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IN THIS ISSUE

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Universal vs. standard precautions: Do you know which you use?

Protect staff, patients from airborne and contact contagions

All home health agencies have policies to prevent the spread of infection but with recent focus on the threat of a pandemic, home health managers need to look more closely at how well prepared their agency will be for a situation that requires a higher level of protection than universal precautions, say experts interviewed by *Hospital Home Health.*

"Universal precautions are mandated for home health agencies but the type of pathogens that exist today require standard precautions that protect staff and patients against more threats of infection than universal precautions," says **Barbara B. Citarella**, RN, BSN, MS, CHCE, president and CEO of RBC Limited, a home care consulting firm located in Staatsburg, NY. It is also important to note that the Centers for Disease Control and Prevention (CDC) guidelines for pandemic flu require standard precautions as opposed to universal precautions, she adds. **(For tips on recognizing seasonal flu vs. pandemic flu, see chart on p. 15.)**

The first step in evaluating your infection control program's readiness for pandemic flu is to understand the difference between universal and standard precautions, says Citarella.

"Universal precautions were developed in 1991 to address the risk of bloodborne pathogens because at that time the majority of high-risk infectious disease was transmitted through blood," explains Citarella. "Now, with the threat of avian flu, West Nile virus, biological weapons,

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and pandemic flu, we face the risk of contact and airborne transmission as well as bloodborne transmission," she says.

Standard precautions were developed by the CDC to synthesize the major features of universal precautions, which were designed to reduce the risk of transmission of bloodborne pathogens, and body substance isolation, which was designed to reduce the risk of transmission of pathogens from moist body substances.

"It is important to recognize that even if a pathogen is usually transmitted by contact, the pathogen can be aerosolized by saliva," points out Citarella. For this reason, gloves alone won't protect the employee, she adds.

"We use standard precautions, so all of our clinicians have gloves, masks, goggles, aprons, and gowns in their bags," says **Frances Traver**, RN, BSN, quality improvement manager for St. Francis Home Health Care in Poughkeepsie, NY. "Aprons, gowns, and goggles are important in wound care if there is a risk of splash back when irrigating the wound," she says.

Respirator masks essential

Gloves, masks, goggles, and gowns are required by standard precautions in specific situations, but the most important piece of infection control equipment that many agencies don't have or don't have in adequate quantities is an N95 respirator mask, says Citarella. "I recommend that every agency have enough respirator masks for every employee for a three- to four-week period," she says. While the masks can be worn repeatedly, if a mask is contaminated, it must be replaced, so one mask per employee won't be enough, she adds.

Linda Rashba, RN, BSN, MS, administrator of

Additional Resources

- www.pandemicflu.gov
  Select "health care planning" on the top navigational bar. Scroll down to "checklists" and select "home health services checklist" to find policies, guidelines, and resources.
- http://www.cdc.gov/ncidod/dhqp/index.html
  This is the web site for the Centers for Disease Control and Prevention's Division of Healthcare Quality Promotion. Guidelines related to handwashing, multiple drug-resistant organisms, catheter site infections, and other infection control issues are located on this site.
- *The Home Care Handbook of Infection Control*, a home care-specific quick reference was developed by the Missouri Alliance for Home Care (MAHC) and the Association for Professionals in Infection Control and Epidemiology (APIC). To order a copy, go to www.homecaremissouri.org and select "MAHC products" on the left navigational bar. Scroll down to *Home Care Infection Control Handbook* to print a copy of the order form. The cost of the book for members of MAHC and APIC is $29 and the cost to non-members is $38.

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St. Francis Home Health, says that although every employee has one respirator, she plans to purchase extra respirator masks. "Every new employee of our hospital system is fit-tested when they are hired and all home care nurses carry their respirator masks with them," she says. Even though the agency nurses have the mask, Rashba admits that in the case of a pandemic, nurses should have backup masks that can be used immediately if the first mask is contaminated.

"Fit-testing is required because there is no one size fits all with N95 respirator masks," says Citarella. "An employee who wears glasses will be more comfortable with a flexible mask as opposed to a pre-formed mask," she says. "Of course, in an emergency any respirator mask is better than none," she says.

