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INSIDE

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Make it a goal this year to improve wound care outcomes, costs, referrals

Key to success is changing product formulary

Home care agencies are in a good position to improve their wound care treatment and enhance referral base by moving into the 21st century with new wound care products and protocols.

"We have gone to great lengths to develop a very advanced wound care program," says **Michelle Mullins**, RN, BSN, manager of clinical operations for the Alexian Brothers Medical Center Home Health Department in Hanover Park, IL.

"The benefits have been that it has allowed us to control our costs, provide consistent quality care to patients, and have good outcomes," Mullins says. "That's the No. 1 one thing people are looking for with the prospective payment system [PPS]."

Since last May when the agency redesigned its wound care product formulary and treatment guidelines, the agency's wound patients have been healing much faster, Mullins says. While this always is the primary objective, it also helps that the improvement has helped the agency's bottom line under PPS reimbursement.

"We're using advanced wound care techniques, and the new products are helping us drive down the number of visits required to accomplish our goals," Mullins explains.

"These are products that everyone has the capability of using in home health," she adds. "It's just a matter of to what extent you've gone to assess what's out there and to look at your wound formulary."

Here's how Alexian Brothers' home health agency made those changes:

1. Redesign wound care formulary.

The goal is to find wound care products that will improve wound healing times and maintain safety. Health care manufacturers have developed a wide variety of products that do just that. New technology also makes it easier for clinicians to evaluate a wound. A committee looked at the available products and selected a vendor.

Then home health managers met with clinicians to decide which products to use and place on the new formulary. "We looked at what was already on there and what we could get rid of; and what new stuff to adapt, make uniform, and go from there," Mullins says.

The agency then developed the formulary and wound care treatment guidelines, using the vendor's product information. **(See wound care guidelines, right.)**

For example, the home care agency has begun to use a digital camera that when used in conjunction with a computerized wound care program can track a patient's wound healing progress.

When a nurse visits the patient, he or she can take a picture of the wound and use that image to consult with a wound care specialist. The specialist will oversee the wound care and make sure field staff use the best products for that particular type of wound.

The digital images of the wound also can be used to offer visual documentation on the chart. "This is great for state surveys, for physicians, and for payers," Mullins says.

"Some physicians like these so much, they say, 'If I have so clear a picture of what the wound looks like, I won't have to provide so many follow-up visits,'" she says. "So we can save a cardiac surgeon an office visit because their follow-up visits are part of the surgery package."

Seeing this as a clear benefit, physicians are more likely to refer patients to the agency for home care treatment.

The Alexian Brothers agency also has used those digital images during surveys by the Joint Commission on Accreditation of Healthcare Organizations of Oakbrook Terrace, IL. "The Joint Commission really likes it because it shows a clear picture and tells a story in the chart about what is happening with a patient," Mullins notes. "They can see the patient's progress; it's a great documentation tool."

The images can be sent to payers and physicians by e-mail or fax. New technology also has resulted in products that can be substituted for the "wet-to-dry" method of wound healing. One such product is a Hydrogel-impregnated gauze dressing that promotes moist wound healing. Another one is an absorbing gel called Iodosorb, which can absorb the drainage and minimize the bacterial load when applied into the wound bed. This product also reduces wound odor and will change color to indicate that it's time to apply a new dressing.

2. Train staff how to use new products.

Alexian Brothers Home Health

GENERAL WOUND AND SKIN CARE GUIDELINES

The following general wound and skin care guidelines should be followed for all residents with potential and/or actual impairment in skin integrity.

1. Perform agency's pressure ulcer risk assessment on admission and PRN.
2. Wash hands before and after patient contact. Observe standard precautions.
3. Evaluate support surface need for bed/chair.
4. Teach patient/caregiver to turn/reposition accord ing to individualized repositioning schedule. Instruct other interventions to prevent pressure ulcers.
5. Teach patient/caregiver to perform incontinence care every AM and PRN.
6. Teach patient/caregiver wound management interventions (i.e., dressing changes, signs and symptoms of wound infection, etc.).
7. Perform agency's nutritional assessment and make nutritional support interventions as needed. Encourage fluids unless contraindicated.
8. Dress chronic wounds using clean technique, since all chronic wounds are contaminated.
9. Cleanse wounds using a nontoxic agent (Dermal Wound Cleanser) or normal saline per MD order prior to making wound assessment and applying a new dressing.
10. Select a dressing that keeps the wound bed moist and the periwound skin dry.
11. Select a dressing that is at least 1 inch larger than the affected area.
12. Prepare the periwound skin with a skin sealant (Skin-Prep), prior to the application of any adhesive dressing or tape.
13. Perform the wound treatment. Picture frame dressings, as needed with tape, PRN.
14. Reevaluate dressing selection and skin integrity with every dressing change.
15. Reevaluate the wound's response to the prescribed treatment. Make recommendations for changes PRN. Inform MD of changes in wound status.
16. Know the indications and contraindications for the wound products used.
17. Date, time, and initial all dressings at times of application.
18. Use care when removing all dressings and tapes. Use adhesive removers PRN.
19. Document wound assessment, treatment performed, and response to treatment on the appropriate documentation form.
20. Contact members of your wound and skin care team and/ or wound care consultant if you have any questions.

