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IN THIS ISSUE

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Don't accept depression as the norm for elderly; ask the right questions

If you evaluate correctly, treatment can be successful

Your patient is sleeping more, seems less energetic when awake, has lost interest in a favorite hobby, or has trouble following conversations. For home health patients, these symptoms can be the result of myriad conditions from diabetes to neurological problems. The symptoms also can indicate depression, a problem found in many older adults.

In fact, older Americans disproportionately are likely to die by suicide. Although they represent only 13% of the U.S. population, people 65 and older accounted for 18% of all suicide deaths in 2000. Among the highest rates, when categorized by gender and race, were white men 85 and older — 59 deaths per 100,000 people in 2000, more than five times the national rate of 10.6 per 100,000.[1]

Age is not the only risk factor for depression, says **Kathryn Ringham**, MA, MSW, care manager and caregiver coach for the Wilder Foundation and ElderCare Partners, a nonprofit health and human services organization in St. Paul, MN. "Home care represents a change in the person's life, a worsening of their health, and loss of control in their life," she points out. All of these factors increase a person's risk for depression, she adds. **(Ringham recommends using a depression scale, see box, p. 99.)**

It's more important than ever to properly assess depression as well as other cognitive disorders. Now the results of 11 quality indicators are available to the public for eight pilot states and soon will be available nationwide, says **Phyllis W. Fredlund**, RNC, BSN, executive director for Health Personnel Inc. in McKees Rock, PA. **(For more information on national rollout, see box, p. 98. For more information about quality indicators, see *Hospital Home Health*, February 2003, p. 13.)**

"Being able to correctly assess cognitive problems means that your documentation will be more accurate, and that will mean more accurate outcomes," she explains. **(For information on training nurses to assess cognitive problems, see article, p. 100.)**

If your patient seems confused, has difficulty concentrating, or seems to be sleeping too much or too little, rule out physical causes by taking

the patient's temperature, checking blood sugar, checking urine, and asking if the patient has experienced diarrhea or skin rashes, Fredlund suggests.

Don't forget to look for signs of hyperthyroidism such as hair loss. As you evaluate the patients for physical problems that might produce the symptoms you are observing, don't forget to evaluate the patient for depression, as well, she says.

Symptoms of depression can be nonspecific, so it's important that nurses remember to include depression in their list of conditions to consider when evaluating a patient's complaints, says **Marsha Johnson Schulte**, RN, MSN, an adult nurse practitioner with St. Charles (MO) Medical Group.

"The physical complaints can include fatigue, sleep disturbances, headaches, and gastrointestinal symptoms," she says. Beyond the physical symptoms are behavior changes such as a loss of interest in a hobby or even the way the patient interacts with the home health nurse.

"You may notice an increase in minor, multiple complaints, with more frequent calls from the patient or a request by the patient for more visits," Schulte points out.

"Don't assume that these behavior changes are part of their illness or the normal aging process." Instead, the nurse should focus on the patient's history to see if there is a history of depression in the family, or evaluate medications that can increase the risk of depression, she suggests.

Certain physical conditions put patients at more risk for depression, Schulte adds. "Strokes, heart attacks, diabetes, cancer, Parkinson's disease, and Alzheimer's disease are more likely to increase risk of depression."

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This fall, all states in home health compare measures

The Home Health Quality Initiative began with the publication of home health quality measures for eight states in the spring of 2003.

The Home Health Compare web site, sponsored by the Centers for Medicare & Medicaid, (CMS) makes home health quality measures available to consumers to help them choose a home health agency.

Home Health Quality Measures currently are available for home health agencies in eight states:

- Florida
- Massachusetts
- Missouri
- New Mexico
- Oregon
- South Carolina
- West Virginia
- Wisconsin

Measures will be available nationwide in late fall 2003, according to a CMS spokesperson.

Home Health Compare for the national rollout will reflect data in OSCAR as of Aug. 8, 2003.

Because the processing time of changes varies from state to state, home health agencies should contact their state survey agency OSCAR/ASPEN coordinator as soon as possible to ensure that changes are reflected in the national rollout, the spokesperson suggests.

