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the monthly update for executives and health care professionals

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Proper home care can keep patients from being fall guys

Where does home care fit into the equation?

Every year, thousands of Americans experience a severe fall. The Itasca, IL-based National Safety Council (NSC) estimates that falls caused or led to the death of more than 17,000 Americans in 2000; of those, 9,600 stemmed from falls that occurred in the home. Nearly one-fourth of all people who suffer a hip fracture as the result of a fall die within the year, and another 50% never fully regain their prior level of independence or mobility.

The statistics are even grimmer for elderly Americans: Falls are the No. 1 cause of injury-related death in the United States for men 80 and older and for women 75 and older. Eight out of 10 of those who die from a fall are over the age of 65. Particularly pertinent to home care, 60% of fatal falls for adults 65 years old or older happen at home, according to the Centers for Disease Control and Prevention in Atlanta **(see boxes, pp. 99-100)**.

For many elderly Americans, a devastating fall is why they are in the home care system. For others, who perhaps began receiving home care for an unrelated reason, it means a longer program of care that in some cases can extend to the end of their lives. Clearly, home care cannot prevent every fall, yet with careful patient analysis and monitoring, home care nurses and aides, along with family caregivers and friends, can implement a program that will greatly reduce the chance that a patient will suffer a fall in the home.

The causes of falls are as varied as the falls themselves. There can be physical reasons that contribute to falls — factors such as physiological dysfunctions that manifest as gait and balance problems or musculoskeletal disabilities — as well as psychoactive medication use, dementia, and visual impairment. Then, too, there are environmental factors such as slippery surfaces, uneven floors, loose rugs, poor lighting, unstable furniture, and objects left on the floor.

Environmental factors are obviously the easiest to remedy; as such, home care aides and nurses should constantly monitor the patient's home surroundings for any of these factors and work with family caregivers either to correct these issues or to modify the situation so as to pose the least possible harm to the patient. Sometimes it can be as easy

as keeping a clear path to the kitchen, bathroom, bedroom, and living areas and can be remedied by keeping toys, magazines, and other loose items put away or in another room. Floors should be kept clean and dry, and any spills should be cleaned up immediately. As for loose floorboards or uneven floors, aides should talk to the family caregiver about possible ways to ameliorate the problem.

The NSC offers several recommendations for keeping the home environment as patient-friendly as possible. Among them are tucking phone and electrical cords out of walkways (or using a cordless phone to prevent rushing for the phone), installing handrails / grab bars in bathrooms and along stairwells, installing nightlights in bathrooms and kitchens and along the hall or stairs, using non-skid throw rugs over slippery linoleum floors, and avoiding the use of wax products on floors.

Lorraine Waters, BSN, MA, CHCE, director of Southern Home Care in Jeffersonville, IN, says her agency has a handout on safety in the home that addresses things like making sure family members or caregivers remove throw rugs and tuck away extension cords a patient can trip over. "We can do the instructional portion and work with families and patients to make them aware of the risks," she says, "but since we're not in there 24 hours a day, it's difficult."

As for the physical side, home care nurses and aides can do a lot to reduce the chance of a patient falling. Patients should be encouraged to get annual eye examinations, as failing eyesight can prevent a person from seeing potential hazards. Regular monitoring and assessment of a patient's medication also should be done regularly. Many times, certain medications can lead to an unsteady gait or difficulties with balance and mobility.

"Clutter is not the biggest issue we see with falls," says Waters. "We have more problems with polypharmacy, where the patient might have three different practitioners — and prescriptions from all of them — until we come in. No one is monitoring it and evaluating it, and sometimes they aren't taking it [medication] right, so a lot of education comes into play.

