Providing the highest quality information for 24 years

Hospital Home Health®

the monthly update for executives and health care professionals

AHC Media LLC

IN THIS ISSUE

■ **Clinical:** Antibiotic-resistant infections pose challenge in HHAs . . . . . cover

■ **Guidelines:** CDC addresses risks, precautions of resistant organisms 135

■ **Behavioral health:** Trauma can impact patients in unexpected ways 136

■ **Assessment:** Symptoms that indicate potential trauma . . 139

■ **LegalEase**: Liability for negligent premature discharge 141

■ **News Briefs** 142

■ **Inserted in this issue:**
— 2007 Index

Financial Disclosure:
Editor Sheryl Jackson, Managing Editor Jill Robbins, Associate Publisher Coles McKagen, Board Member Elizabeth Hogue, and Consulting Editor Marcia Reissig report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

DECEMBER 2007
VOL. 24, NO. 12 • (pages 133-144)

Rising rate of MRSA increases need for staff and patient education

Identification of infection, proper home isolation techniques critical

Antibiotic-resistant infections are not new to the health care setting, but headlines throughout the country have increased public awareness of the potential risk of infection.

According to a study by the Association for Professionals in Infection Control and Epidemiology, methicillin-resistant *Staphylococcus aureus* (MRSA) accounted for only 2% of all *Staphylococcus aureus* health care-associated infections reported to the Centers for Disease Control and Prevention (CDC) in 1972. Today, MRSA accounts for more than 60% of *Staphylococcus aureus* infections.

Although there are no studies that have looked specifically at home care, infection control experts point to the need for home care staff members to be knowledgeable about these organisms in order to minimize risk. Unfortunately, even with increased publicity of MRSA in the community, not all health care providers recognize the infection.

"I went to visit my 90-year-old mother who lives on the East Coast and she showed me a wound that wasn't healing," says **Marcia R. Patrick**, RN, MSN, CIC, director of infection control at Multicare Health Systems in Tacoma, WA. "It was classic MRSA so we went to see her physician," she says.

Although the culture that Patrick had to insist upon did show the presence of MRSA, it became clear to Patrick and her mother that the physician did not know how to treat the infection. After visiting a vascular surgeon, then treating the wound with silver dressings, the wound healed, but not before it had grown from the size of a quarter to a 4-by-6 inch area that left a permanent scar, she points out.

"We don't always know who has MRSA or any other antibiotic-resistant infection because a patient can be a carrier without having an active infection," Patrick says. "Many hospitals are testing a wide range of patients upon admission to identify patients who may be carriers."

Although testing of all home health patients is not practical or necessary, Patrick recommends an increased awareness of the signs and symptoms of bacteria-resistant infections so that treatment can be provided early and so that home health staff can ensure good outcomes for patients.

Patients at risk

Patients at highest risk for MRSA or vancomycin-resistant enterococci (VRE), the two antibiotic-resistant organisms seen in the community, are those with wounds, catheters, a history of boils, or patients on dialysis, says Patrick. It is critical to recognize these patients higher risk for infection and monitor them carefully, she says. "MRSA often appears as a spider bite that doesn't heal, or a wound that won't heal," she adds.

"We don't screen all patients for MRSA or VRE upon admission but we have an active staff education program designed to heighten awareness of these infections for all staff members," says **Shannon Quaritsch**, RN, MS, CPHQ, quality improvement specialist at Northwest Community Home Care in Arlington Heights, IL. Staff education includes guidelines that identify different organisms and describe the type and duration of isolation necessary to prevent spread of the infection, she says.

Inservices include case scenarios that give nurses a chance to discuss the challenges faced by home care providers when a patient must be isolated, points out Quaritsch.

Although nurses use standard precautions in patients' homes, not all nurses were handling patient education in the same way before the awareness program, she admits. "Now, all of the nurses have a checklist that they use to ensure that patients and family caregivers are taught about laundry procedures, the need to clean the patient's area frequently, and the need for gloves or aprons when dealing with body fluids," she says.

CDC prevention recommendations

The most common methods to prevent spread of the infection in the home that are recommended by the Atlanta, GA-based CDC are:

- Caregivers should wash their hands with soap and water after physical contact with the infected or colonized person and before leaving the home.
- Towels used for drying hands after contact should be used only once.
- Disposable gloves should be worn if contact with body fluids is expected and hands should be washed after removing the gloves.
- Linens should be changed and washed if they are soiled and on a routine basis.
- The patient's environment should be cleaned routinely and when soiled with body fluids.
- Notify doctors and other health care personnel who provide care for the patient that the patient is colonized/infected with a multidrug-resistant organism.

(For other CDC information related to antibiotic-resistant infections, see p. 135.)

One part of Northwest Community Home Care's protocol for antibiotic-resistant infections is the need to culture any unimproved wound at the two-week point, says Quaritsch.

"Pressure ulcers are more difficult to culture

Hospital Home Health® (ISSN# 0884-8998) is published monthly by AHC Media LLC, 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.

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $499. Add $12.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. 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 $83 each. (GST registration number R128870672.)

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is intended for nurses, managers, directors, and management involved in hospital-owned home care agencies, including health care professionals involved with home care issues such as end-of-life care, pain management, multicultural issues, elder care, and similar issues. It is in effect for 24 months from the date of publication.

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**.
Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).
Production Editor: **Ami Sutaria**.

