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IN THIS ISSUE

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Make sure your disaster plans include the recovery phase

Address lack of staff, power, and other resources

(Editor's note: This is the first of a two-part series that looks at accreditation standards that pose compliance problems for home health agencies. This month, we look at emergency preparedness and what components are necessary to satisfy a surveyor. Next month, we will examine do-not-use abbreviation lists, written orders, and competency assessments.)

Emergency preparedness is on the minds of home health managers, as they look at the devastation and extensive recovery efforts following hurricanes Katrina and Rita. Additionally, it is the No. 1 standards compliance issues for agencies accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

Seventeen percent of home care agencies surveyed by Joint Commission did not comply with the standard that requires the organization to address emergency management (EC.4.10), says **Maryanne L. Popovich**, RN, MPH, executive director of home care accreditation for the Joint Commission. Agency managers are inclined to plan for natural disasters, but they don't always plan for disasters that might be due to mechanical or technological problems and that might result in an extended power outages, Popovich points out. **(For information about handling a lengthy power outage, see "Working in the dark: Recent blackout teaches new crisis-planning lessons," *Hospital Home Health*, October 2003, p. 109.)**

Even with natural disasters, it is important to plan for the recovery period following the disaster when you may lack power, water, gasoline, or even staff, for a period of time, she suggests.

The 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City is the reason that Oklahoma health care organizations are well prepared for emergencies, says **Sue Gibson**, director of Midwest Home Health in Del City. That tragedy, as well as subsequent devastating tornadoes and the ever-present high risk of terrorism due to military bases in the area, spawned a network of health organizations that are linked together by computer so that resources quickly can be identified, she reports.

Gibson's agency disaster plan has several components, she says. "We

have a plan when the disaster affects our agency and our patients, when the disaster affects the hospital but not our patients, and when the disaster affects the community to a point that our assistance is needed."

They also have assigned a priority code to their patients so that if they are short-staffed following a disaster, if resources such as gasoline are limited, or if travel to certain areas is difficult, they know who can wait, says Gibson. If a patient cannot be seen as frequently or as soon as he or she is normally scheduled, an agency nurse will talk with the patient by telephone, she explains. "Our nurses are trained to assess and counsel patients by phone so that we can focus efforts following an emergency on patients who must be seen."

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The agency also assigns a disaster classification that enables the agency to notify police if there is a patient who does live alone and cannot be contacted, she says. "We are able to make sure that someone checks on the patient," Gibson says. The disaster classification is assigned at start of care and reviewed at recertification periods.

Looking beyond your own agency is a key component of a good emergency preparedness plan, says Popovich. "We want to see agencies define the role that they will play in a communitywide disaster," she adds.

Gibson's agency participates in the community's terrorism emergency planning. "We not only participate in the drills, but our home health nurses have been designated as nurses who will administer the smallpox vaccine in the event it is needed," she says.

Dealing with rising gasoline prices is one aftereffect of Gulf Coast hurricanes this season, but the staff at Marion (KY) Home Health Services just schedules patient visits as efficiently as possible to keep costs down, says **Sharon Darnall**, RN, director of the agency. "We are a small agency with only three nurses, so we group patient visits on a daily basis. All of the patients are comfortable not seeing the same nurse each visit because with only three nurses, there is still continuity," she explains.

Because they group patients geographically, a nurse may see more patients on one day than the next, Darnall admits. This arrangement gives them a day to complete paperwork and take care of things in the office, she points out.

At Castle Home Care in Kaneohe, HI, "way out here in the ocean," mileage is not an issue. "Traffic and road delays are our problems, so we always try to schedule patients close together," says director **Judith McGuire**, BSN, MHA. "We pay a mileage allowance according to the Internal Revenue Service limits, so we just simply increased it," she adds.

Popovich is seeing agencies in all areas of the country talking about reviewing their plans in light of the tragedy in Louisiana and Alabama. "People realize that there may be long-term issues following a disaster that can affect their ability to provide care for their patients," she says.

A plan must address the time after the disaster and spell out how you will find your employees and patients following an evacuation, Popovich says. "You also need to be prepared to find another building from which to run your agency and be able to establish backup communications."

SOURCES

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An emergency preparedness plan needs to include the recovery period and the needs of other organizations in the community, says Gibson. Keeping a plan updated and reviewing it regularly is important, she says. "You have to plan what needs to be done before and after a disaster so that you can make sure you are providing services when they are needed." Gibson says. ■

2005 Salary Survey Report

Employees want honest and communicative leaders

Listen and respond to employee concerns

Three of the top five issues identified by more than 102,000 health care employees surveyed by Press Ganey, a South Bend, IN-based satisfaction survey company, related to the effectiveness of communication between employees and senior leadership.

