Providing the highest quality information for 21 years

Hospital Home Health®

the monthly update for executives and health care professionals

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

AUGUST 2004
VOL. 21, NO. 8 • (pages 85-96)

Flu season still means physician orders for most home health patients

Pneumococcal and pediatric flu vaccines not offered universally

Although the Centers for Medicare & Medicaid Services (CMS) changed the rules governing flu and pneumococcal vaccines in 2002 to allow the use of standing orders for home health patients who receive the vaccines, most home health agencies still opt to obtain physician orders for each patient.

"We have always operated with physician orders, so it is hard to shift to a process in which we use standing orders," says **Mike Ellis**, RN, BSN, director of support services at Henry Ford Home Health Care in Detroit.

"Our nurses assess the patient's risk factors for flu and flu complications, and contact the physician to obtain an order if there is a need. After the order is received, the pharmacy is notified, the vaccine is drawn, and the syringe is marked with the patient's name," he explains.

Not only does obtaining a physician order keep the physician in the loop so that he or she knows what vaccinations or medication the patient is receiving, but it is a nice marketing tool to be able to show the physician that the home health agency is providing a service to his or her patients, Ellis points out.

Although her agency uses standing orders for the community flu clinics that the agency sponsors, physician orders are obtained for all home health patients, says **Jill Bodamer**, RN, BSN, quality improvement and education coordinator for Chesapeake Potomac Home Health Agency in Hughesville, MD.

"The majority of our home health patients fall into a high-risk category for flu because of their ages," she points out. "We don't have any problems getting the order within a 24-hour period," she says.

"We also offer the flu vaccine to family caregivers as well. It's important that they stay healthy, too," Bodamer explains.

"We try not to [administer] the flu vaccination if the patient or caregiver has never had one before," she adds.

"If we do have to give the first vaccination, we have the person sign the consent form and we screen for allergies that might cause a reaction to the vaccine," Bodamer notes.

"We also inject the vaccine at the beginning of the visit, so the nurse has about 45 minutes to observe the patient for any adverse reaction," she says.

Bodamer's agency does not offer the pneumococcal vaccine. "Our local health department and a community outreach department of the hospital offer pneumococcal vaccination clinics so we didn't want to duplicate their efforts," she says.

Henry Ford clients can receive the pneumococcal vaccine if they ask for it, or if the physician adds it to the order, Ellis says.

"We offer our patients both the flu and the pneumococcal vaccines," says **Lorraine Walker**, RN, BSN, CHCE, MA, director of Southern Home Care in Jeffersonville, IN. "We do get a physician order, and we check with the physician to see if there is a record of the patient's last pneumococcal vaccination," she says.

Nurses also ask the patient and the family caregiver if the patient ever had a pneumococcal vaccine just in case the current physician has not cared for the patient for a long time, Walker adds.

"If they can't remember if they've had a pneumonia shot and if the physician has no record of one, we give the vaccination," she explains.

The physician order for Walker's nurses also includes epinephrine just in case there is an allergic reaction, she says. Not all agencies include this in their order, but Walker points to it as an extra patient safety precaution.

Publicity of children's deaths due to the flu created a higher demand for pediatric flu vaccinations, but not all agencies offer them.

"We don't give pediatric vaccinations because

Hospital Home Health® (ISSN# 0884-8998) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Home Health**®, P. O. Box 740059, Atlanta, GA 30374.

This continuing education offering is sponsored by Thomson American Health Consultants, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: customerservice@ahcpub.com. World Wide Web: http://www.ahcpub.com. Hours: 8:30-6 Monday-Thursday, 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), $499. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $80 each. (GST registration number R128870672.)

To reveal any potential bias in this publication, and in accordance with the American Nurses Credentialing Center's Commission on Accreditation guidelines, we disclose editor Sheryl Jackson and board members Gilliland, Halamandaris, Hogue, Howard, Solecki, Walden, and Walker report no relationships with companies related to the field of study covered by this CE program. Board member Schulmerich is an adjunct faculty member for graduate and undergraduate nursing program at Mt. St. Mary's College. Board member Ball is a consultant and stockholder for Steris and Encision and serves on the speaker's bureau of AORN. Board member Leahy is a consultant for Foundation Management Services and on the speaker's bureau for Creative Solutions. Board member Christiansen, did not complete a disclosure form.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Sheryl Jackson**.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Jayne Gaskins**, (404) 262-5406, (jayne.gaskins@thomson.com).
Senior Production Editor: **Ann Duncan**.

Editorial Questions
For questions or comments, call **Jayne Gaskins** at (404) 262-5406.