Respirator masks cost about $1.25 per employee per mask, says Citarella. "I recommend that agencies start building their inventory slowly," she says. Even though some state public health departments have plans to distribute respirator masks at a central location in a pandemic situation, no agency manager should rely upon an outside organization to protect agency employees, she emphasizes. "OSHA [the U.S. Occupational Safety and Health Administration] requires home health agencies to provide protective equipment to employees," she says. "If an employee becomes ill because you are waiting for the state to provide the equipment, you are responsible," she points out.

Although respirator masks have no expiration date, be sure that they are checked regularly for signs of deterioration, suggests Citarella. "Heat, humidity, and light can affect the rubber parts of

Seasonal or pandemic flu? Learn the differences

Seasonal Flu

- Outbreaks follow predictable seasonal patterns; occurs annually, usually in winter, in temperate climates
- Usually some immunity built up from previous exposure
- Healthy adults usually not at risk for serious complications; the very young, the elderly, and those with certain underlying health conditions at increased risk for serious complications
- Health systems can usually meet public and patient needs
- Vaccine developed based on known flu strains and available for annual flu season
- Adequate supplies of antivirals are usually available
- Average U.S. deaths approximately 36,000/year
- Symptoms: fever, cough, runny nose, muscle pain
- Death often caused by complications, such as pneumonia
- Generally causes modest impact on society (e.g., some school closing, encouragement of people who are sick to stay home)
- Manageable impact on domestic and world economy

Pandemic Flu

- Occurs rarely (three times in 20th century; last in 1968)
- No previous exposure; little or no pre-existing immunity
- Healthy people may be at increased risk for serious complications
- Health systems may be overwhelmed
- Vaccine probably would not be available in the early stages of a pandemic
- Effective antivirals may be in limited supply
- Number of deaths could be quite high (e.g., U.S. 1918 death toll approximately 675,000)
- Symptoms may be more severe and complications more frequent
- May cause major impact on society (e.g., widespread restrictions on travel, closings of schools and businesses, cancellation of large public gatherings)
- Potential for severe impact on domestic and world economy

Source: Centers for Disease Control and Prevention, Atlanta, GA. January 2007.

the masks so you do want to inspect masks that you are storing," she says.

In addition to making sure that employees have the proper protective equipment, be sure to continue to educate employees about the importance of handwashing, says Traver. Because her agency tracks the incidence of flu and multiple drug resistant organisms in her agency's population and reports the information to staff members, all employees are very aware and knowledgeable about practices that minimize risk of infection, she says. **(For other infection control concerns, see story on p. 16.)** "We also educate patients and their families about the importance of handwashing and give them a handout that they can use to educate other family members," she adds.

"Our office staff is also very aware of the importance of keeping their workspace clean," points out Traver. She says, "I don't know if our nursing staff's focus on infection prevention caused this increased awareness but I've noticed that office staff employees regularly wipe down their workspace, desk top, and computer keyboards."

Don't forget to thoroughly clean telemedicine equipment as well, suggests Rashba. "We have a protocol for cleaning telemedicine equipment when it is returned to us so that we can be sure we are not transporting pathogens to a new patient's home."

As agency managers evaluate their infection control plan, Citarella suggests that they look at moving toward implementation of standard precautions for all patients at all times. She explains, "We are seeing more guidelines require standard precautions as opposed to universal precautions so I believe that standard precautions will become the regulatory requirement for home health agencies in the future." ■

Bedbugs, drug-resistant pathogens pose challenge

Monitor rates to reduce spread of infection

While it is important for home health agencies to prepare to handle a flu pandemic, there are other infection control issues that agencies face more today than in past years, says **Barbara B. Citarella**, RN, BSN, MS, CHCE, president and CEO of RBC Limited, a home care consulting firm located in Staatsburg, NY.

"There are new guidelines from the CDC [Centers for Disease Control and Prevention] that direct agencies to identify risks and incidence of multiple drug-resistant organizations for their specific area," says Citarella. "Not only do the guidelines require agencies to develop protocols to address the identification and care of patients with methicillin-resistant staphylococcus aureus [MRSA] and vancomycin-resistant enterococci [VRE] but the guidelines also require agencies to track the infection rates," she says.

