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HOMECARE
Quality Management™

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Push for an improved fall prevention program brings better patient health

Florida agency cuts falls from 12% to 4%

You can cut your patients' risk of falling by 75% as an Inverness, FL, home care agency did by following a program that includes comprehensive fall risk assessment, patient education, and thorough outcomes tracking.

"We began tracking patient falls in 1994 after noticing the number of patients admitted to the hospital or ER [emergency room] due to falls," says **Jan Powers**, RN, director of Citrus Memorial Home Health Agency, a hospital-based agency in Inverness.

The agency had routinely tracked patients admitted to the hospital or ER, but needed a standard for tracking admissions caused by falls.

First, the agency reviewed literature on fall risk and prevention in the elderly, looking for benchmark data. The quality improvement (QI) department divided the information between the risky activities that a home care agency could prevent and those it couldn't.

"The literature told us how falls happen," Powers says. "We tried to see what area we could work on and to understand what areas of fall prevention we'll never have any control over."

For example, a home care agency cannot make a patient use a walker or cane when the agency's staff are not present.

Still, there are many ways home care aides and nurses can help patients prevent falls, so the QI staff selected a goal of limiting hospital readmission and ER visits due to falls to 10% of the agency's patient census during a particular month.

When the percentage of patients returning to the hospital due to falls rises above 10%, it triggers a chart review process in which the quality manager assesses the cause of the problem, says **Lisa Place**, RN, quality improvement supervisor.

Since the agency's program began, the percentage of readmission and ER visits due to falls has dropped from 12% in the worst month to 4% in a recent month.

Here's how Citrus Memorial Home Health Agency achieved those results:

1. The QI staff created an outline for a fall prevention program.

The QI staff conducted research into the stages of fall prevention and how to identify risk factors. Then they incorporated their findings in a two-page outline that also includes admission procedures, ongoing procedures, and documentation requirements. **(See fall prevention program outline, p. 83.)**

The outline covers the areas the agency planned to teach staff, such as how the nurse determines when to refer a patient to the fall prevention program and how to teach the patient and family about fall prevention. The QI staff passed the program out to all staff and covered it at a staff meeting.

The staff also helped with the outline and program revisions. For example, the first version made no mention of a risk factor involving patients on multiple medications. The staff pointed out that this was a problem, and that is now listed on the outline.

2. Give staff patient education material.

The QI staff wrote a one-page fall prevention guidelines sheet for patients to sign. The tool serves as a way to educate patients and their caregivers about how to make their homes safer, wearing safer clothing and shoes, using adaptive equipment, and taking safety precautions when in motion. **(See Fall Prevention Guidelines, inserted in this issue.)**

The staff put the tool in patient education folders so nurses can easily pull it out and hand to patients.

"On the first visit, nurses present guidelines to patients and say, 'We're here to help you prevent any unnecessary injuries, and your cooperation is essential,'" Powers says.

Then nurses discuss the safety precautions listed on the guidelines; after the patient signs the guidelines, the nurse also signs.

3. Show staff how to conduct thorough and accurate risk assessments.

At first, the agency QI staff left the risk assessments to the nurses' discretion. If a nurse felt a patient was at risk for falls, then the nurse could conduct a risk assessment. A high score on the assessment tool would put the patient into the fall prevention program. The tool consisted of 25 fall risk items, nine mobility safety assessment items, and additional space for nurses to comment. **(See fall risk assessment tool, inserted in this issue.)**

While it seemed that everything was working well under this system, the hospital readmission percentage climbed to over 10% — the control limit — the QI staff knew it had to make a change in the process.

"We changed our risk assessment procedure to automatically putting everyone on it rather than just leaving it up to the nurse to decide," Powers says.

The agency gave nurses a new assessment form that included a small section on fall risk. The fall risk items were condensed to 15 items, and if the nurse checked more than two of these, he or she was instructed to initiate the fall prevention program. **(See assessment tool, inserted in this issue.)**

Read the instructions

4. Educate aides on how to use home care equipment.

The aide care plan lists all of the different devices that may be used in a patient's home. It's up to nurses and supervisors to make sure aides know how to use them and how to make safety precautions in the home.

For example, the one-page home health aide care plan lists 12 different pieces of equipment, six safety precautions, and 13 limitations that may result in patients being at a greater risk for falls.

