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INSIDE

■ **Inserted in this issue:** Sample newsletter with Joint Commission tips

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Multiple mock surveys are the key to Maryland agency's JCAHO success

Agency receives two accreditations with commendation

If you check the home health agency list on the Web site for the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO), you'll quickly see that very few agencies receive the much-coveted "accreditation with commendation" designation.

Even fewer sustain such honors for two consecutive surveys. This is because such an accreditation achievement is only slightly less difficult to achieve than a perfect 10 on the parallel bars at the Olympics. Joint Commission surveyors go into an agency looking for mistakes, tiny slip-ups, little lapses of duty and knowledge, and most of the time they find what they're looking for.

But not so with Adventist Home Health Services in Silver Spring, MD. The home health organization, which has five offices in the Maryland, Washington, DC, and northern Virginia area, has earned accreditation with commendation in its two last surveys.

Follow the survey guide

There was no magic to the agency's achievement: It was plain hard and smart work, says **Carolyn Stevenson**, RN, BSN, assistant director of clinical services for Rockville, MD-based Adventist HealthCare Alternate Care Services, which helped the home care agency prepare for its surveys. The Adventist services organization, which also consults with other home care agencies, and the Adventist home care agency are owned by Adventist Health Care in Rockville.

Stevenson, who helped the Adventist staff prepare for the surveys, offers this guide to survey success:

1. Prepare continuously.

Don't wait until the last minute or the last year to begin preparing, Stevenson says. Adventist started survey preparation a full two years before the actual survey.

First, the company held a mock Joint Commission survey, following exactly the same survey manual that a real surveyor would follow. The

Joint Commission sells its survey package, complete with computer software and print-out reports. This can be invaluable, Stevenson says.

The mock survey was conducted by two registered nurses from a consulting company. Since the surveyors were not employees of the home care agency, it ensured that the mock surveyors would be objective and the staff would take it seriously.

"The mock survey lasted a whole week, and the nurses did everything just like a Joint Commission surveyor," Stevenson says. "It's only beneficial if it's conducted just like a surveyor would do it."

The staff did take the mock surveyors' report seriously. They listened to the instructions and followed up on the problems the mock surveyors noted in the report.

"There's no sense paying someone to do a mock survey unless you listen to the recommendations laid down by the experts," Stevenson says.

2. Give staff Joint Commission areas to cover.

About 18 months before the Joint Commission survey, the agency formed a Joint Commission oversight committee of about 12 members.

Each member of the multidisciplinary committee was assigned one or more chapters from the JCAHO manual. The committee members could enlist help from other employees to go over the agency's own policies and procedures to make sure they matched with what the Joint Commission said. For example, a member might ask for help from the agency's clinical records department to work on the information management section.

"Staff went through each of the standards within the chapters and made sure that our agency was meeting the requirements of that standard; if it was found we were not, a plan would have to be put into place to make the necessary changes," Stevenson explains.

This job took about six months. Agency management gave the committee a fairly loose rein in making small changes. But if a change required administrative support or additional funding, the committee could make a recommendation to the operations committee for approval. Then the operations committee would make recommendations to the professional advisory committee and ultimately meet board approval.

"The oversight committee was given the authority to do what they needed to do within some boundaries," Stevenson says.

Since the area of infection control and safety is such an important part of a Joint Commission survey, the agency also had the safety committee perform a mini-mock survey of their own. Safety committee members made additional recommendations based on their findings.

3. Then repeat the mock survey.

One year after the first mock survey, and a year before the actual survey date, the agency held a second mock survey. This time the Adventist consulting arm of the health care organization conducted the survey.

The second survey confirms that the staff have improved the problems found in the first survey. It's also a second dress rehearsal for the real thing. But since it is conducted a full 12 months before the actual Joint Commission visit, it gives the agency time to clean up any last-minute issues or problems.

Adventist's mock survey found a problem with the timeliness of doctors' orders. In Maryland, home care agencies must have the orders signed, returned, and in the report within 28 days — two days shorter than what the Joint Commission requires.

"This an area that's a problem for every agency, and the Joint Commission requires 100% compliance," Stevenson says.

The mock survey also found a problem with how some staff followed wound care orders. "Some nurses wanted to document it and do it slightly differently from what the original order said," she recalls. "But these must be followed exactly."

The agency tackled these projects during the year before the survey.

4. Educate, reinforce, educate staff.

Managers eschewed the boring lecture-format inservices and instead held Joint Commission "Jeopardy" games during staff meetings.

