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INSIDE

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Palliative care training helps hone observation, communication skills

Five-point guide focuses staff's attention on patients' needs

Home health aides and certified nursing assistants (CNAs) are in an ideal position to alert nurses to patient needs — if they can astutely observe symptoms and changes in patients and clearly communicate them to others. A special training module for aides and CNAs focuses on honing those observation and communication skills. It's part of a palliative care program being developed by Alexandria, VA-based MKHP Associates, LLC, says **Mary Hamil Parker**, PhD, principal investigator for the project.

MKHP has received a grant from the National Cancer Institute of the National Institutes of Health to develop training modules for health professionals, paraprofessionals, volunteers, and family caregivers in the area of palliative care, which seeks to manage the symptoms of patients who cannot be cured of their diseases.

Along with recognizing such symptoms as pain and immobility, home health aides and nursing assistants play a vital role in seeing how the symptoms affect the quality of patients' lives and letting nurses know when problems arise. "We're finding that home health aides and CNAs and even some experienced hospice aides need training on how to observe and report symptoms in a way that looks at the needs of the patient in all domains of care: physical, psychological, social, and spiritual," she says. "Their training is task-focused, and what we're teaching is affective behavior. You look at not simply, 'How do you give a bed bath?' but, 'How do you help the person achieve what they wish to achieve that day?'

> **"We're finding that home health aides and CNAs and even some experienced hospice aides need training . . . ."**

"Palliative care is not only reporting the fact that somebody has pain, but also that there's disruption with the family and that family dynamics might be contributing to the patient's suffering — or the patient's suffering might be contributing to problems with the family," Parker says. "All of that is the dynamic in which palliative care takes place."

The training module offers home health aides and CNAs a five-point guide to observing and communicating changes in the patient's condition, keeping the four domains in mind. "We hope people will learn to use this as a way of organizing and presenting information," Parker says.

The guide lays out these five steps:

1. Be alert to a problem or change, through observation or by speaking to the patient or family. "That should probably be the first responsibility of any home health aide or CNA, to observe and report a problem or change with the patients," Parker says.

2. Find out how long the problem or change has been going on.

3. Observe how the symptom or change has affected the patient's or family's usual ability to do what they want to do.

4. Determine what remedies have been tried. "Patients and families do try things. Some of them work and some of them don't," she says.

5. Determine who or what may be able to help. "We [have had] a very positive response from home health aides and CNAs that we've trained and also nursing supervisors and others, because they find this method of organizing information empowering," Parker says. "They say, 'Now, somebody's told me how to do it.'"

A sample case study

As part of the training, Parker presents case studies, asking participants to use the five-point guide to make observations about the patient. Here is an example of a case study:

Mr. A has been experiencing more frequent episodes of shortness of breath over the past week. In the past 12 hours, the problem has worsened. When you arrive, Mr. A is still in bed and short of breath. He says, "I can't do anything. I'm tired of not feeling well." You notice that his breathing is shallow and his pulse rapid. The window is open, and a fan is blowing air on him. He has turned up his oxygen setting to 4 liters per minute.

In that instance, a participant might make the following observations using the five-point guide:

1. Observed change. Mr. A's increased shortness of breath is a change.

2. How long has this been going on? In the past 12 hours, or since last night.

3. How has it affected the patient's ability? Mr. A is unable to get out of bed.

4. What has been tried? Somebody has figured that increased air circulation might help and has opened the window and turned on a fan. Mr. A himself has turned up his oxygen setting.

5. Who or what may be able to help? Usually, when a home health aide sees a patient is having a medical problem, his or her immediate responsibility is to call a nurse, Parker says.

Nonverbal pain management

The approach also can be used in connection with pain management, even in situations in which the patient can't verbally express what he or she is feeling. In this case study, a home health aide is attending a 75-year-old man who has suffered a stroke:

Mr. D takes a baby aspirin daily and is working hard to regain his functioning, but he has difficulty speaking. His aide notices that when he tries to sit up in bed, he grunts and makes a face.

He does the same thing during range-of-motion exercises, even when she tries positioning him in a chair to make him comfortable. Today, he is refusing to exercise. She decides she needs to report her observations to the nurse, using the five-point guide for communication.

1. Observed change. Mr. D grunts and makes a face when he tries to sit up. He does the same thing when he tries to do range-of-motion exercises. Today, he's refusing to exercise.

