



Management

The monthly update on Emergency Department Management



Georgia hospital hit by F3 tornado — All patients evacuated through the ED

Emergency nurses take lead role in triaging inpatients

IN THIS ISSUE

- **In tornado's wake:** Setting up emergency treatment center in a church 39
- Neighboring hospital takes on evacuated patients 41
- Service can update your web site during a disaster. 41
- OSHA guidance gives valuable tips on disaster planning. 42
- Do you know how much of your staff will report if pandemic strikes? 44
- What's age got to do with patient satisfaction? 45
- **Inserted in this issue:** Annual ED Management Reader Survey

Financial Disclosure:

Author Steve Lewis, Senior Managing Editor Joy Dickinson, and Associate Publisher Coles McKagen report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Executive Editor James J. Augustine discloses he is a consultant for The Abaris Group and conducts research for Ferno Washington. Diana S. Contino, Nurse Planner, discloses that she performs consulting for hospitals.

Most ED managers are prepared to respond to a disaster in their communities, but what do you do when your hospital *is* the disaster? An F3 tornado struck Americus, GA, after 9 p.m. on March 1, 2007, and Sumter Regional Hospital was directly in the path of harm.

The ED staff had been warned of the tornado, says **Schelly Murray**, RN, BSN, nurse manager and ED clinical coordinator. "They were getting ready to transfer a patient, and a pastor said, 'You might not want to do that. [A tornado] has touched down.' Four minutes later, it hit," she says.

Charlie Robertson, paramedic, was in the ED. "All the doors were flopping, and the windows broke out," he recalls. Eventually, the two main doors to the ED broke off. "Pine straw from the flower bed blew through the ED." It was 1½ minutes of chaos, he says. "People were screaming and hollering," Robertson recalls.

Murray was at home when the tornado struck. She immediately left to run three-fourths of a mile to get to the hospital. "I was climbing through power lines to get in to the hospital," she says.

The area surrounding the hospital had been devastated, and two people died in a residence directly behind one of the hospital buildings. Because of the warning, all patients, including those in the ED, had been moved to interior hallways and away from windows, Murray says. There were few serious injuries among patients, visitors, or staff.

There was debris in the ED, including branches, dirt, grass, and leaves, and

Executive Summary

When an F3 tornado severely damaged a hospital in Americus, GA, all patients had to be evacuated through the emergency department.

- Fifty-three patients were evacuated by area ambulances and a school bus to other hospitals in the region.
- The hospital advises others to have an internal evacuation plan as well as two-way radios, a megaphone to direct staff and volunteers, and additional security.
- A temporary treatment area was set up at a local church.

APRIL 2007

VOL. 19, NO. 4 • (pages 37-48)

NOW AVAILABLE ON-LINE! www.ahcmedia.com/online.html
For more information, call toll-free (800) 688-2421.

patients were everywhere in the hall. Because of its location, which is mostly below ground level, the ED suffered only cosmetic damage. However, the building was not structurally sound. The hospital had one side that was collapsing; additionally, it had lost part of the roof, had many windows blown out, and was flooding. Seventy-five cars in the parking lot were toppled on top of each other.

ED Management® (ISSN 1044-9167) is published monthly by AHC Media LLC, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA. POSTMASTER: Send address changes to **ED Management**®, P.O. Box 740059, Atlanta, GA 30374-9815.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 9 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 12.5 Contact Hours.

This program has been approved by the American Association of Critical Care Nurses (AACN) for 12.5 Contact Hours, Category), file number 10852.

AHC Media LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media LLC designates this educational activity for a maximum of 15 *AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Approved by the American College of Emergency Physicians for 18 hours of ACEP Category 1 credit.

This activity is intended for emergency physicians, ED nurses, and other clinicians. It is in effect for 24 months from the date of the publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291

(customerservice@ahcmedia.com). **Hours of operation:** 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST. Subscription rates: U.S.A., one year (12 issues), \$489. Add \$9.95 for shipping & handling. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are \$82 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media, LLC. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421, ext. 5491. Fax: (800) 284-3291. World Wide Web: <http://www.ahcmedia.com>.

Editor: Steve Lewis (steve@wordmaninc.com).

Senior Vice President/Group Publisher:

Brenda Mooney, (404) 262-5403,
(brenda.mooney@ahcmedia.com).

Associate Publisher: Coles McKagen,
(404) 262-5420, (coles.mckagen@ahcmedia.com).

Senior Managing Editor: Joy Daughtery Dickinson,
(229) 551-9195, (joy.dickinson@ahcmedia.com).

Senior Production Editor: Nancy McCreary.

Editorial Questions

For questions or comments,
call Joy Daughtery
Dickinson,
(229) 551-9195.

Copyright © 2007 by AHC Media LLC. **ED Management**® is a registered trademark of AHC Media LLC. The trademark **ED Management**® is used herein under license. All rights reserved.



The hospital declared a Level 3 disaster and was evacuated. It was decided that two ED nurses would triage patients from the entire hospital. Murray had the role of evacuator.

Triage was relocated a couple of times as the building became increasingly unstable. Ultimately triage ended up being conducted in the OR hallway with patients moving out through the ED. Despite the precarious state of the building, staff members were calm and comforted patients, says **Susie Fussell**, BSN, RNC, vice president of nursing at Sumter Regional Hospital in Americus, GA. "We were in ankle-deep water, with water pouring over our heads and down stairwells, Fussell says. In the middle of those dismal circumstances, staff members were carrying inpatients down stairwells on mattresses into the ED, she says. "Everybody was all business."

