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2018 International Nurse Regulator Collaborative Symposium - Panel Discussion:
Responding to Mission Critical Risks Video Transcript
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Event

2018 International Nurse Regulator Collaborative Symposium

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Presenter

Moderator: Jim Cleghorn, MA, Executive Director, Georgia Board of Nursing

Panelist: Lynette Cusack, PhD, RN, President, Nursing and Midwifery Board of Australia

Panelist: RADM Susan Orsega, Assistant Surgeon General, USPHS Chief Nurse Officer, U.S. Department of Health and Human Services

Panelist: Katherine Thomas, MN, RN, FAAN, Executive Director, Texas Board of Nursing

Panelist: Donnie Woodyard, MAML, NRP, COO, National Registry of Emergency Medical Technicians (NREMT)

- [Jim] So I want to take a moment to introduce our panelists today. First of all, we have Lynette Cusack. She's on the nursing and Midwifery Board for Australia. She served on that board since 2010 and has been the chair since 2014. She participated in the regulation of nurses and midwives at the state level prior to that, has a background in [[00:00:30]] drug and alcohol nursing, and also completed a postdoctoral fellowship at Flinders University with research in the area of disaster response and resilience.

Next, we have Rear Admiral Susan Orsega. She leads the Commissioned Corps of the U.S. Public Health Service, the Nurse Professional Affairs Unit. She advises the office of the surgeon general and the Department of Health and Human Services on the recruitment, assignment, deployment, retention, and career development of the nurses in the Commissioned Corps [[00:01:00]] and the U.S. Public Health Service and has been deployed to over 16 national and international disasters. And then next we have Kathy Thomas. Kathy serves as the executive director of the Texas Board of Nursing and has been in that role since 1995, has served in multiple roles on the board of directors for the National Council of State Boards of Nursing, including most recently, the president and has responded to six declared disasters during her tenure in Texas. So let's welcome our panelists today. [[00:01:30]]

So we'll start with Lynette and take some time, take about 10 minutes and share with the folks your disaster.

- [Lynette] Thank you very much. This presentation briefly reflects on a couple of Australian studies that explored the lack of policy direction in Australia on Australian emergency nursing willingness to go to work during disasters and altered standards of care in a disaster. I will then briefly consider the messages from these studies that are important for us as nurse regulators to consider.

Many of us come from areas where there has been or there is a potential for a disaster. The disaster that nurses may be called upon to respond to are hazardous terrorism, [[00:02:30]] pandemic, dynamics and natural disasters which may threaten the safety of nurses and their families and communities. International experience has showed that nurses can also become victims of disasters. The debate on this issue has been ongoing for some time in international health and disaster response communities stimulated in part by the severe acute respiratory syndrome that we know as source pandemic and the flow on effect on an unprecedented impact [[00:03:00]] on health facilities. In Australia, the nursing profession has not gone beyond considering disaster preparedness to a broad and more difficult discussion on how to respond. When is it the nurses right to refuse to attend work in a disaster, and if they do attend, what supports are in place to assist them to understand the risks and how their practice may have to change under extreme conditions. [[00:03:30]]

The literature contains evidence of a strong sense of professional duty among nurses worldwide. And a study in Australia that I was part of on emergency nurses willingness to go to work during disasters highlighted this strong sense of professionalism as one of the most important factors associated with their willingness to respond to a disaster.

The participants talked about an invisible line in the job description [[00:04:00]] that no one rarely talked about. They found that the question, what would you do, stay or go, was not openly discussed because it was a difficult conversation to have. This raises questions related to the legal, ethical, and moral issues that have to face when they consider working during a disaster. The nurses talked about weighing up the risks against nurses' moral obligation to the public [[00:04:30]] and to their colleagues and the preparedness, quality, and trust of the administrative nursing and medical leadership at work. The assessment of how these risks affect their willingness and preparedness to respond for emergency nurses as they consider all of the issues that can become a battleground of emotional turmoil. Do they stay home with family or do they go to work? Can they be reported to the nurses' board if they stay [[00:05:00]] at home as stated by one participant? This tears at your heart. In the Australia study, some nurses reported it as their professional responsibility to be at work even if there was an increased degree of risk. There were views expressed by the participants in the focus groups that we ran, that they may be legally required to go to work through the nursing regulation legislation. All that they had to because it was embedded in their scope of practice, code of conduct [[00:05:30]] and code of ethics.