The agency makes sure aides are taught how to use the equipment and how to handle the safety precautions that are checked on each care plan. The plan also has a place for checking activities that require the aide to help the patient. Plus there may be special instructions written on the plan. **(See Home Health Aide Care Plan, inserted in this issue.)**

"The plan tells aides how much assistance they need to give, whether they need to have the caregiver help them, and whether they will be transferring the patient from the bed to the chair, etc.," Powers explains.

5. Continue evaluating program's outcomes.

When the agency's fall statistics climbed above 10% in 1997, the agency conducted an in-depth survey by reviewing charts of all patients who had falls.

"The QI department looked at whether the patient was put on the fall prevention program or whether anything was left out that should could have prevented the fall," Place says.

The chart reviewers asked these questions:

- **Was the patient identified at admission as at risk for a fall?**
- **Was the patient given the fall prevention guidelines?**

• Was the fall caused by something the agency could have prevented?

• Was the fall caused by patient noncompliance?

Depending on the answers, the QI staff recommended changes. For instance, if the patient exhibited noncompliance, the nurse was told to reinforce patient education on fall prevention.

That was also when the QI staff decided to switch to having fall risk assessments done on each patient.

Soon, the percentage fell and remained stable below 10%, and the agency stopped the automatic chart audits. It will initiate them again only if the number of falls rises above 10%, Place says. ■

A Florida agency tackles a fall prevention program

Citrus Memorial Hospital in Inverness, FL, has created a successful fall prevention program that included teaching nurses how to identify patients at risk for falling and teach them strategies to prevent falls.

The agency built its program from this outline, which it shares with *Homecare Quality Management*:

Fall Prevention Program

• Fall definition: An event resulting in a person or body part of the person coming to rest inadvertently on the ground or other lower surface level.

I. Stages of Fall Prevention

A. Prefall (primary prevention): Preventing or decreasing the likelihood of falls

1. identify persons at risk;
2. educate for prevention;
3. modify environment;
4. adaptations for mobility safety;
5. maintaining/improving fitness.

B. Actual falling event (secondary prevention): Decreasing the morbidity that results from falls

1. identify current mobility status;
2. limit injury.
   a. teach balance techniques;
   b. teach assistive devices.

C. Postfall (tertiary prevention): Decreasing disability from falls; preventing complications

1. ensure medical attention is available;
2. rehabilitation.

II. Identification of Risk Factors

A. History of previous falls

B. History of neurological defects

C. History of dizziness

D. History of compromised mental status

E. History of impaired sensory function

F. Environmental hazards present

G.History of health problems

H. Frequently degree of social isolation or lack of personal support in home

I. Female older than 75 years of age

J. History of usage of assistive devices

K. History of general inactivity, decreased mobility

L. History of multiple medications

M. History of alcohol/substance abuse

III. Procedure

A. Admission

1. RN will initiate fall risk assessment if appropriate.
2. If fall risk assessment score indicates program participation, RN initiates fall prevention program.
3. RN issues fall prevention guidelines to patient/family, begins education. The nurse and patient/caregiver will sign form.
4. RN may contact physician for physical therapy evaluation.
5. RN will instruct home health aide (as appropriate) on program participation and enter interventions on aide care plan.

B. Ongoing

1. Nurse and/or therapist will review the status of the program, including compliance on a weekly basis with the patient, caregiver, team, and document ongoing status.
2. If patient is not on the fall prevention program and a fall occurs, nurse will initiate fall prevention program on that patient.
3. At any time that nurse/supervisor deems necessary/appropriate, nurse can initiate program on patient.
   a. may be referred through home health aide department;
   b. may be referred through therapy discipline.
4. Supervisor/nurse will contact physician as necessary to inform physician of occurrence and patient status.

C. Documentation

1. Nurse will document on initial assessment that fall prevention program has been initiated.
2. Nurse will enter aide participation onto home health aide care plan as appropriate.
3. Nurse will maintain documentation on clinical notes, delineating teaching, interventions performed, and patient/caregiver response to teaching and interventions. ■

Turning your survey into child's play

Preparation, preparation, preparation is the key

Editor's note: This is part of a continuing series of stories about agencies that received accreditation with commendation from the Joint Commission on Accreditation of Healthcare Organizations.

