Changing the Mindset: Implementing a Hospice Program on a Medical-Surgical Unit

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Abstract
Developing and implementing a hospital – hospice inpatient unit takes many key stakeholders as well as providing the patient with a comfortable and compassionate time during the end of their life journey. Redirecting the thinking of a curative-focused medical and nursing staff, within an academic medical center, to one of providing comfort and compassion during the final days of one’s life takes time and perseverance. Through education, assistance of the supportive care team, spiritual care services and hospice care organization, staff members are becoming more aware of the goals of Hospice inpatient program. Hospital inpatient hospice units are continuing to grow as the population ages and provides families with an alternative from curative treatment, yet maintaining symptom management for comfort and compassion during their loved ones final days.

ABBREVIATIONS
GIP: General In-Patient; EoL: End of Life; CMS: Centers for Medicare & Medicaid Services; EMR: Electronic Medical Record

INTRODUCTION
Developing and implementing a hospital – hospice inpatient unit takes many key stakeholders as well as providing the patient with a comfortable and compassionate time during the end of life journey. Redirecting the thinking of a curative-focused medical and nursing staff, within an academic medical center, to one of providing comfort and compassion during the final days of one’s life takes time and perseverance. Through education and collaboration of the supportive care team, spiritual care services and hospice care organization, staff became more aware and engaged in the goals of the hospice inpatient program.

The goal of hospice is to provide comfort, compassion, dignity and support, minimizing pain and suffering during the patient’s final days. Hospice care is available under Medicare if the patient is entitled to Part A and elects this benefit. Hospice will admit the patient upon the recommendation of the attending physician and the medical director [1]. This benefit of Medicare is primarily carried out in the home setting. However, more hospice organizations are collaborating and contracting with hospitals to provide inpatient facilities to develop a more coordinated transition of care, particularly when the patient’s symptoms are not controlled effectively and all curative methods have been exhausted.

Additionally, a hospice inpatient program may provide the hospital with savings by decreasing the length of stay, reducing ancillary charges and preventing unnecessary inpatient utilization [2]. An additional plan, hospice can help reduce and prevent readmissions to the hospital requiring extensive medical treatments. Obermeyer, et al., [3], identified the daily costs for hospice beneficiaries during the last week of life totaled $556 compared to the non-hospice beneficiary cost of $1760, a savings for the hospital of $1203. The hospital costs for patients who die in the hospital without hospice are about twice the amount of those patients who die in the hospital with an inpatient hospice in the same hospital [4]. Partnering with local hospice agencies would provide beneficial savings for the hospital in reducing costs.

One level of hospice care is general inpatient (GIP) and defined by the Center for Medicare and Medicaid Services (CMS) regulations for control of pain or symptom management within an inpatient facility that can’t be managed in other settings, particularly the home [1]. When a patient’s symptoms are uncontrollable in the home setting and requiring 24-hour nursing support, this would qualify the patient for a GIP stay. Inpatient stays are short-term, and may be provided in an inpatient hospice facility, a hospital or a Skilled Nursing Facility (SNF) and is the second most expensive level of hospice care. Nationally in
2013, 60% (2163) hospice agencies provided GIP services in the hospital setting [5]. The OIG reported in 2013, twenty three percent of hospice patients received GIP services [6]. The average number of GIP stays was 1.1, with the majority (92.5%) having just one stay, and <1% had 4 or more GIP stays [7]. One third of those patients has length of stays that exceeded 5 days, while 11% received services lasting longer than 10 days [6].

On the day preceding a GIP stay, 65% of the patients were not in hospice program and this stay was the first while 23% were receiving hospice care at home [7].

Some of the symptoms for admission to the GIP stay would include unrelieved pain, severe nausea and vomiting, severe shortness of breath, anxiety or panic attacks [8]. With 24 hour/day nursing care and hospice support, this short term stay aims to help the patient regain comfort and peace from the out of control symptoms of a terminal illness or accident. Patient admission to hospice GIP hospital program will be referred by the supportive care team and physician. These individuals may be in the intensive care unit and all curative measures have been exhausted or has been a hospice patient in the home and has arrived in the emergency room experiencing uncontrolled symptoms. Providing GIP services, hospice patients with uncontrolled symptoms, will receive care that is aligned with preferences from an established hospice agency, thus eliminating costly measures if admitted to an acute hospital inpatient stay [4].

