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Recruit and retain staff following a customer service model of employment

Hospice expands skills set required of staff

As hospices become more competitive and challenged by the 21st century market forces, some are searching for more efficient ways to hire and retain the team-working staff they most desire.

One way to improve the recruitment and retention process is by moving from a clinical model to a customer service model.

While clinical capability and competency remain the chief characteristics managers look for in new hospice employees, the Hospice of the Cleveland Clinic in Independence, OH, has added some new skills to the list, and some are a little more challenging to assess.

"We also look at someone who possesses good communication skills, can demonstrate good boundaries, and we do that through new processes we have put in place, such as behavioral interviewing," says Barbara Volk, RN, BSN, MBA, administrator of Hospice of Cleveland Clinic.

The goal of behavioral interviewing is to learn more about a particular job candidate's other important attributes, including integrity, honesty, and team work, Volk says.

"The usual and customary way that health care looks at hiring practices was looking at professional licensure," says Cheryl Carrino, RN, manager of program development for Hospice of the Cleveland Clinic.

"Now what we did was begin to look at skill sets within the staff we're hiring," Carrino says. "We began to look at the initiatives that give us the desired skills, and we were looking more at the person themselves."

Assessing new job candidates is done in two phases, Carrino says.

First, the human resources department screens people for clinical capabilities, and those who are selected in this phase then meet with a manager who conducts a behavioral interview, Carrino explains.

"The manager is looking for behaviors of that person through questions, and then we move the candidate on to a peer interview," Carrino says. "The peer interview is done by a designated team of employees in our hospice program, who then are part of the process of making the eventual selection."

Peer interviewers are asked to evaluate candidates through a set of questions in which they assess the person's communication skills, team work boundaries, and prioritization ability, Carrino says.

"Can the person adapt and commit to our type of culture here?" Carrino says. "We want people who are open to learning and growth and development, so the interview becomes a way to make a connection with this employee and make a connection with our organization."

Peer interviewers evaluate job candidates' answers to their questions in terms of behavior, she adds.

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Using a decision matrix, the questions asked are selected based on the skills a particular job requires, as well as what the job candidate's prior employment and skill sets were, Carrino says. (See sample matrix questions, p. 136.)

"Each question is weighted from is it essential or not important, and each response is scored from one to five, with one being poor and five excellent," Carrino says. "Each member of the team does a score, and then they come together and look at what everyone else scored the candidate and average those scores as a team before presenting the scores to management."

After changing the recruitment process to better reflect the hospice's goals for staff skills, hospice managers changed the orientation process, Carrino says.

"We made major revisions in terms of adding customer service pieces to the orientation," Carrino says. "Now we're doing a clinical orientation and are working on a customer service orientation, in terms of how to prevent hospice services, how to communicate with patients and families."

Also, the hospice has added some initiatives for improving telephone service and feedback to referral sources, as part of a goal to improve processes and communication with all customers, she says.

"Another thing we've done is to enhance the orientation experience," Volk says.

When new employees are hired, their manager will send them a letter welcoming them to the organization and follow it up with a phone call, Volk says.

"The manager will meet with new employees weekly, if necessary, depending on what the person does," Volk says.

Even past the orientation and probationary period, the manager will continue to have personal contact on a weekly or monthly basis with the new employee to make certain the person is comfortable with the organization and on the right track, Volk adds.

The orientation itself is competency based, requiring employees to demonstrate they understand their role and can function independently, Carrino says.

It's divided between structured formal classes and structured field time, and soon the hospice will implement a preceptor program with formal training, Carrino notes.

The preceptor program will give experienced staff an opportunity to grow professionally with-

out having to move into a managerial position, she says.

Each selected preceptor would receive formal training and productivity standards, and each would receive financial incentives, including salary increases.

Preceptors would be given some time apart from their regular work to help new employees with orientation, Carrino says.

"We're beginning with registered nurses and will eventually look at rolling this out to all disciplines," Carrino says. "Right now the people who are preceptors are the people we call 'high performers,' the people who serve on committees and who contribute to the organization by doing presentations for other staff."

Each preceptor will take a new employee out into the field for about 2.5 to three weeks, Carrino says.