There are growing opportunities for agencies that provide pediatric services — perhaps as much as a $5 billion market for pediatric home care is there for the taking. But such growth can create problems — like how to find adequate and appropriately trained staff, plus trouble with limited third-party insurance reimbursement, and the work it takes to meet state and federal government regulations.

But Pediatric Services of America's (PSA) Santa Cruz, CA, branch overcame those obstacles a year ago to become accredited with commendation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

According to **Bev Grammer**, RN, MPA, director of nursing and an administrator at the agency, says PSA's success was predicated on the same fundamentals that other agencies profiled in this series indicated were important: long term preparation and reviewing the JCAHO manual page by page.

"We didn't prepare at the last minute," says Grammer. "We started a year before the survey."

The agency took every chapter in the JCAHO standards manual and created training sessions. "The four supervisors and management read through the materials at least a dozen times," she says. "Then we did an inservice."

The hourly inservice was done as part of the regular weekly supervisor's meeting. As part of a larger corporation — there are 110 branches around the country — PSA also benefited from the experience of other branches and the resources of the corporate office.

"Our national quality improvement director came out and spent time with us," Grammer recalls, "doing training, auditing personnel files and charts." The results of those audits were discussed with the Santa Cruz management and passed on to supervisors and staff in the form of a checklist of items that needed attention.

After management and nursing supervisors went through those items, the staff was apprised of the problems through memos and a quarterly quality improvement newsletter. "It just didn't make sense to pull 90 or 100 people in for an inservice, especially when some live an hour away," Grammer explains. "We wanted to get the most information out as quickly and cheaply as possible, and this was what we decided to do."

Once the agency went through the manual and had the corporate audits, PSA held a mock survey. The benefits of that early preparation paid off in some concrete ways. In one instance, chart audits found that inadequate attention was being paid to matching medical and administration records to the medication profile for clients. That led to an ongoing medication tracking system.

Above and beyond the norm

But Grammer thinks there was more to the commendation than just preparing to JCAHO standards. She says it was successful partly because PSA Santa Cruz went beyond what the commission and even PSA's corporate policies demand. For example, the agency has been concerned about staffing trends and the difficulty the agency was having in keeping good employees on staff.

Grammer formed a committee that looked at percentages of staffing per client and tried to find ways to deal with turnover and retention problems — something that plagues most agencies these days. The result was some new and better ways to recruit nurses. "I think the surveyor was impressed that we had a year of documentation on this committee and its efforts and that it went beyond what our corporate office demanded. To take the tools we have available to us and turn it into something that achieves a positive outcome is something special."

What makes the surveyors sit up and take notice, Grammer continues, is to take a problem and look at it in a structured way. "You have to go beyond the basic, and then you have to track your records and monitor them meticulously."

Grammer says it's easy to fall into the trap of preparing for a survey just a couple of months prior to recertification. "But if you have your procedures in place and adhere to them, you don't have to scramble. There are just some things you have to do continuously."

For instance, she says, you can't look through every chart two months before a survey. Nor can you read every nursing note. But you can have your supervisors divide the task of looking at

SOURCE

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chart orders, medical records, and medication profiles for a several-month period. Those kinds of continual efforts pay off. In one instance, Grammer found that nurses were not thoroughly documenting patient weight. "It was hard for bed-bound patients, but it's important to do."

Grammer never thought the survey would turn out badly. "I knew we were thorough. But I was still pleasantly surprised when we got the commendation."

Luck — or at least felicitous timing — can play a part in such success, too. One client came out from the hospital the day before the survey and the surveyor was taken to the client's home. "The case was beautifully set up, the family could demonstrate we communicated education to them, and the discharge went well. I'm sure that helped."

There is a danger that staff can get complacent, Grammer says, especially after you let them know you received a commendation. "But another trap you can fall into is that they don't come for another three years. The key is not to do nothing during that time. You have to stay on top of changes, both from our corporate office and guidelines and rules from the government and from the commission." ■

Track infection control to minimize troubles

Here's how one agency tackled the job

Tracking infection control problems in home care might be a little like trying to count beaks in a flock of migrating birds.

But as tricky as the task might seem, it can be done through a careful quality improvement process. Done correctly, thorough surveillance could lead to better infection control outcomes.

