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HOME INFUSION THERAPY MANAGEMENT™

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MAY 1999

VOL. 7, NO. 5 (pages 49-60)

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California law mandates new rules for preventing needlesticks

Enforcement issue now resolved for new legislation

When the California Legislature passed a law requiring all health care providers to use safety devices to prevent needlestick injuries in health care workers, many wondered just how strict the new law would be. As requirements fall into place, it is becoming quite clear that Cal/OSHA (California Occupational Safety and Health Administration) and the Department of Health Service (DHS) are taking the law quite seriously.

DHS, for instance, recently mailed a survey to all manufacturers of safety devices.

"As we identify new manufacturers and products, we would like to include them in our survey," says **Martha Davis**, MSPH, EMT, program director/epidemiologist for DHS in Oakland. She notes the list is not an "approved vendor" listing, but a list "that will assist purchasers in safety product selection" in terms of what is on the market.

In order for a product to be listed on the state's safety device list, the product must be either a needleless system or a sharp with engineered sharps injury protection. These terms are defined in the revised Cal/OSHA Bloodborne Pathogens Standard as:

A. Needleless System means a device that does not utilize needles for:

1) The withdrawal of body fluids after initial venous or arterial access is established.

2) The administration of medication or fluids.

3) Any other procedure involving the potential for an exposure incident.

B. Engineered Sharps Injury Protection means either:

1) A physical attribute built into a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, which effectively reduces the risk of an exposure incident by a mechanism such as barrier creation, blunting, encapsulation, withdrawal, or other effective mechanisms.

2) A physical attribute built into any other type of needle device, or into a non-needle sharp, which effectively reduces the risk of an exposure incident.

Dean Fryer, a spokesman for the Department of Industrial Relations, Cal/OSHA, in Sacramento, says there are two areas in which Cal/OSHA will be able to monitor a provider's adherence to the law.

"Any time there is a complaint, we are required to investigate. And that is where the majority of our workload is, so a lot of it will fall into that category," he says. "At any point in time, we would go out and investigate a complaint from an employee regarding safe needles not being used. It's considered an unsafe practice in the workplace and a potential hazard to the employee. [So a complaint by an employee] would initiate an investigation."

Fryer points out Cal/OSHA will not conduct random, surprise visits of providers.

"In regards to doing routine spot inspections, we only do that for industries that are considered high hazard — and this is not considered a high-hazard industry — so we would not go out and do spot inspections," he says. "It would only be as the result of an accident or a complaint that we would do anything."

It's unclear exactly when the legislation will take full effect, but Aug. 1 is the latest date.

"The enforcement aspect must be in place by July 1," says Fryer. "July 1 is the date we're looking at in order to give all the employers time to get up to date on the standards. This provides a window of opportunity for them to come into compliance."

Davis notes Aug. 1 may be the actual deadline. "It depends on how long things take with the standards board for everything to be finalized," she says. ■

Abbokinase released to market

Product now has new warning label

With the Food and Drug Administration's (FDA) release of Abbott Laboratories' Abbokinase product to the market, the shortage is over. At the bottom of the pulling of the product apparently was the deviation from Good Manufacturing Practices (GMP), resulting in a new warning label for Abbokinase.

Lenore Gelb, FDA spokeswoman, says there were "collected deviations from the GMP," and the FDA will continue to review and monitor its progress.

The reason for the new warning label is simple.

"We wanted to make sure physicians knew everything about the risks [associated with the product], says Gelb. "They may decide then to make a different decision based on the risk and benefit of the product. We can't quantify [the risk]. We can only say that we know there were manufacturing issues and the products were not screened properly. All biologics have some inherent risks. We're not 100% sure we've identified all possible infectious agents."

For example, the new label, supplied to *Home Infusion Therapy Management* by Abbott, states the following:

• **Warnings.**

"Abbokinase is produced from cultures of primary human neonatal kidney cells. Products manufactured from human source materials have the potential to transmit infectious agents. Procedures to control such risks can reduce but cannot completely eliminate the risk of transmitting infectious agents. The procedures used in the manufacture of currently available Abbokinase raise concerns regarding the risk of transmission of infectious agents. In considering the risk, the prescriber should be aware of the following information regarding the available lots of Abbokinase:

Inadequate screening process?