At St. Francis Home Health in Poughkeepsie, NY, not only are the rates of MRSA and VRE tracked but clusters of any infectious disease are tracked, says **Frances Traver**, RN, BSN, quality improvement manager for the agency. "We track wound infections and infections associated with Foley catheters to identify reasons for increased infections, but we also track staff infections to minimize the spread of any illness," she says. "If we see a cluster of staff members reporting gastrointestinal symptoms that may be viral, we tell staff members that if they have those symptoms they are to stay home until they are symptom-free for 24 hours," she says.

Another increasing issue for home health patients is bedbugs, says Citarella. The most common bedbug, *Cimex lectularius*, is making its way into more homes because increased travel throughout the country and around the world makes it easy for the insect to hide in clothing or luggage, she points out. While the bugs don't transmit disease, for home health patients who already have a weakened immune system, allergic reactions or potentially infected bug bite sites can be a problem, Citarella points out.

There is no way to prevent bedbugs but home health nurses should be aware of the potential problem if they have patients who wake up in the morning with insect bites they did not have when they went to bed, says Citarella. "Clinicians should know how to check bedding and other furniture in the house to look for signs of infestation," she says.

Create tracking method

Because tracking infections among staff members and patient populations is the only way to identify increases in rates, it is important to have

an effective system, says Traver. "I have tried relying on staff members to report infections as they occur but our nurses are so busy and they are focused on providing care, so reports were not also sent to me," she admits. "Now, I regularly go into our system and look at charts to determine if we are developing unanticipated infections," she says.

For example, one month Traver might pull wound care patient charts to look for additional antibiotics that are ordered after care has begun. If there is a new antibiotic, Traver reviews the chart further to see what type of infection developed. By monitoring infections on an ongoing basis, she adds, the agency has time to identify causes of a rising trend in infections and implement protocols to reduce the risk.

(Editor's note: For more information about bedbugs, go to www.mayoclinic.com/health/bedbugs/DS00663 and www.hsph.harvard.edu/bedbugs/.) ■

LegalEase

Understanding Laws, Rules, Regulations

Providers must take action to get patient compliance

Elizabeth E. Hogue, Esq.
Burtonsville, MD

Home health, private duty, hospice, home medical (HME), and case managers encounter frequent instances of non-compliance. Diabetic patients do not stick to their diets. Wound care patients or their caregivers do not follow instructions for dressing wounds. Bed-bound patients do not regularly change position in bed as instructed. Patients smoke while on oxygen.

Providers may be reluctant to confront instances of non-compliance and to attempt to assist patients to achieve compliance. On the contrary, it is imperative to take action to bring patients and/or their primary caregivers into compliance or, if they cannot achieve compliance, to discontinue services to them for the following reasons:

Risk Management

When providers continue to render services to non-compliant patients, their risk of legal liability is greatly enhanced. The "bottom line" is that it is extremely difficult to separate substandard care from non-compliance by patients and caregivers. Sooner or later, patients' attorneys are likely to get to the heart of the matter which is: If practitioners knew that patients or their primary caregivers were non-compliant, why did they continue providing services to them?

Reimbursement Based on Quality of Care

Payors, such as the Medicare Program, are determined to implement payment systems based on the quality of care provided as evidenced by outcomes such as the pay-for-performance (P4P) program. Private insurers and managed care organizations (MCO's) such as Aetna are also implementing payment programs that are tied to outcomes achieved. Non-compliance may produce poor outcomes. Regardless of the cause, providers are likely to experience reductions in reimbursement as a result of poor outcomes. Many providers simply cannot afford such reductions in reimbursement.

Financial

Caring for non-compliant patients and/or primary caregivers is likely to be more expensive than caring for patients and caregivers who adhere to their plans of care. Wound care patients, for example, may not achieve healing of their wounds, or they may require more lengthy or expensive treatments as a result of non-compliance. These factors may increase the cost of care substantially.

Ethical Considerations

There is an important ethical principle called "distributive justice" that says all patients being cared for by a provider, for example, are entitled to appropriate care. Non-compliant patients and caregivers tend to require a great many resources, including expenditures of huge amounts of energy by staff. In some instances, the resources expended on non-compliant patients and caregivers may mean that other patients do not receive appropriate care. This result is unacceptable from an ethical point of view.

With enhanced risks of legal liability and unethical conduct and emphasis on outcomes and quality of care, providers cannot afford to care for patients whose non-compliance hampers the results of their treatment. Now is the time to confront non-compliant patients and their caregivers and to take action. ■

Humor enhances staff education, patient care

Jokes, skits, stories reduce stress & improve learning

We've all heard that laughter is the best medicine, but home health managers have also found that humor can help staff members provide better care and learn more effectively as well.