For instance, a Lexington, KY, agency has found through tracking infection rates that it is unnecessary for the agency to pull cultures from wounds of every patient and then treat them with antibiotics. "Our medical director is adamant that you very rarely culture wounds," says **Casey Hamblen**, RN, QA specialist for Saint Joseph Home Care Services in Lexington. The hospital-based agency serves a six-county area around Lexington.

"He's on the conservative side as far as treatment and I've seen a significant decrease in the number of wound cultures we do, but we still have the same rate of healing," Hamblen says.

Nurses follow the new philosophy by not calling a patient's doctor unless the patient's wound meet the infection criteria the agency adopted as part of its new surveillance program. For example, cloudy urine doesn't meet the criteria for a urinary tract infection because this could also be a sign of some other problem, such as a change in hydration. But if the patient is feverish and also has cloudy urine, this does meet the infection criteria.

This was a major shift in the agency's culture because traditionally patients were treated more liberally. This created an environment conducive for antibiotic-resistant bacteria to flourish. "Patients would get resistant organisms because the doctor treated them with two to three different antibiotics and the organism would [infect] a wound and be impossible to treat," she adds.

Without having a good surveillance program in place, the agency wouldn't have realized that a more conservative treatment regimen could lead to the same positive outcomes.

Secrets of St. Joseph

Saint Joseph Home Care Services started its in-depth infection surveillance program two years ago with these steps:

1. Seek expert help.

"I was very fortunate because our medical director happens to be an infection disease doctor and was an excellent resource," Hamblen says. "He helped me come up with the idea that we needed to develop a way to have patient days and device days so that our numbers made sense to people."

For every device used, Hamblen broke it down by devices, such as an indicator for how many days a patient had on a Foley catheter.

Other indicators were:

- **How many patient days?**
- **How many days for intravenous lines?**
- **How many days for tracheostomy tubes?**

While the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations recommends that agencies monitor

all infections, the agency decided to report only home health care-related infections.

"Before that I was reporting everything, including ear infections," Hamblen says.

And while the agency still looks for specific infection trends that are unrelated to devices — such as a spread of bronchitis if a particular nurse has bronchitis — for the most part the surveillance tracks only infections that clearly could be related to home health care treatment.

The medical director also steered Hamblen to finding infection definitions in literature published by the Atlanta-based Centers for Disease Control and Prevention (CDC). **(See sample of CDC's infection definitions, p. 87.)**

Hamblen wrote the agency's infection definitions according to 1988 CDC criteria for nosocomial infections. These criteria included definitions for:

- **surgical wound infection;**
- **primary bloodstream infection;**
- **urinary tract infection;**
- **bone and joint infection;**
- **cardiovascular system infection;**
- **central nervous system infection;**
- **eye, ear, nose, throat, and mouth infection;**
- **gastrointestinal system infection;**
- **lower respiratory tract infection (excluding pneumonia);**
- **reproductive tract infection;**
- **skin and soft tissue infection;**
- **systemic infection.**

Hamblen's last step was to develop a surveillance plan that outlined how the data would be collected and reported, and which definitions would be used. **(See infection surveillance plan, p. 87.)**

2. Develop surveillance tools.

The agency's new infection report form is a simple, one-page form with places for nurses to put check marks next to the site of infection, signs and symptoms noted, and the current status of the patient. **(See Saint Joseph's infection report, inserted in this issue.)**

The agency also uses a patient device control report, which also is a simple, one-page form. This report lists the various devices and has a spot for up to five patient identification numbers, the number of days the device was in place, and whether an infection was noted. **(See patient device control report, inserted in this issue.)**

Since the agency is small and its documentation is not entirely electronic, nurses fill out the forms on paper and Hamblen keeps a paper log, listing the patient's name, the nurse's name, the onset date of infection, the site of infection, and how it was treated.

She has also started to use a census field on her computer to track which patients had devices and the dates those devices were put into place.

Finding a shortcut

Each month, Hamblen adds up the infection numbers and indicators' data and reports them to the agency's quality assurance committee and medical director.

But most of her surveillance work was done manually. "For six months, I read every order that our nurses wrote to see when patients were put on antibiotics," Hamblen says. "Now we have a method where if a director, who receives copies of all prescription orders, sees an order with an antibiotic, she copies that and gives it to me."

3. Train staff and monitor infection control trends.

Nurses learned that they must follow the CDC definitions for infection and refer to the 1988 report if they had any questions.

