FAMILY SUPPORT

Introduction

In addition to the challenges of caring for large numbers of patients, the hospital must be prepared to manage family members seeking information about their loved ones following a mass casualty incident (MCI). The volume of inquiring family members often exceeds the number of patients from the MCI, and the resulting stress on the hospital and its systems can be significant. In some cases, rapid expansion of usual services such as telecommunications is needed. Depending on the nature of the incident, specific plans may be required to meet unique family needs. Regardless, hospital services must be coordinated with those provided to victims and family members in the community, including at other hospitals. A scaled plan for addressing family support needs should be in place prior to an incident.

Family support should provide virtual and physical hubs for situational information, patient linkage to family and loved ones, psychological and spiritual support, and access to selected resources.

Activation of staff and resources to support the flow of information into and out of the hospital for reunification purposes is critical during a disaster and should be regularly integrated into exercises.

This chapter describes the challenges and strategies associated with providing family support processes onsite immediately after an MCI.

Related Resources
Additional resources are available in ASPR TRACIE's Family Reunification and Support Topic Collection, including Tips for Healthcare Facilities: Assisting Families and Loved Ones after a Mass Casualty Incident and Mass Violence/Active Shooter Incidents: Family Assistance.

Loved Ones Seeking Patient Information

Concerned loved ones may call or arrive at a hospital seeking information without knowing whether the victim is still on scene, at the hospital, at another hospital, or missing. Some inquiries may be about individuals who were not even involved in the incident. Information

Related Resource
ASPR TRACIE's HIPAA and Disasters: What Emergency Professionals Need to Know provides additional details about the release of patient information during emergencies.

about patients shared in the process of family reunification following a disaster is specifically exempt from Health Insurance Portability and Accountability Act (HIPAA) regulations. This should be made clear to all staff who participate in family support functions.

Hospital phone systems often become rapidly overloaded following an MCI. Multiple options for managing call volume are available depending on the facility's resources and its integration with community plans to reduce strain on the system. Options include:

- Diverting calls via an auto-answer system to a secondary number or site.
- Adding in-person or remote operators to handle the surge in calls.
- Coordinating with 311 or an alternate jurisdiction-based system.
- Using a website or other means of virtual contact (e.g., texting).
- Promoting public messaging about where to go or what number to call for family reunification information.

The family support process should not provide information to the media (they should be directed to the Public Information Officer) or those who are simply curious, even if they are asking about a specific person. Any person seeking information about a patient should be able to define a clear and direct relationship (familial or relational [e.g., domestic partner]) that has a need to know and is able to provide the name, address, and birthdate of the loved one. The name(s), stated relationship, and contact information of the inquiring individual should be logged during the family support process.

Hospital operators or other staff who will be responsible for answering family calls should have access to the current census/electronic health record (EHR) to check if there is an immediate match by name with a patient in the hospital. If there is *not* a match, the hospital should collect contact information for the family member and details about their missing loved one. This information allows the hospital to reach the family if a match is made later in the process or if additional information is needed from the family to determine if an unidentified patient matches the description. It may be helpful for operators to have access to electronic forms to facilitate rapid information collection, filing, and sharing with the family support center at the hospital (e.g., via electronic workspace/shared drives).

When there are multiple hospitals in an area, shared patient lists can prevent family members from having to make multiple phone calls and having hospitals record the same information. This system may be as robust as a dedicated patient tracking website or as simple as a shared virtual workspace where the sought patient name and family contact information can be logged, shared, and searched by all hospitals.

From the Field
A large metropolitan jurisdiction maintains a website, which is linked to a regional health information exchange, that can be activated following an MCI. Family members can search all hospitals in the area for their loved one by name. The website is promoted via the hospitals and major media after an

Onsite Family Support Center

Large scale MCIs involving multiple hospitals (and particularly those with multiple fatalities) require setting up a Family Assistance Center (FAC), which is established by the jurisdictional emergency management agency or another entity depending on the type of incident. To distinguish from the FAC, a hospital-based, onsite support area for families is often referred to as a Family Support Center (FSC).[1] The FSC is a temporary location to register and reunite families. It does not provide ongoing social support services and is not a nexus for law enforcement or medical examiner activities. However, the FSC should share information with the jurisdictional FAC and transition activities to the FAC as soon as possible so that loved ones can receive briefings and access additional support functions present at the FAC that are not offered by the hospital.

The FSC location should be close enough to the Emergency Department (ED) so that family members can easily be referred, but it must be a secure location that is not widely advertised to avoid media and attorney disruption. It should also not impede ED operations, patient throughput, or dedicated parking areas. Subsequently, scaling the FSC for large incidents may require using a different area with more capacity, such as a central room (e.g., a classroom) with additional adjacent rooms available for individual family counseling/discussion. Auditoriums can also be used, though they are less private and tend to prevent the natural flow and clustering of family members. The area should be easily secured and should generally not be within a patient care area. Adequate restrooms in close proximity are also important. An adjacent work area for staff involved in patient tracking is helpful as well. The rooms should have several landline phones (or at least phone jacks), robust wi-fi (including a public option), good cellular reception, and spare chargers if available. If the space(s) designated are not open off-hours, there should be a plan with facilities/security to open those areas while maintaining the security of the campus.

