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IN THIS ISSUE

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Assess use of anticoagulants to meet new NPSG requirement

Have a policy that addresses precautions for blood thinners

With one death every day and about 1.3 million people injured annually due to medication errors,[1] it is no surprise that reducing the risk of patient injury due to medication error is a National Patient Safety Goal for The Joint Commission.

While Goal 3 — "improve the safety of using medications" — has always been a safety goal, it is regularly reviewed and requirements for meeting the goal are adjusted as needed, says **Peter B. Angood,** MD, vice president and chief patient safety officer for The Joint Commission. The 2008 addition to Goal 3 is requirement 3E, which states that organizations must "reduce the likelihood of patient harm associated with the use of anticoagulation therapy."

"This topic [anticoagulation therapy] has surfaced in our Sentinel Events Advisory Group's reviews quickly in the past couple of years," says Angood. "Anticoagulation therapy can be safe for patients if they are monitored carefully by their primary care doctor and their home health provider to make sure that the correct dose is taken."

Unlike new goals in previous years, requirement 3E must be implemented within a specific timetable, says Angood. "In past years, we have identified a goal and given organizations one year to prepare for implementation," he says. The one-year time frame gave organizations a sense that there was no need to do anything for one year, he admits. The checkpoints outlined in the rationale for requirement 3E call for: assignment of leadership responsibility by April 1, 2008; implementation work plan in place by July 1, 2008; pilot testing in at least one clinical unit by Oct. 1, 2008; and full implementation by Jan. 1, 2009. "These checkpoints should help organizations better prepare for full implementation," he adds.

"I don't anticipate any problems complying with this patient safety goal," says **Sharon Darnall**, RN, director of Marion Home Health Services at Crittendon Health Systems in Marion, KY. "We care for a lot of post-surgical orthopedic patients so we have to monitor them carefully," she says. Because many of these patients had to discontinue anticoagulants prior to surgery, knowing when to restart anticoagulation

therapy and making sure the patient understands medication instructions is already an important part of the nurses' responsibility, she adds.

The main issue for home health agencies will be the need to establish guidelines for the monitoring and management of patients on anticoagulant therapy, says Angood. "The agency will need to define the management process, establish protocols for baseline and ongoing monitors, and define the process for identification of problems and solutions to those problems," he says. The key to continuous compliance will be staff and patient education, he adds.

Requirement 3E is the only new addition to The Joint Commission National Patient Safety Goals for home health programs for a reason, Angood points out. "We are aware that new goals or new requirements create a need for our accredited organizations to re-evaluate systems and procedures," he says. "Our field review demonstrates that organizations are coming up to speed

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SOURCES/RESOURCES

For more information about meeting the anticoagulation therapy requirements of National Patient Safety Goal 3, contact:

• Joint Commission Standards Interpretation Group, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181. Phone: (630) 792-5900. Web: www.jointcommission.org. To submit a question by e-mail, under "Standards," click on "Standards FAQs." Select "Click here to go to the Standards Online Question Submission Form."

To see a copy of the 2008 National Patient Safety Goals and implementation expectations, go to the web site. Select "Patient Safety" on the top navigation bar, then choose "National Patient Safety Goals." Select "Home Care" to see the goals. Links to the appropriate chapters that describe the rationale and implementation expectations are at the top of the page.

For information about anticoagulation therapy and tools you can use, go to:

• **ClotCare Online Resource:** www.clotcare.com Provides information for clinicians and patients/caregivers on anticoagulation topics such as warfarin, anticoagulant medications, blood clots, DVT, PT, INR, cancer, thromboembolism, atrial fibrillation, and antithrombotic therapy.
• **Institute for Clinical Systems Improvement (ICSI):** www.icsi.org. ICSI has developed an evidence-based Anticoagulation Therapy Guideline Supplement and a Venous Thromboembolism Guideline. The supplement provides recommendations regarding the indications and contraindications, adverse effects, dosing, monitoring of anticoagulant drugs, correction of supratherapeutic dosing of anticoagulants, and information on bridging therapy. The guideline is a resource for the diagnosis and treatment of venous thromboembolism including deep vein thrombosis of the lower extremities and pulmonary embolism.
• The University of Utah Pharmacy School has developed a list of Internet resources for anticoagulation therapy information, guidelines, and education. Go to: http://uuhsc.utah.edu/pharmacy/rxweblinks/rxlink28.html.

on the goals, so we eased off on the number of new goals that organizations must address in 2008."