"We defined senior leadership as anyone responsible for decisions related to an organization's mission or goals," explains **Monica Locker**, MPPA, director of the employee perspectives division of Press Ganey. Depending on the size and structure of the organization, these leaders can be chief executive officers, chief financial officers, administrators, directors, or managers, she points out. More than 53% of the respondents to the 2005 *Hospital Home Health* Salary Survey place themselves in the category of senior leadership.

"This is the first time that senior leadership's involvement in communication was identified at this high level of importance for employees," says Locker. Specifically, employees said that they wanted organizational leaders to "listen to employees, be trustworthy, and to respond to employee concerns," she says.

Each leader should pay attention to communication because satisfied employees mean fewer turnovers and a positive image in the community that leads to easier recruitment of new employees, Locker says.

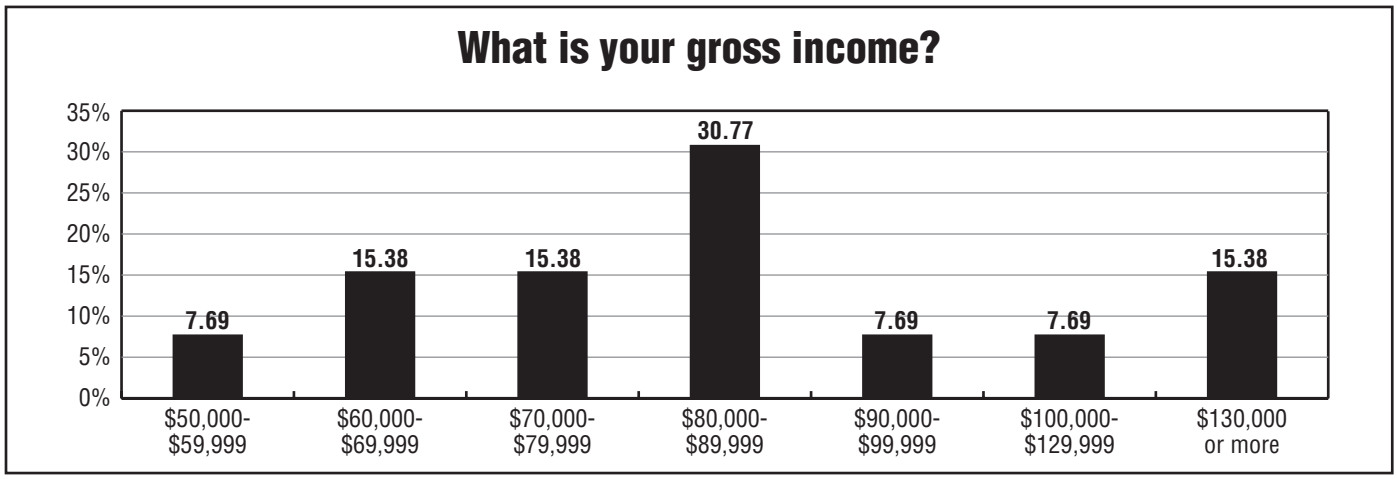
While more than 61% of respondents to the *Hospital and Home Health* survey report salaries of $80,000 or more, and almost 67% of respondents report an increase of 4% to 6% in the past year, salaries are at the bottom of the list for employees rating issues that affect their job satisfaction in the Press Ganey survey, says Locker. **(See charts on salaries and increases on p. 124.)** "It's obvious that salaries may affect an employee's decision to choose one employer over another, but money does not affect overall job satisfaction," she adds.

At Henry Ford Home Health in Detroit, employees always say they would be happier if they were paid more money, but there also are other issues that the organization's employee survey identifies, says **Greg Solecki**, vice president of the home health agency. Employees at Henry Ford did indicate that they wanted agency leadership to respond to their ideas and suggestions, he says. "This did not surprise us, but it is a challenge to find ways to solicit input effectively," he says.

There are several techniques that effective leaders use to communicate with employees and solicit their input, says Locker. "While specific activities differ from organization to organization, they need to be frequent and be designed to keep employees up to date on organizational issues," she says. "Town hall meetings, newsletters, intranet sites, and suggestion boxes can all be effective, but they need to fit your organization's culture and they need to be consistent."

Meetings are a routine part of the workday for all staff member at Southern Home Care in Jeffersonville, IN, so there never is a problem with attendance, says **Theresa Uhl**, RN, BSN, interim director for the agency.

"We have a morning report meeting each day



as all of our field staff, therapists, and nurses, get ready to visit patients," she explains.