2. How long has it been going on? The refusal to exercise began today.

3. How has the symptom affected the patient's ability? He doesn't want to do his exercises or move. If he doesn't continue his exercises and

grow stronger, his recovery from the stroke might be impaired.

4. What has been tried? She has tried positioning him in a chair, but today he doesn't want to move.

5. Who or what may be able to help? The aide "is thinking through these five points: 'I need to tell the nurse that Mr. D is having more pain.' That's the process that she'd mentally go through," Parker says.

More in-depth guide for pain symptoms

The training module provides home health aides and CNAs with more specific questions in the area of reporting pain. That information can help them give a detailed account of what a patient is experiencing.

Parker says it's vital for the aides and CNAs to use the exact words patients use to describe their pain — "aches all the time," "worse with breathing," "worse when I move," "comes and goes," "cramp," "spasm," "burning," and "stabbing," for example. Those words can give doctors and nurses the description they need to identify the type of pain.

"It's very important to understand a new pain may mean something different and need a different kind of treatment from the kind they're normally getting," she says.

The following case study illustrates the questions aides and CNAs should ask when confronted with a patient experiencing pain:

Mrs. C. has advanced lung cancer. When you arrive, she is sitting in a chair in a hunched-over position. She's rubbing the area under her right arm and around the back, almost reaching back to her spine.

She says, "This pain is different. It's very deep, inside there, and it aches worse than the usual pain at that spot. It even hurts when I take a deep breath. It started about eight hours ago. When I take my pain medication, it goes to a four [on the pain scale], but after three hours, it's back to an eight again.

❑ **Where is the pain?** The words Mrs. C used were "deep inside" and "aches." It extends under her right arm and around the side of her waist to her back, indicating pleural pain.

❑ **Is it at more than one site?** No.

• **What does the pain feel like?** It's "different"; it hurts when she breathes. It aches "worse than the usual pain at that spot."

❑ **How bad is the pain at each site?** Mrs. C rates it as eight on the pain scale.

❑ **What makes the pain better or worse?** The medication helps for a while. Moving makes it worse. Breathing makes it worse.

❑ **What activity can she do or not do because of the pain?** She can't get up from her chair. She can't move easily.

❑ **Has the pain changed in any way?** Mrs. C says this pain is different.

❑ **Is she taking medication?** Yes.

❑ **How long does it take for relief to start?** In this case, we don't know. The aide needs to ask Mrs. C that question.

❑ **Does the medication reduce pain?** Yes, from an eight to a four.

❑ **How long does the relief last?** Three hours.

❑ **Is the patient having side effects from medication?** That question needs to be asked. Parker points out, for example, that constipation is common among patients using opioids.

❑ **Is the patient having any problem getting medication**? Parker says this is an important question, especially in rural areas or situations in which patients can't get out to get medication and there's no one to get it for them.

"What we're doing is teaching people an orderly process of thinking about what they're going to tell someone," Parker says. "That's what they find empowering about this."

She says the palliative care training also includes modules on topics such as communicating with patients and family at the end of life and dealing with food and fluid issues. Modules, some of which still are in the process of being written, will be available in CD-ROM or diskette format. A facilitator could use a computer and a Microsoft PowerPoint presentation to present it to a class.

Eventually, Parker says, the training may offer certification for palliative care caregivers, based on a 16- to 18-hour program. ■

SOURCE

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Teach staff emotional effects of amputation

Home health nurses can help smooth transition

Helping an amputee with the physical effects of surgery is only part of the challenge for home health workers. Being alert to the emotional needs of patients who have lost one or more limbs can speed recovery and smooth the transition to a new life.

Deanna Lieving, RN, CNS, director of mental health for Olsten Health Services in Virginia Beach, VA, says home health nurses can be a vital link in the chain of support for amputees, because so many of the emotional issues patients face arise after they have left the hospital.

"The impact doesn't really hit home until they go home," Lieving says. "So the home health nurse going in on a case is going to get the whole range of emotions, more so than I would in a hospital. As soon as they go home, they face a familiar place where they can't function like they functioned before. It may be temporary, but they don't know that. All they know is they're a one-legged person in a two-legged world, and that hurts."

Lieving, a psychotherapist, has been involved with amputation patients in hospital and home settings for 15 years and teaches a course at Old Dominion University on the psychosocial issues following amputation. She says many of her patients are older and have lost limbs due to diseases such as diabetes, although some suffered traumatic losses through accidents.

In every case, she says, the patient goes through a grieving process similar to that of losing a loved one, and medical professionals should understand that such a response is normal and even healthy.