"We really want them to focus on the competencies necessary to coordinate patient care, and focus on things such as admissions, discharges, overall case management in terms of medication supply, and focus on the necessary competencies to manage a caseload," Carrino explains.

"In the structured formal classes, new employees learn about the coordination of care and technical pieces of hospice and conditions of participation and bereavement care and psychosocial care," Carrino says. "In the field they are teaching new employees the application of these pieces."

After the four week period, the preceptor then becomes an informal preceptor, a go-to person for the new employee, Carrino adds.

"The ultimate goal is that the preceptor will move them and help them get integrated into their own clinical team," Carrino says.

Another change the hospice has made to enhance its customer service focus is to script the admissions process for staff, Volk says.

"We make sure everyone is presenting the information and material in a somewhat similar fashion, with the same message," Volk says.

For example, the admissions script would have the admission nurse introduce herself and the organization by saying, "Hi, my name is so and so, and I am here today to do this," Carrino says.

Other examples of scripted messages for the admission process are as follows:

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- "Our care is designed to assist both you and your family to coordinate your health care from home."
- "The goals of care are driven by the needs of you and your family and are focused on comfort and not cure."
- "Under your benefit for hospice care Hospice of the Cleveland Clinic is responsible for coordinating the care related to your hospice diagnosis."
- "Therefore, when services are needed, Hospice of the Cleveland Clinic is responsible for managing your care for this diagnosis."
- "Your traditional Medicare part A and B benefit/Medicaid are waived for this diagnosis only. You can still use your Medicare/Medicaid benefit for medical care not related to your hospice diagnosis."

The idea is that the nurse will help patients and families set their expectations during the explanation about services and disciplines and what the roles are, she says.

"One reason we've done the scripting is because we want to present hospice services in a positive manner," Volk explains. "We want to put a positive spin on our services."

A scripted opening will prevent the natural tendency of staff to focus on drawbacks, such as what the hospice benefit might not pay for, Volk adds.

"We've heard the staff say, 'We can't do this or that,' and we say, 'That's not the way to look at it,'" Volk says. "By listening to staff and doing role playing, we found that we needed to flip the switch and find a more positive manner to do this."

Also, the script includes a closing statement at each interaction with patients and families: "Thank you for choosing Hospice of the Cleveland Clinic," Volk says. ■

Hospice of Cleveland Clinic's behavioral interviewing decision matrix manager

Here are sample questions from the matrix

The Hospice of the Cleveland Clinic in Independence, OH, has developed a behavioral interviewing decision matrix that is used when staff interview candidates for hospice positions.

The matrix includes a column for question weight, meaning that a score of one is a question that is preferred, but not necessary; a score of two is a question that is moderately necessary, and a score of three is a question that is essential. Each job candidate is scored according to one for very poor, two for poor, three for fair, four for good, and five for excellent.

There are 14 categories of questions, including conflict resolution/problem solving, leadership/management style, boundaries, coping skills, personality, etc.

Here are some sample questions, reprinted with permission from the Hospice of the Cleveland Clinic:

Work Environment:

1. Describe a work situation that irritated you—how did you respond?
2. Giving you a choice-tell us about the best and worst boss you ever had—what was good about working for him/her or difficult about working for him/her?
3. Tell us what responsibilities you want in a job and why?
4. What kinds of results do you expect to achieve in your next job?
5. What expectations do you have from this job/company that you presently do not have in your job setting?

Boundaries:

1. Describe an experience of setting a professional boundary from a past job.
2. Explain the difference between sympathy and empathy using a job-related experience.
3. Scenario: On your caseload you have a patient who is young. His spouse has given up her job to be a caregiver. They have two small children. It is almost Christmas. They have utility bills that need to be paid, and they have used their savings. Comment on how you would help this family.

Coping Skills:

1. Describe a time on a job when you faced a problem or stress that tested your coping skills.
2. Give an example of what you do when your schedule gets interrupted.
3. When you become overwhelmed on the job, how do you deal with the situation?
4. Give us an example from your job experience of how you have dealt with loss or disappointment.
5. Tell us how you maintain your ability to cope; not allowing personal issues to affect job performance.
6. Give us an example of how you have avoided or dealt with burnout.

