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Coping skills intervention improves quality of life and reduces stress of caregivers

Intervention requires 3 brief sessions

New research shows that a three-session, educational intervention with caregivers of cancer patients in hospice can significantly improve the caregivers' quality of life and reduce burden related to the patients' symptoms and duties.[1]

Investigators adapted a psycho-educational intervention used in stress research, called Brief COPE, to use with hospice cancer patients, says **Susan McMillan**, PhD, ARNP, Lyall & Beatrice Thompson professor of oncology quality of life nursing at the University of South Florida College of Nursing in Tampa, FL.[1,2]

"We realized that the difference in hospice and other cancer patients is by the time they get to hospice they are very ill and fragile and weak," McMillan says. "So we couldn't use an intervention of self-care practices as you might do with healthier patients."

Instead, the intervention is designed for the caregivers since most hospice care in the United States takes place at home, she adds.

"Hospices support family caregivers, so our intervention was designed to support, aid, train, and help the family caregiver," McMillan says.

COPE is an acronym that describes the intervention, as follows:

• C for creativity: "We want the caregiver to be creative in managing the symptoms," McMillan says.

• O for optimism: "We want caregivers to believe they can manage the symptoms," McMillan says. "We find a lot of situations where people believe pain cannot be relieved, and so they give up and don't try."

• P for planning: Caregivers need to plan around events that might cause symptoms, such as pain and shortness of breath, and help patients better cope with them, she says. "For instance, if the family is

going to have a get-together, then plan the pain medication around that event so the patient can be comfortable for most of the event."

• E for expert: When in doubt, caregivers should consult expert sources, such as hospice staff and the COPE manual that they're given, McMillan says.

The manual is in a 3-inch binder, and its sections are written in an accessible style so caregivers can easily refer to chapters of particular interest whenever they have questions or problems, she explains. (*See sample from COPE manual, p. 40*).

Investigators added a chapter on constipation to the COPE manual, McMillan notes.

"Whenever you manage a patient's care with opioids, you almost always cause constipation, so it's foolish to think you'll manage pain and ignore constipation," McMillan says. "It's an under-assessed problem throughout the health care arena."

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After modifying the intervention for the hospice caregiver, investigators began to test it to see if it would be effective and immediately translatable to the bedside, McMillan says.

When designing the study with the intervention group and the group that received standard care, researchers decided to add a third arm that would receive standard care plus three extra visits in the home, McMillan says.

"As we were designing the study, we thought the intervention group might benefit from the extra attention," she explains. "Maybe just the effect of the time was what we were measuring, so we added a second control group that we called attention control."

The results showed that the COPE intervention group of caregivers had a significantly better quality of life than both the standard care group and the standard care plus extra time group, McMillan says.

"The intervention group experienced less stress from the patient's symptoms," she says. "Our randomized scheme worked, and it was the training we gave the caregivers that made the difference."

Also, the study found that the COPE intervention decreased burden related to patients' symptoms and caregiving tasks, meaning the caregivers were better able to tolerate patients' pain and constipation or the personal care tasks.[1]

The study's findings suggest that COPE intervention is a way to improve caregiver's well-being and enhance existing hospice care.[1]

Typically cancer patients do not stay in hospice care for long, so the intervention was designed to be presented with three visits in nine days, McMillan says.

Registered nurses provided the intervention visits, and the first one was conducted within the first 2-3 days of admission, the second was on days 5 or 6, and the third was on the 7th to 9th day, she says.

The study enrolled only patients who had at least two of three main symptoms, including pain, shortness of breath, and constipation, McMillan says.

The interventions basically were implemented in this way:

• First visit: The RN introduced herself and spoke about the COPE approach, explaining what each letter in the acronym stands for, McMillan says.

"Then we focused on one of the patient's symptoms, letting the caregiver decide which

was the priority symptom," she says. "We taught the caregiver how to do the COPE intervention, and gave the caregiver homework about the second symptom."

The first session lasted about 45 minutes, although initially it was supposed to be 1.5 hours long, McMillan notes.