"The kidney cells used in the manufacture of this product were obtained from populations at high risk for a variety of infectious diseases, including tropical diseases. Although efforts were made to screen and test the mothers and neonate donors, the screening and testing measures were inadequate and were not consistently or reliably performed.

"For example, the screening of potential donors did not include the questioning of the mothers to determine infectious disease status or specific risk factors for infectious disease, and donors were not tested for hepatitis C virus (HCV) infection. While Abbott has recently instituted a test for HCV in kidney cells used in the manufacture of currently available lots of Abbokinase, this test has not been validated. A viral inactivation procedure that has been shown to substantially inactivate HIV and HCV in other biological products was used in the production of the currently available product. However, this process has variable effects on other

infectious agents and has not been validated for viral inactivation of Abbokinase."

Gelb notes the above "is not really a drug warning, *per se*. It's an attempt to summarize our findings."

Melissa Broats, an Abbott spokeswoman, notes the company is "doing everything to improve and update manufacturing processes according to the areas identified by the FDA." ■

When are you liable for malpractice?

Four simple steps to gauge your legal susceptibility

"Would I be liable if . . . ?" It's a question that has probably popped into your mind more than once over the course of your nursing career. As confusing as the legal world can be though, there is a simple way to answer the above question for yourself. It can be as simple as addressing four basic issues.

John Gilliland, JD, of Gilliland & Associates, a Crestview Hills, KY-based health care and labor employment law firm, and **Kammie Monarch**, RN, MS, a senior policy fellow at the American Nurses Association in Washington, DC, say that, in essence, you must look at these four simple questions:

1. Did you owe a duty to the person/patient?
2. Was that duty breached?
3. Did the breach of duty cause damages?
4. What were the damages?

A quick lesson in law

Don't let the word "malpractice" fool you. According to Gilliland, there's nothing fancy about it.

"The concept we refer to among professionals is malpractice, which is really just a euphemism for professional negligence," he says. "And the above four basic elements are a broad brush test for malpractice and is the same for any negligence action. Whenever you look at whether you would be liable from a malpractice end, you would look at those four questions."

Gilliland says he is often asked by health care professionals, "Was I negligent?" or "Would I be liable?"

"When someone asks those questions, they are primarily thinking of the first two elements," he says. "Then legally, we move on to causation and damages."

In the strictly legal arena in terms of malpractice, Gilliland advises you should be concerned with all four questions because without any one, there is no malpractice lawsuit.

"When a patient sues, they have to prove all four," notes Gilliland. "And to successfully defend, you only have to knock down one of them. So you'll have malpractice cases where the defense will say only, 'There was no duty owed. You're confusing me with Mary.' Or a defense may say, 'Yes, there was a duty owed, but we didn't breach it. We did what was supposed to be done.' Or the defense could argue, 'There was a duty and it was breached, but it didn't cause any harm.'"

1. Was there a duty?

"This arises when a professional relationship develops with the patient," says Gilliland. He defines a duty as "the duty to exercise reasonable care in providing the services."

The trick then becomes defining reasonable care, and this is where Gilliland says a malpractice case will most dramatically differ from a normal negligence case in that expert witnesses are permitted to testify what should or should not have been done.

"In the typical auto accident, you don't need anybody telling you what should have happened, but in the malpractice case you will typically have other professionals and other nurses testify as to what should have been done or not done and you get a battle of the experts to assist the jury in determining the standard of care," says Gilliland.

When looking at what the duty owed was, juries will typically look at the various standards of practice.

"What are the prevailing standards in the profession for the procedure that the nurse is performing?" is a critical question, according to Gilliland.

For home infusion providers, sources of standards include other infusion nurses or home infusion providers, journals, physicians, textbooks, Nurse Practice Acts, the provider's policies and procedures, or an individual with a unique expertise in the specific issue at stake. One area that many providers put their nurses at unnecessary risk is when establishing its own policies and procedures.

"People in home care in general tend to write policies trying to achieve the optimum. They get

idealistic and never think, 'I may be held to this,'" says Gilliland. "Those policies can be put in as evidence to prove the standard of care. So agency policies are a source that a court will look at to decide what is the standard of care."