Conflict Resolution/Problem Solving:

1. How would you manage conflict within your assigned team?
2. Explain problem-solving techniques that you have found successful.
3. Scenario: A team member comes to you seeking consideration to an exception regarding a department policy. Approval needs to be provided by an administrator. Tell us how you would handle this situation.
4. Scenario: Recognizing that relationships exist for you within the team, tell us about the same hurdles you may encounter and how you might manage the same. ■

Hospice has developed award-winning program for serving pediatric patients

First pediatric patient seen in 1980's

As community providers, managers at the Hospice of the Western Reserve in Cleveland, realized more than a decade ago that its community increasingly will include pediatric hospice cases, so something needed to be done to ensure this population was well served.

The hospice responded to local trends by implementing a pediatric hospice program after serving the first pediatric patients in the mid-and-late-1980's, says **Mary Kay Tyler**, MSN, pediatric team leader and nurse practitioner of the Hospice of the Western Reserve. The hospice received a Rose and Sam Stein Award, presented

by the Ohio Hospice & Palliative Care Organization (OHPCO) of Dublin, OH, in 2004 for its perinatal palliative care program.

"In the late 1990's, across the country people started looking at pediatric palliative care and hospice movement, which has always been behind the adult movement," Tyler says. "At that time we were getting 20 to 24 new pediatric referrals a year, and we thought we should be getting more patients with the demographics of this area."

In 1999, the hospice conducted a feasibility study that looked at pediatric centers and found that there remained a need for pediatric palliative care, but the program needed to be structured in a different way in order to meet the need, Tyler says.

"We needed more staff to care for children, because their needs are different from adult needs," Tyler says. "We talked with physicians, nurses, and social workers about what types of patients they felt would benefit from palliative care and what were the barriers to palliative care and hospice services."

Hospice staff also surveyed families they had served previously and brought them together into focus groups, as well as talking to them in telephone interviews, Tyler notes.

"We also provided counselors just in case the focus group evoked any emotional responses that needed some counseling afterwards," Tyler says.

"The physician interviews were conducted by a pediatrician who was a pediatric oncology fellow," Tyler says. "I did the nursing interviews, and we had an outside consulting group do the parent interviews."

The consulting group was hired to provide some neutrality so that families could talk about issues that made them unhappy, but there also were counselors available at all sessions, in case anyone needed assistance, Tyler says.

"We took all of the feedback and received recommendations from the outside firm," Tyler says.

From this information, hospice managers decided to restructure the pediatric program to meet the community's specific needs, including having a strong nurse practitioner/physician component, Tyler says.

Before there were patients, the facility committed resources for the program, hiring two nurses and a social worker, she adds.

"We had to add staff at the front-end to meet the expectations," Tyler says.

The facility also found from its surveys that physicians and other referral sources expected the pediatric practitioners to be able to have a very fast response time, responding to a referral within a few hours instead of 48 hours, Tyler notes.

"They'd call in the morning and want someone sent to the clinic that day," she says. "They also expected to have a primary nurse who would be working with the family and who would open the case and be the first person to meet the patient."

Initially, the hospice had a program in which a team would open the case and then turn it over to a primary team, but physicians expected there to be a smaller group of individuals working with the family, Tyler says. (See story on how pediatric program works, p. 138.)

"That's challenging to provide because we service a large geographical area, and to serve them with a small group of people is very challenging," Tyler explains. "Physicians also expected us to be able to take care of patients even if they were still receiving very aggressive therapy, including chemotherapy and radiation."

This also posed a challenge, but the rationale was understandable, Tyler says.

"Families don't want to give up the aggressive therapy, and nor should they have to because aggressive therapy can buy a lot of quality time for the child," Tyler says.

The other expectations of physicians and referral sources were that the child would be brought back to the hospital as frequently as the family desired and that the physician would be managing the patient's care, she says.

"They were afraid we would take over and they wouldn't have the same level of control," Tyler says. "So we had to convince them that we wanted to work with them and had no intention of taking over their patients."

Tyler offers this example of a typical pediatric case:

A child of about age 5 has a brain tumor that is not operable, but does respond to radiation, Tyler says.