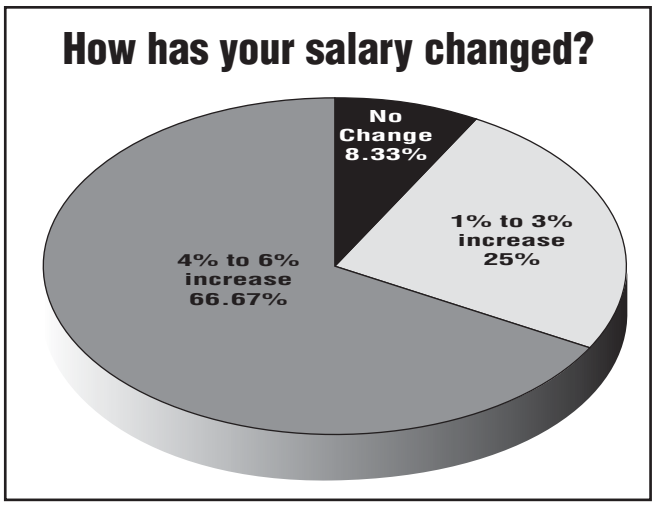
While these meetings last no more than 15 minutes, staff members can review new admissions, reports from on-call nurses, and issues that affect staff on a day-to-day basis, Uhl reports. "This morning, we reviewed the use of our new cell phones to make sure that everyone knew how to use the options." Not all staff members work each day, so housekeeping issues such as new phone use are covered several days in a row to enable all staff members to get information or instruction, she adds.

Bigger issues such as process or policy changes, updates on reimbursement issues, and reports on home health agency performance are addressed in monthly staff meetings that are run by the senior management of the home health agency, says Uhl. "We are getting a new computer system, and the monthly meeting is the best place to discuss how the changes will affect staff members because we have more time and can answer everyone's questions at one time," she reports.

The third type of meeting held for employees is a quarterly employee forum conducted by the hospital's administrative team, says Uhl. "This meeting lasts about 90 minutes and covers organizationwide issues that relate to mission, goals, and values," she explains. Attendance at the meetings is part of the workday, she explains.

"One part of every meeting is devoted to responding to employee suggestions or concerns," says Uhl. "We make sure that all employees know that we are taking all of their comments seriously," she adds.

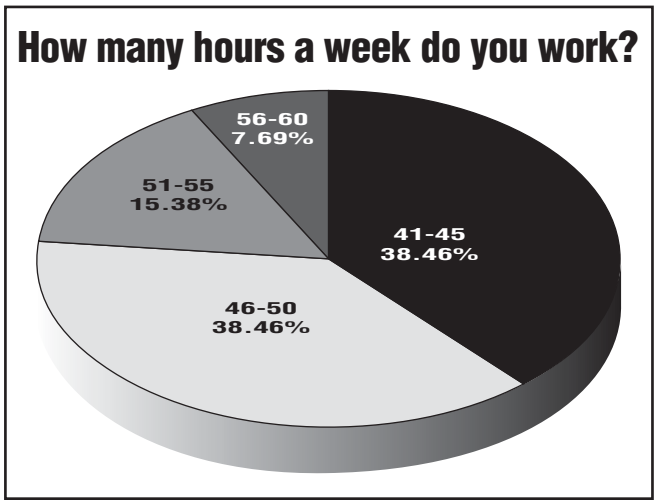
When responding to employee input in meetings or in any follow-up communication, use specific language, suggests Solecki. Use phrases such as "in the employee survey, you said you wanted this, and here's how we evaluated your



suggestion," or "at a recent meeting, several of you asked for this, and we are providing it," he says. By emphasizing that management's actions are in direct response to an employee request, you emphasize the fact that you are listening, he says.

At Southern Home Care, they are careful to be concise, stick to an agenda, and keep meetings as short as possible, says Uhl. "Home health staff members work long hours and have to accomplish a lot in that time," she says. **(See chart on hours worked, p. 125.)** "We know that sitting in a meeting that you don't think is beneficial is stressful, so we make each meeting as informative and useful as possible."

Even if you conduct regular employee satisfaction surveys, be sure you are clear about what employees say they want, suggests Solecki. "We conduct focus groups composed of employees from different areas of the agency to clarify information from the surveys," he explains. "The surveys may show that employees believe they need more resources to do their jobs, but do they mean computers or ink pens?" he asks. A focus group can help better define the actions you need to take, he says.



Technology also is helpful to stay in touch with employees, give them a chance to express concerns, and respond to their input, says Solecki. At Henry Ford, supervisors and managers are responsible for making sure that all employees are using voice mail effectively to keep communications between each other and other departments open, he says.

"Senior managers and directors are required to use e-mail whenever possible so that both of these technologies become an everyday tool to keep information flowing," he says.

