BRIDGING the STAFFING GAP

Insights from the 3rd Annual Hospice Nurse Survey

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MISSOURI HOSPICE & Palliative Care Association

Disclosure

Shelley Henry, faculty for this educational event, has no relevant financial relationship(s) with ineligible companies to disclose.

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Learning Outcomes

Upon completing this session, participants will be able to:

- ❑ Recognize current challenges and difficulties faced by hospice nurses;
- ❑ Identify contributory and mitigating factors;
- ❑ Compile a series of steps to develop an action plan designed to attract and retain hospice nurses;
- ❑ Identify key areas crucial to the development of processes to support sustainable change.

MISSOURI HOSPICE
& Palliative Care
Association

INTRODUCTION

SHELLEY HENRY, RN, CPHRM, CHPN

President The Amity Group, Inc

Amity Hospice Staffing

MISSOURI HOSPICE & Palliative Care Association

SURVEY DETAILS

Survey Monkey

3 Months (Oct 01 – Dec 31)

1,349 Responses

RN, LPN/LVN, NP

Hospice Field Experience

Anonymous

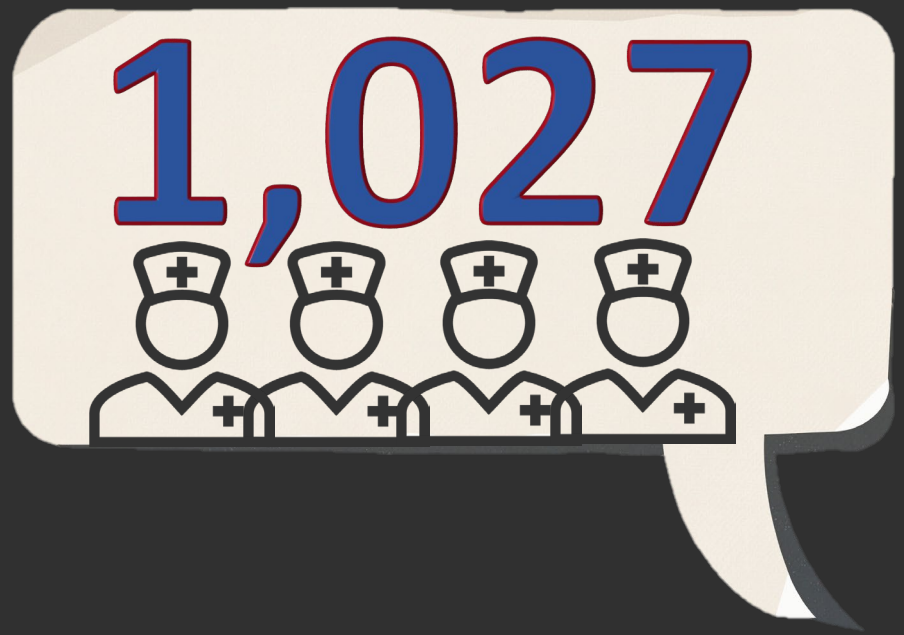
No Affiliates / No Agenda

TOP 3 CONCERNS EXPRESSED BY HOSPICE NURSES

1. DOCUMENTATION
2. HIGH CASELOADS
3. HIGH ACUITY

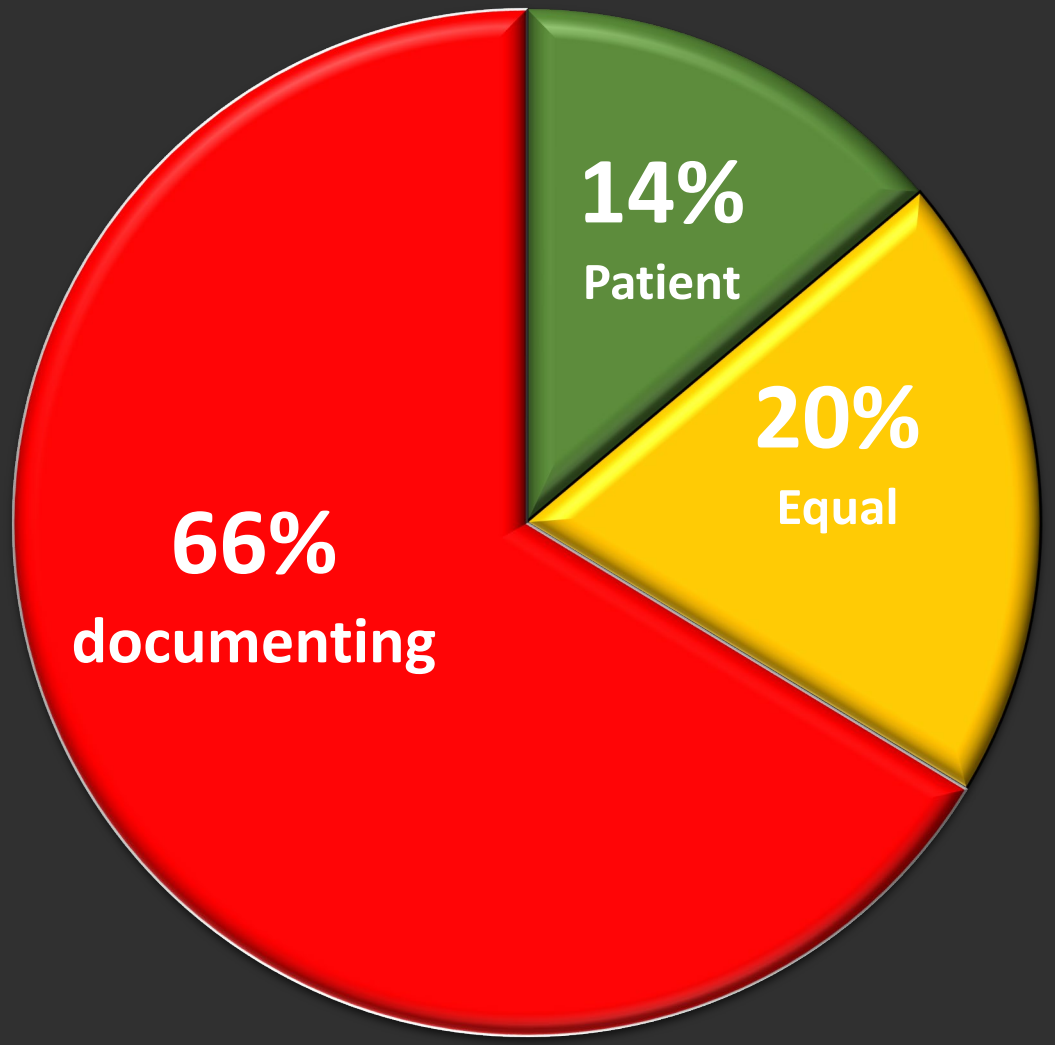
NURSES COMMENTS ON DOCUMENTATION

"What do you consider the biggest barrier to patient care"



