HOSPICE Management ADVISOR™

Integration • Outcomes • Managed Care • Medicare Compliance • Risk Management • QI • End-of-Life Care

AHC Media LLC

IN THIS ISSUE

March 2007
VOL. 12, NO. 3 • (pages 25-36)

Is your hospice prepared for a major tragedy in the area?

Lexington hospice helps after plane crash

When Delta flight 5191 crashed shortly after takeoff on a Sunday morning last August, staff from Hospice of the Bluegrass in Lexington, KY, got involved, and managers put into place a plan to provide support to the families who had lost a loved one in the disaster.

After the Sept. 11, 2001, terrorist tragedy, Hospice of the Bluegrass managers decided the hospice needed to have a specific plan in place to handle a major area disaster, says **Sherri Weisenfluh**, MSW, LCSW, an associate vice president of counseling for the hospice, which has an average daily census of about 870 people and a staff of approximately 600 people.

"After Sept. 11 occurred, that certainly resulted in our putting a big focus on disasters and the kind of training that people need to prepare," Weisenfluh says.

Hospice staff trained with the American Red Cross to handle mental health issues after a major tragedy, she says.

"The idea was if a crisis occurred then those people would be responders, and that's what happened after flight 5191 crashed," Weisenfluh explains. "A number of our staff was called to respond."

The airline had the families impacted by the tragedy stay at a single hotel where they could be kept up-to-date. So hospice staff took brochures about sudden loss to the hotel and left these in the lobby where family members could pick them up, Weisenfluh says.

When they ran out of the brochures, the National Hospice & Palliative Care Organization had a number of these sent to them overnight so they could re-supply the hotel several times, she says.

Also, some of the hospice's staff were involved with a private memorial service for the families of the 49 passengers who were killed in the tragedy.

Hospice staff members also were present as mental health professionals to assist when the airport had family members visit the crash site, Weisenfluh says.

"We had some chaplains participate in the community-wide memorial service, and that was done by the Lexington Urban County Government," Weisenfluh says. "That was a much more public service, and some families attended that, and our staff worked with families and offered to sit with families."

The hospice's work continued as new issues arose.

For example, when a local newspaper ran an advertisement by law firms that suggested family members might want to sue the airline, there was public outcry about the crassness of the ad, and the paper decided to pull the ad and donate all income generated by it to the United Way of the Bluegrass, Weisenfluh recalls.

The United Way took these funds, plus additional donations on behalf of the tragedy's victims, and provided the hospice with $60,000 in funding for providing bereavement counseling to any people impacted by a sudden loss, including the families of the plane crash victims, she says.

The hospice held two group counseling sessions on sudden loss in December 2006, and one in January 2007.

Hospice Management Advisor™ (ISSN# 1087-0288) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Application to mail at periodicals postage rates is pending at Atlanta, GA 30304.. POSTMASTER: Send address changes to **Hospice Management Advisor™**, P.O. Box 740059, Atlanta, GA 30374.

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

SUBECRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). **Hours:** 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

Subscription rates: One year (12 issues), $399. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

Editor: **Melinda Young**, (864) 241-4449.

Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).

Managing Editor: **Leslie Hamlin**, (404) 262-5416, (leslie.hamlin@media.com).

Editorial Questions

For questions or comments, call **Leslie Hamlin** at (404) 262-5416.

"We started to get calls from family members through the holidays, and they said they were having a hard time and wanted some information," says **Mary K. Fedorchuk**, LCSW, OSWC, a social worker with the Hospice of the Bluegrass.

"Most were receiving individual counseling, but they also wanted to come together as a group to get some information about how to cope through the holidays," Fedorchuk says.

Weisenfluh and Fedorchuk explain how the hospice prepared for a major area tragedy:

• Develop partnerships with other community agencies.

"Partner with other agencies in your community before any disaster strikes," Weisenfluh suggests. "It's essential because you'll want to coordinate a response."

After the plane crash, information was scarce at first and things were chaotic, so it was immensely helpful that the Hospice of the Bluegrass already had good relationships in place with the American Red Cross and other organizations, she says.

"You can get together quicker and have a quicker response, and it creates less chaos," Weisenfluh says. "This is very important because you can't do it all on your own."

• Train staff in sudden loss and trauma.

It's essential to train staff to handle sudden loss and trauma, Weisenfluh says.

"Those are very different issues than what you see from hospice families," she says.

For the Hospice of the Bluegrass, the training was handled partly by the American Red Cross, so this served the dual purpose of enhancing the partnership between the two organizations, making it logical for the Red Cross to contact the hospice after the tragedy occurred.