For example, patients who have Foley catheters have a higher rate of urinary tract infections (UTIs). So the agency reinforced staff education about the correct techniques to use with patients on these devices.

"And we made sure everyone is treating according to the criteria for UTIs," Hamblen says.

Sometimes the nurses have no control over whether a patient is treated for a UTI because patients occasionally will treat themselves by calling their physicians, asking for antibiotics when they feel they might have an infection, she notes.

"In those cases we don't know if they had a true UTI, but we document it as one," Hamblen says.

After collecting data each quarter and after one year, Hamblen gave a report on the trends and the results to the home care agency's quality assurance committee, advisory board, and even to the hospital's quality improvement committee.

She found no evidence that the agency's nurses had problems with techniques and were causing infections, so there were no resulting QI infection control projects. However, Hamblen says, she continues to track all infections. "But I only write reports on the ones where we've had some impact."

(Editor's note: For a copy of the "CDC Definitions for Nosocomial Infections, 1988," which is from the Hospital Infections Program, Center for Infectious Diseases, CDC, contact the National Technical

SOURCES

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Information Service, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161, order No. PB 88-187117.) ■

Check these definitions for wound and other infections

The Atlanta-based Centers for Disease Control and Prevention (CDC) has created concise definitions for a variety of nosocomial infections. Here are some sample definitions of what the CDC says should be observed before the patient is diagnosed as having a nosocomial infection:

• **Surgical wound infection**

Surgical wound infection includes incisional surgical wound infection and deep surgical wound infection.

Incisional surgical wound infection must meet the following criteria: Infection occurs at incision site within 30 days after surgery AND involves skin, subcutaneous tissue, or muscle located above the fascial layer AND any of the following:

1. Purulent drainage from incision or drain located above fascial layer.

2. Organism isolated from culture of fluid from wound closed primarily.

3. Surgeon deliberately opens wound, unless wound is culture-negative.

4. Surgeon's or attending physician's diagnosis of infection.

Deep surgical wound infection must meet the following criterion: Infection occurs at operative site within 30 days after surgery if no implant* is left in place AND infection appears related to surgery, AND infection involves tissues or spaces at or beneath fascial layer AND any of the following:

1. Purulent drainage from drain placed beneath fascial layer.

2. Wound spontaneously dehisces or is deliberately opened by surgeon when patient has fever (>38° C) and / or localized pain or tenderness, unless wound is culture-negative.

3. An abscess or other evidence of infection seen on direct examination, during surgery, or by histopathologic examination.

4. Surgeon's diagnosis of infection.

• **Urinary tract infection**

Urinary tract infection includes symptomatic urinary tract infection, asymptomatic bacteriuria, and other infections in the urinary tract.

Symptomatic urinary tract infection must meet one of the following criteria:

1. One of the following: fever (>38° C), urgency, frequency, dysuria, or suprapublic tenderness AND a urine culture of $>10^5$ colonies / ml urine with no more than two species of organisms.

2. Two of the following: fever (>38° C), urgency, frequency, dysuria, or suprapubic tenderness AND any of the following:

a. Dipstick test positive for leukocyte esterase and / or nitrate.

b. Pyuria (>10 white blood cells [WBC] / ml^3 or >3 WBC / high-power field of unspun urine).

c. Organisms seen on Gram stain of unspun urine.

d. Two urine cultures with repeated isolation of the same uropathogen** with $>10^2$ colonies / ml urine in nonvoided specimens.

e. Urine culture with $<10^5$ colonies / ml urine of single uropathogen in patient being treated with appropriate antimicrobial therapy.

f. Physician's diagnosis.

g. Physician institutes appropriate antimicrobial therapy.

3. Patient <12 months of age has one of the following: fever (>38 degrees C), hypothermia (<37 degrees C), apnea, bradycardia, dysuria, lethargy, or vomiting AND urine culture of $>10^5$ colonies / ml urine with no more than two species of organisms.