"You have to do education in fun ways," Stevenson says.

Managers also published a monthly newsletter for employees, *Compass,* which included Joint Commission information updates, cartoons, tips, policy highlights, and notes on changes the agency was making in policy and procedure. **(See newsletter, inserted in this issue.)**

The newsletter also included word games, scrambled word games, and crossword puzzles. The first person to call in the correct answers would win "Joint Commission bucks," which could be exchanged for prizes.

"The whole slogan for the Joint Commission preparation was 'Mission Possible,'" Stevenson

SOURCE

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says: "We tried to make it fun."

The agency also displayed bulletin boards in its five offices. "Each bulletin board had a specific topic that was identified when we did the mock surveys," Stevenson says. For example, the bulletin boards featured information on infection control, case coordination, and discharge planning.

A last educational step involved chart reviews. Management teams conducted these as a way of ensuring that employees had corrected areas identified as problems. If they found problems, they'd give staff feedback on how to correct the errors.

Finally, as the survey time approached, the agency made sure the office looked organized and that everything was neat and tidy.

"You must present a professional atmosphere for the surveyors," Stevenson says. "Make sure everyone is wearing their name tags and that everyone is aware what our mission is."

[Editor's note: For more information about Adventist HealthCare Alternate Care Services' Joint Commission mock surveys and preparation, contact Ann Kirwan at (301) 315-3570; fax: (301) 315-3019; or e-mail at akirwan@adventisthealthcare.com.] ■

Meeting the needs of immigrant patients

Agency program wins kudos from JCAHO

The San Francisco Bay area has some 100,000 immigrants from eastern Europe, about 40,000 of whom are senior citizens. Numbers like those led to the creation of InCare in 1996, a home care agency that specializes in meeting the needs of this emigrant population.

Along with catering to a growing niche, the 11-nurse agency has been able to build in the kind of quality improvement programs, administrative, and clinical excellence that won the agency commendation from the Joint Commission in its first survey earlier this year.

Yana Leveton, the managing director of the agency, says one of the biggest problems the agency has had to overcome has been the lack of education many of her patients have on basic issues, such as what diabetes is and how to control it.

"We have to start with the basics, like the signs of the disease with our patients," she says. "We probably have twice the educational materials as other agencies."

The material has to be in Russian and English, too, notes clinical director **Vadim Markovich**, PA, RN. "JCAHO loved that," he says. The materials have had to be customized to fit the Russian mentality, as well. For instance, the agency had to create a brochure on how to cook traditional Russian food with less fat and sodium.

Much of the educational material has been developed with or borrowed from other community resources and institutions that work with the immigrant community, Markovich adds.

This kind of networking has enabled InCare to build a reputation of premium customer service. A local pharmacy, for example, provides Russian-speaking drivers to deliver medications to InCare patients. "It's an added value," he says. Nurses also accompany patients to appointments with physicians who don't have Russian language skills. This was another thing that the JCAHO surveyors liked. "They said one of our strongest assets was this bond between nurses and patients, and their extended family."

If nurses didn't go the extra mile, says Markovich, there is a danger that the traditional accommodating nature of Russian patients would cause medical problems. "They want to provide the right answer that causes the least trouble," he explains. "They don't understand that they might be jeopardizing their health if they say they are taking their medications but are not. Our nurses have to be investigators to work with these patients."

Staff building

Finding this kind of staff has been difficult. "Language skills are just not enough," Markovich explains. "You really have to know and understand the culture to provide the best health care."

The nurses are matched, as often as possible, to patients from the same area. Along with the nursing staff, there are also two physical therapists and two occupational therapists. InCare also has

the only speech therapist in a 60-mile radius who is a native Russian speaker. She travels from the south Bay area one or two days a week to deal with InCare patients, and Leveton says they often get referrals from hospitals just because she is part of the team.

In a way, the difference in culture is one of the biggest headaches for InCare, says Leveton. "In Russia, if you call 911, you get a doctor or a PA coming to your home to give them help there. Here, they get a paramedic who can take them to a hospital, but can't make critical decisions. That is both more than they wanted and less than they needed."

"Our nurses have to provide high-quality health care at home to people who don't understand Western-style health care," adds Markovich. "They are the intermediary between what they had before, and what they get now."

Leveton says nurses have to be experts at getting information from patients. "The patients often have little pharmacies of homemade remedies or medicines sent to them from Russia. We have to be able to find out everything they are taking."