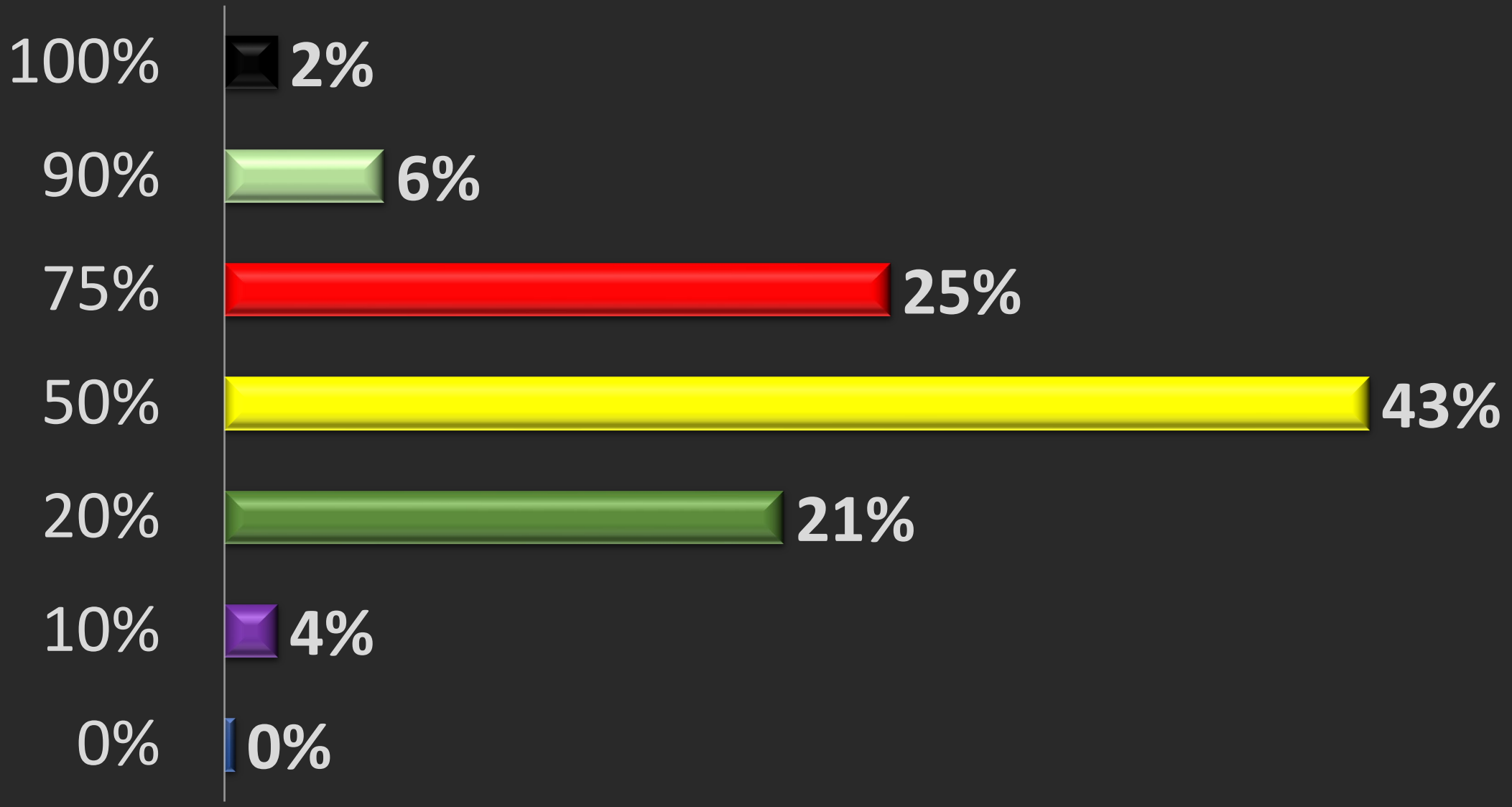
Excessive Documentation

PATIENT CARE TIME VS DOCUMENTATION TIME



REDUNDANT DOCUMENTATION

Information already in the medical record and/or entered 2 or more times

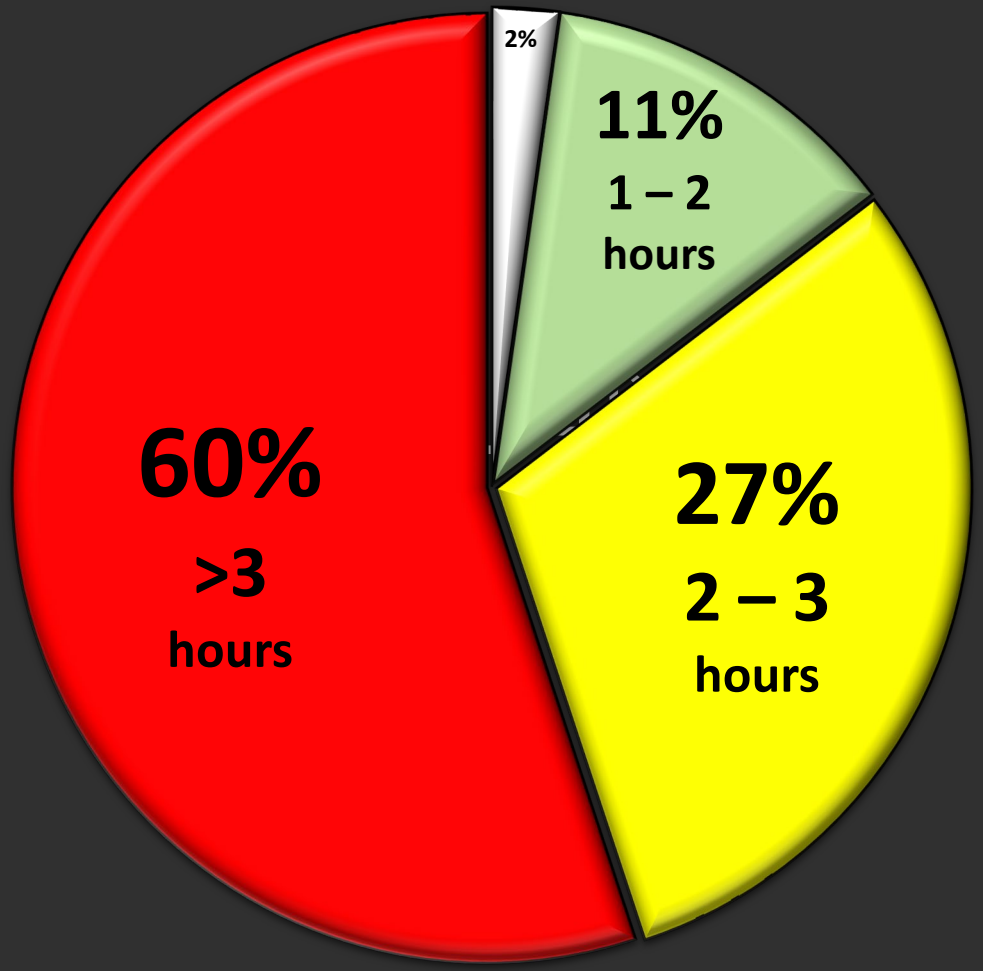


TIME COST OF REDUNDANT DOCUMENTATION

1 Hour / Day
5 Hours / Week