"We cut the time in half because of the caregiver's attention span," she says.

Also, the intervention's first approach was to show caregivers a short video that demonstrates the COPE method, but investigators quickly found that patients didn't have the patience to sit through the video and then concentrate afterwards on what the nurse had to say, McMillan says.

"So we piloted the first 25 patients with the video, and then eliminated it and, instead, had the RN go through the intervention, using the COPE book," she says.

• Second visit: This session focused on the second symptom that concerned the caregiver, going over the homework assignment. Then the nurse briefly would go over the information from the first session, McMillan says.

This session lasts one-half an hour and it includes an assignment regarding the third symptom.

• Third visit: This visit focuses on the third symptom, recapping the information provided for the second symptom.

Also, since this is the last visit, part of the half hour session includes a closure process to make certain the caregiver understands that this particular nurse won't be returning to the home, McMillan says.

The study's COPE intervention is immediately translatable for hospices with cancer patients, and there already have been requests for the COPE manual from hospices around the world, McMillan says.

Eventually the entire intervention and manual will be available electronically so that it might be easily sent to anyone who requests, she adds.

"We manualized this intervention so that we could share it with other investigators or other hospices that asked for it," McMillan says. ■

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2. Carver CS. You Want to Measure Coping But Your Protocol's Too Long: Consider the Brief COPE. *Int J Behav Med*. 1997;4:92-100.

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Decrease hospice denial rates through documentation education

Hospice shows how to support limited prognosis

A Pennsylvania hospice reduced its denial rate by more than 80 percent after instituting a formal educational program that taught staff how to properly document patients' need for hospice care.

"We realized we weren't painting the picture as we see it," says **Janet Carroll**, MSN, CHPN, vice president of clinical services for Hospice of Lancaster County in Lancaster, PA. Carroll also is the chair of the National Hospice & Palliative Care Organization's (NHPCO's) regulatory subcommittee.

"To say a patient is weak does not paint the picture," Carroll says. "We have to say what it is about this person's weakness."

The hospice focused staff training on how to support the gut feelings they had about patient's prognosis, she explains.

"Hospice eligibility is determined by limited prognosis," Carroll says.

"What we were able to do with our own staff and what we're sharing with others in the industry is that perspective," Carroll says. "And the other piece of our documentation is how one supports the level of care."

A hospice patient's symptoms will improve by virtue of the fact that the hospice team is providing symptom management and support, but symptom relief does not necessarily change the prognosis, Carroll explains.

When assessing patients, hospice staff should

Caregiver Manual Offers Tips on Caring for Cancer Patients

Researchers created a simple, three-visit intervention to assist caregivers of cancer patients who are in hospice because of advanced cancer. Part of the intervention includes a manual called "The American College of Physicians Home Care Guide for Advanced Cancer: When quality of life is the primary goal of care."

The revised manual includes tips that caregivers can use to help relieve their family member's pain, shortness of breath, and other symptoms. In the chapter on cancer pain, there are some of the tips about the five ways to relieve pain resulting from cancer. Included in this section are suggestions for managing the more common side effects of pain medicine. The excerpt below provides a sample look of the tips in the following section:

Manage the more common side effects of pain medicine

o Prevent constipation with stool softeners and laxatives.

Narcotics are dehydrating. They take water from the stool, which results in constipation. Stool softeners are pills that put the water back in, making the stool softer and easier to pass. Some people take one or two stool softeners in the morning and one or two at bedtime to prevent the problem.

If stool softeners and laxatives do not work and the patient has not had a bowel movement in 2 or 3 days, give a product that is purely a laxative, such as Milk of Magnesia. You also may have to increase the number of stool softeners and stimulants taken each day. One Dulcolax rectal suppository every day can be very helpful. Problems with constipation mean that you need the help of hospice workers. If your family does not have help from a hospice, call the pain clinic or hospital and ask for a referral. These staff members know how to solve problems of constipation and pain, and they will help you with many aspects of caring at home for someone who has advanced cancer.

o Relieve a dry mouth with crushed ice, hard candy, and frequent rinses with water or products that do not contain alcohol.

o Relieve painful, dry nasal passages by humidifying the air or breathing in moisture from a sink full of warm water.

o Avoid an upset stomach by taking medicine with food or antacids unless instructed otherwise.

o Expect drowsiness for a few days when pain medicine is started or increased.