The staff are all licensed in California, and all documents must be completed in English, including nursing notes, says Leveton. "We have some problems in grammar and spelling, but in the end, these documents have to satisfy Medicare, state surveyors, and the Joint Commission."

Often nurses spend half an hour on documents that might take others five or 10 minutes, adds Markovich. "They think very carefully about what they are writing and how they are translating. I think that makes the quality a lot higher."

Indeed, the JCAHO surveyor said the strongest point in the records was the clear communication, he says. "We check their records carefully. We spend hours on them."

Currently, the agency is 100% Medicare, which makes complete computerization financially impossible. "We are very lean, and we survive because of our niche. Even as we diversify, it will be some time before we have our nurses on laptops."

Better than expected

Although Leveton was confident the agency would do well in a survey, she didn't leave anything to chance. For a year, they prepared by going through the JCAHO manual "page by page" says Markovich. "That was a great exercise. Our quality improvement program is in great shape now."

SOURCES

- **Yana Leveton**, Managing Director, **Vadim Markovich**, PA, RN, Clinical Director, InCare, 675 Geary Blvd., Suite 500, San Francisco, CA 94118. Telephone: (415) 673-8989.

Many of the forms were changed to make them more user-friendly. For instance, many were expanded to include more room for notes at the suggestion of the nursing staff.

Mock survey does its job

One major change that the agency made in the run up to the survey was a change in the medication profile. "We found out that when we received change orders for medications, we would send it to the physician for a signature before it was entered in the computer," says Markovich. "But entering it in the computer is what generates the new patient education materials. It could be up to a week before we get the signed order, and all that time, the patient doesn't have that education."

The process was altered so that the change is entered in the computer as soon as the change order is received verbally. "The nurse is then in the home with the medications and teaching materials from the start," he says.

In going through past charts, he adds there were about a dozen cases where drug interactions could have been an issue. "It was important to get that right," Markovich adds.

InCare also paid for a mock survey before the real one, which Markovich says provided some additional insights.

Leveton says the surveyor was so impressed with organization of the charts and extensive documentation that she told them she thought they would make a nice example for other agencies. In all, the surveyor only had a page of comments for the agency.

While going through the manual and conducting a mock survey certainly helped InCare to fly through the first survey, Markovich says it is as important to concentrate on finding "real ways to help people. In almost every weekly staff meeting, I say that the nurses should ask themselves, 'Is there something more they can do for the patient?' All the standards and legal requirements are finally addressing the same issue of regulatory guidelines. But what you really are here for is the patients."

Leveton says her future planning is all geared toward looking at the whole patient. "We want to see the big picture," she says. "The nurses have to approach each patient as if they are developing a story. The way they write their notes is more than putting facts on paper. When you read the documentation, you need to get a clear picture of this person."

By the end of the year, Leveton hopes to expand her business into temporary staffing and private pay, reducing Medicare to about half of her business. That way, she thinks she can bring her agency's way of meeting the special needs of patients to a wider community. ■

Agency works to improve outcomes with new teams

Goal is also to increase home health referrals

A West Virginia home care agency has begun a project that is expected to improve patient outcomes in cardiac care and other areas, as well as increase referrals to home health services.

Plus, since the agency is hospital-based, its new program may help the hospital prevent readmissions and emergency room visits by providing patients with home-based support. Although the results aren't in yet, managers are optimistic that the new program and its performance improvement teams will meet all of these objectives, says **Terrye O'Sullivan**, RN, assistant director of the Visiting Nurse Association of Medical Park in Wheeling, WV. The agency is a department of Wheeling Hospital.

"We formed a huge hospital discharge team, looking at the discharge process from beginning to end, including continuous care and home care," O'Sullivan says.

The hospital's focus on discharge strategies has an added benefit of encouraging more referrals to home health. Since the Wheeling area's managed care penetration is growing, home health services are looking more attractive to physicians who now must be cost conscious, O'Sullivan adds.

For instance, 45% of the overall home care population is covered by managed care companies, and soon that number will grow as Medicare patients switch to managed care products, she says.

This has shifted how and when patients are admitted to the hospital, as well as how long they are permitted to stay for observation. "Say a patient comes into the hospital emergency room last night, and the ER doctor thought they needed to be admitted into the hospital," O'Sullivan says. "The managed care case manager nurse can come in and say, 'This patient doesn't need to be admitted, and I'm putting this person on a 24-hour observation.'"