20 Hours / Month
240 Hours / Year

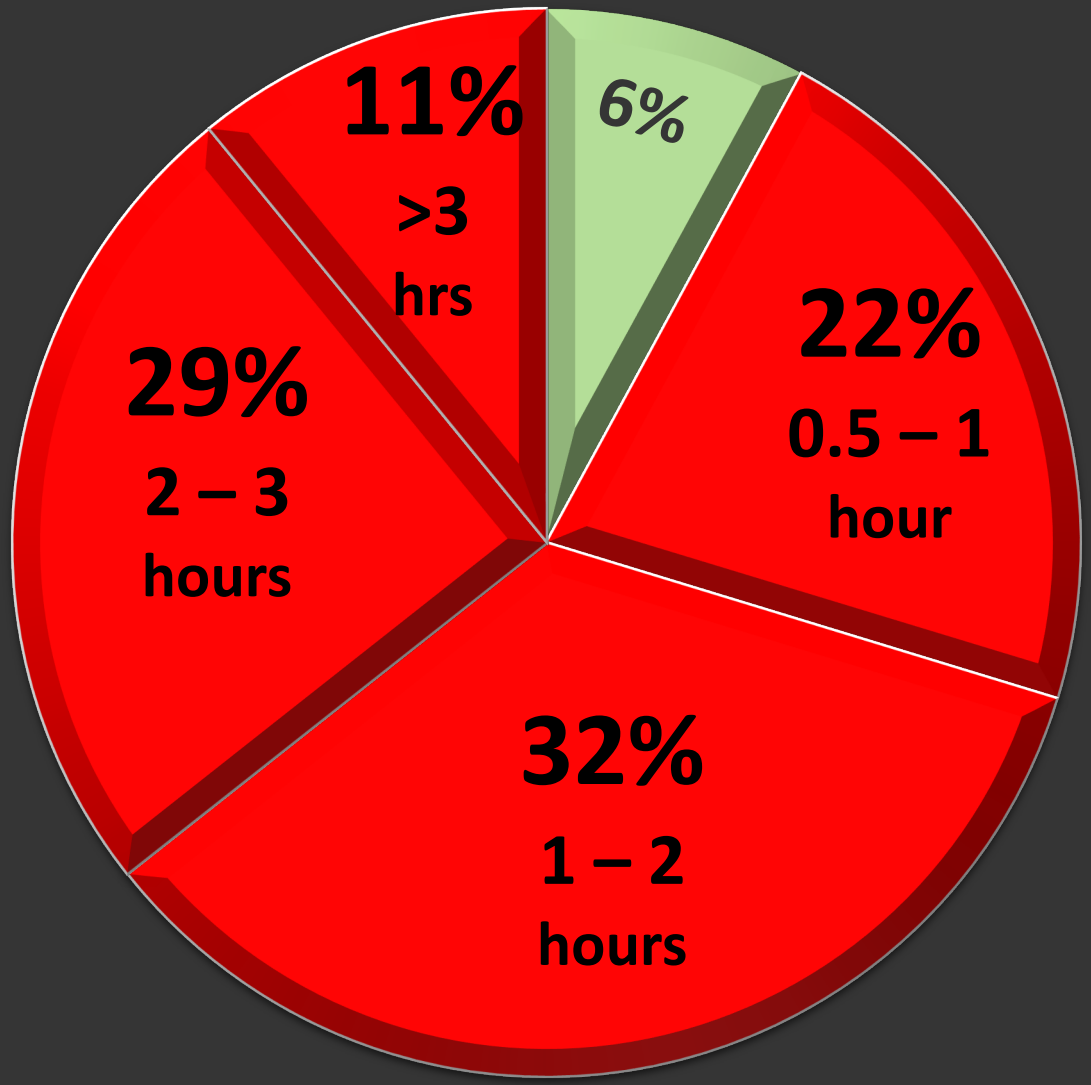
ADMISSION DOCUMENTATION TIME

Including Internal Notifications



HOURS DOCUMENTING AT HOME

Routine Documentation Only



BEDSIDE DOCUMENTATION

"Well, I've been told that documenting at the bed side is considered Best Practice"

