



Hospice of the Twin Cities

Hospice Insights

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*“The bravest are the tenderest,
The loving are the daring.”*

~Bayard Taylor~

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Bereavement for Long-Term Care Staff

Historically, long-term care has focused on meeting the physical and medical needs of residents. In the last few years the need for staff support has become as important in an effort to maintain staff morale and staff productivity. Maintaining the morale and productivity of staff improves the quality of care, as well as the quantity of care, many times a direct result of empowering staff to express their grief and loss issues.

What are the specific bereavement issues faced by staff in a long-term care setting? Long-term care staff bereavement needs may include such issues as:

- Not having the proper environment in which to express feelings over the actual or impending death of a resident,
- Inability to attend visitation or funeral to find closure,
- Not having the opportunity to attend a facility memorial service, if one is available,
- Conflict over allowing personal losses to become a staff or facility issue,
- Multiple loss issues (many deaths or loss of long time residents),
- What to say to better assist bereaved families,
- Guilt over not allowing the dying resident to talk out emotions,
- Avoiding dying resident,
- Learning of resident’s death by accident,
- Not validating death of resident appropriately (“fill the bed quickly”), and
- Inattentive to grieving needs of roommate and other residents.

Knowing what the bereavement issues are, how can these specific bereavement issues be faced?

- Providing a safe environment for staff to express their grief and loss.
- Giving staff time off to attend the funeral or visitation of the deceased resident.
- Hold facility memorial services at regular intervals if unable to hold them for individual deaths.
- Personal losses **DO** become facility issues if the individual does not have the ability to experience their grief in a safe environment.
- Institute special bereavement support when the facility experiences many deaths or the death of a long-term resident to whom the staff is very attached.
- Offer education on “Communicating with residents who are dying, and their families.”
- Teach staff how to allow residents to talk about death (can be in conjunction with the “Communication” education).
- Teach staff not to avoid the dying resident—with proper training and the ability to reflect on one’s own mortality, staff becomes more comfortable with the subject, and consequently, more comfortable with the residents who are dying.
- Set a policy on how to disseminate information regarding a resident’s death so it is **NEVER** a surprise to staff.
- Allow staff to spend time in the empty room. It allows them a safe environment to feel and express their grief.
- Remember, it is not only staff who grieves when a resident dies ~ room-mates and other residents need to have their grief validated.

Making a Hospice Referral

The patient must meet the criteria for hospice care.

- The patient has a limited life expectancy, usually six (6) months or less, as certified by their physician.
- The patient understands that hospice care is palliative, focused on pain and symptom control, rather than a cure for the disease.

- 1. The Attending Physician's order for Hospice is obtained.**
- 2. Hospice care is chosen by the patient and/or family.**
- 3. Call Hospice of the Twin Cities at (763) 531-2424 to make a referral. Ask for the referral office.**
- 4. An information/admission meeting is arranged with the hospice, patient, family and/or any other individuals involved in providing care.**
- 5. The patient or designated decision-maker signs consents for hospice care to begin.**
- 6. The hospice team assigned to the patient develops a plan of care and begins to provide care and services.**

Ten Myths About Hospice & Palliative Care

MYTHS	REALITY
Hospice is where you go when there is nothing more a doctor can do.	Hospice is a philosophy of care providing medical, emotional, and spiritual care focusing on comfort and quality of life.
Good care at the end of life is very expensive.	Medicare beneficiaries pay little or nothing for hospice, and most insurance plans, HMOs and managed care plans include hospice coverage.
Hospice is only for the last few days of life.	Hospice patients and families can receive care for six months or longer, depending upon the course of the illness.
Choosing hospice means giving up all medical treatment.	Hospice places the patient and family at the center of the care planning process and provides high-quality pain management and symptom control.
Everyone dies in a hospital.	Hospice goes to the patient and family at home ~ whether that is a private home, a nursing home or assisted living residence, or a residential hospice.
Hospice is only for cancer or AIDS patients.	Fifty percent of hospice patients are diagnosed with conditions other than cancer or AIDS.
Families are not able to care for people with terminal illnesses.	Hospice involves the family and offers professional support and training in caring for their loved ones.
Hospice is just for the elderly.	Hospice serves anyone facing a life-limiting illness, regardless of age.
There is no hospice in my area.	Less than one percent of Medicare beneficiaries live in an area where hospice is not available.
Hospice only focuses on the dying process.	Hospice offers grief and bereavement services to family members and the community.



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We're on the Web!
www.hospiceofthetwincities.com

Mission Statement

Hospice of the Twin Cities' mission is to enhance the quality of the lives of our patients and their families by providing respectful care based on maintaining dignity, alleviating physical, psychosocial, and spiritual suffering, advocating for fundamental rights, and affirming the sacred value of life.