Source: Alexian Brothers Medical Center Home Health Department, Hanover Park, IL.

The agency created a new position called the certified wound care specialist, a clinician who attended additional courses on wound care and received certification. The specialist's role is to consult with other field staff on wound care treatment, answering their questions when problems arise.

The wound care product vendor provided educational material that was used in giving staff inservices on the new treatment protocols.

3. Develop wound care grid.

The wound care grid has detailed pictures of different types of wounds. With each wound description, there are lists of products and procedures on how to handle that particular type of wound.

This provides staff with a uniform and illustrated example of how to best provide wound care in any given situation.

For example, the wound care grid for a cavity wound shows two photo examples of stage IV wounds, offering a definition that says, "Full-thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures (i.e., tendon, joint capsule). Then it lists the following information:

• Treatment C — minimal exudate to no exudate

1) Cleanse area with saline or Dermal Wound Cleanser. Pat skin dry.

2) Apply 3M No-Sting Wipe. Allow to dry thoroughly.

3) Fluff SoloSite Conformable Dressing into wound. Be sure to lightly pack tunneled areas.

4) Cover with appropriate Tegaderm or CovRSite.

5) Change dressing Q 1-3 days or PRN.

6) Discontinue treatment when wound characteristics change or when area is healed.

• Treatment D — moderate to heavy exudate

1) Cleanse area with saline or Dermal Wound Cleanser. Pat skin dry.

2) Apply 3M No-Sting Wipe. Allow to dry thoroughly.

For granulating/clean wound beds:

• Place AlgiSite M in wound. Be sure to lightly pack tunneled areas.

• Cover with Allevyn or Allevyn Adhesive Dressing.

3) Change dressing as appropriate

• OR debride enzymatically.

4) Discontinue treatment when wound characteristics change or when area is healed.

Such involved details leave little guesswork in wound treatment and ensure a greater consistency in care, Mullins says.

"This way there is not much variance in how each clinician handles a wound," Mullins says. "This has seriously helped us, and it's one of the contributing factors to decreasing our costs."

4. Educate physicians, other referral sources.

The agency's wound care specialists meet with physicians who are reluctant to prescribe new products. The specialists give them a history on the new products and explain how using these have helped improve wound healing times and reduce complications. "When we get referrals of patients who have wound infections, we meet with the physicians and educate them on the wound care products," Mullins says.

The home care agency also has been working closely with cardiac surgeons to obtain more patient referrals. Many physicians are also under reimbursement constraints, and they understand how PPS has changed the home care industry. "With PPS, the name of the game is to fix the stuff early on," Mullins says. "You can do it right away to limit the number of visits, providing the appropriate amount of care but doing what you can to control costs." ■

Source

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NM, MT agencies' disaster plans tested by fire

In emergency, keeping track of clients is Job One

It's the worst possible way to learn how your agency will cope in a natural disaster — by weathering one.

For a number of agencies across the West, this summer proved to be a trial by fire, literally. Forest fires raged out of control for weeks, scorching hundreds of thousands of acres and causing evacuations and property damage.

The operators of two such agencies, one in western Montana and another in New Mexico, say that all the disaster planning in the world doesn't fully prepare you for how a true emergency will test your staff and yourself. **(See article, p. 18.)**

"A disaster plan can sit there for years and years without anyone pulling it out and looking at it," says **Jane Hron**, BSN, home care director for Marcus Daly Home Care, Hamilton, MT. "Even if it's part of your mandatory review, you don't look at it that closely until you're right in the middle of [an emergency]."

And the effects of a natural disaster can last long after the event itself has passed.

Sarah Rochester, director of the Los Alamos (NM) Visiting Nurse Service (VNS), says she's still coping with the financial problems caused by the evacuation of her agency in May. In addition, the dislocations caused by the fires have increased turnover and lowered morale among staff.

"Two of my full-time nurses lost their homes," Rochester says. "And we have lost both of them, because they can't go through this community anymore. I would think it would be difficult to jump in your car and drive by your own home that had burned down or the route you would have taken. That would have to be devastating."

Warnings, but still surprises

In both cases, the directors say, there were warnings that the fires might threaten residential areas and cause evacuations. But the slow movement of the fires was deceptive: A shift in winds or other factors could put a whole new area at risk overnight, causing agencies to scramble to keep up with clients who were being moved.

In fact, both say keeping track of the movements of their clients and staff constituted the greatest challenge in operating during the fires.

In western Montana, forest fires began threatening residential areas in late July, with residual effects continuing through August and up until rains came over the Labor Day weekend, Hron says.

In Hamilton, Marcus Daly Home Care kept a large map of the coverage area studded with pins marking where clients were living. As the media released information about the movement of the fires in the area, Hron says it was fairly easy to figure out who might be affected.

She says the agency's planning efforts were aided by emergency management personnel, who tried to alert residents days in advance when they were on standby to be evacuated. "That gave us the leeway as a provider to be talking to patients and saying, 'If they put you on standby, let us know.'"

However, she says, there were a few instances in which clients left without notifying the agency and had to be tracked down. "That only happened a couple of times, because then the staff were getting better at talking with the patients ahead of time and they started to let us know [about relocations]," Hron says.

She says the mapping procedure already was part of the agency's disaster plan. But missing from the plan was a way to keep track of the staff, who themselves were being evacuated. Staff members often would have to take several days off to move their own households, Hron says.

