



**American
Red Cross**

Mass Care
Observations/Lessons
Learned from
Hurricane Isaac and Sandy

Where to start?

	ISAAC	SANDY
Disaster Responders	5,333	16,322
Meals & Snacks	648,932	9,810,048
Relief Items	140,998	6,900,413
Shelter night stays	19,768	161,635
Health & Mental Health Contacts	16,358	107,031



As of 1/4/13

Agenda

1. Sheltering
2. Feeding
3. Bulk Distribution
4. Safe and Well
5. Hinderances to Service Delivery
6. Staff
7. Good things!
8. Next Steps



Material was compiled from:

1. DRO Narratives
2. DRO leadership feedback
3. NHQ MC experiences

Many recommendations, will cover some.

Sheltering

- FNSS
 - Facility selection
 - Services
 - Equipment
 - PAS
 - Dietary needs
 - Subject matter experts



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Facility – vertical sheltering, restroom/shower accessibility (1 accessible toilet for 60 people creating 30 minute wait). Segregation into “FNSS areas.” Many were gov’ t shelters, but when ARC vests are in them, it’s perceived as our shelter.

Services – 25+ clients had cot-wetting incidents with no effort to provide bedpans, medical cots or assistance going to the restroom.

Equipment – procurement issues, need more urgency. Lack of medical cots, 8-10 Clients with mobility issues lost their wheelchairs with no effort to acquire them one for first 5 days.

Clients slept in their wheelchairs for days. Problems getting medical cots (inclining head) or other means for them to sleep.

PAS – Contract was initiated by FEMA in NY & NJ, used sparsely, ARC needs to understand the process and allow access.

Dietary needs – not a priority, low-sodium and diabetic needs not addressed. Religious and vegetarian meals not in high demand.

SME’ s – need to allow our SME’ s in HS & DMH to take the lead, work together as a team to help clients, resolve issues and communicate.

RECOMMENDATIONS:

- 1.Planning w/ all types of partners to increase Whole Community response.
- 2.Education at all levels of chapter of FNSS issues, services, needs, community demographics.

Sheltering cont.

- Preparation
 - Facility selection for clients and staff
 - Materials & Staff
 - Shelter agreements
- Staff Shelters
 - Management & staffing
 - Volume
 - Location
 - 3-way ownership



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Facility Selection - inadequate # toilets/showers (takes too long to mitigate), obtaining last minute, gov' t lead, put staff in shelters we wouldn' t use for clients (under construction, not safe, sanitation issues...). Scrambling last minute to find.

Materials – lack of enough shelter kits, cots, blankets,...

Staff - Inadequate staffing initially, inexperienced/untrained shelter mgrs, poor delegation, mean spirited...

Shelter agreements – problems obtaining them by LOG.

STAFF SHELTERS

Mgmt/staffing – poorly staffed in quantity and quality, which impacts ALL service delivery. Run them as you would for clients, we need to take care of our workforce.

Volume – not knowing # of incoming staff, not enough space, not enough facilities.

Location – not near worksites.

RECOMMENDATIONS:

1. Shelter kit – national product
2. ID more staff shelters pre-disaster, work with partners (Elks Lodge).
3. During response, create a leadership team comprised of 1 SH, 1 SS and 1 LOG rep to solely run staff shelters. If lacking facilities, add External Relations group also.
4. Get SS rep in each staff shelter.
5. Read Staff Shelter handbook.
6. Large DR' s, get support teams of Staff Wellness and DMH.

Sheltering more

- Hot issues
 - Sex offenders
 - Unaccompanied minors
 - Communal showers
- NSS
 - Reporting
 - FROST team (Field Remote Operations Support Team)
 - Age demographics
 - Capacity
 - Mapping



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Sex offenders – staff didn't know/follow procedures. Sex offenders were placed in a special area off of dorm, but they weren't there, they were all over, including playing in children's area. Mothers in shelter had raised issue.

Unaccompanied Minors – handled well!

Showers – unrelated adults showering with children, conjugal visits.

NSS

Reporting – continue to have problems getting #'s. Daily Shelter Report form!

FROST - did amazing work. Work with MC NHQ for connection to them.

Age demographics – first time use. Breakdown: 0-3, 3-7, 8-12, 13-18, 19-65, 65+. Helped partners provide appropriate services, prepare for long term recovery,...