In our study, the participants indicated that whether or not they chose to go to work or in going to work, the circumstances were so difficult that even with the best of attentions, patients died, will they have to account for that decision to the nurses regulation authority. Willingness of an emergency nurse to go to work is influenced by the type of disasters you will see and read. [[00:06:00]] The type of disaster will determine the degree of risk to self, family, and community, and willingness can be influenced by increasing the feeling of preparedness to respond to a disaster and manage the risks at home. Is their

family safe? Are the pets looked after? Will the children be alright at work? Will I feel supported? Will my colleagues be there? Will I have the right equipment to keep me safe? And professionally, what are my roles and responsibilities [[00:06:30]] professionally? By increasing preparedness, the emergency nurses will then feel more confident in their own and their family safety, their work environment, and their professional ability to respond and therefore more willing to go to work if they are able to get there.

As yet in Australia, we do not have any specific guidelines regarding nurses' legal obligations during a disaster. The Nursing and Midwifery Board of Australia has a very brief document, but we have not instigated [[00:07:00]] the difficult conversations about the expectations of nurses in an extreme event. We have done nothing to remove the myths about the legal or ethical obligations in the event of a declared national disaster. The Australian nursing profession has not yet facilitated broad discussion and debate at the professional and institutional level about adapting standards of care under extreme conditions. A dialogue which goes beyond the content of basic emergency and disaster [[00:07:30]] preparedness. The current expectations of our community and health professionals have a high level of technically supported healthcare may not be achievable for a number of reasons. If there is no electric power or running water or the buildings are underwater or a limited number of personnel are able to willing to work, what guidance can we, as Australian regulators, give to Australia? Nurses?

I turned to the American Nurses Association [[00:08:00]] standards of practice that states that the standards are the rules or the definition of what it means to provide competent care. The registered professional nurse is required by law to carry out care in accordance with what other reasonably prudent nurses would do in the same or similar conditions. The key to applying the NAA and a definition is not the resource gaps negate standards of care, but the precise manner in which the accepted standards of nursing practice [[00:08:30]] are adapted to change certain circumstances.

Kenneth Lin and I prefer the term crisis standard of care to indicate the degree of change in practice that may be needed under extreme conditions. Other discussions have used alternate standards of care or adapted standards of care. Given a disruption to the health system or an event which results in an overwhelming number of individuals seeking care, the involved healthcare staff may find themselves pushed [[00:09:00]] to the limits of the individual competency. These types of situations, raise questions for appropriate standards of practice, whether such standards are altered or transformed in a crisis as well as ethical issues.

In Australia, a paper titled "Alternate standards of Care: Are we ready?" strongly urged the professional nursing organizations, chief nurses, unions, and nursing and midwifery regulation authority to convene a working group that will consider key topics. [[00:09:30]] Do current standards of care documentation provide adequate guidance for application under extreme conditions? Are there emergency laws or regulations that would have an impact on nurses' practice? What content on adapting standards of care should be included in preregistration nursing curricula? And what content on adapting standards of care should be provided routinely to all practicing nursing professionals? And how would the nursing profession engage the community in these discussions? [[00:10:00]] Do they understand what alternate standards of care actually means to them? And how would the nursing profession engaged other professions and the broader national emergency services in these discussions? Nursing regulators do have a responsibility with the other key nursing organizations to also be prepared with their own systems in place to respond to extreme events or call for assistance from our international colleagues. Regulators can also influence and guide curriculum, practice standards and guidelines on disaster preparedness

[[00:10:30]] and response to seriously consider and communicate the regulators position and most appropriate response to the community and profession about the expectation of nurses in a disaster response. Thank you.

- [Susan] Hi. Good afternoon everyone. It is an absolute pleasure to be with you here this afternoon. First of all, I really want to applaud. [[00:11:00]] I'm going to go for my 10 minutes probably. Maybe I'll get this subtracted. The National Council of State Boards of Nursing leadership. Dr. Alexander David and the leadership team for bringing all of you together in a room to talk about a topic that most of our profession likes to run away from and particularly hard to galvanize individuals across the world because [[00:11:30]] at the end of the day, as you'll hear me talk about my reflections, if you walk away with anything, walk away with the networks that you already have because they are levers that you can use, whether you sit in the office of the surgeon general that I sit in or you sit in one of my colleagues in the State of Texas because those levers come to bear when you were addressing [[00:12:00]] disasters or situations like the Ebola crisis.

So this is my obligatory slide. These are my perspectives, my views not of the United States federal government. I'm hoping you'll walk away with three points today. One, just to get a quick snapshot of the Public Health Service, the United States Public Health Service Commission Corps of uniform that I'm in. Understand the challenges that impact regulations, practice authorities [[00:12:30]] as well as that ethical delivery of care and also to think about preparing nurses and for resilience and complex environments.