In New Mexico, fires set in Bandelier National Monument in May spread out of control, threatening the Los Alamos National Laboratory and the city of Los Alamos.

Rochester says the warnings there came with less preparation time — and had a crushing impact on the VNS' operations.

Not only did the fires strike one of the areas of town with the largest concentration of retirees, but the agency's offices also were evacuated.

"They suggested part of the community evacuate on a Monday," she says. "On Tuesday, that group stayed evacuated and one other area of the community was put on potential alert. On Wednesday morning, everything looked much better, and the firefighters were saying they thought they had it under control.

"Wednesday at noon, the winds whipped up, the fire jumped the canyon, and we were all told to evacuate immediately. It was just amazing."

Rochester says she had 10 minutes to figure out what to take with her from the agency offices. She had the forethought to grab a notebook that listed minimal information about each patient.

After moving the operation to her own home, Rochester and her staff began calling the area's makeshift shelters — schools, churches, casinos, anywhere the Red Cross had put cots for people to stay.

"Whenever anybody was placed in a shelter, they had to register. We called the shelters — all of them — to find people," she says. "And at the same time, we were hearing from relatives who haven't heard from their family, saying, 'Do you know where my mother is?' or 'Have you seen my sister?'

"There were a few who took us a few days to find," Rochester says. "Some of them stayed in motels and we had trouble finding them."

The pall of smoke that hung over the towns both before and after the evacuation exacerbated some patients' existing health problems. In Los

Alamos, Rochester says nurses tried to convince respiratory patients to leave the area a week ahead of the evacuations.

One man who decided to stay developed smoke inhalation problems. "I stopped at the storage shed and got a nebulizer and I just thought we'd take care of him," Rochester says. "We got out there and realized we had no infrastructure! We couldn't possibly used a nebulizer because there was nothing to plug it in to."

Instead, she says, they rigged a camp shower-type apparatus to help give him immediate relief.

In Montana, Hron says people who weren't in evacuation areas were instructed to keep windows closed and even keep family pets inside. "It was disruptive for breathing most of the time, and for anyone who was compromised at all with asthma or anything else, it would cause a problem," she says. "Our hospital was handing out masks, but along with the masks came the caution that they really only took out the larger particles. It really was still unsafe to be out."

The fires created other challenges. Arrangements had to be made with oxygen companies to get oxygen to patients who needed it. Agencies had to make do with skeletal staffs. Arrangements also were made with outside home health agencies to take on relocated patients, often with sketchy documentation.

The evacuation of Rochester's office, which lasted about a week, created a logistical nightmare. Her nurses had no access to patient charts. Patients didn't know where to call — Rochester had local radio stations broadcast alternate phone numbers so patients could get in touch with them.

And she had no supplies to speak of. Rochester laughs when she thinks back to what she took with her during the evacuation.

"I took the ultrasound machine with us — don't ask me why," she says. "You don't think when you leave. I was thinking, "I'd better take the things that will be difficult to replace."

On the bright side, she says the reaction of the entire region was tremendous, and helped fill in many gaps. Hospitals in Santa Fe and Albuquerque helped out with supplies. New Mexico Blue Cross collected donations to help out Los Alamos health care providers. **(See article, p. 18.)**

"The day after the fire, the phone rings at my house and it's one of the pizza places saying they're delivering six pizzas for our staff and anyone else who might want it," Rochester recalls. "It was a gift from the Rural Hospice Network."

Rochester says her agency is still coming to terms with the tremendous destruction of the fire. Morale has suffered, and bereavement counselors have been called in to help.

Aftermath: Still picking up the pieces

Even those who didn't lose their homes are coping with overwhelming emotions, she says.

"We have a lot of secondary grief here — people who have guilt because their houses didn't burn and because they do have everything," she says.

Then there is the financial damage. Rochester describes the response of fiscal entities to her agency's crisis as "laughable."

"We contacted Medicare to let them know we were going to be in a very large financial crunch, and had our CPA talk with the person who was our liaison at [the agency's fiscal intermediary]," she says. "After much arguing, they agreed to give us an advance.

"But as it turned out, we only had the advance for seven days — they turned around and took it out of our payments."

Rochester says she's still arguing with VNS' Medicaid reimbursers, who require billing within 30 days of visits. "That was a joke, there was no way to do that. We're still arguing that this was a special circumstance; that we were out of compliance for reasons that were beyond our control."

She also learned that the agency's insurance policy was not sufficient to cope with the special needs of a home health operation. The policy only reimbursed for losses incurred while the agency was unable to use its building. Rochester says losses continued after the evacuation had ended.

"That (type of policy) probably would work for hospitals and day care centers, but it didn't work for us. Our payment was cut greatly because of the way our policy was written."

Still, both Rochester and Hron count themselves as lucky to have weathered the crisis as well as they did.

Hron says that fortunately, her agency had reviewed its disaster plan in depth as part of preparations for Y2K in 1999.

"I'm sure that helped," she says. "Providers really do need to review their disaster plans with the mindset that they may need to use it, and not just as a mandatory exercise."

Rochester says that even if she's unable to recoup her losses, she can appeal to the Federal Emergency Management Agency for relief.

And she says she's happy just to have gotten through the fires.