Capacity – embarrassing when CNN asks how 250 people fit into a shelter with 0 capacity.

Mapping – redcross.org and app only show models 1 & 2. Continue to ensure the shelter is mapped (“Lookup” button next to Lat/Long data). You'd be surprised who and how many look at this.

Sheltering still

- Shelter support
 - Shelter Teams
 - Direct Deployment
 - Shelter Assessment Teams
- Independent shelters
 - Expectations
 - Population numbers
 - Support



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Shelter Teams – pre-formed teams from chapters worked very well. Willingness to do something else was good and bad. Need flexibility to meet operational needs.

Direct Deployment – Orange, TX, created shelter teams and sent directly to shelter sites. Breakdown in communication, sites/district/GIA didn't know who/how many/where many times. DROHQ leadership didn't know either. HS/DMH needed more of a connection with their folks on these teams, needed ability to move them to meet operational needs. Current project team working on SOPs.

Shelter Assessment Teams – piloted new program developed from multi-agency concept. Was just ARC reps from SH, HS, DMH, and later CC. Great way to help inexperienced shelter mgrs, meet client needs faster, improve communication, increase situational awareness.

INDEPENDENT SHELTERS

Expectations – clear definition of roles and responsibilities, especially with gov't. Big disconnect on this which caused poor decision-making and poor service to clients, mostly not our fault, but perception was different.

Population #'s – NSS expanded reporting is still a protocol, paint the big picture. Still difficult.

Support – guidance vs. reality. SH Assessment teams able to visit some and found numerous issues (lack of food, supplies, equipment). These visits also helped w/ reporting issue.

Feeding

- Kitchens
 - Managers
 - Locations
 - Support/setup
- Food
 - Chapter food orders
 - Food waste
 - Unreliability of shelter meals



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Kitchen Mgrs – Isaac - District model caused outpouring of SME's to the districts and away from typical sites, such as the kitchens. Lack of appropriate staff at beginning caused problems with routes, quantity of food, waste, procurement, reporting etc.

Kitchen locations – Sandy - State took too long on decision of kitchen locations, caused loss 3+ days of hot food service delivery.

Kitchen support/setup – Sandy – lack of support equipment, trailers, etc. Gov't unable to help in timely manner, needed fuel, toll relief, etc. Seemed state didn't like working with ARC.

Chapter food orders - in excess of \$140K for food/snacks without DRO knowledge. 2 trailers full of food in a parking lot that no one knew about until we got the bill.

Food waste – excessive because 1. kitchen manager inexperience, 2. longer time in “seek and serve”, 3. political pressures, 4. poor communication b/t chapter & DRO.

Ex. Non-food product put on a reefer, ruined food.

Started tracking “overage” to help stop routes and for finance and planning purposes. Overage is any food product that is disposed of, or food that you have to find a place to deliver to so as not to waste it.

Shelter meals – 1. not the right amount (in both directions), 2. Low quality, clients preferred Salvation Army food (better taste & arrived on time).

Feeding cont.

- ERV's
 - Too many inexperienced/untrained crews
 - Preloaded
- Mobile Feeding Partners (IKD)



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ERV crews – Isaac – some had never been in an ERV, didn't know what an NFO or spoodle were.

Preloaded – Sandy – many came empty. Need to be pre-loaded with life essential items (shelf stable meals, snacks, water, etc.)

IKD mobile feeding partners expressed concerns about not being able to touch base with Mass Care about feeding needs, locations, etc...

Bulk Distribution Issues

- Politically driven instead of ARC planned
- Hampered by support services
- Reporting
- Tracking standards
- Item push
- In-Kind Donations



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Politics – Asking for CUK’ s before storm passed. Need to educate EM on the process of BD and improve relationship.

Support Services – waiting on warehouse, forklifts, etc.

Reporting –Sandy – separate BD push complicated reporting. Sheer size of DRO’ s crippled our ability to count. BD operation should have been consolidated weeks earlier.

Tracking standards – need standard way to track BD vehicles, too much key swapping between FF, BD and LOG.

Item push – too much pushed into area without knowing need, also applies to partner organizations. (However, with our slow procurement system, it’ s better to overpush than have clients wait for days on needed product.)

IKD trailers were continually moved. Several in-kind refrigerated trailers were lost or continually misplaced for a 3 week period. (In some cases feeding partners were in possession of the in-kind trailers without Mass Care being aware.)