So I am the chief nurse officer of the United States Public Health Service, established in 1789 and led by the United States Surgeon General. We are 6,500 commissioned corp officers one of the seven uniform services who meet the complex [[00:13:00]] needs of the underserved populations around this great nation. And we lead federal policies. We formulate programs and implement policies and regulations that are focused around health and work in assignments from downtown here in Chicago all the way up to the most extreme remote areas of Alaska. And so part of our response while we are [[00:13:30]] in our respective agencies from the CDC, the National Institutes of Health and FDA Indian health service, we also are deployed in response to national and international disasters. And as it was said in my bio, I've had the honor and privileged to have been deployed both nationally and internationally. And also I have a dual... Had a position. So I'm going to talk to you a bit today [[00:14:00]] about my other job. Not as the chief nurse, although it'll intersect, but I'm responsible for work in a office under the National Institute of Allergy and Infectious Diseases, one of the institutes of NIH that responds to international clinical research responses. So I've been a nurse practitioner, have been involved in disaster response and clinical research throughout my entire professional [[00:14:30]] career. And in both of those settings I embrace complexity and I embrace it as a matter of a core principle to addressing the health no matter where I am and no matter what setting I'm in. And as many of you regulators here in this room, you like order, you like precision and you like data and you have established procedures. If you don't, they may be you're in the wrong room. [[00:15:00]] But this is particularly important because when I'm implementing a clinical research trial in many cases where the efficacy is not known or even deploying as part of a clinical research, we have to focus on that order in the established procedures. And we stick to those regulatory protocols that circumscribe what we can and what we cannot do, [[00:15:30]] and also do the same in deployment responses in very strict those clinical research protocols. And they can't be changed or can they? Because there are many sacrosanct regulations that you all know very well. But

I wanted to talk to you today about being flexible in these environments and thinking innovatively when working in settings such as Ebola [00:16:00] or disasters.

The world's more connected than ever. And we know that and this conference is actually emblematic example of people with like minds coming together for around the world and it's purposeful and it's very deliberate that you're all in this room but very divergent from an emerging infectious disease outbreak. And we know from the Ebola virus outbreak in 2014 the distance [00:16:30] is not a barrier from a disease or an endemic. And in fact, if you take two countries around the world, far, far away from each other, you can connect them with a commercial flight. And when a disease like Rift Valley Fever comes up and presents itself in Mali, along the Mali, west African Mauritania border, and the patient comes in to the ER with that nurse seeing him or her with fevers and arthralgia symptoms, individual who had returned recently from that border, just like the patient and the nurses who were infected in Dallas. We have to be poised to be responsive and be keen observers in the practice of global health at home. And if you look at, at Ebola as that good example, where you had those three already hard hit areas as [00:17:30] demonstrated on this map here. And then that trigger came when Mr. Duncan traveled back from his home to Dallas and it transformed that endemic that was in that far, far away place to something that hits home. So as a result, the United States have subsequently spent more funds to deal with scientific development and finding ways to invest in infrastructure and public health systems in the United States and actually globally. [00:18:00] And so this is really a good example of a wakeup call that we're not ready to respond to large scale epidemics. We are not ready to respond to large scale epidemics here in the United States and also globally and partly it's because of the foundations and the infrastructure and the response or it's just not as strong as it should be.

And it is clear that there is no one [00:18:30] magic bullet to improve the reactivity to epidemics or disasters. But I'd like to propose a few thoughts as you consider your roles as regulators. So the first one is insufficient monitoring and preparing yourself in the community. And there were a lot of resources that are available, but it's how you talk and sort of bridge that connects the nurses in your respective states about the importance [00:19:00] of the emergency preparedness, importance of being familiar with systems. Because in a heartbeat they can be that nurse who's in that ER taking care of that patient to being that nurse who's taking care of that potential Ebola infected patient or that nurse who had a disaster in a hurricane that is coming upon them in a matter of eight hours. [00:19:30] And so that we have to get the nurses more familiar about FEMA and the incident command system and understand the health challenges at a very macro level. So if you look at the Democratic Republic of Congo, in fact, my colleagues, a ton of them are now over in that region working to do the similar work that I did in west Africa. But there are 200 cases as of yesterday [00:20:00] and it's not too far off that someone could be coming from the DRC and landing in one of the nurses, the states that you're responsible for in that ER. It's not too far-fetched of a theory. So I challenge all of you to think about preparing yourself, preparing your communities.

The unnecessary decisions and consequences are avoidable. [00:20:30] And what I mean by unnecessary quarantining of healthcare professionals believed to be possibly infected with the virus highlights the need for education of the public, of public health and government systems as well as healthcare providers just as well as the nurse who was in the area of New Jersey who was quarantined. I could very easily be one of those traveling back and forth every other month to Sierra Leone or to Liberia [00:21:00] and receiving my obligatory thermometer and my 21 days of monitoring my temperature every other or twice a day. So it's incumbent upon all of you to think innovatively and be

forward thinking about that what ifs. And the issue that warrants addressing is whether nurses have the duty to treat.