Editorial Questions
For questions or comments, call **Jill Robbins** at (404) 262-5557.

SOURCES

For more information about antibiotic-resistant infections, contact:

• **Marcia R. Patrick**, RN, MSN, CIC, director of infection control, Multicare Health Systems, 315 Martin Luther King Jr. Way, Tacoma, WA 98405. Phone: (253) 403-1622. E-mail: marcia.patrick@multicare.org.
• **Shannon Quaritsch**, RN, MS, CPHQ, quality improvement specialist, Northwest Community Home Care, 3060 Salt Creek Lane, #110, Arlington Heights, IL 60005. Phone: (847) 618-7855. E-mail: squaritsch@nch.org.

For information about the methicillin-resistant S*taphylococcus aureus* study conducted by the Association of Professionals in Infection Control and Epidemiology, go to www.apic.org. Select "Research Foundation" on the top navigational bar, and then select "National MRSA Prevalence Study."

in the home so they generally have to be biopsied in the hospital," she adds.

Once MRSA or VRE are diagnosed, patients are started on antibiotics that are known to work on these infections and caregivers are taught how to keep the patient's area, linens, and clothing clean to prevent the spread of the infection, she says.

It is difficult to treat patients with MRSA in the home because you have to rely upon family caregivers who may not be able to take care of themselves, as well as a patient who requires additional care, says Quaritsch.

"They are also reluctant to ask for help so it is up to the nurse to notice if additional help is needed, or if the patient must be transferred to another provider until the infection is controlled," she says.

"It is not unusual for a home care patient with MRSA to go to an extended-care facility for a brief time to ensure proper treatment of the infection," she adds.

The best way to approach diagnosis of MRSA and VRE is to realize that MRSA is everywhere, says Patrick. "It all goes back to basic hygiene and washing hands," she says. "Teach patients and staff members to wash hands and the risk of infection decreases." ■

CDC answers questions related to MRSA

Awareness and identification of risks important

Although the prevalence of methicillin-resistant *Staphylococcus aureus* (MRSA) is not as high in home care as it is in hospitals, the Centers for Disease Control and Prevention addresses the risk and identification of the infection as well as precautions to take to prevent spread of any antibiotic-resistant infection in non-hospital settings on its web site (http://www.cdc.gov/ncidod/dhqp/ar_mrsa.html).

• What are "non-hospital health care settings"?

They refer to residential settings (e.g., long-term care and skilled nursing homes), home care, hemodialysis centers, and physicians' offices.

• What are multidrug-resistant organisms?

They are bacteria and other microorganisms that have developed resistance to antimicrobial drugs. Common examples of these organisms include:

• **MRSA** — methicillin/oxacillin-resistant Staphylococcus aureus
• **VRE** — vancomycin-resistant enterococci
• **ESBLs** — extended-spectrum beta-lactamases (which are resistant to cephalosporins and monobactams)
• **PRSP** — penicillin-resistant *Streptococcus pneumoniae*

• Which multidrug-resistant organisms are most commonly seen in non-hospital settings?

MRSA and VRE are the most commonly encountered multidrug-resistant organisms in patients residing in non-hospital health care facilities, such as nursing homes and other long-term care facilities. PRSP is more common in patients seeking care in outpatient settings such as physicians' offices and clinics, especially in pediatric settings.

• What conditions increase the risk of acquiring these organisms?

There are several risk factors for both colonization and infection:

• severity of illness;
• previous exposure to antimicrobial agents;
• underlying diseases or conditions,

particularly:
— chronic renal disease;
— insulin-dependent diabetes mellitus;
— peripheral vascular disease;
— dermatitis or skin lesions;
• invasive procedures, such as:
• dialysis;
• presence of invasive devices;
• urinary catheterization;
• repeated contact with the health care system;
• previous colonization of by a multidrug-resistant organism;
• advanced age.

• Should patients colonized or infected with these organisms be admitted to non-hospital health care facilities?

Non-hospital health care facilities can safely care for and manage these patients by following appropriate infection control practices. In addition, non-hospital health care facilities should be aware that persons with MRSA, VRE, and other infections may be protected by the Americans with Disabilities Act or other applicable state or local laws or regulations.

• What can be done to prevent or control transmission of these pathogens in my facility?

The CDC's recommendations for preventing transmission of MRSA/VRE in hospitals consist of standard precautions, which should be used for all patient care. In addition, the CDC recommends contact precautions when the facility (based on national or local regulations) deems the multidrug-resistant microorganism to be of special clinical and epidemiologic significance.

The components of contact precautions may be adapted for use in non-hospital health care facilities, especially if the patient has draining wounds or difficulty controlling body fluids.

In addition to standard and contact precautions, the following procedures also may be considered for non-hospital health care facilities:

• **Patient placement** — Place the patient in a private room, if possible. When a private room is not available, place the patient in a room with a patient who is colonized or infected with the same organism, but does not have any other infection (cohorting). Another option is to place an infected patient with a patient who does not have risk factors for infection.

• **Patient placement in dialysis facilities** — Dialyze the patient at a station with as few adjacent stations as possible (e.g., at the end or corner of the unit).

• **Group activities** — It is extremely important to maintain patients' ability to socialize and have access to rehabilitation opportunities. Infected or colonized patients should be permitted to participate in group meals and activities if draining wounds are covered, bodily fluids are contained, and the patients observe good hygienic practices.