Or the managed care company may limit a patient's stay to three days, when previously the patient would be there twice as long. When this happens, it is in the physicians' best interest to write a home care referral prior to the patient's discharge. This way if the patient has a relapse of symptoms, a nurse will be able to provide assistance and contact the physician, perhaps preventing an emergency room visit.

The agency recently began working on convincing doctors to write referrals to home health while the patient still is in the hospital, and this way, it gives the patient enough time to choose a home health provider. Plus, the home care agency can begin treatment immediately after discharge, O'Sullivan says.

Agency lobbies for referrals with hospital booth

The VNA of Medical Park's lobbying efforts include setting up a table display in the hospital with patient educational material and other information about home health care. The table was set where both patients and hospital staff could see it.

O'Sullivan also gave an inservice on home health for every department in the hospital. She brought attendees pencils and pens with the agency's name imprinted on them.

"Hospital employees didn't know everything we did in home care," O'Sullivan says. "They thought we only treated patients with wounds and intravenous lines, and they didn't realize we could take care of patients just for teaching."

So far, it appears physicians are responding and increasing home health referrals, she adds. The agency is now receiving referrals from the emergency room (ER) department. Some of these referrals involve patients with Foley catheters who are at risk of forgetting their instructions about how to take care of the catheter — ending up back in the ER with an infection or another problem. Now, a home health nurse visits the patient after the patient leaves the ER simply to teach the patient how to take care of the catheter.

The agency also receives referrals from the recovery room and from other hospital

departments. While the referrals were a little slow at the start, O'Sullivan says she's encouraged that doctors are beginning to understand the importance of home care.

"It's new to doctors; they don't like insurance companies telling them what to do," O'Sullivan says. "But they also recognize the need to identify these [potential home care] patients earlier because of managed care pressures."

The performance improvement teams — called design teams — first began to focus on treatment of congestive heart failure patients. The 250-bed hospital had a high readmission rate with these patients, and hospital officials didn't want the rate exacerbated by the trend of payers pushing for lower hospital lengths of stay.

Also, when hospital officials looked at what type of education was given to CHF patients, they found that it wasn't consistent from nurse to nurse, says **Marsha Buterbaugh**, RN, clinical supervisor at the VNA of Medical Park, and a member of the design team.

Patient education lacked consistency

"Some patients were given a higher quality of education about how to take care of themselves, prior to discharge, and some were not," Buterbaugh says. "I was interested in the topic, because my background is in cardiac care and I wanted a continuation of patient education in the home care arena."

Buterbaugh and other members of the design team worked on a plan that would make patient education consistent and seamless as the patient went from the hospital into home care.

The hospital recently has begun to measure cardiac outcomes, looking at various indicators, including:

— Was the patient started on an ACE inhibitor at discharge?

— Was the patient instructed on a low-sodium diet?

— Is there documentation of patient education?

— Is there an order for home health follow-up visits?

"We want to keep patients from being readmitted; we feel that home health is a key component to reduce admissions," says **Tish Thoburn**, RN, BSN, case coordinator for care management at Wheeling Hospital.

The hospital is tracking the outcomes by calling patients. "We make follow-up phone calls, asking patients whether they understand the importance of a low-sodium diet and going over their medications with them," Thoburn adds. "And we're looking at all readmissions within 15 days."

Whether an agency is hospital-based or free-standing, it probably will help improve patient care and increase the agency's referrals if the agency aligns itself with a local hospital to provide consistent education and follow-up care to patients. Here's how the VNA of Medical Park and Wheeling Hospital did exactly that:

• **Design team members researched CHF treatment.**

The multidisciplinary team, consisting of a cardiologist, care management staff, respiratory therapy, pharmacy, and hospital and home health nursing staff, reviewed current medical literature about cardiac treatment. For example, they researched the use of pulse oximetry, which is a way of measuring oxygen in blood for CHF and other cardiac patients.

• **They created standards for CHF care.**

The design team drew up a plan for routine admission orders for CHF patients, and these orders would have to be signed by physicians, Buterbaugh says.

Then the team created a patient-care map that begins with admission and continues through discharge. The map lists exactly what patients are taught during each day of their hospital stay. So if a home care nurse begins to see a CHF patient after the patient leaves the hospital, the nurse will know where to begin with education and which areas to focus on, Buterbaugh explains.

"We review the education the patient received in the hospital and go on from there," she explains. "That way, we're not duplicating and know what is expected to have been done in the hospital so we can evaluate what the patient has retained."