"Humor is a wonderful coping mechanism and stress reliever," points out **Rosa Cunha**, BSN, RN, performance improvement manager for Englewood Hospital and Medical Center in Englewood, NJ. "Home health patients who are tense are disarmed by a nurse who sets a pleasant tone with light-hearted humor," she says.

Humor doesn't necessarily mean jokes, points out Cunha. "Comedians don't tell jokes as much as they talk about everyday situations that can be funny," she says. Remember that patients are often scared or worried about their condition or being home bound, so focus on light stories that are not health related and tell stories about yourself, she suggests. Starting a story with "I did the silliest thing" or "I saw a funny show on television," relaxes patients and gets them thinking about something other than their situation, she adds.

There are some caveats to using jokes or humor, warns Cunha. "Jokes may have ethnic, religious or other cultural overtones that a patient might find offensive, so be very careful which ones you use," she says. While everyone has some sense of humor, get to know the patient before you use sarcasm because not all people appreciate sarcastic humor, she suggests. "Also, the humorous statements we make in the office to co-workers may be too dark or seem harsh to patients so be aware of what type of humor is appropriate," she explains.

Humor in the office is wonderful, says Cunha. "Inservices and employee communications can be much more interesting if we remember to incorporate humor," she says. For example, in a presentation about clear writing in documentation, Cunha took samples of mistakes made in e-mails to show how written messages that are not carefully proofread can communicate a different meaning. An e-mail explaining the delay in cleaning the hospital parking lot was sent to managers with the note that the author was "sorry for the incontinence." Cunha could not resist sharing the e-mail with the comment that she "now understood the reason the parking lot had to be cleaned."

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Humor improves education

Not only do employees pay closer attention in classes that incorporate humor, but studies have shown that they retain the information presented in these classes, says Cunha. "You can always find a way to use humor to break the monotony of an inservice with funny stories, cartoons in your presentation, or games that get the audience involved," she says.

Simon Says is a terrific game to get people laughing, says Cunha. "People start out so seriously because they don't want to make a mistake, but soon everyone realizes how ridiculous the game is," she says. "It is also one way the instructor can feel very powerful. There are few times that any of us can make an entire room of people do exactly what we say!" she laughs.

Even though there were no staff members trying to rub their stomachs and pat their heads at the same time, managers of Cascade Home Health and Hospice in Eugene, OR, were able to make staff members laugh during an OASIS inservice. "We used a skit to demonstrate a nursing visit," she says. "We had just started using

point-of-service laptops so we exaggerated everything from leaving the computer open for the patient to play with while the nurse went to another room to hitting the wrong keys," she explains.

"We were focusing on the OASIS questions regarding medications so our nurses found loose pills in shoeboxes and socks; worked with obviously mislabeled pill bottles; and, in one situation, popped a bottle of pain pills open to have them spill into the nurse's lap," says **Judy Howe**, RN, manager of the agency. "One pill fell to the floor but she recovered it quickly and announced to the patient that the five-second rule applied so the pill was fine to take," she adds.

Inappropriate attire only increased the laughter as a therapist attempted to transfer a patient with a recent amputation from a wheelchair to the bed, says Howe. "We had staff members rolling in the aisles," she admits.

This particular inservice, which was repeated twice to enable all staff to attend and later videotaped was talked about for a long time, says Howe. "All of the actors were members of the management staff and I do believe the clinical staff appreciated the fact that we were willing to act foolish," she says. "It also helped that all members of our management staff are not at all shy and quite willing to perform in a funny skit," she adds.

If you have the right topic, the right performers, and the right situation, a humorous skit or presentation is a great way to educate staff members, says Howe. She adds, "Everyone gets tired of the same old inservices and if you can surprise staff members with an unexpected approach, they pay close attention, remember the material, and don't dread the next inservice." ■

Wound care helps patient's self-esteem

Hospice received CHAP commendation

When staff at the Hospice of Chattanooga in Tennessee provide wound care, they work to help the patient recover a sense of wholeness.

Families sometimes feel that even if their loved one is dying, they want to help heal the wound because it's at least one thing they can accomplish, says **Terry A. Melvin**, MD, FAAHPM, a fellow of American Academy of Hospice and Palliative Medicine, and the chief medical officer at the Hospice of Chattanooga.