For more information about the measures, go to: www.medicare.gov and select "Home Health Compare." ■

This risk is due not only to the severity of the illnesses and the loss of independence they may represent, but to the medications used to treat them, she adds.

In addition to physical conditions, remember to evaluate their lifestyles, Schulte says. "Patients who use alcohol are more susceptible to depression, as are patients who are isolated from others."

Two symptoms that are unique to depression are constant sadness or withdrawal from others as well as a loss of interest in people or activities that have been important, she says.

"If a patient is no longer interested in gardening or does not want to watch or discuss a favorite television show, the nurse should ask questions about mood, sleep patterns, and other symptoms of depression," Schulte notes.

Look at caregivers for signs of depression as well, she suggests. "If a patient's husband no longer takes care of the car of which he has always been proud, talk with him to see how he is doing as well," Schulte adds.

The good news is that depression is treatable, Ringham emphasizes. Antidepressants, as well as talk therapy, or a combination of both can be very effective.

"Talk therapy is often given short shrift," she says. "Older people think that talking with a psychotherapist means that you're crazy, and everyone seems more interested in a pill that can eliminate the symptoms.

"Don't rule out talk therapy for all people,

Geriatric Depression Scale[1]

A simple form with 15 questions can be used to identify home health patients who may be suffering from depression, says **Kathryn Ringham**, MA, MSW, care manager and caregiver coach for the Wilder Foundation and ElderCare Partners, a nonprofit health and human services organization in St. Paul, MN. "It's important that nurses feel comfortable asking these questions because depression is often undiagnosed in elderly," she explains. By using the questions below, a home health nurse who is concerned about behavior changes in a patient can make a better decision on whether or not to refer to patient to a physician, she says.

Circle yes or no. Instruct patients to answer yes or no, whichever is closest to how they feel.

1.	Are you basically satisfied with your life?	Yes	**No**
2.	Do you often get bored?	**Yes**	No
3.	Do you often feel helpless?	**Yes**	No
4.	Do you prefer to stay home rather than going out and doing new things?	**Yes**	No
5.	Do you feel pretty worthless the way you are now?	**Yes**	No

If fewer than two answers are in **bold**, stop.
If two or more answers are in **bold**, continue with the remaining questions.

6.	Have you dropped many of your activities and interests?	**Yes**	No
7.	Do you feel that your life is empty?	**Yes**	No
8.	Are you in good spirits most of the time?	Yes	**No**
9.	Are you afraid that something is going to happen to you?	**Yes**	No
10.	Do you feel happy most of the time?	Yes	**No**
11.	Do you feel you have more problems with memory than most?	**Yes**	No
12.	Do you think it is wonderful to be alive?	Yes	**No**
13.	Do you feel full of energy?	Yes	**No**
14.	Do you feel your situation is hopeless?	**Yes**	No
15.	Do you think that some people are better off than you are?	**Yes**	No

A score of six or more answers in **bold** warrants referral to a physician for further evaluation for depression.

Reference

1. Sheikh JI, Yesavage JA. "Geriatric Depression Scale (GDS): Recent Evidence and Development of a Shorter Version." In: *Clinical Gerontology: A Guide to Assessment and Intervention*. New York City: The Haworth Press, 1986, pp. 165-173.

though. Be aware of your patient's personality, and make that suggestion to the social worker or physician if you believe it might help," she adds.

If you think that your patient might be suffering from depression, address the social issues that might exacerbate the depression, Ringham says.

"It is critical to find help for patients with substance abuse problems." Also, try to include some sort of exercise, or even getting outside for a period of time in the daily schedule, she adds.

Address isolation by finding other programs that can help your patients, Schulte recommends.

Adult day-care programs, art, or social programs offered by the local Agency on Aging, church visitation programs, Meals on Wheels, and other community-based programs that increase the patient's contact with the outside world can help to reduce the feeling of isolation, she explains. **(For more on adult day care and home health working together, see article, p. 101.)**

The key to helping your patients is to realize that depression is not a normal part of aging, Ringham adds. "Although over half of older adults believe that depression is normal, it is up to home health personnel to educate our patients and their families that depression is a biological illness that can be treated."