DISCUSSION

After identifying the need for an inpatient hospice program, the hospital began the work of collaborating and contracting with local hospice programs, in hopes of developing an inpatient hospice program since the nearest inpatient hospice facility was located about three hours away. After months of planning, the implementation of an inpatient hospice program became a reality. The intraprofessional hospice planning team included the outside hospice organization’s leadership team in its implementation. Refer to Table 1 for key stakeholders involved in the inpatient hospice program. All key stakeholders played a pivotal role in getting the program running.

This practice change involved writing a policy for the inpatient hospice program. The policies encompassed the nursing staff, and the staff from the hospice organization. The policy outlined admission criteria and required a consult from the supportive care team prior to being transferred to the GIP inpatient hospice program. The supportive care team meets with each patient and family to determine and clarify the patient’s goals and options as well as making referrals if appropriate. Nursing care guidelines and a hospice order set were developed and placed into the electronic medical record (EMR). The hospice order set in the EMR offers the physician a selection of medications, dietary orders, and nursing orders and care plan for the patient.

Educating the nursing staff began with presentations on what instituted hospice GIP service, and the process of determining how a patient would become a hospice inpatient. The educational sessions for the bedside nurse included symptom management of several different crises the patient may be experiencing, e.g. dyspnea, anxiety, and out of control pain. The nurses were educated on the documentation, since most nurses’ document on how patients are improving, but in the hospice patient population, the nurse documents symptom management and any decline in the patient’s status. One session was videotaped for educating new employees in the future. The nurses and clinical associate (CA), (role similar to nursing assistant) also received education regarding grief management from the spiritual care department. A detailed process document was developed and distributed to all unit clerks who would be transitioning the patient to a hospice GIP bed, during admission. This medical surgical unit has been given priority to admit GIP patients, particularly from higher levels of care e.g. ICU and step-down units.

The nursing staff was provided with a written guideline defining the items that needed to be completed and the items that would not need to be documented in the EMR. The hospice nurse would be responsible for the initial assessment of the GIP patient. The education for the implementation of this program was carried beyond the unit receiving the hospice patient. Education was provided to unit clerks on other units within the hospital, the bed coordinators, admissions and environmental services, in order to maintain a smooth transition. It was determined in order to maintain continuity of care for the hospice patient, only nurses who have received this hospice focused education would provide care for the hospice patient on this medical surgical unit.

Prior to accepting the first hospice patient, a table top exercise simulation using multiple scenarios was trialed to identify possible areas of weakness and concern. Once all the required documents and policy and procedures were written and approved, staff education provided, and hospice agency employees were complete, (such as updated immunization records and attending a class on documenting in the EMR), the unit was ready to accept the first hospice patient. The unit accepted the first hospice patient in October of 2014. Through shared governance, all entities were invited to debrief after the first hospice patient’s arrival. The hospice program started admitting patients slowly, but has shown continued growth through 2015 seen in Graph 1, data on admissions from January through September 2015.

Once the patient has been admitted to GIP, the admitting physician, along with the hospice nurse, develop the plan of care for the GIP patient. The bedside nurses collaborate with the hospice nurse to provide care to manage the patient’s symptoms.

Table 1: refers to key stakeholders involved with development of the inpatient hospice program.

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<tr>
<th>Vice President/Chief Nursing Officer</th>
<th>Physicians</th>
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<td>Quality Management</td>
<td>Risk Management</td>
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<td>Information Technology</td>
<td>Pharmacy</td>
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<td>Respiratory</td>
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<td>Admissions</td>
<td>Unit Leadership Team</td>
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<td>Hospice Agency Leadership Team</td>
<td>Nursing Staff</td>
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which are uncontrolled, either with use of medications and/or non-pharmacologic methods according to the plan of care. Hospice aides and the CAs provide comfort and hygiene care ongoing during the stay. The hospice nurse visits daily to assess the patient and if needed, contacts the physician for issues and problems. Documentation of the assessment in the EMR of the hospital as well as the hospice agencies EMR is also consistently completed. The hospice nurse spends a great deal of time supporting and answering questions of the family members. The bedside nurse focuses on patient comfort and management of the symptoms during the shift. If patient’s symptoms become out of control with the current regimen, the bedside nurse contacts the hospice nurse for evaluation. The hospice nurse would notify the physician about the patient’s change and the physician would either enter the orders in the EMR or contact the bedside nurse ordering medications or modalities in the care.