"The second-largest problem we see would probably be the fact that you have a frail, elderly person who refuses to stop moving around on their own or use an assist device, and they end

(Continued on page 100)

CE questions

21. According to its newest regulations, the Joint Commission requires home health care agencies to report unwitnessed falls.
    A. true
    B. false

22. The costs of fall-related injuries are such that:
    A. In 1994, the average direct cost for a fall injury was $1,400 for a person over the age of 65.
    B. The total direct cost of all fall injuries for people age 65 and older in 1994 was $20.2 billion.
    C. By the end of this year, the cost of fall injuries is expected to reach $32.4 billion.
    D. All of the above
    E. A and B

23. To the extent that practitioners must play a much more active role in completion of the OASIS form, they must take what action so that inconsistent results are avoided?
    A. refer to previous reports
    B. exercise professional judgment
    C. have their work checked by management
    D. ask their patient to fill in the form

24. Medication should not be stored in bathroom medicine cabinets because:
    A. The warm temperature and humidity can damage medication.
    B. It's too close to the sink and therefore too easy for pills to fall down the drain.
    C. Medication may be confused with other products stored in the medicine cabinet.
    D. A and C
    E. All of the above

Falls and hip fractures among older adults

How serious is the problem?

• In the United States, one of every three adults 65 years old or older falls each year.

• Falls are the leading cause of injury deaths among people ages 65 years and older.

• In 1998, about 9,600 people over the age of 65 died from fall-related injuries that occurred in the home.

• Of all fall deaths, more than 60% involve people who are 75 years old or older.

• Fall-related death rates are higher among men than among women and differ by race. White men have the highest death rate, followed by white women, black men, and black women.

• Older adults are hospitalized five times more often for fall-related injuries than for injuries from other causes.

• Of those who fall, 20% to 30% suffer moderate to severe injuries that reduce mobility and independence and increase the risk of premature death.

What other health outcomes are linked with falls?

• Among older adults, falls are the most common cause of injuries and hospital admissions for trauma.

• Falls account for 87% of all fractures for people 65 years and older. They are also the second-leading cause of spinal cord and brain injury among older adults.

• Each year in the United States, one person in 20 receives emergency department treatment because of a fall. Advanced age greatly increases the chance of a hospital admission following a fall.

• Among older adults, fractures are the most serious health outcomes associated with falls. About 3% of all falls cause fractures. The most common are fractures of the pelvis, hip, femur, vertebrae, humerus, hand, forearm, leg, and ankle.

What is the impact of hip fractures?

• Of all fractures from falls, hip fractures cause the greatest number of deaths and lead to the most severe health problems.

• In 1996, there were approximately 340,000 hospital admissions for hip fractures in the United States.

• Women sustain 75% to 80% of all hip fractures.

• People ages 85 or older are 10 to 15 times more likely to experience hip fractures than are people between the ages of 60 and 65.

• Most patients with hip fractures are hospitalized for about two weeks.

• Half of all older adults hospitalized for hip fractures cannot return home or live independently after their injuries.

• In 1991, Medicare costs for hip fractures were estimated to be $2.9 billion.

• Because the U.S. population is aging, the problem of hip fractures will likely increase substantially over the next four decades. By the year 2040, the number of hip fractures is expected to exceed 500,000 annually.

Where are people most likely to fall?

• For adults 65 years old or older, 60% of fatal falls happen at home, 30% occur in public places, and 10% occur in health care institutions.

What factors increase older adults' risk of falling?

• Factors that contribute to falls include problems with gait and balance, neurological and musculoskeletal disabilities, psychoactive medication use, dementia, and visual impairment.

• Environmental hazards such as slippery surfaces, uneven floors, poor lighting, loose rugs, unstable furniture, and objects on floors may also play a role.

What can older adults do to reduce their risk of falling?

• Maintain a regular exercise program. Exercise improves strength, balance, and coordination.

• Take steps to make living areas safer. Remove tripping hazards and use non-slip mats in the bathtub and on shower floors. Have grab bars put in next to the toilet and in the tub or shower and have handrails put in on both sides of all stairs.

• Ask their doctor to review all of their medicines in order to reduce side effects and interactions.

• Have an eye doctor check their vision each year. Poor vision can increase the risk of falling.

Source: Centers for Disease Control and Prevention, Atlanta.

Costs of fall injuries among older adults

Calculating cost estimates

• The cost of fall-related injuries is usually expressed in terms of direct costs.

• Direct costs include out-of-pocket expenses and charges paid by insurance companies for the treatment of fall-related injuries. These include costs and fees associated with hospital and nursing home care, physician and other professional services, rehabilitation, community-based services, the use of medical equipment, prescription drugs, local rehabilitation, home modifications, and insurance administration.