Staffing: Staffing requests during Sandy were disregarded immediately following landfall. SWL responders were not assigned until day 4. Staffing requests were submitted by MN pre landfall

PROMOTION

Safe and Well Website was poorly promoted on media during both Sandy and Isaac.

Shelter managers at ARC run shelters needed to actively promote Safe and Well paper registrations at registration intake tables on day 1 of shelter opening.

RECOMMENDATION: Shelter worker(s) need to be assigned to this task at each shelter.

Sandy: Computers and paper registrations were in the shelter kits at ARC Shelters but not utilized and were found later by SWL workers and set up for clients.

CALL CENTERS

Sandy and Isaac Chapters needed desperately to have a SWL representative assisting in answering phone calls from clients looking for loved ones on day 1 post landfall.

Hinderances to Service Delivery

- NHQ
- Supply chain
- Staff Lodging
- Idle staff
- Process over service delivery/Sense of urgency
- Expectations of partners, public, government,...



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NHQ – Micro management. Direct involvement in Service Delivery decisions without local understanding. Writing of feeding purchase orders from NHQs, failing to provide copies of the PO to the DRO in a timely manner. Diverting assets for public relation purposes.

Supply Chain- not having accurate inventory/location of product, status of 6409's, slow system, lack of support trailers (kitchen & shelter). Need LOG rep at each kitchen.

Lack of understanding that if the resource is for a health related issue or FNSS issue, the resource should be purchased or rented from our two national contracts if not readily available locally.

No consolidated purchase process between regions and DROHQ. Frequently orders were entirely missed or doubled. Includes reqs for staffing, logistical items and meals. Too many people receiving on Mass Care side which made it difficult to track reqs.

MCPC – read the brochure, fill out register and save receipts. In jeopardy of losing this resource.

Staff lodging – too much moving staff, poor staff shelters, poor locations... Didn't have a hot meal for dinner in NY b/c of staff lodging locations. Many people simply went home because we failed them here, including our SBC partners.

EXPECTATIONS

Number of community partners wanting services. Sometimes they were right next to each other. We should have worked to get them to work together instead of separately.

Cannot take a request at 11:30 for hot meals at 12:00. It should become standard operating procedures to make it mandatory that hot meals need 24 hours notice.

Need clearly defined roles and responsibilities with gov't and community partners.

ARC initially based shelter staffing models on assumptions of state role, which led to overwhelmed shelter staff and sub-par shelter conditions.

Hinderances cont.

- Death by paperwork
- Common Operating Picture
- DRO structure
- Standard Operating Procedures (SOPs)/Checklists
- Communication
- Reporting



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Paper – playing catch up on 5266, 6409, facility agreements, MCPC, etc. New tools developed during each DRO.

Operating Picture– Need a system to track and show all service delivery, would allow all activities to do better planning and service delivery, alleviate many information sharing issues.

Unable to provide up-to-date shelter addresses and contact info to other activities for first 10 days.

DRO Structure– Can't staff 3 OHQ's per state. Each DRO had issues that caused communication challenges between DRO, NHQ and service delivery sites. Better initial conversations on transition from chapter to DRO and a clear structure could resolve that. Clear and consistent roles and responsibilities.

RECOMMENDATIONS: 1. Consistent template of how this works when we start up a DRO. Each operation seems to have a new twist and yet it never is clearly communicated from the start or it changes from week to week or job director to job director. 2. Playbooks/checklists to include best practices.

SOPs – success too dependent on site manager's KSA's – need checklists & exercises/drills to standardize field operations for managers and site managers, not reinventing wheel every DRO. MC at DROHQ also operates differently depending on who's running it. Operations should begin, transition and end in standard, professional and sustainable way.

Communication – 1. Couldn't accurately tell our story and show what and where of service delivery. 2. MC didn't communicate plans well with other activities (HS, CC, LOG) at times, so they couldn't keep up. 3. Too many layers for and opportunities for breakdown. 4. Info not reaching worker level. LOG not knowing BD is shutting down and stranding BD trucks.

RECOMMENDATIONS: 1. Use technology to show our service delivery and do planning! Also use to share with stakeholders. 2. Poll OM & government partners to discover patterns of info requests so we can update forms & procedures appropriately.

Sandy – MC Planning Cell – collected data of service and needs for planning.

