



THE CRISIS PLAN

Somewhere in the files of virtually every hospital executive is something called a "crisis plan." Some plans are pretty good. Some are recipes for disaster. Both kinds generally go unread until an actual crisis occurs, when it is too late to discover that the plan does not work.

Having a plan, even a good one, is not enough. Readiness to follow it is absolutely vital. Being ready requires preparation in many areas. Otherwise, what appears to be a good plan will fail. Part of the preparation involves learning how to gain control of the message you want to convey to the public at a time when things seem out of control.

Recent events demonstrate how quickly hospitals can move from treating disaster victims to becoming victims themselves. In southern Florida, hospitals found themselves operating under incredibly difficult conditions when Hurricane Andrew struck in the spring of 1992. The Midwestern floods of 1993 affected hospital operations in numerous communities. And Los Angeles, which had had riots two years earlier, began 1994 with an earthquake.

January's earthquake left many hospitals without power, water, or communications. Some had to be evacuated. TV viewers watched unforgettable scenes: Grenada Hills Community Hospital's emergency department operating in a parking lot; mothers and newborns on the lawn

*Nearly Every
Hospital
Has One;
Not All Are
Ready to
Follow It*

BY LARRY MAISEL

at Holy Cross Medical Center in Mission Hills; and other hospitals still functioning, but under the most difficult conditions.

In such circumstances, the need for *both* a crisis plan and nuts-and-bolts preparation becomes obvious. But the same need exists for less dramatic crises, those which are fairly quiet, mostly internal, and not widely known, at least initially. They can be just as dangerous to the organization and require just as much forethought. Despite this threat, one administrator told me last year: "We know we have to do something about our

Summary It is not enough that a health-care facility have a "crisis plan" somewhere in its file cabinets. Indeed, unless the facility's executives have made thorough preparations for putting it into action, their plan could make a crisis even worse.

Shortcomings commonly found in crisis plans include:

- Failing to make sure that the people designated to implement the plan are actually present when a crisis occurs
- Having a crisis team that is too large and unwieldy to be effective in a real crisis
- Forgetting that, while the crisis team acts, others must keep normal operations running
- Failing to designate a single, trained spokesperson to deal with the media
- Being unprepared for a long siege—the crisis that goes on for hours, days, or even weeks
- Forgetting during a crisis to inform, not only the general public, but also one's own staff, patients, and others
- Failing to have an understanding with staff and their unions that, in a crisis, some persons may be expected to perform duties other than their normal ones



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crisis plan, but we don't have time now. We'll get around to it."

PLANS ARE NOT ENOUGH

Serious problems can occur when good intentions are not carried out. Here are two cases in point.

One hospital had made fairly elaborate preparations in several areas, including designating a workroom for media use in case of a crisis. The room had been wired with extra phone jacks, and the hospital had even bought spare phones for the media to use. The phones were kept in a cabinet with a heavy padlock. It was good security, but no one could remember where the key was. Fortunately, the problem was discovered during a disaster drill, not the real thing.

Less fortunate was a hospital that had planned ahead to cover a failure of both its main phone system and its backup power supply. This unlikely event did occur, and the staff scrambled to distribute the new cellular phones to key areas so operations could continue. Still, disaster was not averted: No one knew the phone numbers for any of the cellular phones.

In these two incidents, each of the hospitals had a crisis plan. Each met the emergency response criteria set down by various agencies. But neither had a *workable* plan.

It is not surprising that crisis plans often do not get the attention they deserve. Few enterprises are more saddled with complicated policies and procedures than hospitals, and they seem to take on a life of their own. Because various state, joint commission, and other regulations mandate committee approval of nearly everything, swift decision making can become nearly impossible. Process often seems more important than results.

In such an atmosphere, a crisis plan draft can be viewed as one more tedious document to review and get only a quick once-over. Seldom does anyone perform a detailed examination or genuine test of the plan.

WHERE PLANS FALL SHORT

Some crisis plans are far too detailed to be followed by staff members under pressure. Others are worded so broadly that it is unclear who is

responsible for what. In a disaster there is no time for sorting out lines of authority. They must be clear in advance. Frequently, the lines of authority spelled out in a crisis plan may differ from the normal ones. Within multihospital groups, the occasional confusion about what is "corporate" and what is "local" can be troublesome.