4. Patient <12 months of age has one of the following: fever (>38 degrees C), hypothermia (<37 degrees C), apnea, bradycardia, dysuria, lethargy, or vomiting, AND any of the following:

a. Dipstick test positive for leukocyte esterase and / or nitrate.

b. Pyuria.

c. Organisms seen on Gram stain of unspun urine.

d. Two urine cultures with repeated isolation of same uropathogen with $>10^2$ organisms / ml urine in nonvoided specimens.

e. Urine culture with $<10^5$ colonies / ml urine of a single uropathogen in patient being treated

with appropriate antimicrobial therapy.

f. Physician's diagnosis.

g. Physician institutes appropriate antimicrobial therapy.

Asymptomatic bacteriuria must meet either of the following criteria:

1. An indwelling urinary catheter is present within seven days before urine is cultured AND patient has no fever (>38 degrees C), urgency, frequency, dysuria, or suprapubic tenderness AND has urine culture of $>10^5$ organisms / ml urine with no more than two species of organisms.

2. No indwelling urinary catheter is present within seven days before the first of two urine cultures with $>10^5$ organisms / ml urine of the same organism with no more than two species of organisms, AND patient has no fever (>38 degrees C), urgency, frequency, dysuria, or suprapubic tenderness.

• **Lower respiratory tract infection (excluding pneumonia)**

Lower respiratory tract infection (excluding pneumonia) includes infections such as bronchitis, tracheobronchitis, bronchiolitis, tracheitis, lung abscess, and empyema.

Bronchitis, tracheobronchitis, bronchiolitis, tracheitis, without evidence of pneumonia, must meet either of the following criteria:

1. Patient has no clinical or radiographic evidence of pneumonia AND has two of the following: fever (>38 degrees C), cough, new or increased sputum production, rhonchi, wheezing, AND either of the following:

a. Organism isolated from culture obtained by deep tracheal aspirate or bronchoscopy.

b. Positive antigen test on respiratory secretions.

2. Patient <12 months of age has no clinical or radiographic evidence of pneumonia AND has two of the following with no other recognized cause: fever (>38 degrees C), cough, new or increased sputum production, rhonchi, wheezing, respiratory distress, apnea, or bradycardia AND any of the following:

a. Organism isolated from culture of material obtained by deep tracheal aspirate or bronchoscopy.

b. Positive antigen test on respiratory secretions.

c. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen.

Other infections of the lower respiratory tract must meet one of the following criteria:

(1) Organisms seen on smear or isolated from culture of lung tissue or fluid, including pleural fluid.

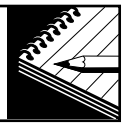
(2) Lung abscess or empyema seen during surgery or by histopathologic examination.

(3) Abscess cavity seen on radiographic examination of lung.

*A nonhuman-derived implantable foreign body (e.g., prosthetic heart valve, nonhuman vascular graft, mechanical heart, or hip prosthesis) that is permanently placed in a patient during surgery.

**Gram-negative bacteria or *S. saprophyticus.* ■

GUEST COLUMN



12 C's of home health care clinical documentation

These are all 'C'ritical to your success

By **Michelle Boasten**

Worried about getting your documentation right? If you get these dozen items right, you will have a lot less to worry about.

1. Clinical Note.

Each home care visit by any discipline requires an individual record of the visit. It must include the client's full name. The state surveyors are looking for the note and if it's missing, it's as good as not being done. The clinical note itself is the only evidence that a billable home care visit has taken place. The clinical note is the legal accounting and record of the visitation made between the home health care professional and the client.

2. Clarity.

The note needs to be legible. If the surveyors cannot read the note, it is not as bad as if it were not there at all, but it's the next worse thing to not begin there. If the field staff have illegible handwriting, then it should be printed.

3. Content.

The content of a note is what was done in the home — what happened on the visit. Content are things like skills, tasks, duties, patient responses, etc. Certain skills in home care are not reimbursable. Therefore, you need to be sure that what was done is worthy of being billed.

4. Compliance.

Each note must be compliant with the visit pattern established on the doctor's orders. Best known to home care professionals as the 485 or plan of care, an established visit pattern like 2wk8 means two visits every week for eight weeks. If one is missing or if one is added, it must be justified and documented. This justification should properly be handled on a telephone order. This order needs to be signed by the physician.

5. Congruence.

The message each discipline sends must be congruent with the other disciplines. If the aide documents the patient is walking and the nurse documents that the client is bed-bound, there's a problem. This is a frequent problem found by surveyors. It is important that everyone be on the same page. When reviewing a home care record, it is very important to assess all notes from all disciplines in sequential order.