• Direct costs do not account for the long-term consequences of these injuries, such as disability, decreased productivity, or decreased quality of life.

The costs of fall-related injuries

• In 1994, the average direct cost for a fall injury was $1,400 for a person over the age of 65.

• The total direct cost of all fall injuries for people age 65 and older in 1994 was $20.2 billion.

• By 2020, the cost of fall injuries is expected to reach $32.4 billion.

Fall-related fractures

• The most common fall-related injuries are osteoporotic fractures. These are fractures of the hip, spine, or forearm.

• In the United States in 1986, the direct medical costs for osteoporotic fractures were $5.15 billion. By 1989, these costs exceeded $6 billion.

• Over the next 10 years, total direct medical costs for osteoporotic fractures among postmenopausal women will be more than $45.2 billion.

Hip fractures

• In the United States, hospitalization accounts for 44% of direct health care costs for hip fracture patients.

• In 1991, Medicare costs for this injury were estimated to be $2.9 billion.

• Hospital admissions for hip fractures among people over age 65 have steadily increased, from 230,000 admissions in 1988 to 340,000 admissions in 1996. The number of hip fractures is expected to exceed 500,000 annually by the year 2040.

• A recent study found that the cost of a hip fracture, including direct medical care, formal nonmedical care, and informal care provided by family and friends was between $16,300 and $18,700 during the first year following the injury.

• Assuming 5% inflation and the growing number of hip fractures, the total annual cost of these injuries may reach $240 billion by the year 2040.

Source: Centers for Disease Control and Prevention, Atlanta.

up hurting themselves. It's sad, but patients usually have three or four falls before something breaks. We see a pattern of falls and try to do intervention at that point, and sometimes we're fairly successful. It's a matter of laying it on the line with them and reminding them what will happen if they fall and break a hip."

A recent study, "Medical Profile of a Group of Elderly Fallers," found that the first step in preventing falls is determining who is most susceptible. From there, tracking a patient's fall and its cause or causes can be crucial to ensuring that a second or third fall doesn't occur. It would seem that in the home care environment, all patient activity would be monitored, including falls, regardless of whether they were witnessed by a home care employee. **Marjorie Jones**, director of home care services for St. Francis Medical Center in Grand Island, NE, says that as recently as October 1999, her agency was being told by its Joint Commission on Accreditation of Healthcare Organizations (JCAHO) surveyor that it must collect and report data on all falls, whether witnessed or not. Other home care professionals say they have been told not to report unwitnessed falls. What's the deal?

Says **Gregory Solecki**, vice president of Henry Ford Home Health Care in Detroit, "Being aware of and documenting an unwitnessed fall was never a Joint Commission standard, but rather an interpretation of the standard to which such activity would apply. In other words, under the standard of patient assessment, asking about and documenting an unwitnessed fall could be interpreted as support of compliance with the standard."

Patient assessment checklist

Today's home health care agencies, such as Community Home Services in Naples, FL, have taken to incorporating a patient's history of falls in its patient assessment forms. **(See excerpt of Community Home Services' patient assessment, below.)** "We have expanded our comprehensive assessment to include history with the patient," explains **Carol Johnson**, RN, director of clinical services for the agency. "We document if the patient is on sedatives, hypnotics, laxatives, or diuretics, and if physical therapy is a referral," she says.

Safety Hazards found in the patient's current place of residence: **(Mark all that apply.)**

☐ 0-None
☐ 1-Inadequate floor, roof, or windows
☐ 2-Inadequate lighting
☐ 3-Unsafe gas / electric appliance
☐ 4-Inadequate heating
☐ 5-Inadequate cooling
☐ 6-Lack of fire safety devices
☐ 7-Unsafe floor coverings
☐ 8-Inadequate stair railings
☐ 9-Improperly stored hazardous materials
☐ 10-Lead-based paint
☐ 11-Other (specify)

HISTORY OF FALLS? ☐ YES ☐ NO
☐ In hospital ☐ In home
☐ Other EXPLAIN_____
☐ IF YES OR PATIENT IS OVER 75, PLEASE REVIEW FALL BROCHURE WITH THE PATIENT