"So her parents decide they will proceed with a course of radiation, and we're not called initially on this particular case as the child receives six weeks of radiation," Tyler says. "But after one month of radiation treatment the girl starts to have problems and the tumor is growing again."

At that point the oncologist has a conversation with the parents, telling them that things are not going well, and he suggests chemotherapy,

although it normally doesn't work. The oncologist also recommends calling the pediatric hospice program.

"The family was resistant, but they were open to hospice when she relapsed six weeks later," Tyler says. "We came in at that point in time and the family did not want any further treatment, instead wanting to focus on the quality of life with her and her two older siblings."

The hospice nurse saw the girl and family twice a week, checking vital signs and doing physical assessment, and helping the child with problems, such as unsteady gait. Also, a social worker met with the family to focus on concrete problems, including the family's reduced income from the mother's not working, Tyler recalls.

"We had a spiritual care coordinator working with the family to start focusing on how the parents were very angry," Tyler says. "They were very religious and couldn't understand how God would do that to them, so the spiritual care coordinator was working with the parents on this."

The little girl loved music, so the hospice brought in a music therapist, and the hospice provided staff to assist teachers and a guidance counselor at the girl's school, Tyler says.

The hospice sent out letters to the girl's kindergarten classmates to obtain parental permission prior to meeting with the students. There also was a parent meeting where the hospice worker went over what would be discussed with students, Tyler says.

In the classroom, the hospice worker would ask students about their own experiences with death, including the loss of a grandparent, and there's a discussion about how the child is sick and on some days won't be in the classroom, Tyler says.

"The child could be in the classroom when this discussion is going on—it's all geared toward the child," she says. "What you end up doing is take the lead of the child and when children ask questions you reflect the questions back and have a conversation, going in the direction the children lead you, stopping when they're done."

The hospice's caregiver guide assists family members and teachers with having these conversations at other times they might arise.

"We try to do as much education with the classmates as we can before the child dies to prepare the kids," Tyler explains. "Then once the child dies we also respond with a crisis type of response and help the children through an ongoing follow-up."

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The kindergarten class made a special wreath for the family in which each child wrote a memory on a piece of ribbon and the ribbons were tied to the wreath, which was given to the family at the funeral, Tyler says. ■

Here are some of the main features of Ohio hospice's pediatric program

Neonatal services are included

The Hospice of the Western Reserve of Cleveland, has an award-winning pediatric hospice and palliative care program that integrates some of the same hospice elements of an adult program with services that are particular to a pediatric population.

The program has gained community-wide acceptance and enhances the hospice's reputation among referral sources and others, says **Mary Kay Tyler**, MSN, pediatric team leader and nurse practitioner for Hospice of the Western Reserve.

Here are some of the chief features of the pediatric hospice and palliative care program:

• It has a consortium of providers. "Instead of one pediatric medical director, we have a consortium of six pediatric physicians in the community," Tyler says. "They're all with competing health care systems that wouldn't normally be working together, but because they're all committed to pediatric palliative care, they put aside their differences."

The physicians rotate a certain number of weeks with the program and help the hospice provide care to children, regardless of where a

particular child receives his or her medical care, Tyler explains.

"Each has a different area of expertise," she says.

One physician is a pediatric ethicist, another is a palliative medicine specialist, a third is a family practice physician, and another is a pediatrician who specializes in taking care of children with complex disabilities, including cerebral palsy and multiple systems problems, Tyler says.

Another physician is a medical director of a residential facility for children with multiple handicaps and disabilities, and another is one of the hospice medical directors, she adds.

"They each provide 24/7 back-up to the team, consulting from their particular institution and providing a presence at their institution for palliative care," Tyler says.

Some of the physicians had been through palliative care training prior to participating in the program, and the others have sought education in the field since then, she says.

• Work out reimbursement issues individually. "We work with private insurance case managers on a case-by-case basis, and we try to work with case managers to see if payers will pay us per visit, while continuing to pay for chemotherapy and radiation treatment," Tyler says.

"There is a hospice per diem reimbursement out there, and some patients are eligible for that," she says. "Sometimes chemo and radiation are appropriate on the hospice benefit, so you have to take each case and determine what's appropriate for that particular patient."