6. Changes.

Every change must be documented. Medicare wants to see changes. Medicare does not pay for custodial care only or even for maintenance visits. Be sure to look for the progress of the client. Any change, whether progressing or digressing, needs to be clearly documented.

7. Contradiction.

The initial paperwork includes a referral and new orders. The 485 is generally established within 48 hours of the initial assessment. Make sure that everything else that follows throughout the clinical documentation makes sense. Let's say you start to find blood sugar reports, but there are no orders; and furthermore, there is no diagnosis of diabetes anywhere. This is an obvious clinical contradiction. Likewise, say that the aide is doing tub baths, but the care plan clearly states bed baths. This is a contradiction. Contradictions are red flags to surveyors.

8. Continuity and Consistency of Care, NOT the Caregiver.

Many times in home care you would love to have continuity of the caregiver, meaning the same caregiver for each visit. But this can be nearly impossible as an agency grows. Medicare isn't looking for consistency of caregivers; it is looking for continuity of care. That means that every caregiver delivers the same type of care. That means that Nurse Maggie, Nurse Ann, and Nurse Nancy all deliver the insulin in the same way or that they conduct their cardiac assessments in the same way. This is true in an inpatient setting, and it should also hold true in a home care environment.

9. Complaints.

Surveyors want to see the complaints of the clients and how you follow up with them. Each agency should have grievance procedures and protocols. If there is a complaint or problem, documentation and follow-through needs to be evident throughout the documentation.

10. Comments.

Your clients are introduced to the surveyors by and through your words. Bring your clients to life by quoting them in your notes. What comments do they make? Jot down what they say about their care and about the services you provide. Remember that your notes have to justify payment.

11. Conflicts and Confrontations.

If anything is not right, if anything does not look right, if there's a problem, it needs to be on a note, case conference, or incident report. Again, each agency should have a protocol and procedure on how to handle problem or incident reports.

12. Closure.

Each note needs to have a complete end. The note is a legal record and accounting of what happened and when. It must include the worker's signature, date, visit start time and visit end time.

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Train your staff to keep abuse in check

Are your policies up to date?

It is the kind of case that makes readers cringe. For decades, a disabled woman was abused by her spouse. The warning signs were either ignored or, when reported, lost in the bureaucratic shuffle between social workers and state health department officials. The case, which broke in Washington state in May, has led to calls for changes in policies by the governor, and increased training for state and private health care workers on how to deal with suspected abuse cases. As the population ages, the potential for abuse — physical, verbal, sexual, or financial — among the most needy populations increases. Is your staff properly trained?

According to attorney **John Gilliland II**, whose law firm has offices in Kentucky, Ohio, and Indiana, states have laws requiring that health care workers report suspected abuse. "The situation will vary from state to state," he says, "but generally, most laws that I have seen require health professionals to report suspected abuse to an adult protective services-type agency."

Indiana's state law, for example, requires that an agency employee notify his or her superior, who in turn should report to the appropriate state officials — either adult protective services or a law enforcement agency.

Your staff should be aware of the laws, and your agency should have some policy in place and known to staff outlining the course of action for suspected abuse, Gilliland says **(see sample policy, p. 91)**. "You should do inservices so that employees know their responsibilities under state law."

Not complying with the law could lead to criminal or civil action against the staff member or agency for failure to do a duty imposed by law. Professionals could also lose their licenses.

In-Home Health, in Minnetonka, MN, starts the education from orientation, says **Cathy Nielsen**, RN, CPHQ, vice president of clinical services for the agency. Along with the corporate policies and procedures, they also include various state requirements. California, for instance, has some stricter guidelines than in other states. Those rules have led to some corporate changes, too, says Nielsen. For instance, along with physical, verbal, sexual, and financial abuse, they now also train staff to look for signs of physical, sexual, and financial exploitation. The policies include examples of all of those items, as well as examples of neglect, verbal abuse, and failure to provide care. **(See Guidelines for Recognizing Abuse, inserted in this issue.)**

Get entire team involved

Nielsen says that when a nurse or aide first suspects something might be amiss, the first step should be to report it to his or her supervisor and call a team conference. "Care conferences can be very helpful to see what other people who have responsibility think might be going on. It also helps in outlining options."