☐ IF YES, IS THE PATIENT TAKING SEDATIVES, HYPNOTICS, LAXATIVES OR DIURETICS?
PHYSICAL THERAPY REFERRAL ☐ YES ☐ NO Assistive Device: ☐ YES ☐ NO Type _____

(M0330) Sanitation Hazards found in the patient's current place of residence: **(Mark all that apply.)**

☐ 0-None
☐ 1-No running water
☐ 2-Contaminated water
☐ 3-No toileting facilities
☐ 4-Outdoor toileting facilities only
☐ 5-Inadequate sewage disposal
☐ 6-Inadequate / improper food storage
☐ 7-No food refrigeration
☐ 8-No cooking facilities
☐ 9-Insects / rodents present
☐ 10-No scheduled trash pickup
☐ 11-Cluttered / soiled living area
☐ 12-Other (specify)

Does the patient understand safe food handling? ☐ YES ☐ NO

(M0340) Patient Lives With: (Mark all that apply.)

☐ 1-Lives alone
☐ 2-With spouse or significant other
☐ 3-With other family member
☐ 4-With a friend
☐ 5-With paid help (other than home care agency staff)
☐ 6-With other than above

Source: Community Home Services, Naples, FL.

Even so, many of today's home health care agencies are choosing to err on the side of caution and still keep records documenting a patient's history of falls, be they witnessed or not. For many, the decision is rooted not only in maintaining an accurate patient history but also in self-protection. **Laresa Boyle**, RHIA, business office / medical records coordinator for CRH Home Health Agency in Cushing, OK, notes that her agency reports "all falls to protect ourselves. If bruises show up on a patient, the family wants to know what happened. Filing an accident report protects us from being accused of any harm."

"Our policy was to document only witnessed falls," says **Ellen Madigan**, administrator for Farmington, CT-based Interim HealthCare of Hartford, "but we had our Medicare survey a month ago, and they were not happy. They wanted to see more documentation and follow-up on all falls, including doctor notification, fall prevention, teaching, etc."

Madigan says that as a result of this survey, her agency has reinstituted its policy of using incident reports on all falls so that they may better track them and make sure the proper follow-up is done and documented.

Rebecca Schlegel, RN, manager of regulatory operations for Visiting Nurse Services & Affiliates in Akron, OH, also says her agency still reports "all patient falls, whether or not the clinician was present. We feel that safety education and home safety assessment, equipment usage, recommendations for therapy, etc., may all have an impact on a patient's risk of falling. Therefore, we feel it is important for us to track falls so that we can review and determine whether we did all we could have to prevent the accident."

Prevention is surely the strongest reason agencies have for documenting a patient's history of falls. "Whether a fall was witnessed or not, if one occurred, then it has potential impact on the patient's health and need for services," says **David W. Perry**, PT, MS, of Perry Therapeutics in Grosse Pointe Woods, MI. "The patient should be reassessed to determine if the fall was an isolated event or has greater significance. The Plan of Care may or may not require modification. It seems we are missing the point if we focus on whether or not JCAHO or state surveyors have this as their focus this year. Their focus is constantly changing. Our focus should be on what is best for the client. And a fall is a potentially adverse event that needs to be assessed and then addressed as appropriate based on that assessment."

Perry is not alone in his view. **Carol Johnson**, RN, director of clinical services for Community Home Services in Naples, FL, notes that her agency carefully studies fall rates among patients. "At each comprehensive assessment, we evaluate the fall situation, and on discharge, we document the number of falls a patient experienced during the care and if any changes were made as a result of it. Unwitnessed falls are our No. 1 variance in the home, with witnessed falls lagging in second place. We analyze every variance to see if we could have prepared our patients better."

One home care professional explains that her agency used to report only witnessed falls in an event report for legal reasons, but that as of late, it has begun looking at tracking reported, unwitnessed falls in an internal report, not only for safety reasons but to trend those occurrences as well. Her agency also might institute a fall assessment process to help identify patients at high risk for falls.