If sleepiness increases just after starting or increasing pain medicine, wait about 3 days. Sometimes sleepiness happens because a person is finally getting relief from his or her pain and needs to catch up on missed rest, or the body just needs time to adjust to new medicines or doses.

compare them to well patients, not to dying patients, and they should explain why there has been an improvement if there is any improvement in symptoms.

This is why thorough documentation is necessary, Carroll says.

Hospice of Lancaster County held 1.5-hour workshops on documentation, attended by groups of eight to 12 employees, Carroll says.

The workshops covered the critical times, including admission, course of care and change of level, and recertification, she says.

The staff education also explained to employees that all hospice notes must do the following:

- paint the picture in words;
- be written for someone who does not know the patient;
- support the prognosis.

Also, the staff is taught that the visit note requires staff to do the following:

- begin the note before the visit;
- anticipate: know what you are going to look for before you walk through the door and achieve balance;
- know what you will need to document;
- know what the patient and family need today.

The visit note should include the following:

- patient and caregiver report;
- physical assessment with details beyond "weakness, pain, and shortness of breath";
- disease-related signs, symptoms, changes, including wounds;
- function: activities of daily living, compliance;
- nutrition: weight, intake, change in diet;
- emotional health: coping, caregiving, family dynamics;
- spiritual health, including coping, meaning,

faith, spiritual support;

- other changes and other needs;
- nursing and certified nursing assistants assessments; and
- physician assessment and orders.

Hospice staff should continually ask themselves the question, "What did I see, what are we monitoring?" Carroll says.

For example, if a hospice nurse documents that a patient has no nausea when there was a problem with nausea before, then that gives an incomplete report. The truth that should be documented might be that the patient is receiving medication for nausea every six hours around the clock to control the symptom, Carroll says.

"If you say there's a decrease in the patient's activity, what does that mean?" Carroll says.

It would be better to document that the patient used to walk up and down the stairs, but now can only get out of bed to go to the bedside commode, she explains.

"In terms of whether a patient appears weaker, tell me what that means," Carroll says. "If I ask the person who makes the assessment where did you get the idea the patient was weaker, the person might say, 'Last week the patient greeted me at the door, and we walked out into the backyard, and this week the patient greeted me at the door, but barely made it to the couch in the living room.'"

But if the hospice nurse doesn't document both examples of the patient's activity then there is no reference point for comparison, showing how the patient has become weaker, Carroll says.

Even saying the patient appears more uncomfortable is not sufficient documentation.

What might be said instead is that the patient last week was able to sit in a chair, move around easily, and now he is guarding his right side and his breathing is shallower because of increased pain, she says.

In another example, it could be that a patient who used to be short of breath when greeting the nurse at the door now is breathing normally when opening the door. While this might appear to be an improvement, the truth might be the more complex answer that the patient had been walking down the stairs before opening the door, and now the patient's breathing has become so difficult that the patient doesn't take the stairs at all anymore, Carroll notes.

"That's a case where it may appear things have improved, but it's because the patient has accommodated," she explains. "So the patient may be less short of breath, but it's because the patient has become less active."

Key points to remember when documenting hospice notes are to not confuse the word decline with prognosis, or to think that an improvement in symptoms means an improvement in prognosis, Carroll says.

By including all of these details in documentation, the hospice employee is providing a clear picture that essentially shows how the intervention is working, but it doesn't mean the reason for pain or shortness of breath has gone, Carroll says.

Hospice eligibility uses the time frame of six months prognosis, but the benefit is unlimited as long as at each point of recertification someone is still saying that if the patient's disease runs its normal course the patient will die within six months, Carroll says.