It's also important to have plenty of brochures and educational information about coping with sudden loss. These materials can be made available for people who experience the more typical types of sudden loss, such as having a loved one die in a car crash or because of a heart attack, but they especially are useful when a bigger tragedy strikes.

"Having materials on hand that are specific to sudden loss is very important," Weisenfluh says. "A lot of times people will want to read something, and they may not know what they need right away because they're often raw and numb."

It's helpful if people experiencing such a tragedy have a short brochure to point them in the right direction, she says.

Having staff trained in sudden loss and disaster situations also helps with wider community outreach.

For instance, the Hospice of the Bluegrass sent some staff to Louisiana after Hurricane Katrina struck, Weisenfluh notes.

"We let a couple of our staff go to those areas because they had Red Cross training, and we paid their salaries while they were gone," she says. "Financially, there is a commitment because if people are part of the Red Cross they're supposed to respond to disasters which may not be in [their] own community."

• Gear specific services to people impacted by sudden loss.

"Think of the losses happening in any community," Fedorchuk says. "There are accidents and suicides happening every day."

Hospice leaders should assess the community's needs and see which areas have unmet needs, Fedorchuk suggests.

For example, the Hospice of the Bluegrass has a survivors of suicide group that meets regularly.

"Lexington in a sense is a very small community, so we knew the flight 5191 crash would have a ripple effect," Fedorchuk says. "Someone knew somebody, or the tragedy triggered another loss, so we wanted to open up our doors and say, 'We are here.'"

The hospice has a year-round grief group that's open to anyone in need, and there's a spouse grief group, as well as camps for children who are struggling with a loss, she says.

Since the plane crash disaster, the hospice's three sudden loss group sessions have combined education about coping skills with the support that's possible because of people sharing a common experience.

"Hospice of the Bluegrass is incredibly committed to offering community bereavement services," Fedorchuk says. "We have people who are not hospice patients who come into the grief and loss center and have benefited from therapy."

Hospices interested in providing this type of community assistance and outreach need to be committed philosophically, Weisenfluh says.

"The hospice board has to feel like this is part of something they could do, because if they don't view that as part of the hospice's mission, then they might not want to even consider doing it," she says. "That philosophy is an important part of it, and you need support from your board and chief executive officer."

Hospices could offer individual counseling and group counseling services to people impacted by sudden loss. And these types of services could be increased after a major tragedy strikes.

Also, the hospice's participation in public memorial services provides an important outreach function because a major tragedy has a wide emotional impact. People who may not have known any of the victims also could be experiencing grief of some sort.

"A lot of people after flight 5191's crash felt that it could have been them on the plane," Weisenfluh says.

The flight was a popular morning flight, she notes.

"A lot of people had the experience of 'Gee, you get up in the morning, and you don't know what could happen,'" she says. "They think, 'That could have been me on that flight,' and thinking this makes people stop and think about mortality, and it also brings out the compassion in people."

The hospice's own staff knew several of the families impacted by the crash, and even one of the first responders to the crash site had lost a sister in the tragedy, Weisenfluh notes.

"There were side things like that going on, and the whole community just gasped — I can't think of any other word," she adds. ■

Need More Information?

- **Mary K. Fedorchuk**, LCSW, OSWC, Social Worker, Hospice of the Bluegrass, Lexington Office, 2312 Alexandria Drive, Lexington, KY 40504. Telephone: (859) 276-5344.
- **Sherri Weisenfluh**, MSW, LCSW, Associate Vice President of Counseling, Hospice of the Bluegrass, Lexington Office, 2312 Alexandria Drive, Lexington, KY 40504. Telephone: (859) 276-5344.

Program dealing with sudden loss makes holidays easier

Focus is on learning coping strategies

Several months after Delta flight 5191 crashed in Lexington, KY, killing 49 people, family

members of those who perished continued to have problems coping with their loss, particularly as the December holiday season began.

So the Hospice of the Bluegrass, Lexington office, offered a series of group sessions to help people who experienced a sudden loss, including those affected by the plane crash, to cope with the holiday season.

The first group session was titled, "Just coping with the holidays," says **Mary K. Fedorchuk**, LCSW, OSWC, a social worker with the hospice.

"We talked about how to focus on what's normal," Fedorchuk says. "Wherever someone is in his or her grief, it's a normal and okay place to be."

People dealing with sudden loss also were given ideas about how to change some traditions and keep others in a way that keeps their loved one a part of the family tradition, she says.

For example, the session attendees made candles that could be lit at evening meals to evoke the presence of the person who has died, Fedorchuk says.

"In these groups, people have the ability to share or not share," she notes. "What we heard from people is how difficult the holidays are, but how it was nice to come to the group session because they felt cared for."

Each group session provided attendees with meals, as well as the materials needed for the group activities.