• **The hospital and home health share educational materials.**

The design team decided that patient education needs to be consistent. The hospital nurses couldn't start teaching some things, and then home health nurses would teach something else. Now, the hospital and home health share educational materials.

This consistency also makes it easier for the home health staff to assess which information the patient has learned and which needs to be reinforced. For example, Buterbaugh says, it's quite common for CHF patients to be given new medications while in the hospital. The hospital nurses will teach them about their medication change,

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but when the patients return home, they become confused and often revert back to using their old medications.

As a result, the home health nurses will have information about exactly which medications the patient should be taking, plus documentation of how the patient was taught about these prescriptions. And when home health nurses report to physicians that the patient is taking they wrong medication, they also can give details about how the patient didn't retain this part of the hospital education. Therefore, it needs to be reinforced for X number of home care visits.

"That problem is one reason the hospital started the program for cardiac patients because doctors weren't aware of this issue," Buterbaugh says. "Now, home care nurses go out to visit a patient the day after hospital discharge and first check the patient's medications." ■

Check out these eight tips for better documentation

Home health standards expert gives advice

The next time you prepare for an accreditation survey or decide to speak with staff about documentation, you may want to clip these handy guidelines about how everyone may improve documentation.

"People do the care, but sometimes they don't document," says **Tina Marrelli**, MSN, MA, RNC, president of Marrelli & Associates in Boca Grande, FL. Marrelli is the author of the popular home care guide *Handbook of Home Health Standards and Documentation Guidelines for Reimbursement*, published by Mosby-Year Book Inc. of St. Louis in 1988. The third edition was published in 1998.

However, it's more important than ever in today's home care environment that nurses understand the importance of documentation, Marrelli says. "And maybe documentation hasn't been given the emphasis it needs."

This way to better documentation

Marrelli offers these eight simple guidelines to better documentation:

1. Educate staff on documentation.

"Documentation is an ongoing concern in all health care settings; but particularly in home care, education is the key," Marrelli explains. "And maybe some of us weren't taught documentation when we were hired, or maybe we didn't learn it at the last job."

Home care quality managers should make sure their staffs are taught about documentation when first hired, and they should review documentation annually in an inservice, she advises.

2. Remind staff that clinical records are important.

"Make sure their writing is legible and that everyone documents what they did," Marrelli says.

For example, if a nurse gives an injection, or wound care, the nurse should observe the patient's response and document that.

"What was the patient's response to our care intervention and what sort of analysis did we do?" she asks. "Look at all the assessed information and care provided and ask, 'How does that change the plan?'"

Then, the nurse should document whether the doctor was called and updated, and whether the agency needs to change the projected timeline for the patient, maybe discharging the patient earlier or providing more care and why, Marrelli adds.

3. Tell story through documentation.

The nurse's notes and the record documentation tell the patient's story from admission through discharge. Everyone involved in the documentation should make sure the story is complete.

"Make sure anyone reading that nursing note knows what's going on with the patient, including the specific wound care provided, and whether it was a sterile or non-sterile technique," Marrelli says. "This is so the patient receives the same level of care, regardless of who the provider is and everyone is literally on the same page."

4. Focus on identified problems.

Home care staff should change its mindset from that of working with potential problems to a mindset of focusing on identified problems, she suggests.

SOURCE

- **Tina Marrelli**, MSN, MA, RNC, President, Marrelli & Associates, P.O. Box 391, Boca Grande, FL 33921. Telephone: (941) 697-2900. Fax: (941) 697-2901.

"The classic example is a patient who has congestive heart failure (CHF) and diabetes," Marrelli says. "But if the patient's diabetes management is stable, then we're in there to focus on CHF and getting those medications regulated or whatever the problem is that got us involved in the care."

In home care's good old days when agencies were reimbursed based on costs, a home care nurse might have had the luxury to also reinforce the CHF patient's diabetes education. But those days are gone under the interim payment system (IPS), and agencies have shorter time frames to provide patients the care they need, so they need to focus on the identified problems, she explains.

5. Patient education is the key.

The new documentation environment calls for formal patient education. "This means, for example, the development of standardized patient education tools to make sure that all nurses are teaching from the same sources," Marrelli says.

The patient education sources should be reviewed by clinical specialists or be nationally accepted standards of practice, such as the standards developed by the Agency for Health Care Policy and Research in Rockville, MD.

The AHCPR has a national mandate from Congress to develop clinical practice guidelines for physicians, hospitals, and other health care providers.