Regardless of your reasons for documenting and assessing patient falls, every step you take to help patients at risk avoid a potentially life-threatening fall brings the NSC one step closer to its goal — preventing almost 50,000 fall-related injuries by 2008 and 75,000 by 2012.

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LegalEase

Understanding Laws, Rules, Regulations

For OASIS, use best judgment

By **Elizabeth E. Hogue**, Esq.
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(Editor's note: This is one of a continuing series about legal and ethical issues related to the implementation of the prospective payment system.)

Assessments of patients' conditions and recording assessment information on OASIS forms play an integral role in the new prospective payment system (PPS) for home health agencies. As just one of many examples, assessment

information determines the Home Health Resource Group (HHRG) into which patients are placed. The amount of reimbursement received by agencies is, in turn, closely related to the HHRG into which each patient is placed. That said, accurate assessment of patients, including placing assessment information onto OASIS forms, is one of the most critical steps for the success of agencies under PPS.

A further reason why accurate assessment of patients is so important is that it's part of an overall campaign to prevent fraud and abuse. When inaccurate assessments result in placement of patients in incorrect HHRGs, agencies may find that they are engaging in fraud and abuse in the form of overutilization or underutilization of services. These types of fraud constitute violations of the False Claims Act, a federal statute.

Don't just be a reporter

In view of the importance of the correct completion of OASIS forms, it is not surprising that a number of issues with legal and ethical implications have already arisen. One of these issues involves the role of practitioners in the completion of the OASIS forms.

Because of the question-and-answer format of OASIS forms, it may be tempting for staff to view their role as that of a reporter, i.e., someone who simply asks patients questions and records the information patients provide on the forms in front of them. On the contrary, the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) has made it clear that providers must play a more active role in completion of these forms.

For example, it has been reported that officials at one of the fiscal intermediaries have informed agencies that the intermediary will conclude that patients are not homebound if the OASIS form indicates that they can shop with assistance. Staff at the intermediary may reach this conclusion even if other information on the OASIS indicates that the functional limitations of patients are so severe that the patient in question could not possibly shop with assistance.

So why are providers submitting such inconsistent, and potentially harmful, information on OASIS forms? It appears likely that these results occur because practitioners are simply asking patients if they can shop with assistance, and patients state that they can do so. Without exercising any professional judgment, practitioners are simply reporting the answers that patients provide.

To that extent, it is clear that practitioners must play a much more active role in completion of the OASIS form. They must exercise professional judgment so that the inconsistent results described above are avoided.

The stakes are high. Agency managers know that regulators will be looking for instances of fraud and abuse under PPS in the form of underutilization of services. When providers fail to exercise professional observation and assessment to complete the OASIS accurately, despite patient reports to the contrary, the result may be instances of underutilization.

Providing additional information

Agencies also should be mindful of the risk-management implications of OASIS forms. These forms require short answers. They do not appear to allow for elaboration of information that may be necessary in order to have an accurate picture of the patient's clinical condition.

Again, field staff should enter additional information directly onto OASIS forms if such information is necessary to portray patients' conditions accurately. In other words, OASIS forms are a crucial part of patients' medical records. Despite the question-and-answer format of the forms, practitioners are nonetheless required to comply with applicable standards of care regarding documentation that includes all necessary information regarding assessment of patients' conditions. Such information may also assist agencies in defending themselves should there ever be allegations of fraud and abuse.

The additional information that practitioners may enter onto OASIS forms will not, of course, be transmitted to CMS. But it will be available for review by regulators, patients and their families, and attorneys for patients, if the quality of care rendered by agencies is questioned.

The standardization of home care documentation through the use of OASIS forms may produce beneficial results for both agencies and patients. Practitioners should bear in mind, however, that CMS' mandate to use certain forms for assessments of patients does not change applicable standards of care regarding assessments of patients' conditions and documentation of the results of these assessments. ■

Medications: They are alike and they're trouble

Keeping sound-alike medicines apart

It seems that a new prescription medication enters the market every day. With so many hitting the pharmacy shelves, pharmaceutical companies are running short of innovative names. Confusion over similar drug names, either written or spoken, accounts for approximately 15% of all reports to the U.S. Pharmacopoeia (USP) Medication Errors Reporting program, notes a recent issue of the Joint Commission on Accreditation of Healthcare Organizations' *Sentinel Event Alert*.