The following are recommended for prevention of MRSA / VRE in hospitals and may be adapted for use in non-hospital health care facilities:

• Obtain stool cultures or rectal swab cultures of roommates of patients newly found to be infected or colonized with VRE, and nasal swabs for MRSA.

• Adopt a policy for deciding when patients can be removed from isolation (e.g., VRE-negative results on at least three consecutive occasions, one or more weeks apart.)

• Consult health departments regarding discharge requirements for patients with MRSA or VRE.

• How should clusters or outbreaks of infections be handled?

Consult with state or local health departments or an experienced infection control professional for reporting requirements and management of MRSA or VRE outbreaks.

Reference

1. Centers for Disease Control and Prevention. *Multidrug-Resistant Organisms (MDRO's) In Non-Hospital Healthcare Settings.* Web site: http://www.cdc.gov/ncidod/dhqp/ar_multidrugFAQ.html. 2007. ■

Buried trauma can impact patient in unexpected ways

Here's how experts recommend handling it

Hospice professionals need to be aware that end-of-life patients sometimes are dealing with post-traumatic stress from previous traumas, whether they served in a war or were abused as children. These buried memories and feelings can complicate physical symptoms, including patients' pain and suffering.

Some types of behavior often thought to be

characteristics of a certain generation could be symptoms of the patient suffering through this unspoken trauma, says **Ric Baxter**, MD, hospice medical director and director of palliative care services at St. Luke's Hospital and Health Network in Bethlehem, PA.

When St. Luke's opened an inpatient hospice facility about two years ago, Baxter began to have unanswered questions about some patients' behavior.

"Early on, there was a particular patient who really sparked this gut feeling that something significant was going on," Baxter recalls.

The patient was an 84-year-old woman with pancreatic cancer, and she was admitted to the inpatient hospice unit because of intractable pain, nausea, and vomiting, Baxter says.

Her son was the caregiver, and he was overwhelmed, Baxter adds.

"Her presentation was of a patient who could only make eye contact with her son," he says. "And she was almost writhing in pain, but would only acknowledge that it hurt a little."

Also, the woman couldn't be left alone at night. As her story was revealed, staff learned that the woman had been in a violent relationship for more than 20 years; her children had been raised in that environment. The care-giving son exhibited high anxiety.

Susan Vollmer, MA, MDiv, BCC, chaplain and bereavement coordinator at the Hospice of the VNA of St. Luke's in Bethlehem, had asked the woman some open-ended questions about her life and her marriage, and as they spent time together, the woman confided to having an abusive marriage in which her husband would lock her in closets and batter her physically and emotionally — even in front of the children.

"So I went back to the team and said, 'Here are the things going on in her heart and head,'" Vollmer says. The hospice nurses had wanted to document the woman as in need of a routine level of care because her symptoms could be managed with medication, Baxter notes.

Nonphysical suffering requires care, too

"Our position was that her nonphysical symptoms remained acute for two to three weeks, and we needed to look at her total suffering, including psychological, emotional, and spiritual suffering, which required an extra level of care," he says.

The woman needed help in alleviating her fears and in gaining trust, Vollmer says.

So Baxter and Vollmer helped to develop a plan of care that included using volunteers who would be dedicated to the patient, as well as having hospice staff visits timed in such a way that the woman was never left alone for more than 20 minutes at a time.

"We left the TV and lights on for her at night," Vollmer recalls. "And if I saw her in the morning, I'd say I'd be back in the afternoon, and then I'd really do that, providing follow-through."

The extra care included assisting the son so that he could be with his mother in a way that was comfortable for them both, Vollmer adds.

The patient told the hospice workers that being there was the best thing that had ever happened to her, she says.

As the patient's life story unraveled, it became clear that the hospice team sometimes missed important cues about a hidden trauma in patients' lives, Baxter says.

"We needed the hospice staff, particularly nurses, social workers, and administrative staff, to see these patients in a slightly different light, in terms of the amount of suffering they experienced related to non-physical symptoms," he says.

"Very quickly, we began to see somewhere around 50% of the people who were admitted had some kind of story, and it frequently was a silent story," he adds.

Hospice staff observed symptoms that didn't quite fit with the physical aspects of the disease, and they found that patients sometimes would respond to hospice care and services in an unpredictable way, says Vollmer.

"A lot of my work with families is in life review," Vollmer notes. "It includes things that were hard to go through, things they regret they had to go through."

As she did this work with hospice patients, Vollmer began to hear stories about traumatic events, including natural disasters, neglect, abuse, and war experiences.

"It became apparent that there were symptoms related to these stories," Vollmer says. "At times, we had people with symptoms who didn't have any stories, so we became more intentional about working with patients and families and finding out what they could tell us about the patient's past."

Assessing patients

Through observing these symptoms and seeing in anecdotal evidence how frequently certain symptoms were tied to traumatic life experiences, Vollmer and Baxter developed a two-page tool

for assessing traumatic life experiences.

They also developed a one-page form that instructs hospice staff on how to ask for clarifying information from patients who have symptoms of past trauma and post-traumatic stress disorder.

Some of the suggestions included in the form are as follows:

- What can you tell me about your life? Your relationships? Your childhood? Your adult years?
- Is there anything in your life that feels scary, frightening, or troubling when you think of it?
- Have you had flashbacks?
- Do you have a history of abuse?
- Do you have a history of painful events, such as injuries, disasters, illnesses?
- How do you sleep at night? Do you have bad dreams? Do you have trouble going to sleep, staying asleep, or waking? Are you afraid of going to sleep?

