Staffing for End of Life: Challenges and Opportunities

EXECUTIVE SUMMARY

What would staffing look like if we committed to end-of-life experiences that were designed to honor the needs of the person dying, their loved ones, and the needs of the nurses and care team involved in the dying experience?

When we think about the experience of death in a health care setting, it is essential we look at the needs of both patients and caregivers.

Attending to the needs of patients and their families facing death, even if well defined, can be difficult to design into staffing plans and budgets in a way that would not put an organization at further financial risk.

If we are going to commit to staffing practices that honor dying, in all its dimensions and for all who are potentially impacted, we will most likely have to step outside traditional thinking to find answers.

The topic of death in this country, even within health care, is not one easily approached. By devoting an entire issue to the topic, Nursing Economics continues to demonstrate its ongoing commitment to not shying away from the hard subjects. The opportunity created by establishing this venue and getting this difficult topic out into the open is a powerful one. By pulling together research and thought leadership, we pave the way for meaningful dialogue and informed action.

This column is dedicated to the area of staffing. When first presented with the subject of this special issue, it was difficult to imagine how these two topics could come together. Perhaps influenced by how infrequently the subject of death is explored, there was hesitation. Or perhaps influenced by some unspoken sense that, in hospital care, death can represent some kind of failure; a failure to heal, a failure to save someone. But that hesitation was only momentary. Through taking some time for personal reflection and speaking with colleagues on the subject, there surfaced a myriad of considerations related to staffing and dying.

Many people, in many organizations have resources and structures in place to support end-of-life situations. What follows is in no way intended to bring into question their good work, but rather to shed light on the topic and call for collaboration and innovation in finding solutions that can be adopted broadly.

Entertaining what might be considered ideal scenarios for staffing at end of life, it quickly became apparent that most of the thinking on the topic was headed in the direction of adding to labor costs and thus adding more to the consideration, “How can we afford to die?” With costs as a constant constraint our challenge may well be, how creative can we get to assure we are effectively meeting the needs of a dying patient?

Not an uncommon situation to contemplate, the tension between costs and quality offers up some very interesting questions. Are we asking, “How can we afford to die?” “How can we afford to die well?” “How can we afford to handle the needs of the dying, the needs of their loved ones, the needs of individuals who are caring for the dying?” Before we can address staffing requirements, these questions need to be answered first, so we know what we are staffing for. To help ground the weight of these questions, it seems right to make a connection to the very personal and human nature of the end of one’s life before entering the theoretical realm, so a true story.

Making the Connection

When the phone rang, waking us at 3:00 a.m., we were not surprised at the purpose of the call; it was to talk about dying. We had heard earlier in the evening that Virginia had taken a turn for the worse. The remainder of the evening was spent urgently on-line and on the phone making arrangements to get the first flight out, as Virginia was over 2,000 miles away. The ICU nurse on the other end of the line was explaining to us that Virginia would likely not make it through the night. While she was still alert, her body was failing fast. She offered to help us talk to Virginia, too weak to hold the phone, her nurse held the phone next to her ear and for several minutes we exchanged our love and good byes. Distraught by the distance separating us at this moment, when the nurse got back on the phone I had one request, “Please do not let her die alone.” The nurse promised me she would not leave her side.

Even before dawn broke I was on a plane, out of communication, so hard during all of this. While changing planes in Denver, I was able to reach the hos-
pital and learned that Virginia had passed away while I was in the air. Her nurse had gone home. When I reached Florida, Virginia’s closest friend met me at the airport and took me straight to the hospital, explaining that the nurses had arranged to keep Virginia in her bed until I could see her. So many things go through one’s mind at times like these, but the most urgent thing I needed to know, was that she did not die alone in an ICU hospital bed. When they told me what happened, my heart sang with joy and gratitude.

The three people closest to Virginia in Florida had all happened to come to the hospital early in the morning, not sure what was calling them there, not knowing, at least on a logical level, that this would be their last visit with Virginia. The three of them were at Virginia’s bedside for some time, when they asked her nurse if she had other patients to care for or needed a break. She replied, “I promised her daughter that I would not leave her side.” Virginia passed away surrounded by her closest friends, and a nurse who kept her promise.

I do not know what the staffing situation was when this nurse made a commitment to stay at Virginia’s side, but I do know that in today’s care environment this could not have been easy. Other team members most likely stepped up to cover other work required by her. What this meant to us was beyond words. For every caregiver, for every person who has lost a loved one in a hospital, there are stories. Some of these stories are inspiring, some heartbreaking.

Okay, let’s go back into another part of our mind for a minute. How do we staff for moments like this, and should we? Let’s begin by considering what staffing might look like if we committed to end-of-life experiences that were designed to honor the needs of the person dying, their loved ones, and that honors the needs of the nurses and care team involved in the dying experience.

To provide some framework, it can be helpful to go back to the model for staffing based on evidence (see Figure 1), part of the work on staffing excellence (see www.staffingexcellence.org for more information).