Reference:

1. Food and Drug Administration. "Medication errors." Accessed at www.fda.gov/cder/handbook/mederror.htm. ■

Proactive study standard trips up 27% of agencies

Use FMEA process to meet standard

(Editor's note: This is the second of a two-part series that discusses the most challenging Joint Commission standards for home health agencies. Last month the top two challenges, standards for which agencies are cited 28% of the time, were discussed along with tips for compliance. This month, five more challenging standards are discussed.)

Home health managers are very aware of the need to conduct performance improvement projects, but 27% of home health agencies surveyed in 2006 by The Joint Commission did not have an ongoing program for proactive identification or resolution of potential adverse events.

"Standard PI.3.20 requires an organization to proactively review a high-risk process once a year to identify potential risks to the patient," says **Carol Mooney**, RN, MSN, senior association director of the standards interpretation group for The Joint Commission. While agencies do have performance improvement studies or committees in place to review processes once a problem has occurred, the key to complying with this standard is to choose a process or issue for which your agency has not experienced any problems to date, she explains.

The best approach to meet this standard's requirements is to use a failure mode evaluation analysis (FMEA), which requires identification of the process to be studied and a dissection of all the steps involved in the process, says Mooney. Flowchart every step, and question every step of the process to identify points at which a failure to protect patient safety might occur, she says. The next step is to prioritize the failure points to highlight the failures that would be critical to the patient. "Once the failure points are identified, solutions that eliminate or reduce the process failures must be implemented; then the agency must test the success of the changes," she adds.

Topics for a proactive study could include patient falls, home oxygen fires, medication errors, or a new service that is offered by the agency, says Mooney. Ideas for topics can come from sentinel event alerts by The Joint Commission, safety issues identified by other organizations in the industry, or suggestions from clinical staff and managers, she adds.

Mooney also recommends that home care managers focus on very specific processes that can easily be identified, such as proper use of certain equipment including patient lifts. Keeping a narrow focus enables an agency to thoroughly evaluate the process in a way that results in meaningful information and improvements, she adds.

The challenge that most agencies face in complying with this standard is the difficulty identifying a topic that represents a high risk to patient safety and the challenge of producing a flowchart that describes the failure points, says Mooney. "Documentation for this process includes the flowchart, minutes of FMEA committee meetings that report the study findings and implementation of changes, and documentation of the assessment form to evaluate the changes," she points out.

Not all FMEAs result in major process changes, points out Mooney. "If the study is performed and no major risks are identified, that is fine as long as the FMEA process was followed," she adds.

Document phone orders

An 18% non-compliance rate for providing care, treatment, and services according to a physician's order (PC.5.20) may sound terrible, but the reality is that most agencies cited for this standard are not documenting physicians' phone orders, says Mooney. "There is a lot of documentation required and sometimes the phone order is a basic, simple change to the treatment plan, but it is essential that any change be documented," she points out.

Improper hand hygiene still shocks some surveyors, admits Mooney. Fourteen percent of agencies surveyed in 2006 were cited for noncompliance with National Patient Safety Goal 7 that requires agencies to reduce the risk of health care-associated infections. With hand hygiene an important part of any infection control program,

Mooney points out the need for continuous re-education of staff members. "Sometimes the lack of knowledge is due to staff turnover but often it is due to a need for better education," she says. Without continuous reminders, staff members can easily lapse into old habits and neglect to soap and rinse hands for a minimum of 15 seconds or to wash hands between patients, even if gloves are used, she adds. **(To see the Centers for Disease Control and Prevention hand hygiene guidelines, go to www.cdc.gov/handhygiene/.)**

"I also suggest that supervisors reinforce education by observing staff members' hand hygiene practices on visits and include these observations as part of employee evaluations," Mooney says.