The second session held in December was called "A night of remembrance," and attendees were asked to bring something that spoke to them about the person who was lost, Fedorchuk recalls.

People brought stuffed animals, photos, and other types of items that reminded them of their loved ones, she says.

"We talked about the reality of the loss and how that was for them," she says. "So the night of remembrance was letting them talk about their loved one, letting them share their story."

About one-third of those attending the second session had lost a loved one in the plane crash, but the circumstances of the sudden loss were not important as they each shared the common experience of loss and shock, Fedorchuk says.

"There were murders, auto accidents, drug overdoses," she says. "There was a bonding, and we didn't single out any one person's loss or talk about the plane crash, but focused on a general overview of sudden loss."

The people who had lost family in the plane crash did not want to be singled out because they were aware that other people were suffering less public losses, Fedorchuk says.

Finally, after the holidays in January, the third session was about "Taking care of yourself."

It was an evening of care in which attendees talked about massage, touch therapy, aroma therapy, music and art therapy, Fedorchuk says.

"We talked about the ways in everyday life you can take a moment to care for yourself," she says. "You don't have to go out to do something, but you can put on some soothing music or cook something that evokes a sense of comfort for you."

People who are creative can make something or write in a journal, she says.

This session also focused on the importance of sleep, exercise, and eating appropriately.

"And we ended the session with a visualization, giving people that sense that there are things out there that they can do by themselves or in a group or have a professional help them with," Fedorchuk says. "Because of the mind-body connection and how our bodies react to that kind of stress, we have to acknowledge this and take care of the whole person, including the spiritual side."

The people who attended the sudden loss sessions expressed feelings of safety in coming there where they can be part of a group and have some of their needs met, Fedorchuk says.

"There is a challenge for them because people tend to want to isolate and they have a fear of expressing themselves in an open forum, but once they come here they find it very healing," she adds. ■

Create competency training for volunteers

Program adds quality, reduces staff stress

About five years ago, the Hospice of Northwest Ohio in Perrysburg, OH, had volunteers who said they'd like to do more hands-on work than what their duties typically allowed.

"Our staff said it would be lovely if these volunteers who come regularly could assist them," recalls **Carol L. Nichols**, MSW, a volunteer coordinator for the hospice.

The inpatient director, team leaders, nursing staff, volunteers, and Nichols talked about the

idea and decided to move forward with a plan that would enable volunteers to provide hands-on care for patients in the inpatient facility, she says.

"Then we developed competency training, which is similar to home health aide training," Nichols says. "The tasks are not as comprehensive as home health aide tasks as we've limited the tasks volunteers do in assisting staff."

For example, volunteers assist but do not provide care without direct supervision of a nurse or home health aide, she says.

"The training is task-identified, broken down into different steps of how it's done," Nichols says. "It defines important issues, such as infection control, and it's taught by an RN and volunteer coordinator."

Volunteers are assessed with a competency skill demonstration checklist for each task they are trained to perform. **(See sample volunteer competency checklist, p. 31.)**

Now that a number of volunteers have been trained, they provide an additional 120 hours of hands-on care per week, Nichols says.

"That's the equivalent of three full-time staff members," she says.

From a budget standpoint, the volunteers provide $6,000 to $7,000 in labor per month. While there are supervision and training costs, there still is a significant financial benefit to using volunteers to perform these types of tasks, Nichols says.

"The financial benefit would vary for each organization according to how much they used volunteers and how much supervision they felt the volunteers needed," Nichols says.

Here's how the training works:

• **Identify tasks for volunteers:** "We had a list of possible hospice tasks, and we went down the line and said, 'Yes, no, yes, no,'" Nichols says.

They decided that volunteers could assist with passing trays, feeding, and oral hygiene, but could not do catheter care, for example.

The training includes the list of personal care skills, as well as a review of infection control, isolation precautions, call light system, and phone system.

Here is a list of the personal care skills that are taught as part of the volunteer skills competency training:

- Assist with passing trays and set up;
- Assist with feeding;
- Assist with bag bath;
- Assist with oral hygiene;
- Assist with shaving;
- Assist with nail care;
- Assist with skin care;
- Assist with foot care;
- Assist with back rub;
- Assist with application of clothing;
- Assist with urinal;
- Assist with bedpan;
- Assist with brief application;
- Assist with H.S. care;
- Assist with ambulation;
- Assist with positioning;
- Assist with making occupied bed;
- Assist with making unoccupied bed;
- Assist with transfer techniques;
- Assist with post mortem care.

"They're doing tasks that a nonprofessional can appropriately handle given this competency training," Nichols says. "But that's it; it's not like going to nursing school, and this is only used in the inpatient setting."