As patients decline their usual defenses against PTSD, symptoms also decline, and they have less of an ability to control what is happening, which increases the symptoms, Vollmer says.

"People work hard to keep symptoms and painful memories at bay, but once you can't do that as well, the memories don't go away," she explains. "It's their opportunity to rise up because they can't be held down anymore."

As a result, patients may have flashbacks and have panic attacks at night, Vollmer adds.

The traumas largely have been suppressed because of society's judgments and inhibitions about certain types of victimization.

The victims themselves may have felt they deserved the trauma that happened to them, and they certainly know that it's hard for other people to hear their stories, Vollmer explains.

The shame behind the trauma

"There's a huge amount of shame attached to the individual and the person's experience, and over time, nobody really wants to listen to this, so they stop talking and bury it," Baxter says.

For example, women in abusive relationships often experience having people tell them to get away from the man without really listening to who the woman is and where she is with regard to independence, Baxter explains.

He offers this case study of a hospice patient with suppressed trauma that was discovered because of physical and behavioral symptoms:

The woman, who was in her fifties, had a brain tumor. She'd been referred to the inpatient hospice unit from the hospital because of troubling hallucinations and difficulty walking, Baxter recalls.

The woman was married with several children, including a stepchild. When Baxter met with the woman at the initial assessment, a female social worker accompanied him.

"Every time I asked the patient a question, she would answer the social worker, and she could not make sustained eye contact with me at all," Baxter says.

"When we asked her a general question about herself, and this is a woman who knows she is dying of a brain tumor, her story was about her mother's death two years earlier," Baxter adds. "When we asked her to tell us about her relationship with her mother, her description of that relationship is when she was a young child, and she said her mother couldn't be without her."

As the woman spoke about her life, she revealed that she had been married three times, all to abusive men, including her current husband.

"The first husband beat her when she was pregnant, and she lost the child," Baxter recalls. "The third husband was abusive to her and their children."

When asked about the abuse, the husband said he had stopped the abuse eight years earlier when he stopped drinking, and the patient confirmed this. Also, the patient wanted to return home, but she needed to know she'd be safe, Baxter says.

"She was able to attend a group meeting to say to her husband, 'I need to know you won't hurt me, that you won't drink, and that I can be safe,'" Baxter says. It took some assistance from Baxter and the hospice staff before the woman had the courage to make her end-of-life desires known.

"The woman sat in bed and pulled up her legs, almost in a fetal position, and she kept her whole body drawn in," Vollmer says. "She probably had never confronted a male before in her life, but she did it."

The patient's husband agreed to her terms, and he brought her home, where she stayed for more than a month. Hospice staff continued to visit her and would ask her about her safety at each visit, Baxter notes.

"We were very intentional about having a presence in the home on a regular basis, so the social worker made visits more often, and the home health aide visited at times of the day when there wasn't going to be any other outside help," he explains.

Finally, the woman returned to the inpatient

unit to die, but by then her husband's behavior had changed dramatically, Baxter and Vollmer say.

"He was an entirely different person," Vollmer says. "I met him in the hallway on the day she was brought back to us, and he stood in the hallway and cried." This was a man who would never have shown that level of vulnerability a month earlier, she adds.

"He sat with her the entire time when she was dying," Vollmer says.

As the woman was dying, she asked her husband to promise not to drink and to be there for the children and grandchildren, and he made her the promise, while he was holding her hand and telling her how much he loved her, she says.

The hospice staff witnessed the husband's transformation from an aggressive, arrogant, and intimidating man to a humble, vulnerable man, Baxter says. ■

Here are the symptoms that indicate a potential trauma

Experts explain how and why

Past traumatic experiences can result in current physical, emotional, and behavioral symptoms among hospice patients.

For example, a patient who once experienced sexual abuse as a child might be afraid of having the lights out in her room, or she might have trouble speaking with male health care practitioners.

Here are some of the symptoms hospice staff might encounter among patients who have experienced past and even forgotten trauma:

• **Uncontrolled pain:** "This is pain that is out of proportion to the physical findings," explains **Ric Baxter**, MD, hospice medical director and director of palliative care services at St. Luke's Hospital and Health Network in Bethlehem, PA.

"That can work either way: It can be pain that is at a much higher level than the physical findings suggest," he adds. "Or it can be that the physical findings indicate there should be a lot of pain, and instead, the patient is saying, 'I'm fine.'"

The clue is the disconnect between the symptoms and the physical findings and pathological processes under way, Baxter says.

"Suppose you walk into a patient's room and ask if she is experiencing any pain, and she says she's fine, but her body and face are telling you something different," Baxter says. "So the question is why some people can't report their own pain and other people can take the smallest pain and over-report it?"

In the past, hospice professionals have attributed any under-reporting of pain to a generational stoicism, but they shouldn't make that assumption, Baxter says.

"Often these characteristics are assigned to the World War II generation, and we say they tend to be stoical," Baxter says. "Or with dementia patients, we say they have terminal agitation."

Symptom complexes are stereotyped, and this makes the hospice staff less sensitive to other meanings behind the symptoms, he says.

"They think we just need to medicate the symptoms away," Baxter says. "What we're saying is that maybe it's not just a stoical World War II veteran, and maybe it's not just terminal agitation."