For example, assume your company policy states that nurses will visit a patient within 24 hours of receiving a referral, physician's order, etc. If a nurse visits a patient in 36 hours, and numerous expert witnesses say for that patient in that particular instance 36 hours was fine, a court may very well find that you set your own standard in 24 hours and failed to abide by that.

"You need to keep that in mind when you are writing policies for your own agency," says Gilliland. "When I mention that in a workshop, people tend to do a much better job. I tell them to say that there will be exceptions, that generally the visits should be made within 24 hours, or to put an overall disclaimer that the policy is not to establish a standard of care but to achieve optimum performance."

2. Was the duty breached?

Once a standard is established, it is then considered whether that standard was adhered to.

Monarch points out the duty and breach thereof requires a great deal of patient advocacy on the nurse's behalf.

"The nurse may not be able to tell that the pharmacist incorrectly mixed the medication; but if the label says the bag has been mixed a certain way and it's wrong and the nurse administers it, he or she is still legally responsible for administering the wrong dose," says Monarch.

Also, if a nurse disagrees with a physician's order, case law dictates the nurse's responsibility to the patient.

"If the physician orders something that is out of the normal range of dosing for a particular diagnosis and situation, the law says the nurse has a responsibility to not administer it until the order is clarified and the situation is resolved," says Monarch. "If the nurse is uncomfortable administering medication based on a doctor's order, they can and should refuse to give that. Because if they do administer the medication and something happens to the patient, the nurse is going to be responsible."

The elements of duty and breach of duty come under risk management. Nurses and providers know what their duty is and what should be done. The risk managers then make sure everyone does just that. That's why Gilliland says the key is knowing what your duties are and then living up to them.

"If the nurse can show that he or she abided by (a) the institutional policies and procedures that govern the actions of the case and their job description, and (b) national practice standards like those issued by the professional associations; they have gone a long way to negate the breach element that the patient has to show," says Monarch.

3. and 4. Did the breach of duty cause damages?

Even if there was a duty and it was breached, unless that breach of duty was a proximate cause of damages, there is no malpractice liability. In the legal setting, the damages and causation are just as important as the breach of duty.

"What the nurse did had to be the cause of the patient's harm," says Monarch. "If the nurse gives the patient too much of a vitamin and the patient goes into cardiac arrest two minutes afterwards, it must be shown that the administration of the vitamin was the cause of the cardiac arrest and that is going to be a very hard thing to do.

"There then may be a five-day trial trying to find out, 'Was it the vitamin?'" says Gilliland.

What's the case law?

"In the area of home health care, especially when it comes to infusion, there are not that many cases because there hasn't been that much time for the case law to really develop," says Monarch.

Gilliland points out that health care attorneys don't have an answer for why there aren't more malpractice suits in such a rapidly expanding industry, although he offers two hypotheses:

❒ "People generally do not sue people they like," he says, and home infusion nurses tend to establish a relationship with a patient and the patient's family.

"It goes back to the best thing a physician can do to avoid malpractice is to establish the physician-patient relationship: Talk to the patient and listen," says Gilliland.

❒ "In the home, the patient is where they want to be and they are participating in what is going to be done: the whole relationship is different," he says. "And of course, it could be that [why] maybe the nurses are careful."

The lack of case law does not mean it is nonexistent, though. Monarch points to a case of *Semmler, Lunny, Gaiti, Poole, and Melendez v. Metropolitan Life Insurance Co.*, 94CIV.5549, U.S. District Court (NY, Sept. 15, 1995).

Monarch explains that Gaiti was the recipient of an epidural catheter while the rest of the plaintiffs were recipients of central venous catheters.

"The issue in the case was whether the charges related to these lines were going to be paid by the defendant's insurance company," she says, "but the issue that was important for infusion nurses was that . . . testimony considered by the court included the following:

'IV infusions are maintained by nurses and it is the exception rather than the rule to need anesthesiologist visits subsequent to his/her routine post-operative visit. It does not seem appropriate for an anesthesiology to charge a patient for a visit specific to pain management. It is the nurse who instructs the patient on the use of the pump.'