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Reference

1. Office of Statistics and Programming, National Center for Injury and Prevention Control, Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS). Web site: www.cdc.gov/ncipc/wisqars/default.htm. ■

Assess cognitive problems to treat illnesses early

Homework now will save emergency visits later

"Don't worry, Mom; I'm not going to make you go to a nursing home. You're not sick enough to have to leave your home. After all, home health nurses will be visiting to make sure you're OK."

This is a familiar scenario for home health personnel. A family member makes a promise that may not be in the best interest of the patient. While environmental, safety, and even clinical issues can be addressed in most cases, what about cognitive problems?

"Being able to correctly assess cognitive problems is critical to keeping patients in their homes safely or to making a correct referral to another living arrangement," says **Phyllis W. Fredlund**, RNC, BSN, executive director for Health Personnel Inc. in McKees Rock, PA.

Medical conditions can cause impairments

"Cognitive impairments can be the result of medical conditions such as diabetes, depression, lack of oxygen, thyroid malfunctions, hearing loss, pain, or toxicity from a variety of medications," she says.

"It's important to conduct a thorough physical assessment that checks blood sugar and oxygen levels, temperature, blood pressure, and signs of infection."

The nurses at Health Personnel have a good working relationship with their physicians, Fredlund explains.

"We can call and ask for extra blood work, urine cultures, or other lab tests if we suspect that any cognitive impairment is the result of an ongoing or a new disease. We have trained all of our nurses to conduct a thorough cognitive assessment so that we can give the physician a complete picture of the patient and what we suspect," she says.

An example of good detective work is the congestive heart failure patient who lived in an assisted-living facility but used emergent care four times within a month of being discharged from the hospital, Fredlund says.

The patient's physician told her not to use salt, but the home health nurse discovered that although no additional salt was added, the meals prepared for the patient contained foods

in which salt was used in cooking, or foods that naturally contain high salt levels, she says.

After the home health nurse worked with the assisted-living facility dietician to ensure that the patient did not receive foods with salt, the emergent care visits stopped, Fredlund adds.

Combine training and experience

The success with which Health Personnel nurses pick up on cognitive problems and their causes is the result of a combination of training and experience, Fredlund points out.

"First, our patients have a primary nurse who sees them on each visit and gets to know them well enough to notice small changes in behavior. Secondly, we have a cognitive assessment checklist that prompts nurses to ask about sleep patterns, diet, ability to concentrate, mood, confusion, mental state, and ability to handle activities of daily living," she adds.

The agency also offers regular inservices on topics such as identifying and treating causes of confusion, interactions of medications that result in cognitive impairment, and evaluation of signs such as color of fingernail beds, Fredlund says.

"It's important that a nurse remember to check for pale or white fingernail beds for anemia and blue fingernail beds for respiratory problems that result in low oxygen in the blood," she explains.

Because home health patients often are on multiple medications, Fredlund emphasizes the importance of understanding interactions. "A pharmacist can explain interactions of medications, but we also had a pathologist conduct an inservice that explained the physiological interaction of medications with other medications as well as with physical conditions.

"It's important to realize that some antianxiety or antidepressant medications as well as pain medications can actually increase confusion and mask other symptoms," she adds.

Being alert to even the smallest changes in a patient's cognitive behavior also is important, Fredlund adds.

When one of her nurses made a visit to an elderly, mentally disabled patient who never has been able to communicate, the nurse noticed that the patient seemed less alert than normal in terms of responding to prompts or activities of the nurse with her eyes or head motions, she explains.

"The nurse took the patient's temperature and discovered a fever, then listened carefully to the patient's lungs where she heard rales," Fredlund says. After calling the physician and getting a chest X-ray for the patient, a diagnosis of pneumonia was made.

"This is a good example of the nurse catching a minor change in cognitive behavior that was a result of an illness," she adds. ■

Home health and adult care programs team up

Find compatible services, goals to ensure success

In February 2001, the Centers for Medicare & Medicaid Services changed the wording in its definition of homebound to allow for Medicare home health patients to attend adult day care without jeopardizing the patients' home health coverage.[1]

Although **Sylvia Nissenboim**, MSW, LCSW, director of adult care and enrichment programs at the St. Louis Red Cross and president of the Missouri Adult Day Care Association — known as MAHC — in St. Louis, says she thought that she would start seeing more referrals between her adult day program and local home health agencies, nothing happened. After surveying home health agencies in the area, Nissenboim discovered a need for education of both industries.