Instead, the symptoms might be related to the process of emotional memories haunting patients more intensely as they are dying.

"Those coping mechanisms break down, and we see manifestations of underlying trauma that they've carried for years," Baxter explains.

When a patient under-reports pain, it begs the question: "Do we really know what the source of this response is, and can we know for sure unless we ask the patient questions?" Baxter says.

Often, hospice patients will not consciously know their own traumatic stories, and yet these buried feelings and experiences are impacting their end-of-life experience, he says.

• **Agitation and anxiety:** Hospice professionals often see patients who become agitated and are unable to soothe themselves, says **Susan Vollmer**, MA, MDiv, BCC, chaplain and bereavement coordinator at the Hospice of the VNA of St. Luke's in Bethlehem.

"We see people who have an inability to see the world as a safe place, and they have an inability to trust others," Vollmer says. "They are suspicious and fearful about anyone who walks into their room." In the hospice's inpatient unit, there are shift rotations, so a hospice patient might have a number of different people walking into his or her room, she notes.

"Patients can't get out of bed, and they don't know these people, so that can kick into their fears," Vollmer says.

Hospice patients who have suffered from past traumas might have a sense of hypervigilance or

hyperarousal, Vollmer says. Every noise and person they encounter results in heightened anxiety.

"People can become irritable and withdrawn," Vollmer says. When a hospice nurse observes anxiety in a patient, he or she could ask for a social worker or chaplain to visit the patient and see if there's anything they can do before medication is prescribed, Vollmer says.

"Sometimes, the conversations and support a patient receives can change their need for medication," she adds.

• **Numbness and disassociation:** Another symptom you might note is an emotional blankness, as though the patient has checked out, Vollmer says.

"They can't tell you how they're feeling, and their emotions are far away," she explains. If you were to ask this patient how he felt about dying, he'd say, "I think it's ok."

While some patients might actually feel this way, this reaction also could indicate that the patient has had an unresolved traumatic experience, Vollmer says.

"Quite a few times we've seen disassociation, which is a psychological term, but is very important," Vollmer says. "When you're talking about post-traumatic stress disorder, this is a step back from reality, maybe with memory gaps."

The person might start to tell a story about his or her past, but there will be memory gaps and a flat affect.

"Someone will need to communicate to you a horrific event, but he'll tell it to you like he's reading a grocery list," Vollmer says.

"Or the person will tell the story in the third person," Baxter says. "It's like they're talking about somebody else they witnessed and it's not about them."

Disassociation is a creative way for the mind to protect the person who has suffered the trauma, Vollmer explains.

"Whatever the experience and emotions are, it's too painful to really be there, so the mind says, 'I'll keep you safe and put it at a distance,'" she adds.

• **Past self-destructive and other coping behaviors:** Another clue that someone has undergone PTSD is a medical history of substance abuse, depression, or anxiety, Vollmer says.

"We may also see people who are very controlling and really need to be in charge," she says.

"In my mind, being controlling is a safety issue where the patient thinks, 'I need to take charge because you might not do the right thing,'" Vollmer says.

For example, a patient might not want to have a male worker or doctor in the room, Baxter says.

"The female patient might be able to make eye contact with the female nurse, but she can't look at her male doctor," Baxter says. "Her body is relaxed when the nurse is in the room, but when the doctor walks in, she's rigid and on guard."

Other symptoms might include obsessive compulsive disorder, panic disorders, and self-harming behaviors, such as cutting or burning Vollmer says.

"Sometimes their self-harm might be in terms of how they handle their illness," Baxter suggests. "A woman, who has breast cancer growing that she's known about for years and never said anything about to anyone, is [engaging] in a form of self-harm."

• **Difficulty with sleeping:** "People who have difficulty with sleeping or whose anxiety level goes up when the sun goes down often are people who've experienced abuse or violence that happened at night," Vollmer says. "The night time is enough of a trigger for their symptoms and behaviors to rise a little higher."

Whenever these or related symptoms are observed in a hospice patient, it's important to encourage the patient to tell his or her story, Vollmer and Baxter say. "Telling stories is an important part of what hospice does," Baxter says.

"In upwards of 50% of patients, we find that stories are important to the patient's dying process." It's also important for hospice staff to be offered support after listening to these often sad and disturbing stories.

"It's hard to hear those stories," Vollmer says. "When someone trusts us enough to give us their story, what do we do with it and what do we do to take care of ourselves?" Hospice workers need to support each other and acknowledge that hearing these life stories can be upsetting, Vollmer adds.

"It's not something they need to take home to keep them up at night," she adds. "It's important to have the gift of a hospice team and to rely upon our team members, as well as to know how to care for ourselves and to receive the support we need." ■

LegalEase

Understanding Laws, Rules, Regulations

Liability for negligent premature discharge

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

Providers of home health services and other post-acute services provided in patients' homes frequently observe that patients are discharged from hospitals who are still in need of acute care. When providers arrive at patients' homes to consider initiating services, they find patients whose clinical needs cannot be met at home.

In these circumstances, discharge planners/case managers may have liability for negligent premature discharge of patients.

In *Wickline v. California*, for example, Mrs. Wickline had surgery for vascular disease followed by a number of complications. The MediCal or Medicaid program stopped payment for inpatient care. Mrs. Wickline's physician asked for further payment for eight days. MediCal agreed to pay for four additional days.

