Hospice and Community Care
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Important news about insurance and risk management for hospices and home health care agencies.

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Who To Contact

We welcome your comments and questions.

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Falls Prevention & Safety

Barbara Stover Gingerich, RN MS FACHE CHCE

One of the Outcome Based Quality Monitoring [OBQM] reporting elements that the Centers for Medicare & Medicaid Services (CMS) has included in the home health-specific quality initiatives is the need to use emergent care for an injury caused by a fall or accident at home. This means that providers need to closely monitor any falls and accidents and include preventative and/or corrective action in its quality improvement program.

One description of a fall is an unintentional lowering of the body, with or without injury, most often to the ground. When an individual is able to regain balance prior to falling, this is not considered to be a true fall. Some individuals are prone to loss of balance from either internal or external factors or from both internal and external factors. A fall risk assessment should be conducted and an evaluation of the environment undertaken, both of which will assist in understanding the fall risk of each patient. Attention should be paid to the patient's functional ability, including strength, balance and activity tolerance when conducting fall risk assessments.

Home Health Compare

Among the quality measures that CMS has established for Home Health Providers, are three measures that specifically focus on the individual patient's improvement in getting around. CMS reports through its Home Health Compare System [www.medicare.gov/HHCompare] the percentages of patients who have improved at walking and moving around, getting into and out of bed and who are experiencing less pain with moving around. Several other quality measures can also be related to patient falls at home. These are reported in the percentages that measure the number of patients requiring admission to the hospital, needing urgent or unplanned medical care and remaining in the home after the home health episode of care is completed.

Accreditation Expectations

The Joint Commission has established a Patient Safety Goal specifically focused on Fall Prevention. This goal [Number 9] directs providers to establish a safety objective to reduce the risk of patient harm resulting from falls. As part of this overall patient safety goal, providers are expected to implement and evaluate the effectiveness of a fall reduction program. Other community based accreditors; i.e., Community Health Accreditation Program [CHAP] and Accreditation Commission for Health Care [ACHC] also have similar patient safety standards and expectations for the provider type organizations, which they accredit.

Patient assessments in the areas of balance, strength, orthostatic changes, as well as visual and hearing deficits that could contribute to patient falls, should be conducted.

Fall Risk Assessment

Because of the ongoing emphasis and scrutiny on this important aspect of care, the first step in fall prevention is to conduct a fall risk assessment at the time of admission to the organization. The results of the initial fall risk assessment can trigger specific preventative measures to be taken or indicate a schedule for conducting follow-up risk assessments. Repeat fall risk assessments should also be conducted when changes in the patient's conditions take place that impact functionality and independence.

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There are many examples of fall risk assessments available for adaptation and use by organizations. The Hospice and Community Care Insurance website has a sample Fall Safety Assessment available for downloading and use. In addition to the screening elements contained within this tool, available at www.hccis.com, there are some recently suggested factors to consider and integrate into the organization's Fall Risk Assessment Program. One Fall Risk Assessment tool, the Hendrich II Fall Risk Model identifies 7 factors that have the potential to increase the fall risk in patients. These factors/groupings are:

1. Confusion, Disorientation, Impulsivity
2. Symptomatic Depression
3. Altered Elimination
4. Dizziness, Vertigo
5. Male Gender
6. Any Administered Antiepileptics
7. Any Administered Benzodiazepines

Other patient factors commonly found in fall risk assessment tools are the presence of multiple diagnoses, usually three or more, and the individual's age. Many tools use a similar age breakdown, such as that used in the Johns Hopkins Hospital Fall Assessment tool. This tool uses the following age parameters, with specific weights assigned accordingly:

1. 60-69 years
2. 70 -79 years
3. Over 80 years

The inclusion of age as screening and assessment criteria is supported by the reported incidence of falls based upon age and residence. It has been reported that each year 35-40% of community dwelling older adults over the age of 65 years fall, with this percentage increasing to 50-60% for those over the age of 75 years. [Krulish, 2008].

Monitoring

Once the organization has developed its own risk assessment tool, the next step is to complete the assessment thoroughly and accurately at the time of admission. Upon completion and scoring of the fall risk assessment, an appropriate preventative action plan needs to be implemented.