THOMSON
AMERICAN HEALTH CONSULTANTS

ACIP recommends these vaccinations for children

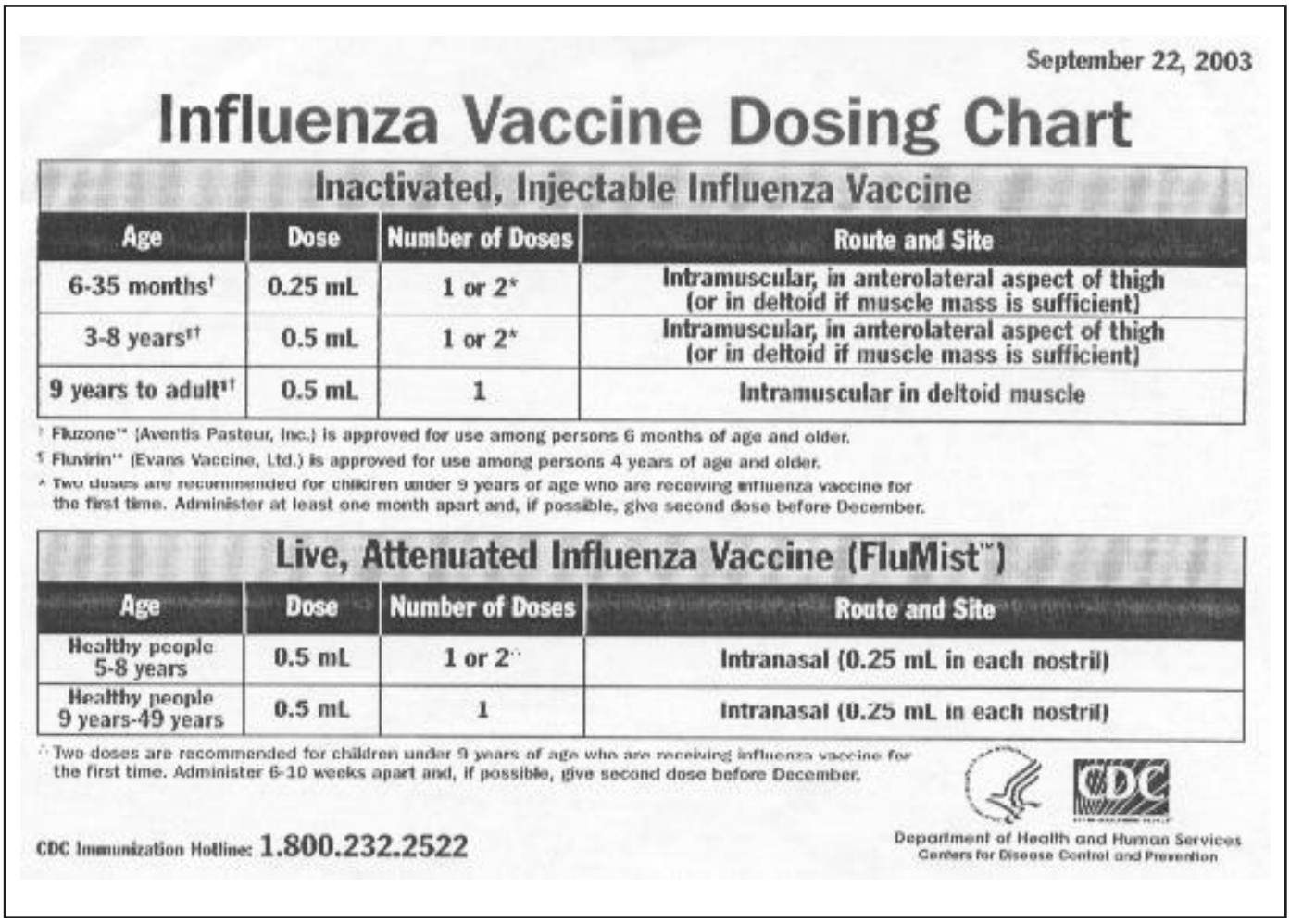
The Advisory Committee on Immunization Practices (ACIP) recommends that children 6 to 23 months of age be vaccinated annually against influenza.

Previously, ACIP encouraged rather than recommended vaccination for children in this age group, when vaccination was feasible.

For children younger than 9 who were not previously vaccinated, two doses of inactivated influenza vaccine should be administered more than one month apart. If possible, the second dose should be administered before December.

Vaccination is not recommended for children younger than 6 months of age, and the current inactivated influenza vaccine is not approved for use among children 6 months and younger. Live attenuated intranasal vaccine is approved only for healthy people ages 5 to 49 years. Children younger than 5 years should not receive this vaccine.

For more information about recommendations for influenza immunization, visit the Centers for Disease Control and Prevention's web site at: www.cdc.gov/flu/index.htm and choose references and resources on the left navigational bar. ACIP recommendations and links to applicable *Morbidity and Mortality Weekly Reports* are available on this page as well as information on vaccine supply, infection control, diagnosis, treatment, and patient education materials. ■



September 22, 2003

Influenza Vaccine Dosing Chart

Inactivated, Injectable Influenza Vaccine

Age	Dose	Number of Doses	Route and Site
6-35 months†	0.25 mL	1 or 2*	Intramuscular, in anterolateral aspect of thigh (or in deltoid if muscle mass is sufficient)
3-8 years††	0.5 mL	1 or 2*	Intramuscular, in anterolateral aspect of thigh (or in deltoid if muscle mass is sufficient)
9 years to adult††	0.5 mL	1	Intramuscular in deltoid muscle

† Fluzone® (Aventis Pasteur, Inc.) is approved for use among persons 6 months of age and older.

†† Fluvirin® (Evans Vaccine, Ltd.) is approved for use among persons 4 years of age and older.