Here are some of the common shortcomings found in hospital crisis plans.

Failing to Make Certain That Someone Will Be There to Implement the Crisis Plan

This seems an easy one. Most hospitals remember to provide for backup personnel in the plan. Less often covered are situations in which *both* the regular and the backup persons are at a conference out of town. Taking time to track them down is usually not an option. Administrators should plan now to cover every possibility—even those which "just couldn't possibly happen." They can, and do.

Having a Crisis Team That Is Too Large

Hospitals tend toward large, broad-based committees. That can be deadly in a crisis. The crisis

team should be made up of your *best* people, probably drawn from several layers of management.

Choose people who do well under fire. Hurt feelings and managerial insecurities can be dealt with later. If you are unsure about whether to include someone on the team, plan to call him or her in on an as-needed basis.

One person—your chief executive officer (CEO) or the next highest-ranking officer—should be in overall charge initially. Later, depending on the kind of crisis it is, someone with expertise in the area may take over team leadership.

Forgetting That Someone Has to Keep Normal Operations Running

Not every crisis involves the whole facility. A surprising number of managers will want the "prestige" of being on the crisis team (at least until they have actually been through a crisis). But smaller is better, and regular operations should not be left to lower-echelon managers.

Normal hospital operations—to the degree that they can be kept "normal" during a crisis—will be difficult at best. Some of the best managers should remain involved in ongoing operations, perhaps with temporarily expanded authority and





duties. Otherwise, you risk giving the impression that only the people management considers "important" will work on a crisis. Allowing that attitude to become widespread can create a whole new crisis after the dust from the first one has settled.

Having Too Many Voices In nearly every case, one spokesperson should talk with the media. The choice of that person may have nothing to do with the "pecking order." Forget rank; you need results. Your CEO may not be the most effective person in dealing with the media. Indeed, in some circumstances (particularly when the crisis is internal) the use of the CEO may give an impression that things are worse than they really are. On the other hand, if the incident is truly catastrophic, the CEO should probably be out in front. This is a judgment call that cannot be made in advance.

Failing to Prepare the Spokesperson The best plan in the world will not be effective if your spokesperson is not trained in media response techniques. Reporters will push to get a statement from the highest-ranking person they can. A well-trained, senior spokesperson will have more credibility than your public relations person. The entire senior staff should go through

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media training periodically.

Not long ago organizations could buy time with the media by saying "No comment" to reporters' questions. It was seen as the safest answer. In today's world of live television news coverage, "No comment" is the worst way to go: It gives away your chance of having some control over what the media will say.

TV and radio will "go live" from the scene when you have what they see as a major story. Unfortunately, live coverage is a monster that reporters and producers must feed. Its "food" is information—and it will get it from *someone*. That person may be a bystander or someone in uniform who looks authoritative. You want the information to come from you.

Even in the early stages of a crisis, when hard facts may be few, the spokesperson can appear positive and in control of the situation. He or she should avoid appearing to be on the defensive. A good media-response training firm can show the spokesperson how to appear to be in control.

Being Unprepared for a Long Siege Crises can last for many hours or days or even weeks. Persons involved in a crisis need sleep. While they sleep, designated backups must take their places. In the early stages, so many things will need attention that everyone will lose track of time. Both crisis team members and their backups need to understand that there comes a time when the most important thing they can do is get some sleep. That will be one more thing someone will have to coordinate.

A senior secretary, or someone else accustomed to working with senior administrators, should be designated to keep track of the length of time team members have been working. Also he or she should keep a log of problems and oversights, so they will not be forgotten and can be corrected before the next crisis.

Forgetting That It Is as Important to Inform the Internal Audience as the General Public Too often no one remembers to inform employees, staff, volunteers, and trustees from the outset.

How to inform the medical staff depends on the corporate culture. Some hospitals, using the medical staff structure, have the chief of staff keep physicians informed. Teaching hospitals often use department chairpersons. Do not forget backups in either case, since the primary person assigned may be in surgery or otherwise unavailable.

Some hospitals prefer having the CEO brief physicians informally. Some make no special provisions, thinking that doing so only adds an unnecessary level through which information must pass.