Unfortunately, the hospice does not receive reimbursement for all of the care it provides, so it does depend on donated funds and grants to sustain the program, Tyler notes.

"We grew from taking 20 to 24 new pediatric patients a year to having 70 new pediatric patients a year, so we're working with about 100 families a year now," Tyler says. "We have had a steadily increasing number of patients that we see each year since we changed our program, and we're very proud of that."

• Design a guide for caregivers. The hospice has a caregiver guide for parents. It explains how children view death according to different age groups, Tyler says.

"Kindergarteners, five and six year olds are very concrete when it comes to death," Tyler says. "So we explain to them in concrete terms what death is about."

For example, it would be a mistake to tell a kindergartener that someone who has died has gone to sleep, because then the child will be afraid each time he or she goes to sleep that he or she won't wake up, Tyler explains.

"Tell them the body stopped working because they'll understand that," Tyler suggests.

The caregiver guide's chart about general concepts of death has age category rows divided by ages 2-5, 5-8, 8-12, and 12-18. After each age category there are three columns with points, and these are common developmental characteristics, grief reactions, and helpful approaches.

For example, under grief reactions for ages 2-5, these items are listed:

- Confusion
- Agitation at night; afraid to go to sleep
- Able to appreciate a profound event has occurred, but may not understand permanence of death
- Seem unaffected
- Repeated questions

Also, under helpful approaches for ages 8-12, these items are listed:

- Answer questions directly and honestly
- Reassurance about the future
- Create times to talk about feelings and questions
- Offer physical outlets
- Reading
- Include in funeral plans and rituals

The caregiver guide also includes sections on patient care, emotional care, reference material and notes. Emotional care includes information on the special needs of siblings and school-age children and helping a child heal, as well as adult grief and relationship to your community.

• Help caregivers/parents cope with other people's expectations. When the hospice patient is a child, the caregivers sometimes have multiple burdens regarding their decisions.

For instance, they have to devote some of their energy to the dying child's siblings, who might feel anger and guilt, thinking they had something to do with their sister's illness because they had sometimes hated her for being a brat, Tyler explains.

Hospice workers can help the family reassure the siblings that they did not cause the sister's illness, and they can help the family recognize signs that the sibling is having problems coping, Tyler says.

Also, hospice staff can assist when the parents are having problems with their extended family.

For example, in one case the parents of a five-

year-old hospice patient decided not to return the child to the hospital, but their extended family was having a hard time understanding their decision, Tyler recalls.

"They chose not to go across the country to seek experimental therapy, but family members couldn't understand why they weren't," Tyler says. "So they felt like they were not supported by their extended family members."

The parents had come to terms with the reality that no matter what they did, their daughter was going to die, so it would be better to make her comfortable and keep the family together, and they were well-educated in their decision, Tyler says.

"So we spent time with the extended family members to try to educate them and help them realize the stress they were putting those parents under," Tyler says. "When all was said and done, people came to terms with it and ended up being supportive to the family."

• Assist with funeral ceremony and aftermath. "Being able to put together a meaningful ceremony is difficult," Tyler says. "Most of these are young families who don't know how to put together a ceremony for a child, and hospice can help with that."

If the child is old enough to understand, then the child can participate in the planning, Tyler notes.

"Most of us forget that children have innate communication with a higher being, and spiritual care coordinators are very good at helping families recognize this," Tyler says.

Tyler recalls one case where a girl had a wisdom and sense of peace that was very apparent, and she could express this to others with a little bit of assistance.

After the child's death, the hospice will follow families for at least two years, recognizing that families need to be followed for a longer period of time after this kind of loss, Tyler says.

"Whenever we can we try to get our bereavement coordinator in to see the family before the child dies and establish that relationship," Tyler says.

"We also follow the family more frequently than we do in the adult model, and we have a number of support groups, including a monthly support group for both parents and siblings," Tyler says.

• Accept neonatal referrals. "We will take neonatal referrals, so we work with families who have been given a diagnosis while the mother is pregnant," Tyler says.

"We had one mother who had a routine prenatal visit and the ultrasound picked up that the baby had a cardiac defect," Tyler says. "It was the most severe heart defect there is, and there was no guarantee that the baby would live without a heart transplant, and the family was against aggressive therapy."