* Two doses are recommended for children under 9 years of age who are receiving influenza vaccine for the first time. Administer at least one month apart and, if possible, give second dose before December.

Live, Attenuated Influenza Vaccine (FluMist™)

Age	Dose	Number of Doses	Route and Site
Healthy people 5-8 years	0.5 mL	1 or 2**	Intranasal (0.25 mL in each nostril)
Healthy people 9 years-49 years	0.5 mL	1	Intranasal (0.25 mL in each nostril)

** Two doses are recommended for children under 9 years of age who are receiving influenza vaccine for the first time. Administer 6-10 weeks apart and, if possible, give second dose before December.

CDC Immunization Hotline: 1.800.232.2522

Department of Health and Human Services
Centers for Disease Control and Prevention

determining the dosage for children is very different from adults," Bodamer explains. The health department, local hospitals, and pediatric offices offer pediatric vaccinations, she adds.

"Because we have a mother-baby program, we felt that we needed to offer pediatric vaccinations," Walker points out. "We consulted a pediatrician who provides the correct dosing information, and we stocked up on lollipops," she adds.

If the child requires more than one injection and is a sibling rather than the home health patient, the first injection is given by the home health nurse and the subsequent injection must be received in a health department clinic, hospital clinic, or pediatrician office to meet the required time frame, she explains. **(See related article on pediatric vaccinations, p. 86.)**

All three agencies interviewed for this article offer free flu vaccines to their employees. "We usually have about 98% of our staff take advantage of the free vaccination," Walker says.

Family members of employees can get the vaccination through the hospital, she adds.

Walker suggests that home health agency nurses look carefully at the needles they use for vaccinations.

"We had considered using pre-filled syringes for our patients, but the needles were larger than we like to use on our elderly patients. Because our patients can be very thin, a larger needle can be painful," she adds.

"We opted to purchase the vaccine in vials, then fill the syringes ourselves so we could use smaller needles that are more comfortable for our patients." **(See dosage chart, above.)**

{For information on vaccination programs, contact:

- ***Jill Bodamer**, RN, BSN, Quality Improvement and Education Coordinator, Chesapeake Potomac Home Health Agency, 7627 Leonardtown Road, Hughesville, MD 20637. Phone: (301) 274-9000, ext. 116.*
- ***Mike Ellis**, RN, BSN, Director of Support Services, Henry Ford Home Health Care, One Ford Place, 4C, Detroit, MI 48202. Phone: (313) 874-6549. E-mail: mellis1@hfhs.org*
- ***Lorraine Walker**, RN, BSN, CHCE, Director, Southern Home Care, Clark Memorial Hospital,*

1806 E. 10th St., Jeffersonville, IN 47130. Phone: (800) 582-7655 or (812) 283-9190. E-mail: lorraine.walker@clarkmemorial.org

For up-to-date information on flu vaccine, diagnosis and treatment of flu, as well as questions and answers related to the vaccine, contact:

- ***Centers for Disease Control and Prevention**, Atlanta. Web site: www.cdc.gov/flu/index.htm*

For information on Medicare reimbursement for flu vaccinations, contact:

- ***Centers for Medicare & Medicaid**, Baltimore. Web site: www.cms.hhs.gov/medlearn/refimmu.asp]* ■

Strategies key to boost health provider flu shots

APIC: Educate staff as well as patients

Health care workers need an annual influenza vaccine to protect themselves and their patients, advise national infection control officials.

The Association for Professionals in Infection Control and Epidemiology (APIC), based in Washington, DC, has added its voice and power to that message. APIC recently released a position paper on influenza immunization and is urging hospitals to improve their rates.

Only 36% of health care workers receive the vaccines annually, according to the National Health Interview Survey.

"With other preventable diseases, we've placed much more emphasis on making sure we have immunity," says **Jeanne Pfeiffer**, RN, MPH, CIC, APIC president, who is infection control program coordinator at Hennepin County Medical Center in Minneapolis.

APIC joins other organizations, including the National Foundation for Infectious Diseases and the Centers for Disease Control and Prevention, in making a greater push for influenza immunization.

It won't be easy, acknowledges Pfeiffer. "Even in our facility, where we've had an active program in place for about 10 years, we are at a little over 50%," she says.

The recommendations issued by APIC include the following:

1. All health care facilities should prepare a written policy stressing the importance of influenza vaccination among health care workers. This policy should strongly recommend that health care workers receive annual influenza vaccination to prevent spread of the virus to vulnerable patients. Every organization, regardless of size or type, should demonstrate its commitment by creating and distributing the policy to all employees.
2. Influenza immunization programs should be designed and implemented annually to increase vaccination rates. These programs should be designed to:
   - Educate health care workers about the importance of influenza immunization in health care settings and the low risk of adverse events associated with immunization.
   - Increase vaccine demand among health care workers.
   - Reduce barriers to health care worker immunization by developing programs that increase access to immunization and reduce cost of the vaccine.
   - Facilitate the influenza vaccination process, such as through the use of standing orders issued by the occupational health program for health care worker influenza vaccination.
3. Monitor annual immunization rates of employees, and provide feedback through the infection control and patient safety programs.
4. Monitor and track health care-associated influenza, in comparison to the health care worker immunization rates. Providing this information may stimulate health care workers to seek vaccination.
5. Track community incidence of influenza with public health officials using data from emergency departments, physician offices, and clinics. As the incidence increases, infection control and hospital administration should work together to identify pending admissions of potential influenza cases and to establish parameters for visitor restrictions. Specific interventions facilities should consider include:
   - Holding vaccine clinics in easily accessible locations and at varied times, so clinics are convenient for workers on all shifts.
   - Bringing vaccine to employees, wherever they might be, via a rolling cart. Areas to consider include cafeterias, employee entrances, medical records department, medical wards, and grand rounds.
   - Educating employees, through a variety of channels about the need to be vaccinated, and dispelling myths. For example, employee