The reason for the inpatient setting requirement is that volunteers will not perform the tasks on their own, and they'll always be under the supervision of a nurse, she explains.

"Certainly in the home care situations, caregivers are doing everything — all of these things," Nichols says. "But in a home care situation, we don't have volunteers doing those kinds of tasks."

The idea is not to replace staff, but to improve the quality of care for patients, Nichols notes.

"When you've got more people to help you and your team, your stress level goes down, and we think with more hands available to help there's going to be better patient care," she says.

• **Assess volunteers' level of commitment:** "You have to make sure the volunteers you're offering this training to are people who want to help in this way," Nichols says.

These volunteers must go through the original eight-week volunteer training, commit to volunteering in the inpatient unit, interact with staff and families and patients in a positive way, and know how to ask for help, she says.

Also, they must understand their role as volunteer, Nichols says.

"You hand-pick the people you offer this training to from the people who are interested," she adds.

Commitment is very important. The inpatient unit schedules volunteers from 8 a.m. to 8 p.m., Monday through Friday.

Volunteers who take on this new role are told that they can refuse to do any task that makes

them uncomfortable, Nichols says.

"We tell our volunteers that even though they've been trained in some of these tasks, it doesn't mean they have to do them," Nichols says. "We have volunteers who are not comfortable with changing briefs, and they don't have to do this."

Also, while it's a good idea to have volunteers work consecutively, covering the 12 hour-period during the week, it rarely works out that efficiently, Nichols says.

Sometimes, two volunteers are available only on Monday mornings, and so that time slot is covered twice and another time slot may not have volunteer help, she says.

"Volunteers very frequently are not there because they go to Florida or visit their grandchildren," Nichols says.

• **Use role playing during training:** At Hospice of Northwest Ohio, the volunteer training is offered three or four times a year to six volunteers at a time. The training lasts three-to-four hours and takes place in an empty patient room or skills lab, where there is the necessary equipment of a bed, wheelchair, and supplies.

"In class we start with the volunteer coordinator playing the patient, and the nurse is teaching," Nichols says. "One of us is lying on the bed, getting fed, getting a brief changed, and we try to make it as real as possible for them."

Part of the training involves showing staff how to talk with volunteers and explain the various tasks each time they work together.

"The staff will say, 'We're going to be rolling Mrs. Smith this way,'" Nichols says. "They should always be talking with the volunteer and working together as a team."

The first tasks covered in training are feeding, passing trays, and setting up.

This task could take a couple of hours, but the nurse will be aware of what the volunteer is doing and will stay attuned even while doing other jobs, she says.

"Then we teach volunteers how to assist staff with bathing someone who can no longer get up and get out of bed," Nichols says. "They learn how to bathe someone and give them fresh linens."

Next, there is training in oral hygiene.

"We help someone brush their teeth or dentures, and that's generally done with the nurse in the room, doing something else," Nichols says. "Then there is the shampoo, nail care, and skin care, which involves lotion."

Volunteers will assist with dressing the patient, using the urinal and bedpan, and positioning the patient.

"We talk about the proper body mechanics and make sure they take care to protect their backs," Nichols says. "We talk about patient safety and working together as a team so the people who are helping the patient transfer from the bed to wheelchair can talk with each other."

Infection control is discussed, and volunteers are told to wash hands often and use gloves. They are told to answer call lights with a smile, saying, "Can I help you?"

"And if it's something they can help with, like 'I can't reach the remote control,' or something, they can do it for the patient," Nichols says. "At the very least they are smiling and responding immediately."

• **Survey for volunteer/staff satisfaction:** The hospice surveyed volunteers and received a favorable response, Nichols says.

"Volunteers enjoy this role, and the staff enjoys having volunteers assist them," Nichols adds. "Some personalities work better with volunteers than others."

The hospice regularly receives positive feedback from volunteers, and patients have accepted the expanded volunteer role, as well.

"The staff is taught to ask patients if they're okay with a volunteer helping them," Nichols says. "They introduce the volunteer this way: 'This is Mary, and she's a very experienced volunteer who is here to help your with your bath this morning. Is it okay?'"

The goal of improving hospice care quality while expanding the volunteers' role has succeeded for the hospice, Nichols says.

"Volunteers assist with high-touch activities that allow the nurses to attend to high-tech activities," Nichols says. "We say that more people equal less running, less stress, and more smiles." ■

Need More Information?

☎ **Carol L. Nichols**, MSW, Volunteer Coordinator, Hospice of Northwest Ohio, 30000 East River Road, Perrysburg, OH 43551. Telephone: (419) 661-4001.