"A doctor will call me and say, 'Go see Frank Smith. He's depressed.' This is post-op, three days. I go see Frank Smith; he's not depressed — he's tearful over the loss. That is a normal response to any amputation. That's not depression. When I see a patient crying, I see that as a good thing."

She points to a second coping mechanism, denial, which also can be confusing to home health workers. "Denial is not a bad thing," Lieving says. "It's a natural defense mechanism built into our brains to protect us from harm that our mind cannot tolerate at the time. I never ever try to tear someone's defense mechanisms down. They'll come around; some people take longer than others."

However, she says it is important to keep a watch for signs of true clinical depression — weight changes, sleep disturbances, agitation, loss of interest or pleasure, decreased sex drive, fatigue, feelings of worthlessness and guilt, or a prolonged sadness that persists for more than a month.

Assess patient's needs, reactions

A home health nurse attending an amputee should perform these functions to bolster the patient's emotional health, Lieving says:

- **Encourage communication.** Patients should feel free to verbalize feelings of anger, frustration, and fear as they deal with new problems and limitations. "When women feel loss, most women get depressed. When men feel loss, most men get angry," Lieving says. "So it's important. The woman needs to feel anger, and the man needs to feel that sadness."
- **See the situation through the patients' eyes.**
- **Identify support systems.** Those systems can be many and diverse — friends and family certainly are among them. Lieving also includes religious belief, "which actually gets a lot of my patients through this."
- **Try to involve family in the process.** She says family members often tell her things the patient won't. "A patient might say, 'Yeah, I'm getting up once a day. Yeah, I'm walking around the house,' and [family members] will say, 'Oh no, he's not. He's not getting out of bed.'"

Family members also have emotional needs, as they try to be strong for the patient and deny their own feelings of anger and loss, Lieving says.

At Olsten, home health nurses are often the ones to notice that a patient is having difficulty coping during the difficult process of healing and learning to use a prosthetic limb, and they will suggest referrals to mental health professionals.

Other tips for home health workers include the following:

- **Answer questions honestly.** Some questions can be odd — many amputees, for instance, want to know what happened to their amputated limb. Others can be hard to answer, such as a realistic assessment of the patient's new limitations. Lieving says answering such a question over-optimistically — saying, "You'll do everything you did before you lost your leg," for instance — isn't telling a patient the whole story.

SOURCE

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"They may be able to do the things they did before, but they're going to do it a little slower," she says. "It's a little bit like the aging process, I tell them."

• **Empower patients to participate in his care.** Medical professionals must try to get patients to reclaim their independence, Lieving says. "You have to give that sense of control back to the patient. A lot of times, that is just done with empathetic caring."

• **Prepare patients for setbacks.** Lieving says she teaches coping skills for continual failures, which inevitably occur during the course of recovery. She praises any progress and sets realistic goals. "I tell them that they need to set their goals in tiny steps. I think that's important. I try to always reflect on their progress."

• **Have patients discuss their self-image.** The loss of a limb can be a devastating blow to a person's body image, Lieving says. They worry about being seen in public, about how they can be intimate with their spouses, and other important considerations. Sexual issues often are compounded by the patient's underlying illness, such as diabetes, which can cause impotence problems.

"Ask them, 'What do you think of the prosthesis?'" she says. "'What do you think when people stare at you?'"

Home health nurses also can help prepare patients for the inevitable embarrassing moments that come with dealing with a prosthetic limb. As an example, she points out that an above-the-knee prosthetic leg can make a small burping sound when slid into place. "That's embarrassing enough, but if the fit isn't good, when you walk, it's going to sound like you're expelling gas. That's so embarrassing. If you warn a patient that's going to happen, then they're a little less embarrassed about it."

• **Invite patients to meet with other amputees.** Often the best time for this is after a patient has gone home and already is beginning to see other amputees in physical therapy and at the prosthetist. Lieving encourages her patients to join support groups, while pointing out that such groups can include people with very different outcomes and problems. She says emotional support from home health workers can make the difference between a lingering period of coping problems and a shorter one. "The emotional part is not touched on. If you don't treat the emotional aspects of amputation, it will take two years for your body to recoup. If you treat it, it may take three months. It's the part that a lot of physicians do not even want to come to terms with." ■

Access live televised inservices via satellite

Training goes coast to coast

What started as a way for the Alabama Department of Public Health to save money and standardize its training of home health workers has evolved into a high-tech training option for home health employees across the country.