And this is not going to answer this question, but, you know, what do society [[00:21:30]] owe nurses and what do nurses owe society. And if you look at sort of backwards in time at the duty to treat, if you look at the HIV epidemic in the '80s and 10 years ago, the avian flu epidemics, soars. And then certainly if you fast forward to the ethical challenges around caring for Ebola patients, those ethics are real. And it's about thinking through those now. And certainly [[00:22:00]] the world has challenges around the delays of identification of epidemics and the delays in declaring epidemics of being a political decision. I mean, and what really makes it work is that when you have this crosstalk. So the picture to your far right is actually the U.S. ambassador to Liberia who had a celebration and she brought [[00:22:30]] all the individuals who were caring for impacted Ebola patients who had survived. We had survivors there. We had healthcare professionals, we had individuals like myself, but brought them together for one reason, as she said in her speech. And that was to bring everyone together to maintain those networks and collaborations. And that's what we need to do. We need to think about this intersection across our health sectors in order to [[00:23:00]] move ahead and have that fundamental support at the highest level. Practice Authority is certainly for the United States, all the uniform service officers were covered under the federal tort acts. So we're covered to be able to go from one state to another state to be able to respond to national disasters. That's not [[00:23:30]] so much the case of nurses who work in each of your perspective states. And in fact, using one example of New Orleans and Katrina where nurse practitioners who were unable to work because they didn't have a requirement for the collaborative physician was not met because those physicians, many of which evacuated. So those are the types of complexities that we need [[00:24:00]] to move away from being in the sort of reactive wait till it comes for us to address it, but be very forward thinking. And I challenge all of you to use this meeting to think about ways in which you can be responding and have systems and infrastructure in place.

So regardless of these geographical boundaries, [[00:24:30]] challenges, and this is actually a really true picture that I took, and this picture represents doing more with less in employing innovation and by strengthening the roles that each of you play. It calls on all of us to be more strategic and to realize what the accomplishments you're truly trying to achieve and then to drive with greater focus towards those objectives. And I hope that you'll pause [[00:25:00]] and listen and think about the possibility of flexibility because the Ebola epidemic challenged that conventional wisdom and how there's a delicate balance of being innovative while not compromising your regulations to approaching solutions. And it's led to saving lives, resilience in our profession, and provided a new roadmap for an integrated approach that will be required for any emerging infectious disease or disaster. So thank you.

- [Katherine] Thank you. [[00:25:30]] Well, I'm going to talk about a large scale weather event that happened in my state in 2017, but it might be worthwhile to reflect on this. This morning I awoke to an emergency email that alerted me to a need to boil water in my city of Austin, Texas. Many of you have heard on recent news that the central Texas area has been inundated [[00:26:00]] by floods. This started in the highland lakes area, north of us and flow downstream to our reservoir Lake Travis, and then onward to two more lakes we have in the city. Yesterday we noticed that Lady Bird Lake, which is right downtown where we are, was brown. So I guess there shouldn't have been a surprise that we need to boil our water today, but the filtration system can't keep up with the silt and the mud and the debris that is coming downstream from the flooding. [[00:26:30]]

And so for the first time I've been there 30 years, this has never happened, but that's what we're doing today. And I alerted everybody to bring bottled water to the office today. So even a small scale disaster has implications for us and we deal with far many more of them than we deal with these very large scale disasters. I like to say if you've seen one hurricane, you've seen one hurricane. Weather events have a lot of commonalities. We all know that, [[00:27:00]] but there are differences and particularly the predictability of the path and the intensity of these storms. We've all seen those spaghetti diagrams of all the various past the storm may take right? And it could hit you head on or it could go back over the ocean and die somewhere else. But we do know that when you deploy an evacuation, you have to weigh these risks [[00:27:30]] without all the data you need because we know that if you have a tropical storm that comes ashore and hits your area, there will be far fewer deaths than if you have an evacuation because many accidents occur on the road during evacuations.

So I'm going to talk a little bit about Hurricane Harvey. This is a hurricane, a category four hurricane that [[00:28:00]] made landfall in Texas August 26, 2017. It caused record rainfall of between 40 and 60 inches of rain. Something we never see. This was a new record for the entire United States for any storm, that amount of rainfall. And it tied Hurricane Katrina, which came in 2005 in New Orleans as the costliest tropical cyclone on record, [[00:28:30]] a hundred and billion dollars. It displaced more than 30,000 people and prompted more than 17,000 rescues. It damaged over 200,000 homes and three-fourths of those homes were not in 100-year flood plain. Seven hundred and 38,000 people required assistance from FEMA. Unbelievable, really. We had had experience [[00:29:00]] with hurricanes before. Katrina directly affected us. Rita, Ike were big hurricanes that occurred in the previous 15 years. But this time the governor decided to declare the disaster early.