"I hope it never happens to anybody else," she says. "For us, we just felt grateful that we survived, that the agency survived, because we don't have a corporate deep pocket." ■

Is your disaster plan ready?

Could your agency cope with a major disaster that displaces you or your clients? Here are some tips from **Jane Hron**, home care director for Marcus Daly Home Care, Hamilton, MT, and **Sarah Rochester,** director of the Los Alamos (NM) Visiting Nurse Service, about what they learned from their experiences:

✔ **Keeping track of clients is your toughest, most important job.** Many home care clients are part of formal evacuations, while others are moved by family members to homes or motels. When disaster threatens, make sure your patients know to apprise you of any moves. At Marcus Daly Home Care, the agency installed a map with pins showing where patients were located. This made it easy to see who was affected by an evacuation.

✔ **Don't forget your staff.** They too, may have to evacuate their homes. It's useful to know where everyone lives, so that you can predict staffing shortages as neighborhoods are evacuated. Hron says Marcus Daily Home Care provided housing for any evacuated employees to help them adjust and retain as many staffers as possible to continue patient care.

✔ **Maintain a portable file of patient information.** If all of your information is on mainframe computers or in bulky paper files, you won't be able to transport it in an evacuation. Rochester suggests putting together a binder with an information sheet on each patient to take with you in case your office is evacuated. Not only will it help you find relatives quickly to locate patients, but it can aid in care and make it easier to transfer patients to other agencies if necessary.

✔ **Let your patients know what to expect in an emergency.** Marcus Daly distributes an emergency preparedness handout in admissions packets **(see insert)**. It includes an emergency checklist for the client and caregivers. Staff were able to review it in depth with clients when a disaster actually materialized, Hron says.

✔ **Know what disasters threaten your area.** Rochester says she had no idea that her Los Alamos community also was in a flood zone — something that could become a factor on acres stripped of foliage.

✔ **Check your insurance coverage.** Does it take into account the unique demands of your business? Because a home health agency does so much of its work offsite, your insurance coverage may not be as comprehensive as you need, Rochester says. ■

Be ready to pitch in to help disaster-ravaged areas

ND agency helped care for displaced flood victims

It's not just agencies in the line of fire, or flood, or earthquake victims who are affected by disaster. Neighboring agencies, as well, can get drawn into the relief process.

When floods along the Red River in 1997 displaced residents of Grand Forks, ND, it affected an agency in Devils Lake, 90 miles west.

Cheryl Rayer, RN, manager of Mercy Home Care in Devils Lake, knew her agency would soon be pressed into service. "They had to come west," she says of the flood victims. "East was East Grand Forks, and it was flooding that way. South was Fargo, and it was flooding that way. North, there was flooding because that's where the Red River runs. So they had to come west, and we're the biggest city west of Grand Forks."

She had prepared by storing extra supplies and by stationing herself at the area community college, which was serving as an intake point for flood victims.

"There was a social worker who would guide me as to who was on home care, if she knew," Rayer says. "The only other way to find out was to take a history from the client, which the screening people did. If they mentioned they were on home care or had needs, then we could pick them up."

Other people became ill as a result of the dislocation, and were released to home care after a brief hospitalization.

In many cases, nurses were visiting patients at temporary Red Cross shelters, which presented special challenges. "There was no privacy," she says. "It was most difficult because we could not obtain actual histories and physicals from the patients — everything was tied up in Grand Forks. That was a prerequisite for admission to home

Sources

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care. You've got to have a history and physical, at least in the past year."

A physician was brought in to quickly assess the patients at the evacuation sites and have them admitted to home care. Rayer says that despite the unusual circumstances, it was necessary to provide the paperwork required by Medicare. But she suspects the agency understood the special strain health providers were under in the flood areas. "I think they must have, because we didn't end up on focused review," she says. ■

Telephone documentation saves agency time, money

Agency quickly recouped initial expense

No one in home health care will deny how cumbersome it is to rely on paper documentation. For this reason, many agencies have switched to using handheld computers and other types of electronic documentation systems.

However, this can be quite expensive, and it often requires extensive computer training of staff. The Visiting Nurse Service of Rochester & Monroe County Inc. of Webster, NY, has found a third alternative: a telephone documentation system.

The agency, which has more than 600,000 visits a year and is partnered with the University of Rochester Strong Health System in Rochester, NY, first began to look for a solution to the paper-driven system five years ago.

"Every patient seen by a home health aide had a separate sheet, so the amount of paper was astronomical," says **Annette L. Mackin**, MBA, chief financial officer.

"The document sheet we had in the field was used for billing, payroll, and medical record documentation," Mackin adds. "So the timeliness of getting it and accuracy were paramount because so much depended on that sheet."

At first, the agency had a task force meet to discuss how they could reduce the amount of errors that occurred in documentation. But the task force soon determined that it would be impossible to eliminate all or nearly all errors while the agency continued to rely upon paper documentation. "We began researching various options and decided to develop a telephone-based system," she says.

Defining critical roles is necessary

A committee consisting of representatives from payroll, billing, medical records, clinical care, and managers determined which were the most critical elements for each of their jobs.