"The court said it was the nurse who is responsible for the pump and administration of the medication," says Monarch. "So it was pretty clear when it said it is the nursing responsibility." ■

Are you getting patient consent forms?

If not, you're a lawsuit waiting to happen

Patient consent forms can be a sticky situation for home infusion providers inserting peripherally inserted central catheters (PICCs). When are they necessary? When are they not? Who exactly do they protect? Depending on who you listen to and your own situation, the answers vary.

When it comes to liability, **Elizabeth Hogue**, JD, a health care attorney in Burtonsville, MD, says you should have a patient sign a consent form for every PICC line you place.

"Court cases basically say that you have to get informed consent for all invasive therapies. I don't see any change in that standard, and never would I regard the insertion of a PICC line as routine," she says. "I'm not aware of [a court case] that specifically addresses the PICC line issue, but it's irrelevant because the general principle laid down by court cases all over the country is that any non-routine invasive treatment requires informed consent in advance."

Darnell Roth, CRNI, president of D/R Intravenous Therapy Consulting, of St. Louis, agrees that consent forms are not an option with PICC placement based on certain factors.

"There should be no doubt that the placement of the PICC is more traumatic than the insertion of a traditional peripheral cannula," she says. "Even when the placement of an indwelling PICC is performed by a competent, PICC-knowledgeable nurse, there are inherent PICC-associated complications."

Roth points out complications associated with peripheral vascular access, such as phlebitis, thrombophlebitis, ecchymosis, hematoma, insertion site infection and sepsis are all distinct possibilities, as well as compartment syndrome, antecubital nerve trauma, catheter tip malposition, catheter emboli consequential to catheter failure, and catheter tip migration.

"Considering this 'menu,' one should readily recognize the importance of having obtained specific consent for PICC placement," says Roth.

While consents may not be required for all infusions, when it comes to PICCs, Roth says there is nothing to consider: get a signed consent.

"From a risk management standpoint, in my opinion potential PICC placement candidates should be given a clear explanation of what the insertion procedure entails, potential insertion-related and post insertion-related complications including signs/symptoms heralding the development of same, restrictions in life style secondary to the presence of an indwelling PICC, and other options for treatment," says Roth. "Only then can the individual intelligently provide consent for PICC placement." **(For Roth's sample consent form, obtained from the late Joe Brown, CRNI, see p. 54.)**

However, what is the situation if the patient has already signed a general consent form that does not specifically mention PICCs or any other non-routine invasive treatment by name?

"It comes back to policies, procedures and protocols within a system," says **Kay Coulter**, CRNI, owner of Coulter Consulting, in Clearwater, FL.

For example, one provider Coulter is aware of has a policy requiring an additional patient consent if a catheter longer than 2¼ inches is placed. Some oncology centers require a consent form if a chemotherapy agent is given, while others require only the initial consent to treatment and any chemotherapy agent can be given under that umbrella consent.

"A patient always signs a general consent form any time they come into a health care system, so we have what is more or less considered blanket consent for treatment up to a point,"

(Continued on page 55)

Sample PICC Insertion Consent Form

- I, _____ agree to have a peripherally inserted central catheter (PICC) inserted into my arm.
- I understand that Dr. _____, my attending physician, has given the order for the placement of the PICC and that he/she also designated where the tip of the catheter should be situated.
- Alternate methods of administering my medication(s) have been fully explained to me.
- I understand that my health care has determined that a PICC line would be the most effective means of administering my medication(s).
- I fully understand that the insertion of a PICC is an invasive procedure which is accompanied by certain risks which include, but are not limited to, unsuccessful placement, local and/or systemic infection, irregular heart beat, catheter embolism, air embolism, hematoma at the insertion site, catheter tip malposition, phlebitis, and thrombophlebitis. I further understand that all appropriate measures will be employed to reduce or eliminate the chance of these risks occurring.
- I understand that although the catheter's point of insertion will be in my arm, the tip of the catheter will be situated in a blood vessel located in my upper chest or in an area near my heart.
- I understand that the procedure will only be attempted if evaluation of my upper extremities substantiates the fact that I am an appropriate candidate for PICC placement.
- I understand that there is a slight chance that insertion of the PICC may not be successful in which event other options for administering my medication(s) may be employed.
- I have been informed of my right to voice any questions or concerns I have about the procedure and received clear answers to my questions.
- I fully understand the insertion of the PICC will be performed only by an experienced and qualified registered nurse or physician. My PICC will be inserted by _____.