So before the storm made landfall, he declared a disaster and required agencies to submit waivers, waivers of their law and waivers of their regulations in order to expedite the response by healthcare professionals. So we [[00:29:30]] got together with medicine and pharmacy the most directly affected professions and we all submitted waivers to the governor. We received permission to waive fees. We just didn't think that was something we should do. And we received permission to waive criminal background checks so we had to rely on self-disclosure like the old days. But those processes take a lot of time and we didn't want to delay individuals from being able to respond. We also had a waiver [[00:30:00]] from written prescriptive authority agreements, which Rear Admiral Orsega referred to with physicians. We asked for this because it is a requirement in our state. And verbal agreements were still expected, but it didn't require the time to sit down and write the thing up. That would have delayed needs, or care needs of patients, and that's what we didn't want to do.

So compact nurses could come freely. We have an interstate [[00:30:30]] compact in the United States that is an agreement between states that allows a nurse to have a license in their home state and practice in any other participating state without getting any other approval or licensure. These nurses could come freely to the state and they did not have to notify the Board of Nursing. So what did we do with everybody else? Well, we screened them. Nurses who were licensed in another jurisdiction, currently licensed in good standing [[00:31:00]] and were employed in nursing, were eligible for a temporary license. We screened them, we asked them about criminal charges, current substance use disorders, and a current board order. And then we verified that information. If they were in good standing, they were given a license within 24 hours.

The Board of Nursing, however, had to do a lot of things on the fly, if you will. We had to [[00:31:30]] develop web notices, Facebook notices. We had to develop frequently asked questions and answers in response to all of the deluge of questions we were getting over the phone and over the web. We staffed our offices seven days a week and after we overcame the initial hurdle, then we staffed over time for a period of time in order to respond to all of the questions and inquiries we were getting. Nurses didn't know who to call to find a place [[00:32:00]] to go and we weren't that agency, but we did take most of the calls because they knew to call their Board of Nursing and they did.

What we learned is there was not really a good coordinated deployment of nurses in to areas of need. They didn't know where to go and we didn't know where to tell them to go. It resulted in some conversations we have with hospitals. They ended up hiring some outside recruiters and getting the recruiters to get the nurses in and run the nurses through the board's process [[00:32:30]] and that that worked well although I wish I had known that earlier at the time.

Clinical facilities in our region, we're really taxed more than we even thought they would be or that they thought they would be. People showed up at hospital seeking shelter. Sometimes they didn't know where the shelters were. Sometimes they couldn't get there and sometimes they just felt safer going to the hospital than the auditorium. Security was not [[00:33:00]] adequate in these facilities to deal with the numbers of people who showed up and supplies were short as well. We had an experience where dialysis patients were not able to get dialysis. Either their dialysis facility that they normally went to was closed for flooding or they couldn't even get out of their homes because the floods were all around them and they were isolated. And this was a great public health risk. We also had the experience of [[00:33:30]] evacuating some really critically ill patients at the time the storm first hit or just before. Neonates from Corpus Christi from the Neonatal ICU were evacuated to Dallas. That was fine except when you got to Dallas, you still had to have the physical capacity to deal with these neonates and you had to have the nursing expertise. It turns out the specialty nurses like neonatal were in short supply. They had to be recruited from other states. [[00:34:00]]

Lynette talked about the problem of nurses and their dilemma with to stay or to go, right? So we had nurses in the affected areas whose own homes were flooded, whose children could not go to school, who felt they had to evacuate their own families from the area and yet they had been threatened by employers in some instances of being reported to the board for abandoning their patients. [[00:34:30]] They were relying on a contractual agreement they had with their employees to stay in the event of disasters. And I don't think anybody really contemplates what that'll mean to them personally if they find themselves in that situation. But we had to clarify right away that our contractual agreement of employment was not the same as your licensure duty. And we did not define the situation as abandonment. We have since had conversations with the hospital association to help get that word out there in advance so that this doesn't happen again. [[00:35:00]] And facilities lack support services for their employees, particularly in the area of behavioral health. This was a psychologically devastating event for these individuals personally, not just the overwhelming, you know, work shift after shift and stay in the hospital because you couldn't even go home, but because they were worried about their families as well.

So what have we learn from all this? We learned that the [[00:35:30]] nurse licensure compact nurses were the most helpful for our immediate needs because we could say, come on in. We didn't have to delay them at all. A compact nation is certainly going to be the best model for future disasters. We learned the importance of nurses, and this cannot be overstated. Nurses is a national licensure and

discipline database at NCSBN. And for those who had to be screened by us, [[00:36:00]] that information was centrally located, readily available 24 hours a day and allowed us to expedite licensure for that purpose.