"If a patient has a limited prognosis then the patient should be recertified for hospice care, and we should paint the picture of why we think that," Carroll says. "We need to translate our gut feeling into something that would convince someone else as to why we think this is the situation." ■

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Hospice partners with university to provide education for nurses

Collaboration benefits all sides

When the West Virginia School of Nursing needed a new instructor for its parish nursing Internet class, the woman who had been teaching the course approached two officials with Hospice Care Corp. of Arthurdale, WV.

"My supervisor, Malen Davis, and I were approached by Dr. Deborah Harr, who was the instructor of the parish nurse program at WVU, and she was a mutual acquaintance," says **Robin Shepherd**, MSN, CHPN, vice president of faculty and parish nurse programs for Hospice Care Corp.

"So we took the faculty training at the International Parish Nurse Center and also completed the basic nurse preparation course through WVU in order to be certified to teach," Shepherd says. "Then we began our first on-line course in late August 2005 with 15 students."

The hospice's parish nursing outreach has resulted in at least one referral to Hospice Care Corp., although there is the potential for many more referrals to hospices in the various regions in which parish nursing students live.

A local pastor referred Shepherd to a family where a member was gravely ill, and the family decided to request hospice care after meeting Shepherd, she says.

Since the parish nursing role is as an educator within faith communities, it's a natural fit for hospice work, Shepherd says.

"Parish nurses serve as community referral source and a linkage with parishioners," she says. "In my own church I'm working on a health fair in April with vendors and speakers and I'm coordinating it with hospice care."

"This is a link to our faith-based community because we're a community hospice," Shepherd says. "We've expanded to 12 counties and cover a lot of territory, and we're intimately involved with our communities."

The hospice staff can serve as resources for church congregations when needed, and this might mean providing educational sessions for the parish nurses on advanced directives or having a parish nurse contact the hospice when they need resources about a particular medication, Shepherd says.

"Or the parish nurse might call us to say, 'I have a person who needs someone to discuss hospice with him,'" she adds. "Hospices want to be seen as someone who can help."

Parish nurses work within the church to bring holistic health care services to the congregation, including spiritual support, education, home visitation, and health care information, Shepherd adds.

"The thing that is unique about this type of nursing and why it fits in with hospice care is because we use the holistic approach of mind, body, spirit to health care," Shepherd says. "And hospice uses the holistic approach to dying, so it's a short jump to hospice."

Hospice Care Corp. has had three staff members take the parish nursing training, and this is another way to increase the hospice's community outreach and visibility.

"It's absolutely worth investing in this training," Shepherd says. "If we're really providing spiritual care to our patients and families, why not share that with people who are not dying and help to educate them about their choices and resources when their time of life comes."

The parish nursing college program works this way: The university supplies technical support and has paired Shepherd with an information technologies employee. Together they placed the curriculum in a structure that works for on-line education, Shepherd explains.

"Basically the technical person and I sat down and altered the coursework to make it user-friendly on the computer," Shepherd says.

Students who would like to register for the class must apply and verify that they are registered nurses with two years of nursing experience, as well as submit two reference letters, including one from a clergy source, she says.

"The reason for this is to establish the student's spiritual maturity," Shepherd says. "You want to see some evidence of some kind of spiritual involvement because it's a ministry done through a faith community."

After the student's application is accepted, the student is told how to register on-line through WVU, and WVU sends Shepherd a list of students who have paid and registered for the course. She then mails them a textbook.

The course is for one semester, and there are 21 modules over 14 weeks. Each module is followed by an assignment and/or discussion board. The modules cover these topics:

- Introduction to history and philosophy of parish nursing;
- introduction to health, healing, and wholeness in the faith community;
- ethics in parish nursing;
- legal issues and accountability in parish nursing;
- assessment: individual, family, congregation;
- functions of the parish nurse: personal health counselor;
- functions of the parish nurse: integrator of faith and health (spiritual caregiver);
- function of the parish nurse: health educator;

• function of the parish nurse: health advocate;
• function of the parish nurse: referral agent;
• function of the parish nurse: coordinator of volunteers;
• function of the parish nurse: assessing and developing support groups;
• getting started;
• functioning within a ministerial team;
• health promotion and wellness;
• prayer and worship leader;
• grief and loss;
• end-of-life transitions;
• family violence;
• documentation, and
• self-care for parish nurses.