One immediate problem in the ED was that gases were leaking and needed to be cut off. A house supervisor already had assessed that no ventilators were available, and she had deployed portable oxygen tanks.

Members of the fire department and emergency medical services were able to assist, and they joined all available hospital staff in moving patients, with the critical care patients being brought down first. There were few serious injuries inside the facility from the tornado. However, five inpatients fresh out of surgery on the third floor were a particular concern. Those patients needed pain medications after they were moved to triage. Amazingly, the pharmacy operated during the evacuation. The staff used an old-fashioned "runner" system and had staff go to the pharmacy to obtain medications, Fussell says.

Murray had all patients lined up in single file in this order:

- critical care unit patients;
- post-op patients;
- a patient in labor;
- general med-surg patients;
- psychiatric patients. All of the psychiatric patients were stable and ambulatory, Murray says.

In the midst of the evacuation, the ED staff stabilized five patients having symptoms of heart attacks and one gunshot wound. "Emergencies continue, regardless of your conditions," Murray says. Also, one employee went into false labor, she says. "You have to be able to triage your own employees," Murray says.

Getting patients out the door

Murray was familiar with area hospitals, so she served as the destination coordinator for individual patients, based on their diagnoses and acuity. The most critical patients were sent to the largest hospital in the

area. (See story, p. 41.) A small nearby hospital with one floor unit received stable nursing home patients.

Because Sumter Regional had not fully implemented an electronic system, staff members were able to send each patient's full record with them when they evacuated.

Many staff and area physicians showed up, with their identification badges on, to assist. "We had to know who was in there," Fussell says. Each patient had a nurse at his or her side, and many had a physician there as well.

As each patient reached Murray, she yelled, "What's wrong?" "I didn't want to know their history," she says. "I wanted to know the immediate problem."

At least two staff members stood outside the door where patients were being evacuated at all times, and they verified armbands, patients' names, their chief diagnoses, and where they were going. "People were going to get away from you, so we always had two or three people keeping that list," she says. Because power was out, that information was recorded manually with pen and paper.

Two of the ambulances at the hospital were damaged by the tornado, although one of those was usable. Area ambulances responded, as well as a school bus for ambulatory patients, and 53 patients were evacuated to area hospitals. The evacuation took about three hours.

Here's what they learned

As in any disaster, there were lessons to share. One is to be prepared for the unthinkable — that your facility will be hit by a disaster — by developing an internal evacuation plan, Murray advises.

Another lesson involves the internal wireless phones and cell phones. They were working initially, but most eventually were unusable, Fussell says. "Two-way radios would have been most useful," she says. Also, have backup batteries on hand for the radios, sources suggest. Additionally, Murray had difficulty supervising the triage and patient flow because she was constantly bombarded with questions. "There was so much help on top of me, it was difficult to organize," she says.

Additionally, Murray struggled to make her voice heard and to get people's attention above the noise and chaos, she says. "That was one of the biggest obstacles. We needed a megaphone," Murray says.

The hospital could have used additional security, Fussell says. "Everyone wanted to help and was coming in to help," she says. Murray was faced with directing patients *and* volunteers. "Eventually, we put volunteers in a waiting room and told them to await instructions," she says.

When she requested help from the police, Murray learned they were shorthanded trying to keep roads clear and manage traffic. The police requested backup from the Department of Natural Resources (DNR), which sent a game warden. "He stood behind me to keep people away from me," Murray says. The game warden, who was more than 6 feet tall, repeated Murray's instructions over her head when she couldn't be heard.

After the evacuation was complete, approximately six men from the DNR performed a final check of every room on every floor to ensure no one was left behind. (For more information on evacuations, see these *ED Management* stories: "When disaster strikes: Treating patients when your department shuts down," October 2004, p. 109; and "Warning: Are you prepared to evacuate your ED after a natural disaster?" October 2001, p. 110.)

Next on the agenda was the establishment of a treatment area in the town. Someone suggested First Baptist Church, which already was being set up as a Red Cross shelter. "I called the pastor, and he said, 'You can have my church,'" Murray says. (See story, below.)

In hindsight, the hospital staff responded wonderfully to the disaster, Fussell says. Even though the hospital had never drilled for an internal disaster, all the members of the staff knew their role, sources say. Previous disaster drills were a significant help, they say. Murray says, "They gave us a game plan on how to evacuate internally, because they were about handling massive amounts of patients."

Fussell agrees. "They might have not done it just by the book, but they knew someone had to track every patient as they were transferred, and they knew all hands had to be on deck to evacuate," she says. "We practice and we practice all the time, I'm telling you. When you get so panicked and in the midst of chaos, it takes that practice, because it becomes what you do instinctively." (Editor's note: To see photos of the tornado damage, go to www.sumterregional.org and click on the hyperlink for the disaster photos.) ■

How to set up emergency treatment area at a church

When patients were evacuated from Sumter Regional Hospital in Americus, GA, after an F3 tornado hit on March 1, 2007, a temporary treatment center was set up next to the shelter area inside the town's First Baptist Church.

Much of the ED's equipment was salvageable, even

though there was water on the floor, says **Schelly Murray**, RN, BSN, nurse manager and ER clinical coordinator. After all of the patients were evacuated from the badly damaged hospital, Murray moved two \$15,000 pieces of equipment that recently had been purchased: a glide scope and an ultrasound machine. Other equipment that wasn't needed immediately was moved to a large warehouse that the hospital recently had purchased, Murray says.