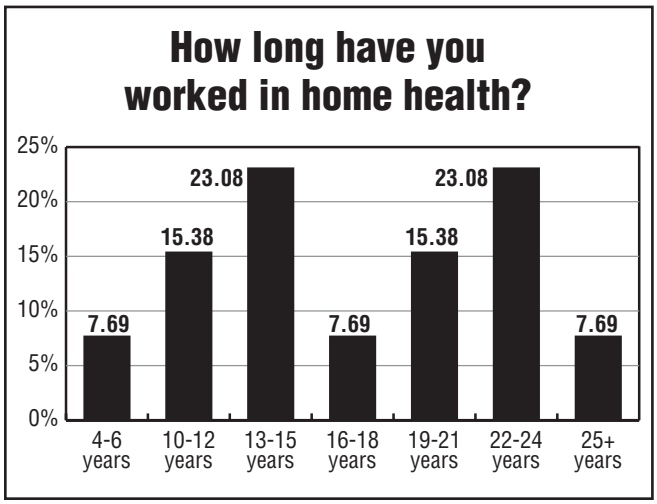
By cutting down on telephone tag and handwritten notes, you can make sure you respond to employees in a timely manner, he says. ■

Let employees know they're taken seriously

Being above board pays dividends

Sometimes you can't say yes to the solutions devised by employees, but you have to be ready to show that you listened and took the suggestions seriously, says **Theresa Uhl**, RN, BSN, interim director of Southern Home Care in Jeffersonville, IN.

Southern's nurses have undergone a difficult transition from hourly pay to salary over the past year, she says. Now, nurses want to work four 10-hour days for their workweek instead of five eight-hour days. "I have told them that I can make it work from a scheduling standpoint, but this is an issue that must be reviewed by our human resources department to see if the new pay structure and hospital policy will allow it," Uhl says.



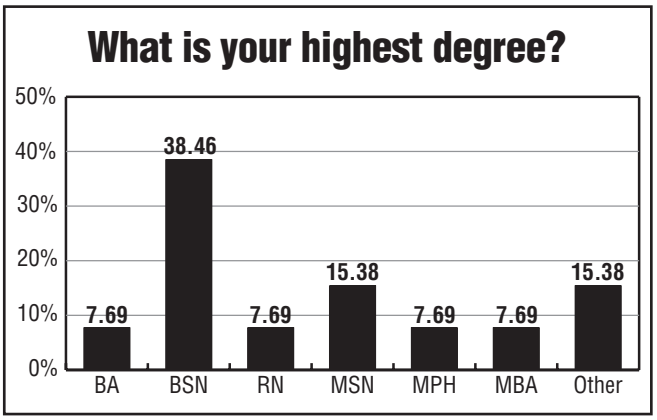
Even if the agency is unable to change the schedules, nurses will know that their request was taken seriously and that it was evaluated carefully before a decision was made, she adds.

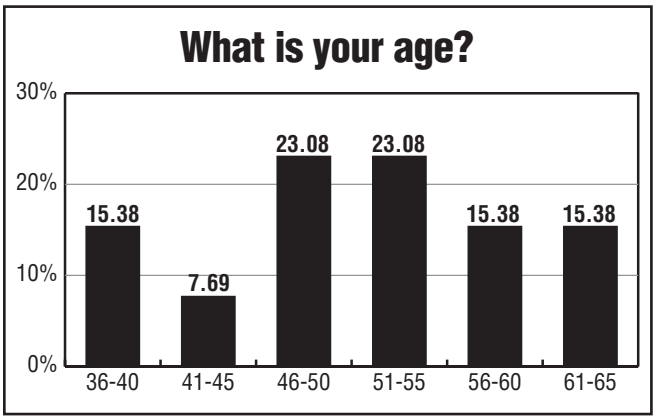
While almost 54% of salary survey respondents report more than 15 years in home health and more than 92% report more than 19 years in health care, experience alone is not an indicator of how well a leader will communicate, says **Greg Solecki**, vice president of Henry Ford Home Health in Detroit. **(See chart on home health experience above.)**

"I know that we've fallen short of developing true leaders as we've dealt with the staffing shortage," he admits. Sometimes the rush to fill positions, even supervisory or management positions, resulted in leadership positions not having true leaders in them, he says. "While experience, age, and education can be good indicators of a person's qualifications for a leadership position, personality usually determines who will be best," he says. **(See charts on education and age of survey respondents on p. 126.)**

A good leader knows how to listen without interrupting or appearing distracted or impatient, says **Monica Locker**, MPPA, director of the employee perspectives division of the Press Ganey satisfaction survey company.

"A good leader must also be sincere and credible," she adds. Credibility comes not only from experience in home health or in a particular position, but it also comes from doing what you say you will do, Locker adds. "This means that when a manager says that a problem will be evaluated, the manager comes back to the employee and shows how the problem was evaluated and addressed if possible," she explains. "A good leader also is able to talk and listen to everyone from physicians, to office staff, to nurses, and to housekeeping employees with the same level of attention."