Preventative Action Plan

Education

The first step in the Fall Prevention Care Plan is education of the patient and family caregivers. A Fall Prevention Care Plan with specific patient outcomes should be initiated and updated as outcomes are achieved. An excerpt of a sample tool is provided below and would be part of the patient's permanent clinical record.

FALL PREVENTION CARE PLAN

Education Provided	Date	Outcome Established	Outcome Status	Date	Staff Initials
Floor Safety: Avoid slippery wet, throw rugs		Patient can list examples of floor safety			
Shoes: Wear well-fitting, non slip shoes		Patient demonstrates proper shoe wear			
Stairs: Well lit, free of clutter, handrails present		Patient demonstrates proper stair climbing/descending			

Outcome Status Key:
M=Met, P=In Progress, R=Reinstruct

Other education headings to be included in this education plan are: bathroom safety, emergency reporting, kitchen safety, transfer safety and standing and positioning safety.

Exercise

Participation in planned exercise programs increases the patient's strength, balance, and mobility and can assist the individual to compensate for sensory and balance deficits. Patient assessments in the areas of balance, strength, orthostatic changes, as well as visual and hearing deficits that could contribute to patient falls, should be conducted in order that the home exercise program addresses specific patient needs. Included in this aspect of the patient Fall Prevention Care Plan, are exercises that improve standing, sitting and walking posture/habits, as well as instruction on good body mechanics. Smooth slow exercise movements are emphasized, as well as changing positions slowly to avoid orthostatic drops in blood pressure, which can often contribute to falls.

Nutrition and Diet

Conducting a nutritional assessment identifies any diet deficiencies and nutritional factors that could impact physical functioning and strength. Once the nutritional assessment is complete and areas for improved nutrition identified, these activities and learning objectives are integrated into the Fall Prevention Care Plan.

Summary

As organizations continue to refine their existing fall prevention and safety programs, ongoing consideration should be given to national initiatives, such as the National Patient Safety Goals, Centers for Medicare and Medicaid Outcome Based Quality Monitoring and Home Health Compare expectations. In addition to these initiatives, the organization should remain abreast of changing accreditation expectations and make use of the myriad of resources available designed to address this aspect of care quality. One such resource is The National Center for Veteran's Affairs' National Patient Safety Center [http://www.patientsafety.gov/CogAids/Fall Prevention/index.html]. This website has extensive falls prevention tools that can be adapted and incorporated into the organization's fall prevention program. By reviewing available resources and programs, organizations are able to further expand the impact of their fall reduction and safety programs. ♥

References/Resources:

Gray-Miceli, D. Fall Risk Assessment for Older Adults: The Hendrich II Fall Risk Model Issue Number 8, Revised 2007, *Try This: Best Practices for Nursing Care to Older Adults*. The Hartford Institute for Geriatric Nursing, College of Nursing, and New York University.

Krulish, LH. & Anemaet, WK., Fall Risk Assessment & Prevention in Home Care, *Home Health Care Management and Practice*. Volume 20. 2. February 2008.

Fall Assessment Tool. The Johns Hopkins Hospital© 2006. Retrieved February 6, 2008 from http://www.mnhospitals.org/inc/data/tools/Safe-from-Falls-Toolkit/John_Hopkins_Hospital_Fall_Assessment_Tool.doc

PLAYING IT SAFE:

The Need for a Comprehensive Safety Program

Betty Norman, BSN, MBA, CPHRM

Does your organizational Safety Program and committee focus solely on employee injuries and workers' compensation issues? If that is the case, you are not alone. Due to the rising cost of workers' compensation insurance, more stringent OSHA regulations, and an increase in employee injuries that result in lost work time, many organizations have zeroed in on these issues and lost sight of the other safety concerns that are part of doing business.