We had this little dilemma of trying to issue a piece of paper to a person that gave them the authority to come here and practice if they needed a temporary license because there was no time to do it any other way. But our IT processes didn't allow the fast generation of such a document. [[00:36:30]] So we had our IT people immediately that first weekend come in and write a program and this program generated temporary licenses by connecting our emergency permit licensing database with our document generating system. And we were able to produce those documents as soon as the application was finished. The system produced a letter. The letter went in in email. This all happened automated so that the nurse once [[00:37:00]] approved, had this in a matter of minutes. We learned that social media was the best way to get information now. We did post on our website. When we posted it on social media, we got a huge reaction. Nurses were wondering how much they were going to get paid and various things that we had no answers to, but they also knew the agencies to get in contact to find out about deployment and placement. They knew where the areas of need were and they knew our process that they had to go [[00:37:30]] through

After this was all over, we surveyed nurses in hospitals that were involved in this crisis. We found that the majority of the respondents thought that the board should be screening the applicants. They didn't want the applicants coming straight to them without that process. The majority also were very satisfied with the expediency we had for issuing the temporary licenses. But one interesting thing we learned is that about half the nurses who received the [[00:38:00]] licenses never made it to Texas. And the reason is because they could not find an organization to place them. So all the coordination of getting through that process and having an assignment is something we're still working on. But of those who did come, 89% of them stayed between one and three weeks in our state. So they were able to make a big difference. And that disaster remains in effect to this day because we are still in recovery from Hurricane [[00:38:30]] Harvey. So I'm going to stop at that and I think we have questions from the moderator.

- Thank you to each of you for sharing your experience and your expertise. So we do have a few questions. We'll ask each question and allow each of you to respond before going on to the next. So starting with Lynette, what advice would you offer in terms of [[00:39:00]] preparation for a future crisis?

- I'm not sure. I think that's on. I don't know where to begin with that, Jim. That's absolutely huge. I think it's from a regulation perspective, are you thinking? I really liked some of the points that Katherine has made. I think first of all, we've got to start the dialogue[[00:39:30]] with the emergency services. This is from an Australian context. We have to start the dialogue with, as I mentioned, the chief nurses, the employers, you know, whole group of people around what is required, what are their roles and responsibilities and therefore what are ours as regulator. Do we have a role in this space or are the systems and the legislation there once a national disaster has being declared. I think also in that preparation, we've got to put that [[00:40:00]] message out that this is not notifiable, you know, the board is not there for people to use to get people to work as Katherine mentioned. They were very frightened that if they did the wrong thing, they would be notified at the board and we've got to stop that. And there was also a misconception around what was expected in the codes of conduct and

standards of practice. So I think really we've got to start the dialogue first and be very clear about roles and responsibilities and clear [[00:40:30]] around the messages that we put out as a regulator.

- Rear Admiral Orsega?

- Thank you for the question. I think as my colleagues to the right and left quite eloquently pointed out, I think the big message is to think broadly, you know, to really push your brain a bit and to create what we often do with these tabletop [[00:41:00]] exercises. And the table top exercises are ways in which creates a scenario for you to think outside the box and it pressurizes you to be able to do things, learn from the lessons that Katherine pointed out and to think how it might apply to your respective state. And just here, I think, you know, boards of nursing, I don't think you realize [[00:41:30]] what a safe haven you are for nurses. They are oftentimes, as you pointed out, Katherine, it's the first line that nurses will often pick up and call to get guidance. They're looking to the boards of nursing to give them guidance on practicing either how can I help out with Texas. How can I respond to disaster? You know, our profession is [[00:42:00]] a profession that has the duty and interest to treat patients.

- Okay. Katherine?

- I think, as I pointed out earlier, if the board has to get waivers from the rules and law to have that done in advance, just go ahead and submit them if you think the storm is imminent and that way they would be processed from the get go instead of waiting. I think we all have to have templates [[00:42:30]] for what we're going to do. We need to have our website notices, our social media notices, our FAQs to the extent we can think about what might happen or borrow this from other states who have had similar experiences. I think that'd be really helpful. And then the other thing that occurs to me is in the future, if this happens to me again or to our state, I'm going to send notices to all the compacts dates and ask them to post this on their website [[00:43:00]] to get those nurses to respond before others respond because they can come right away without any delay.

- Donnie.

- [Donnie] Great. Three considerations from the mind. One is to reinforce the importance of a systems approach. And, you know, we hear it here in it's a great joy to actually be here representing, EMS is my background. And so the intersection, especially in disaster cyber aside of [[00:43:30]] disaster work between the nursing profession in EMS and other health care professions is so key. And I think that the more pre-planning and collaborative work we can do in advance will help that in the disaster scenario. And a great example of that is the compact itself. And so from the lead of the nursing compact, EMS has entered into a very similar compact where we now have 16 states in that compact. So I think the value of compacts is important. The final component is the messaging platforms [[00:44:00]] and although there's a great need for having resources, it's important to also balance that with a message against self-deployment. And that's really the things that we have done in the past few storms through our social media channels is reminding those who want to assist, do not self-deploy, but yet this channels you through these established systems so that we can get you properly credentialed and make impact and not go and contribute [[00:44:30]] to a disaster or make a disaster even worse.