When you have a leader who is comfortable talking with people of all backgrounds and experiences, you have someone who can ask for input in formal and informal settings, says Locker. This gives you a chance to gather feedback by "making rounds with a purpose," she adds.

"Rounding with a purpose is an excellent way to increase visibility of your senior leadership and get feedback from employees," suggests Locker.

"Rounding with a purpose" is more than just walking around the facility, she says. "You walk around with the intention of asking employees about specific issues or asking for general feedback," she explains.

While an administrator may not be the person to address concerns, it is important that the administrator to whom the employee expressed the concern be sure that the correct person addresses the problem and that the administrator communicates results, she says. "This is the best way to show that a leader not only listens but will also take action."

At Southern Home Care, all managers are required to turn in weekly "rounding logs," reports Uhl. "We keep a log of day-to-day interactions with employees that have uncovered issues we need to address."

Logs are passed along from supervisors to managers to directors and to administration, she says. Each issue is assigned to the appropriate people to address, and these issues and solutions are included on the agenda for the agency's staff meetings. For example, complaints about unfilled staff positions that increase the workload on other employees would be addressed with a verbal report on efforts to filled positions and the number of new employees in orientation, she says.

Whatever tactic your agency uses to communicate with employees, the key is to be honest, suggests Solecki. "Show that you have made a meaningful attempt to listen to the employees' concerns, evaluate the situation, and develop a solution," he says. "Make sure that you are honest and fair in your response, and your employees will know that you are listening." ■

SOURCES

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Building hospice homes catches on nationwide

Community involvement is crucial

About one in five hospices in the United States operate an inpatient facility or residence, and the number of hospice homes is growing, hospice officials say.

"You do find more folks starting to think about offering a residential facility to serve their communities," says **Jon Radulovic**, spokesman at the National Hospice & Palliative Care Organization (NHPCO) in Alexandria, VA.

"The needs of patients and families at the end of life are sort of changing, and they're more

complex than they probably were 30 some years ago when hospice began as a predominantly grass-roots movement," he says.

While the hospice goal remains to keep people at home, challenges arise when patients' symptoms can't be controlled at home or when caregivers are in need of respite assistance, he notes.

Also, hospices increasingly are serving patients with diseases other than cancer, including Alzheimer's disease, heart disease, and combinations of illness, Radulovic says.

"Our statistics show that in 2003, for the first time, end of life patients with a cancer diagnosis dropped below 50% to 49%," he reports. "These other serious illnesses can be more complex, and people may have symptoms that are harder to manage at home."

Plus, hospice patients with noncancer diagnoses may not follow as predictable of an end of life trajectory, so their needs will vary, Radulovic notes.

"The more comprehensive the range of services a hospice offers, the better equipped it is to meet those evolving needs of dying Americans," he says. "And having an adequate inpatient facility can be one of those ways to meet those evolving needs."

Another factor contributing to the hospice home trend is the changing nature of American family dynamics, says **Ted Williams**, CFRE, executive director of the Hospice Foundation of Lake and Sumter in Tavares, FL, which has plans to break ground in November and December for two residential hospice homes. The foundation already has funded 12-bed hospice home that opened two years ago.

"The family used to take care of their loved ones, and I can remember my own family taking care of my grandparents," Williams says. "But we're double-income families now, and I hate to say it, but we don't have the time."

Also, hospitals used to provide several beds or a wing for hospice units, but fewer hospitals can afford the space, Williams adds.

"In addition, people are living longer, to their 80s or 90s, and the caregiver or spouse may be too frail to consider looking after loved ones even if they'd like to," Williams says.

Also, while many hospice patients want to die at home, others prefer to be removed from the home near the end, says **Donna Shafar**, RN, patient care supervisor for The Villages (FL) Hospice House.

So a welcome alternative is a hospice home where the facilities often are new, well furnished, and comfortable, but have round-the-clock care for residents in their last weeks or days, she notes.

Hospice homes often provide respite care or symptom control for short-term stays of patients who want to remain at home during their end-of-life, but sometimes need additional help, Shafar says.

"We transition patients from the hospital to here," she says. "A lot of times, patients are very sick in the hospital, and they'll come here for a few weeks and maybe then transition to their home."

About 80% of the hospice home's referrals come from the hospital, and usually these patients will stay in the home, Shafar adds.

"Clinicians with patients who are very ill and whose life expectancy is very limited try to send them to us so the family can spend quality time with them in our facility, rather than their being in the hospital," she explains.

'Field of Dreams'

Residential and inpatient hospice care has been an unmet need for some time, reports **Debbie Flippin**, RN, MBA, CHPN, vice president and director of the Kate B. Reynolds Hospice Home of the Hospice and Palliative CareCenter in Winston-Salem, NC. The hospice home, which opened eight years ago with 20 beds, expanded to 30 beds at the end of June.