Conducting drills to test emergency management procedures (EC.4.20) also proved to be a challenge for 14% of home health agencies. "One fire drill a year is not enough to meet this standard," says Mooney. Although fire drills are important and should be conducted, in order to meet EC.4.20, the agency must participate in or conduct its own mock scenario of an emergency, she explains. "If an agency is hospital-based, the manager needs to make sure that the home care staff are involved in the hospital's emergency drill," she adds. This doesn't always happen, she adds. **(For information on emergency drills, see "Make sure your disaster plans include the recovery phase," *Hospital Home Health*, November 2005, p. 121.)**

Because many communities conduct community-based drills that involve police, fire, and local health care organizations, the agency can meet the standard by participating in the drill, says Mooney. "After the drill, the agency should critique its performance and develop recommendations for improvement if needed," she adds.

Goal 8 of the National Patient Safety Goals, which calls for the accurate and complete reconciliation of medications across the continuum of care, was a problem for 13% of the agencies surveyed. "Nurses should get a complete list of medications by talking with the patient, the family, the hospital if the patient was referred after a hospital stay, and the patient's physician," says Mooney. "It is also a good idea to ask the patient if medications are kept in different places in the home so the nurse can look for them." Because home care patients take a number of medications that may be changed frequently, a home care nurse should always ask if the patient has seen a physician since the last home care visit, or if any medications have changed since the last visit, she suggests. A copy of the most up-to-date list developed during home care should be given to the patient's family upon discharge. "The list should also be given to the next provider, whether that is a nursing home, or the patient's primary physician," she says. "Never assume that the physician knows what medications the patient is taking," she adds. **(For other tips on reconciling medication lists, see "Verify medication lists to improve outcomes," *HHH*, July 2006, p. 75.)**

Overall, home health agencies are doing well in their surveys, says Mooney. The switch to an unannounced survey process has not affected agencies' ability to be survey-ready, she says. "Home health agencies have had unannounced surveys by state agencies for years, so the switch to unannounced Joint Commission surveys was not a problem for them," she explains.

One tip that Mooney offers to help agencies be sure that the surveyor is well prepared is to ensure that your application information is correct. "Agencies should review their application to make sure they delete discontinued services, add new services, or correct any other information about the agency that may have changed," she says. "If the surveyor has updated information, the survey will go more smoothly." ■

SOURCES

For more information on Joint Commission standards, contact:

- **Joint Commission Standards Interpretation Group**, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181. Phone: (630) 792-5900. Web: www.jointcommission.org. To submit a question by e-mail, under "Standards," click on "Standards FAQs." Select "Click here to go to the Standards Online Question Submission Form."
- **The Institute for Healthcare Improvement** web site includes a section on medication reconciliation review, including samples of a reconciliation tracking tool and a medication reconciliation flow sheet. Go to www.ihi.org, click on "topics" on left navigational bar, choose "patient safety," then choose "medication systems." Under "medication systems," click on "tools," then choose "medication reconciliation" to see a list of forms and tools that can be used for medication reconciliation.

‘Hopefulness’ contributes to good end-of-life care

More education and experience also are benefits

Researchers at a large children’s hospital found that nurses who were comfortable working with dying children and their families were also nurses who reported high levels of hopefulness.[1]

“The study was prompted by our desire to see why it appeared that some nurses were more comfortable with end-of-life care and, in particular, talking to the families and having difficult conversations with them,” says **Gina Santucci**, MSN, RN, nursing coordinator, Pediatric Advanced Care Team (PACT) of the Children’s Hospital of Philadelphia.

Investigators analyzed nurses’ work experience, education levels, and hopefulness, and compared these to their self-assessment of competence in palliative care.

The study found that nurses with more nursing experience tended to express higher levels of comfort working with dying children and their families, and the same was true with nurses who had more years of education and higher levels of hopefulness, according to the Adult Dispositional Hope Scale.

Santucci wanted to include “hopefulness” in the study due to her own personal experiences as a nurse.

“I’ve worked on the floor and taken care of patients, and when I look back at my experiences, I can remember situations where I didn’t feel hopeful about what I was doing,” Santucci says. “Then there were other experiences that were equally difficult, but I felt everything was working well, and I felt hope had something to do with it.”

The study was a web-based questionnaire, and 932 nurses at the hospital were invited to participate, via e-mail. Nurses also were reminded of the survey at staff meetings.

In all, 410 nurses completed the questionnaire, which is a 44% response rate, Santucci says, adding, “We were happy that the response rate was over 20%.