For example, the payroll representatives were concerned about obtaining data that they could use to process payroll since the documentation was the basis for determining the number of hours an employee worked. Under the paper documentation system, payroll staff would review mounds of paper each Monday, summarize all the hours, and then send use this to generate checks, Mackin explains.

The new telephone documentation system has a payroll tracking report that collects the hours, the base pay on those data, and interfaces with the computerized payroll system. In that department alone, the telephone documentation system has cut down the necessary medical record filing staff needs by two full-time equivalents (FTEs), Mackin says.

Full-time position, time saved

Another FTE is saved in the data entry and processing department, and it saves managers time in conducting chart audits, she adds.

The home care agency's information system staff selected the best software to do the job, and the committee developed an outline, plan, and flowchart for how to implement the new system.

"We piloted it with a small group," Mackin says. "We needed to make some modifications to make sure the phone calls were short and that the scripts were accurate and not confusing."

One change that became necessary was in the timing of staff's calls to the system. Initially, managers wanted staff to call right after they arrived

Source

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in the patient's home and again when they left. But that proved unworkable, Mackin says.

"Now staff are instructed to call after the visit or soon after," she says. "They enter the time they arrived, the patient's number, the employee number, and when they left the home."

Staff call from a regular touch-tone telephone line, dial into the server, and give information via the touch-tone pad. The tasks they performed are coded with numbers that they use when inputting the data. After the employee telephoned in the information, the computer has an automatic validation check that can match the employee and patient with the visits authorized and scheduled to make sure the employee stuck to the care plan.

When the bugs were worked out, the agency added extra telephone lines to handle the documentation calls. The agency's information systems staff made sure the telephone documentation software was interfaced with the regular computer documentation, Mackin says.

Then the home health aide staff were trained how to use the system over the course of two days. "We individually took people and walked them through the script of how to dial in and how to answer questions," Mackin says. "We did one-on-one training with 650 aides."

Supervisors also received the training and staff receive remedial training whenever necessary.

Electronic data simplify job

All documentation now is saved electronically. Specific charts can be printed out for surveys or audits, and data are much easier to find now that they're all electronic, Mackin says.

"We back up our systems daily with off-site storage, and now we have a redundant server so that if one goes down the other one goes up immediately," Mackin says.

The entire software and equipment cost was about $25,000. The agency saved some start-up costs by developing its own documentation script and worked with the home care software vendor to interface necessary data, Mackin says. ■

Patient satisfaction info only as good as survey

Agency decides it is time to drop homegrown tool

Home care clients of Watertown (WI) Memorial Hospital Home Health consistently rated the agency high on the agency's homegrown patient satisfaction survey.

On a scale of 1 to 5 with five being the highest rating, most of the responses fell in the 4.5 to 5 rating, recalls **Sandy Roberts**, RN, BSN, manager of home health for the hospital-based agency. "So it was kind of like, 'What do you do with this information?" Roberts says. "Everybody is rating us 'good' or 'excellent,' and it seemed like there was something missing."

For one thing, the agency had no way of putting its "excellent" ratings into perspective. Would every other agency rate as high, or were there problems that were not showing up on the survey? "It was hard to make a quality assurance project out of the survey information," Roberts adds.

For example, there was one small trend of therapists being rated "poor" during two quarters. On the surface, this would appear to be a good place to start a quality improvement project. But upon closer examination, Roberts realized that this lower rating was due to one or two complaints about therapists not being as receptive to patients' complaints about discomfort as the patients wanted them to be. Since there was such a small sampling size of surveys, one or two complaints could drastically affect a satisfaction rating.

Also, they realized that the complaints came from patients who were covered by private insurance and their coverage allowed few visits.

Nonetheless, managers asked therapists to be more sensitive to patients' needs, particularly when patients had limited visits. "We worked with therapists to change how they presented this to patients," Roberts says. "They can say, 'You haven't met your goals yet, but we're limited by what your insurance will pay for, and so we need to look at some other options for you.'"

While the homegrown survey did produce at least one positive change, it was limited in its scope and managers decided they needed more and better information about patient satisfaction.

Watertown Memorial Hospital had begun using a satisfaction survey from Press, Ganey Associates of South Bend, IN. The hospital recently was

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named a finalist in the Press, Ganey client success stories. But the home care agency was too small to obtain benchmarking data using that survey.

Instead, the agency turned to the VHA Southwest Inc. of Dallas for a home care survey that could be benchmarked against home care agencies in the Upper Midwest. VHA Southwest is a nonprofit organization. The agency began to use the survey in January 2000, and managers quickly found that it provided them with more detailed satisfaction information. **(See comparison of homemade survey and VHA survey, right.)**

When the first benchmarking data returned, the agency's score was in the 81st percentile for timeliness, but higher for other categories. The agency scored in the 100th percentile for the question asking whether the staff member treated the patient with respect. "That's going to be the area we will focus on," Roberts says. "We'll work on improving our responses as far as timeliness, both for visits scheduled and timeliness of the on-call response."

The quality improvement (QI) project focused on staff education about admission visits.

"We told staff we'd like them to take extra time with patients at the admission visit and explain to patients what the home care visit would be, when we would be there, and what they can expect for a response if they call in," Roberts says.

Staff were also told to give patients a range of times when the patient might anticipate a visit, such as saying "before 10 a.m.," instead of promising to be there at 9 a.m. "Patients understand that emergencies come up," Roberts explains. "And the staff felt it would be difficult for them to get there at specific times."