After four days, Mrs. Wickline's physician took no further action and Mrs. Wickline went home. She developed additional complications that resulted in the loss of her leg.

She sued the MediCal program claiming that if she would not have been discharged, she would not have been injured.

In order to prove that discharge planners negligently discharged patients prematurely, patients must prove all of the following:

- Duty.
- Breach.
- Cause.
- Injury or damage.

If patients fail to prove any one or more of the above, they will lose their lawsuits.

Discharge planners/case managers owe patients a duty of "reasonable care."

Practitioners can determine what others are doing by examining applicable national, as opposed to local or regional, standards of care.

Sources of national standards for discharge planners include:

- conditions of participation (CoPs) of the Medicare Program related to discharge planning;
- licensure and accreditation standards;
- court decisions;
- standards of professional associations such as the Case Management Society of America.

Discharge planners can breach their duty to patients in two ways: (1) An act (i.e., doing something that they should not do), or (2) an omission (i.e., failure to do something they should have done).

The best way to define causation is in terms of "but for." "But for" the act or omission of the provider, the patient would not have been injured. Causation also can be defined in terms of "foreseeability."

If it was foreseeable that the patient would be injured or damaged by the breach of duty by the discharge planner/case manager, then there is causation. If injury or damage was not foreseeable, there is no causation. In other words, there must be a causal connection between acts and/or omissions by the provider(s) and injury or damage to patients.

Patients must usually show that they were physically injured by providers. Injuries that are emotional only usually will not satisfy this requirement.

There is one exception to this general rule. Courts require providers to pay patients, even when their injuries are emotional only, when providers engage in extreme and outrageous conduct.

Extreme and outrageous conduct is barbaric, shocking, cannot be tolerated in civilized society, and generally causes one to gasp. A very high standard to meet!

What constitutes extreme and outrageous conduct? Staff in a delivery room, for example, refused to perform an emergency Caesarean section on a woman who died precipitously during labor based upon their understanding that no one who was qualified to perform the surgery was present in the hospital.

They failed to respond to the repeated anguished pleas of her husband who begged the staff to save the life of his unborn infant.

Applying these requirements to negligent premature discharge, case mangers may be liable for negligence because they owe a duty to patients, according to Medicare CoPs and other

standards of case management, to develop and implement an appropriate discharge plan for patients.

Discharge planners/case managers may breach this duty when they refer patients who still need acute care to home care providers.

If patients are injured as a result, they may be able to provide negligent premature discharge.

Some discharge planners/case managers still refer patients for home care services because "something is better than nothing" or because they think that every patient is appropriate for home health services.

The stakes are high for discharge planners/case managers who continue to discharge patients whose clinical needs cannot be at home. They may be found liable for negligence which may result in the loss of any professional licenses they hold. ■

Prescription spending caps and seniors

Many seniors quit taking drugs for chronic illnesses such as diabetes and high blood pressure when they exceed their drug plan's yearly spending limits, according to a recently released study by the Rand Corp.

Even when drug benefits resume at the start of a new health plan year, a significant number of seniors do not resume their prescription medications, according to the findings.

The study, which examined the behavior of seniors enrolled in a national private health plan, provides insight into how seniors may act under provisions of Medicare's new drug benefit plan that will leave about one-third of enrollees without drug coverage for some part of each benefit year.

"Prescription use falls significantly as patients reach their benefit caps," said **Geoffrey Joyce**, the study's lead author and a senior economist at Rand. "Most of the drugs we studied help prevent long-term complications of chronic disease so there are likely to be adverse health consequences for seniors who hit their caps."

Researchers studied prescription drug use from 2003 to 2005 among more than 60,000 people enrolled in a health plan offered to retirees by a large national employer. Enrollees had a choice of two drug plans that offered annual drug benefit caps of $1,000 or $2,500 and one drug plan that had no spending limit. Participants had to pay a portion of individual drug purchases in each of the plans.

The study examined enrollees' use of drugs used to treat high blood pressure, drugs that target cardiac problems, diabetes drugs, ulcer treatments, and antidepressants. Researchers also studied prescription pain medications that have over-the-counter substitutes.

About 6%-13% of the people enrolled in drug plans with caps reached their spending limits in each of the years studied, with about half the affected enrollees going without benefits for more than 90 days, according to the study.

High spenders in the capped plans were more likely to discontinue use of their medications than people enrolled in the plan with no spending limits, according to researchers. Discontinuation rates differed by type of drug, ranging from 15% for anti-cholesterol medication to 28% for cardiac drugs. Rates were higher for pain medications and anti-ulcer drugs where over-the-counter alternatives were available. Among patients who stopped taking a medication in the capped plan, more than half did not restart their prescriptions during the first three months after benefits resumed.

"Given the importance of these drugs, it's distressing that the resumption rates are not higher," said **Dana Goldman**, the study's senior author and director of health economics at Rand. "Drug caps are a cost-saving measure, but our findings raise the issue of whether in the long run they may lead to other medical costs such as increased hospitalizations." ■

COMING IN FUTURE MONTHS

- Use multidisciplinary approach for diabetes care
- How clean is your nurses' bag? Tips to prevent spread of infection
- Improve CHF patient outcomes
- Know your costs before negotiating with managed care

Joint Commission offers new COPD program

The Joint Commission is accepting applications from facilities interested in obtaining certification for chronic obstructive pulmonary disease (COPD) management.