newsletters, e-mails, posters can be used to address the misconception that inactivated influenza vaccine can cause the flu, and other similar myths. Employees should be educated about prevention of transmission, as well as benefits of vaccination.
- Removing all costs associated with vaccination. As a patient safety measure, institutions should provide employees with influenza vaccination just as they do other infection control interventions, such as personal protective equipment and hand hygiene products (e.g., soap or alcohol hand rubs).
- Conducting a public health campaign with media coverage.
- Adding influenza immunizations to the standard curricula in teaching institutions. Immunizations should be available to students at the academic institutions and paid for through student fees.
- Implementing additional mechanisms as necessary to facilitate the administration of vaccinations to health care workers in all settings.

(Editor's note: For a copy of the APIC position paper on influenza vaccination of health care workers, go to www.apic.org and click on "Protect Your Patients. Protect Yourself.") ■

Should you get the live attenuated flu vaccine?

ACIP to present new guidelines

Moving to clear up the considerable confusion of the last flu season, the Centers for Disease Control and Prevention (CDC) has drafted new guidelines for health care workers who receive the live attenuated influenza vaccine (LAIV).

The CDC's Advisory Committee on Immunization Practices (ACIP) is expected to soon release new guidelines that will allow the LAIV nasal spray vaccine (FluMist, MedImmune Vaccines Inc., Gaithersburg, MD) to be used more liberally in health care settings with fewer restrictions on immunized workers.

Tom Tolbert, MD, MPH, an infectious disease physician at Vanderbilt University Medical Center in Nashville, TN, is the lead researcher of a recent study that directly resulted in the new CDC guidelines. The data from this study show health care workers who receive LAIV are unlikely to shed flu virus more than seven days after vaccination, meaning the previous 21-day furloughs are unnecessary.

"If you going to reduce the activities of health care workers, we think you could probably limit that to a week," he continues. "In the first few days after vaccination with live flu vaccine in adults, [shedding] is fairly [common]. Half of the adults in our study shed. But by one week after that, that number was markedly reduced, and we did not find any evidence of shedding after day seven.

"This is an attenuated virus. It is temperature-sensitive, and it is not supposed to replicate in the lower respiratory tract," Tolbert explains. "So in theory, if you were to transmit this virus, it should not cause disease. In actuality, you are almost secondarily vaccinating individuals. But the one caveat is that we don't know if there is a chance that the attenuated virus could cause disease in an immunocompromised individual. There are people who think 'no' and people who think 'yes.'"

In that regard, the new ACIP guidelines will stress that potential transmission from a recent vaccinee only poses a threat to the most severely immunocompromised patients.

Health care workers need influenza vaccine

While the ACIP guidelines remain to be finalized, the draft version, **Jeff Stoddard**, MD, MPH, senior director of MedImmune's medical affairs influenza program, has seen emphasizes the importance of flu vaccination for health care workers, he says.

"One thing that the new ACIP guidelines will say very clearly is that health care workers, first and foremost, need to be vaccinated against influenza," he notes. "That was a point that got lost in the all the confusion last year. A lot of conscientious health care workers were surprised by how much focus there was on what one shouldn't do in terms of immunization as opposed to what one should do."

In general, ACIP recommendations will express no preference between the inactivated vaccine and LAIV for most health care workers treating most patients, Stoddard adds. Indeed, some see the arrival of the new vaccine as an opportunity to improve traditionally dismal levels of health care worker flu immunization.

"I think everyone on all sides of this debate would agree that health care workers need to improve their rate of immunization," he says.

"Influenza is a major of cause of nosocomial infections and morbidity and mortality in many high-risk populations. The fact that so many health care workers in this country forgo immunization against this preventable disease is really a national disgrace. It needs to be rectified," adds Stoddard.

Logistics difficult to manage

While few would dispute health care workers need to improve their rate of influenza immunization, **William Schaffner**, MD, chairman of the department of preventive medicine at Vanderbilt, finds a few devils in the details. For example, even if the furlough period can be reduced safely from 21 to seven days, the vaccine still presents logistical problems, he notes.

"I believe the furlough issue will continue to pose difficulties," Schaffner says. "We're in circumstances where [agencies] are running on very tight budgets, and the notion of using a vaccine that will oblige [an agency] to give a worker seven days off — or even if they arrange it around a weekend or whatever the call schedule is — it will present difficulties. It is still much easier to use the injectable vaccine."

Home health facilities also must factor in that the mist vaccine is generally more expensive and the at-risk patient population remains somewhat nebulous, he explains.