The next phase of the QI process is to monitor the time frames for on-call responses. The agency will track those from the time the nurse is paged to the time the nurse calls the patient. The goal is to have a 15-minute response time.

The home care agency's switchboard is capable of logging the time a patient calls and the time the nurse returns the call; this is how the agency will track the response time. "We plan to monitor all on-call times for a month," Roberts says. "Then we'll look to see if our patient satisfaction improves." ■

Here's a quick comparison of agency's two surveys

Homegrown survey lacks critical details

Watertown (WI) Memorial Hospital Home Health switched from using its own homemade patient satisfaction survey to using a survey that could be benchmarked with information collected by VHA Southwest Inc. of Dallas.

Here's a quick comparison of the two surveys, which demonstrates how the new survey is better suited for targeting important details related to patient satisfaction. This includes excerpts from both surveys. The new survey's questions are in italics.

1. How EASY was it to reach staff in the Home Health office?
__ Very Easy
__ Somewhat Easy
__ Neither Easy nor Difficult
__ Somewhat Difficult
__ Very Difficult

Thinking about your experience with us, how would you rate the following:

• Your ability to access us with your comments/questions
__ *Poor*
__ *Fair*
__ *Good*
__ *Very Good*
__ *Excellent*
__ *N/A*

2. How CONVENIENT were the times of the Home Health visits for you and your family?
__ Very Convenient
__ Somewhat Convenient
__ Neither Convenient Nor Inconvenient
__ Somewhat Inconvenient
__ Very Inconvenient

Thinking about your experience with us, how would you rate the following:

• Our ability to handle your concerns
__ *Poor*
__ *Fair*
__ *Good*
__ *Very Good*

__ *Excellent*
__ *N/A*
• *Our responsiveness to your requests*
__ *Poor*
__ *Fair*
__ *Good*
__ *Very Good*
__ *Excellent*
__ *N/A*

3. How well did staff keep you INFORMED of your treatment and discharge plans?
__ Very Informed
__ Somewhat Informed
__ Neither Informed nor Uninformed
__ Somewhat Uninformed
__ Very Uninformed

Thinking about your experience with us, how would you rate the following:
• *How we involved you in your care*
__ *Poor*
__ *Fair*
__ *Good*
__ *Very Good*
__ *Excellent*
__ *N/A*
• *The teaching and explanation of care*
__ *Poor*
__ *Fair*
__ *Good*
__ *Very Good*
__ *Excellent*
__ *N/A*
• *Our communication to each other about your care*
__ *Poor*
__ *Fair*
__ *Good*
__ *Very Good*
__ *Excellent*
__ *N/A*

4. Please rate the CARE you received from Home Health providers:
Nurse
__ Excellent
__ Good
__ Average
__ Fair
__ Poor
__ N / A
Nurse's Aide
__ Excellent
__ Good
__ Average
__ Fair
__ Poor
__ N / A
Occupational Therapy
__ Excellent
__ Good
__ Average
__ Fair
__ Poor
__ N / A
Physical Therapy
__ Excellent
__ Good
__ Average
__ Fair
__ Poor
__ N / A
Speech Therapy
__ Excellent
__ Good
__ Average
__ Fair
__ Poor
__ N / A
Social Services
__ Excellent
__ Good
__ Average
__ Fair
__ Poor
__ N / A
• *Overall, how do you rate our staff*
__ *Poor*
__ *Fair*
__ *Good*
__ *Very Good*
__ *Excellent*
__ *N/A*
• *Overall, how do you rate our service*
__ *Poor*

COMING IN FUTURE MONTHS

■ Agency develops detailed electronic pathways

■ Could home care doctor visits be in your future?

■ Home care legislation: How will the new Congress respond?

■ PPS update: Successful coping strategies for new problems

■ Train staff to spot potential mental health problems among home care clients

__ *Fair*
__ *Good*
__ *Very Good*
__ *Excellent*
__ *N/A*
• *Would you recommend our service to others?*
__ *Definitely Not*
__ *Probably Not*
__ *Might or Might Not*
__ *Probably Would*
__ *Definitely Would* ■

CA agency: Assessments can help prevent falls

Reports drop by more than a third

A fall in the home can do more than leave a patient shaken and bruised: It can cause serious fractures, and lead to a severe overall decline in health for a person already vulnerable to illness.

Instituting a fall prevention program can be a proactive step to avert just such patient catastrophes. One California agency found that a simple program to assess fall risks and educate at-risk patients about preventative steps could make a big difference.

Reported falls at Home Care of America / San Marino (CA) dropped from 13 in 1998-99 to eight the following year, says **Theresa Dudley**, MSN, RN, director of patient care services.

Dudley says she developed the assessment tool for the program in response to concerns that her agency's patients were at a higher-than-average risk for falls. "We could see from our risk management logs that we had too many fractures," she says, noting that Home Care of America has population that's older than the norm by home health standards.

Dudley studied log entries of falls and their causes to develop a list of risk factors that can contribute to falls in the home."When nurse calls in regarding a fall, we log it, we find out what happened and get the particulars," she says. "I developed a tool, an environmental assessment **(see insert)** that helped our nurses determine if the patient was a high risk or not."