The department began broadcasting live inservices to its employees across the state via satellite nearly five years ago. Now, it offers the same broadcasts to outside home health agencies as far away as Wyoming and Minnesota.

For the cost of a steerable satellite ($1,000) and a per-person registration fee, agencies can tap into the state's regular series of inservices on topics ranging from safety to medical issues.

The public health department developed the satellite system in part to cope with the enormous challenge of training nearly 2,000 home health aides scattered across the state, explains **Carol Honaker**, RN, C, BSN, program consultant for aide accreditation and education with the department's Bureau of Home and Community Services.

"The cost of training [aides] in area meetings was very expensive, and we didn't have the personnel at that time to do that," Honaker says. "So we began to look for other avenues of doing that in a way that was more cost-effective."

At the same time, the state was pursuing accreditation, making it necessary to ensure that training was standardized.

The satellite program, now run out of studios in the public health department, enables trainers in Montgomery to conduct an inservice on fire safety, for instance, and beam it to health department offices across the state. The program is broadcast live, so participants can ask questions via telephone or fax. Each office is equipped with a satellite dish and given the coordinates to pick

Use technology to create televised inservices

In these days of budget tightening, the equipment costs to create an in-house studio for satellite inservices might be far beyond the reach of the average home health agency. But an agency that serves a far-flung area still may be able to use new technology to create its own more personalized training economically.

"There are organizations within the community that are technically set up to do distance learning," says **Norma Kay Sprayberry**, RN, MSN, director of program development and accreditation for the Bureau of Home and Community Services in the Alabama Department of Public Health.

Sprayberry notes that the technology may be available at low cost at local cable television stations, college television studios, and public agencies such as her own. "An agency that has some size to it but isn't willing to fund the initial start-up costs from a technical standpoint could contract with a facility such as ours. We would just provide the facility and satellite technology."

Even a simple video camera could make a difference, says **Gayla Hollis**, BSN, who works with the bureau's aide accreditation and education program. "If you have one instructor who is required to cover a large area, you can set up a video camera, videotape her presentation and send it out to other areas," she says. ■

up the program, which is shown on conventional televisions.

The technology frees trainers to take innovative approaches to conventional inservices, says **Gayla Hollis**, BSN, who works with the bureau's aide accreditation and education program. For example, working with the department's video technicians, she and other trainers can tape record segments that illustrate points they will make during the lecture portion of the training. A fire safety program included a taped segment that showed the dangers of stove fires and how to pull a bedridden patient from a burning home atop a mattress, Hollis and Honaker say.

"The fire department was there, and we used an old stove to demonstrate how to put out a grease fire," Hollis says. "The firefighter showed how to put it out and also demonstrated how you could easily catch on fire if you picked up [a burning object] and tried to go out the door with it."

A driving safety segment created in conjunction with AAA showed how to jump-start a dead battery and how to drive in bad weather.

Pre-taped segments also can be reused for orientations of new employees, Hollis says, or to conduct inservices on medical topics. The department filmed a breast exam as part of a program on breast cancer. An inservice on immune deficiencies featured a participant who discussed living with AIDS. "People were able to call in and actually ask this person questions live. To me, that was one of our special programs."

In an inservice on documentation, she used the same technology that allows meteorologists to point to storm fronts on a weather map. In this case, however, the weather map was replaced with images of documentation.

Use a studio audience

For the actual satellite broadcast, Honaker says, the trainer always works in front of a live group so he or she can see whether participants are following the topic or need further explanation. "We always have aides and home attendants who live fairly close to the studios in Montgomery, so the presenter has that feedback," she says.

At each satellite site is a facilitator who is responsible for the paperwork associated with the inservice, such as registration and training records. The facilitator gets mailed information packets for an upcoming session, handles any technical glitches that arise, and administers any required tests.

At first, the satellite system was used for paraprofessional training. But with its success, its reach has been extended, says **Norma Kay Sprayberry**, RN, MSN, director of program development and accreditation for the bureau. "It now includes the professional staff as well — registered nurses, social workers, and other staff members," she says. "We also use it to do management training. We do staff meetings statewide, whereby either our state health officer or other members of management present information or communication to folks statewide. It's a tremendous benefit in terms of providing consistent information."

The department has branched out even farther, providing access to the transmissions to other agencies across the country. A participating agency pre-registers and is sent a packet of handouts for the program, as well as coordinates to which it can set its satellite dish. Honaker says the average program is beamed to agencies in as many as 20 states.

