

a major tourist destination, and during New Year's Eve, there are many festivities. The AZ Sint-Jan is the largest hospital providing medical care to the area.

Aim: To examine the impact of the New Year's Eve festivities on the workload of the emergency department of AZ Sint-Jan.

Methods: Data was analyzed for every patient presenting to the emergency department from the 31st of December starting from 06:00 PM until the 1st of January 08:00 AM from 2009 until 2018. The time of entry, type of injury, gender, age, and whether the patient was intoxicated were evaluated. Ten other dates in this time period were obtained for comparison via a random date generator. Data were analyzed using Jasp®.

Results: There were 826 patients included for analysis. On average, 41 patients presented themselves to the emergency department on New Year's Eve between 06:00 PM and 08:00 AM. On a random day, there were only 31 patients. Most of the patients on New Year's Eve arrived between 00:00 AM and 08:00 AM. 57% of all patients were male. 22% of all patients were intoxicated with alcohol. From 00:00 AM until 08:00 AM, one in three patients were intoxicated. The average age on admission was 36 years.

Discussion: During New Year's Eve there is a consistently higher workload in the emergency department. There is an influx of young males who are intoxicated. These patients tend to stay a long time to "sleep it off" and put considerable stress on the available resources. More attention should be given to risk mitigation strategies tailored to this group to prevent excessive drinking.

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Health Care Provision during a Sporting Mass Gathering: A Structure and Process Description of On-Site Care Delivery

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Introduction: During mass gatherings, such as marathons, the provision of timely access to health care services is required for the mass gathering population as well as the local community. However, effective provision of health care during sporting mass gatherings is not well understood.

Aim: To describe the structures and processes developed for an emergency team to operate an in-event acute health care facility during one of the largest mass sporting participation events in the southern hemisphere, the Gold Coast marathon.

Methods: A pragmatic qualitative methodology was used to describe the structures and processes required to operate an

in-event acute health care facility providing services for marathon runners and spectators. Content analysis from 12 semi-structured interviews with Emergency Department (ED) clinical staff working during the two-day event was undertaken in 2016.

Results: Structural elements that underpinned the in-event health care facility included: physical spaces such as the clinical zones in the marathon health tent, tent access, and egress points; and resources such as bilingual staff, senior medical staff, and equipment such as electrocardiograms. Critical processes included: clear communication pathways, interprofessional care coordination, and engagement involving shared knowledge of and access to resources. Distinct but overlapping clinical scope between nurses and doctors was also noted as important for timely care provision and appropriate case management. Staff outlined many perceived benefits and opportunities of in-event health care delivery including ED avoidance and disaster training.

Discussion: This in-event model of emergency care delivery enabled acute out-of-hospital health care to be delivered in a portable and transportable facility. Clinical staff reported satisfaction with their ability to provide a meaningful contribution to hospital avoidance and to the local community. With the number of sporting mass gatherings increasing, this temporary, in-event model of health care provision is one option for event and health care planners to consider.

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Health Needs Assessment in Disasters by Emergency Medical Teams in the ASEAN Region

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Introduction: Japan International Cooperation Agency has started the project for strengthening the ASEAN regional capacity on disaster health management (ARCH Project) since 2016. This project conducted the start-up regional collaboration drill in ASEAN. All participants from ASEAN countries realized the need for a standardized assessment tool. Several UN agencies and international organizations launched assessment tools, but there is no standard assessment tool.

Aim: To develop an integrated rapid health needs assessment (HNA) tool in the ASEAN region. This paper reports the development process of the HNA tool.

Methods: The project established the project working group (PWG) to developing some tools. PWG consisted of the expert team, project team, Japanese Advisory group and twenty delegates from ten ASEAN member states. PWG established the cycle of the developing process of the HNA tool.

Results: We created a health needs assessment form and a summary form. The assessment form consists of (1) Informant information, (2) Site information, (3) Overall situation of the site, (4) Public health, (5) Health facility damage. The summary form consists of (1) Informant information, (2) Site information, (3) Critical areas for support, (4) Situation of the site.