"The students have a week to complete the assignments, and there are some questions placed on line so students can answer questions and discuss their viewpoints back and forth with one another," Shepherd says.

"There is also an opportunity for them to chat on-line if they choose to do so," she says. "I access all emailed assignments, which are submitted every week, and I read the on-line discussion questions and will give input when it's appropriate to do so."

When Shepherd receives a student's assignment that is particularly outstanding, then she will email the student and ask them to share it with other students, and then she'll email it to all participants.

"Some students have done extraordinary work," Shepherd says.

For instance, one assignment is to design a healing service. "I found in the first semester that they were so beautifully written and inspiring that I wrote all the students to see if I could share all of them, and the students were thrilled," Shepherd recalls.

"I did the same thing with their final project, which was to design a parish nurse program for their congregation, listing three priorities for the first six months of practice," she says. "So they're building on what they're learning for the entire course, and they can take the information and put it into practice."

For the grief and loss module, one assignment was for students to describe and discuss the experience they had with a dying person, Shepherd says.

"Those were some of the most moving stories," she says. "You could see where they made the connection from health care ministry and dying."

Need More Information?

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So far, most of the students have been from West Virginia, although there have been students from as far away as Vermont who've signed up for the course, Shepherd notes.

"A lot of students have told me they love the on-line course because it's conducive to their lifestyle," she adds. ■

Cut hospitalization rates with 24-hour availability, visits at start of care

Top performers share best practices in national study

(Editor's note: This is the first of a two-part series that addresses reduction of hospitalization and strategies to improve performance in Home Health Compare measures. This month, findings of the National Home Health Hospitalization Reduction study are discussed, with tips from the best performers. Next month, strategies that help successful home health agencies reach the top 10% of Home Health Compare categories will be discussed.)

As performance improvement programs and the ability to track data and trends from OBQI reports have become more sophisticated, home health agencies report improvements in all categories, except hospital readmission rates.

That lag was the primary reason hospital reduction was chosen as the topic for a national home health study conducted by the Briggs Corp. and co-sponsored by the National Association for Home Care & Hospice and Fazzi Associates Inc.

"The national average for hospitalization from the home health care setting is 28%," points out **Robert Fazzi**, EdD, president and CEO of Fazzi Associates, a benchmarking and consulting company in Northampton, MA. While the average has not changed significantly in a negative direction, it also has not improved over the years, he adds. "We wanted to identify the best performers, the agencies that were in the top 10% of this category, and document what strategies they were using to reduce their hospitalization rates," he explains.

After identifying and contacting slightly more than 700 agencies that are in the top 10% of agencies with the lowest hospitalization rates, more than 200 agencies were resurveyed in the final stage of the study, which focused on specific strategies used to reduce hospitalization.

"While 333 agencies responded to the first contact with descriptions of strategies they used, we went back to the final 205 because they were intentionally using these strategies in an effort to reduce hospitalization," he explains. "We did find that the most successful agencies used multiple strategies rather than only one," he adds.

The most prevalent strategies used to prevent hospitalization by study participants were:

• Falls prevention

The elderly population cared for by home health makes fall prevention a high priority for many agencies, Fazzi points out. A total of 66% of survey respondents use environmental assessments of the home, evaluation of medications that can cause dizziness, and identification of balance difficulties as key efforts to prevent injuries from falls, he adds.

• Front-loading

The most unexpected strategy to make the top of the list was front-loading, a method used by 64% of agencies in the study, says Fazzi. "These agencies identify patients at risk for hospitalization and adjust their visit schedule to see the patient more frequently in the first few weeks after admission," he explains.