Volunteer competency and skill demonstration checklist

The Hospice of Northwest Ohio in Perrysburg, OH, has developed a set of skill demonstration checklists that are used to assess volunteer competency with various tasks volunteers perform at an inpatient hospice. With the hospice's permission, *Hospice Management Advisor* offers this example of one of the competency checklists:

Skill demonstration checklist

Bedpan

Performance objective:

Assist the patient with the use of the bedpan

Performance Behavior

Satisfactory/Unsatisfactory Comments

1. Washes hands prior to contact with patient
2. Explains procedure to the patient
3. Apply gloves
4. Provide privacy
5. Lower head of bed, roll patient onto side, apply bedpan correctly under patient's buttocks: standard bedpan — position bedpan so wider end of pan is aligned with client's buttocks'; fracture pan — position bedpan with handle toward foot of bed
6. Raise head of bed
7. If able to use tissues, leave within reach; leave call-light within reach
8. Lower head of bed before removing bedpan
9. Apply gloves
10. Roll patient onto side, remove bedpan and empty contents into toilet; measure urine if ordered making sure container is at eye level
11. Cleanse perineal area
12. Clean bedpan and return to storage
13. Remove gloves and offer washcloth to patient to wash hands
14. Wash hands
15. Place call light within reach

Essential behaviors

1. Follows all rules of asepsis
2. Protects patient and self against physical harm
3. Takes action to prevent or minimize emotional stress to patient or significant others
4. Explains procedure to patient before initiating it
5. Reports abnormalities or changes

Universal vs. standard precautions: Which to use?

Protect staff, patients from airborne, contact contagions

All home health agencies have policies to prevent the spread of infection, but with recent focus on the threat of a pandemic, home health managers need to look more closely at how prepared their agency will be for a situation that requires a higher level of protection than universal precautions, experts say.

"Universal precautions are mandated for home health agencies but the type of pathogens that exist today require standard precautions that protect staff and patients against more threats of infection than universal precautions," says **Barbara B. Citarella**, RN, BSN, MS, CHCE, president and CEO of RBC Limited, a home care consulting firm located in Staatsburg, NY. It is also important to note that the Centers for Disease Control and Prevention (CDC) guidelines for pandemic flu require standard precautions as opposed to universal precautions, she adds. **(For tips on recognizing seasonal flu vs. pandemic flu, see chart on p. 33.)**

The first step in evaluating your infection control program's readiness for pandemic flu is to understand the difference between universal and standard precautions, says Citarella.

"Universal precautions were developed in 1991 to address the risk of bloodborne pathogens because at that time the majority of high-risk infectious disease was transmitted through blood," explains Citarella. "Now, with the threat of avian flu, West Nile virus, biological weapons, and pandemic flu, we face the risk of contact and airborne transmission as well as bloodborne transmission," she says.

Standard precautions were developed by the CDC to synthesize the major features of universal precautions, which were designed to reduce the risk of transmission of bloodborne pathogens, and body substance isolation, which was designed to reduce the risk of transmission of pathogens from moist body substances.

"It is important to recognize that even if a pathogen is usually transmitted by contact, the pathogen can be aerosolized by saliva," points out Citarella. For this reason, gloves alone won't protect the employee, she adds.

"We use standard precautions, so all of our clinicians have gloves, masks, goggles, aprons, and gowns in their bags," says **Frances Traver**, RN, BSN, quality improvement manager for St. Francis Home Health Care in Poughkeepsie, NY. "Aprons, gowns, and goggles are important in wound care if there is a risk of splash back when irrigating the wound," she says.

Respirator masks essential

Gloves, masks, goggles, and gowns are required by standard precautions in specific situations, but the most important piece of infection control equipment that many agencies don't have or don't have in adequate quantities is an N95 respirator mask, says Citarella. "I recommend that every agency have enough respirator masks for every employee for a three- to four-week period," she says. While the masks can be worn repeatedly, if a mask is contaminated, it must be replaced, so one mask per employee won't be enough, she adds.

Linda Rashba, RN, BSN, MS, administrator of St. Francis Home Health, says that although every employee has one respirator, she plans to purchase extra respirator masks. "Every new employee of our hospital system is fit-tested when they are hired and all home care nurses carry their respirator masks with them," she says. Even though the agency nurses have the mask, Rashba admits that in the case of a pandemic, nurses should have backup masks that can be used immediately if the first mask is contaminated.

"Fit-testing is required because there is no one size fits all with N95 respirator masks," says Citarella. "An employee who wears glasses will be more comfortable with a flexible mask as opposed to a pre-formed mask," she says. "Of course, in an emergency any respirator mask is better than none," she says.