"There was confusion about the language that described adult day services as intermittent, so home health nurses believed that a patient who attended an adult day program on Mondays and Wednesdays would no longer qualify for Medicare services," she says. "I also discovered that home health nurses didn't realize that many adult day programs have skilled nursing services available."

To foster communication and create a network that would generate referrals between the two types of services when appropriate, MAHC set up a monthly meeting of home health managers and adult day-care managers to get to know each other.

"Each group has learned from the other," says Nissenboim. "Home health managers thought of adult day care as bingo and lunch, while I realized that I had no idea of the differences in Medicare home care, private duty, and therapy services offered in the home," she says.

The Home Health/Adult Day Care Network — as the group of nine home health and adult day care organizations has named itself — spent

the better part of its first year educating each other and developing a flyer to use in community education programs that explain the variety of services available to older adults.

Now that members of the network better understand each others' services, the group has developed a protocol in which a question about home health or adult day care will be asked by each organization upon assessment of new clients, Nissenboim explains.

"Within our adult day program, we now ask family members if they would be interested in talking with a home health agency about services for the client on days that they are not in our program. Home health agencies are asking clients if they have ever attended an adult day-care program and if they would be interested in having someone contact them with more information," she adds.

Not the answer for every patient

Although adult day care might provide needed respite for a family member, or additional social interaction for a patient who may feel isolated, the suggestion might not be welcomed, says **Natalie Jablonski**, marketing director for St. Andrews At-Home Services in St. Louis.

"Some clients relate better on a one-to-one basis, while others are comfortable in a group setting. It's important for the home health nurse to assess the patient's ability to function in a group," Jablonski explains.

"We ask patients and their family caregivers if the patient's social needs are being met," says **Nancy Bax**, RN, BSN, director of nursing for Lutheran Senior Services Home Health and Private Duty in St. Louis.

"Adult day care can be a welcome relief for caregivers who are overwhelmed, but they have to be ready to let go," she explains.

Jablonski agrees and points out, "Some caregivers are in a pattern of providing care to the family member, and they feel guilty if they allow someone else to assume that responsibility."

Caregivers who do send a family member to adult day care for even a couple of days each week need to be reassured that it is beneficial to the patient and is the right thing to do, she adds.

"You also need to be alert to the caregiver's loneliness or disrupted pattern now that the family member no longer needs complete attention for the whole day," Jablonski continues.

Support caregivers' decisions to use adult day care by pointing out in a positive way the benefits of adult care for the patient and the advantages for the caregiver to be able to schedule his or her personal appointments more easily, she says.

Plan schedules carefully

While referrals of Medicare home health patients to adult day-care programs do not reduce reimbursement levels, it does require some extra planning,

"Because home health services, such as dressing changes, have to be performed in the home by our nurses rather than at the day-care center, we have to make sure we schedule around the day-care schedule," she says.

The difficulty of this scheduling varies, with transportation of the patient being a key factor, Bax says. "If the adult day-care program provides the transportation, the patient usually has a longer day at day care; but if a family member is bringing the patient home, the length of time at day care may be shorter."

One way to work around this problem is to refer patients to adult day-care programs that offer skilled nursing services, she says. If the day-care nurse can handle a dressing change and daily wound care when the patient is at the program, the number of home health visits required would decrease, something that is not detrimental under the prospective payment system, Bax points out.

Before you refer any of your home health clients to adult day care, be sure to check the program thoroughly, Jablonski suggests.

Not only do you want to be clear about what services they offer, such as skilled nursing, meals, social services, therapy, and supervision, you also want to find out what types of clients they accept, she says.

Is their clientele a mix of dementia and non-dementia patients, or do they have different groups? "If the day-care program mixes early-stage Alzheimer's patients with late-stage patients, the early-stage patients may find it very frightening," Jablonski points out.

In addition to the types of services they offer, talk to different people in the community, as well as contacting references provided by the day-care program, to find out what type of reputation the program has, she recommends.