The temporary treatment center was set up primarily by **Betsy Jordan**, RN, CEN, clinical analyst in the Clinical Informatics Department at Phoebe Putney Memorial Hospital in Albany, GA. Jordan, who is married to a paramedic at Sumter Regional and knew Murray, had worked in the ED at Phoebe Putney for 12 years and was a former flight nurse. While the Sumter ED staff were evacuating patients and meeting, Jordan loaded supplies into her car and the car of a soldier who had showed up to help.

Lifesaving equipment, including crash carts, was transported. Murray says, "We emptied the ER completely of supplies." Many of the linens had been used to transport patients to the ED for triage, but they were replenished by area hospitals, a nursing home in Americus, and the Red Cross. An EKG machine was transported from the ED in a staff member's car.

Setting up in the social hall

At First Baptist, Jordan unloaded the supplies in the dark as large spotlights were set up. The treatment area was set up on about one-half of the first floor of the church building.

The treatment center included a treatment room (normally a chapel and social hall) that contained a triage area, cots provided by the church, a physician examination area, and a treatment area. A pharmacy was located in a small kitchen area of that room that includes a sink, refrigerator, and cupboards. Adjacent Sunday school rooms were designated as a resuscitation unit; an obstetrics room, with fetal monitors, for emergency deliveries if needed; and a room stocked with emergency supplies and equipment. Pieces of paper labeled different areas of supplies, such as suction, respiratory, gloves, and orthopedics.

Two entrances were set up: one for emergency medical services (EMS) and one for ambulatory patients. The greeting process was established with two nurses placed at each of two triage tables. As more nurses showed up, Jordan asked them about their jobs, credentials, and experience. Nurses who knew first aid were assigned to the treatment area.

After the evacuation, Murray salvaged her computer, policies, and data, including contact information for

staff. "Policies are supposed to be on the network, but I'm not sure it's salvageable," she said.

About 500 hard copies of a one-page form were used for treatment center medical records. That form has been used previously when the hospital was out of power or had managed multiple victim incidents. Having the 500 copies proved valuable as there was no copy machine available at the church, Murray says.

Jordan says the form worked well. "It may not meet [requirements of The Joint Commission] with every 'I' dotted and every 'T' crossed, but it statistically tracked patients, or could be used if family members were looking for loved ones."

For the walking wounded, the original forms were kept at the treatment center. For patients who were moved to area hospitals, nurses wrote a general summary of the patient on another sheet of paper and sent the original paper with the patient. "We had a trail of the patient," Jordan says. Accepting hospitals were notified of what patients were coming with which conditions.

Any infection control concerns?

Because the treatment center was set up in an area of the church that was used regularly, it was fairly clean with no dirt or dust on the walls or floors.

To prepare for patients coming in, Jordan put trash cans with red bags in each treatment area. "I decided people might be bloody," she says. She also set up sharps disposal areas. Jordan put waterless antiseptic agents on all tables. Gloves of all sizes were placed at every station.

Dirty linens were sent to an area hospital for cleaning.

What made it work well?

Help came from near and far away. First Baptist set up phones for the hospital to use. Orthopedic supplies were donated by a doctor's office in a nearby town.

Some paramedics from Medical College of Georgia Hospital in Augusta made repeated runs to the hospital to retrieve ED equipment and medications, including wheelchairs, stretchers, and tetanus. The night of the tornado, before the pharmacy was established at First Baptist, CVS brought a mobile pharmacy and was able to provide medications.

Within the first three days of the tornado, the center treated about 50 patients.

One of the critical elements for making the treatment area work well was communication, Jordan says. As nurses showed up, Jordan gave them a walking tour and oriented them to the process. "Communication needed to be clear in order to deliver efficient care,"

Resource

For information on temporary treatment tents and other disaster mitigation products, contact:

- **EMS Innovations**, P.O. Box 239, Pasadena, MD, 21123-0239. Phone: (888) 236-1267.

Jordan says. “Otherwise, there would be more chaos.”

The EMS command set up in the hallway at the back door of the building, where ambulances arrived, and just outside the treatment area. Jordan suggested putting a nurse there as well who would know what was happening in the treatment area. That nurse made a list of facilities accepting patients and was able to have them designate one contact person at each. “They knew our situation and our process,” Jordan says. “We knew if they could take none or three patients.”

Another lesson shared for hospitals faced with relocating is to act quickly and decisively, emphasizes Jordan, who felt led to take this role. “Don’t stand around and ask for direction,” she says. “We were working at 4 a.m., and by 6 a.m., we had patients rolling in. And we had a process in place.”

Within a few days, Sumter Regional opened a temporary tent ED across the street from the hospital building. (See **contact information in resource box, above.**) The three tents, which are intended to be used for two weeks, house a 50-bed unit. Patients can stay in the unit for 23 hours for stabilization and corrections of problems such as breathing difficulties. The buildings are sealed, so they can be heated and cooled.

There was a hard surface building being delivered for the ED to move into, but at press time, it wasn’t certain when that ED would be established, Murray says. ■

Nearby hospital accepted evacuated patients

After an F3 tornado severely damaged Sumter Regional Hospital in Americus, GA, and led to an evacuation of all patients, Phoebe Putney Memorial Hospital in Albany, GA, was designated as one of the accepting hospitals. During the evacuation, Phoebe Putney accepted 45 patients, which included inpatients and emergency patients from Sumter Regional.

When Sumter Regional announced the evacuation, Phoebe Putney implemented its disaster plan, according to **Todd Braswell**, RN, BSN, MS, CEN, director of the Emergency Center at Phoebe Putney. “We began

looking at our census to determine who could be transferred and what beds were available,” he says. A few patients were discharged from the ED, he says. Inpatient areas were asked to perform an assessment and determine what staff could assist in the ED.