34%

66%

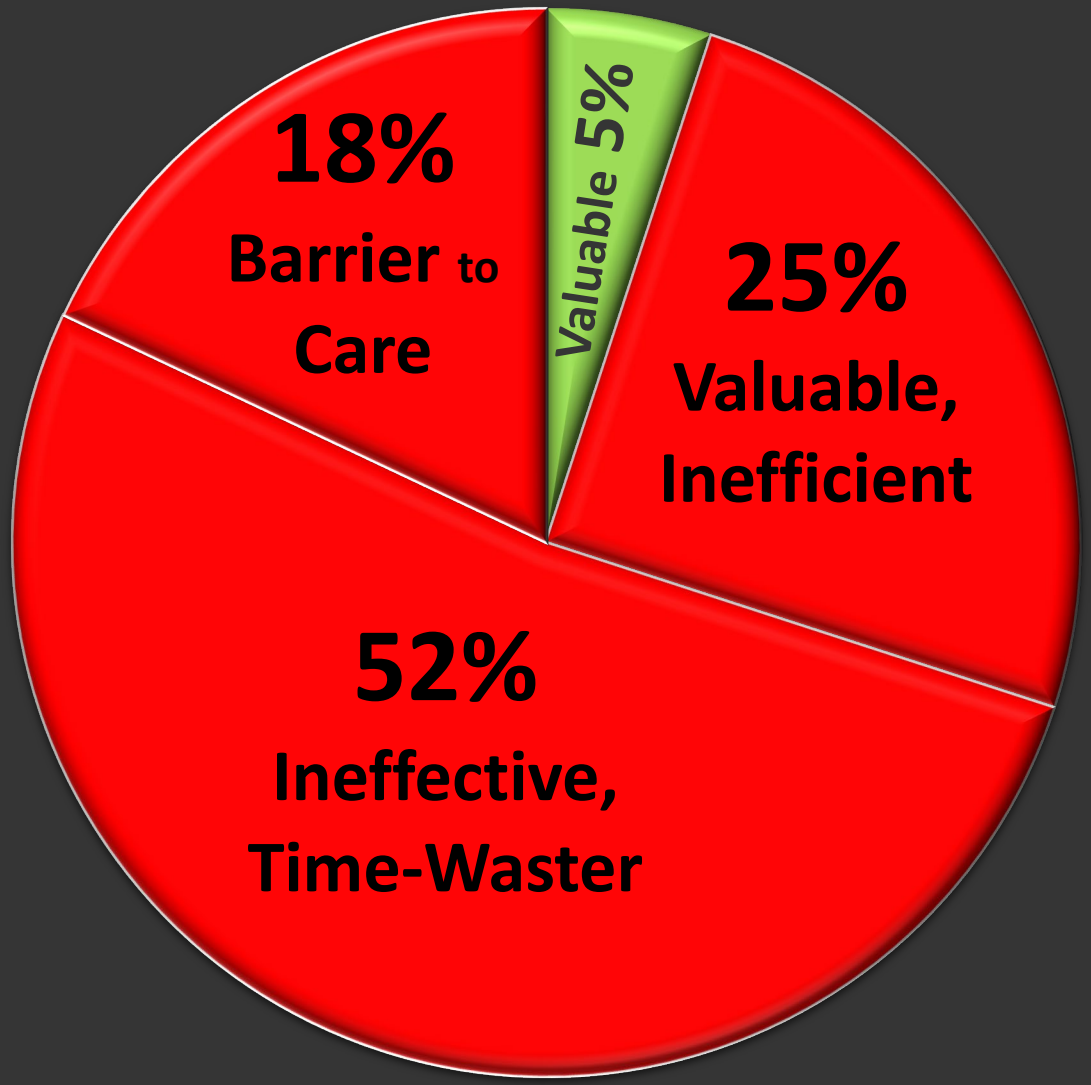
BEFORE ADDING OR INCREASING DOCUMENTATION ASK YOURSELF THESE 3 QUESTIONS

Does it…

1. Promote Better Patient Outcomes
2. Support Eligibility
3. Improve Clinician Communication

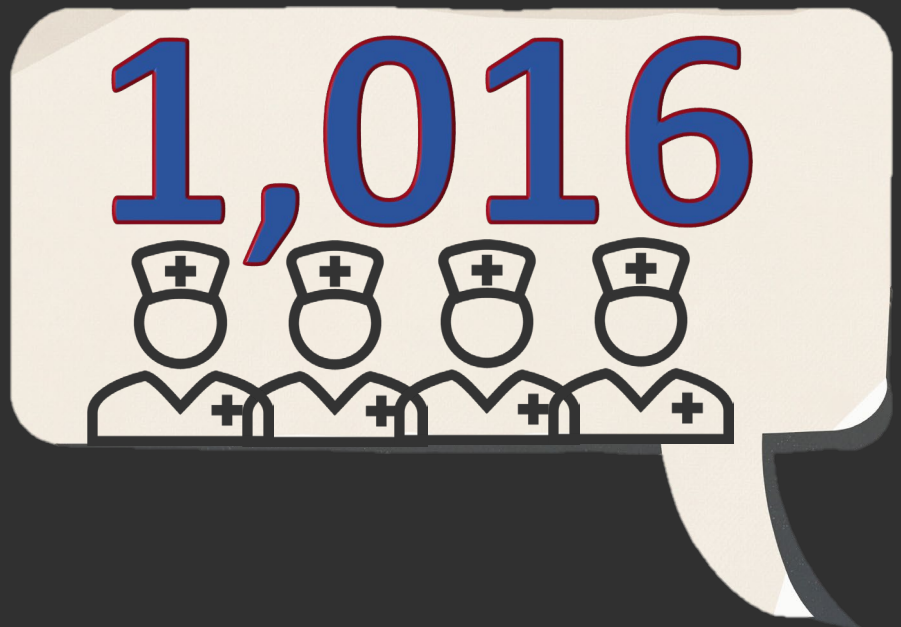
HOW BENEFICIAL IS THE HOSPICE PLAN OF CARE

How valuable do you feel it is to the overall care of your patients?



NURSES COMMENTS ON CASELOADS / PATIENT RATIOS

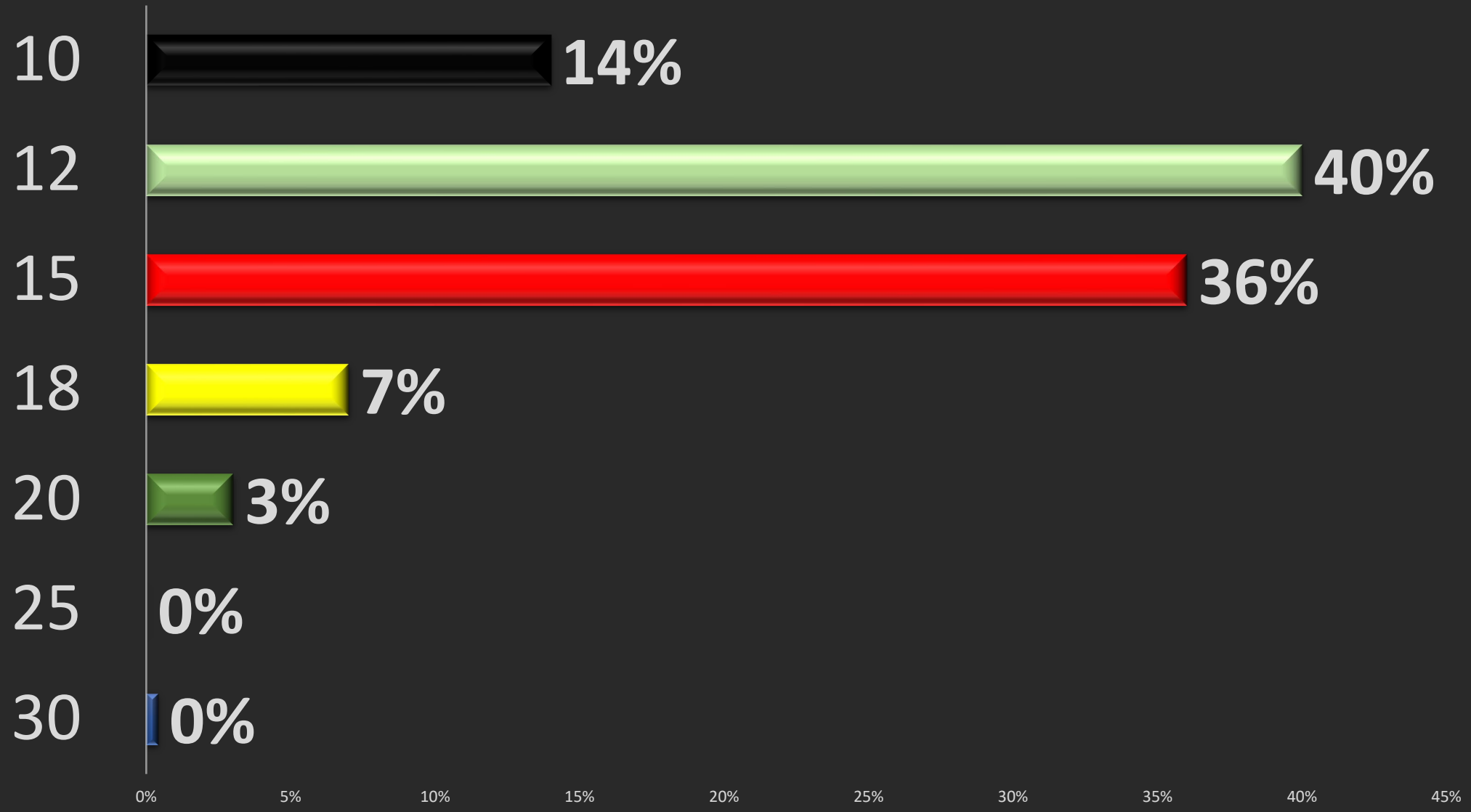
"Changes that could improve conditions for hospice nurses"



Manageable Caseloads

What Do You Consider an Appropriate Caseload?

Consider your needs, the patient's needs and the needs of your company



What Is Your Average Caseload?

8 WAYS MANAGEABLE CASELOADS SAVES MONEY

1. Decreases on-call / after-hour visits
2. Decreases live discharges
3. Decreases staff turnover
4. Decreases cost per patient day (PPD)
5. Decreases risk of audits resulting in recovery demands
6. Increases quality scores
7. Increases patient / caregiver satisfaction
8. Increases revenue from SIA visits

IS PATIENT ACUITY CONSIDERED WHEN DETERMINING CASELOAD?