The family decided to continue the pregnancy and bring the baby home if the baby would live for more than a few hours, so hospice staff helped the parents develop a birth plan, including an outline of what they wanted done at the time of birth and how aggressive the therapy would be, Tyler says.

"We're one of the few hospices across the country that will take babies at that point in time, and sometimes they die before birth, but we give the same bereavement support as for any family," Tyler says. ■

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Will HCWs come to work during a disaster?

Barriers differ with SARS, snow storm

If a major disaster struck your community, how many of your employees would show up for work?

A snow storm would likely draw in just about anyone who could make it to the hospital, but in an infectious disease outbreak such as SARS, about half of your employees might be unwilling to work, according to a study published in the *Journal of Urban Health*.[1]

"Different crises present the responder with different challenges and obstacles," and emergency plans need to address that reality, says lead author **Kristine Qureshi**, RN, DNSc, assistant professor of community health nursing at Adelphi University in Garden

City, NY.

Some emergencies will tax employees' ability to report for work, due to childcare or eldercare responsibilities or transportation difficulties, Qureshi notes. In other disasters, some health care workers may simply be unwilling to work due to the perceived risk to themselves or their families, she says.

Qureshi and her colleagues at the Mailman School of Public Health of Columbia University in New York City surveyed 6,428 workers from 47 health care facilities in the greater New York City area. The survey encompassed a variety of acute care hospitals — both teaching and non-teaching facilities, ranging in size from fewer than 200 beds to more than 600 beds. It also included long-term care facilities and community clinics. The findings were consistent for all types and sizes of facilities, the researchers reported.

About half (48.9%) of employees said they would be able to report during a snowstorm, while most expected to be able to report for a mass casualty event (82.5%) or environmental disaster (80.6%). Barriers to reporting for work included transportation (33.4%), childcare (29.1%), eldercare (10.7%) and pet care (7.8%). Many also had health care problems (14.9%) that could affect their ability to report. That might include the need for treatment, such as dialysis, or for medications.

Hospitals should stress the need for personal emergency planning, including backup caregivers and emergency contacts that are updated annually, says co-author **Robyn Gershon**, DrPH, associate professor at the Mailman School of Public Health.

They also should have emergency plans for providing care for employees' family members, she says. For example, a temporary childcare center could be set up, and elderly relatives may be able to help with the care of the children. Hospitals should also consider employees' needs for pet care, she adds.

"People don't want to be separated in a time of disaster. They want to know where their family is," Gershon says.

Willingness to report to work involves different barriers. Less than half of those surveyed said they were willing to work during a SARS outbreak (48.4%). They also were less likely to be willing to work during radiation (57.3%), smallpox (61.1%), or chemical (67.7%) events.

The reason: concern for their family or themselves.

"For those events where employees perceive they are at higher risk of injury to themselves or their family, they are less likely to be willing to report," says Qureshi.

Health care workers must believe that they are going to be safe at work, she says. "In the United States, we normally do not tell people when they're hired in health care that you have an obligation to respond, even if it's going to hurt or kill you."

Health care workers might be worried about being stigmatized during an infectious disease outbreak. During the SARS outbreak in Toronto, some health care workers reported that their children were ostracized as their friends' parents worried they might carry the virus, Gershon says. Nurses also were quarantined during the outbreak, allowed only to go home or to the hospital. They even wore respiratory protection at home when they were around their family.

The survey was conducted shortly after the SARS outbreak.

In some cases, the perception of risk may not reflect the true level of risk, Gershon reports. Hospitals may address perceptions of risk through education, she says. They also can improve trust by providing for adequate personal protective equipment and other worker safety provisions in emergency planning, she says.

Health care workers also were very willing to help out another facility during an emergency (79%), but that willingness depended in part on proximity. For example, only 17.5% said they would be willing to work in another state.

The recent Katrina disaster demonstrated the willingness of health care workers throughout the country to pitch in. Some volunteered for medical support teams that traveled to the Gulf Coast. And in many communities, nurses and other health care workers volunteered to provide medical care and assessments to evacuees.