From the time Phoebe Putney was notified, it was two hours before the first patient arrived from Americus, which is about 60 minutes away. Sumter Regional notified Phoebe Putney of what type of patients were being sent. EMS brought patients who were on stretchers through the ED, Braswell says. “We had a ready bed waiting for every inpatient transfer,” he says. “It made tending to emergencies easier.”

A bus brought a large group of ambulatory patients, he says. They were triaged in the EMS dock intake area, Braswell says. “We would route them to the appropriate areas: inpatient, ER, or the admit/discharge unit [ADU] for the walking wounded,” he says. Normally, the ADU functions Monday through Friday as a holding unit. The night of the tornado, it was staffed with nurses from the inpatient areas and the Emergency Center, plus a physician who responded to the call for help.

Each inpatient was assigned to an inpatient physician. “It was fairly seamless,” Braswell says.

The night was not without challenges, however. In setting up the command center, staff callback was a problem, Braswell says. “Due to the weather in Albany, it was dangerous for some to come in,” he says. “But we decided to handle it with the staff in-house. Forty-five is not an overwhelming number.” ■

Hospital used service to update web site

When Sumter Regional Hospital in Americus, GA, was severely damaged by an F3 tornado, one thing administrators didn’t have to worry about was keeping their web page updated with disaster information.

The hospital already had a contract with FastHealth Corp. in Tuscaloosa, AL, a digital disaster management company, to provide a web-based disaster response system, called FastConnect, if ever needed. Ironically, FastHealth representatives had visited Sumter officials the week before the tornado and discussed preparing for a tornado to hit the hospital. Hospital officials contacted FastHealth within a couple of hours after the tornado. Sumter Regional was unable to update the web site because they had lost their communication ability. Within 10 minutes of the call, FastHealth had information about the tornado on the web site.

“We help hospitals with logistics and communication

Executive Summary

As the new guidance from the Occupational Safety and Health Administration (OSHA) points out, there are practical steps you can take to protect your staff and to prepare for the inevitable increased absenteeism should a pandemic occur.

- Cross-train staff in three or four functions so they can fill in for others if needed.
- Encourage employees who are sick to stay home, to reduce the likelihood of spreading disease and to combat employees coming to work when they are not at their best.
- By reassuring staff they will be safe if they report to work, you can keep attendance numbers as high as possible.

during a disaster,” says **Kevin A. Foote**, CEO of FastHealth. Working with the hospital’s public information office, the company posted information about the tornado, along with photos, on the web site. FastHealth followed up with information for employees about what to do about coming to work.

“Some people don’t have access to get to the hospital,” Foote says. “They might be able to log in to get information about what they should be doing.”

Also, people who visited the site were given an opportunity to donate to a disaster relief fund for the hospital, staff, and community. Charlotte Regional Medical Center in Punta Gorda, FL, used FastHealth after Hurricane Charley in 2004 and raised just over \$100,000 through its web site, according to **Danielle Dreher**, spokeswoman.

Hospitals pay FastHealth approximately \$7,000 as a setup fee, depending on their size, and they pay \$750 a month to have disaster services available. The company also provides a nurse answer service.

Preparedness mandates from The Joint Commission require an emergency communications system. “There’s nothing better than the Internet,” Foote says. “You can access it from a laptop or with satellite communication.” The web is the future tool for disaster communication, Foote says. “A disaster may have just happened, but the whole world can access and get a status update.” ■

OSHA pandemic guidance reinforces need to plan

Guidance serves as valuable reminder for ED

Newly published guidance from the Occupational Safety and Health Administration (OSHA) on preparation for the possibly debilitating effects of an influenza pandemic serves as a valuable reminder to ED managers of just how vulnerable their departments could be during such an event.

Despite the fact that this is “only” a guidance, it should nevertheless be taken seriously by ED managers, experts say. “Unlike other OSHA documents, it’s not regulatory,” notes **Betsy Hackman**, RN, CIC, director of infection control for Emory Healthcare in Atlanta. “It’s telling us what we *need* to do in the face of a pandemic.”

James J. Augustine, MD FACEP, director of clinical operations at Emergency Medicine Physicians, an emergency physician partnership group based in Canton, OH, says, “This is a good step by the federal government — an attempt to give guidance on what it considers good hygiene practices and preventive

measures for health care employees.”

Such a guidance is a good idea, Augustine says, “because oftentimes [OSHA] gets to see and identify best practices in a way no one else can do, to find out what does and doesn’t work effectively, and then allow us to deal with the bigger issue: keeping employees safe.”

EDs are one of the “prime targets” of the guidance, says **Peter Kelly**, JD, a partner in the Chicago-based law firm Vedder Price, which has created a pandemic preparedness task force to help clients address pandemic-related legal issues. EDs “are in the hierarchy of organizations that are at very high exposure risk because they will be exposed to those infected,” Kelly says. On other hand, because EDs recognize this status, many already use protective equipment in terms of masks, globes, shields, and so forth, “so much of what is noted by the guidance is already in use,” he says.

The guidance, however, does go farther than recommending the equipment to be provided; it also says it should be properly fitted and periodically refitted; properly and consistently worn, maintained, and replaced; and properly removed and disposed of.

Addressing absenteeism

Kelly and Augustine agree that the areas of the guidance of greatest value to the ED manager are probably those that deal with absenteeism. “There are a number of issues that have to be planned for,” notes Kelly. “For example, many are predicting that in a pandemic, the [health care] employer may lose 40%-50% of their work force.”