Patient _____ Date _____

Witness _____ Date _____

Source: Darnell Roth, D/R Intravenous Therapy Consulting, St. Louis.

notes Coulter. "That is why the example of chemotherapy consent will be the same for vascular access."

Accordingly, Coulter notes you need to look at your general consent form and see what is covered.

"The responsibility for legal protection is on the nurse to know the system's policies and procedures and requirements," she says. "There is too much variation and not enough standardization at this point for a statement to be made that anything is the norm."

So Coulter's word to the wise is to protect yourself. "Err on the side of consent," she says. "If I could not resource the protocols within my system, or if there is nothing specific in the policies and procedures, I would get patient consent verifying that they have received information about the procedure."

If you don't have a formal PICC consent form, Coulter says at the very least you should document in the narrative notes that the PICC placement and all potential complications resulting from a PICC placement were explained to the patient, as well as making a note as to the patient's understanding, comprehension and consent for placement of the PICC.

"I would also suggest that home infusion providers realize that the consumers are increasing their scrutiny of IV-related care," says Coulter. "Obtaining consents prior to any 'non-routine invasive treatment,' as stated by Ms. Hogue, is the best practice choice." ■

Cover bases with patient education materials

Consider information and presentation

If educating patients was as simple as giving them information, you could loan them an infusion therapy textbook and be on your way.

Such an approach has its obvious shortcomings, which is why **Theresa Harper**, MSN, patient education specialist for Hamilton Health Sciences Corp., in Hamilton, Ontario, says patient education materials are much more than providing information.

According to Harper, the first step in creating effective patient education materials is to consider the audience. "We try to create information that is patient-centered," she says. For its home infusion patients, this means consulting more than journals and professional sources. Originally we had IV nurses and patient family members help develop prototypes, then we developed a committee of community nurses and nurses from our corporation to expand them."

Families can prove invaluable throughout the development of education materials. Hamilton Health Sciences uses family members to fill out evaluation forms and test material. All such feedback is solicited by the nurses who work with the families in the field.

"The nurses have had a long working relationship with these families," says Harper. "It all goes through the nurses. Some sit down with the family and discuss the materials, and some will write information down and have the families look over it. We really value the patient input because this is for patients."

It wasn't long ago that the centralized IV team was handwriting instructions.

"We started this project in the early '90s because we were having pediatrics go home with ports and nurses were handwriting instructions for parents as a supplement to their teaching," says Harper. "They came to me and asked if I could help them develop written materials, and that is how it started."

Families and patients aren't the only outside sources used. Harper also collects patient education materials from other providers. She says the main difference was in the supplies and equipment of each provider, which would have a dramatic impact on the specific information included in the education tools. But by simply reviewing other's tools, Harper was able to come up with several pitfalls that were fairly common:

- **Too much to read.**
- **Too much text or type that is too small, making for a "dense" page.**
- **Too many medical terms and inclusion of complex information.**
- **Outdated information.**
- **Difficulty in following the steps provided.**

Of course, in addition to patients and other providers, product literature and medical journals were used to reinforce the experience and evidence-based information of the nurses.

It is often stated that first impressions are everything, a cliché that holds true for patient education materials.

"They have to be readable and inviting," says Harper of patient education materials. "They

Hooking Up Your Implanted Port or Tunneled Catheter for Therapy

✔ Supplies

- ❒ Alcohol wipes
- ❒ Clean unused towel
- ❒ Primed IV tubing
- ❒ Antibacterial soap
- ❒ Tape
- ❒ Gloves (Gloves are worn if you have a cut, a rash or an infection on your hands or if the caregiver is not the patient.)

If your IV tubing contains medications you will need to check the type of flush solution you use. If the flush solution in your catheter is heparin you will need to flush the catheter with sterile normal saline before you hook up.