- Okay. Thank you. So from your experience, do you think there's a need for any changes to our education system? This could be related to our licensees or our regulatory staff?

- I think one thing that's been excellent about the new scheme that we have in Australia is that we have one register. So we actually don't have, if people cross states and territories, they are still registered with the nursing [[00:45:00]] and midwifery board of Australia. So we don't have those issues of licensed here, which I think has just been fantastic. I think the other piece of work I do is around students. What is the role of students in a disaster? Are they a resource that can actually be tapped into and how do we use that to facilitate that? So of course, if we use students, they need to have some understanding of what's expected for them. Now that would be very much a challenge for the higher education sector knowing that [[00:45:30]] already their curriculum is absolutely jam packed full, now how much should we be influencing the curriculum of preparing students to also step up at these times of extreme events.

- We've come so far advanced than when I deployed back in... I know I look young but in 1995 my very first deployment [[00:46:00]] and then in 2001 after September 11th. So I think in my view, education has really made strides in being incorporated into France, one in education systems in nursing, schools of nursing. And then also in many of the boards of nursing have both done either trainings, [[00:46:30]] volunteers. I know in the State of Maryland there is an opportunity for individuals to sign up to be a volunteer for the state. And those are great examples of where we've moved ahead tremendously. Then back in 1995. So I think more efforts such as those really help increase the knowledge. There has been a lot of studies that have reported that in hospital based systems [[00:47:00]], this is the second final point, the data suggests that ERs are better prepared than they were five, seven years ago, but the nurses that are back in the clinics or back in the surgical units or not in the ER, they're not receiving the same level of training as the nurses in the ERs. [[00:47:30]] And often it's because it's just the bandwidth. So it's really incumbent upon our profession to continue to look for increasing those opportunities for preparedness and training on all fronts.

- Our educational institutions, particularly in the Houston area were affected by the hurricane. So they had flooding in their buildings and that stops education unless you come up with a different plan. So one of the things [[00:48:00]] that worked really well was that educational institutions that weren't flooded opened their institutions to other students and faculty. So they were able to use their classrooms, their labs, their simulation labs and so on with their students so that their education was not interrupted and that was very successful. And I think the other thing that worked really well was some creative faculty in that area said, I am Red Cross certified. [[00:48:30]] I will take a group of students and I'll take group after group and go to the shelters and work as volunteers. And so she, well this faculty member who organized and got many other faculty involved and they were able to go to multiple shelters in the area and provide clinical experiences to those students that they'll probably never have and they certainly would never have had as a student. So that was very beneficial.

I think when you think about this from a regulatory staff [[00:49:00]] perspective, any opportunities for disaster preparedness by boards of nursing should be taken advantage of by NCSBN for one at the IT ops conference because those staff, our frontline staff, they are involved when these disasters happen. For them to have training in disaster response would be invaluable. And I think for executive officers too, because those are where all the executive decisions are made [[00:49:30]] kind of on the fly at the last minute, trying to figure out what the best possible solutions are. So I think sharing that information, and it isn't just my state. You can see a little along the Gulf states, Florida, Georgia, North Carolina, South Carolina, Alabama, all these states were affected by these storms and they have great experiences too that would be good to share.

- I would categorize the education into three components. One is what can we add [[00:50:00]] to initial education in the nursing profession or EMS profession. And recognizing the colleague's comments, you know, we recognize that curriculum is already jam packed and there's a lot of competing priorities for that. But what is the minimum introductory level that can be in there. The second component of the education I would say is, "Well, what's the expansion on that on a systems approach on a national level." And that's where the FEMA training and the other training and much of that is available online or through training. And that's a part of the process [[00:50:30]] and to reemphasize that, make sure that we're awarding proper use in medical education credit and value that type of training as a systems approach and make sure that it's built into, not as an add on but as a continuous of the profession. Then the third component is that hyper-local level of specific training and that's training that is important because although all disasters have commonalities, every disaster is uniquely different in those structures, [[00:51:00]] the local level are important. And that's probably a balance of just in time training combined with ongoing organizational training.

- And Lynette, this may be an interesting question to start with you, but what did you find to be the most challenging aspect of dealing with the crisis? Because I know you didn't reference a specific crisis. It was more research. But the most challenging aspect of dealing with the crisis and what could be done to help alleviate that for the future.