Signage directing family members to the FSC should be available in the ED and at major entrances for rapid posting. Consider placing the signage in locations where only loved ones will have access to avoid unwanted visitors to the FSC. Boxes of supplies for the FSC should be stored in proximity to the location and may include paperwork (e.g., sign in/sign out forms, information sheets on what to expect at the FSC, unidentified patient information worksheets), additional signage, phone chargers, water, and tissues. A list of additional items needed (e.g., refreshments, tablets/computers, message boards) and where to obtain them should also be included.

Designated staff for the FSC should include security/escorts, greeters, trackers/filers, scribes/phone assistants, and, ideally, social work and spiritual services personnel, and/or staff trained in psychological or emotional first aid. Staff may need job aids for these positions. In-person and remote interpreter services should be available. Administrative personnel can often

[1] Hospitals use a variety of terms, including Family Information Center, Hospital Family Reunification Center, Family Staging Area, Family Assistance Area, or Family Meeting Area, to refer to FSCs.

be pulled from usual duties to assist with greeting, registering, and obtaining information from the family members. Off-hours staffing and concurrent demands on staff during a disaster should be considered. Designated staff should know their responsibilities and be able to rapidly set up the FSC when an MCI is declared without waiting for a specific request. Additional needs can be communicated to the Hospital Command Center. Staffing needs will be most pronounced in the first several hours after an incident.

From the Field
One hospital has a QR code that family members can scan to complete registration on their handheld device rather than completing paper forms or requiring a greeter to enter the information. This QR code can also be shared on a webpage or electronically allowing a common database to be populated in real time while reducing staffing needs.

Quick reference sheets should be available showing the physical set-up of the FSC (e.g., configuration of tables and chairs for initial sign-in, collection of information, waiting and notification areas). Established policies should define how family members sign in, what kind of information is provided by them, how information is tracked, how matches are made, the family notification process (how, where, who), and who will escort family members to visit the patient. For pediatric patients, additional policies and verification of parent/guardian status may be needed. Policies should also cover who can be in the FSC as crowd control may allow only immediate family members (and, in some cases, only the spouse or parent/guardian) to remain in the FSC itself. Policies on behavior, consumption of external food/beverages, and photography in the FSC should also be available for reference.

A registration area should be present at the entrance to the FSC where loved ones who are cleared to enter can receive a name badge (with their name and optionally their loved one's name) or wristband. FSC staff should greet and sign in family members. Optional security and bag screening can also occur after registration. Information about their loved one and contact information should be obtained from the family. The EHR should be queried to see if there is a match. Ideally, patients should match by both name and birthdate. Particular care should be taken when querying patients with common names to avoid misidentification. Available data from other hospitals should also be referenced.

If the patient information matches a patient in the hospital, the family should be escorted to a private room and a caregiver can provide current information and facilitate reunification when appropriate in the care process.

If there is a provisional match at another hospital, the family should be referred there. Ideally, the hospital would be able to point the family directly to the FSC at the other hospital to prevent families from showing up to a potentially overwhelmed ED.

If there are no matches, the family should be offered the option of going home and waiting for updates (particularly if there are multiple hospitals and it is not clear where the victim could be) or await further information at the FSC. Staff should maintain a list of sought patient names and compare it to information from the hospital(s) as it is updated. Information flow will be

dynamic in the first few hours. Appropriate hospital personnel (such as an executive, spiritual care provider, or social work leader with crisis experience) should regularly provide overall updates to the waiting family members, including updates on the registration process and how many patients remain unidentified. After the first few hours, more detailed information should be collected from waiting families (if not provided initially) to facilitate identification of remaining patients. FSC activities typically peak in the first few hours and wind down rapidly. The Hospital Command Center should monitor activities in the community; when a FAC is opened, remaining family members should be referred there and the FSC closed.

Some disasters may result in systems being down or unavailable. The FSC staff should understand the downtime procedures for each system and adapt operations accordingly. Decedent management may also require downtime processes.

Unidentified Patient Processes

A large number of unidentified patients is possible in the early aftermath of an MCI as disaster registration may not have kept up with arrivals or patients may be unconscious and lack identification. In HAZMAT situations, identifying documents may be bagged with contaminated belongings and be unavailable. Some patients may be carrying inaccurate identification, which further complicates the process (e.g., underage students with falsified identification or a person who was holding someone else's wallet or purse).

The hospital should collect a standard set of information from both family members and bedside staff to try to match patient to family. This should include characteristics such as gender, height/weight, hair/eye color, unique identifiers (e.g., tattoos, birthmarks), and last-known clothing or accessories/jewelry worn. The data worksheets should clearly designate whether the information originates from family or bedside. FSC staff should review worksheets for potential matches and notify the family. A possible match may need to be verified via family photos or other means prior to a bedside visit depending on the specificity of information.