“Our most substantial finding was with education, specifically, in palliative care; that was the highest,” she says.

Nurses who had more hours of palliative care education were the most comfortable in providing palliative care and talking about death and dying with their patients and families, Santucci says.

The web-based survey included these kinds of questions — asking for a rating from four, which means extremely competent to zero, meaning not competent — to assess a nurse’s opinion of her/his own competency in each of these areas:

- proving nursing interventions to improve the child’s quality of life;
- managing pain;
- managing other symptoms;
- talking with children and families about dying;
- emphasizing goals, not limitations;
- understanding the role of hospice;
- recognizing impending death;
- understanding advance directives;
- being sensitive to spiritual needs;
- being sensitive to cultural values and issues;
- understanding ethical issues surrounding end-of-life care; and
- knowing where to find help within the hospital when faced with an ethical dilemma.

Also, nurses with the most education reported feeling more competent, she adds.

The second highest correlation was between experience and feelings of comfort and competence in dealing with dying patients.

Researchers found that nurses with more experience expressed being comfortable with talking to dying patients and their families, Santucci says.

“But once nurses had five to six years of experience, their comfort level hit a plateau,” she adds. “Also, their difficulty in talking with families was higher if they were new nurses, and would gradually decrease with years of practice, reaching a plateau at about 10 years of practice.”

The study found that there also was a slight increase in comfort with higher levels of hope, Santucci says.

“With increased hopefulness, there was a significant decrease in difficulty in talking to families about end-of-life challenges, and there was a slight increase in confidence,” she says.

While the solution is fairly obvious with education and experience, enhancing hopefulness among nurses is more of a challenge, Santucci says.

“The question is, ‘How do you engender hope and how do you change things to make nurses more hopeful?’” Santucci says. “How do you eliminate those things we do to take away hope.”

There likely will be another study that looks at this issue, she adds.

"My ideas are that when people are dying at home, sometimes they get less and less visitors because people are not comfortable around death," Santucci says.

Although nurses in a children's hospital are wonderful, it's difficult sometimes for them to sit and be with a family, not saying much, but just being present, she explains.

"It's having an understanding of what the family may want, and that can only be done when you sit and listen for a long time," Santucci says. "It's hard to express, but when a child is dying, knowing what you need to do and being in tune with the child and family takes a lot of time, and it's difficult for everybody."

Reference

1. Feudtner C, et al. Hopeful thinking and level of comfort regarding providing pediatric palliative care: A survey of hospital nurses. *Pediatrics*. 2007;119:e186-e192. ■

Hospices, NHPCO prepare for anticipated CPs

Experts offer advice on how to plan for the change

Time is running out for hospices to prepare for the new Medicare conditions of participation (CPs), and experts say the best strategy is to make quality improvement changes now and not wait until sometime in 2008 when it will become the law.

The major change hospice industry leaders expect to find in the final rule for Medicare CPs involves the quality assessment and performance improvement (QAPI) requirement.

The Centers for Medicare & Medicaid Services (CMS) will ask providers to put together a comprehensive assessment of where their organization is in business, as well as in clinical practice. Then they'll be asked to do some performance improvement projects, including analyzing data and making certain they're measuring improvement, says **Judi Lund Person**, MPH, vice president of quality for the National Hospice & Palliative Care Organization (NHPCO) of Alexandria, VA.

"The whole idea of collecting data is not new," Person says. "The whole idea that you will measure your performance against yourself and other hospices in the country is a new area."

These quality improvement (QI) measures will be more challenging for hospices than they are for other health care entities, Person notes.

"You have the challenge of having at least half of our patients who are not responsive enough to answer questions directly," Person says. "So hospices will need to get information and data from family members."

Another challenge is that patients won't be enrolled with hospices for very long. Many patients may be in the program for less than a week, and this makes it difficult to track QI, she adds.

NHPCO launched its Quality Partners program a year ago to help hospice providers incorporate QI into their process, Person says.

"Quality Partners is very tied to CPs, and it helps providers get ready for this process, and it's one of the reasons why we have over 2,000 individual providers who have signed up for it and 250 hospice providers who have signed up," Person says.