At the center of this model two groups or two individuals are represented (see Figure 2), the patient and caregiver/patient and family, and the care team.

The Patient Side
Beginning with the patient side of the model, we know end of life is full of unique and complex possibilities. This makes it difficult to project needs requirements. In part because the process of
dying can take it’s own course and in part because the needs of a patient or family member facing death can be highly variable and may sit outside standard measures used to define patient needs. The story of Virginia is an example. Adding to the challenge is that we may not know enough about the process of death to effectively determine need. For example, if a dying patient has slipped into a non-responsive state, does this decrease his or her need for support during the dying experience? We have all either had or read about experiences that would indicate the answer is no, it does not. Thus, adding even more complexity to the situation, what are the needs and do we know how to respond to them?

In assuring that, when facing death, the physical, emotional, and spiritual needs of a patient and his or her family are attended to, we need a way to capture the needs and then staff appropriately to meet those needs. When it is recognized that a patient is close to death, he or she is often moved into a hospice situation where the staff have specialized training and are well equipped to handle the special needs of the patient and family. But for those who remain in acute care settings, this may actually call for more specialized training of staff and a new kind of staffing model, one that specifically includes end-of-life situations.

The Caregiver Side

When we think about the experience of death in a health care setting, it is essential that we look at the needs of both groups represented in the model. Often our attention is more on the patient side of the model, but one does not need to be around death very much to know that attention to the caregiver/care team side is essential.

Here we need to ask the question, “How well do we understand and attend to the needs of a caregiver who has gone through one or many death experiences?” To make this point, one situation stands out. A pediatric nurse recently shared a situation in which she lost three children under her care within a short period of time. She shared that when she finished her tasks and completed her charting, she was given a new patient assignment immediately. Her story gives pause. How often does the practical and business side of the equation override what we in the caring professions know is right, and at what cost? If we design our staffing budgets and practices to accommodate the need for caregivers to grieve and process loss, we may see nursing hours per patient day increase, but overall costs would most likely decrease. If we don’t allow room for our care teams to manage feelings, over time it will manifest in other ways: sick calls, burn out, compassion fatigue, leaving one’s job, leaving the profession. The truth is, death and loss are hard things and the needs around these situations do not diminish because one is a nurse, or on a care team.

Another question we should consider is, “How well do caregivers understand their own needs in these situations?” A colleague was recently describing the design of a new children’s hospital that features areas called “off stage” where staff members can spend time away from patients and their families. This is a place where staff can rest, reflect, or process with other team members difficult situations such as a child dying. This is a wonderful resource in theory; however, she finds it is difficult to get staff to use it. The typical response is, “I don’t need it, I’m okay.”

Caregivers expect a lot of themselves and it can be easy to fall into a pattern of ignoring and pushing away self needs. When a nurse supports a patient and family through a death experience, he or she may feel good about the role he or she played, but the nurse has also experienced the loss. With loss comes a need to process the experience. This may call for an investment in education around understanding and attending to self-care needs.

The Dilemma/Innovation Opportunity

Within the concepts of staffing excellence, in addition to positive outcomes for patients and the workforce, outcomes for the organization that provides the care environment are also considered. When we reintroduce the subject of costs, the realities of cost containment, and the realities of reimbursement, our challenge grows significantly. Attending to the needs of patients and their families facing death, even if well defined, would be difficult to design into staffing plans and budgets in a way that would not put an organization at further financial risk.

Thus the dilemma, what can we do short of setting aside the needs of patients/families, caregivers, and our organizations, because in traditional thinking, something has to give somewhere? Therein may lay the answer. If we are going to commit to staffing practices that honor dying, in all its dimensions and for all those who are or potentially impacted, we must step outside traditional thinking to find answers. Here are a few ideas to start the conversation:

- Look at ways patient classifications systems can help capture needs for end-of-life situations.
- Rethink care criteria, care interventions, and support requirements in ways that leverage the wisdom of nursing, the input of the care team, and the patient and/or family in collaboration with the physician.
- Redesign budgets/staffing models to add consideration for end-of-life situations.
- Identify and address education needs of individuals supporting death and dying.
- Consider a new caregiver role – much like a dula for expecting mothers with specialized training, yet perhaps more cost effective.

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• Consider how to better leverage the labor force and experience of retired nurses, retired social workers, and volunteers.
• Lobby for better financial coverage for end-of-life scenarios.

There is much to think about, and much to consider. May this special issue, on this important topic, become a catalyst for inspiring new ways to support this mysterious part of the human experience – death.

In terms of the question, “Should we invest in better solutions that meet the needs of all involved in dying?” Well...we are all going to do it...die...so...

Join the conversation. Do you have good solutions in place at your organization? Help others learn how you are staffing for end of life and assuring the needs of patients, caregivers, and your organization are met. Share your voice on the Crucial Conversations page at www.nursingeconomics.net