SOURCES

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From the patient's perspective, a healed wound can help the patient feel whole and presentable to visitors, Melvin adds.

Melvin worked with a hospice nurse to develop a standardized wound care program with the goal to heal patients' wounds whenever possible and to improve them when healing isn't possible.

"I looked at all of the different products and came up with something affordable that works for our hospice budget," she says. "In the year and a half we've been doing this, we've had patients die and their wounds had healed."

Healing wounds is less dependent on the patient's physical or nutritional status than it is on the consistency of the care of the wound, Melvin says.

"The theory is that because a patient has low albumin and the nutritional status is poor, then on that basis the wounds won't heal," she explains. "My theory has been that I don't care if your albumin is low; if I have consistent wound care and turning, I can help that wound heal."

One patient told hospice staff that she wanted them to work with her to heal the wound on her abdomen, even if it meant she would spend three hours each day to do her own dressing change, Melvin recalls.

"And she did heal," she says. "That was the patient's sense of wholeness: 'I know I'm going to die, but at least I feel whole.'"

Wound care rarely is a top priority in hospice care, but it is one of those services that can make a big impact on a patient and family, partly for emotional reasons.

"When a family member sees a wound or pressure ulcer on their loved one's bottom, and it won't heal, they think they have failed and didn't do a good job," Melvin explains.

Checklist for creating wound care program

The wound care program's main components are selecting the best products to use, identifying at-risk patients, and educating family members.

• **Finding the right products:** "We honed in on a debridement agent that worked for us," Melvin says. "It's important to me that everybody is getting a high standard of care."

Melvin's model of care is the answer to this question: Is this the care that I would want my mother to receive?

To this end, wound care needs to be standardized, tried, tested, and improved.

"From a home health standpoint, the goal is getting somebody better — that's the standard," she says.

In hospice care, you take that standard, acknowledge that the patient will die, but let the patient know that you will do everything you can for that person until he or she dies, and that includes doing your best to heal his or her wound, Melvin explains.

"We've had patients who died with a stage 3 wound, and they had started off with a stage 4 wound," she says.

"We've had patients with a stage 4 wound, and they died with a stage 4 wound," Melvin adds. "But it was clean and not smelly, and the care that the patient was receiving was something that the patient and caregiver got into, and it was a ritual for them."

• **Identify at-risk patients:** Hospice staff need to prepare for tackling a wound care case before the program begins. One way they do this is by identifying which patients may be at risk for wounds and having a special mattress placed in those homes, Melvin says.

"We need to teach the family turning techniques to prevent wounds from occurring," Melvin says.

While the hospice receives the same per diem rate no matter how much money is put into wound care prevention and education, this is a model that will save money in the long run, Melvin notes.

"Prevention saves money, and our supply costs have actually decreased and the cost per patient per day has not increased," Melvin says. "It's more constant because we're ordering all of the same things, and there is a system by which the products are being used."

When the hospice began the program, no one knew if it would prove to be very costly or whether some of the spending could be recouped, Melvin notes.

"But I felt we had to do everything we could to prevent and to improve wound care," she says. "We even sent one of our nurses to school and paid her salary, so we now have two ostomy nurses — that's how important it is."

The ostomy nurses keep staff updated and educated and assist with nursing skills lab, and they're available for a consultation when a nurse believes a patient is at risk, Melvin adds.

• **Educating the patient and family:** Educating patients and family is an important part of the wound care program.

An interdisciplinary team teaches family members about wound care, but only if they're willing to learn, Melvin says.

"There are families who won't clean the wounds, so for those families we increase visits or bring in certified nursing assistants, so we can get the wound to the point where there isn't a need for a daily dressing," Melvin says. "So when the family sees that you're really working hard with this, they kind of pitch in, knowing that we're doing this for them, and they're doing it for their loved one."

The hospice's wound care program has gained a very favorable reputation in the area, and now there are calls for its support at nursing homes and elsewhere.

"We have two wound care nurses making rounds in the nursing home, in homes, and in the community," Melvin says.

"So are we spending a little bit more attention to it? — Yes," she says.

The worst-case scenario is a hospice admission where the patient has a smelly wound that is painful to change, but after the hospice's wound care, it loses its odor and becomes cleaner, Melvin says.