Respirator masks cost about $1.25 per employee per mask, says Citarella. "I recommend that agencies start building their inventory slowly," she says. Even though some state public health departments have plans to distribute respirator masks at a central location in a pandemic situation, no agency manager should rely upon an outside organization to protect agency employees, she emphasizes. "OSHA [the U.S. Occupational Safety and Health Administration] requires home health agencies to provide protective equipment to employees," she says. "If an employee becomes ill because you are waiting for the state to provide the equipment, you are responsible," she points out.

Although respirator masks have no expiration date, be sure that they are checked regularly for signs of deterioration, suggests Citarella. "Heat, humidity, and light can affect the rubber parts of the masks so you do want to inspect masks that you are storing," she says.

In addition to making sure that employees have the proper protective equipment, be sure to continue to educate employees about the importance of handwashing, says Traver. Because her agency tracks the incidence of flu and multiple drug resistant organisms in her agency's population and reports the information to staff members, all employees are very aware and knowledgeable about practices that minimize risk of infection, she says. "We also educate patients and their families about the importance of handwashing and give them a handout that they can use to educate other family members," she adds.

"Our office staff is also very aware of the importance of keeping their workspace clean," points out Traver. She says, "I don't know if our nursing staff's focus on infection prevention caused this increased awareness but I've noticed that office staff employees regularly wipe down their workspace, desk top, and computer keyboards."

Don't forget to thoroughly clean telemedicine equipment as well, suggests Rashba. "We have a protocol for cleaning telemedicine equipment when it is returned to us so that we can be sure we are not transporting pathogens to a new patient's home."

As agency managers evaluate their infection control plan, Citarella suggests that they look at moving toward implementation of standard precautions for all patients at all times. She explains, "We are seeing more guidelines require standard precautions as opposed to universal precautions so I believe that standard precautions will become the regulatory requirement for home health agencies in the future." ■

Bedbugs, drug-resistant pathogens pose challenge

Monitor rates to reduce spread of infection

While it is important for home health agencies to prepare to handle a flu pandemic,

Seasonal Flu

- Outbreaks follow predictable seasonal patterns; occurs annually, usually in winter, in temperate climates
- Usually some immunity built up from previous exposure
- Healthy adults usually not at risk for serious complications; the very young, the elderly, and those with certain underlying health conditions at increased risk for serious complications
- Health systems can usually meet public and patient needs
- Vaccine developed based on known flu strains and available for annual flu season
- Adequate supplies of antivirals are usually available
- Average U.S. deaths approximately 36,000/year
- Symptoms: fever, cough, runny nose, muscle pain • Death often caused by complications, such as pneumonia
- Generally causes modest impact on society (e.g., some school closing, encouragement of people who are sick to stay home)
- Manageable impact on domestic and world economy

Pandemic Flu

- Occurs rarely (three times in 20th century; last in 1968)
- No previous exposure; little or no pre-existing immunity
- Healthy people may be at increased risk for serious complications
- Health systems may be overwhelmed
- Vaccine probably would not be available in the early stages of a pandemic
- Effective antivirals may be in limited supply
- Number of deaths could be quite high (e.g., U.S. 1918 death toll approximately 675,000)
- Symptoms may be more severe and complications more frequent
- May cause major impact on society (e.g., widespread restrictions on travel, closings of schools and businesses, cancellation of large public gatherings)
- Potential for severe impact on domestic and world economy

Source: Centers for Disease Control and Prevention, Atlanta, GA. January 2007.

there are other infection control issues that agencies face more today than in past years, says **Barbara B. Citarella**, RN, BSN, MS, CHCE, president and CEO of RBC Limited, a home care consulting firm located in Staatsburg, NY.

"There are new guidelines from the CDC [Centers for Disease Control and Prevention] that direct agencies to identify risks and incidence of multiple drug-resistant organizations for their specific area," says Citarella. "Not only do the guidelines require agencies to develop protocols to address the identification and care of patients with methicillin-resistant staphylococcus aureus [MRSA] and vancomycin-resistant enterococci [VRE] but the guidelines also require agencies to track the infection rates," she says.

At St. Francis Home Health in Poughkeepsie, NY, not only are the rates of MRSA and VRE tracked but clusters of any infectious disease are tracked, says **Frances Traver**, RN, BSN, quality improvement manager for the agency. "We track wound infections and infections associated with Foley catheters to identify reasons for increased infections, but we also track staff infections to minimize the spread of any illness," she says. "If we see a cluster of staff members reporting gastrointestinal symptoms that may be viral, we tell staff members that if they have those symptoms they are to stay home until they are symptom-free for 24 hours," she says.

Another increasing issue for home health patients is bedbugs, says Citarella. The most common bedbug, *Cimex lectularius*, is making its way into more homes because increased travel throughout the country and around the world makes it easy for the insect to hide in clothing or luggage, she points out. While the bugs don't transmit disease, for home health patients who already have a weakened immune system, allergic reactions or potentially infected bug bite sites can be a problem, Citarella points out.