✔ Getting Ready

1. Wash your hands, rubbing them hard and well. Use antibacterial soap.
2. Put your supplies on clean unused towel.
3. Prepare the IV bags and tubings.
4. Remove the tape on the clamp, if present.

✔ Hooking Up

1. Put on gloves if needed.
2. Clean the connection between the cap and the catheter with an alcohol wipe. Rub with friction for 30 seconds.
3. Make sure the clamp is closed. Remove the injection cap.
4. Attach the primed IV tubing to your catheter.
5. Open the clamp.
6. Turn on your IV or pump.
7. Secure the catheter as taught.

Source: HHSC, St. Joseph's Hospital, SEN, VON, CCAC 1997.

can't be threatening when you look at it."

There are several ways to make the materials inviting to patients, such as the sample patient education form **(see form, above)**, rather than intimidating:

1. Use plain language.

Avoid giving patients technical excerpts from the latest medical journal.

"Try to avoid jargon, and if we have to use jargon, we define it," says Harper.

2. Liven it up.

There's no need to lecture a patient or give them dull notes on technique.

"We try to make it conversational," says Harper. "We write for the audience in a personal tone and an active voice."

This is the area that is often most difficult.

"Many nurses realize it's important to write in simpler terms, but some just don't know how to do that because it can be a matter of relearning how to write," says Harper.

3. Looks are important.

Illustrations can be an effective way to enhance education materials. But Harper says to use the illustrations for that purpose alone. "We use illustrations to enhance the learning, but we don't use it for marketing, so we made a distinct decision there," she says.

The use of graphic artists is kept to a minimum, though, due to the added expense of bringing in an outside contractor.

When creating patient education materials, Harper recommends keeping a specific goal in mind. Are you looking to give patients an understanding of their therapy and illness? Do you want to educate them what to do and who to contact in case of an emergency? The goals and intent of your patient education materials will vary their content.

"We try and go the self-management route," says Harper. "We try and give the patient the skills that allow them to manage their line and decrease the need to use a care provider. It makes them feel like they own the line."

More specific than general self-management are the goals of troubleshooting and problem solving, according to Harper. It's also important to note the tools are not a reference in and of themselves but are meant to be used in conjunction with nurse's educating the patient.

"This is not a pamphlet you leave and never see the patient again," says Harper. "It is an interactive tool, not a stand-alone tool. We want our nurses to teach every time they work on a line."

The process usually begins when a clinician comes to Harper with written information for patient education. "I'll ask them questions like, 'What is the purpose of the material?' and, 'Who is the audience?'" she says. "I read it from the patient's perspective, and then I start editing. I write up a draft and send it back to the IV team."

Harper says the draft will often go back and forth for up to a year while both sides make additions and revisions. Without an open staff, this process can be difficult.

"You have to be open, honest, and accept feedback without worrying about someone being critical of your work," she says.

As tools are completed, Harper avoids putting everything in one home infusion book. This allows for changes and revisions to be made at any time.

"Even when it's done, we get feedback from patients or nurses on things that need to change," says Harper. "By printing sheets rather than in a book we can make those changes without reprinting everything." ■

GUEST COLUMN

Protect yourself against bloodborne pathogens

A quick look at preventing needlestick injuries

By **Nina Moore Elledge**, CRNI
Castro Valley, CA

Bloodborne pathogens are an everyday occupational risk for nurses, particularly those of us practicing in the specialty of intravenous therapy and line placement.

In a study of 63 hospitals conducted by the Health Care Worker Safety Center, sharp object injuries occurred at a rate of 27 per 100 occupied beds per year.[1] This amounted to 3,552 total incidents in a three-year period. Of these incidents, almost 69% were caused by hollow-bore needles, the kind you and I use every day.

Of these sharp object injuries, 50% were to nurses (only .1% of these injuries were to IV team members), 13% to physicians, and 5% each to nursing assistants and housekeeping staff. The most frequent injuries were caused by IV catheter stylets, followed by butterfly needles, phlebotomy needles, blood gas syringes, and injection syringes, respectively.[1]

We must also take into account when reading these statistics that under-reporting has been documented in several studies by 40% to 53% for nursing personnel, and up to 92% for laboratory technicians.[2] In addition to the risk of tissue, nerve, and bone trauma, we are also exposed to over 20 pathogens each time we incur a contaminated sharps injury.[3]

Safer devices are the answer

We can insure workplace safety by proper training of employees in the use of safety devices, handling contaminated sharps, and generally increasing the level of awareness of the dangers we may face in our daily routines.