CMS published the proposed CPs in the Federal Register on May 27, 2005, and the final rule is expected to be published in May 2008. While the final CPs will be changed somewhat from what was proposed two and a half years ago, hospice experts say they likely will include the major changes, such as the QI requirement.

The new CPs likely will focus on quality performance measures, as did the proposed CPs, says **Cordt Kassner**, PhD, executive director of the Colorado Hospice Organization of Colorado Springs.

"Many hospices have their own internal quality/performance improvement process, but they aren't specifically required through the CPs, and in the new CPs, they'll be required," Kassner says. "So the hospices that don't have an FTE [full-time equivalent] dedicated to quality assurance are in for a change and need assistance on how to develop these programs and how to be in compliance with the new CPs."

It's important to put the changes in context.

Current hospice rules are 25 years old, and the proposed new CPs will update the existing rules, as well as provide more consistency and clarity, Kassner says.

"I believe this is a reasonable request to show the good work that hospices do," he adds.

When the Medicare agency changed the rules

for home care organizations more than five years ago, it led to many organizations closing their doors. But this is unlikely to happen with hospices because the changes are not onerous, Kassner says.

"It doesn't seem like these new CPs are really out to significantly shrink the hospice industry, as other fields have experienced," he says. "I think there are some factors out there and some issues and concerns that we're monitoring that may have some impact on hospices, but it's nothing in the CPs."

Hospice leaders express some concerns about implementing the required changes, but none of them express fear that the changes may force them to go out of business, Kassner says.

"People aren't necessarily excited about it, but most hospices see how this is a good requirement in the new COPs," Kassner says. "Even for smaller hospices that don't have specific quality assessment programs in place, do not think it will be an overwhelming burden."

On the positive side, smaller hospices may be able to implement the new CP changes more quickly and more smoothly than larger hospices because they won't have as much staff to train or as complex communication systems to adjust, Kassner notes.

Colorado Hospice Organization (CHO), like other state hospice organizations, has joined NHPCO's Quality Partners program and is offering services and resources to hospices that need help in preparing for the CP changes.

There have been two statewide telephone conferences on the proposed CPs, Kassner says.

And CHO's annual fall conference, held Oct. 11-12, 2007, in Vail, CO, will focus on the quality initiative, and four of the 10 quality components will be addressed in plenary sessions and workshops, Kassner notes.

"We selected the following components: patient and family-centered care, workforce excellence, clinical excellence and safety, and performance measurement," Kassner says.

For some hospices, quality performance has long been a focus.

"We have been preparing for this long before there were new CPs," says **Janet L. Jones**, RN, BSN, CFO of Alive Hospice Inc. of Nashville, TN.

As a large hospice with more than 400 patient visits per day, Alive Hospice has been measuring quality performance organizationally for the past decade, Jones says.

"We attend to not just the clinical quality measures, but also the financial and other operational measures," Jones says. "So in preparing for the new CPs, it was a matter of pulling together things we were already doing and focusing on these a little differently."

The hospice was one of the first to participate in the NHPCO Quality Partners program, says **Tamara Royse**, RN, BS[Ed], MSQA, director for quality improvement and training at Alive Hospice.

"That helped us learn new techniques for improvement, and it was a fantastic learning experience," Royse says.

Royse works with other hospices as a faculty coach, assisting them with their performance improvement projects.

Another major change hospice leaders made in preparing for the CPs was to assess the hospice's overall education and leadership training, notes **Karen York**, MA, CPHQ, executive vice president of organizational excellence and mission at Alive Hospice.

They started off with broad staff education, followed by updates on quality assurance plans, and incorporating changes suggested by the proposed CPs, York says.

At Family Hospice and Palliative Care in Pittsburgh, part of the preparation for the new CPs involves having a detailed assessment done on all patients, says **Virginia Valentine**, RN, MS, CHPN, director of performance improvement.

"We evaluate right up front what their ability is to communicate," Valentine says. "We have tools for measuring pain in patients who are cognitively impaired or non-communicative, and we used guidelines in relation to non-cancer diagnoses."

Through using these tools, hospice leaders guide staff in making individual adjustments as needed, Valentine says.

Hospice leaders also hold discussions about the anticipated CPs and what these will mean to hospice professionals' daily work.

"We talk about current regulations related to the care planning and setting goals, and we looked at the proposed regulations out there because there are major changes in that whole area of care planning," Valentine says. "We've looked at doing care planning that would yield a focus on outcomes we could measure."