"It's been like the 'Field of Dreams,'" she says. "Build it, and they will come."

When the hospice first built the hospice home, administrators had no idea how well it would be supported by the community, but it has stayed at full capacity, Flippin says.

"About 60% of our patients come to us having never been in a hospice home care program, and that's a population that would never have been served by hospice without the home," she says.

"Most of the home's patients come from the acute care setting, and while cancer still is the primary diagnosis, the home also sees heart and chronic lung conditions," Flippin adds.

NHPCO's data show that about 52% of hospice homes are freestanding, while 19% are in hospitals and 5% are in nursing homes. Also, the data indicate that 43% provide acute and general inpatient care as well as residential and routine care, while 34% provide acute care and 23% provide residential care.[1]

Reference

1. Beresford L. Hospice inpatient facilities extend the continuum of end-of-life care. *Newsline* June 2005; 3-6, 50-51. ■

Adding hospice beds: Profiles of two efforts

Here's a look at new hospice home projects

Hospices from coast to coast are expanding or building new hospice homes as part of a trend of providing inpatient or residential care to end-of-life patients.

Here's a look at two hospices' involvement in building or expanding residential hospice beds:

• **The Villages (FL) Hospice House:** Lake County in Florida is one of the state's fastest growing areas, as it is a bedroom community of Orlando and Disney World.

Also, the area increasingly hosts year-round residents, who are replacing the "snowbirds," says **Ted Williams**, CFRE, executive director of the Hospice Foundation of Lake and Sumter in Tavares, FL.

So when the Hospice of Lake and Sumter in Tavares, FL, was offered free land for the purpose of building hospice homes, a foundation was formed and the money was raised, he reports.

"When you have something with community involvement and community commitment, plus the land up front, that's telling us they want us to be there, and there's a need to be met," Williams says.

The hospice has had a small hospice home facility in Tavares since 1987, but with the donated land, the Hospice Foundation of Lake and Sumter was able to raise more than $3 million to build a 12-bed hospice home and its $400,000 serenity center in The Villages, Williams says.

In July, the hospice received a first runner-up award for The Villages Hospice House at the Florida Medical Business newspaper's 16th annual Golden Stethoscope awards dinner in Fort Lauderdale, FL.

The home is located within a 55 years-plus development community that has nearly 100,000 residents, a shopping center, a bowling alley, a hospital, and its own zip code, Williams says.

Although the hospice home is located within The Villages, it is open to anyone, regardless of their ability to pay its sliding-scale room and board charge, Williams notes.

The 2-year-old facility has private rooms, each with a lanai, which is a screened-in back porch, says **Donna Shafar**, RN, patient care supervisor of The Villages Hospice House.

Patients' beds can be rolled outside, where a fan on the porch will keep them comfortable, Shafar says.

Rooms also have personal computers on wheels so patients can play computer games or access the Internet and e-mail, and there are DVD players in each room, along with pull-out beds and refrigerators, Shafar adds.

"We have a lobby area that would look like a family room, very comfortable and open with several couches and two round tables so families can eat lunch or dinner there," Shafar says.

A more private room contains a plasma screen television, and behind it is an office for family members who have to do work, including using a computer or fax machine, while they are staying with their loved one, she adds.

The hospice home operates with 15 nurses, 10-12 nursing aides, a patient care supervisor, a regional team manager, a housekeeper, a chief executive officer, and a part-time chef, Shafar says.

Plus, there are many trained volunteers, including cooks, servers, and greeters, she adds.

The average length of stay is 14 days, and while the home's residents may receive some Medicare or other payer reimbursement, it also relies on community contributions, Shafar says.

The foundation's plans include breaking ground in November on an eight-bed hospice home, and in December on a 10-bed hospice home. All four hospice homes will be within a 30-mile radius, Williams says.

"I'm running a $5.5 million capital campaign and have raised half of it so far," he reports. "The campaign has been under way for less than a year."

Also, future plans might include fundraising for endowments that would cover unreimbursed operational expenses at the homes, and there probably will be expansions down the road, Williams adds.

Each of the newer homes could be expanded, with The Villages Hospice Home having the space to add 36 additional beds in 12-bed units, he explains.

• **Kate B. Reynolds Hospice Home in**

Winston-Salem, NC: The hospice home opened with 20 beds eight years ago, and in June it was expanded to 30 beds, says **Debbie Flippin**, RN, MBA, CHPN, vice president and director of the Kate B. Reynolds Hospice Home, Hospice and Palliative CareCenter in Winston-Salem, NC.

The hospice also has built an education and counseling center at the hospice home site, she says.

Patients admitted to the home have either inpatient or residential needs. Inpatient beds are for patients typically seen in an acute care hospital, Flippin says.