"You give back some hope to the patient and the family," Melvin says. "We show the patient that we respect him and his body, even though we know we can't heal him of the terminal illness."

It took some time to achieve staff buy-in on the new wound care program, and the staff initially were resistant to change, Melvin says.

"We picked nurses within each of the teams and tried to get them to buy-in," she says. "We educated them on when to use this product, and when a patient had a wound issue, the team would ask the trained nurse or back-up ostomy nurse or me what to do."

Over time, the entire team learned to provide the same quality wound care, and referrals from nursing homes began to increase because of the hospice's reputation in dealing with wounds, Melvin says.

"We have families who say, 'Daddy has metastatic cancer, and his bottom has broken down, and we want your hospice because we know you will do something for his wound,'" Melvin says. "We had a survey from CHAP, and they gave us a commendation as a result of our wound protocol." ■

Programs face challenge with older patients

Physiological, psychological needs differ

With individuals who are ages 65 and older undergoing almost one-third of the 25 million surgical procedures performed annually, and with people ages 85 and older representing the fastest growing segment of our population[1], it is important that any surgical program pay close attention to the special needs of older patients. Because you send patients home within hours of their procedures, it is especially important for outpatient surgery staff to be aware of these special needs, according to experts.

"Perioperative nurses must become geriatric specialists in order to fully meet the needs of this burgeoning population," says **Patricia Stein**, RN, MAOL, CNOR, nurse education specialist for perioperative services at Palomar Pomerado Health System in Escondido, CA. "An elderly surgical patient has less 'bounce back' after surgery, and there is less wiggle room for error of any kind," she says.

Assessment particularly important

While perioperative care for all patients requires thoroughness and attention to detail, it is particularly important to pay close attention to your assessment of an older patient, says **Jim B. Wilkerson**, RN, BSN, CCRN, outpatient surgery supervisor at Pomerado Hospital in Poway, CA. "Older patients are often on a number of medications, and you must be aware of how those medications, as well as their own physiological changes, might affect surgery," he says.

"The definition of elderly or older may differ for various outpatient programs, but generally it is defined as age 65," says **Jackie Close**, RN, MSN, certified nurse specialist in gerontology at Palomar Pomerado Health System. "Age 65 is used only because it has been set by the government as the age for retirement and therefore the beginning of 'old age,' but 65 is nothing more than an arbitrary number with no scientific data to support the decision," she says. Nurses must consider individual differences and characteristics when planning and implementing care for the older adult, such as overall health, activity level, and cognitive function, Close recommends.

One example of a difference between a younger patient and an older patient is skin resilience, Wilkerson points out. "A patient that might have been on steroids for a long time will have fragile skin," he says. This fragile skin means that the patient might bruise easily from a blood draw or have skin torn by adhesive bandages, he adds. "Also, be sure to ask if the patient is bruised or suffering from skin breakdown anywhere on their body so you can pad and position the patient to prevent further pressure on these injured areas," he suggests.

Even starting an intravenous line should be done with special care, recommends Stein. An everyday elastic tourniquet can injure fragile skin, so consider using a blood pressure cuff

instead of a tourniquet to apply a more even, less pinching device to properly obtain access, she suggests.

Another key difference between an older patient and a younger patient is mental status, Stein says.

"There is a decrease in short-term memory, and patients are at risk for postoperative dementia and confusion," she says. Add these cerebral function changes to the effects of multiple medications for a variety of medical conditions, and you must be especially careful that the older patient understands what will happen during their time in the surgery program and after discharge, she points out.

Patients also experience sensory changes that they may not want to admit, says Wilkerson.

"A patient may not be able to see clearly enough to read discharge instructions or may not clearly hear or comprehend the instructions you give verbally, but they will nod and react as if they do," he says. To ensure comprehension, Wilkerson suggests that nurses ask the patient to point to or read something, such as the phone number of the physician to call if there are problems. Asking the patient to repeat information back to the nurse also is effective, he adds.

Requiring a family member, friend, or other responsible adult who will be with the patient when he or she goes home to listen to the discharge instructions is also critical, Wilkerson says. "We require the responsible adult to sign the discharge forms because the patient is still under the effects of anesthesia and won't know what is being signed," he says. "Older patients often don't remember being told anything about care at home, so it is important for another adult to be there to hear the instructions and remind the patient that the nurse explained everything before discharge."