A comprehensive, organization wide safety management program needs to address not only the safety of its employees, but also its patients, visitors, volunteers and all those who interact with the organization. What should be included in a comprehensive safety program? Some basic components of a comprehensive program are:

- Written program, with policies/procedures
- Ongoing surveillance and inspections
- Information collection and reporting
- Compliance with regulatory standards
- Committee Structure
- Education

Written Program

Written policies and procedures validate the organization's commitment to the Safety Program. In general, the organizational Quality Improvement Plan should adequately address patient safety issues, but there are a myriad of other safety issues that need to be captured so that there is a truly proactive approach to safety management. These include equipment safety, fire safety, building and grounds safety, and driver safety just to name a few.

A designated Safety Officer is a key component of an effective program. In smaller organizations this will likely be someone who has a number of other responsibilities as well, but unless someone assumes responsibility for the program it is likely to fail. Key responsibilities for the Safety Officer should include Safety Committee chair, participation in the review of existing safety policies and development of new policies, participation in hazard surveillance activities, oversight of safety education activities, and knowledge of applicable laws and regulations. All safety policies and procedures, both organization wide and department specific, should be reviewed annually and updated as needed.

Surveillance

Ongoing assessment of safety and health hazards is one of the most effective risk reduction strategies of any Safety Program. Department managers should be encouraged to perform daily safety inspections of their own areas of responsibility. Periodic inspections of all patient care and office areas by a Safety Committee sub-group allow the organization to determine if existing safety policies/procedures and processes are being practiced correctly and are effective (Joint Commission Standard EC.1.20). A safety inspection checklist should be utilized to assure consistency. All service and office locations should be surveyed at least once a year. Surveillance should also include the grounds around the office and residential locations, since many accidents/incidents result from unsafe conditions in these areas.

Information Collection

Data collection is a very important part of an effective safety management program. Sources of information might include:

- Incident reports
- Vehicle accident reports
- Safety inspections
- Equipment breakdown information
- Drug and product recall information
- Fire drill and emergency response drill evaluations
- Workplace ergonomic assessment data

Some information sources may overlap. For example, an incident involving patient injury due to a piece of equipment might need to be reported through the Quality Improvement Program as well as the Safety Program.

Compliance with Regulatory Standards

Safety policies must also undergo regular evaluation based on national and state laws and standards. There are many

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agencies that regulate safety in the healthcare arena. Most notably, these include the Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control (CDC).

Professional standard setting organizations play a large role in shaping government regulations and it can be valuable to familiarize yourself with these standards. For organizations with residential or overnight locations, the most important of these is the National Fire Protection Association (NFPA).

Organizations that are accredited by outside agencies, such as the Joint Commission or the Council on Accreditation, will need to stay up to date on any changes with those standards. The key to compliance is to assure that someone (or several individuals) within the organization is knowledgeable about current regulations and standards.

Committee Structure

The Safety Committee serves a multidisciplinary oversight function for the overall Safety Program. Those who are assigned to the committee are expected to review and evaluate the existing program and make recommendations that will improve the organization and make it a safer place for employees, patients and visitors. The committee should have representation from administration, maintenance, patient care areas, housekeeping, infection control and dietary. It is recommended that the membership include non-supervisory personnel as well as department heads. Some committee attributes that lead to a more effective Safety Program include:

- Meetings are held at least every other month
- There is a standing agenda
- Participation of all members is encouraged
- Committee minutes are maintained in writing
- There is evidence of follow up of all identified problems until resolution
- Membership is limited to less than 15 individuals

Education

Employee education and training is a key component of an effective Safety Program. The orientation program should focus on safety issues and introduce new employees to the organization's Safety Plan. Annual mandatory safety training sessions should be held. It is estimated that unsafe acts are responsible for up to 90% of all work related accidents.

One area that is often not addressed in employee training is driver safety. Since hospice and home care workers and volunteers are out on the roads in a work related capacity on a daily basis, it is important to include driver safety training in both the orientation and annual safety training processes.