"If the program's mission and goals are compatible with yours and the organization has a good reputation, you can feel comfortable

referring to them," Jablonski says.

When looking for an adult day-care program to which you can refer, remember that your goal is to be able to provide services that meet all of the needs of your patients and their families, Bax explains. "We want to provide a full range of services that will make it possible for the patients to stay in their homes for as long as possible."

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Reference

1. Center for Medicare & Medicaid Services. *Program Memorandum Intermediaries — Clarification of the Homebound Definition Under the Medicare Home Health Benefit.* Feb. 6, 2001. Web site: www.medicare.gov. ■

Educational initiatives create valuable staff

Language, high-school equivalency classes pay off

(Editor's note: This is the second of a two-part series that looks at home health aide retention issues such as training, supervision, and benefits. Last month, experts talked about factors that motivate and retain aides. This month, innovative programs that enhance aide education and tips on improving retention are described.)

Finding the secret to successful retention of home health aides is not easy, but HomeCare Options, a Paterson, NJ, agency with 350 aides with an average tenure of eight years, may be holding the key to the success other agencies want.

Because aides are most interested in learning skills that help them now in both their jobs and their personal lives, HomeCare Options took a close look at who made up their work force, says **Ken Wessel**, MSW, ACSW, LSW, executive director of the agency.

"The majority of our aides are Hispanic, many without a high school education and many for whom English is a second language," he says.

To help the aides gain the education needed to address these issues, HomeCare Options set up two programs:

1. High school equivalency degree program

"We partnered with the Paterson [NJ] Adult School to develop a high-school equivalency program for our aides," Wessel says. The classes meet Monday and Wednesday nights from 5:30 to 8, and there were 40 aides in the initial class.

"We don't pay the aides to attend the class, but we do pay for the teacher's salary and FICA expenses, as well as books used in the class," he says.

The funds to cover the cost of the program come from a customized training grant offered by the state's department of labor (DOL), Wessel explains. "It was very easy to show how this program will help our aides further their education and their chances to advance in their jobs and improve their salaries, which means they will continue to be self-sufficient and independent of state assistance."

Of the 40 aides in the initial class, 11 received high-school diplomas within nine months, he says. "This was a tremendous accomplishment for these aides because they worked during the day and went to class at night while juggling their family responsibilities."

The success of this program is due to the individual who was hired to teach the class, Wessel points out. "She is a certified teacher who is bilingual in Spanish [and English] and is a nurse." The combination of Spanish and nursing background means that she relates to her students and understands what their work and personal lives are like, he adds.

There is an added benefit to this program: Wessel now has potential employees applying to his agency's home care aide training program, specifically because the agency has the high-school equivalency program. "They plan to complete the training program, get hired, and attend the high-school equivalency classes."

2. English as a second language

"When we started the high-school equivalency

classes, we found that some aides' English was not strong enough to learn the material easily," he says.

With another grant from the DOL, HomeCare Options offered English as a second language (ESL) classes for employees. Ten employees graduated from the first ESL class in May.

"We found that the ESL class makes it much easier for the aide to understand their job, communicate with patients, and go on to other educational opportunities," Wessel adds.

Because the topics used in the class to practice English are the same topics covered in the U.S. citizenship test, students who were not citizens prior to the class found the test much easier to pass, he says.

"We've also taken other steps to make it easier for our aides to apply for citizenship by partnering with the local Catholic Services Agency to help aides complete the application," Wessel explains. His agency also pays the fees for the application and test as well. "We recently had 12 aides become new citizens," he says.

While these programs require planning time and funds, Wessel says that the efforts are worthwhile.

"You can't do just one or two things and say that you've shown aides that you appreciate them. You have to look at what is important to their lives and develop programs that work together to help them develop," he adds.

Not only do these efforts help retain aides for the agency, but Wessel points out that his agency does no recruiting.

"Whenever we offer a training class that is required in our state for any person to work as a home health aide, we fill it up. Word of mouth from our own aides rather than advertising is the reason for our success," he says.

An added benefit: Aides gain skills and confidence; they want to add to their education and help HomeCare Options keep good nurses, Wessel stresses.