"I think we will have some [intense] discussions about what 'severely immunocompromised' means," Schaffner adds.

"We will have to sort out who could or could not get the nasal spray vaccine based on that. Then there will be other clinicians who come forward with questions about other categories of immunocompromised patients — cancer patients at the nadir of their chemotherapy. Isn't that comparable? There will be some HIV patients who are profoundly immunocompromised, and that question will come up. How can the ACIP distinguish between these patients?" he asks.

What about workers who receive LAIV from their own provider or visitors who have recently used the mist immunization?

"I think asking health care workers to tell their supervisor if they receive the spray vaccine will continue to be requested," Schaffner notes. "I don't know how much you can do about visitors [or family members] in any practical sense."

Schaffner maintains that the likelihood of any actual transmission of vaccine virus to a patient is "infinitely small." The issue may be as much about legal liability as infection control.

"There remains the issue, which came up last year, about the distinction between the ACIP recommendations and what is stated in the package insert [the 21-day period]," he says.

"For all of those reasons, plus cost, I believe that the injectable vaccine will continue to be the dominant vaccine used in the [health care] environment. A few years from now when more experience [with LAIV] has accumulated, and if there is no evidence of transmission, then everyone may be a bit more relaxed about its use," adds Schaffner.

A factor that gets somewhat lost within all the debate is that LAIV has not been primarily marketed to health care workers. "That has not necessarily been a targeted group," Stoddard says. "But certainly, we do feel that any vaccine that is licensed by the FDA to prevent influenza ought to be available to health care workers who are hoping to do the right thing and protect their patients."

Impact on children

Indeed, the needleless vaccine may have its greatest ultimate impact on children, a population the CDC is viewing with more concern regarding influenza. As of March 27, 2004, the agency had received reports of 142 influenza-associated deaths in U.S. residents age 18 and younger during the 2003-2004 season.

There is accumulating evidence to suggest that immunizing greater numbers of children would not only protect the pediatric population but their adult high-risk contacts, Stoddard notes.

"Children over the age of 5 are on label [for LAIV]," he says. "We did our pivotal efficacy study in children down to 15 months, but we only got the label for kids over 5 years. That is because we need more data on the younger kids. We hope to have this vaccine licensed down to early infancy in the next couple of years."

While the vaccine holds much potential to reduce the toll of annual flu, the live virus moniker has become something of a lightning rod.

"Unfortunately, there are a lot of misconceptions about live, attenuated vaccines," Stoddard says. "People forget that polio was eradicated primarily

through the use of live attenuated vaccines. People forget that every day, pediatricians use four live attenuated vaccines in their patients: measles, mumps, rubella, and chickenpox."

And a couple of fairly staggering numbers may be lost in the minutiae as well: Every year, influenza hospitalizes 114,000 people and kills 36,000 in the United States.

"It is important to understand that influenza is the No. 1 vaccine-preventable cause of death in this country," Stoddard points out. "It is one of the only communicable diseases that has not been brought under control despite having several tools in the armamentarium, including an inactivated vaccine."

Recommended reading

• Centers for Disease Control and Prevention. Advisory Committee on Immunization Practices. Using live, attenuated influenza vaccine for prevention and control of influenza. *MMWR* 2003; 52(RR13):1-8. ■

Say yes to that cup of tea! Sharing food builds trust

Get in touch with patients' cultural practices

Anyone listening to news programs in recent months will say that we are a nation obsessed with food and eating. If the news report isn't talking about overeating and obesity rates, it's focusing on the latest diet program to find favor with the public.

While the media may be focusing on food and our culture, home health managers may be overlooking the social importance of sharing meals or food with patients, says **Gottfried Oosterwal**, PhD, director of the Center for Intercultural Relations in Berrien Springs, MI.

"Universally, eating together is a way to form a bond, build a sense of community, and develop trust among people," he explains.

"In different parts of Africa, strangers are not allowed into a village until they have shared a meal with someone from the village; and in Mexico, a business lunch may last two to three hours with no business discussed at all," notes Oosterwal.

"We don't want to do business or share our personal information with strangers, but if we've shared a meal, we aren't strangers," he adds.

Cultural Resources

The following publications and web sites provide information on cultural diversity and health care:

- ***Culture & Nursing Care: A Pocket Guide***. Published by the UCSF Nursing Press, the book discusses cultural differences that can affect nursing care. Contact UCSF Nursing Press, University of California, San Francisco, School of Nursing, Box 0608, 2 Koret Way, #N-535C, San Francisco, CA 94143-0608. Phone: (415) 476-4992. Fax: (415) 476-6042. A description of the book and an order form is available at http://nurseweb.ucsf.edu/www/book4.htm. The book costs $21.95 plus shipping charges from $6 to $15 depending on quantity ordered. There is a 25% discount for prepaid orders of five books or more.
- ***Henry Ford Health System Multicultural Resource Guide*** contains background, family, social, food, spiritual, and health practice information on more than 20 cultural, racial, and religious groups. Copies of the book can be purchased for $29.95. For more information, or to order the book, contact Karen Giovannini at (313) 874-3766 or kwierci1@hfhs.org. The most recent issue will be available September 2004.
- **Diversity Rx** is a clearinghouse of information on how to meet the language and cultural needs of minorities, immigrants, refugees and other diverse populations seeking health care. The web site (http://www.diversityrx.org) offers sample models and practices, resources, overview of legal issues, and networking opportunities.
- **The Education Center for Texas Health Steps** offers an on-line continuing education course on cultural competency for health practitioners. To review the material, go to: http://thsteps.org/cultural_index.htm.