"Every person that I talk to within the system wants to help," says **Sharon Marsden**, RN, employee health nurse at Seton Medical Center in Austin, TX, where nurses, social workers, and pastoral care staff were able to take time from work to care for evacuees at the Austin convention center. ■

Reference

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Chief nursing officer recounts Katrina efforts

HCWs put patients first in storm

[Editor's note: This e-mail was written by ***Pamela McVey****, RN, CIC, chief nursing officer at Biloxi (MS) Regional Medical Center, to a chief nursing officer in Natchez, MS. McVey was formerly director of infection control/employee health at the hospital. She gave* Hospital Employee Health *permission to reprint this e-mail, and added this postscript: "We all understand that there is no 'getting back to normal.' We are now in the process of redefining what is normal. There is a great spirit here in the coastal counties of Mississippi. We'll be OK."]*

Well, we just got our e-mail up and running. I hope this actually goes through to you. It must have been your prayers that saved us. If you came down here and saw firsthand the death and destruction on the coast from Ocean Springs to Waveland, MS, you would see that there is NO WAY that Biloxi Regional Medical Center should still be standing!!!

All of our staff, to the best of our knowledge, survived the storm as far as no major injury or death. Everyone is blessed to be alive. However, a large percentage of our staff have suffered catastrophic losses of homes and belongings. Many, many, many of us have lost absolutely everything we own, myself included. My home was in an area, in Pass Christian, that is so badly demolished, that the National Guard and EOC [Emergency Operations Center] cannot even get to it yet. Some of my pets were in a kennel in Pass Christian that more than likely no longer exists. Everyone continues to put all of the personal loss behind them and tend to the patients, our first priority. It is only in the silence of a broken heart, when alone for a few minutes, or with a trusted co-worker, that the tears flow briefly. Then it's back to business. I do believe that most of the patients do not know the extent of the loss of the health care workers that are caring for them. And, they shouldn't know it. It should not be their burden.

You just would not believe it here. The city of Biloxi has no water, so we have had no water to run our air conditioners. Of course we have had mid 90-degree weather. Inside, it has to be well over 100 degrees. Of course, this also means that we cannot bathe or flush toilets. Think of 100 degrees, nobody bathing, and no toilets flushing. Can you spell "STINK"? We must constantly watch the staff for heat exhaustion in addition to watching the patients for the same thing. We have had only generator power; so needless to say, in order to conserve the generator power, there were frequent and extended times that the elevators were not working. (We have six floors in our hospital.)

We had been cut off from all outside communication. During the storm, we lost cable, so could not monitor the weather. Our EOC radio did not work, the phones went down, and the cell phones would work very sporadically. Windows in patient rooms started flying in and we had to evacuate the patients out of their rooms and into the hallways. As windows continued to fly in and ceiling tiles were ripped from the ceiling, glass was flying all over. We had to try to nail the doors shut, because after a certain time, the broken windows were trying to suck everything out.

We then had to evacuate the sixth-floor patients to the first floor. We no sooner got 38 patients from Med Surg down to the first floor, when it became apparent that the Gulf of Mexico was in our hospital loading dock, just about ready to lap over into the ER.

Things were flying off of our roof, patient rooms were leaking, not really from the roof, but the force of the wind, close to 145 mph, which was driving the rain straight through our bricks. Water was then seeping down onto the ceiling of the floors below and then that started the whole domino effect of ceiling tiles falling, things getting ruined by water coming through the ceiling, etc.

When the storm ended, we were all still alive. We didn't have any idea of what it looked like outside of our little world.

We finally were able to start getting in touch with corporate and once that happened and they started getting a list of our needs, things got mobilized really fast. I can't say enough about HMA [Corp., owner of the hospital]! They are busting it, trying to get our every need met!

Our sister HMA employees are arriving to help and they are a godsend! Supplies and ice and fuel and clothes and chocolate and our every need is being seen to! You would just bust down and cry if you could see the response from our Mississippi division and all of corporate and our sister hospitals!

Homeland Security is here and there are federal police protecting our ER doors. The National Guard is here, [National Disaster Medical System] is here, and it is overwhelming to see all of this all in and around our beautiful little hospital.

Tonight, for the first time since the storm, we have some air conditioning going. We are not sure how long it will last, but we believe that as we sleep on the floors all over the hospital tonight, we'll get some sleep for the first time. We are running out of food and we do hope that a food truck will reach us tomorrow. It was supposed to have come yesterday and did not make it.