"We have more aides each year take advantage of our tuition-assistance program that reimburses up to $1,000 of tuition expense as they go on to nursing school," he adds.

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Look for same values to predict who will stay

There is no such thing as a crystal ball that will tell you which employees will be with you after a year, but there are ways a manager can tell if an employee is likely to stay with you, says **Patricia Jump**, RN, president of Acorns End Training and Consulting in Stewartsville, MN.

First, find out if the job applicant has the same values and goals as those of your agency leadership. During the interview, be sure to ask situational questions, she says.

"You want to evaluate the job applicant's values and principles," Jump says.

For example, ask applicants what they would do if an elderly client gave them a valuable vase during a visit, she suggests. If they say that they won't accept it, but do so in a manner that doesn't offend the client, you know that they are ethical and compassionate, she explains.

Also, ask how the applicant would handle a conflict with a co-worker, a concern about a client's family member, or observations of behavior changes in the client. "You want to ask questions that allow the applicants to demonstrate their attitude toward people," Jump explains. Make sure your questions are phrased so that you get more than yes or no answers, she adds.

Also, be sure you know why people leave you, Jump says. Every home health manager should make sure that exit interviews are conducted. Although not all employees leave to work for other agencies, it is important to find out why those who go to other home health agencies decide to leave, she says. You may discover that you have a supervisor with whom aides have troubling working, clients or families who are a problem for the aide, or a less flexible work schedule than other agencies.

When you find these problems, correct them so that you don't unnecessarily lose other aides, Jump adds.

In addition to surveying your employees who leave, be sure to interview the good employees who stay with you. "We know that a sense of being appreciated, a belief that the job is meaningful, and flexibility in schedules or work locations all contribute to an employee's length of employment," Jump states.

But you need to find out if your good employees believe that these, or other things that increase

loyalty, are found in your agency in order to predict if you'll be keeping these employees, she adds.

If they express satisfaction, be sure to ask what else they would like to see. "Some people might suggest inservices that help them manage their home budget or better plan their time, both at work and at home," Jump says.

Your supervisors also should be trained to identify the possibility that an employee is planning to leave. "Look for increasing absenteeism and an increase in problems such as tardiness," Jump adds.

"People don't suddenly elect to leave a job. Their decision usually follows a period of dissatisfaction with the job that shows up as sloppy work and an inattentiveness to the job," she points out.

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LegalEase

Understanding Laws, Rules, Regulations

Document carefully to prove your actions

By **Elizabeth E. Hogue**, Esq.
Burtonsville, MD

There is an old saying among health providers: "If you did not document it, you did not do it." Harsh as this adage may sound, generally it still is true.

Staff members frequently do the right thing in the course of patient care, but fail to document the quality of care that was rendered to patients. Then, when care is questioned, practitioners are in a much more vulnerable position than they would have been in if the treatment was properly documented.

Providers must be especially meticulous with regard to documentation of:

- monitoring and observation of patients;
- physician responses to reports of changes in signs and symptoms;
- receipt of laboratory results within appropriate time periods;
- patient falls;
- additions or corrections to documentation in patients' charts.

Staff members are responsible for monitoring patients for changes in signs and symptoms and to report them to patients' attending physicians. They have the responsibility to perform an adequate initial patient evaluation and also are required to continuously monitor patients for changes in their conditions.

Staff must report changes in patients as situations warrant. When patients' conditions worsen because staff did not make reports within an appropriate period of time, the issue becomes whether the problem should have been reported earlier.

The law does, however, apply a standard of reasonableness to such situations in recognition of the fact that many home care patients cannot be monitored continuously 24 hours per day. The frequency of staff observations, therefore, is determined by patients' individual needs, the type of provider, customary practice, physicians' orders, and providers' policies and procedures.

Beyond listing the factors that will be considered, it is impossible to establish hard and fast rules for reasonable conduct with regard to monitoring and observation. Determinations of reasonableness in these areas will be made on the basis of individual cases.

Some staff members behave as though their only obligation is to report changes in signs and symptoms to physicians. They are all too familiar with situations in which patients' conditions changed and were clearly worsening over a period of hours. Patients' attending physicians may be unresponsive to contacts from staff.