Cross-training is one strategy recommended by the guidance that could help offset this loss of staff, Kelly says. “The guidance says that each task should be

understood and able to be performed by three or four different employees to account for absenteeism,” he notes.

Absenteeism, he adds, may not only arise as a result of workers who are infected, but also as a result of workers who have family members who are infected. “It’s important that management have policies and plans that encourage infected employees to stay home and not come to work,” says Kelly.

Augustine agrees. “You should definitely encourage [sick] staff to stay at home,” he says. This guidance not only involves absenteeism, but a concept that may not be familiar to all ED managers, called “presenteeism” — employees coming to work when they are not at their best, he says.

“If people feel they have to come to work to get paid, to be thought of as a team player, or in order not to lose their job, they might bring disease to the worksite,” he explains. To avoid presenteeism, “you need to establish an illness program that allows them to call in sick and not be penalized,” he says. Typically, such policies are hospitalwide, Augustine says. If your facility does not already have such a policy in place, lobby for one, he advises.

Finally, notes Augustine, absenteeism will be greater if employees are unsure they will be safe at work. “ED managers must think ahead about the feelings of employees when they come to work,” he says. “This is a critical piece.”

Augustine notes that in 2001, when workers in several facilities had to deal with the reality and/or threat of anthrax, smallpox, and severe acute respiratory syndrome (SARS), “We realized what a huge amount of stress there is on an employee, and that if you do not make them feel safe, they are not going to come to work,” he says. “It’s really important to look ahead, to decide to educate our employees, and do what is necessary to reinforce their confidence in the worksite.” **(For more on assessing and addressing employee attitudes about working during a pandemic, see story, p. 44.)**

Liability limited

Because the guidance itself is not mandatory, and there are no specific requirements that would apply, there is no direct potential liability linked to it, says Kelly.

“On the other hand, OSHA *does* have a ‘general duty clause,’ that contains a generic requirement to maintain a workplace that is free of hazards that could expose employees to serious injury or fatality,” he says. “I could possibly foresee a situation where a particular employer or manager could act in such a way as to completely disregard the risks associated with pandemic — like requiring sick employees to come in — thereby exposing

others to a potentially fatal illness, or failing to have common-sense quantities of sanitizers, gloves, and so forth.”

While such an event seems unlikely, Augustine says the ED manager should remain on top of infection control procedures. “For EDs, we need to think about the patients who will be coming in ahead of time,” he says. “Good ED managers have established respiratory programs that involve, for example, having Kleenex, alcohol-based hand washes, and instructions available at the ED entrance.” Universal respiratory etiquette, which involves practices such as coughing into one’s elbow and asking family members who are ill not to come into the ED, is followed, he says.

ED managers also should seek to increase use of masks, says Augustine. “We have gotten very, very, very generous recently about putting masks on patients,” he notes. “This is a fabulous addition to the ED armament, because we will then not be infesting the room with patients’ germs.” It’s more than OK to ask people with respiratory illness to cover their mouths, wear masks, and take similar precautions, Augustine adds.

“The bottom line for ED manager is to reinforce day-to-day use of personal protective equipment and infection control procedures so when the next outbreak of disease occurs, the staff will face it with the knowledge that the hospital and their manager will be taking care of them,” he says.

Prepare well in advance, he concludes. “If you wait until an outbreak, you will not have a ghost of a chance,” Augustine warns.

Kelly echoes his concerns. “I think it’s important for an ED manager to read this guidance, to assess the

Sources/Resource

For more information on the new guidance on pandemic preparedness, contact:

- **James J. Augustine**, MD, FACEP, Director of Clinical Operations, Emergency Medicine Physicians, 4535 Dressler Road, Canton, OH 44718. Phone: (330) 493-4443. E-mail: JAugustine@emp.com.
- **Betsy Hackman**, RN, CIC, Director of Infection Control, Emory Healthcare, Atlanta. Phone: (404) 778-7777.
- **Peter Kelly**, JD, Partner, Vedder Price, Chicago. Phone: (312) 609-7875.

To read the entire Occupational Safety and Health Administration report “Guidance on Preparing Workplaces for an Influenza Pandemic,” issued February 2007, go to www.osha.gov/Publications/OSHA3327pandemic.pdf.

potential for a pandemic to adversely affect his department, to do some planning and training, anticipate situations, and think about what policies should be applied in their ED,” he says.

Finally, work within the framework of your facility’s overall emergency preparedness plan, Hackman says. “It would be difficult for an ED manager to go off on their very own and do all the things OSHA says to do,” she observes. ■

If pandemic strikes, how much staff will you have?

Project availability, plan for homebound staff

Do you know the main reasons your staff would be reluctant to report to work during a pandemic? Do you know how many of your staff will come to work if a pandemic strikes your community?

No one knows for sure, but a recent survey indicates that conflicting duties (i.e., multiple jobs, family responsibilities) or concern for personal safety could lead to an even lower response than might be anticipated. According to a recent survey, hypothetical response to an epidemic ranged from 80% of health care workers for a mild disease with treatment to 18% for a potentially fatal disease with only experimental treatment.¹

To get a better handle on what to expect, **Colleen Connelly**, RN, BSN, emergency preparedness manager at the University of Utah Hospital in Salt Lake City, surveyed the entire hospital staff. The online survey included questions such as what the respondent’s role was; if they felt they were really informed about avian and pandemic influenza; if they’d be willing to come to work in the event a pandemic occurred; and if not, why not. In addition, they were asked what the hospital could

Executive Summary

A survey of your staff can give you insight into the reasons why they would not come to work during a pandemic and point to new strategies that might encourage them to come to work.