27% "Yes, how long each visit will take is evaluated, and my caseload is adjusted accordingly"

73% "No, I am required to see the same number of patients, regardless of how long each patient needs"

FACTORS IN DETERMINING PATIENT ACUITY

- Physical Acuity
- Demographical Acuity
- Emotional Acuity
- Nurse Safety

EXAMPLE OF ACUITY SCORING SYSTEM

MEDICAL ACUITY	Score
Wounds (3 or more)	
Tracheostomy (requiring care)	
IV Infusions	
Drains (para/thoracentesis)	
Colostomy / Ileostomy	
Extensive, Complex Meds	
Other	

EXAMPLE OF ACUITY SCORING SYSTEM

Patient #1

Care Time = 1.5 hours
Drive Time = 1.0 hour
Docu Time = 0.75 hour
Total = 3.25 hours

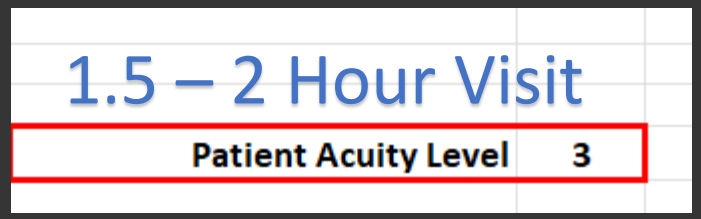
Patient #2

Care Time = 1.0 hour
Drive Time = 0.5 hour
Docu Time = 0.5 hour
Total = 2.0 hours

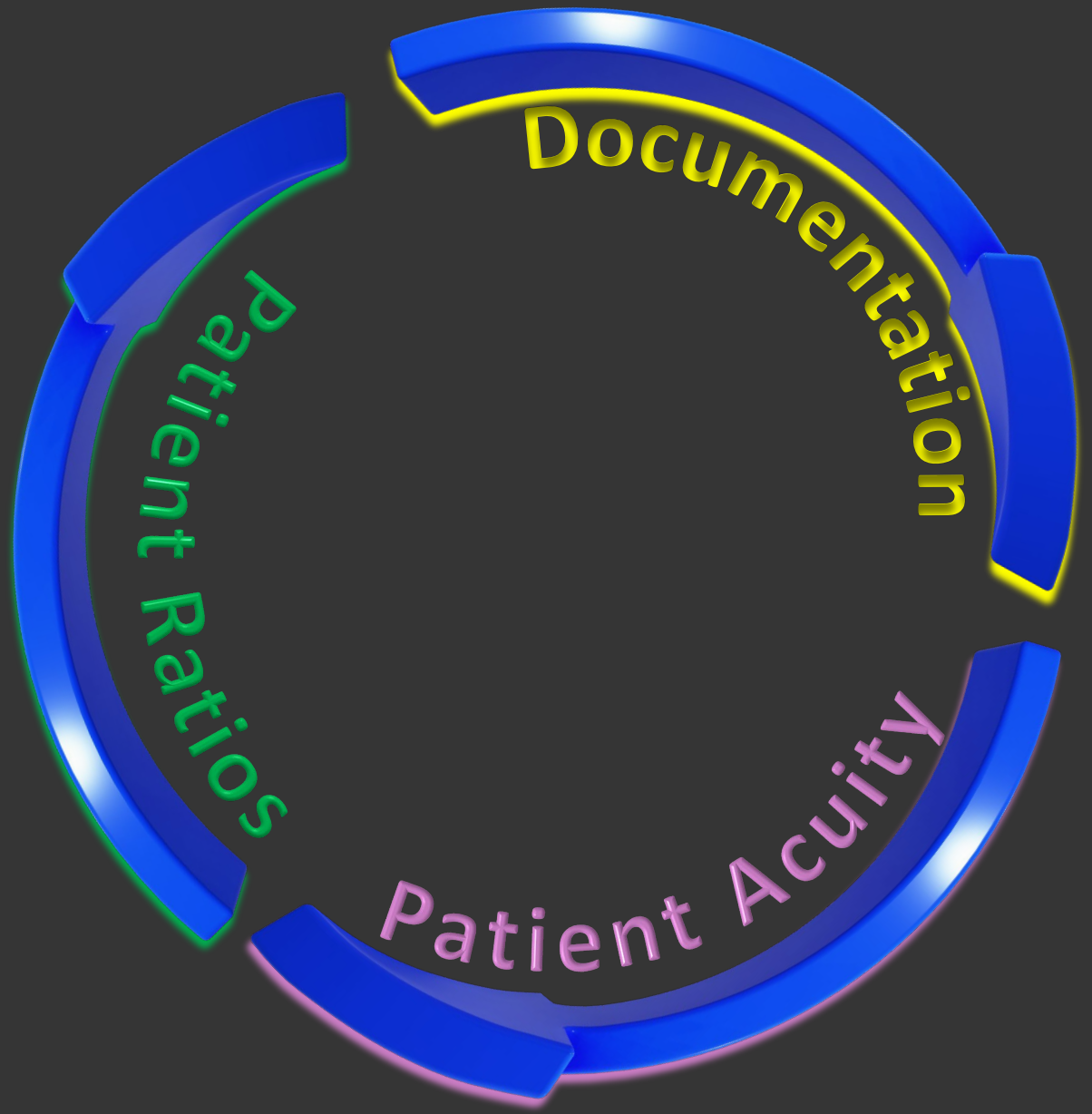
Patient #3

Care Time = 0.5 hour
Drive Time = 0.25 hour
Docu Time = 0.25 hour
Total = 1.0 hours

Total Time for 3 Patients = 6.25 hours



SOLUTIONS



DOCUMENTATION SOLUTIONS

- Form a Task Force
- Remove Redundancies
- Understand the EMR
- Resolve Flow Inefficiencies
- Documentation Templates
- Educate, Educate, Educate

