicine, proffering practical solutions to each of these common yet surmountable barriers.

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(A31) Integrating Health Volunteers into Community-Based Disaster Risk Reduction

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Background: Disaster risk reduction (DRR) has emerged as a core element of sustainable development. (UN/ISDR 2002). Reducing risk requires long-term engagement (O'Brien 2006),

and the actual work of DRR is largely a task for local communities. (Schipper 2006). DRR shares some tenets with preventive medicine (Sidel 1992). As in preventive medicine, risk reduction calls for a basic attitude shift in the minds of many who traditionally get sick first and seek treatment later. The challenge for DRR, as applied to health, is to broaden the focus of disaster management from that of tertiary prevention, (response and recovery) to also emphasize primary and secondary prevention, (prevention, preparedness and mitigation).

Discussion: The role of the health sector spans across the spectrum of DRR to include prevention, mitigation and preparedness activities. DRR, as applied to health, is intended to prevent and/or reduce the negative health consequences of disaster hazards. This is accomplished by two means: hazard avoidance and vulnerability reduction. Health and medical volunteers at the community level can play an important role in reducing human vulnerability to disasters by: (1) reducing susceptibility – “healthy people” (2) reducing exposure to disaster hazards – “healthy homes; (Srinivasan et al. 2003); and (3) increasing resilience – “healthy communities”. Volunteers help to reduce exposures to disaster hazards through participation in population protection measures such as shelter-in-place, evacuation and mass care. They work to reduce susceptibility by participating in health care, health promotion, and immunization programs. Finally, volunteers may build resilience by way of their participation in community-level preparedness, response and recovery efforts. (Keim 2008)

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(A32) Emergency Preparedness in Louisiana Nursing Programs – Response Roles, Impacts, and Competencies

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Introduction: Nurses are leaders and primary health responder/providers in natural, anthropic and technological disasters. Preparation and education for nursing emergency and disaster response should begin before nursing program graduation and before disaster events occur. In Louisiana, 17 federally-declared disaster declarations were experienced from 2000 – 2009, ranging from the Space Shuttle “Columbia” to Hurricane “Katrina”. This presentation overviews Louisiana nursing programs’ disaster preparedness and operational planning as demonstrated to Louisiana’s Schools of Nursing Aligned for Emergency Responsiveness (SAFER) Conference, New Orleans, 2010. Co-sponsored by Dillard University, Division of Nursing, New Orleans, and Northwestern State University, College of Nursing, Shreveport, the invitational conference brought expert nurse and physician preparedness speakers from federal, state and local venues to review disaster planning, experiences, needs, and nurse preparedness competencies with nurse faculty leadership.

Methods: A multiple choice survey was developed, trialed and emailed to 42 Louisiana Nursing Programs. Programs surveyed included Associate degree, Bachelors and Graduate-level providers for Registered Nurses as well as Vocational Technical programs for the Licensed Practical Nurse. National Planning Scenario threat priorities; impacts of federally declared disasters