Not only does this pose a problem for physicians and pharmacists who must decipher handwriting and a host of abbreviations when filling an order, but it can lead to disastrous consequences if the incorrect medication is administered or the correct medication is administered incorrectly. A prime example, says **Matt Grissinger**, safe medication management fellow with the Institute for Safe Medication Practices in Huntingdon Valley, PA, is the confusion that can result from such seemingly easily distinguishable medications as Coumadin (warfarin), for people with a history of strokes, and Avandia (rosiglitazone), a new medication for type 2 diabetes mellitus, when they are handwritten.

An issue of *ISMP Medication Safety Alert!* (1999; 4:1) reports an incident of a pharmacy technician misreading a prescription for Avandia 4 mg and instead filling the prescription for Coumadin 4 mg. Both a nurse and a pharmacist who had just filled three Coumadin prescriptions reviewed the initial order, and both read Coumadin. The patient received one dose of Coumadin before the error was discovered by the prescribing physician during a routine review of the patient's medication administration chart.

Says Grissinger, "When the two medications are typewritten, they're not alike at all, but still we get reports of this type of thing happening. The key thing from a nursing standpoint is to make sure that every medication the person is taking has an appropriate indication. When a nurse visits a patient, she should sit down and go over the meds and look to see if they are diagnosis-appropriate. If there are any questions, then the nurse should talk to the pharmacist to make sure the medication is diagnosis-appropriate. For example, if the nurse sees a patient is taking Coumadin, then they should double-check that the person has a history of strokes, or if it's Avandia that the person is in fact diabetic."

Many times, he says, patients simply go to a retail pharmacy, pick up their prescription, pay their bill, and go home without asking any questions. "This is especially true with the elderly," he notes, "because they're often afraid to ask questions. It's up to the nurses then to act as the checkpoint down the road. The nurse should encourage patients and family caregivers to ask questions of the pharmacist.

"A good pharmacy will take a moment with the patient to check that the right pill is in the right vial. Have them take the pill out of the vial and show the patient or caregiver the pill, especially if it's a refill, so the patients can see for themselves if it's the same. It's important to teach patients to get the interaction going — it only takes a minute."

Among Grissinger's other tips for keeping medications in order:

• **Beware the medicine cabinet.** "Everyone thinks you should store meds in medicine cabinets, but in reality, the bathroom temperature and humidity are not always good for medications, especially capsules and tablets," he points out. Instead, consider storing them on a table or countertop (out of the reach of children) in another room. Inclement conditions aren't the only threats to proper medication administration, though. Grissinger says he has heard of cases where an ointment used for angina was mistaken for toothpaste.

• **Throw them out.** "If a patient isn't on the medication any more, we recommend that they throw the medication out," he says. "We know that pills are expensive and that people don't want to do this, so we suggest that nurses take the pills and put them someplace where they won't get mixed in with medications currently in use." That advice only goes so far, though, because Grissinger and the ISMP advocate throwing out anything that's more than 2 years old or that's past its expiration date.

• **Don't mix and match.** While different medications might be used toward the same end, such as pain relief, they are not interchangeable. "When I was a Joint Commission surveyor, I ran across a case where the husband was down to

(Continued on page 106)