6. Use clinical pathways.

"We're going to see an increased use of clinical pathways because it makes sense," Marrelli says. "It's a good way to standardize the care provided to a patient because we admit the patient in the same order, explain care in the same way."

One of the best features of clinical pathways is that the best standards of practice are already incorporated into them.

Or agencies can use other standardized care protocols that help support sufficient completion of documentation and cue interventions based on best practices.

7. Continually review documentation systems.

Look at your whole documentation system, including checklist tools and how the assessment form drives the care plan, Marrelli advises.

"If you just have a big narrative hole in your documentation form, then it's really hard for a nurse to think of what to write and what to leave out," she adds. "A lot of the best tools are a blend of narrative and checklist, and maybe even backed up with a glossary of what things mean at a given organization."

For example, a wound category could be referenced within a home care agency so that all nurses and physicians use the same terminology describing the wound and its treatment.

Everyone should be using documentation forms in the same way, whether these are the visit forms, care coordination forms, or any other type.

"Give clinicians a completed sample form as part of orientation or when there's an update to show them what this form should look like when it's completed," Marrelli says. "The form should be supporting care coordination so that anybody following up on care really has a picture painted of what happened to that patient."

8. Standardize care practices and documentation.

"As we move to a more outcomes-oriented environment, the only way we're going to get there is through standardization of care practices and documentation," Marrelli states.

"If the ingredients to get there aren't the same, there's no way to standardize comparisons," she adds.

Some home care agencies, for instance, will have a nurse follow up another nurse who has completed an OASIS assessment form by filling it out the same way. This way, the organization can make sure the form's documentation is standardized.

Also, a manager might validate the documentation on an OASIS tool as part of a standard performance improvement process. Quality managers could conduct random sample reviews of OASIS forms to make sure they are completed correctly and uniformly.

This focus on standardization should include all assessment tools, including pain management tools, Marrelli adds.

Standardization, along with these other guidelines, will help home care agencies protect themselves during payer or Medicare audits.

"There's no question that home care documentation continues to be under the spotlight," Marrelli says. "The government's initiatives like Operation Restore Trust are looking for ways to save money, and unfortunately, they've been successful in home care; our documentation can either help protect us, or maybe not." ■

An herbal primer for your agency

What's moved into your patients' medicine chests?

When the Irondale, AL-based home care agency Alacare installed a new computer system, it turned up an unexpected problem.

"We put in the new drug database, and all of a sudden I got a lot of nurses calling me to say there was no listing for Kava-Kava," recalls **DeAnna Minard**, RPH, the agency's pharmacy director.

Kava-Kava is an herb **(for more on popular herbs and their uses, see box on p. 78)**, and Minard noted there was no code number for this class of medication. That meant that neither it nor any other herb was in the off-the-shelf drug databases. At the same time, news about herbals was increasing, and Minard's professional associations started encouraging members to educate themselves on these issues.

The confluence of occurrences led Minard to create a series of inservice designed to help Alacare's nurses understand herbals and their uses. They, in turn, would be better able to assist patients who choose to use these — either as an alternative to more traditional drugs or in conjunction with them.

"If a patient complains of having red urine and you find no blood and nothing in their medications, you need to know that horse chestnut seed extract — a common treatment for hemorrhoids — might cause that effect," says Minard.

Herbal remedies are becoming so common that you can find well-known vitamin brands like One-A-Day including them in supplement preparations. You can even find teas and foods that have herbs such as ginkgo or St. John's wort added to them.

Lorraine Waters, MA, BSN, C, CHCE, director of Southern Home Care in Jeffersonville, IN, says her agency is also gearing up to deal with this issue.

"We have gathered articles, and I have distributed a newsletter on various drug-herb interactions," she says. Southern Home Care has also ordered a copy of the new Physician's Desk Reference for herbal medicines, which includes some 600 monographs on herbs. **(For more reading**

SOURCES

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- **DeAnna Minard**, RPH, Director of Pharmacy, Alacare, 2300 Crestwood Blvd., Irondale, AL 35210. Telephone: (205) 981-8556.