Providers must recognize that they have an obligation to obtain and document a response from patients' physicians whenever they report changes in patients' conditions. In other words, they cannot throw reports to physicians down a black hole.

When physicians are unresponsive despite repeated requests for assistance, staff members have an obligation to do whatever is necessary to make certain that patients receive needed care. It may be helpful to involve medical directors or

consulting physicians in obtaining needed care.

Providers must establish and monitor a system for making certain that patients' laboratory results are received on a timely basis and that physicians are notified of the results. It is an unacceptable situation for staff to send work to laboratories and providers are never sent the results.

The system must track lab work from beginning to end. That is, providers must be able to demonstrate through documentation that specimens were obtained and sent to the lab and that results were received in at timely manner and communicated to physicians.

If the system of documentation indicates that results are overdue, practitioners have a legal duty to follow up with the lab and to obtain the results promptly. In other words, staff cannot get off the hook by saying that it is the lab's responsibility to return results promptly.

Patient falls — your liability

Providers are especially vulnerable to claims of liability in the area of falls. The key to avoidance of this type of liability is evidence of adequate precautions by staff in order to prevent patient falls. In *Burks v. Christ Hospital*, 19 Ohio St. 2d 128, N.W. 2d 829 (1969), for example, an obese patient in severe pain who was sedated to the point of disorientation was placed in a bed with no side rails. It is not surprising that she fell out of bed.

The decisive fact for the court in this case was that the provider had no nursing policies and procedures that outlined appropriate precautions to be taken by staff in order to prevent liability.

The court clearly wanted to see written policies and procedures regarding prevention of patient falls and documentation in patients' charts that staff followed their own internal policies and procedures.

However, the good news concerning falls is that sometimes patients fall and practitioners are not liable in large part due to effective documentation. Such a case is *Killgore v. Argonaut-Southwest Insurance Co.*, 216 So. 2d 108 (La. App. 1968).

In this case, there was clear documentation that the patient was alert and able to call for assistance. Documentation also established that she was placed in bed by staff and that the guardrails were in an upright position. The patient fell when she apparently attempted to climb over the rails to get out of bed.

In *Killgore v. Argonaut-Southwest*, the patient's suit was rejected by the court. Because of the detailed documentation in this case, the only basis for her suit was that nurses had an obligation to watch her continuously, a contention that was decisively rejected by the court.

Finally, practitioners certainly recognize that their documentation sometimes fails to meet required standards.

Staff responsible for quality assurance or continuous quality improvement are especially conscious of deficiencies in documentation. In view of surveyors' zero tolerance for deficiencies and the increase in liability suits against providers, the temptation is to fix the documentation after the fact. It is not uncommon for practitioners to approach other personnel to ask them to repair documentation.

The temptation to do so without clear evidence of the circumstances under which corrections were made is too great for some staff members.

Providers are reminded that the following rules regarding documentation apply:

- **Errors in documentation may be corrected only if one line is drawn through the incorrect documentation.**

Corrected documentation may be added to the record but it must be dated with the time it was actually written, not when the original documentation was written.

- **Erasures and correction fluid may not be used in patients' charts to correct incomplete or inaccurate documentation of patient care.**
- **Staff may correct documentation after the fact only if they actually remember the supplemental information they provide.**

Documentation after the fact of normal findings, therefore, often is suspect. It is incredible to think, for example, that a staff member remembers a patient's normal blood pressure reading three weeks after it was taken. Supplemental documentation of abnormal findings or unusual events has more credibility.

- **Pressure on staff members to supplement documentation outside of these rules is inappropriate and may result in discipline by licensure boards of offending practitioners.**

Supervisors constantly harp on the importance of complete, accurate, contemporaneous documentation. Staff members tend to tune out at this point because they have heard the same admonitions so many times.

Documentation is one of very few sources of evidence of quality of care. In short, good documentation is often the hallmark of good care.

[A complete list of Elizabeth Hogue's publications is available by contacting: Elizabeth E. Hogue, Esq., 15118 Liberty Grove, Burtonsville, MD 20866. Telephone: (301) 421-0143. Fax: (301) 421-1699. E-mail: ehogue5@comcast.net.] ■

Providers gear up for new HIPAA regulations

The Centers for Medicare & Medicaid Services won't seek out and issue fines and penalties to health care organizations that don't comply with the Health Insurance Portability and Accountability Act (HIPAA) transactions and code sets rule after the Oct. 16 deadline, but will focus on helping covered entities meet the new requirements.