The five primary activities associated with most needlestick injuries are:

1. Disposing of needles used during patient care procedures.

2. Administering injections.

3. Drawing blood.
4. Recapping needles.
5. Handling trash and dirty linens (a.k.a. "downstream injuries").

Certainly using universal precautions and personal protective equipment have decreased the incidents of occupational exposure to bloodborne pathogens. However, we must remember that most personal protective equipment is penetrated easily by a needle. Safer needle devices have been shown to significantly reduce the incidence of accidental needlesticks and exposure to bloodborne illness.[4]

More steps to safety

The recent passage of legislation in California (AB 1208, Migden) is also a step in the right direction of protecting healthcare workers appropriately. It mandates a revision of CalOSHA's bloodborne pathogen standard to include needleless systems and needles with engineered sharps injury protection.

These engineering controls (many of which have been available on the market for several years) must be provided by employers in work areas no later than Aug. 1. Non-compliance with this revised standard is a misdemeanor. Similar legislation is likely to be enacted in other states in the near future.

Another method of protecting ourselves against contaminated needle injury is the one-handed recapping technique. This procedure is addressed in sections (d)(2)(vii)(A) and (B) of the OSHA Bloodborne Pathogen Standard Number 1910.1030.[5]

While it is not advisable to recap contaminated needles, there are occasions when this technique can protect you if no other alternative to safe disposal of the sharp object is available. Several examples include unobtainable sharps container or needle cork (after an arterial blood gas has been drawn). The procedure involves placing the tip of the needle cover against a solid, immovable object (such as the rim of a bedside table) prior to obtaining your sample or giving an injection. After completing the procedure, you would then use your dominant hand to gently slide the needle into the needle cover. The object's resistance will allow you to apply gently pressure to secure the needle cover. Then, dispose of the unit in the nearest sharps container as soon as possible. It must be noted that shearing or breaking a contaminated needle is prohibited by OSHA Standards.

A final note on the proper use of our 'tools of the trade.' We must be aware that manufacturers' recommendations for devices which carry the potential for user injury state that we must be trained in the proper use of these devices. This protects them from legal liability. It also reminds us that if we are expected to use a piece of equipment with which we are unfamiliar, we must be instructed on its proper use (it is also a good idea to have this training documented in your employee file).

Doing so will protect us in cases of litigation. Most of us can think of instances in our personal careers where improper or non-existent training affected us directly or indirectly, and may have resulted in an incident report, or worse, and injury to ourselves or our patients. To this end, we all need to practice with a jury in mind. Proper training, proper equipment, and proper documentation protect all of us.

Nina Elledge is an independent nurse consultant in the San Francisco Bay Area of California. She has been clinically active in intravenous therapy for nearly 20 years from the ICU to the home setting. She also is a legal consultant specializing in plaintiff and defense litigation in pediatrics, home care, and vascular access issues.

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COMING IN FUTURE MONTHS

- Team up: One provider's example of the advantage of IV teams
- Safety first: Tips on creating a safe home care environment for staff
- The Holy Grail: A look at profit margins and what they really mean
- Look out: The latest outcomes data for home infusion providers
- Bottom line: How to figure the real cost of a needlestick injury

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Profit margins: The misunderstood objective

It's constant improvement, not a magic number

Everybody wants the best possible profit margin for their company. However, there's a right way and a wrong way to approach profit margins, and how you go about chasing profit margins could make the difference between simply staying alive and thriving.

"Everyone is looking for profit margin and it seems to be the magic number," says **Gary Collins,** president of Professional Reimbursement, a consulting firm based in Orlando, FL.

❒ **The wrong way.**

The first tip experts give in terms of analyzing profit margins (income minus contractual allowances minus all expenses) is to stop the comparison game: Don't look at any organization other than your own.