COMING IN FUTURE MONTHS

- ■ Make your data crisp, clean, credible
- ■ Now that you've got the data from OASIS — here's what to do with it!
- ■ Improve wound care following these tips
- ■ Pediatric home care is a hot area. Learn how one agency is making it pay
- ■ How staff satisfaction can improve your patient satisfaction scores
- ■ What to expect from the next JCAHO manual

Top 10 Herbal Remedies, Uses, Possible Contraindications, and Side Effects

- **Echinacea.** Commonly used to stimulate the immune system. Should not be used in patients allergic to plants in the daisy family. Patients with kidney disorders should not take for longer than 10 days. Use with caution in pregnancy or lactation.
- **Garlic.** Commonly used as a treatment for atherosclerosis, hypertension, and immune-stimulating properties. Rare reports of allergic reactions. Those taking aspirin or anticoagulants should avoid large amounts due to potential bleeding problems. May cause heartburn, flatulence, and halitosis.
- **Ginkgo Biloba.** Ginkgo has been shown to enhance circulatory functioning by increasing vasodilatation and peripheral blood flow rate. Used to improve memory and concentration, cerebrovascular insufficiency, heart disease, and dementia. May be of concern in patients taking anticoagulants. Can cause GI disturbances, headache, skin reactions, restlessness. Death has occurred with large doses.
- **Ginseng.** Most commonly used to increase stamina and endurance and protect against stress induced illness. Avoid in children and in patients with hypertension, psychological imbalances, headaches, heart palpitations, insomnia, asthma, inflammation, infections with high fever, and pregnancy. May cause hypertension, euphoria, restlessness, nervousness, insomnia, skin eruptions, edema, and diarrhea. May also have an estrogen-like effect in postmenopausal women. Has an increased effect on hypoglycemics and possible toxicity with MAO inhibitors.
- **Hawthorn.** Widely used in Europe to dilate the smooth muscles of the coronary vessels as a treatment for angina. Not useful for acute angina attacks, and may increase heart rate.
- **Horse Chestnut Seed Extract.** Used as an astringent and anti-inflammatory on the vessels of the circulatory system. May aid the treatment of phlebitis, varicose veins, and hemorrhoids. May increase the effect of anticoagulants. May cause GI irritation. Isolated cases of renal, hepatic toxicity, and anaphylactic reactions have been reported.
- **Kava-Kava.** Used as a local anaesthetic. The root has also been used to treat gonorrhea, vaginitis, nocturnal incontinence, and as a diuretic for treatment of gout, rheumatism, and bronchial ailments due to heart disease. Most commonly used to treat nervous anxiety, stress, and restlessness. Not recommended for treatment of depression, during pregnancy or lactation. Avoid concomitant use with alcohol, barbiturates, and CNS depressants. May cause mild GI disturbances, allergic skin reactions, or accommodative disturbances.
- **St. John's Wort.** Used as an antiviral, antibacterial, and antidepressant. Avoid concurrent use with SSRIs, MAO inhibitors, tyramine-containing products, alcohol, or narcotics. May cause photosensitivity, GI disturbances, fatigue, weight fluctuations, dry mouth, and dizziness. May increase digoxin effects.
- **Saw Palmetto.** Used for its anti-inflammatory effects on the prostate. May also have beneficial effects in the treatment of asthma, bronchitis, and breast enlargement in women. May cause mild GI disturbances.
- **Valerian.** Used to treat nervous tension relate stress, insomnia, anxiety, muscle tension, and PMS. The "Valium of the 19th Century." Should not be taken during pregnancy or lactation, or with alcohol. May cause headaches, giddiness, restlessness, nausea or agitation. May increase the effects of CNS depressants.

Suggested reading

- DerMarderosin A. *New Ideas in Herbal Therapy*. Power-Pak Communications; 1998.
- Fetrow C., et al. *Complimentary & Alternative Medicines*. Springhouse Corp.; 1999.
- American Council for Pharmaceutical Education. *Guidelines for Recommending Natural Supplements to Patients, Part 1*.
- Muller J., et al. *Top Herbal Products Encountered in Drug Information Request (Parts 1 & 2). Medscape, Drug Benefit Trends,* [10(5) & 10(6)]: SCP Communications; 1998.
- Tyler V. *Herbs of Choice: The Therapeutic Use of Phytomedicinals*. Pharmaceutical Products Press; 1994.

Source: Alacare, Irondale, AL.

and information sources, see box, p. 79.)

She plans to have staff record herbals in the patient medication record and provide education to patients on side effects and danger signs to patients. Unfortunately, Waters doesn't think that she can add information on the herbs to her existing electronic drug portfolio.

Minard says before she started providing education, she had to decide what nurses needed to at inservices. "We wanted it to be

More Resources

Web sites

- American Botanical Council — www.herbalgram.org.
- National Institutes of Health Office of Dietary Supplements — odp.od.nih.gov/ods.