"For the cost of $1,000, they can buy that satellite dish, and they can pick up the programs on any conventional television," Honaker says. "They can pick it up at a very nominal cost per person. It's less costly than it would be to pay a staff person to develop the program."

Live programs offered have included home safety, diabetic foot care, caring for patients with Alzheimer's disease, and skin and oral care. The fee for each two-hour home health aide/home attendant program is $20 per person, while the fee for a nursing program is $30. Sprayberry says the department also offers videotapes of previously broadcast inservices for $125 per tape.

Continuing education credit is issued to nurses who view the live broadcasts, which meet the standards of the American Nurses Credentialing Center, she says. Programs for home health aides, homemakers, and personal care attendants comply with all federal regulations and meet paraprofessional standards set by the National Association for Home Care Accreditation Commission.

Honaker and Sprayberry note that some topics aren't well-suited for a satellite format. "There are some types of training, such as CPR, where you must do a return-type demonstration, and some kinds of clinical training that require a check-off return performance of that procedure," Honaker says. "We would have to find somebody locally to do that. There are some kinds of clinical and technical training that may not be appropriate."

Sprayberry points to vascular access devices as an example of a topic that an agency might not want to attempt via satellite because nurses must practice with the equipment. "But the number of types of educational offerings that you can offer via satellite far outnumber [those] that are desirable not to, because there's so much you can do with the technology," she says. ■

SOURCES

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Internet is great tool to update staff knowledge

Use Web sites to keep training up to date

The Internet can be an important tool to maximize precious training time and keep abreast of continual updates in medicine that affect your staff.

It doesn't take a lot of high-end equipment or in-depth computer literacy to use the Internet for educational purposes, says **Suzanne Hatch**, BSN, MED, CPHQ, staff development coordinator and quality manager for Lee Visiting Nurse Association in Lee, MA.

"I know nothing, basically nothing [about computers]," says Hatch, who has had Internet access in her office for about six months. "I just know that I want to get somewhere, so eventually if I ask enough questions, I find out."

Be critical of Internet information

Hatch often uses the Internet to help provide answers to medical questions from her staff. "They'll say, 'I just got a referral, and I don't a lot about this particular disease or this medication,' and I'll go on the Internet and pull up what I can and go from there."

She uses Web sites with search engines that allow her to type in a few words — the name of a disease, for example, or a medication — and look up all of the publications in which the words appear. A number of sites provide access to the National Library of Medicine's MEDLINE database of articles and abstracts. She can access the *Journal of the American Medical Association* and the *New England Journal of Medicine* on the Web.

Hatch also uses a popular general-use search engine, Yahoo!, to look up information. In that case, she says it's important to be sure the provider of the information is reputable, a point echoed by **Robert Anderson** of Anderson Management Associates in Windham, NH. "Agencies and organizations need to provide known quantities to the public, to their patients and to their staff," he says. You might want to visit the American Heart Association as an educational access point, for example, or the American Diabetes Association.

Using Yahoo!, Hatch looked up a rare lymphoma encountered by one of her nurses. "The

American Cancer Society had a 26-page handbook for clinicians and patients that was absolutely excellent," she says. "It's a very rare disease, and I had it right away. I had it before the nurse went out to make a home visit, and we could review all the information and learn new things that she needed to know.

She points to the timeliness of articles on the Internet, compared to what she could find in a medical textbook. "A lot of these things are updated in a very current way, in a way a textbook can't be," Hatch says. "If something has a copyright of 1999, it was written in 1998. A lot of things could have happened in the meantime, but some of these Web sites are updated weekly with information."

Information found on line is useful for more than just handling individual cases. Hatch currently is putting together an inservice for home health aides on spinal cord injuries, using information she found on a Web site run by the National Spinal Cord Injury Association.

"They had material just at the exact level that I needed," Hatch says. "It's for the layman — simple, very clear-cut language and yet covering all the things that are important. I printed out several of their chapters and have diagrams that I can blow up onto overhead transparencies, so I now have handouts and an outline for the inservice program that I want to see happen. From that point of view, that's helped me." She's already made an overhead transparency of a diagram of the spine she found on the site, for use in a recent back safety inservice.

Anderson says Web searches are just the start of using Internet technology in home health care training. Agencies can keep in touch with their peers and leaders in the field via e-mail and listservs, which are mailing lists that conduct running conversations on issues of mutual interest. Employees can sign up for interactive, on-line continuing education courses for certification.