Dangerous Dosages and Suggested Alternatives

Abbreviation/ Dose Expression	Intended Meaning	Misinterpretation	Correction
Apothecary symbols	dram, minim	Misunderstood or misread (symbol for dram misread for "3" and minim misread as "mL").	Use the metric system.
AU	aurio uterque (each ear)	Mistaken for OU (oculo uterque — each eye).	Don't use this abbreviation.
D/C	discharge, discontinue	Premature discontinuation of medications when D/C (intended to mean "discharge") has been misinterpreted as "discontinued" when followed by a list of drugs.	Use "discharge" and "discontinue."
DRUG NAMES			Use the complete spelling for drug names.
ARA-A	vidarabine	cytarabine (ARA-C)	
AZT	zidovudine (RETROVIR)	azathioprine	
CPZ	COMPAZINE (prochlorperazine)	chlorpromazine	
DPT	DEMEROL-PHENERGAN-THORAZINE	diphtheria-pertussis-tetanus (vaccine)	
HCl	hydrochloric acid	potassium chloride (the "H" is misinterpreted as "K")	
HCT	hydrocortisone	hydrochlorothiazide	
HCTZ	hydrochlorothiazide	hydrocortisone (seen as HCT250 mg)	
MgSO4	magnesium sulfate	morphine sulfate	
MSO4	morphine sulfate	magnesium sulfate	
MTX	methotrexate	mitoxantrone	
TAC	triamcinolone	tetracaine, ADRENALIN, cocaine	
ZnSO4	zinc sulfate	morphine sulfate	
STEMMED NAMES			
"Nitro" drip	nitroglycerin infusion	sodium nitroprusside infusion	
"Norflox"	norfloxacin	NORFLEX (orphenadrine)	
µg	microgram	Mistaken for "mg" when handwritten.	Use "mcg."
o.d. or OD	once daily	Misinterpreted as "right eye" (OD-oculus dexter) and administration of oral medications in the eye.	Use "daily."
TIW or tiw	three times a week.	Mistaken as "three times a day."	Don't use this abbreviation.
per os	orally	The "os" can be mistaken for "left eye."	Use "PO," "by mouth," or "orally."
q.d. or QD	every day	Mistaken as q.i.d., especially if the period after the "q" or the tail of the "q" is misunderstood as an "i."	Use "daily" or "every day."
Qn	nightly or at bedtime	Misinterpreted as "qh" (every hour).	Use "nightly."
Qhs	nightly at bedtime	Misread as every hour.	Use "nightly."
q6PM, etc.	every evening at 6 PM	Misread as every six hours.	Use 6 PM "nightly."
q.o.d. or QOD	every other day	Misinterpreted as "q.d." (daily) or "q.i.d." (four times daily) if the "o" is poorly written.	Use "every other day."

Abbreviation/ Dose Expression	Intended Meaning	Misinterpretation	Correction
sub q	subcutaneous	The "q" has been mistaken for "every" (e.g., one heparin dose ordered "sub q 2 hours before surgery" misunderstood as every 2 hours before surgery).	Use "subcut." or write "subcutaneous."
SC	subcutaneous	Mistaken for SL (sublingual).	Use "subcut." or write "subcutaneous."
U or u	unit	Read as a zero (0) or a four (4), causing a 10-fold overdose or greater (4U seen as "40" or 4u seen as 44").	"Unit" has no acceptable abbreviation. Use "unit."
IU	international unit	Misread as IV (intravenous).	Use "units."
cc	cubic centimeters	Misread as "U" (units).	Use "mL."
x3d	for three days	Mistaken for "three doses."	Use "for three days."
BT	bedtime	Mistaken as "BID" (twice daily).	Use "hs."
ss	sliding scale (insulin) or ½ (apothecary)	Mistaken for "55."	Spell out "sliding scale." Use "one-half" or use "½."
> and <	greater than and less than	Mistakenly used opposite of intended.	Use "greater than" or "less than."
/ (slash mark)	separates two doses or indicates "per"	Misunderstood as the number 1 ("25 units/10 units" read as "110" units.	Do not use a slash mark to separate doses. Use "per."
Name letters and dose numbers run together (e.g., Inderal40 mg)	Inderal 40 mg	Misread as Inderal 140 mg.	Always use space between drug name, dose and unit of measure.
Zero after decimal point (1.0)	1 mg	Misread as 10 mg if the decimal point is not seen.	Do not use terminal zeros for doses expressed in whole numbers.
No zero before decimal dose (.5 mg)	0.5 mg	Misread as 5 mg.	Always use zero before a decimal when the dose is less than a whole unit.

Source: Institute for Safe Medication Practices, Huntingdon Valley, PA.

one pain pill. When I asked if he had a prescription waiting, his wife chimed in to say that he could always take some of hers," says Grissinger. Needless to say, this is a no-no, and home care nurses should be sure to teach family members that medications are prescribed for specific purposes and given within the context of other prescriptions and possible interactions.