The program was developed in collaboration with the American Lung Association and requires organizations to meet standards and performance measurement requirements. Successful efforts include:

- A standard method of delivering or coordinating care;
- Implementation of evidence-based clinical practice guidelines;
- A secure and timely system for sharing information across settings and providers, which safeguards patient rights and privacy;
- A comprehensive performance improvement program which uses outcomes data to continually enhance existing treatment plans and clinical practices;
- Clinical practices that support patient's self-management activities. ■

Providers reminded NPI required beginning Jan. 1

Claims without it 'unprocessable'

Beginning Jan. 1, 2008, the Centers for Medicare & Medicaid Services (CMS) will require hospitals and other health care providers to use a National Provider Identifier when they bill Medicare fiscal intermediaries and Medicare administrative contractors, the agency said in a recent notice.

Claims that contain only a legacy provider identifier in the primary fields will be returned as "unprocessable," CMS said. The agency said it was taking "the next step toward full implementation of the NPI" because the "vast majority" of institutional providers already include the NPI on their Medicare claims.

Providers may include both an NPI and legacy identifier in the primary fields through April 2008. CMS recommends, however, that they submit at least some claims with only an NPI to ensure their claims will be processed successfully when an NPI alone is required beginning May 1, 2008.

Rejected claims, delayed reimbursement, and potentially lost reimbursement will result if hospitals don't have the proper processes in place, cautions Beth Keith, CHAM, senior management consultant for ACS Healthcare Solutions.

Providers should have taken the following steps, Keith says:

- Obtained NPI numbers for all required providers;
- Cleaned and corrected existing provider

CNE *questions*

9. How does **Shannon Quaritsch**, RN, MS, CPHQ, quality improvement specialist at Northwest Community Home Care, ensure that nurses properly educate patients about the precautions to take in the home when MRSA or VRE is diagnosed?
   A. She relies upon their years of experience.
   B. She reminds staff wash their hands.
   C. She provides a checklist to use in the home.
   D. She covers MRSA in new employee orientation.

10. The CDC says PRSP most often is seen in patients in long-term acute care.
   A. True
   B. False

11. Which of the following questions are included in the one-page form used by hospice staff to access patients who have symptoms of past trauma?
   A. Is there anything in your life that feels scary, frightening, or troubling when you think of it?
   B. Do you have a history of abuse?
   C. How do you sleep at night?
   D. All of the above

12. According to **Susan Vollmer**, MA, MDiv, BCC, patients who have experienced trauma get particularly anxious at night.
   A. True
   B. False

Answer Key: 9. C; 10. B; 11. D; 12. A.

master files;

• Mapped a crosswalk with NPI numbers and UPIN, payer identifiers, etc., for all providers

The change affects providers' information technology systems as well as their reimbursement, Keith notes, in that current claims processing systems must accommodate the NPI identifier. ■

ED visits up by 5.1 million according to CDC report

Visits to hospital emergency departments increased by 5.1 million in 2005 to 115.3 million, according to a recent report by the Centers for Disease Control and Prevention.

That is an average of about 30,000 visits per ED, nearly one-third more than in 1995. The ED visit rate for patients without health insurance was about twice that of those with private insurance, according to the report. Infants under age 1 had the highest visit rate by age. The leading diagnosis for children under 13 was acute upper respiratory infection.

Other top diagnoses by age were bruises, adolescents; abdominal pain, adults under 50; chest pain, adults 50-64; and heart disease, seniors. About 12% of ED visits resulted in hospital admission. The leading diagnosis at discharge was heart disease. ■