- Ask them to prioritize their reasons for staying home, ranking them from one to 10.
- Keep the responses anonymous, which will encourage your staff to respond to the questions honestly.
- Make it possible for staff members who opt to stay home to still work by manning the call-in center.

do to convince them to come to work if they didn’t want to.

“We conducted the survey as part of one of our hospital disaster drills — one of the deliverables,” Connelly explains. “The hospital medical director sent it to all department medical directors for distribution, and the pandemic flu panning committee pushed it as well.”

What really matters

Connelly’s survey indicated 64.5% of employees would report to work during a pandemic. However, her goal was not so much to come up with a number indicating how many of the staff would report, but rather to assess their concerns and address them, in order to secure an optimal number during a pandemic.

“In the initial phase, as we went around and talked to people, we got everything from elder care and child care to pet care, so in the actual survey we asked staff to list their needs from one to 10, with one being the most important,” she notes.

The survey, which was distributed July 19, 2006, was left open for two months. The responses were anonymous. “We felt that was important, so staff could answer honestly,” says Connelly.

Because of the anonymity, it was not possible to break out numbers for a specific department, such as the ED. However, says Connelly, based on the responses, changes will be made that should benefit all departments. “The main message we got from the staff was, ‘Keep me safe at work, and help me take care of my family,’” says Connelly, “And we have used that to try think of alternative ways to respond to a pandemic.”

First, she says, the hospital will set up a little store on-site so that people can visit it after their shift and pick up food and other necessities. “This is modeled after what they did in Toronto following the SARS epidemic,” she explains. “It might be hard to find things like this out in the world.”

Single parents, whose kids would be at home since schools will be closed, or staff with immunosuppression who are unable to report to work, will be used to help operate the call-in center from home.

Additionally, “We’re also spending a lot of resources for personal protective equipment such as Positive Air Pressure Respirators for all those staff taking care of patients,” says Connelly.

There also was one message that came out of the survey that should be of particular interest to ED managers, Connelly adds. “The request for education was really significant overall in the hospital, so from the ED perspective, education and updates on the progress of avian flu, when they need to be worried and when

Sources

For more information on using surveys as part of pandemic preparedness, contact:

- **Colleen Connelly**, RN, BSN, Emergency Preparedness Manager, University of Utah Hospital, Salt Lake City. Phone: (801) 585-3134. E-mail: colleen.connelly@hsc.utah.edu.
- **Betsy Hackman**, RN, CIC, Director of Infection Control, Emory Healthcare, Atlanta, GA. Phone: (404) 686-2358.

they don't, is critical," she says. "It's particularly difficult for ED staff, because every patient who comes in during the winter has flulike symptoms — so that knowledge is critical."

Might an ED manager conduct a similar survey targeted just to ED staff? "I think it's a great planning tool," says Connelly. "Each of our facilities and departments are a little different, and you hate to put all these resources into planning if you are not planning for the right thing."

Age can make a difference in patient satisfaction

Lower, higher expectations depend on patient age

Every patient in your ED may receive the same level of care and attention, but that doesn't mean they will all perceive that care and attention with the same level of appreciation, according to a new patient satisfaction survey by South Bend, IN-based Press Ganey Associates.

Press Ganey's 2007 Healthcare Satisfaction Report showed, for example, that younger patients are generally much harder to please. More specifically, it found:

- Patients between 18 and 34 were the most displeased, with only 76% saying they were satisfied with their experience.
- The 35-49 age group was the second least satisfied in the ED, with a rate of 82.7%.
- The highest satisfaction level, 87.6%, was reported among those 56 to 79.

These findings make a great deal of sense to **Wanda Della-Calce**, RN, director of emergency services at North Mississippi Medical Center in Tupelo. "The 18-year-olds have grown up with computers, cell phones, and so forth, so they are not used to waiting; they have different expectations," she notes. "They will be harder

It's important to ask your staff what they think, she continues. "If you include them in the [planning] process, you will get a lot more buy-in," Connelly advises.

Betsy Hackman, RN, CIC, director of infection control for Emory Healthcare in Atlanta, agrees. Her own models indicated 40% of her staff would not show up during a pandemic, so she has purchased Tamiflu (Hoffman-La Roche; Nutley, NJ) for staff members who are considered appropriate. "The ED is certainly in line for that," says Hackman.

To help offset the staffing shortage, Hackman says she also plans to institute remote triage centers outside the hospital. "In those centers we would have a combination of nurses and doctors from Emory who could do triage to tell the patients whether they should go to our ED or not, depending on how sick they were," she explains. "They will probably be located a little bit way away from the hospital; could be in [Emory] clinics or drive-thrus."

Reference

1. Syrett JI, Benitez JG, Livingston WH III, et al. Will emergency healthcare providers respond to mass casualty incidents? *Prehospital Disaster Medicine* 2007 (in press). ■

to satisfy because they want quick, fast service, and will not understand why they have to sit in the lobby four or five hours."

As for those in the 35-49 range, says Della-Calce, they are well informed, because they tend to look up their diagnoses on the Internet before arrival. "They, too, have higher expectations and will not like it if you are not on top of your game," she says.

Older patients, on the other hand, often find companionship and compassion in the ED that they do not have at home, she continues. "A lot times when we do patient callbacks, they enjoy and appreciate the fact that someone is checking on them," she says.

Matt Mulherin, a spokesman for Press Ganey, says

Executive Summary

A survey demonstrates that not all patients will perceive the care they receive in the same manner. Learning facts like these about your customers will help you improve your patient satisfaction efforts.