"They generally have a short-term need for symptom management," she explains. "The residential beds are for someone who either does not have a home or does not have a caregiving system that allows the person to stay at home."

The average length of stay for the combined levels of care is nine days, Flippin says.

Rooms are larger than the typical hospital room and all are singles with bathrooms. The initial 20 bedrooms had a large window seat that could be used as a makeshift bed for caregivers, she notes.

"We have rollaway cots available and a recliner that folds flat to make a bed, and we encourage caregivers to stay," Flippin says. "We also have family rooms on each wing, and we have a sun porch on each wing."

Each room has a small desk table and computer and phone hookups.

About 75-80 employees, both full and part time, staff the hospice home, Flippin says.

The hospice decided to build a hospice home after deciding that it was difficult to provide a continuum of care for patients who moved between acute care, the home, and long-term care facilities, Flippin explains.

"Our patients were getting lost in the system, and as hard as we tried to have a continuum of care, we found it didn't always happen," Flippin says. "Even simple things like finding parking for family members was difficult."

After two years of meetings, including joint meetings with local hospitals, the hospice decided a hospice home was the best way to meet the needs of patients who had short-term acute management needs, Flippin says.

"Both hospitals started with giving us a million-dollar loan to start the capital campaign," she adds.

Initially, the capital campaign raised $2.2 million for the hospice home, and the cost of the addition was $1.7 million, Flippin says.

Although the home remained at full capacity since it opened, it took a while for the hospice to convince the state, which requires certificates of need, that additional beds were needed, Flippin says.

The hospice home charges $120 per day on a sliding income scale, and private insurance will reimburse some costs with the community fundraising covering deficits, Flippin says.

"We have several fundraisers a year and a fair number of memorials left to us," she reports. ■

Improve bedside manner with 'tuck-in' program

Reduce off-hour calls, improve teamwork

Sometimes a hospice's client satisfaction and staffing problems stem from repeated and often unnecessary off-hour calls by patients and families.

A Colorado hospice has addressed this issue by starting a "tuck-in" program that includes additional staff training and scheduling changes.

The Hospice of Metro Denver identified several problems in the past year, including a disappointing client (77.69%) satisfaction score on a family evaluation survey, says **JoAnne Foulk**, RN, CHPN, clinical manager for the nursing home Northwest team of the hospice.

As a result, hospice managers began to look at all patient data to identify the nurses who were what they called "the best tucker-inners," or the nurses who had the fewest weekend and evening calls from patients, she says.

"We got these nurses together and tried to figure out what they did that was different from what the other nurses were doing, and we came up with a list," Foulk explains. "Then we presented the data we received to the home staff."

Hospice managers held four mandatory meetings for nurses and will expand the education to social workers, certified nursing assistants, and other staff, she says.

The chief items on the list were communication, clinical skills, and pathophysiology, including how well nurses understand what is going on with a particular patient's disease process, Foulk notes.

"Clinically, what we found was we had a lot of calls about leaking Foley catheters and people

running out of diapers," she says. "It was simple stuff, including medications and people not knowing they had medication in the refrigerator that could help them with pain control or nausea and vomiting."

The nurses knew how the clients could take care of these mostly minor issues, but for some reason they weren't doing a good job of communicating what they knew about the patient comfort packs and how these could help the patients, Foulk says.

So the hospice began to teach nurses how to improve their communication skills, including how to sit down with a patient and family member, who still are shocked by the recent knowledge that the patient will not recover, and answer their questions and concerns, she explains.

"We have to reassure the patient and family that everything is going to be OK and that we'll be there for them and they are capable of doing what needs to be done for their loved one," Foulk says. "We want to increase the family and patient's confidence, their understanding of the disease process, and their understanding of medications being used."

Hospice managers teach nurses to bring in all of these details right from the start of meeting with patients, but this information also has to be reinforced many times because the family may only digest about one-tenth of the information at the beginning, she says.

The more patients and families hear instructions repeated, the easier it is for them to deal with that piece, says **Maureen Pangle**, RN, ND, CNS, clinical manager.

"Nurses need to help them deal with their loved one," she adds.

As part of the nursing education, Foulk asked nurses to imagine that they were the only nurse on call every night and on weekends, and if they were called at 2 a.m., they'd have to travel the hospice's service area, spanning 50 miles across. Then, if they were that only nurse, what would they do to prepare patients and families for all possible small emergencies?

This scenario worked for **Maryjean Blair**, RN, CHPN, primary care nurse at the hospice, because she has done work on weekends, she says.

"So I started thinking about my patients and what could happen tonight and in the next few days," Blair says. "I started to get a feel for where a family was and whether they could take in all of the information."

As a result, she began to go through the medications in the comfort pack and try to get families and patients comfortable with these, particularly toward the end of the week.

