

## **El Dorado, Arkansas – Hillsboro Manor Nursing Home**

The director of nursing received a page from the 911 system while attending church and was told to be prepared to evacuate and to prepare for a return call to evacuate. After this initial contact, Hillsboro started to evacuate the residents before the order to evacuate was received. Shortly thereafter, a call was received to evacuate the nursing home.

### ***Transportation***

The police department and volunteers from the community acquired buses for the transportation of residents to their designated public shelter. There were approximately 96 patients and more than 50 staff that needed to be evacuated. Most of the residents could be moved by either school or church bus (regular and wheelchair accessible), but residents who could not walk were transported by ambulances to the hospital or other nursing homes.

One man from a church brought a truck that was used to move wheelchairs, bedding, linen, the medicine carts, and food prepared for lunch.

The police department provided an escort to the public shelter.

### ***Lessons Learned***

There are several lessons learned:

- Be prepared and delegate responsibility to others to help during an emergency.
- Give people a designated assignment.
- Have drills and know what everyone's role is.
- "It was a good experience, something deadly could have happened. It makes you understand and appreciate who you rely on. Take care of your own."
- Request wheelchair lift-equipped buses. This type of equipment facilitates the entry and exit of the residents onto and off the buses.
- Through firsthand experience, Hillsboro knows its own abilities and which churches have what form of transportation and who to contact first.

### ***Why a Success***

There are numerous reasons why the evacuation was a success:

- Community volunteers assisted in the evacuation, such as by providing a truck to transport items or church buses to transport residents and staff.
- There was easy access to transportation.
- Hillsboro had written procedures on evacuations.
- The delegation and assignment of activities to staff kept the staff focused on the evacuation and not on what-if scenarios. The nursing home had practiced, at least annually, an emergency drill for evacuation of the nursing home
- There was the experience of previous partial evacuations.

## **El Dorado, Arkansas – Oakridge Nursing Home**

At 9:30 on Sunday morning, the assistant administrator was contacted at home and informed by the 911 system that the Teris plant was exploding. Within 10 minutes of the phone call, the assistant administrator arrived at the nursing home. At this point, it was decided to start shelter-in-place procedures.

The air conditioning was turned off, windows and doors were closed, and the building was secured. In preparation for an evacuation, staff were instructed to get residents out of their rooms, place them in the hallway, and place wet towels in the doorways to prevent contaminated air from coming into the facility. Residents that were bed ridden were moved to the front of the line, while ambulatory residents were moved to the back of the building where they were met with buses.

After this initial activity, the assistant administrator was waiting for the word to evacuate Oakridge. Approximately 1 hour after the initial call, someone from a church arrived to help Oakridge evacuate. This individual informed the assistant administrator that "everyone was evacuating," and the evacuation started at this point.

A business partner of Oakridge offered the use of his church as an evacuation facility. This facility was located 5 miles away and has an auditorium, a restroom, and a kitchen facility. Residents were evacuated to this location. However, not all residents were evacuated to the church; a few residents were evacuated by ambulance to the hospital or another nursing home due to their condition.

Since the church did not have cots, staff went to a former nursing home, 17 miles south of town, and carried away the beds from that facility.

The evacuation took approximately 2.5 hours for 176 residents and 100 staff.

### ***Concerns***

The assistant administrator was concerned that Oakridge did not receive an official call to evacuate the facility. He feels that it may have been due to a mistake in their address, which is on Hudson, and the Hudson Memorial Nursing Home may have received the notice to evacuate by mistake. However, the Hudson Memorial Nursing Home was contacted, and no evacuation call was received at that nursing home.

There was no official call from the local emergency management officials for an evacuation, nor were there Red Cross officials assisting in the evacuation. The assistant administrator would have liked to have emergency officials helping during the evacuation: "If not for the churches and family members, we would have had a problem."

The assistant administrator would have liked to know whom they could call on and who would call on them in case of a next time. He did not like volunteers informing him of the need to evacuate. There needs to be "better communication from an official person." He called after the incident and received an apology.

### ***Focus***

At the beginning of the evacuation, the focus was on "do we shelter in place or evacuate?" There was no worry about Teris exploding, but there was worry about the fumes since Oakridge is located 5,000 feet from the Teris facility. In addition, the focus was on keeping the communication lines open since people were calling in seeking information and tying up the telephone lines.

During the evacuation, the focus was on the safety of the residents and the transportation of the wheelchair-bound residents. There was a concern with the slowness of the ambulances used to transport the wheelchair-bound residents.

During the evacuation, volunteers arrived and helped transport ambulatory residents to the church.

After the evacuation, the focus was on making residents comfortable and taking care of them. Staff volunteered to come in and help, and there was a concern to make sure that the facility could handle the crowd.

### ***Procedures***

There are written procedures for the evacuation of the facility, and they may not have been followed. However, Oakridge self evacuated, and it went smoothly without injury or death.

Every month, a fire drill is practiced at Oakridge, along with semi-annual disaster drills for tornadoes and a shelter-in-place scenario. In addition, the county has a tape on sheltering in place, and the video has been seen several times by the staff and is incorporated into their training.

### ***Shelter***

Oakridge has a contract with a church up the street for evacuation purposes in case of a fire or a tornado. However, since the church was in the evacuation zone, residents could not be evacuated to that site. Upon re-examination of their needs after the incident, Oakridge determined that the facility was not big enough for them.

### ***Transportation***

A total of six church and school buses were used to evacuate the residents. One of the school buses was wheelchair lift-equipped, and Oakridge could have used more of those types of buses.

### ***Lessons Learned***

Lessons learned include:

- Examine the space of a facility to be used as a shelter and ensure it meets your needs for space, accommodations, restrooms, and a kitchen.
- Not everything needed for an overnight evacuation was taken initially, such as diapers, supplies, and feeding pumps. Rethink the need to gather up supplies during an evacuation and have assigned staff to gather up the supplies.

### ***Why a Success***

Oakridge staff have received training on evacuation and reviewed the shelter-in-place video. That information combined with the knowledge of how to handle other types of emergencies led to a successful self-evacuation.