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. ■

Hospital Home Health
2007 Index

Accreditation

Assess use of anticoagulants to meet new NPSG requirements, SEP:97

CHAPS offers on-line service, AUG:95

Communications and falls top list of challenges, AUG:88

Joint Commission posts potential NPSGs, JAN:11

Joint Commission web site promotes collaboration, NOV:131

Patient safety FAQs released, APR:48

Proactive study standard trips up 27% of agencies, SEP:99

Centers for Medicare & Medicaid Services

Collaboration key in new discharge notice rule, AUG:93

CM program serves young Medicaid beneficiaries, NOV:129

CMS awards grants for nursing home alternatives, JUL:82

CMS expands preventive service coverage, JAN:11

CMS: No late fees for low-income enrollees, FEB:23

CMS proposes HHA payment changes, JUN:65

CMS releases health spending estimates, FEB:22

HHABN tools and resources available, JAN:12

IOM report: Medicare should switch to P4P, JAN:10

States contracting with SNPs for Medicaid benefits, AUG:89

Why doesn't your agency volunteer for the P4P demonstration project?, MAY:49

Clinical issues

Addressing incontinence: Agency's outcomes improve more than 24%, JUN:61

Assess use of anticoagulants to meet new NPSG requirements, SEP:97

Be on the lookout for depression, MAR:33

Bedbugs, drug-resistant pathogens pose challenge, FEB:16

CDC addresses MRSA in non-hospital settings, DEC:135

CM program keeps preterm delivery rate low, JUN:69

End-stage renal disease patients need hospice care, MAR:30

Heart failure patients present challenges, APR:46

Humor enhances staff education, patient care, FEB:18

Keep pediatric skills high with competencies and education, MAR:25

MDRO guidelines draw fire on active surveillance issue, JAN:6

Multi-pronged plan helps members with chronic illness, AUG:91

No crystal ball needed; study to help predict pressure ulcers, AUG:85

Palliative care program stresses teamwork, OCT:114

Patients discharged on Fridays likely admitted, MAY:58

Programs face challenge with older patients, FEB:21

Rising rate of MRSA increases need for staff and patient education, DEC:133

Seasonal or pandemic flu? Learn the differences, FEB:15

Simple test can prevent pneumonia after a stroke, SEP:104

Train nurses to improve outcomes for depression, MAR:27

Web site offers diabetics way to track glucose levels, SEP:107

Wound care helps patient self-esteem, FEB:19

Emergency preparedness

Are your employees ready for an emergency?, OCT:110

Financial

As identity theft increases so does your responsibility, APR:37

CM program serves young Medicaid beneficiaries, NOV:129

Coding expert must be a master at solving puzzles, JAN:3

Complexity of coding requires special coding staff or in-house expert, JAN:1

Cover pediatric underfunding with new services, MAY:52

Disease management plan helps unfunded patients, NOV:127

Games, tests, and CE make class worthwhile, JAN:4

States contracting with SNPs for Medicaid benefits, AUG:89

Three levels of therapy thresholds, new diagnosis codes in place for 2008, OCT:109

Hospice

End-stage renal disease patients need hospice care, MAR:30

First hospice PACE program opens doors, MAY:54

Grief counseling should be supported despite bad rap, OCT:117

Hopefulness contributes to good end-of-life care, AUG:101

Hospice as continuation of care not just end of the road, JUN:66

Hospices, NHPCO prepare for anticipated CPs, SEP:102

Kansas hospice describes how PACE program works, MAY:56

What hospice docs need to know for a home visit, OCT:115

Wound care helps patient self-esteem, FEB:19

Infection control
Bedbugs, drug-resistant pathogens pose challenge, FEB:16
MDRO guidelines draw fire on active surveillance issue, JAN:6
MRSA rampant among patients on dialysis, MAY:57
Seasonal or pandemic flu? Learn the differences, FEB:15
Universal vs. standard precautions: Do you know which you use? FEB:13
CDC addresses MRSA in non-hospital settings, DEC:135

LegalEase
Determining fair market value of consulting services, OCT:112
Liability for negligent premature discharge, DEC:140
OIG provides more guidance on free services, NOV:127
Providers must take action to get patient compliance, FEB:17
When are patients deemed "unsafe" for home care, SEP:105

Legal/risk management
Address legal and ethical issues related to P4P, MAY:50
Attorney: 'Rotation' referrals may compromise care, JAN:5
As identity theft increases so does your responsibility, APR:37
Security breach laws, MAY:59

Management (See also staff/staffing and recruitment)
Address legal and ethical issues related to P4P, MAY:50
Agency reduced re-hospitalization rate by 7%, JUL:76
As identity theft increases so does your responsibility, APR:37
Choose point-of-care based on your needs, MAR:29
Cover pediatric underfunding with new services, MAY:52
Home visits help members avoid preterm births, JUN:68
It's a good idea, but will it work? How to evaluate a new service, JUL:73
NPs bridge gap between discharge and first visit, JUL:76
Partnering with respite care agency expands marketing efforts for HHA, NOV:121
The laptop is gone. What do you do now? APR:40
Why doesn't your agency volunteer for the P4P demonstration project? MAY:49

Marketing
Don't forget hospitalists in your marketing plan, JAN:4
Get more by adopting technological advances, APR:42
Home visits help members avoid preterm births, JUN:68
It's a good idea, but will it work? How to evaluate a new service, JUL:73
Partnering with respite care agency expands marketing efforts for HHA, NOV:121
Show the value of telemedicine services, APR:42
Wanted: Focused, motivated person to sell, APR:40

Patient safety
Assess use of anticoagulants to meet new NPSG requirements, SEP:97
Joint Commission posts potential NPSGs, JAN:11
Patient safety FAQs released, APR:48
Study proves danger of abbreviations, OCT:119

Physician relations
Attorney: 'Rotation' referrals may compromise care, JAN:5
Don't forget hospitalists in your marketing plan, JAN:4

Quality improvement
Addressing incontinence: Agency's outcomes improve more than 24%, JUN:61
Agency reduced re-hospitalization rate by 7%, JUL:76
Attorney: 'Rotation' referrals may compromise care, JAN:5
No crystal ball needed; study to help predict pressure ulcers, AUG:85
Proactive study standard trips up 27% of agencies, SEP:99

Staff education
Are your employees ready for an emergency?, OCT:110
Buried trauma can impact patients in unexpected ways, DEC:136
Games, tests, and CE make class worthwhile, JAN:4
Here are symptoms of buried trauma, DEC:139
Humor enhances staff education, patient care, FEB:18
Keep pediatric skills high with competencies and education, MAR:25
Tackle nursing shortage by attracting senior nurses, NOV:123
Train nurses to improve outcomes for depression, MAR:27

Staffing and recruitment
Coding expert must be a master at solving puzzles, JAN:3
Effective job descriptions are specific, detailed, JUN:63
Motivate employees with meaningful evaluations, JUNE:65

Technology
Choose point-of-care based on your needs, MAR:29
Get more by adopting technological advances, APR:42
Show the value of telemedicine services, APR:42
Very few hospitals using HER, says a new study, JAN:9