Discussion: Frequently, the public health emergency operation center in an affected country is not able to obtain the critical information of an affected area in the acute phase of disasters. This HNA tool would be used in the acute phase by the Emergency Medical Teams (EMTs) because the EMT has mobility and workforce for assisting the affected country. We have agreed on the usage of the assessment form as a kind of an “interview guide”. The purpose of this assessment form is to assess a disaster situation. The next step will be to provide more opportunities for the ASEAN member states to use and learn more about this HNA form.

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HESPER SW: A Web-Based Tool to Assess Needs

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Introduction: The Humanitarian Emergency Settings Perceived Needs Scale (HESPER) evaluates experienced needs among disaster-affected populations and has been frequently used in both humanitarian emergencies and research. Today, the use of this tool is increasing among people affected by crises and emergencies. Web-based methods have shown to reduce several methodological and practical challenges in disaster health research.

Aim: This project aims to develop and evaluate HESPER SW (a self-administered, web-based version of the HESPER scale).

Methods: Alternative reliability and test-retest validity of HESPER SW were evaluated using different analytic statistical methods.

Results: The first analysis suggests that HESPER SW is a reliable and valid instrument which is easy to use and that it reduces several methodological and practical challenges in disaster health research.

Discussion: HESPER SW can be used both for humanitarian and research purposes and offers a quick, self-administered, web-based, and scientifically robust way to investigate experienced needs in populations affected by disasters or humanitarian crises.

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The HOPE Model for Disaster Nursing

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Introduction: Despite a large number of nurses involved in disaster situations in different ways, there are few theories or models that define and describe the goal and content of disaster nursing.

Aim: This study aimed to present a model for disaster nursing, based on a literature review of the concept and content of disaster nursing.

Methods: A systematic literature review of 15 original qualitative or quantitative articles was conducted. A thematic synthesis was used to analyze the data.

Results: The main theme of Disaster Nursing: Crossing Borders, included three dimensions (personal borders, professional borders and environmental borders) and four themes describing the process of disaster nursing (being hit by reality; adapting to the conditions; providing aid, relief, and caring; recovering, remembering, and growing). Based on these results the HOPE model was developed. ‘HOPE’ stands for ‘Holistic health assessment and promotion; Organization and management of immediate response; Professional adaptation; Endurance and recovery.

Discussion: The HOPE model for disaster nursing describes the core element and essence of nursing in the disaster response phase and can serve as guidance both for nurses deployed in disasters and in disaster nursing training.

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Hospital C.O.D.E (Clinical, Operational, Disaster, and Emergency) Terminology

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Introduction: Healthcare facilities frequently use disaster codes as a way to communicate with employees that an emergency or incident is occurring. As increasing numbers of providers work at multiple facilities, and healthcare systems continue to build disaster response teams and protocols covering multiple facilities, standardization of disaster code terminology is critical. A lack of consistency in terminology can potentially have a devastating impact on the understanding and response of visiting or relief staff.

Aim: To evaluate the level of standardization in terminology of disaster codes in healthcare facilities.

Methods: A convenience sample was taken from a private Facebook™ group consisting of emergency department nurses from a wide range of facilities. The Facebook™ group was asked to share their hospital disaster codes. Of the 40,179 total members, 78 commented, including 55 photos of quick reference badges, and the rest were descriptions/lists of codes. One badge was excluded due to a blurry photograph. Results were collated and analyzed for trends and standardization.

Results: The most common codes were, “Code Red” for fire (72.7%), “Code Blue” for cardiac arrest (44.9%), “Code Silver” for active shooter/weapons event (37.7%) and “Code Orange” for hazardous materials (33.8%). There were 168 instances of a code term being associated with a particular event by five or fewer facilities. Two facilities used numeric systems, with 11 using plain language descriptions.