- Young adult patients are the least likely to be satisfied and do not understand the necessity of long waits.
- Building loyalty with younger patients can pay dividends for years to come.
- Breaking down satisfaction survey data into subpopulations can help point out the areas in which you need to improve.

this trend of expectations determined by age has been fairly consistent over the past few years. “Typically, the younger patients have higher expectations and lower satisfaction,” he says. “It reflects an emerging perspective of consumers of health care.”

Part of the reason, Mullherin notes, is that many people are investing more of their own money in their health care through vehicles such as health savings accounts. “That makes someone like me have higher expectations,” he says.

Data such as this can be valuable to an ED manager, Mulherin continues. “Patients in the younger age groups are not only less satisfied and potentially less loyal, but they will also be your prime consumers in the next 20 or 30 years, so it’s more essentially important to build loyalty among them,” he says.

This type of data “lets folks know where you might have the greatest opportunity to improve patient satisfaction,” Mulherin says. In fact, he adds, with patients who subscribe to Press Ganey services, he sees a significant number of managers breaking down their statistics demographically. “We have an online tool that lets them set up as many as 200 users who can then break out the data into the areas they want to study,” he says. “It could be a nurse manager, a shift supervisor, and so forth.”

When they identify a drop in their overall patient satisfaction score, they typically will break it out by demographics to see what could be causing the problem, Mulherin says. “If I’m the ED director, and I see we have a dip in our scores, I want to get to the bottom of it.”

Adjust your care?

Identifying these groups is one thing, says Della-Calce; treating them differently is a bit more complicated.

“I think you have to look at your all processes and the populations you are serving,” she says. “You try not to differentiate, [but instead] to treat the same patient the same way every time.”

However, when pressed about whether it might be advisable, for example, to take a little extra time explaining to a younger patient why the wait was so long, Della-Calce conceded there might be a place for such an adjustment. “I think [demographic data] is one more tool in your toolbox,” she says. “The culture here is patient- and family-centered, with quality care for everybody, but knowing how to address different

Sources

For more information on analyzing patient satisfaction surveys, contact:

- **Wanda Della-Calce**, RN, Director of Emergency Services, North Mississippi Medical Center, Tupelo, MS. Phone: (662) 377-4164.
- **Matt Mulherin**, Press Ganey Associates, 404 Columbia Place, South Bend, IN 46601. Phone: (800) 232-3485.

patients gives you one more way of doing that.”

It’s important to know your audience, know their expectations, communicate clearly, know what they are expecting of you and how to address those expectations, Della-Calce says.

Mulherin says there can be a place for using such departmental data, “but it really depends on what your data says.” In other words, he continues, such surveys can be used to show you where you will get your biggest return on investment in patient satisfaction. Mulherin calls that a “priority index.” “So if, for example, your patients who are between the ages of 35 and 49 are not as satisfied as some other groups of patients, while you would not want to roll out a program just for them, you might look to provide them with a lot of information about their care, how long it will take to see a doctor, and so forth.”

However, you should never lose sight of the basic principles of patient satisfaction, he says. “All patients want the same kinds of things,” he says. “Some may just want *more* of it.”

So if your data show a certain group of patients is less satisfied, “you could definitely give your staff a special heads-up, but make sure they adhere to the same principles,” Mulherin concludes. ■

University of Chicago offers preparedness master’s

The Graham School of The University of Chicago has introduced a master’s of science in threat and response management program, an interdisciplinary

COMING IN FUTURE MONTHS

■ 13 ED docs quit over compensation issues — What’s a manager to do?

■ EDs test chest pain patients differently based on demographics

■ EDs can play a major role in Rapid Response Teams

■ Patient revisits hospital as a bogus ED worker

course of study in emergency preparedness. The program provides students with education in understanding and managing all aspects of a major public health hazard — such as natural disasters, disease outbreaks, and man-made threats — from preparation through response and recovery.

The university considers all professionals responsible for preserving and protecting the public's health and safety, including medicine and public health, as appropriate candidates for the program,

The program is designed as a two-year curriculum, and it is taught by a faculty comprised of leaders in the threat-management field, many of whom have been involved directly in the planning for or responding to major hazards affecting public safety.

For additional information, visit the program's web site at grahamschool.uchicago.edu/mstrm, or contact Marsha Hawk, administrative director for the program, at (773) 702-0460 or via e-mail at MSTRM@uchicago.edu. ■

Knowledge can aid in call negotiations

What specialists want for ED call

A growing number of specialists are negotiating hard for payment for taking ED calls. If you're involved in such negotiations, it helps to know what the other "side" is looking for.

In the August 2006 edition of *MGMA Connection*, **Hobart Collins**, CMPE, principal with Englewood, CO-based MGMA Health Care Consulting Group, notes that "given human nature, the specialist probably wants as much money as he or she can get, and the hospital probably wants to pay as little as possible; this is a typical starting point in negotiating price."