Summary

Hospice and home care organizations can take a proactive approach to safety management with a well developed Safety Program. The following article illustrates the success that TideWell Hospice and Palliative Care has had with expanding their safety focus beyond the traditional approach of an administrative based function. ♥

SAFETY PROGRAM EVALUATION

COMPONENT	YES	NO
Written Safety Program		
Program addresses regulatory compliance issues	❏	❏
Department/Service Specific Safety Policies	❏	❏
Program and Policies reviewed on an Annual Basis	❏	❏
Designated Safety Officer	❏	❏
Formal Safety Committee		
Meets at least bi-monthly	❏	❏
Standing agenda	❏	❏
Committee reviews all safety related incidents	❏	❏
Maintains written minutes	❏	❏
Includes representation from all disciplines	❏	❏
Includes non-supervisory staff	❏	❏
Minutes reflect follow-up of identified problems	❏	❏
Routine surveillance of all service locations		
All locations are surveyed at least annually	❏	❏
Surveillance includes outside grounds	❏	❏
Safety Program Addresses Education/Training		
Safety included in orientation program	❏	❏
Evidence of ongoing safety training	❏	❏
Driver safety training included in program	❏	❏

Tidewell
HOSPICE AND PALLIATIVE CARE
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"Safety Is Everyone's Responsibility"

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TideWell Hospice and Palliative Care (THPC) is a non-profit organization committed to maintaining a safe and healthy workplace. The Safety Program of THPC encompasses all aspects of staff and patient safety. The organization has had an Environmental Health and Safety (EHS) Committee in existence for many years. It has evolved from a program that was reactive to reported safety issues to a more proactive and preventative process.

As the organization grew to care for more than 1,100 patients per day in a four county area, our employee and volunteer staff also increased. With such a vast geographic area and large patient and staff population, the EHS Committee had to come up with unique ways to manage the Safety Program. The Safety Liaison concept was developed to ensure that there is a "champion of safety" in each of our 17 buildings. The Safety Liaisons are receptionists, clinical directors, nurses, social workers, team coordinators and other department representatives. They are responsible for the flow of safety information to and from their sites. They perform life safety and fire extinguisher inspections, fire drills, safety education and training. They assist the Safety Department with emergency drills, development of policies, and compliance with state and federal regulations.

Membership of the EHS Committee includes the Safety Officer and Specialist, Safety Liaisons, Directors or designees from Materials Management, Infection Control and Human Resources. Due to our large geographic area, we have begun using conference calls for committee meetings. Members call a dedicated phone line and participate in the meeting without having to make a long drive. The agenda and pertinent reports are distributed prior to the meeting, allowing all committee members to participate fully.

Committee agendas include standing items such as Workers Compensation, Drills, Inspections and Infection Control. Other safety related issues are discussed and actions for prevention or management of problems are determined. Cord-tripping hazards are one example of an identified safety issue. It was noted that cords in walk areas were tripping hazards when staff conducted team meetings or presented educational programs. To be proactive in preventing trips, the EHS Committee identified ways to handle these hazards before an injury occurred. Another example of a safety issue that was identified was the use of space heaters in our buildings. The committee discussed the pros and cons of space heater use. With county fire marshal approval for the use of space heaters, the committee issued a safety bulletin on their proper usage.

So how do we know about safety issues in our organization? This information comes to the Safety Officer, Safety Specialist or Safety Liaisons in multiple ways. Problems or potential problems are identified throughout all facets of our daily business. We can receive a phone call, e-mail or formal report — such as an Unsafe Condition Report — from anyone in the organization. We identify issues by tracking and trending employee or patient Incident Reports and through inspections and drills. Some issues may be easy fixes and others may require money or executive decisions to resolve. An example of this was the identification of staff security concerns in buildings. This issue has evolved from the placement of cameras and door alarm systems, to installation of proximity readers for staff to gain entrance to buildings.

In the fall of 2007 the EHS Committee created a Safety Awareness Program called "Safety is Everyone's Responsibility." Colleagues submit safety related issues, observations of others performing safe acts, and safety tips. They are rewarded for their efforts and quarterly prizes are presented to sites with the most submissions. Acknowledgements and safety tips are printed in our monthly organization newsletter.

Another great vehicle for safety communication is our THPC intranet. The Safety Department has a page on the site that includes a picture of each Safety Liaison, forms used for emergency management in each county, evacuation routes, sheltering information, call trees, safe meeting areas, Material Safety Data Sheets and other helpful safety information and announcements. The intranet includes direct links to local weather-related sites, county emergency centers, Florida Highway Patrol, National Fire Protection Association and the National Hurricane Center.