Publications

- McGuffin M, Hobbs C, ed, Upton R, ed. *American Herbal Products Association's Botanical Safety Handbook*. CRC Publishing; 1997. $59.95.
- Medical Economics Data. *Physicians' Desk Reference for Herbal Medicines.* 1998. $59.95.
- Fetrow CW, Avila JR. *Professional's Handbook of Complementary and Alternative Medicines*. Springhouse Publishing; 1999. $39.95.
- Schulz V, Rudolf H, Tyler VE. *Rational Phytotherapy: A Physician's Guide to Herbal Medicine*. Springer Verlag; 1998. $49.95.
- Peirce A, Gans JA, Weil AT. *The American Pharmaceutical Association Practical Guide to Natural Medicines*. William Morrow & Co; 1999. $35.00.
- Foster S, Tyler VE. *Tyler's Honest Herbal: A Sensible Guide to the Use of Herbs and Related Remedies*. Library Binding; 1998. $49.95.

practical and geared towards taking care of patients," she says. "When we started, we included things like medicinal chemistry, mechanisms of action, and pathways."

That wasn't popular with staff.

"Our evaluations were less than good," she admits. "We revamped, spending more time talking about the results of studies and the things that some of these drugs can do."

Part of the inservice seminars also focuses on how to get information out to the patients about herbals, and how to deal with patients who might not be forthcoming about all the preparations they are taking.

"A lot of patients don't recognize that these herbs are medicines," says Minard. Still, others might be embarrassed about taking something like St. John's wort for depression. Yet knowing this can be vital. If a patient is taking another drug for depression, such as Prozac, mixing in an herbal remedy can have serious consequences.

"When nurses do the initial assessment, they have to often look through all the meds, and so that is one way they find out," she says. The nurses seem to have a way of teasing information from otherwise recalcitrant patients.

Waters says that getting this information from patients is something of an art. "I think it depends in part on the interviewer," she says. "Tact is a very useful tool. But remembering to ask can be a problem. Perhaps we should all take our ginkgo biloba!"

Once they know what a patient is taking, nurses at Alacare include information on any herbal preparations as part of the medication profile and forward it to the primary care physician.

Minard says she is still finding a lot of gaps in knowledge about herbs among physicians, and that she has to do some educating, as well. "Some are sending their nurses to seminars on herbals," she says, "but they don't go themselves."

One thing that Minard learned as she prepared for the inservices is that you have to be careful

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about the sources of information you use to educate yourselves.

"A lot of the manufacturers and sellers over the Internet may have information, and it may be legitimate. But if they start telling you how to buy it, then instantly, you should question the validity."

Updates to her educational material are probably inevitable, says Minard, as more information about existing herbal remedies emerges, and as new herbal preparations are released. "But we will probably do a lot of communication through e-mail or newsletter formats."

Patients are much more educated about herbal medicines than you may think, says Minard. "They have read up on this, but you can't always be sure about the quality of the information they get. They may be getting something from their neighbor or sister-in-law, and that might not be appropriate. Or it might come without any information at all. And if our patients are out there using this stuff, then we have to be ever mindful of it. We have to know at least as much as they do." ■

NEWS BRIEF

HCFA delays OASIS again

The latest word from the Health Care Financing Administration (HCFA) on OASIS data collection, encoding, and transmission came down from the organization in late April. According to a release from the HCFA Web site, www.hcfa.gov, until there is some "clearance" under the Paperwork Reduction Act, agencies don't have to use OASIS.

Once those clearances are obtained, HCFA will issue a notice on its Web site, and publish the same notification in the Federal Register. "In the meantime, we are not requiring [agencies] to use the OASIS instrument. HHAs that were not meeting the requirements on or after the Feb. 24 effective date will not be held out of compliance."

For those agencies that were notified that encoding OASIS data was a condition of participation beginning on March 26, with transmission slated to start a month later, that has also been suspended. The HCFA notice says that not only does the organization need to get clearances under the Paperwork Reduction Act, but will also need to prepare and an individual Privacy Act notice for patients, and publish a Privacy Act notice of the existence and character of the OASIS system of records. ■

CE objectives

After carefully reading this issue of *Homecare Quality Management*, CE participants will be able to:

1. Describe good strategies for preparing for a survey by the Joint Commission on Accreditation of Healthcare Organizations of Oakbrook Terrace, IL.
2. Express the major steps needed to improve documentation. ■