The staff at Washoe Home Care in Reno, NV, attribute their agency's hospitalization rate of 17% to front-loading. "We work closely with the hospital discharge planner to identify high-risk patients and we meet with the patients before their discharge," says **Martina Petersen**, RN, interim director of the agency. "If home care is appropriate for the patient but we think the patient and the caregiver will need extra support, we schedule extra visits in the first two weeks to provide extra care and education," she explains.

• Management culture and support

Sixty-one percent of agencies in the study identified their organization's culture as a key factor in reducing hospitalization, Fazzi says. "All staff members are involved and no person puts a 2 p.m. crisis on hold. Everyone addresses a patient's problem as soon as possible so that the patient doesn't feel like he or she needs to go to the hospital for care," he explains.

"All of our staff members know that outcomes matter," says **Patricia Fleming**, RN, chief clinical officer for VNA of Rhode Island in Lincoln. "Outcome data are presented every two months to our board members, every quarter to our quality council, and every month at our supervisors' meeting," she says. Supervisors share information with their staff members and outcome data are posted on bulletin boards, she adds.

Before you can share outcome information, you do have to make sure that someone is reviewing and evaluating the data on a regular basis, Fleming points out. While she is the point person for reviewing the data, all staff members become involved in identifying areas that need improvement and tactics to improve outcomes.

• 24-hour availability

Answering services, nurses on call, and triage teams are used by 59% of the study participants to keep patients at home, says Fazzi. "Some agencies even offer a guarantee of a returned call within one-half hour," he says.

"We are fortunate that our hospital has an RN-staffed answering service for patient calls after hours," says **Eileen Sube**, manager of regulatory compliance for Conemaugh Home Health in Johnstown, PA. "The nurses use standardized protocols developed for our patients to triage the patient," she says. The protocols include questions to identify the cause of the patient's symptom and offer suggestions on what the patient should do, she says. "If the nurse believes that the patient needs attention beyond the protocol, home health nurses are on call to make phone contact or visits to patients," she adds.

• **Medication management**

Because medication can affect a patient's risk for falls and different medications can interact with each other to create unanticipated complications, 59% of agencies in the study focus on accurate lists of medications that patients are using and regularly review this information, Fazzi says.

"Our patients may be on as many as 20 different medications so we check medications every time we visit the patient," Fleming says. Nurses and therapists are instructed to go through medications at each visit, update lists in the chart, and check for contraindications with software on their laptops, she explains. "We tell patients to place all of their medications on the kitchen table so we can be sure to see everything," she adds. "The only way we can avoid complications from medications is to check the medications every time, and make sure patients understand what they are taking and how they should take it," she says.

• **Case management**

Fifty-two percent of study participants use case management to manage patient care, says Fazzi. Having one person who oversees a patient's care, no matter how many disciplines are involved, increases the likelihood that a change in condition or symptoms that indicates a decline, will be noticed, he adds.

While her agency doesn't use case managers, Sube points out that the use of a primary nurse for each patient is also effective. "Our nurses are responsible for between 10 and 25 patients that they visit," she says. "The nurses are also responsible for receiving communications about the patient from other staff members, such as therapists, who visit the patient," she explains. Because the primary nurse knows the patient well, she can identify changes or symptoms that might indicate a problem that could lead to hospitalization, she says.

• **Patient and caregiver education**

"We revised the teaching handouts that we have always used for patients and have found that improved education reduces trips to the emergency room and the hospital," Sube says. A total of 48% of the participants in the hospital reduction study reported that patient and caregiver education was a crucial strategy in their efforts to reduce hospitalization.

"We've always used written handouts for patients and their caregivers, but two years ago we rewrote the handouts to use lay language rather than medical language," explains Sube. "We also increased the size of the type to 14 points and we used bullet points and short sentences," she adds. The one-page handouts that are designed for different conditions clearly spell out signs and symptoms for which patients should be looking.