In some cases, what seems like abuse may be something different, she says. For example, what a caregiver sees as a verbal abuse might not seem so to the client. "You have to see how the patient is interpreting it. If the wife is used to being submissive to the husband and it isn't a problem, maybe you don't address it."

In cases such as this, it can be helpful to get a social worker involved, Nielsen adds. "They can help you to understand the family dynamics."

If, however, the problem happens in front of your employee and it makes him or her uncomfortable, it should be addressed. "You can make it clear that the person should not behave that way

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Sample Policy for Dealing with Suspected Abuse or Neglect

Victims of Suspected or Alleged Abuse or Neglect
Cases of suspected or alleged abuse or neglect must be reported to the director of client services (DCS), who in turn will evaluate the situation and report to the administrator within 24 hours. The DCS and administrator will investigate and evaluate the facts of the situation and report as appropriate to adult protection services and/or the department of human services.

All cases of suspected or alleged child abuse or neglect discovered are to be reported to local law enforcement officials and the department of human services.

This organization will maintain a list of community agencies that provide or arrange for assessment of or support for victims of suspected or alleged abuse. Examples of resources may be Parents Anonymous and the National Child Abuse Hotline.

Detailed notes are to be made in records with respect to the investigation, all observations made, discussions, history and behavior, including the date and place that information was obtained and who was present when the information was gathered.

Staff must separate factual material from opinions, inferences, conclusions, and diagnoses which they conclude from factual material.

This organization will consult and/or refer an MSW or other health care professional who specializes in abuse and neglect as appropriate. It will obtain the necessary medical attention as appropriate.

Legal Liability
Persons mandated to report child abuse (childcare custodians, medical practitioners and non-medical practitioners) are protected from civil and criminal liability. This means that these persons may not be prosecuted or held personally liable, even if subsequent investigation determines that the reported abuse did not occur.

Immunity from liability also extends to the taking of photographs and X-rays, and dissemination of these with the required reports.

Persons not mandated to report are nevertheless encouraged to report suspected child abuse, neglect and exploitation. Such persons who do report are protected from civil and criminal liability. However, making a false report constitutes a misdemeanor.

Criminal Liability
Failure to report suspected child abuse to the appropriate authorities is considered a crime. The department of human services hotline number is_____.

A person mandated to report, who fails to report an instance of child abuse which he or she knows to exist or reasonably should know to exist is guilty of a misdemeanor and is punishable by confinement in the county jail for a term not to exceed six months or a fine of not more than $500 or both.

Civil Liability
Failure to report suspected child abuse could also result in civil liability. A person who is mandated to report suspected abuse, but does not do so could be held responsible for the cost of any damage to the child.

These rules, regulations and laws may also apply to adults and the elderly.

Source: Healthcare Accreditation Consultants, Fairview, TN.

while you are in the house," Nielsen says. "If it continues, then you may want to have a written contract that the behavior will not continue."

In-Home Health's policy requires the employee to report to the supervisor first. "Usually, they have more experience," Nielsen says. "They can decide if it is something that seems reportable or if further investigation is needed."

The employee is asked to fill out a non-employee unusual occurrence report as well, documenting what he or she observed. The supervisor will talk with other employees involved in the case, get feedback, and perhaps make a home visit herself.

The only exception to that, she says, is if there is an obvious immediate danger to the patient or employee. In that case, the authorities are called immediately. "But if we can, we try to correct the situation in the home environment first."

Consultant **Greg George**, who owns Healthcare Accreditation Consultants of Fairview, TN, says your policy should include:

- **A discussion of the chain of reporting suspected abuse.**

• **An outline of the legal responsibilities to report and the penalties for not doing so.** Also, include any relevant telephone numbers of state authorities.

• **Guidelines for recognizing signs of abuse.** George says you should include signs of child abuse, too, if you do pediatric work. If you do, be sure you include a list of characteristics of the non-abusing adult who may also require protective services.

Don't worry that giving this kind of information to your employees will make them over-report suspected abuse. It isn't likely, Gilliland says. Even if they do mistakenly report something, in most cases, state law will protect that person and the agency from criminal and civil penalties for making a report in good faith. ■

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CE objectives

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

1. Identify strategies that will help prevent patient falls.
2. Develop indicators to use in an infection surveillance program.
3. Recognize possible symptoms of patient abuse and understand the laws that could apply to a home health care agency's liability. ■