NURSE TO PATIENT RATIO SOLUTIONS

- Measure Staff Metrics Monthly
- Acuity Based Staffing Model
- Define Safe Ratios
- Plan to Maintain Ratios

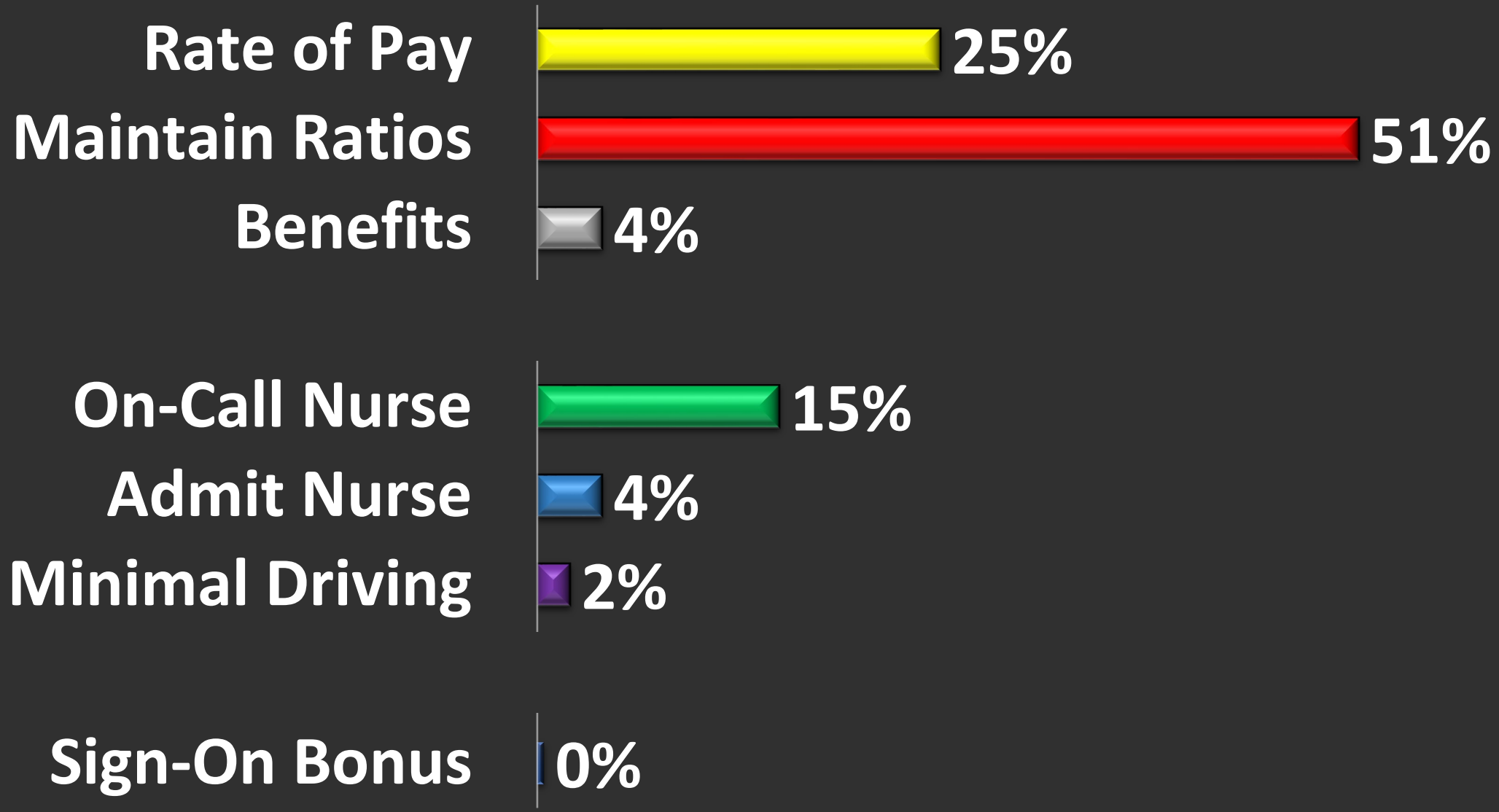
FLEXIBLE STAFFING SOLUTIONS

- Team Nursing
- 4/10’s or 3/12’s
- High Acuity Nurse(s)
- Float Nurse
- Mentorship Program

5 FACTORS ESSENTIAL TO STAFFING STABILITY

- Avoid the Status Quo
- Looks Good On Paper
- Office Support
- Administrative Support
- IT Support

WHAT NURSES CONSIDER MOST (and least) IMPORTANT



SUMMARY

- Know your staffing metrics & challenges
- Mastermind Group / Task Force – include field nurses
- Plan to immediately fix documentation redundancy
- Plan to streamline documentation process
- Define patient ratios and plan to maintain ratios
- Plan for creative, flexible nurse schedules
- Plan to increase the supportive capacity of the office

DOCUMENTATION TIPS FOR AUDIT PEACE OF MIND

Teaching your team techniques to easily audit-proof documentation

Shelley Henry,
RN, CPHRM, CHPN
President, The Amity Group


PAINTING
THE
PICTURE

FIRST WORD POWER

The first word forms an image in our minds and sets the tone for everything that comes after

A negative first word will guide the flow for negative documentation

First Word Principles:

NEGATIVE

Disoriented vs Oriented

DESCRIPTIVE

Frail, Course, Foul …

QUANTIFYING

Extensive, Voluminous, Gross …

BASIC

Diaper, Bruising …

HIGHLIGHT LIMITATIONS OVER ABILITIES

What they CANNOT do vs what they can

Start every sentence with "Can't Do" words :

UNABLE

MOBILITY:
to ambulate without ...
to go down 3 stairs ...