There is no way to prevent bedbugs but home health nurses should be aware of the potential problem if they have patients who wake up in the morning with insect bites they did not have when they went to bed, says Citarella. "Clinicians should know how to check bedding and other furniture in the house to look for signs of infestation," she says.

Create tracking method

Because tracking infections among staff members

and patient populations is the only way to identify increases in rates, it is important to have an effective system, says Traver. "I have tried relying on staff members to report infections as they occur but our nurses are so busy and they are focused on providing care, so reports were not also sent to me," she admits. "Now, I regularly go into our system and look at charts to determine if we are developing unanticipated infections," she says.

For example, one month Traver might pull wound care patient charts to look for additional antibiotics that are ordered after care has begun. If there is a new antibiotic, Traver reviews the chart further to see what type of infection developed. By monitoring infections on an ongoing basis, she adds, the agency has time to identify causes of a rising trend in infections and implement protocols to reduce the risk.

(Editor's note: For more information about bedbugs, go to www.mayoclinic.com/health/bedbugs/DS00663 and www.hsph.harvard.edu/bedbugs/.) ■

Providers must take action to get patient compliance

Elizabeth E. Hogue, Esq.
Burtonsville, MD

Home health, private duty, hospice, home medical, and case managers encounter frequent instances of non-compliance. Diabetic patients do not stick to their diets. Wound care patients or their caregivers do not follow instructions for dressing wounds. Bed-bound patients do not regularly change position in bed as instructed. Patients smoke while on oxygen.

Providers may be reluctant to confront instances of non-compliance and to attempt to assist patients to achieve compliance. On the contrary, it is imperative to take action to bring patients and/or their primary caregivers into compliance or, if they cannot achieve compliance, to discontinue services to them for the following reasons:

Risk Management

When providers continue to render services to non-compliant patients, their risk of legal liability is greatly enhanced. The "bottom line" is that it is extremely difficult to separate substandard care from non-compliance by patients and caregivers. Sooner or later, patients' attorneys are likely to get to the heart of the matter which is: If practitioners knew that patients or their primary caregivers were non-compliant, why did they continue providing services to them?

Reimbursement Based on Quality of Care

Payors, such as the Medicare Program, are determined to implement payment systems based on the quality of care provided as evidenced by outcomes such as the pay-for-performance (P4P) program. Private insurers and managed care organizations (MCO's) such as Aetna are also implementing payment programs that are tied to outcomes achieved. Non-compliance may produce poor outcomes. Regardless of the cause, providers are likely to experience reductions in reimbursement as a result of poor outcomes. Many providers simply cannot afford such reductions in reimbursement.

Financial

Caring for non-compliant patients and/or primary caregivers is likely to be more expensive than caring for patients and caregivers who adhere to their plans of care. Wound care patients, for example, may not achieve healing of their wounds, or they may require more lengthy or expensive treatments as a result of non-compliance. These factors may increase the cost of care substantially.

Ethical Considerations

There is an important ethical principle called "distributive justice" that says all patients being cared for by a provider, for example, are entitled to appropriate care. Non-compliant patients and caregivers tend to require a great many resources, including expenditures of huge amounts of energy by staff. In some instances, the resources expended on non-compliant patients and caregivers may mean that other patients do not receive appropriate care. This result is unacceptable from an ethical point of view.

With enhanced risks of legal liability and unethical conduct and emphasis on outcomes and quality of care, providers cannot afford to care for patients whose non-compliance hampers the results of their treatment. Now is the time to confront non-compliant patients and their caregivers and to take action. ■

Wound care helps patients' self-esteem

Hospice received CHAP commendation

When staff at the Hospice of Chattanooga in Tennessee provide wound care, they work to help the patient recover a sense of wholeness.

Families sometimes feel that even if their loved one is dying, they want to help heal the wound because it's at least one thing they can accomplish, says **Terry A. Melvin**, MD, FAAHPM, a fellow of American Academy of Hospice and Palliative Medicine, and the chief medical officer at the Hospice of Chattanooga.

From the patient's perspective, a healed wound can help the patient feel whole and presentable to visitors, Melvin adds.

Melvin worked with a hospice nurse to develop a standardized wound care program with the goal to heal patients' wounds whenever possible and to improve them when healing isn't possible.

"I looked at all of the different products and came up with something affordable that works for our hospice budget," she says. "In the year and a half we've been doing this, we've had patients die and their wounds had healed."

Healing wounds is less dependent on the patient's physical or nutritional status than it is on the consistency of the care of the wound, Melvin says.