There are weekly team conferences in which staff review an individual patient's case and see how fast the patient's care is moving forward with regard to goals and outcomes, Valentine adds.

It takes time for staff to adjust to this change in how they think about patients and cases, she notes.

"I try to point out there will be a heavy focus on those outcomes," Valentine says. "If the goal is to achieve a certain level of comfort in terms of pain control, then you really need to monitor that and look at that."

Then at a two-week review, staff will have to see how the hospice is doing with regard to this outcome, Valentine says.

"We have to document that we have evaluated those outcomes and that we've moved on to developing new strategies for developing those outcomes," Valentine says.

It comes down to one word: documentation.

"When you talk to hospice professionals, you find that we all feel like we're doing a good job," Valentine says.

"But quality is a nebulous thing," she says. "We have to document with some measurable outcomes that we're in fact doing what we say we're doing."

So how do hospices do this?

The first step is conducting a comprehensive assessment for every patient at admission, Person says.

"It's not that different a process than what providers do now," Person explains. "It's goal setting and identifying each patient's needs."

The initial assessment is the beginning point for starting a quality assessment/performance improvement project, Person adds.

Basically, hospice organizations need to look within themselves to identify which areas need improving, and then they should start a clear and distinct process to make these improvements and measure their success, Jones says.

"Every organization will have to designate someone to be responsible for this process," Jones adds. "It doesn't have to be an additional person, but it has to be someone who has the key responsibility for helping with the process." ■

Simple test can prevent pneumonia after a stroke

Aspiration is main pneumonia risk in stroke victims

Millions of dollars and several hundred thousand lives could be saved if more hospitals followed a simple best practice — the swallow test — for stroke victims, assert researchers in a new study in the journal *Neurology.*[1] Aspiration, note medical experts, is the main pneumonia risk in stroke patients.

A research team from MetroHealth and Case Western Reserve University in Cleveland and led by **Irene Katzan**, MD, MS, assistant professor of neurology at the Cleveland Clinic and MetroHealth Medical Center, reviewed local hospital records of 11,286 stroke patients admitted between 1991 and 1997. They found that 5.6% of those patients developed pneumonia, which tripled a patient's chance of dying within 30 days, and was linked with a greater need of extended care after discharge and a greater chance of re-admittance for complications.

In addition, the study reports that the typical case of pneumonia costs about $15,000 per patient. With an estimated 500,000 such patients nationwide per year, the annual cost would be near $459 million, the authors asserted.

While the study did not specifically determine if the swallow test was given, "other studies done largely pre- and post-implementation of the [swallow test] protocol have shown that implementation of such a systematic protocol can reduce pneumonia by 50%; one even showed a 100% reduction," asserts Katzan.

This particular study, she notes, is part of a larger data initiative to look at the care provided under Cleveland Health Quality Choice on six diagnoses, including stroke. "My background is stroke, and pneumonia is one of the most frequent serious complications after stroke," she explains. "We are doing a fairly large study evaluating the predictors [of stroke] and the best ways to prevent it. This was a supplemental study evaluating pneumonia occurring after stroke."

The study on cost was designed to uncover the incremental costs that hospitals absorb when stroke patients develop pneumonia and require a lengthier hospital stay, she continues. "DRGs like stroke get a certain reimbursement no matter what testing is issued, so when any patient that goes above [the per diem rate] it is absorbed by the hospital," Katzan notes.

Improving poor performance

While the swallow test is a recognized best practice and easy to perform, "it is documented to occur in discouragingly low levels" in hospitals, notes Katzan.

Why?

"The hospitals have a lot to deal with [with stroke patients] and this is one of the systematic things that is hard to do in all places at all times," Katzan observes, "but it is clearly a best practice."

Still, when a stroke victim comes in at 2 a.m., or sits in the ED for eight hours, "the test may not get done," she concedes. Nevertheless, she says, "there is an increased awareness of the importance of doing this test, and over time I suspect the screening will be done more frequently."

