

Conclusion: Additionally, a good cultural understanding of the situation and the adult's feelings are needed in order to provide assistance. The one providing help as well as the one receiving bio-psychosocial help are both part of the link created to overcome the impact of violence, committed to build bridges in the adversity. To prevent post-traumatic stress they are trained in facing disturbing anxiety when facing catastrophes produced by nature or men.

Prehosp Disaster Med 2011;26(Suppl. 1):s38–s39
doi:10.1017/S1049023X11001373

(A137) Prediction of Short-Term Functional Outcomes of Older People in the Emergency Department

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Background: Advancing age and co-morbid illness result in loss of the ability to perform activities for daily living (ADLs), and are important determinants of loss of independence and autonomy among older persons. Acute illness reduces the functional status of previously healthy older persons. The aim of the current study was to determine the change in ADLs due to acute destabilization in old age one month following discharge.

Methods: Older subjects admitted to the General Medical Wards from the emergency services of the All India Institute of Medical Sciences were included between August and February 2008. The Barthel index of ADL was assessed in a longitudinal design at the time of admission and one month post discharge. The values of the indices were compared using paired samples t-test.

Results: Of 108 subjects who presented to Emergency Geriatric Services at the hospital, 11 were excluded due to incomplete records, inability to trace on follow-up, incorrect telephone numbers, or had since died. Advancing age did not show a significant correlation with pre-morbid ADL score ($r = -0.040$; $p = 0.749$) or post-morbidity ADL score ($r = -0.65$; $p = 0.636$). A 45% decline in ADL score was noted one month following discharge after acute illness in older subjects (pre-ADL = 15.85; post-ADL = 8.78).

Conclusions: Older subjects are at a higher risk of poor functional outcome because they are less likely to recover function lost before admission and more likely to develop new functional deficits during hospitalization and after discharge.

Prehosp Disaster Med 2011;26(Suppl. 1):s39
doi:10.1017/S1049023X11001385

(A138) Duration of Emergency Department Stay and Injury Profile of Homeless Patients in a Level-1 Trauma Center

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Background and Objective: Immediate resuscitation and early disposition to definitive care improves outcomes. Homeless patients are neglected in emergency department (ED). The duration of ED stay and profile of injury of homeless patients at a Level-1 Trauma center were measured.

Methods: The study was performed from October 2008 to September 2009. Homeless patients were defined as patients

who had no attendant and did not have any shelter. Duration of ED stay was noted from the ED arrival time to entry time at the definitive care (intensive care unit/ward). Clinical and demographic details were recorded. Subjects who had: (1) an attendant; (2) were discharged from the ED; or (3) expired in the ED were excluded.

Results: Forty-one homeless patients were admitted. The mode of injury was road traffic crash in 73.2%; assault in 7.3%; fall from height in 7.3%; and in 12.2%, the mode of injury unknown. The average Injury Severity Score (ISS) was 6.76, with a maximum of 34 and minimum of 1. A total of 24 subjects (59%) had a Glasgow Coma Scale (GCS) score of ≤ 8 (severe head injury), 10 patients (24%) had GCS score 9–12 (moderate head injury), and seven subjects (17%) had GCS score 13–15 (minor head injury). Breath alcohol test was positive in 13%. The average duration of ED stay was 35 (3–173) hours in the homeless group and 12 (0.5–18) hours for patients with an attendant. Twenty-one subjects were admitted to neurosurgery (51.2%) with an average ED stay of 22.4 hours, five to surgery (12.20%) with average ED stay of 56.6 hours, and 15 to orthopedics (36.6%) with average ED stay of 45.3 hours.

Conclusions: The emergency department stay of homeless patients was 35 hours. Orthopedic trauma subjects had a prolonged disposal time. This addresses serious patient safety concerns and immediate remedial measures.

Prehosp Disaster Med 2011;26(Suppl. 1):s39
doi:10.1017/S1049023X11001397

(A139) Profile of Likely Needs in a Disaster Alternate Site Care in Honolulu, Hawaii

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Background: In the US, a system has been developed to provide disaster sheltering for persons with special needs in what are now termed alternate care sites (ACS). As in many other developed countries, as the population ages, the rates of people with chronic diseases that require complex health care management in the home setting has increased. The aim of this study was to identify the key chronic diseases, conditions, and therapies that should be planned for in ACS operations.

Methods: A convenience sample ($n = 402$) of senior citizens (≥ 65) who resided in Honolulu, Hawaii were interviewed and completed a 15-item survey that asked about demographics, existing health conditions, activities of daily living abilities (ADL), and requirements for ongoing care.

Results: The mean age was 68 years; 56% were female. The most common health issues included: hypertension (53.4%), heart disease (24.6%), diabetes mellitus (23.3%), and asthma (15.1%); while 11% ($n = 47$) reported they required daily physical assistance ADLs, including: getting up from a chair (15.1%), walking (8.1%), taking medications (8.1%), dressing (5.2%), and toileting (4.2%). Of these 47 people, most (81%) had someone who would help them in a disaster shelter, while nine (19% of the total who required assistance) had no one to help them. On average, of the respondents who reported they took medication daily, 14% had less than a seven-day supply of medication for their chronic disease.