Unfortunately, many home health agencies have policies that prohibit a home health employee from eating or drinking in the patient's home, Oosterwal says.

Adherence to this policy can make it difficult, if not impossible, to establish a trusting relationship with members of different cultures, he points out.

It is important to understand how the different cultures represented by your patients view food.

Home health employees need to be aware of the differences and know how they can make the first visit a step toward a trusting relationship, as opposed to an offensive experience for the patient, Oosterwal says.

"There are many resources that explain cultural differences, and you can also rely upon your own employees who share the same cultural background as that of your patients," he notes. **(For more information on cultural resources, see box, p. 91.)**

Even with resources that are available to help you understand cultural differences, remember that immigrants do become "Americanized," Oosterwal notes. For this reason, be prepared to follow the patient's lead in terms of how they want the visit to begin, he suggests.

Staff members don't have to completely ignore a policy about sharing food with patients, but they should be able to have a cup of tea or coffee and a few cookies with a patient on the first visit, Oosterwal continues.

A trusting relationship is an important part of providing good patient care in home health, and the first visit is the point at which that trusting relationship is begun, he points out.

Keep conversation light

While drinking the tea, the nurse should not discuss business, Oosterwal says. "Although we are very task- and time-oriented, it is important to take a few moments to make the visit personal rather than businesslike," he says.

"It doesn't take much time to ask questions that put the patient at ease," he adds. For example, asking patients how long they have lived in the city, admiring a garden in their yards, or commenting on pictures of grandchildren that are displayed are all ways to show that you are interested in the patient as a person rather than a chart that needs to be completed.

To really strengthen the trust you are building, be sure to share something about yourself, says Oosterwal.

You don't have to share personal secrets, but you can refer to a spouse or a sibling who shares the same career as the patient, or you can mention a vacation trip to the city in which a patient's child lives, he adds.

The information you share should be simple and demonstrate that you've been listening to the patient and that you have something in common with him or her, he explains.

Once you've spent a few minutes getting to know the patient and letting the patient get to know you as you've had tea together, you can begin with assessment questions and completion of forms, Oosterwal says.

"The key to developing a trusting relationship is to show interest in the patient, and the sharing of food along with nonbusiness talk for a few minutes is the best way to demonstrate your interest in the patient," he adds.

[For more information about food and culture, contact:

- ***Gottfried Oosterwal,** PhD, Director, Center for Intercultural Relations, P.O. Box 133, Berrien Springs, MI 49103. Phone: (269) 471-1325. E-mail: ccirgob@juno.com]* ■

Thorough assessment is key to wound care

Cause of wound and nutrition drive care plan

The key to good outcomes in wound care is to assess the whole situation and develop a treatment plan that includes patient education and nutrition counseling as well as actual treatment of the wound, say experts interviewed by *Hospital Home Health*.

"We can't say that a wound is just a wound anymore," says **Janice A. Monforton**, RN, BSN, CWCN, clinical specialist with Smith & Nephew Wound Management in Largo, FL.

Because there are many different causes of wounds, it is important for the clinician to understand what is causing the wound, she says.

For example, if the ulcer is a venous ulcer as opposed to an arterial ulcer, you'd use compression therapy, Monforton adds.

Chronic ulcers are difficult to assess because once a wound reaches the stage at which it doesn't heal normally and stays inflamed, there are a number of causes that must be evaluated, she says. "The nurse must look for bioburden, necrotic tissues, poor circulation, tissue breakdown, and pressure as causes."

Once you begin treatment, good debridement is essential, Monforton points out.

The traditional method of mechanical debridement using a wet-to-dry dressing is not the best method for most patients, she explains.

"Wet-to-dry debridement pulls off good as well as bad tissue." Use of enzymes for debridement is more effective in home care because it works faster, can be covered by a bandage, and produces less trauma to the wound, Monforton explains.

Although there still is use of wet-to-dry debridement in home care, she sees changes occurring throughout the industry.

"As more home care agencies establish wound care programs or hire nurses with specific wound care knowledge, traditional approaches to wound care are changing," Monforton says.

"As wound care education improves, we are seeing that nurses are developing treatment plans that are not as programmed as they have been in the past," she adds.

For example, rather than relying on a treatment plan that only addresses the timing of dressing changes, nurses now develop plans that incorporate solutions to some of the causes of the wound, Monforton explains.

"If we are treating a pressure ulcer, we need to educate the patient and family caregivers on how to avoid exacerbation of the ulcer. If the nutritional status of the patient is affecting the healing process, we need to address that issue," she adds.

Vitamins and protein speed healing process

"Nutrition is a vital component of wound care," says **Samantha McLaughlin**, MS, RD, account manager for Novartis Consumer Health in St. Louis.