"Someone can log on, do a home study course off of the Net, downloaded to their computer," Anderson says. "They can do the study, then can answer the questions back to the Web site. It passes them or fails them, it gives them a CEU [continuing education unit] certificate, and logs that certificate with the accreditation agency."

He suggests agencies begin building lines of communication with others in the home care community and use the Internet as a tool to help staff educate their patients. "We all know that an educated patient is going to do better because they're going to understand their disease process, their care process, their medication issues."

Nurses can share information from the Internet with patients who may not have access themselves. Hatch says her agency already does some of that.

"We can find things that are excellent teaching tools and bring that to them," Anderson says. "Guidelines, disease process, clinical pathways — communication about all that is out on the Web already." ■

SOURCES

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Internet Connect

Try these sites to begin your Internet search

There are a number of good starting points to find useful, credible medical information on the World Wide Web:

• **http://igm.nlm.nih.gov** — Internet Grateful Med is one of the popular systems used to search the National Library of Medicine's (NLM) databases on the World Wide Web. Most notably, it provides access to MEDLINE, the NLM's on-line database that contains millions of references to journal articles. The full text of an article can be downloaded via Loansome Doc, which requires registration and establishing an agreement with a medical library that uses DOCLINE, the NLM's automated interlibrary loan request and referral system. Instructions on all are provided at the NLM Web site: **www.nlm.nih.gov**.

• **www.yahoo.com** — Yahoo!, one of Web's most popular portals, provides access to health information geared more toward the layman, making it useful for patient information. To use, click on the "Health" link, choosing from among the "Medicine," "Disease," "Drugs" and "Fitness"

categories. From there, it's an easy, point-and-click path to the information you need. For example, a search for "hypertension" leads to the American Heart Association (**www.americanheart.org**), a story in the magazine *Scientific American* (**www.sciam.com**), and the Pulmonary Hypertension Association (**www.phassociation. org**), which provides easy-to-understand explanations of hypertension and a list of available resources for patients.

• **www.spinalcord.org** — The National Spinal Cord Injury Association offers explanations of terms such as spasticity, flaccidity, and palsy, special information on pediatric injuries, and fact sheets on topics ranging from reproductive function to resources for vent users. ■

Train home health workers to work in assisted living

As more home health nurses and aides find themselves visiting assisted-living centers, they need to understand how these unique facilities work so they can best coordinate care for their patients.

More than 1 million Americans live in an estimated 30,000 such facilities, according to the Assisted Living Federation of America. The centers can range from freestanding apartment buildings to special independent-living wings at conventional nursing homes.

While requirements for assisted-living centers vary widely from state to state, they generally feature apartment-style units, often with carpeting and residential lighting, says **Chris Hollister,** MBA, of Southern Assisted Living in Chapel Hill, NC. They are usually seen as an option for people who need assistance with anywhere from one to five activities of daily living.

People generally understand that care in a nursing home is more detailed than in an assisted-living facility, he says. "But there is a real philosophical difference in how care is given, that this is a residential alternative — we're not institutionalizing people — that we're not a place to go die but a place to go live."

Home health plays a vital role in allowing people to maintain that level of independence, says **Carole Eldridge**, RN, vice president of tenant and health-related services for Assisted Living Concepts, a Portland, OR-based firm.

Eldridge has seen the relationship from both sides: She was chief executive officer for a home health agency that had workers in assisted-living centers. She says communication among home health and assisted-living staff is key to coordinating care successfully for tenants.

"The home health agency needs to understand they've taken on not just the tenant and their family, but they've taken on another element that requires communication," she says. "You can't leave out any of them or you're going to have trouble. The successful relationships I've heard about have been when people were just talking to each other about what was going on in a professional manner."

Problems can arise when one agency doesn't communicate fully, Eldridge says. For example, when she worked in home health, assisted-living staff would complain that other agencies didn't share information about tenants they were treating. "A change in a tenant's medication would occur, and the home health agency took the order and did not communicate it to the facility," she says. "The facility is required under most assisted-living regulations in most states to maintain a current active medication list, whether they assist with their meds or not."

Similar problems would occur in the reverse, with the facility's staff refusing to give out information or not allowing home health staff to make notes in tenants' files. Both sides were concerned about violating their clients' confidentiality.

"But patients in home health agencies and tenants in assisted-living facilities always sign something saying they release that when there's coordination of care involved," Eldridge says. "That's something that both home health agencies and assisted-living facilities need to be aware of, that confidentiality isn't an issue when you're coordinating care for someone."