A hospice social worker and chaplain also visit the patient and family members, providing support and comfort during end of life care. They answer many questions and have time to listen to the family members’ concerns. They document the visit in the EMR each time they see the patient.

Once the patient’s symptoms have become controlled, the patient may return to their previous residence. For the patient whose terminal illness has ended, death is only the beginning of the continuing care for the family members in the form of bereavement services the hospice agency will provide. Although the bedside nurse may only interact in the GIP patient’s life for a short time, the compassion and caring the patient receives will be remembered by the family members for a long time.

Some of the challenges the program experienced were the availability of a bed for the GIP patient as unit census was near capacity each day. This lead to collaborating and communicating with the bed coordinator in getting these patients on the unit in a timely manner to improve the hospital throughput decreasing the time to get the patient onto the unit from the time of referral. Another challenge identified was the availability of the hospice physician to admit the patient, which delayed admission to the GIP program. Referrals into the GIP program are not made until patients and families have made decisions to withdraw curative high-cost medical interventions [4]. This may limit the full scope of care the hospice agency can provide to the patient and family, e.g. patient admitted to GIP and dies within 2 hours of admission. However, during that time, every moment was spent providing comfort and compassion to the patient and family. Educational sessions were provided to all new physicians entering the organization by the supportive care nurses, in hopes of getting referrals earlier for a transition into hospice care.

A few bedside nurses on the unit were uncomfortable with caring for actively dying patient population. After discussion with the involved nursing staff, areas of concern were identified and additional education was provided to alleviate those nurses’ fears. Patient assignment was rotated to help avoid compassion fatigue.

With hospice in the home setting, when a patient dies, the nurse will prepare the patient, the funeral home will be contacted, removing the deceased from the home. In the hospital setting, replicating this has been a change for the local funeral homes. The funeral home attendant would arrive at the morgue to retrieve the families loved one. In hospital setting, if the individual is sent to the morgue, the hospice agency would incur an additional cost associated with holding the deceased until transferred to the funeral home. In order to replicate the process similar to home, funeral home attendants will arrive in the patient’s hospital room to transition them to the funeral home. The detailed process was communicated to all local funeral homes and now has become a seamless process.

Improvements to the program are ongoing. Debriefing sessions have been held to help improve process. Additional medication order sets are being updated to facilitate the patient’s comfort and needs. A dashboard for tracking and trending was developed to identify referring services, and the time of referral to admission to the unit. Graph 2 summarizes the referring services. The dashboard highlights metrics to assist leaders in discussion for program improvement. Implemented monthly meetings with risk management, supportive care nurses and the hospice unit leadership team to evaluate process and identify areas for improvement. Providing the latest in educational development programs, supportive care, nursing and the medical

Graph 1 Total Hospice Patient Days by Admitting Unit.
The staff provided comfort, healing and caring to my family. All of the nurses we encountered were attentive and responsive to all of our needs and the physician has been an inspiration and a gift from God. The nurses went ‘above and beyond’ in their approach.

The nurses were truly empathetic when my grandpa encountered some difficult circumstances and one of the nurses shared her time and compassion when my family needed it. We felt so ‘taken care of’ by the hospice physician. I learned so much about palliative care through this experience and he said all of the things that I needed, personally, to face it. My family will always remember the journey and the role the hospital staff played in helping us make it through.

CONCLUSION

With nearly a year completed, the nurses have developed a compassion for caring the GIP patient population. The openness of the nurses, of welcoming the hospice agency staff to the unit, working alongside, truly exhibits the teamwork which places the patient at the center of everyone’s attention. This has been exhibited by the many letters and thanks from the patient’s families for the care provided. Figure 1 is a thank you letter excerpt, expressing appreciation of the care for their loved one.

As the program grows, future considerations include expansion of more bed availability on the initial unit as well as adding another unit within the organization. Inviting other local hospice agencies to consider utilizing our facility for GIP services. With a growing need in the future, a free standing hospice house, aligned with the organization to care for the GIP population will be beneficial.

Evaluation and improvement of the current processes will strengthen the sustainability of this important program. Establishing hospital-hospice program related goals, including key stakeholders and implementing specific hospice education and policies and procedures, other healthcare facilities may be able to translate this initiative into practice within another setting.

REFERENCES