- One of the areas [[00:51:30]] that I was involved in in South Australia, we had a heat wave and it was about five days of very, very high temperatures to the point some of the railway lines were melting. What we hadn't realized at the time is our aged care sector is overseen by our Commonwealth government, but state and territory, health hospital services are managed by our state and territory government services. So there was no communication between the local hospitals are not big aged care sector [[00:52:00]] to the point where a lot of the aged care sectors didn't have generators. We lost power across the state. We lost water and they weren't ready for this. What they wanted to do was to get the ambulance who's getting the buses, put all of their residents in these and send them down to the acute care sector. There were no buses, there were no addresses. They were all being used elsewhere. So we actually had a lot of older people die in circumstance.

So we actually did a lot of work and working with the aged care sector to actually prepare for either bushfires for us, which is our risk and for heat waves. And for them, to actually look at ways that they can manage this. They also found to the point that my other colleague made is that a lot of the local people who lived around the aged care sector went there to try and seek refuge from the heat or to get access water or to get medicines. So there was a huge impact that they were absolutely not ready for it and it was very much a disaster for that group. So we've done a lot of work in getting them to prepare around this. So now they've actually [[00:53:00]] got generators in place. They're looking at a whole range of different situations and they've now joined the local emergency management services system at the state level. So they are connected in with a very clear message. You don't send your residents to the acute care. You have to look on your own was the message that we had to put out to them. And I think that was the big challenge and for them to suddenly realize, yeah, they're on their own. They have to get organized. So I think probably that would be one of the biggest ones we did.

- Thank you.

- So, you know, [[00:53:30]] oftentimes when you're in those scenarios, and if I reflect back to others, a confluence of really kept competing factors, one, around trying to make sure you're being prepared to respond to, in this case Ebola. And certainly for me, it was about training of the nurses to go into the Ebola treatment units and to capture the right data [[00:54:00]] at the same time have a changing infrastructure with a lot of unpredictability. And it's being confident and being competent. And while those are two separate items, that is achievable by all of us and that competency starts with really making sure you're prepared in the case of that scenario [[00:54:30]] that the world has changed. And we should always anticipate that there will be another Ebola event. There will be another emerging infectious disease and there'll be another disaster whether it's a hurricane, a September 11th, or a situation in Las Vegas. So it's really trying to make sure that we are confident and competent to be able to respond in the face of uncertainty and making sure that [[00:55:00]] those nurses have, which will look to the boards of nursing, have those resources and those tools in their toolkit.

- Katherine?

- I think for us, the most challenging aspect of responding was communications. We thought we were prepared. We had relationships with all of the players. But in a crisis, it's hard to get hold of people. They're busy and they don't necessarily respond timely. [[00:55:30]] And I think the other part of it is organizations tend to operate in silos, right? We do our job, we know how to do that. We don't know what you need or what you want over there. So we stay focused on our job, right? But the fact is we all need each other. So the healthcare professions, licensing boards, we were in dialogue with them every day. They were very responsive to us. The governor's office was tremendous. They responded quickly. The disaster placement agencies, they were another [[00:56:00]] story. Unfortunately, that the registry in Texas, the director had a significant health event at the beginning of the hurricane and was out for the remainder of the time.

Nothing could have prevented that, but unfortunately, there weren't people to fill in her job who knew what to do. And so it became a little chaotic over there. I think dialysis centers, what we're going to do with dialysis patients became a big problem. But we were able to identify that [[00:56:30]] if you want to communicate with hospitals in particular, the best people to communicate with are the hospital association and the HR people because if you can get hold of an HR person, they'll make sure that they get their message to the right person. Recruiters similarly have lots of contexts with hospitals and can sometimes get you to the right person. So we got there in different ways. I think we need to think about how nurses can function as a clearinghouse for disaster relief nurses. We've [[00:57:00]] tackled that problem in the past. It kind of fell by the wayside. Maybe it could be reinvented, but can this be done through a notify. At least could the license list be batched so we could send a list and get responses back on certain questions from the system that would be really helpful too. And then the messages to the Compact states, "Send us your nurses."

- If I take the question from a larger global [[00:57:30]] perspective, one of the things in my experience is looking at the financial sustainability that comes with any disaster. And in particularly looking at the balance of our healthcare systems, be it in the U.S. or across the seas is usually a balanced between a public health and a private health system in the balance of the two. And I think back in particular to the Haiti response that I was involved with when the healthcare system largely had [[00:58:00]] collapsed. Many of the private sector have collapsed. And it was very difficult to try to implement systems to support a private healthcare system in the middle of the crisis. And to figuring out those mechanisms and what a key player the private sector health is within the overall disaster is very important. So

working out plans, especially on a large scale event in advance on how we can sustain all components of the healthcare [[00:58:30]] system and not just singular components.

- Thank you all. So let's thank our panelists again.