He goes on to outline specific goals for payment arrangements for specialists who take ED calls. Those arrangements, Collins notes, should:

CE/CME objectives

1. **Apply** new information about various approaches to ED management.
2. **Discuss** how developments in the regulatory arena apply to the ED setting.
3. **Implement** managerial procedures suggested by your peers in the publication. ■

- satisfy legal and regulatory considerations;
- be fair for both parties — defined as an acceptable compromise;
- be objective — based on concrete and measurable criteria;
- be manageable;

CE/CME questions

1. According to Schelly Murray, RN, BSN, her experience evacuating patients following a tornado made her realize the following strategy would have improved the evacuation process:
 - A. Having an internal evacuation plan.
 - B. Two-way radios.
 - C. Additional security.
 - D. All of the above
2. According to Betsy Jordan, RN, CEN, nurses were selected to work in the treatment area of an emergency center she established in a nearby church based on:
 - A. Their volunteering to work in the area.
 - B. Whether they were reporting for a scheduled shift.
 - C. Whether they knew first aid.
 - D. How long they had worked in an ED.
3. When Sumter Regional Hospital was evacuated following an F3 tornado, what patients were at the front of the triage line?
 - A. Critical care unit patients.
 - B. Post-op patients.
 - C. A patient in labor.
 - D. Psychiatric patients.
4. According to James J. Augustine, MD FACEP, when planning to deal with staffing issues during a pandemic, a concept some ED managers may not be familiar with is:
 - A. absenteeism.
 - B. presenteeism.
 - C. cross-training.
 - D. working from home.
5. According to Colleen Connelly, RN, BSN, her survey of hospital staff indicated the following key considerations:
 - A. Making employees feel safe.
 - B. Assuring employees their family members will be cared for.
 - C. Educating staff about the distinguishing signs and symptoms of avian flu.
 - D. All of the above
6. According to Matt Mulherin, his company's recent survey shows that the patient age group least likely to be satisfied with their treatment in the ED is:
 - A. 18-34.
 - B. 35-49.
 - C. 56-79.
 - D. 80 and older.

- be easily updated.

Objective criteria for establishing specialist remuneration for ED calls, says Collins, include consideration of:

- market-based compensation for specialists;
- specific time commitments of ED calls;
- restrictions the call obligations may impose (for example, the specialist's time on call must be exclusively dedicated to the ED);
- historic frequency of active engagement of the specialist in the ED caring for patients vs. availability in "standby" mode. (In other words, the frequency with which the specialist is actually called to the ED);
- potential private-practice income forfeitures for specialists taking ED calls;
- how the cost of the stipend arrangement with voluntary specialists compares to the cost if the hospital employed an adequate number of specialists to provide the same service. For a 24-hours-a-day, seven-days-a-

week, 365-days-a-year exclusive service, this would require roughly five full-time physicians per specialty;

- market comparables, i.e., what similar organizations in similar markets pay for similar commitments. ■

EDITORIAL ADVISORY BOARD

Executive Editor: James J. Augustine, MD, FACEP

Director of Clinical Operations
Emergency Medicine Physicians
Canton, OH
Medical Director, Atlanta Fire Department and
Hartsfield-Jackson Atlanta International Airport

Nancy Auer, MD, FACEP
Vice President for Medical Affairs
Swedish Health Services
Seattle

Caral Edelberg, CPC, CCS-P, CHC
President
Medical Management Resources,
A Division of TeamHealth
Jacksonville, FL

Kay Ball, RN, MSA, CNOR, FAAN
Perioperative Consultant/Educator
K & D Medical
Lewis Center, OH

Gregory L. Henry, MD, FACEP
Clinical Professor
Department of Emergency Medicine
University of Michigan Medical School
Risk Management Consultant
Emergency Physicians Medical Group
Chief Executive Officer
Medical Practice Risk Assessment Inc.
Ann Arbor, MI

Larry Bedard, MD, FACEP
Senior Partner
California Emergency Physicians
President, Bedard and Associates
Sausalito, CA

Robert A. Bitterman
MD, JD, FACEP
President
Bitterman Healthcare Law &
Consulting
Group, Charlotte, NC
Vice President
Emergency Physicians Insurance Co.
Auburn, CA

Tony Joseph, MD, FACEP
President & CEO
AMC Registry Inc.
Columbus, OH

Marty Karpel
MPA, FACHE, FHFMA
Emergency Services Consultant
Karpel Consulting Group Inc.
Long Beach, CA

Darlene Bradley, RN, MSN, MAOM,
CCRN, CEN, MICN,
Director, Emergency/Trauma
Services, University of California
Irvine Medical Center
Orange, CA

Thom A. Mayer, MD, FACEP
Chairman
Department of Emergency Medicine
Fairfax Hospital
Falls Church, VA

Richard Bukata, MD
Medical Director, ED, San Gabriel
(CA) Valley Medical Center; Clinical
Professor of Emergency Medicine,
Keck School of Medicine,
University of Southern California
Los Angeles

Robert B. Takla, MD, FACEP
Medical Director
Emergency Department
St. John Oakland Hospital
Madison Heights, MI

Diana S. Contino
RN, MBA, CEN, CCRN
Manager
Public Services — Healthcare
BearingPoint
Laguna Niguel, CA

Michael J. Williams, MPA, HSA
President
The Abaris Group
Walnut Creek, CA

Charlotte Yeh, MD, FACEP
Regional Administrator
Centers for Medicare
& Medicaid Services
Boston

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

To reproduce any part of this newsletter for promotional purposes, please contact:

Stephen Vance

Phone: (800) 688-2421, ext. 5511

Fax: (800) 284-3291

Email: stephen.vance@ahcmedia.com

Address: AHC Media LLC
3525 Piedmont Road, Bldg. 6, Ste. 400
Atlanta, GA 30305 USA

To reproduce any part of AHC newsletters for educational purposes, please contact:

The Copyright Clearance Center for permission

Email: info@copyright.com

Website: www.copyright.com

Phone: (978) 750-8400

Fax: (978) 646-8600

Address: Copyright Clearance Center
222 Rosewood Drive
Danvers, MA 01923 USA

CE/CME answers

1. D; 2. C; 3. A; 4. B; 5. D; 6. A.