"The theory is that because a patient has low albumin and the nutritional status is poor, then on that basis the wounds won't heal," she explains. "My theory has been that I don't care if your albumin is low; if I have consistent wound care and turning, I can help that wound heal."

One patient told hospice staff that she wanted them to work with her to heal the wound on her abdomen, even if it meant she would spend three hours each day to do her own dressing change, Melvin recalls.

"And she did heal," she says. "That was the patient's sense of wholeness: 'I know I'm going to die, but at least I feel whole.'"

Wound care rarely is a top priority in hospice care, but it is one of those services that can make a big impact on a patient and family, partly for emotional reasons.

"When a family member sees a wound or pressure ulcer on their loved one's bottom, and it won't heal, they think they have failed and didn't do a good job," Melvin explains.

Checklist for creating wound care program

The wound care program's main components are selecting the best products to use, identifying at-risk patients, and educating family members.

• **Finding the right products:** "We honed in on a debridement agent that worked for us," Melvin says. "It's important to me that everybody is getting a high standard of care."

Melvin's model of care is the answer to this question: Is this the care that I would want my mother to receive?

To this end, wound care needs to be standardized, tried, tested, and improved.

"From a home health standpoint, the goal is getting somebody better — that's the standard," she says.

In hospice care, you take that standard, acknowledge that the patient will die, but let the patient know that you will do everything you can for that person until he or she dies, and that includes doing your best to heal his or her wound, Melvin explains.

"We've had patients who died with a stage 3 wound, and they had started off with a stage 4 wound," she says.

"We've had patients with a stage 4 wound, and they died with a stage 4 wound," Melvin adds. "But it was clean and not smelly, and the care that the patient was receiving was something that the patient and caregiver got into, and it was a ritual for them."

• **Identify at-risk patients:** Hospice staff need to prepare for tackling a wound care case before the program begins. One way they do this is by identifying which patients may be at risk for wounds and having a special mattress placed in those homes, Melvin says.

"We need to teach the family turning techniques to prevent wounds from occurring," Melvin says.

COMING IN FUTURE MONTHS

■ Here's how to leverage your financial advantages

■ Palliative care doc makes house calls before hospice

■ Improve quality of service through staff/family evaluations

While the hospice receives the same per diem rate no matter how much money is put into wound care prevention and education, this is a model that will save money in the long run, Melvin notes.

"Prevention saves money, and our supply costs have actually decreased and the cost per patient per day has not increased," Melvin says. "It's more constant because we're ordering all of the same things, and there is a system by which the products are being used."

When the hospice began the program, no one knew if it would prove to be very costly or whether some of the spending could be recouped, Melvin notes.

"But I felt we had to do everything we could to prevent and to improve wound care," she says. "We even sent one of our nurses to school and paid her salary, so we now have two ostomy nurses — that's how important it is."

The ostomy nurses keep staff updated and educated and assist with nursing skills lab, and they're available for a consultation when a nurse believes a patient is at risk, Melvin adds.

• **Educating the patient and family:** Educating patients and family is an important part of the wound care program.

An interdisciplinary team teaches family members about wound care, but only if they're willing to learn, Melvin says.

"There are families who won't clean the wounds, so for those families we increase visits or bring in certified nursing assistants, so we can get the wound to the point where there isn't a need for a daily dressing," Melvin says. "So when the family sees that you're really working hard with this, they kind of pitch in, knowing that we're doing this for them, and they're doing it for their loved one."

The hospice's wound care program has gained a very favorable reputation in the area, and now there are calls for its support at nursing homes and elsewhere.

"We have two wound care nurses making rounds in the nursing home, in homes, and in the community," Melvin says.

"So are we spending a little bit more attention to it? — Yes," she says.

The worst-case scenario is a hospice admission where the patient has a smelly wound that is painful to change, but after the hospice's wound care, it loses its odor and becomes cleaner, Melvin says.

"You give back some hope to the patient and the family," Melvin says. "We show the patient that we respect him and his body, even though we know we can't heal him of the terminal illness."

It took some time to achieve staff buy-in on the new wound care program, and the staff initially were resistant to change, Melvin says.

"We picked nurses within each of the teams and tried to get them to buy-in," she says. "We educated them on when to use this product, and when a patient had a wound issue, the team would ask the trained nurse or back-up ostomy nurse or me what to do."

Over time, the entire team learned to provide the same quality wound care, and referrals from nursing homes began to increase because of the hospice's reputation in dealing with wounds, Melvin says.

"We have families who say, 'Daddy has metastatic cancer, and his bottom has broken down, and we want your hospice because we know you will do something for his wound,'" Melvin says. "We had a survey from CHAP, and they gave us a commendation as a result of our wound protocol." ■