Standardized orders

What processes can be put in place to improve the regularity with which this test is done? "You should first of all have standardized orders that include the swallow test, so things are less able to fall through the cracks," says Katzan. "The other thing is, as new nurses come on, as part of their training, it should become one of the standards of care." For a nurse with 10 years' experience, she notes, doing the test regularly might represent a change in practice. "But if you learn this when you join the staff, it will just be seen as 'the way it is.'" As for veteran staffers, "in-services are absolutely necessary, because nurses have so much to watch and deal with," Katzan asserts.

Several initiatives are currently in place to help quality professionals and hospital staffs optimize this practice, notes Katzan. One is the American Heart Association's "Get with the Guidelines," and the other is the Physician Quality Reporting Initiative (PQRI) of the Centers for Medicare & Medicaid Services (CMS). "Screening for dysphasia is one of eight stroke quality indicators that is part of a set of PQRI measures being used this year, and that puts dollars behind [compliance]," notes Katzan.

In terms of determining whether your staff are following the standardized order set, she recommends "auditing [the charts for] a subgroup of patients to see whether it was done and documented prior to oral intake, which includes oral medication." For example, she notes, "A nurse might give a stroke patient aspirin without checking their ability to swallow — which is now one of the quality measures. The bar is becoming much stricter with CMS, and it is moving higher."

The direct "take-home" of this study for quality managers, says Katzan:

"Is that the cost of pneumonia care is significant; not only does pneumonia increase the risk of mortality and have negative effects on morbidity, but it is costly." Ancillary data from other studies, she emphasizes, suggest that such pneumonias are preventable, "and screening for dysphasia is one of the simple, basic ways to reduce pneumonia."

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Reference

1. Katzan IL, Dawson NV, Thomas CL, Votruba ME, and Cebul RD. The cost of pneumonia after acute stroke. *Neurology* 2007; 68:1,938-1,943. ■

LegalEase

Understanding Laws, Rules, Regulations

When are patients deemed "unsafe" for home care?

By Elizabeth E. Hogue, Esq.
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Discharge planners/case managers are likely to encounter instances in which home care, hospice, and home medical equipment (HME) providers state that they cannot accept patients because they are "unsafe" at home. The use of this term may be confusing to discharge planners/case managers. What is it about patients' homes that make it "unsafe" for them to receive services there? Aren't all patients appropriate for home care?

First, discharge planners/case managers may not have provided services in non-institutional settings. If so, it may be difficult to make a crucial distinction between institutional care and home health services.

Specifically, in institutional settings the provider controls the "turf" on which care is rendered. In post-acute care at home, providers have

very little control over the environment in which services are provided. In fact, patients control the "turf" in home care because services are rendered in their private residences over which patients have almost absolute control.

Consequently, home care providers often confront barriers to the provision of services that many discharge planners have not experienced. Staff have, for example, encountered "attack geese" when they arrive at patients' homes and risk the consequences of a serious "pecking" in order to reach patients' bedsides! Or, they have come eye to eye with a pet alligator named "Bubba" in a mobile home in Louisiana!

Although patients may not be adversely affected by pecking geese and may have a cozy relationship with "Bubba," there may be other factors over which home care providers have no control that clearly jeopardize the well-being or safety of patients. These factors may make it impossible for providers to render services at home.

Patients' homes may, for example, be in such disrepair that both patients and caregivers are at risk. A home health nurse, for example, recently fell through the floor of a patient's home as she approached the patient's bedside.

Patients' homes may also be invested with roaches, rodents, and/or vermin of various types and descriptions.

Patients may suffer repeated falls at home despite appropriate interventions from providers that make it risky or "unsafe" for patients to remain at home.

Despite these examples, discharge planners/case managers may still be unclear about why patients cannot be cared for at home when post-acute providers decline referrals on the basis that patients are "unsafe." It may be helpful for providers to be much more specific in their communications. Specifically, it may be more helpful for providers to say, "The patient's home environment will not support services at home for the following reasons…"

When providers' communications with discharge planners/case managers are vague or unclear, it may be helpful for discharge planners to prompt more specific communication by asking: "What are the specific reasons why this patient's home environment will not support home care services?"