"I'd try to prepare them for a tuck-in for the weekend, and I always remembered JoAnne's words of how you're the only nurse out there, and so I'd try to think broader about what could happen and what would help the families prepare," Blair says.

The additional nurse education focused on teaching nurses how to anticipate and plan for the next step, Pangle explains.

"They know the disease process and can't exactly predict what's going to happen, but they know basic things that will happen down the road," she says. "So we try to get nurses to think about what will happen at week one, two, and three, if we get that far."

Blair soon discovered that her additional time spent educating patients and families was working.

"As soon as I started doing this reinforcing and teaching, I would hear on voice mail messages that when someone did call in, the family had more awareness of what to do," she says. "Patients started calling less, and from the feedback I knew they knew what to do."

From the initial nursing focus groups, managers learned that nurses who did best with tuck-in were great motivators, says **Julie Isaacson**, RN, MSN, NP-C, palliative care consultant.

"Whether the family was coping well or not, whether they understood what was going on or not, the nurses were motivating the families and giving them confidence," she says.

The most successful tuck-in nurses were telling families that they were doing a great job, really helping their family and loved one, Isaacson notes.

"This gave the family more confidence that if

COMING IN FUTURE MONTHS

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- Mentoring programs that train and retain nurses
- How to get written orders on the chart on time

something did happen after hours they wouldn't freak out, but would remain calm and think about what they could do," Isaacson says.

Foulk encouraged nurses to write instructions down for families, leaving some written record that families could refer to.

This also served the purpose of keeping different shifts of caregivers well informed, she notes.

"Keep in mind that a lot of caregivers during the week may not be the caregiver on the weekend, so it's important to have something written down," Foulk says. "We have a packet that's left in the home, and nurses can leave notes in that packet."

Another aspect to the nursing education is to encourage nurses to learn more about their families and customize their communication style to fit a particular family, Pangle says.

"So, if you have a caregiver who has poor eyesight, maybe you could put the information on a poster board; whereas for another family, you can keep a running notebook of things," she explains.

"The nurses in the original focus group were comfortable with communicating with patients, including talking about death and dying issues," Pangle says. "They could have hard conversations and really be able to listen."

So much of the tuck-in problems go back to communication difficulties because the hospice already was taking care of all of the patient's physical needs, including medication, Foulk reports.

Still, it was important for nurses to attend to the details of making certain patients had enough medicine, diapers, and other items to get them through the weekend, whether the patient was at home or in a nursing home or assisted living facility, Foulk says.

This might mean the hospice nurse would have to communicate with the nursing home nurse to make certain everything was in order, she adds.

"You'd be surprised at how many phone calls were about people running out of diapers, which they could buy at a drug store, but they expected us to have them there if they were in a nursing home or assisted-living facility," Foulk says. "It's our responsibility to make sure they have them there as a backup, and sometimes, they can't leave, so you just want to have all your ducks in a row."

After the training, managers conducted evaluations and found that the majority of staff found the education to be helpful, Isaacson says.

"We had a few outliers who were disgruntled that it was mandatory or who felt it was only needed for newer nurses, but we also had seasoned nurses who found it helpful to review the information," Isaacson says.

After feedback from the first training session, managers altered it to provide more discussion in the second session, Isaacson says.

Finally, the additional training stresses

CE *questions*

5. What is one component of an emergency preparedness plan that many home health agencies neglect to include, according to Maryanne L. Popovich, RN, MPH, executive director of home care accreditation for the Joint Commission on the Accreditation of Healthcare Organizations?
   A. Protection of patient files
   B. Telephone numbers of staff members
   C. How to deal a disaster caused by mechanical or technological problems as opposed to natural disasters.
   D. When to resume billing activities

6. Why is attendance at staff meetings never a problem at Southern Home Care, according to Theresa Uhl, RN, BSN, interim director of the agency?
   A. Staff members receive bonuses for attending
   B. Meetings are a routine part of the work schedule
   C. Managers keep the meetings short and information-filled to make the best use of time.
   D. Both B and C

7. According to information provided by Press Ganey, three of the top five issues reported by a survey of health care workers related to:
   A. Effectiveness of communication between employees and senior leadership
   B. Pay and benefits
   C. Opportunities for advancement
   D. Professional education

8. Which of the following is a factor in the growth of residential hospice beds nationwide?
   A. Consolidation of home health agencies and hospices
   B. Increasing complexity of the illnesses in today's elderly
   C. Medicare policies
   D. All of the above

Answer Key: 5. C; 6. D; 7. A; 8. B.

teamwork, Foulk says.

"When we go into a home people see individuals," Foulk says. "But we want to stress that each member of the team exchanges information about the patient, and the family needs to know that." ■

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After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

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2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■

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