"It's unrealistic to set one number for all home infusion providers," says **Joe Cabaleiro**, RPh president of Excel Consulting, in Cary, NC. With so many variables coming into play, an acceptable profit margin for one provider may be abysmal for another.

"A lot of smaller organizations and hospital systems have a different mission than national, publicly traded companies," says Cabaleiro. "Some providers take all patients to serve the community, but if you do that you're not going to take in a Caremark profit. Those companies are selective and they have to meet expectations on Wall Street."

"Profit margins basically depend on the organization and what profit margins it feels are reasonable," says **Michael Tortorici**, RPh, MS, president of Dayton, OH-based national health care consulting firm Alternacare of America. "If a provider has a 10% pre-tax profit and they are doing $3 million a year in net billings, 10% of $3 million is $300,000 and for an entrepreneur after all the salaries are taken out, that's not bad. However, if you have a large corporation with profitability of 20%, after they take out all the corporate overhead they're not going to have that, so it all depends on the organization."

❒ **The right way.**

The bottom line in succeeding is to look at your profit margin and try to improve upon it, regardless of where it's at.

"You always want to try and do better," says Cabaleiro. "Reduce expenses through all the typical means of reducing expenses. Ask 'Is this a profit margin I can be happy with?' Finally, see if there is some way to increase it."

When looking at your net profit success, Cabaleiro recommends considering the following factors:

Home Infusion Therapy Management™ (ISSN 1082-8648) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Home Infusion Therapy Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6:00 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday EST. E-mail: customerservice@ahcpub.com. World Wide Web: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $369. Approximately 18 nursing contact hours annually, $419. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $221 per year; 10-20 additional copies, $148 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $62 each. (GST registration number R128870672.)

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Editorial Questions

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1. Who are your patients? "Do you serve patients who are not economically well off or are you in a wealthy community with private pay," he says.

It's not just reimbursement, but ancillary constraints that, if you don't have a solid control of your costs, can eat away at your profits.

"If you have a high number of TPN [total parenteral nutrition] patients and they are more time-consuming, you can't compare to a provider who may be doing more enterals which don't take near as much time to manage as a TPN or chemo case," says Collins.

2. What is your overhead? For example, layers of management or staff can dramatically cut into your profits.

"A home infusion company with numerous employees or nurses will end up with a different type of profit margin than a company that may be a more streamlined infusion pharmacy," says Collins.

Overhead includes many areas in which you can possibly reduce your costs.

"One of my clients has a distributor nearby and knows he can have same-day delivery for a product if he needs it," says Collins. "That works well for him because he can keep his inventory low and his costs down."

Keep in mind there is only so much you can do, though.

"If you have personnel and facilities, those costs are fixed and that has a negative impact on your bottom line," says Tortorici. "You can't raise your prices because reimbursement is going down. You can try to increase your volume, but you can also try to become more efficient, but you want to be prudent, not cheap, and there is a difference."

To illustrate this point, Tortorici uses the following example. Consider a local provider with one nurse who does a great deal of traveling and as a result the provider pays a great deal in overtime and mileage. If they bring on a few per diem people and use them to reduce overtime, they don't have to pay the overtime, they don't pay benefits, vacation and health insurance and if the per diem staff visit patients in their geographic area, there is a smaller mileage reimbursement.

3. Look at the big picture. Cabaleiro points out that in some situations a lower profit may be beneficial to your organization's overall health. Why? A figure called days sales outstanding.

"A quick pay at a lower profit may be better than long pay at a high profit if you have to wait six months for payment," he says. "On paper you can be knocking down the world's greatest profit margin, but if none of that money is coming in, that's another thing. It's just a paper gain. Do you want to make a 25% profit but wait six months to get it or do you want to make much less but get my money quicker?"

Collins agrees. "If it's taking you too long to get your money and it's just sitting out there tied up, it could be in the bank or you could have used it," he says. "You need to look at your accounts receivable." ■

CE objectives

After reading the April issue of *Home Infusion Therapy Management*, CE participants will be able to:

1. Define the four areas in establishing malpractice.
2. Identify the precedent set in court cases for when a consent form is required.
3. List the two most important factors in designing patient education materials.
4. Identify the five primary activities associated with most needlestick injuries. ■