Facilities generally set up procedures they ask all home health agencies to follow, including signing in and noting changes in treatment in tenants' charts. When a nurse or aide goes to a facility for the first time, he or she should check to see what arrangements the home health agency has made with the center and then work within that system.

Eldridge advises trying to build an ongoing relationship with assisted-living staff — learn how things work and who to turn to if there are problems. That makes it easier to find the right help when a tenant needs it.

"A home health nurse might go into the facility and see that something needed to be done

SOURCES

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- **Carole Eldridge**, RN, Vice President of Tenant and Health-Related Services for Assisted Living Concepts, 3008 Rush Court, Arlington, TX 76017. Phone: (800) 330-5574. E-mail: creldridge@sprynet.com
- **Assisted Living Federation of America**, 10300 Easton Place, Suite 400, Fairfax, VA 22030. Phone: (703) 691-8100. Fax: (703) 691-8106.

differently in the personal care," she offers as an example. "She would grab the closest attendant, say, 'This is how I want you to do this,' and then would document that she had trained the facility staff. But all she had trained was an attendant who had failed to tell anyone else.

"We always tried to make sure as the home health agency, if we had to do some training or needed to communicate a change in the patient's plan of care, that we communicated it to the administrator or the nurse in the facility and that they knew they needed to communicate it to all their staff."

Although communication is essential, Hollister says, facilities recognize that the tenant is in charge of his or her own care. "I think [home health workers] should think of it very much as if they're with someone in their private home. They hopefully will feel welcomed by the assisted-living owner or manager, but they're dealing primarily with the resident, not the owner or manager."

Skilled nursing services — and who provides them — can be a tricky issue, with regulations varying widely across the nation. In some states, assisted-living staff have authority to do some occasional procedures. In others, regulations are much tighter. The assisted-living communities Southern Assisted Living operates in the Carolinas generally are staffed by certified nursing aides, Hollister says.

"The director of care is typically an LPN, so we can provide care, but the bulk of our home health is physical therapy for people recuperating from a fall or an accident," he says.

Eldridge, who is based in Arlington, TX, says she sees a range of restrictions on assisted-living staff. Home health workers need to understand those restrictions in their own states, so they'll know when they're needed. In Indiana, for instance, nurses in assisted-living facilities can help coordinate care and train staff, but they are prohibited by law from giving direct, hands-on care, she says.

"So they'll call a home health agency and say, 'We have this tenant who needs this skilled nursing service.' But they'll have a lot of home health agencies refuse to come, saying, 'Well, you have a home health nurse in the building. That means you can provide that service; that means Medicare won't pay for us to do it.' They need to understand the rules in their state. Home health agencies need to be real cognizant of what can and can't be done in assisted-living facilities."

The Assisted Living Federation of America and its state affiliates across the country can be a good source of information about state requirements, Hollister says.

Eldridge says access to home health care is vital for assisted-living tenants, particularly seniors, who want to stay as independent as they can for as long as they can. "It's absolutely essential. I believe in the combination of the two with all my heart. It's just very, very important if we're going to help people stay independent, and age in place. I'm a big home health believer." ■

Tips **From the Field**

Use newsletter format to reach busy employees

Getting employees together for mandatory inservices can be a difficult task when everyone already has so much to do. So why not let them get the information when their own schedules permit, by offering the training in a newsletter format?

It's a strategy that's worked well for employees of St. Luke's Hospital of Bethlehem, PA, and the affiliated Visiting Nurses Association (VNA) of Eastern Pennsylvania, say **Debra Phillips,** RN, MSN, director of educational services at St. Luke's, and **Linda Mitman,** RN, BSN, the VNA's performance improvement manager.

St. Luke's began using newsletters more than four years ago at the suggestion of a manager

who had seen a similar project elsewhere, Phillips says. It was an attempt to deal with the time crunch employees were experiencing. Since then, it has become a popular training tool for staff, who can digest the information at their own pace.

"When I first came here eight years ago, we had an education day," Phillips says, recounting the hospital's various education strategies. "We went to videotapes for a while. This was the next step after videotape, and it's probably the most compliant everybody has been, because it's easy, and everybody gets their own copy."

The newsletter includes information on a range of mandatory competencies, including fire safety, dealing with hazardous chemicals and compressed gas cylinders, age-specific care, confidentiality issues, control of bloodborne pathogens, and back safety. An employee from Phillips' office coordinates production with the hospital's safety officer, including input from team of representatives from various departments. An on-staff graphic designer helps produce the publication.