The two-page assessment tool looks at risk factors in a variety of areas:

• **Physical** — asking about conditions such as vertigo, unsteady gait, impaired vision, pain, or

CE objectives

After reading each issue of *Homecare Quality Management*, the quality manager will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care management.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Cite practical solutions to the problems that their profession encounters in home care and integrate them into their daily practices. ■

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Source

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other physical factors that can cause a person to be less coordinated.

• **Medication** — asking if a patient is taking sedatives, antihypertension drugs or other drugs that can cause dizziness or other symptoms that can lead to falls.

• **Environmental factors** — checking for physical factors in the home that can lead to falls, such as stairs without handrails, slippery floors, throw rugs, clutter, even a small dog running around and getting underfoot.

Other factors, which can include anything from an inattentive caregiver, alcohol use, and improper use of assistive devices to urinary incontinence. Some risks were more prominent than others, Dudley says.

The assessment tool was included in every admission packet and administered as part of the overall initial assessment.

Any patient found to have two or more such risk factors was said to be at high risk for falls and became part of the program. Those patients received an education component also developed by Dudley from a wide range of material. "I have a very large home health library at our office, with many books of handouts that can be distributed for patient education," she says.

Topics covered included safety tips for various rooms of the house, including kitchens and bathrooms, safety in stairwells, walking with canes and other assistive devices and safety for Alzheimer's patients.

There was a teaching guide for the nurse as well as the patient. Inservicing was held to explain the program to the nurses and instruct them in how to do the assessment and teaching.

Dudley says the teaching was targeted at nurses because fall prevention isn't necessarily an area of expertise in nursing. "With physical therapy, that is their concentration — developing strength, exercises etc. That's why I addressed this pretty much to nurses."

If a patient who wasn't on the program suffered a fall, he or she was immediately added to the prevention program. Each fall also generated a fall incident report, which looked again at the factors that led to the accident **(see insert)**. Among the questions was an assessment of the patient's mental state: Was he or she confused? Alert? Disoriented?

The education program made a real difference, Dudley says. "There was definite improvement," she says, noting that of the eight falls reported during 1999-2000, only one required hospitalization.

Dudley hopes to do follow-up telephone monitoring of patients to see if their new safety awareness has persisted beyond discharge. She adds that she would like to have solicited more feedback from nurses on what was occurring in the homes as they used the program, to tailor it to individual needs.

"I should have gotten more feedback from them on whether or not we needed to re-evaluate or reassess or to continue with what we were doing with each particular person who was on the program," she says.

But overall, she was pleased with the success of the program. Dudley says that while the fall prevention assessment tool is not an official part of the initial assessment anymore, prevention efforts still are a priority at the agency.

"It's not part of the evaluation packet, but nurses are very much aware of who requires additional teaching because they've been doing it for months," she says. ■

Emergency Preparedness Patient Checklist

Emergency Preparedness
If you are involved in a natural disaster, such as a flood, earthquake, or winter storm, please follow these instructions:

1. **Call 911 if you need emergency medical care. If you are a Hospice client, contact the Hospice on-call nurse for emergency medical care issues.**

2. If you must leave your home, call Marcus Daly Home Care staff. Be ready to give the new address and phone number where you can be reached so your care can be continued in a timely manner.

3. If you decide to stay home, let your nurse know whether your home can be reached by car. If not, Home Care staff will work with you on possible alternatives.

4. If you need medical care or supplies normally provided by Home Care staff and they are unable to get to you, go to the nearest medical facility or hospital for essential care until Home Care services can be resumed.

5. If you are on an IV infusion pump and have no electricity, Home Care staff may give you an emergency "gravity" method of infusing your fluids if approved by your doctor for your therapy. IV pumps generally have a backup battery, which will last for a limited time.

6. If your water is contaminated, you and/or your caregiver should wash your hands with alcohol (rubbing or isopropyl) or hydrogen peroxide prior to doing any sterile procedures. **DO NOT EXPOSE YOUR CATHETER OR CATHETER SITE TO ANY DIRTY WATER**.

7. Marcus Daly Home Care staff will try to contact you, but calling into an area struck by a natural disaster can be very difficult. Telephone lines are often jammed. Please call out and try to make contact with us so we can help you with your specific emergency needs.

HOW PREPARED ARE YOU???? Please turn this sheet over and utilize the checklist to be sure you are prepared for a natural disaster.

Emergency Checklist

MEDICATIONS

____ Be prepared with at least three days worth of medications in advance.

____ If you use insulin, prefill syringes for three days.

____ If you use oxygen, arrange for a backup unit through your oxygen distributor. If you need power for oxygen or an infusion pump, ask your utility company if you can have priority in power outages.

FOOD AND WATER

____ Store three days worth of food and water.

MONEY

____ Have cash on hand to help you make it through the emergency period.

FLASHLIGHT AND RADIO

____ Store a flashlight, battery-operated radio, and extra batteries in case of power loss.

____ A radio will help keep you informed of warnings and instructions.

PLAN AHEAD

____ Select an emergency contact to provide transportation if you need skilled medical care.

____ Post emergency numbers by each phone, including your doctor and home care agency.

____ Consider a personal emergency response unit (e.g., Lifeline).

____ Post medical instructions on your refrigerator or another easy-to-see spot for rescue crews to see, or carry a medical ID card.