The agency does not have the resources to search for noncompliant entities and will deal with noncompliance on a case-by-case basis, according to **Leslie Norwalk,** CMS deputy administrator.

Providers who still need help meeting the requirements that are intended to eliminate the hassle and costs of paper claims forms by requiring payers, clearinghouses, and providers to follow a standardized form for transmitting claims information can visit a web site designed by the Workgroup for Electronic Data Interchange in Reston, VA, and the Council for Affordable Quality Healthcare in Washington, DC.

The web site contains schedules for testing and implementing electronic transactions standards, links to different organizations' best practices HIPAA companion guides, and links to other useful web sites related to transaction and code sets requirements.

To access the web site, go to: www.wedi.org/snip/caqhimptools. ▼

JCAHO revises areas for random surveys in 2004

The Joint Commission of Accreditation of Healthcare Organizations has revised the fixed and variable performance areas that will be evaluated during random unannounced surveys beginning next year.

Starting in 2004, performance will be reviewed in selected critical focus areas: processes, systems, or structures in a health care organization that significantly impact the quality and safety of care. The 2004 fixed performance areas are:

- staffing;
- infection control;
- medication management;
- national patient safety goals that are relevant to an organization's care and services.

A sample of 5% of organizations accredited under the ambulatory care, behavioral health care, home care, hospital, and long-term care programs are selected randomly for unannounced surveys each year.

Random unannounced surveys will end in January 2006 when JCAHO begins conducting all regular accreditation surveys on an unannounced basis. ▼

Free HIV information available for patients

Clearly written, straightforward information about HIV, antiviral dosing, lipodystrophy, and hepatitis C are available for both patients and health care providers at no cost from Visionary Health Concepts in New York City.

To see a complete list of the organizations publications and newsletters, go to: www.freehivinfo.com, or contact Visionary Health Concepts, 224 Centre St., Suite 2E, New York, NY 10013. Telephone: (800) 491-2181. Fax: (800) 407-2505. E-mail: edu@vhconcepts.com. ■

COMING IN FUTURE MONTHS

- Reduce staff burnout
- Adverse event reports can yield positive info
- How to obtain valid informed consent
- Market your services without violating fraud and abuse prohibitions
- How an expanding clinical role affects your staff

CE *questions*

This concludes the CE semester. A CE evaluation form has been included with this issue. Please fill out and return in the envelope provided. If you have any questions, call customer service at (800) 688-2421.

21. To what should you attribute a patient's increasing number of minor complaints and a request for more visits, according to Marsha Johnson Schulte, RN, MSN, an adult nurse practitioner with St. Charles Medical Group?
    A. part of the normal aging process
    B. a predictable advancement of their disease
    C. a possibility of depression
    D. an increase in insurance coverage

22. Why is an inservice offered by a pathologist or a pharmacist important in training nurses to assess cognitive problems, according to Phyllis W. Fredlund, executive director for Health Personnel Inc. in McKees Rock, PA?
    A. Home health patients take too many medications.
    B. It is important to understand how medications interact with each other.
    C. It is important to understand the physiological effect of medications for a patient's specific conditions.
    D. B and C

23. What did Sylvia Nissenboim, director of adult care and enrichment programs at the St. Louis Red Cross and president of the Missouri Adult Day Care Association discover as the reason for a lack of referrals between adult day-care programs and home health agencies?
    A. The paperwork was too extensive.
    B. Neither group understood what the other could offer.
    C. Home health agencies did not want to reduce their reimbursement.
    D. Family members weren't interested.

24. What two programs have helped Ken Wessel, executive director of HomeCare Options in Paterson, NJ, retain home health aides for an average of eight years?
    A. generous vacation and retirement plans
    B. mileage reimbursement and mandatory inservices
    C. employee recognition and 401K plans
    D. English as a second language and high-school equivalency classes

Answer Key: 21. C; 22. D; 23. B; 24. D

CE objectives

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

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