"By explaining the disease and by clearly and simply describing early warning signs of trouble, we are able to better educate the patient and caregiver," says Sube. Patients say that they refer to these handouts more often because they are easy to read, she adds, and nurses reinforce the information on the handouts by using them as teaching tools when they make visits.

Best strategies are low cost

"It is interesting that the top strategies don't cost a lot of money," Fazzi points out. "These strategies don't involve investment in technology or additional staff, but they do require development of policies and staff education," he says.

Other strategies such as telemonitoring did not show up as a top strategy but that doesn't mean it isn't effective, he adds. Only 8% of study participants used telemonitoring as a hospital reduction strategy; but only 5% to 10% of all agencies in the country use telemonitoring, he points out.

"We have used telemonitoring for any of our patients with chronic conditions that may require extra monitoring," says Fleming. By using a telemonitor to capture and transmit information, such as blood pressure, weight gain, and oxygen levels, nurses are able to intervene before the patient reaches a crisis point, she explains.

Home health managers are fortunate that so much data on outcomes are collected and available in a benchmark format, but it is important to use the information to initiate improvement, suggests Fazzi. "Home health managers need to look at Home Health Compare, see where they rank in relation to other agencies, choose a quality improvement project, and set specific targets to reach. Studies that share best practices can help agencies identify ways to reach their goals." ■

JCAHO Alert Addresses Medication Errors

More than 10% of all sentinel events reported to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) relate to medication error; but in home care, over 13% of sentinel events relate to medication error.

According to the Joint Commission, in a *Sentinel Event Alert* issued in January 2006, 63% of the medication errors that resulted in death or serious injury were a result of communication breakdowns. Half of the communication breakdowns would have been avoided with effective medication reconciliation, according to report authors.

To reduce errors related to medication reconciliation, the authors recommend:

• Put the list of medications in a highly visible place in the patient's chart and include essential information about dosages, drug schedules, immunizations, and drug allergies.

• Reconcile medications at each interface of care, specifically including admission, transfer, and discharge; the patient and responsible physicians, nurses, and pharmacists should be involved in this process.

• Provide each patient with a complete list of medications that he or she will take after being discharged from the facility, as well as instructions on how and how long to take any new medications. The patient should be encouraged to carry this list and share it with any caregivers who provide any follow-up care.

• Reconcile medications within specified time frames (within 24 hours of admission; shorter time frames for high-risk drugs, potentially serious dosage variances, and/or upcoming administration times).

• Adopt a standardized form to use for collecting the home medication list and for reconciling the variances (includes both electronic and paper-based forms).

• Develop clear policies and procedures for each step in the reconciliation process.

As part of its current National Patient Safety Goals, the Joint Commission also requires that each accredited health care organization:

• Implement a process for obtaining and documenting a complete list of the patient's current medications upon admission. This includes a comparison of the medications the organization provides to those on the list. The patient should be asked to describe or confirm any prescription medications, over-the-counter medications, vitamins, herbs or other supplements that he or she takes.

• Communicate a complete list of the patient's medications to the next service provider when the patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization.

Preceptors can improve retention of new nurses

Individualized programs create better results

A new job can be overwhelming no matter what industry you may choose, but when the new job is in home care, saying that the job is overwhelming may be an understatement. Traditional orientation programs don't always take into account the myriad details that a home care nurse needs to know to both succeed in the job and to be happy with it; so two agencies are handling new employee orientation with preceptors.

Since her agency started the preceptor program four years ago, new nurse retention has been higher and employee satisfaction has increased as well, says **Suzanne Van Loon**, RNC, BSN, MPH, director of clinical services at VNA of Somerset Hills in Bernardsville, NJ. "Our new hires have been split 50/50, with half of the nurses having home health experience and half of the nurses not having home health experience," she says. "Our three-month orientation program gives all new nurses a chance to adjust both to our agency and to home health if this is a new field for them."

The preceptor's responsibilities are to introduce the new employee to the different protocols and processes of the agency, assess the new employee's learning needs through discussion and observation, and plan the new employee's learning experience, says Van Loon. "Because the preceptor spends so much time with the new employee during the first four weeks, her case load is reduced," she says.