____ If floods are a concern, learn safe routes to high grounds ahead of time.

____ Don't let your supply of fuel get too low.

____ Don't be afraid to ask for help from neighbors, friends, or family.

Source: Marcus Daly Home Care, Hamilton, MT.

Fall Incident Assessment

Name:_____MR#:_____

Date of Fall: _____MD's Name: _____

Diagnosis: _____

Witness Fall? Yes _____No _____

Location of Fall: Bedroom _____ Bathroom _____ Den_____
Kitchen _____ Hallway _____ Stairs _____
Outside _____ Other: _____

Vital Signs: BP _____ T _____ P _____ R_____
Orthos: _____ Lying _____ Standing _____

Description of fall *(if applicable):*

_____ from bed: Side rails up_____ down_____

_____ getting in and out of bed

_____ from wheelchair

_____ ambulating: (___) assisted (___) unassisted

_____ tub, shower

_____ found on floor, wet floor (___) yes (___) no

_____ assistive devices (___) yes (___) no

_____ (___) wheelchair (___) walker (___) cane

_____ Environmental hazards identified?
described: _____
_____
_____

Patient's/PCG's account of the fall:_____
_____
_____
_____
_____

Patient's mental status prior to the fall (baseline): _____
_____
_____
_____

Patient's mental status at the time of fall ( ) alert ( ) disoriented ( ) confused
( ) sedated ( ) other _____

Was the patient experiencing any of the following at the time of the fall?

( ) Acute confusion

( ) Difficulty with ambulation

( ) Bowel or bladder urgency

( ) Emotional upset, anger, or agitation

( ) Medically unstable at time of fall

Previous fall ( ) yes ( ) no

Number during past six months: _____

Number resulting in injury: _____

Number of different medications patient has taken during the last 24 hours, including PRNs: _____

Medication categories:

( ) Cardiac meds

( ) Diuretic or antihypertensive

( ) Neuroleptic (sedative, hypnotic, antidepressive, psychotropic, antianxiety)

( ) Analgesic

( ) Laxative or stool softener

Patient fall risk factors: _____

_____

_____

_____

_____

What measures can be taken to prevent reoccurrence? _____

_____

_____

_____

_____

Post-injury care given:_____

_____

_____

_____

_____

Treatment plan: _____

_____

_____

_____

Was MD notified? No_____ Yes_____

Was the patient hospitalized? No_____ Yes_____

If yes, give details: _____

_____

_____

Signature: _____Date:_____

Source: Home Care of America, San Marino, CA.

Fall Prevention Assessment Tool

Patient's Name: _____ *SOC:* _____ *MR:* _____
Discipline Name/Signature: _____

Major (Must be Present)
Presence of risk factors

Evidence of environmental hazards	☐	Impaired mobility	☐
Lack of knowledge of environmental hazards	☐	Sensory deficits	☐
Lack of knowledge of safety precautions	☐	Multiple meds	☐
History of falls	☐	Multiple meds (i.e., hypnotics, sedatives, diuretics, etc.)	☐

If any of the above are checked, fall prevention care plan must be developed and included in the 485. *(Each appropriate checked-off area needs to be part of POT, if indicated)*

Detailed Assessment *(personal assessment)*:
Gender: M_____ F_____ Age_____

Altered Cerebral Functions:

Tissue hypoxia	_____	Syncope	_____
Post-trauma	_____	Confusion	_____
Vertigo	_____	Mental status (explain)	_____

Altered Mobility:

Unsteady gait	_____	Loss of limb	_____
Poor coordination & balance	_____	Stairs	_____

Impaired Sensory Function:

Vision	_____	Thermal/touch	_____
Hearing	_____	Smell	_____
Pain	_____	Osteoporosis	_____
Fatigue	_____	Cervical spondylosis	_____
Orthostatic hypotension	_____	Vestibular disorders	_____
Arthritis	_____	Carotid sinus syncope	_____
Diabetes	_____	Neuropathy	_____

Medication:

Sedatives	☐	Hypoglycemics	☐
Vasodilators	☐	Diuretics	☐
Antihypertension	☐	Phenothiazides	☐

Urinary incontinence	_____	Faulty judgement	_____
Urinary urgency	_____	Alcohol use	_____
Decrease or loss of short-term memory	_____	Unfamiliar setting	_____
Respiratory disorder	_____	Improper footwear	_____
Dehydration	_____	Inattentive caregiver	_____
Prolonged bed rest	_____	Stress	_____
Improper use of assistive devices	_____		

Environmental Assessment:

Throw rugs present	_____
Torn carpeting	_____
Poor transition from floor to carpet	_____
Slippery floors	_____
Rise between steps greater than 5 inches	_____
No handrails on stairs	_____
Clutter on stairwell	_____
Cluttered pathways	_____
Poor lighting	_____
Improperly labeled medications	_____
No rubber mat or skid-resistant strip in bathtub	_____
No grab bar in shower or tub	_____
No elevated toilet seat/grab bars (if needed)	_____
Assistive devises in poor repair	_____
Unable to perform ADLs	_____

Living Arrangement:

Lives alone	_____
Lives with family	_____
Lives with paid caregiver	_____
Lives in residential arrangement	_____

Source: Home Care of America/San Marino (CA).