Monitoring a home care patient's food intake is difficult because the patient may not always have meals prepared on a regular basis and may prefer to eat sweets and carbohydrates rather than protein because those foods require no preparation, she says.

"A nurse should look in the refrigerator and pantry to see what type of food is available," McLaughlin suggests.

If there aren't nutritional foods available, educate the patient and the family caregiver about the importance of good nutrition for wound care as well as for overall health, she adds.

"If you notice signs of malnutrition, such as skin problems, cracks in the skin around the mouth, or weight changes of 10% of the patient's body weight in the past six months or 5% over 30 months, the nurse should consider a thorough nutritional assessment along with recommendations for supplements," McLaughlin says.

"Of course, we also need to make sure that the patient is able to eat," she adds. "Sometimes, a patient's ill-fitting dentures or other dental problems make it painful to chew, so patients are not eating what is prepared for them," McLaughlin explains.

"Not only do we need to make sure that wound care patients are receiving enough vitamin C and overall calories, but we need to make sure they are eating enough protein to promote healing," Monforton notes.

"A good way to check a patient's protein intake is to measure their albumin level." An albumin level of 3.5 or higher is good, anything below is cause for concern, she adds.

"Arginine, which is a nitrogen-rich amino acid, gives patients 4% to 5% of the protein they need each day," McLaughlin says. The supplement also provides calories that, along with the protein, increase the body's ability to heal wounds, she adds.

Because arginine comes in a powder form that must be mixed and drunk twice each day, and costs about 70 cents a serving, it might not be appropriate for all patients, she says.

"If a patient has a superficial wound and is able to eat protein-rich foods, then a multivitamin with vitamin C may be enough of a supplement to enhance wound healing, McLaughlin explains.

Be aware of other medical conditions that might require a close monitoring of protein or other supplements, she adds.

You don't want to heal the wound and exacerbate another condition with the wound care, McLaughlin says.

While treating a wound, remember that a lot of wounds are overcolonized with bacteria but may not appear to be infected, Monforton notes.

"For surgery wounds, look for warmth and tenderness around the wound. Chronic wounds may present increased drainage, have an odor, or bleed easily when you remove the dressing," she says.

Wound cultures are difficult and may not always produce accurate or complete identification of the bacteria, Monforton adds.

"A tissue biopsy is the most accurate way to identify bacteria but it is expensive," she says. For these reasons, it is important that a nurse identify the infection as early as possible so that a broad-spectrum antimicrobial can be used effectively, Monforton notes.

Dressings that contain medication to kill bacteria can be used, and localized wounds can have

the medication placed directly on the wound bed, she says.

The most important thing a home health manager can do is to provide training or resources for the nursing staff so they can assess wounds properly, Monforton says. "It's hard to treat a wound effectively if you don't know exactly what you're treating."

[For information on legal issues involving management of pressure ulcers in terminally ill patients, see Elizabeth Hogue's LegalEase column in the September issue of HHH*.*

For more information on wound care, contact:

- ***Janice A. Monforton**, RN, BSN, CWCN, Clinical Specialist, Smith & Nephew, 11775 Starkey Road, P.O. Box 1970, Largo, FL 33779. Phone: (800) 876-1261 or (727) 392-1261. E-mail: Janice.montforton @smith-nephew.com*
- ***Samantha McLaughlin**, MS, RD, Account Manager, Novartis, 1119 Mississippi Ave., #202, St. Louis, MO 63104. Phone: (800) 622-2689, ext. 4125. E-mail: Samantha.mclaughlin@ch.novartis.com*

For information about guidelines and clinical protocols for wound care, contact:

- ***Wound, Ostomy and Continence Nurses Society**, 4700 W. Lake Ave., Glenview, IL 60025. Phone: (888) 224-9626 or (866) 615-8560. Web site: www.wocn.org*
- ***American Academy of Wound Management**, 1255 23rd St., N.W., Washington, DC 20037. Phone: (202) 521-0368. Fax: (202) 833-3636. Web site: www.aawm.org]* ■

NEWS BRIEFS

Revised recommendations for flu prevention issued

The Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) has released its revised recommendations for the prevention and control of influenza (flu).

The new recommendations update 2003 ACIP recommendations for the use of the influenza vaccine, including dosage and administration instructions, potential adverse reactions, and populations who should not be vaccinated, as well as the use of antiviral medications.

Among its recommendations, ACIP says health care facilities should offer free, on-site influenza vaccinations to all employees, including night and weekend staff, beginning in October of each year, with special priority given to workers who care for at-risk patients.

ACIP also recommends that acute care hospitals strongly encourage patients who are age 50 or older or have high-risk conditions to receive a flu vaccine before they are discharged.

The complete revised ACIP recommendations for the prevention and control of influenza are available at the CDC web site: www.cdc.gov/flu Go to the "News & Highlights" box and select "MMWR: Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP)." ▼

Influenza vaccine supply increases for 2004-2005

The supply of influenza vaccine will be increased this year in an effort to prevent the shortages that occurred during the past flu season, the Centers for Disease Control and Prevention (CDC) announced.

Manufacturers will make 90 million to 100 million doses for the 2004-2005 season, compared with 87 million doses available last year, the agency said. Media attention about influenza led to an unprecedented demand, according to the CDC.