In areas with multiple hospitals, sharing of unidentified patient information among hospitals prevents duplication of effort and helps direct family members to the appropriate facility. This may be managed by the hospitals through their shared patient listing system or agreements with other community organizations or agencies (e.g., emergency management, public health).

From the Field
One metropolitan area has a voluntary agreement with the local American Red Cross (ARC) chapter to receive unidentified patient information. ARC staff try to match family and victim information and notify the hospital when a possible match is identified. The ARC also collects unidentified patient information directly via a toll-free number publicized via major media that hospitals transfer calls to after an incident. ARC also has access to a patient tracking board to match patients who are already identified.

Death Notifications

In some cases, family members may be searching for a loved one who is deceased. If the hospital becomes aware the victim died on-scene, it should refer the family to the community FAC, where trained staff can assist. If there is no FAC, the Hospital Command Center should consult with law enforcement on the most practical location for the death notification.

From the Field
One hospital used their GI procedure area near the ED as a temporary morgue and viewing area after a mass shooting incident. Families were allowed to view the decedent and caregivers could answer questions. Close coordination with law enforcement and the medical examiner ensured that evidence was preserved appropriately.

If the decedent is in the hospital, staff should follow the usual process for management, including any protocols for preserving evidence. In deaths that result from a criminal action, some limitations may need to be placed on contact with the body and belongings, and these should be understood prior to the family accessing the body or being given belongings. If there are a limited number of decedents at the hospital, usual locations may be used for death notification and viewing. In larger incidents, a location such as a procedural area may be used to increase scale while still allowing some privacy. In this case, initial notifications may be made in rooms adjacent to the FSC prior to viewing.

Other Considerations

Hospitals should be prepared to adapt FSC functions to special situations. For example, if an incident occurs at school or on a school bus, integration of school/bus company personnel and information sharing with those entities will be important. The FSC can serve as a bridge between the pediatric safe area (holding area after discharge/medical clearance) and the parent/guardian(s). Policies should be in place to verify and track release of minors to parents, guardians, or school personnel.

From the Field
In a recent MCI that included a line of duty death, a trauma center had difficulty maintaining operations due to the number of public safety personnel in the ED and vehicles blocking the adjacent streets. Subsequent planning with local agencies and area honor guards proactively established needs and helped staff create a plan for decedent management, personnel direction, and traffic flow that should help reduce future congestion and confusion.

In the case of a line of duty death, “family” may include large numbers of public safety colleagues. An honor guard will likely interface with the family and hospital personnel and attend the body until transfer to the medical examiner’s office, which may take hours. Public safety personnel will generally expect to pay their respects/salute the body as it is transferred from the hospital to the medical examiner vehicle. Planning this transfer with the honor guard and agency leadership is critical to maintain hospital operations while protecting privacy and supporting the decedent’s agency and colleagues. Rapidly directing arriving

agency colleagues to the FSC and having their leadership brief them on the next steps and plan can reduce the number of agency personnel in patient care areas. Quickly moving the decedent to a pre-designated private area away from ED operations where the family and honor guard can attend and liaison to plan next steps is also helpful to maintaining usual operations. Orderly transfer of the body in the ambulance garage or other protected location can then be accomplished.

Interface with Community Services

Sharing family and patient information between hospitals via a healthcare coalition or other construct is critical, particularly in areas with multiple hospitals. As soon as reasonably possible, individual hospital FSCs should be scaled back rapidly in favor of a jurisdictional FAC. This location serves as the hub for family reunification and support activities taking place in the area.

The jurisdiction should have plans to rapidly set up a FAC in the immediate aftermath of a major disaster. Hospitals should be rapidly updated on FAC information sharing practices, the location, when it will be open, and hours of operation. The FAC generally takes on longer term family support issues including connection to a variety of resources, any investigative updates if applicable, and may serve multiple other functions. The FAC is also a resource for families during decedent recovery operations. Staffing should include area hospital representatives with real-time access to their organization's EHRs or a central database. This hub-and-spoke concept expedites information sharing with loved ones and removes the need for them to contact multiple hospitals. It also reduces the impact on area hospitals trying to balance patient care activities and family needs.

Hospitals should consider working with local non-governmental organizations (e.g., the Salvation Army, ARC) to determine what role they may play in supporting family needs after a community-wide disaster and how they may intersect with hospital services.

Jurisdictional support for family reunification may also include joint media messages (e.g., resources available for reunification, current status of FAC) and jurisdictional systems such as 311 may be leveraged in support of community-wide family reunification. This is particularly important when populations are displaced or communications/power is down and the missing family member is more likely in the community than in a hospital.

Conclusion

The absence of well-planned family support functions at the hospital and within the community can rapidly lead to chaos in the aftermath of an MCI, with families descending on the hospital and jamming phone lines. These functions are often treated as peripheral concerns by hospital emergency management but deserve significant time planning location, staffing, and policies, and then providing education and integrating FSC activities into exercises to ensure they can be rapidly implemented when an MCI occurs.

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