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PREPARING FOR A CRISIS: NUTS AND BOLTS

- Include crisis planning and preparation, as well as periodic media training, as a line item in budgets. An ongoing program will allow you to acquire some emergency items and hold some training each year.
- Cellular phones have greatly eased the communications nightmares that once were part of virtually all natural disasters. But they too can fail, and you should have alternative radio communications as part of the communications backup.
- Copiers, clinical terminals, and other data- and word-processing systems may not work during a disaster. Old-fashioned carbon paper and a few old manual typewriters tucked away can prove to be treasures.
- Have multiple vendors whenever possible, and insert clauses in your contracts with them ensuring delivery of goods and services in emergencies. Ask vendors if they themselves have emergency plans.
- Make sure you have a way to get cash in a hurry. In a crisis you may have to deal with new vendors, pay them very high prices, and plead with them to make timely deliveries. Cash talks.
- Get the advice of local emergency officials and other community resources. Your own staff can be helpful in the "what if" process and can give you different and valuable perspectives.
- Talk with those at other hospitals who have been through crises and with those in industry who deal with crises frequently.

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Parent organizations, such as system headquarters or religious sponsors, cannot be overlooked and require senior people to handle. Keeping them informed often falls to the CEO. Remember, too, that your public relations efforts will have to be coordinated with theirs.

Trustees can be difficult and demanding, particularly if they think the crisis could cause them embarrassment in the business community. They do not want to appear to be "out of the loop" about the institution on whose board they serve. They will want to talk with the CEO or someone well up in the organization.

One hospital group has designated a sister in a senior administrative position to reassure trustees and members of foundations and other boards. She brings to the task the weight of both her administrative position and the sponsoring religious institute.

Nearly every crisis plan has some means of keeping nursing and other staff informed. Amazingly, however, institutions often overlook the need to let patients and their families know what is going on. If people are utilizing your facility, they should be getting information from you—not just the media.

One or two persons should monitor media coverage and furnish the crisis team with summaries. This prevents conflicts between what you are telling patients and other internal audiences and what they are hearing from the media. In addition, it assures people that you know as much as the media.

Failing to Have an Understanding with Your Staff and Their Unions That, in a Crisis, Some Persons May Be Expected to Perform Duties Other Than Their Normal Ones A crisis is no time to be negotiating job duties. Orientation for every new employee ought to include possible crisis tasks. The old "and other duties as assigned"

phrase in job descriptions will not explain special duties in a real crisis.

NUTS AND BOLTS

The degree to which hospitals successfully weather natural disasters depends in large measure on the degree to which their leaders have thought about possible crises, prepared thoroughly for them, and moved to shore up weaknesses in advance.


One St. Louis-area hospital requires its vice president for marketing and public relations, attorney, and risk manager to conduct an annual risk assessment listing the top 10 areas of vulnerability and to then prepare possible scenarios based on that list. The hospital also mandates drills to test the 10 scenarios and provides ongoing media training for top administrators and medical department chairpersons. Obviously, not every possible problem can be anticipated, but a "Ten Most Likely" list gives an organization a head start in being ready.

The **Box** on p. 28 gives some "nuts-and-bolts" suggestions.

PUTTING IT TO THE TEST

Crisis plans—even good ones—need to be tested. Outside review by consultants specializing in the subject is the best preparation. Short of that, a review of the plan and preparations by an impartial party might spot weaknesses.

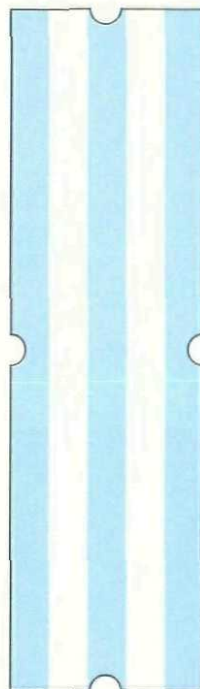
Legitimate mock disaster drills are especially useful. Many drills, conducted internally, are not legitimate. Often, the time and nature of the mock disaster are leaked to those whose response is critical, so that they will look good in the post-mortem critique. Such subterfuge is not only dishonest: It amounts to flirting with disaster. □

 For more information, call Larry Maisel at 614-764-1750.

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