Institutional care and home health services are fundamentally different models of care. Because the differences are so great, it is reasonable to expect that providers who practice primarily in institutions and those who work in home care may not always understand or account for important factors involved in different types of care. Clear, specific communications are, therefore, absolutely essential for the well-being of patients. ■

CMS extends deadlines for first round of DMEPOS

The Centers for Medicare & Medicaid Services (CMS) is extending the bid submission, registration, and accreditation deadlines for the first round of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

On May 15, 2007, CMS issued a request for bids for the first round of the Medicare DMEPOS competitive bidding program. The original due date was 9 p.m., EST, July 13, 2007. All bids are now due by 9 p.m., EST, Sept. 25, 2007.

Suppliers interested in bidding must first register and receive a user ID and password before they can access the Internet-based bid submission system. Got to http://www.cms.hhs.gov/MedicareProviderSupEnroll/ for more information. ■

COMING IN FUTURE MONTHS

- Partner with nonprofit for increased market share
- Emergency preparedness begins at home for real success
- Improve ambulation assessments with therapist involvement
- Tips from HHAs with top patient satisfaction scores

Web site offers diabetics way to track glucose levels

Tracking blood glucose levels, making sense of the numbers, and sharing the all-important data with doctors could all get easier for the millions of people living with type 1 and type 2 diabetes, with the launch of a new web site created by a 24-year-old computer engineer who knows the challenges of the disease first hand.

SugarStats.com offers a web-based system to record and track glucose levels and medication usage, food and carbohydrate intake, and exercise and activity levels.

Studies have shown that web-based programs such as SugarStats.com can help people with diabetes reduce blood sugar levels, as measured by a standard blood test used to monitor average glucose levels over several months. The National Institutes of Health, American Medical Association, and American Diabetes Association studies have all concluded that web-based programs can have a significant impact, as long as the diabetic's health care practitioner can view the data.

Basic registration on the site is free and offers both glucose and medication tracking. A premium level offers the added features of food and exercise tracking for a small monthly or yearly fee. ■

Time spent in ED increased; patient satisfaction also up

The average time spent in emergency departments rose in 2006, but so did patient satisfaction, according to a recent report by Press Ganey Associates. Based on the firm's patient surveys in 1,500 hospitals, patients spent an average of four hours in the ED, 18 minutes more than in 2005.

The more patients an ED saw over the year, the longer the average visit, which increased by 30 minutes for every additional 10,000 patients. Patient satisfaction dropped as time in the ED increased, with the lowest satisfaction reported from 3 p.m. to 11 p.m. and highest from 7 a.m. to 3 p.m.

The 10 metropolitan areas with the highest ED patient satisfaction during the period from Jan. 1

CNE *questions*

21. What will home health agencies need to do in order to comply with the new National Patient Safety Goal related to anticoagulation therapy, according to **Peter B. Angood,** MD, vice president and chief patient safety officer for The Joint Commission?
    A. Hire a staff person to track patients receiving anticoagulation therapy.
    B. Nothing, if they already monitor medication use in general.
    C. Develop guidelines specific to monitoring and managing patients on anticoagulation therapy.
    D. Develop a comprehensive educational brochure specific to their patients.

22. What sets the requirements for compliance with standard PI.3.20 apart from other performance improvement requirements, according to **Carol Mooney**, RN, MSN, senior association director of the standards interpretation group for The Joint Commission?
    A. The study must involve physicians, staff, and patients.
    B. The study must be proactive and use the FMEA process.
    C. The study must address an ongoing problem within the agency.
    D. The study must address an occasional problem within the agency.

23. According to researchers who studied nurses' hopefulness and pediatric end-of-life care, nurses with the most education reported feeling more competent.
    A. True
    B. False

24. The research team that published an article about a test that could prevent pneumonia in stroke victims estimated the annual cost of treating patients with pneumonia at how much?
    A. $359 million
    B. $459 million
    C. $500 million
    D. None of the above

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

to Dec. 31, 2006, according to the report, are Milwaukee; Indianapolis; Columbus, OH; Oklahoma City; New Orleans; Detroit; Nashville, TN; Cleveland; Kansas City, MO-KS; and Chicago. ■

BINDERS AVAILABLE

HOSPITAL HOME HEALTH has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail **binders@ahcmedia.com**. Please be sure to include the name of the newsletter, the subscriber number and your full address.

If you need copies of past issues or prefer on-line, searchable access to past issues, you may get that at **www.ahcmedia.com/online.html**.

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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 **this** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■