Reporting – 1. some MN's had never seen a 5266 collection tool. 2. requirements and processes often changed. Spent too much time educating instead of service delivery.

Staff Issues

- Respect and flexibility
- Lack of trained managers and leaders
- Lack of appropriate leadership in beginning
- Poor supervisory and leadership skills
- Poor integration between local and visiting staff
- Little to no deployment info from home chapter
- Significant delays receiving staff



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These issues led to staff morale problems and many staff relations issues.

SH - New training not being taken, guidance not being shared. No effort during DRO to share.

Shelter manager leading a team, but first time ever in a shelter, didn't say anything.

SV skills lacking

- Turning in numbers in time,
- Sign in sheets for volunteers at the site,
- Knowing there out processing dates,
- Ordering more staff for their site,
- Doing job inductions, putting people in there right positions to start off with.
- Evaluations

RECOMMENDATIONS:

1. Visiting Staff Orientation – start too late. Have 1 pagers ready with local information, that visting staff wouldn't know. Include local resources, restaurants, demographics, etc. Examples: NY – how long it takes to go 5 miles (way underestimated). How to get a cab. LA – parishes. NJ – jug handles.

2. Local resource sheets by site (OHQ, Region, Shelter, Kitchen, Emergency Aid Station).

Isaac – Hinderances

- Slow planning
- Direct deployment
- Structure/Table of Organization
- Kitchen support
- Ineffective preliminary disaster assessment data
- Many staff relations cases
- Government moving shelters



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Slow Planning – storm sitting over land. Insufficient staff pre-landfall.

Direct Deployment - communication issues, staff deployed where not needed and not with right skills.

Structure/T.O. - too many people making decisions.

Kitchen support – Push packages not properly equipped. Lack of qualified staff on kitchen site.

Staff Relations – leadership spent up to 50% of their day on staff relations issues for many days.

Gov' t - ARC is not directed by government – we are directed by our fundamental principles. Not a simple solution. Not acceptable that a state won't open shelters because "don't want the neighboring state/county/parish in them". Have to get smarter and client focused when it comes to government.

Sandy – Hinderances

- Emergency Aid Stations
- Hot shots
- Scaling up too slow
- Untraditional service delivery needs
- Poor reaction time from state on emergency items
- Traffic & tolls
- Social Media – good and bad



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EAS – would have been first choice in service delivery, but didn't have the appropriate support staff (HS, DMH) or vehicles, couldn't get signage, tents, etc.

Hot Shots - This was a cluster because of multiple requests coming from many directions and slowing down the scaling up process, in addition to detracting from efficient tactical operations.

RECOMMENDATION: Standardized way to track requests - prioritize/verify, assign them so 6 people are spinning their wheels and getting 6 different resolutions, close the loop on outcomes.

Slow scaling up - Delayed decisions by State and Feeding Lead, (Salvation Army) on feeding responsibilities and location for ARC kitchens. Took too many days to setup kitchens with needed equipment, supplies, vehicles, staff, fuel, etc.

Emergency items – fuel, propane, water...

Untraditional – high rises.

Tolls - Insufficient support from government, (NHQs) when waiver for tolls expired.

SOCIAL MEDIA – tracking spreadsheet from NHQ pushed to ground, closing loop. For better (fundraising) and worse (directing service delivery), social media is here to stay. We need to create systems that integrate social media during response.

Isaac – Good things!

- Shelter Teams (from chapters)
- Shelter Assessment Teams
- Partnering
- Placement of kitchens post-landfall
- SWL worked well with no problems
- NSS FROST

Sandy - Good things!

- Non-traditional long term feeding program – funded 3 food banks in New York
- Troubleshooting
- Partnering
- NSS FROST
- Shelter Assessment Teams
- NJ Sandy Neighborhood
- Pets
- Mentoring/coaching pilot program



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Food banks – extending our ability to feed with longer term solutions.

Neighborhood – developed late, but helped us have a one stop shop for information so we could hound the DRO less.

Pets

Co-located shelters were run well.

First time distributing pet food through mobile BD on large scale.

Mentoring program, NY – incorporating local leadership into DRO leadership through KSA assessments and development interests.

Next Steps

MC NHQ:

- After action calls with SV's and SA's
- Compile all recommendations and prioritize tasks
- Project teams incorporating field leaders

Contact: NHQMassCare@redcross.org