NUTRITION:
to consume 30% of meals...

SPEECH:
to effectively express thoughts ...

CANNOT

ambulate more than 5 steps without ...

obtain or prepare food ...

speak more than 2-3 words without ...

Incapable Without Lacking Limited Impaired Restricted Insufficient Struggles Ineffective Challenges

COMPARATIVE DOCUMENTATION

Effectively Illustrates Decline

"Patient was _____, now they are _____"

DEMENTIA DIAGNOSES

When the patient is having an unusually good day, use the words **Frequently** or **Essentially** to describe how the patient usually presents

~~AAOX 1~~

Disoriented x3

Disoriented to time,
Disoriented to location,
Disoriented to situation,
Disoriented to person

(to be oriented to person, the pt. must be able to independently identify themselves & others)

~~SPEECH CLEAR~~

Cannot effectively express thoughts, feelings or needs

Unable to say more than the same 1-2 words over and over

Unable to understand or answer most questions

~~PAIN SCORE~~ 2

Unable to quality or quantify pain. PAINAD score = 0 throughout SN assessment

No observable signs of pain/discomfort – facial muscles relaxed, appears calm and relaxed with pleasant affect

~~ACTIVITIES~~

~~Watching TV~~

Propped in wheelchair, facing TV, no observable signs that patient is aware of what is playing on TV

~~Working a Puzzle~~

Propped in wheelchair at puzzle table, no meaningful interaction with puzzle or surroundings observed throughout SN assessment

~~Smiling / Nodding~~

Reacts inappropriately to environment/circumstances aeb: nodding and smiling to everything said to her

MOBILITY

For added impact, preface these statements with, "due to progressively worsening weakness and debility…" or "due to the progression of terminal end-stage …"

~~AMBULATORY~~

Slowly ambulates 3-4 steps then must stop and rest using inanimate objects for support

Patient now must sleep downstairs r/t progressive weakness preventing pt from climbing stairs

~~AMBULATES W/WALKER~~

Unable to ambulate without support of a walker. Even with walker, unable to lift foot to take step. Pt must lean on walker and slide one foot slightly forward, take a break, then slide the other foot forward

~~CHAIRBOUND~~

Unable to stand or bear weight. Totally chairbound and dependent for mobility - requires total assistance to pivot from bed to wheelchair

~~BEDBOUND~~

Unable to bear any weight or tolerate being in upright position. Unable to transfer from bed to chair, even with maximum assistance

Unable to shift position in bed, must be passively turned

NORMAL FINDINGS & INTERVENTIONS

When symptoms are managed, highlight hospice's role in maintaining control and potential outcomes without hospice

~~DENIES PAIN~~

Due to the hospice pain management plan, patient states pain is managed to meet his goal of 3 or less. Pt. has required 2 interventions for BTP over the last 24 hours

~~SaO2 92% on 2L/NC~~

Patient dependent upon supplemental oxygen provided by hospice at 2L per nasal cannula. Patient states "if I take my oxygen off I feel like I can't breathe"

~~Room Air:~~ Supplemental oxygen available and utilized at 2L/NC as needed for periods of dyspnea.

~~Eating 100% of Meals~~

Due to progressively worsening weakness and debility, pt. unable to obtain or prepare meals. Consuming 100% of 3 meals daily, but remains 100% dependent for all nutritional needs

~~ALL NEEDS MET~~

Plan of Care meeting patient and caregiver current needs as assessed this SN visit – no revision to hospice plan of care indicated

Collaborated with Hospice MD regarding above noted decline in condition and orders received to revise CNA visit frequency to 5x week.

EXAMPLE: SWITCHING POSITIVE TO NEGATIVE

Patient is a 79y/o w/m with a terminal hospice diagnosis of end-stage congestive heart failure ……

AAOx3, speech clear, denies pain. Ambulatory, but dependent for all care needs. BBS clear, SaO2 92% on RA. All needs met.

Progression of terminal end-stage congestive heart failure causing patient to have a weak inspiratory effort and diminished lung sounds bilaterally to the bases. Due to progressively worsening dyspnea, pt's only able to speak 2-3 words before having to stop for recovery breaths. Speech is halting and breathy, because pt. is too weak for even the mild exertion it takes to speak. Supplemental oxygen remains available and utilized at 2L/NC as needed for periods of increased dyspnea. Unable to ambulate more than 3-4 slow steps before having to stop and lean on a chair or the wall to rest – chairs placed strategically throughout the home to allow pt to sit and rest frequently. Cg reports it takes pt. 10-15 minutes to walk the few steps from the kitchen to the bathroom. Sat with Cg, away from pt., and allowed her to express feelings of overwhelm at being the primary caregiver – cg has no family or friends in the area that can assist her – collaborated with hospice social worker who will visit tomorrow and assist Cg with plan to meet pt. and Cg needs. Patient has sufficient amount of supplies and medications to last at least the next 7 days – no revisions to hospice plan of care this SN visit.

How can I help my team with documentation?

Understand Your EMR / Documentation Process

- use it in the field
- all levels of care
- multiple patients / locations
- try before you buy

Current Devices In Optimal Working Order

- data plan
- touchscreen
- microphone
- Back-up tablets

Scheduled Documentation Training

- chart audits
- audit-based training
- short / targeted class (15 min)
- immediate remediation

Provide Documentation Tools

- Templates (IDT, Death, Admits, Recerts)
- Templates appropriate to subject
- Examples of phrases to support eligibility
- Reference materials (simplified)

References

- Case Study: *Hospice Nurse "Your Opinion Matters Survey"* October 01, 2023 – December 31, 2023, The Amity Group, Inc

Weekly "Tips for Hospice Nurses" & "Tips for Hospice Leaders"

@forhospicenurses

@theamitygroup

THANK YOU

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