Attached tests that are filled out and returned meet the necessary requirements of the Joint Commission on Accreditation of Healthcare Organizations. Within each department in the hospital, someone is designated to distribute the newsletters and document that everyone has been tested on the information.

Live presentations still are necessary for topics requiring demonstrations or so staff can ask questions. "The key thing is, this is not the be-all, end-all. This is one piece of it. You need to work it into your whole competency program," Phillips says.

The approach was so successful, the VNA has picked it up and adapted it for its own use, Mitman says. "We did it just in sheer frustration of trying to get staff in to fulfill the mandatories in an environment where minutes are precious. When I saw Deb's newsletter, I thought, 'Gee, we could make that.'"

The agency produces one training newsletter a year, in addition to regular staff newsletters that go out with paychecks. Called *Essentials for Home Care*, it uses some of the St. Luke's articles, adapted for a home care environment. Other topics particular to home care, such as automobile safety, are added. "As far as manpower hours, I would just write up the articles and had a clerical person put the bells and whistles on it so that it looked nice," Mitman says. She says the publication is produced using Microsoft Publisher and printed on the agency's own copy machine.

This year, in addition to the newsletter on the standard mandatory competencies, a second edition will go out looking at corporate compliance issues such as conflicts of interest, confidentiality, and ethics. "There was too much to put it all in one," Mitman says.

The VNA also plans to tighten the testing procedure, which she says took too long last time. "We'll give them a month to fill it out and return it. We weren't as strict last time. We had supervisors collect them and turn them in, and it was a nightmare because everybody is so busy."

Home health aides still must review the material and do the test in a classroom setting because any self-learning modules must be proctored, Mitman says. The human resources department will keep records of the newsletter distribution and testing as part of the employees' personnel files. She adds that her staff likes the expedited training. "Anything that won't require them to come in, they're willing to do," she says.

At St. Luke's, Phillips says, the newsletters are so popular that staff don't want to miss a single word. They complained that tearing out the attached post-test removed information from the newsletter they wanted to keep. To solve that problem, Phillips' assistant changed the publication's layout. "We work so that when [readers] clip that part out, they don't lose the newsletter." ■

Appropriate use of the computer

The following is an excerpt from Essentials for Home Care, *the most recent annual newsletter on mandatory competencies from the Visiting Nurses Association of Eastern Pennsylvania:*

"By the virtue of their position, employees who work for the VNA have access to the computer system and to the confidential information contained within its databases. Any unauthorized access of the computer and its databases and / or distribution of information from the databases is in appropriate, harmful to the VNA and cannot be tolerated.

"It is important that all employees understand the agency's expectations with regard to this issue. Accordingly, the computer usage policy has been instituted. Take time to review the computer usage policy in its entirety. Listed are some of the highlights:

SOURCES

- **Debra Phillips**, RN, MSN, Director of Educational Services, St. Luke's Hospital, 801 Ostrum St., Bethlehem, PA 18015. Phone: (610) 954-3031.
- **Linda Mitman**, RN, BSN, Performance Improvement Manager, Visiting Nurses Association of Eastern Pennsylvania, 1510 Valley Center Parkway, Suite 200, Bethlehem, PA 18017. Phone: (610) 691-1100.

"Employees agree to maintain the security of the computer security login code and assignment password.

"Employees will not access information that is not directly related to their functions.

"Only employees assigned as system administrators have authorization to access employee maintenance screens and are able to update or change functions assigned to an employee.

"Patient confidentiality must be maintained while using the laptop in the home environment.

"An employee will be discharged if he/she:

"Accesses, alters or destroys any computer, computer system, computer software, computer program, or database with the intent to interrupt the normal functioning of the agency or to implement any scheme to defraud or control the agency's property or services

"Without authorization, gives or publishes passwords, identifying code or any other confidential information about the computer, computer system or the database.

"At no time should another software product be loaded onto the computer." ■

CE objectives

After reading this issue of *Homecare Education Management*, continuing education participants will be able to:

1. Explain a five-point guide home health aides can use to observe and report patient problems.
2. Detail questions that should be asked when evaluating a patient's pain.
3. Identify ways to help a recent amputee cope with the emotional effects of his or her loss.
4. Organize a live satellite inservice via the Alabama Department of Public Health.
5. Employ the Internet to find educational materials. ■

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