If vaccine shortages occur, the CDC said it may stagger the availability, giving priority to high-risk groups, such as health care workers and people at risk for complications from the flu.

The CDC had these recommendations:

- Vaccination campaigns should begin in mid-October because supply cannot be ensured for early fall.
- The new vaccine will contain three strains, including A/Fujian/411/2002 (H3N2)-like, A/New Caledonia/20/99 (H1N1)-like, and B/Shanghai/361/2002-like antigens.
- "If a health care worker receives live attenuated

influenza vaccine, the health care worker should refrain from contact with severely immunosuppressed patients for seven days after vaccine receipt. No preference exists for inactivated vaccine use by health care workers or other people who have close contact with persons with lesser degrees of immunosuppression." ▼

CMS slower to pay noncompliant claims

On July 6, 2004, the Centers for Medicare & Medicaid Services (CMS) began to treat electronic claims that were not in compliance with Health Insurance Portability and Accountability Act (HIPAA) standards as paper claims.

"The great majority of electronic claims we are receiving meet the required HIPAA standards but, for those still not in compliance, there is going to be a delay in getting their money," says **Mark B. McClellan**, MD, PhD, CMS administrator.

"We are hoping this will motivate more filers to get into compliance soon," he adds.

Under a modification to its HIPAA contingency plan announced in February, noncompliant electronic claims still will be accepted by CMS, but their payment will take 13 additional days which is the same payment time frame for paper claims.

Currently, 90% of all electronic claims comply with HIPAA standards, says McClellan.

"Now, a two-week delay is an important further incentive to get to 100%," he adds. ▼

Audio conference gets your facility ready for flu

Brace yourself: Flu season is right around the corner. Are you prepared?

If an influenza pandemic hits, the entire U.S. population could be at risk.

The annual impact of influenza on the United States is staggering. Ten percent to 20% of the population will get the flu. Some 36,000 people will die. And 114,000 will be hospitalized.

Most of those who die will be older than 65, but children 2 years old and younger will be as likely to be hospitalized as the elderly.

Thomson American Health Consultants is offering an audio conference with the information necessary to help you diagnose and treat patients with flu symptoms and, as important, prepare for an influenza pandemic.

Get Ready For Influenza Season: What You Need to Know About the Threat, Diagnosis and Treatment, which will be held on Tuesday, Sept. 28, 2004, from 2:30 to 3:30 p.m., EST, will be presented by **Benjamin Schwartz**, MD, and **Frederick Hayden**, MD.

Schwartz, who is with the National Vaccine Program Office and is spearheading the development of the National Pandemic Influenza Preparedness and Response Plan, will discuss the potential impact of an influenza pandemic.

Hayden, a professor of Internal Medicine and Pathology at the University of Virginia School of Medicine in Charlottesville, will discuss current methods of diagnosis and the latest information on treatment with antivirals.

This program will serve as an invaluable resource for your entire staff. Your fee of $249 includes presentation materials, additional reading, and free continuing education.

For more information, visit us at www.ahcpub.com, or contact customer service at (800) 688-2421 or by e-mail at customerservice@ahcpub.com

When registering, please reference code **T04118-61332**. ■

COMING IN FUTURE MONTHS

- Document properly to receive therapy reimbursement
- Hospice and home care partnerships improve palliative care
- Patient safety goals — can you meet them?
- Top ethical challenges for home care
- Managerial crises: How to face them and survive

CE *questions*

17. What is one benefit of obtaining physician orders for flu vaccinations, according to Mike Ellis, RN, BSN, director of support services at Henry Ford Home Health Care in Detroit?
    A. Medicare will reimburse the agency.
    B. It keeps physicians in the communications loop.
    C. It serves as a marketing tool to demonstrate the HHA's service to the patients.
    D. B and C

18. Why should home health managers evaluate their agency's policy prohibiting employees from eating or drinking in a patient's home if the agency serves clients from a variety of cultures, according to Gottfried Oosterwal, PhD, director of the Center for Intercultural Relations in Berrien Springs, MI?
    A. Sharing food is a method of building trust in many cultures.
    B. The visit will be lengthened considerably if the nurse has a cup of tea.
    C. Employees can skip meal breaks if they eat with patients.
    D. The assessment form can be completed while the nurse and the patient eat.

19. Why is a wet-to-dry dressing a less preferable form of debridement for home care patients, according to Janice A. Monforton, RN, BSN, CWCN, clinical specialist with Smith & Nephew Wound Management in Largo, FL?
    A. Medicare doesn't reimburse for it.
    B. Documentation is difficult.
    C. This process removes good as well as bad tissue.
    D. Nurses don't like it.

20. Which of the following primary adult groups does the Advisory Committee on Immunization Practices recommend for an annual flu vaccine?
    A. Those at increased risk for influenza-related complications
    B. Those who are between 50 to 64 years of age
    C. Those who live with or care for people at high risk
    D. All of the above

Answer Key: 17. D; 18. A; 19. C; 20. 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. ■

Correction

In the July 2004 issue of *Hospital Home Health*, we used incorrect numbering in the CE answer box. The correct answers for July are:

13. C; 14. D; 15. D; 16. A