At first, the new employee will make visits with the preceptor, but she also will spend time with other agency employees, Van Loon points out. "New employees spend days with our clinical director, our quality improvement director, rehab employees, OASIS coordinator, intake employees, our respite department manager, and our nursing secretary," she explains. "This gives each new employee a real understanding of all of the agency's activities and introduces key people that she will need to know," she adds.

Even though the preceptor and the new employee are not together every day once the orientation period begins, they have regular progress meetings, along with the new employee's supervisor, to review what has been learned and to identify areas that may need to be enhanced, such as computer skills or OASIS training, explains Van Loon. The training is designed to meet the individual's needs, not a time frame, she adds.

"It is a very positive relationship that develops," she says. "It is nonthreatening and it makes it easy for the new employee to ask questions without worrying that admitting a lack of knowledge may result in a poor review," she adds. While the orientation period is defined as three months, the preceptor relationship can be informally extended as needed, she says.

"We select case managers to serve as preceptors," says **Vikki Prochaska**, RN, MSN, CNAA, director of home care at Kenosha (WI) Visiting Nurse Association. The first week of training, the new nurse spends time learning the computer system and OASIS entry, she says. "The next two weeks, the new nurse works with her preceptor, visiting patients, completing documentation, and talking about agency operations," she says. After two weeks with her preceptor, the new nurse will spend the next few weeks visiting patients with a variety of other nurses, she says.

"We like for a new nurse to see how a variety of nurses handle patient visits and paperwork because everyone develops their own way to do the job and you can learn something different from each nurse," she explains. The new employee does stay in contact with her preceptor and the preceptor reviews the new employee's progress.

Prochaska's program is 90 days and comprises orientation and evaluation, but it is very individualized, with different nurses progressing at different paces, she says. "It is important to tailor the training to the nurse's experience and ability so that the job doesn't overwhelm and frustrate the new employee," she explains.

Selecting the right employee to serve as a preceptor is just as important as selecting the right nurse to hire as a home health nurse. "We require that our preceptors have a minimum of two years' nursing experience and at least one year of home health experience," says Van Loon. "We also want someone who loves being in the field and is very organized with a natural talent for teaching," she adds.

"I look for preceptors who consistently do their job the right way, without taking a lot of shortcuts," says Prochaska. "While everyone develops shortcuts as they learn their job, it is important for a new nurse to learn every step of the process the correct way so that mistakes can be easily found and fixed," she explains. "Preceptors also have to be ready to become the new nurse's best friend during a trying period of her life.

"We also encourage our preceptors and our new employees to let us know if personality conflicts do arise," says Prochaska. While she tries to match preceptors and new employees on the basis of personality as well as skills, there may be times that the new employee needs to move to a different preceptor, she says. A move from one preceptor to another does not reflect the skills or ability of either the preceptor or the new employee; it is strictly a personality issue, she emphasizes.

"A preceptor who is very confident may seem intimidating to a nurse who is less assertive, so the new nurse will feel free to ask questions of, and learn more from, another preceptor with a different personality," she explains.

A reduced workload for preceptors does mean an increased workload for other nurses,

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but every one in the agency appreciates the value of a preceptor-based orientation, says Van Loon. While the individual training and orientation may seem costly as first, the real savings are seen in the retention of new employees, instead of a revolving door of nurses who stay fewer than three months, she adds.

Not only does this approach to orientation solve retention problems, but it also is a recruiting plus, Van Loon points out. "Nurses who are new to home health are relieved to find out that that they will have one person, other than a supervisor or manager, to whom they can go with their questions," she says. "This removes a lot of their anxiety about working in a new field and makes them look forward to learning a new job," she adds.

A preceptor-based orientation also addresses the fact that home health care cannot be learned in a classroom, says Van Loon. "The only way to learn home health is to do it. This approach gives new nurses a chance to do home care in a safe, supervised environment." ■

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