

ERUs allow for a rapid and comprehensive approach to delivery of health care in a disaster, with a longitudinal perspective of population needs.

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(A166) Disaster Risk Reduction - Extreme Heat Preparedness

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Background: South Australia is often referred to as the driest state in the driest continent on earth and the community expects summers to be hot. However since 2007 South Australia has experienced several periods of extreme heat which have challenged and required the emergency services including health to consider a new preparedness approach. Any extreme weather condition can cause disruption to the community and the effects of such events as extreme heat are not always immediately obvious. However these effects can silently cause death and an increase to the health burden of the community.

Discussion: In South Australia the term ‘Extreme Heat’ as opposed to ‘Heatwave’ has been quite deliberately chosen as this describes more accurately an unusual climatic situation characterised by higher temperatures and greater length of time than normally expected. A number of studies have been undertaken to consider the impact on the health of the South Australian community and its health services and specific action plans and communication strategies have been developed to respond to extreme heat and encourage an increasing level of community resilience. This paper will describe recent events, some of the research undertaken and the preparedness, planning and response strategies implemented to reduce and manage the risk.

Conclusion: The response strategies introduced in South Australia have been recognised for their excellence and in 2010 SA Health was the recipient of several awards at both state and national level for this work.

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(A167) Patient Tracking In Disaster Drills

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Introduction: Disaster Drills, the world over, test several aspects of disaster response encompassing inter-agency coordination, institutional response and individual proficiency. This abstract analyzes the efficiency and gaps in patient triage in a large inter-agency disaster drill conducted in Mumbai in December 2010.

Methods: Over eighty simulated patients at the mock disaster site in Mumbai were triaged for transport to two hospitals via prioritized EMS vehicle and other modalities. Each patient was tagged with an identifier and his/her final destination compared to the intended destination to gauge accuracy of triage. Arrival and departure time-stamps at each location helped plot triage efficiency

and variation in inter-group response times. EMS responders were trained in START triage during the preparatory phase.

Results: There was no significant difference in time to transport “red” and “yellow” patients to the triage zone. Patients in the “accident buses” were triaged twice as slowly as those outside in spite of the zone being declared safe to enter, by the controlling authorities. 11% of “red patients” were down-triaged and 30% of yellows were “over-triaged.” A significant bottle-neck developed between field triage zone and transport zones.

Conclusions: Our group has conducted disaster drills in several large cities in Sri Lanka, India and the Dominican Republic. Expanding focus to document time-stamps and triage accuracy highlighted need for more robust triage training, allowing local agencies to prioritize training for EMS responders in the coming months. Demonstrating how inaccurate triage could potentially overwhelm the system helped local agencies recognize the need to train first responders in START triage.

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(A168) Medicine at Sea

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Cruising has become a major part of the tourist industry. In 2010, the total passengers carried worldwide was estimated at 18.4 million, on about 230 cruise ships. Large ships can hold up to 6,000 passengers and > 2,000 crew members. A large cruise ship is rather like an island, with two different communities: the well-trained crew, hopefully prepared for every eventuality and trying to make their guest’s stay as pleasant as possible; and the guests, there to have fun. The guest population varies, with up to 40% under 21 years old during school breaks, and the average age is in the fifties or sixties on longer cruises to scenic places such as Alaska. Most of the time ships cannot be reached by helicopter and the medical teams need to cope with a wide range of emergencies from cardiopulmonary, trauma, and psychiatric issues. There are strict public health measures enforced and a range of legislation reducing the risks of cruising to a minimum. This paper reviews the training of the crew for medical emergencies, the incidence of disease, the incidence of medical disembarkation and major incidents on board, and the role of medical teams.

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(A172a) Development of Emergency Medical System in High Speed Train and Station

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Introduction: High speed train is defined as train which can run at the speed of more than 200Km/h and Korean version of high speed train (Korean Train Express: KTX) runs at 300Km/h on average. Because of high speed, safety is the most important issue of high speed train, so the early detection of technical error and