• **Home health dispensary.** If patients are in the habit of moving their medications to a weekly or monthly dispenser, home health nurses should be the one to fill them. "That way, the nurses can assess what the patient is taking and how much. This is especially important if there is a change in therapy and a medication at 80 mg drops down to 40 mg. The nurse can make

COMING IN FUTURE MONTHS

- Coping with verbal abuse
- Ideas for recruiting new employees
- How to utilize home health aides more effectively
- Alzheimer's creates home care challenges
- Trying out on-line distance learning

sure that the change has been made in the dispensers that it has been made correctly. In these cases, don't rely on the patient," says Grissinger.

• **Ask questions.** When in doubt, Grissinger says, ask the pharmacist. "Don't be afraid to ask the pharmacist to put an indication of use on the vial so the patient can see what it's for."

To keep medication errors at bay, the ISMP has published guidelines for clinicians to use. **(See excerpt from guidelines, pp. 105-106.)** The group also offers a medication safety self-assessment on its web site, as well as patient alert information and a chance to report medication errors confidentially. The institute's web address is www.ismp.org.

Also available to health care organizations interested in preventing potentially life-threatening medication errors is "Use Caution, Avoid Confusion," an updated list highlighting hundreds of confusing drug name sets and identifying more than 750 unique drug names that have been reported to the Medication Errors Reporting program. For a quick reference card or poster, interested home care agencies should contact USP's Practitioner and Product Experience department at (800) 487-7776, or visit www.usp.org/reporting/review/rev_076.htm.

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TX Medicaid bill vetoed

Texas Gov. **Rick Perry** vetoed a proposed bill that would have expanded health insurance coverage to the working poor, mentally ill, and children, while also saving the state $416 million. The bill would have covered breast cancer screening and contraceptive services for poor women as well as increased health care access for the mentally ill and HIV patients. The governor's office issued a statement saying Perry believed the bill's objectives could be accomplished in spite of the veto and that he saw the proposed measure as extending health care coverage to people who might then assume they are entitled to it. ▼

VT residents to head north

Vermont Gov. **Howard Dean** urged his state's residents to look to Canada for cheaper prescription medication following the rejection by a federal appeals court of a state plan to lower the cost of prescriptions for some 70,000 state Medicaid recipients. The federal court ruled against Vermont's plan because it found that many state residents who were counted as Medicaid beneficiaries and deemed eligible under the state program did not, in fact, qualify

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for the full range of Medicaid benefits and thus were ineligible to participate in the state's proposed prescription plan. Rather than drive across the border, Dean urged those affected to take advantage of United Health Alliance, a mail-order program that offers medications at Canadian prices. The program requires that a physician fill out a form that details the patient's prescription needs. That form is then faxed to a Canadian pharmacy that in turn sends a three-month supply to the patient's doctor's office, where the patient can pick up his or her medications. ▼

Elderly bear brunt of drug costs

In what comes as little surprise to those in the health care profession, a recent study conducted by the patient advocacy group Families USA found that over the past year, the average price of medications most often prescribed to seniors increased by 6.1%, compared with a 3.4% increase in medication costs for the population at large. The study, which examined the prices that pharmaceutical manufacturers recommend that pharmacies charge, has met with some resistance from the Pharmaceutical Research Manufacturers of America, which counters that the study's findings assume that all elderly people pay the same price for medication. Currently, only about 33% of the nation's 40 million elderly and disabled residents are enrolled in Medicare and have drug coverage. ▼

Doctor fined $1.5M for underprescribing

A California physician was found liable for recklessness and elder abuse for not administering adequate pain medication to a dying man in the final stages of lung cancer. The physician, who treated the man for five days in the hospital before he was discharged home where he eventually died, has been ordered to pay $1.5 million to the patient's family for pain and suffering of the patient. It is the first verdict in a lawsuit brought against a doctor under the California Elder Abuse and Dependent Adult Civil Protection Act. Nurses at the hospital reported charting pain levels of between seven and 10, with 10 being the worst pain imaginable. Family members were eventually able to contact Compassion in Dying, a nonprofit organization that advocates aggressive pain care for the dying, and through the group were able to consult with a second physician who prescribed appropriate pain medication. ■

CE objectives

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

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