I cannot say enough about the staff of BRMC! Through the entire 12-hour beating, this hospital was, even with moving patients all over to the best area of safety, one step ahead of the storm, and only one of our patients had any anxiety. She was a mom with a potential [pulmonary embolism], with a 4-day-old baby in her arms. That is a tribute to our staff that the patients never panicked because the staff never let on how scared they were. They were calm and confident, professional, and positive.

It has been, and remains, an experience like no other. Yesterday evening, I got my first chance to get out of the building and walk around a little bit. It is 100% totally overwhelming. It smells like death and destruction. It looks like someone dropped a big bomb on us. Almost everything is gone or has been moved to a new location.

Our ER and grounds look like a M.A.S.H. unit. There are injured people everywhere! Our morgue is filling up. There are not enough shelters for the stranded, hungry, thirsty people that are approaching our hospital hourly. We had a young man arrive to our ER and die today with a body temp of 108! We have snakebite victims, people who are already septic with *Vibrio* because of seven-hour swims clinging to trees after having been blown out into the storm.

Our nurses, doctors, techs, therapists, and everyone else has been fantastic throughout! The commitment and dedication to the great responsibility of caring for the patients in our community who have been entrusted to our care and protection has been evident this week. It is an awesome and humbling experience to say that I am their chief nursing officer. With a lesser crew, we would not have survived as long as we have. I can't say that I wish this experience on anyone, but I do know, it is and will continue to be, a life-changing experience. God bless you and thank you for praying for us! ■

JCAHO: Small communities not well prepared

Hospitals should take role in planning

Even before hurricanes Katrina and Rita struck the Gulf Coast, the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, worried that small communities were not doing enough to prepare for a disaster.

In a new report, the Joint Commission details 13 steps that communities should take to be prepared for a disaster. The guide is not just for hospitals, but it offers specific suggestions on the role hospitals can play in broader community planning.

Standing Together: An Emergency Planning Guide for America's Communities stresses the need to collaborate with other community entities, consider all possible hazards, and prepare for surge capacity, communication needs, and sufficient resources. (The guide is available at www.jcaho.org/news+room/press+kits/ems/emergency_planning_guide.htm.

A wake-up call

With Katrina, emergency preparedness made a difference in how well hospitals fared, says **Robert Wise**, MD, vice president of the Joint Commission's Division of Standards and Surveying Methods. But that was no surprise. The Joint Commission has been reviewing the impact of disasters on hospitals since Tropical Storm Allison flooded Houston in 2001 and forced a middle-of-the-night evacuation of Memorial Hermann Hospital, he says.

"If [Katrina] is a wake-up call, there have been a number of wake-up calls along the way," Wise says. "Hopefully, you don't need a hammer in the head to get up in the morning."

If your community is not at risk of hurricanes or earthquakes, there's no reason to feel off the hook, he says. Every community has a range of potential crises, from a major industrial accident to a terrorism attack. "There are

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some real risks associated with just being a city in the United States," Wise says.

Or, as it says in the planning guide, "Challenges abound, but perhaps the most threatening of these challenges is complacency."

Too often in smaller communities, there is no single voice for hospitals and they end up being left out of the local emergency planning committee. Wise advises hospitals to set aside their competitive nature and ensure they have a role in communitywide planning.

The Joint Commission developed the guide in partnership with the Illinois Department of Public Health, the Maryland Institute of Emergency Medical Services Systems, and the National Center for Emergency Preparedness at Columbia University. It also convened two expert roundtable meetings in 2004.

Wise notes these lessons learned from past disasters:

- **Hospitals must be able to stand alone for at least 48 to 72 hours.**
- **Hospitals must take care of the personal needs of their staff.**
- **Maintaining a communications system is crucial.**

Even if you make it on your own, you need contact with the outside world. Hospitals need an emergency communications system, says Wise.

For example, after Sept. 11, New York hospitals developed an 800 MHz phone system that would connect hospitals and the Emergency Operations Center. The closed-circuit system would not be affected by overloading on the public circuit. The phone system worked well during the Northeast blackout in 2003. ■

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