An important point to explain to the adult caregiver is an older person's susceptibility to delirium following anesthesia, says Wilkerson.

It doesn't occur with every patient, but it is not uncommon for a patient to become delirious, confused, and even combative in the middle of the night following surgery," he says. Because this can be very frightening to a caregiver, be sure that you explain the possibility of this occurring so that they are not surprised, he adds.

Because the first step in caring for an older surgical patient is the initial assessment, Close suggests, "allow yourself extra time for the interview and assessment. We must not hurry our older patients because when we don't listen, we miss out on very valuable information that could impact their surgical experience."

Reference

1. Muravchick S. *Geriatric anesthesia — Are you ready?* American Society of Anesthesiologists 2006; Web site: www.asahq.org/clinical/geriatrics/geron.html. ■

NEWS BRIEFS

CMS releases health spending estimates

Health care spending growth in the United States slowed for the third consecutive year in 2005, increasing 6.9% compared to 7.2% growth in 2004 and 8.1% in 2003, according to a report recently issued by the Centers for Medicare & Medicaid Services (CMS).

The 6.9% growth in 2005 marks the slowest rate of growth in health care spending since 1999, when growth was 6.2%. Health care spending reached almost $2.0 trillion in 2005, or $6,697 per person, up from $6,322 per person in 2004.

Expenditures for home health care agencies, although a small share of total health spending

(only 2.4%), grew the fastest among all services in 2005, increasing 11.1% to $47.5 billion. This is the third straight year of double-digit growth, driven by strong growth in public payments, which accounted for 75% of total home health spending in 2005.

Growth in overall public spending, 7.7% in 2005, outpaced overall private spending growth of 6.3%. Public spending growth has exceeded growth in private spending in each of the last two years, primarily due to strong growth in Medicare spending, and now accounts for 45% of total health spending.

Medicare spending rose 9.3% to $342 billion in 2005, following growth of 10.3% in 2004. Although growth remained strong, the deceleration was driven by slower growth in spending for hospital care, physician and clinical services, and nursing home and home health care, according to report authors. ▼

CMS: No late fees for low-income enrollees

The Centers for Medicare and Medicaid Services has announced the elimination of the 2007 late enrollment penalty for any beneficiary eligible for the low-income subsidy for a Part D plan even if they failed to sign up by the program's initial deadline.

Generally, Medicare beneficiaries who are qualified to join a prescription drug plan, or Part D, but choose not to enroll during their initial enrollment period, may be subject to a late enrollment penalty (LEP). These fees were intended to encourage Medicare beneficiaries to sign up for the drug coverage plan when they first become eligible, but may cause some low-income beneficiaries to avoid seeking coverage.

"It is very important that we remove whatever barriers may be preventing low-income beneficiaries from taking advantage of this great, cost-saving program," said CMS acting Administrator **Leslie V. Norwalk**. "This is our most difficult population to reach and the one for which we continue to focus our efforts. By continuing to remove the fear of a late fee for those who may not be able to pay, we are taking a positive step aimed at broader coverage for everyone." ■

CNE *questions*

5. Why can't a home health manager just order a large quantity of N95 respirator masks to keep in the store room for staff members to use, according to **Barbara B. Citarella**, RN, BSN, MS, CHCE, president and CEO of RBC Limited.
A. They carry expiration dates.
B. Employees need to be fit-tested to ensure a proper fit and style for comfort
C. You won't know how many staff members will need them.
D. Respirator masks are not required for home health employees

6. The most common bedbug, *Cimex lectularius*, is getting into more homes because increased travel throughout the United States and around the world has made it easier for the bug to hide in luggage, according to **Barbara B. Citarella.**
A. True
B. False

7. Why does humor enhance staff education, according to **Rosa Cunha**, BSN, RN, performance improvement manager for Englewood Hospital and Medical Center in Englewood, NJ?
A. It makes the presentation more interesting.
B. It makes the information more memorable.
C. It keeps staff members focused more closely on the presenter.
D. All of the above

8. Which of the following are integral to a wound care program?
A. the right products
B. identifying at-risk patients
C. educating patients and their families
D. all of the above

Answer Key: 5. B; 6. A; 7. D; 8. D.

(Continued from cover)

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CNE 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. ■

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **March** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■