As the Safety Program evolves, we continue to implement improvements to our processes and plans. We have begun doing ergonomic assessments for employees reporting ergonomic injuries or concerns. The tracking and trending of employee injuries related to such things as car accidents and lifting related injuries are hot topics. Identification of preventative measures is a major focus, not only for staff but also for our patients. We have instituted a new patient assessment form for staff to evaluate safety issues in the patient's living environment. Safety data is very valuable for us to capture, analyze, and use to make improvements.

The Safety Program reports to the Quality Assessment Performance Improvement Committee and is dedicated to making safety a priority. We continually strive to be the best we can be.

Equipment Management and Safety Programs

Barbara Stover Gingerich, RN MS FACHE CHCE

With the Centers for Medicare and Medicaid Services release of its regulations titled, "Establishing Additional Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DME-POS) Supplier Enrollment Safeguards" the Durable Medical Equipment [DME] providers are once again experiencing increased scrutiny, along with greater regulatory and quality expectations. While it is the responsibility of the DME provider to instruct patients and families in the use of equipment they place in the home, it is also important that home health and hospice providers be aware of and provide information on equipment safety and management.

References/Resources:

Ellis, JR et al. *Module for Basic Nursing Skills.* Volume 1. 6th Edition. Lippincott: Philadelphia.

Gingerich, B., Ondeck, D. *Clinical Policies and Procedures for the Home Health Care Organization.* 2nd Edition. Aspen Publishers: Gaithersburg MD.

Gingerich, B. *Safety Manual for the Home Care Organization.* 4th Edition. Advantage HCMR Press: York PA.

There are many assistive devices that can be found within the home care setting. While some of these devices are intended to assist patients in maintaining functionality and independence, other equipment found in the home is used by staff for the provision of care or for the staff's own protection during care delivery. If equipment is not used properly, accidents that result in injury can occur to both staff and patients. For that reason when developing the organization's equipment management and safety policies and protocols, equipment used by patients, as well as staff, should be included.

Key Principles - There are some key principles that apply to all equipment management and safety programs. Three of these principles are education, maintenance and reporting.

Education - Education is essential for both staff and patients and should include the proper use and care of the specific piece of equipment.

Patient Equipment - Patients frequently have an ambulation aid to use within the home setting. This aid can be as basic as a cane, but it can also include walkers, crutches and rollators [rolling walkers]. Bathing and personal care assistive devices are other commonly used types of equipment found in the home care setting. Examples of these devices include shower and tub grab bars, raised toilet seats, bedside commodes, shower chairs and wheelchairs.

Staff Equipment - Some examples of equipment used by staff in carrying out duties and responsibilities include patient lifts, back supports and blood pressure monitors. It is important to provide education for staff about how to safely use and care for each of these equipment items.

Ambulatory Assistive Devices - Educating patients about home safety also includes some important hints to make the home environment safer for the patient using an ambulatory assistive device. For example, when providing home safety education at the time of home care admission, patients are instructed to remove throw rugs and to keep walking pathways clear of clutter and well lighted. These are some basic safety instructions. For patients that use a cane for ambulation, there are additional instructions specific to safe cane use in the home setting that should be provided.

Cane Use - Because a cane should provide proper support and be of correct height for the individual, borrowing another individual's cane is not a good idea. A cane should be measured and made the correct height for the intended individual's use. When using a cane, the cane should be close to the body and held in the hand on the uninvolved or strongest side.

In order to improve traction and prevent slipping, the cane should have a rubber tip and shoes should be sturdy and not skid. When walking, the tip of the cane should be placed around four inches in front of the body and slightly off to the side. Then the weaker leg and cane are moved forward, while the body's weight is on the stronger leg. Once the cane and weaker leg are in place, the stronger leg can then be moved up to the same location. This pattern is followed and repeated slowly and steadily in order that safe ambulation with the cane occurs. It is important to maintain equal step length and pace for both legs.

If stair climbing is necessary with the cane, the patient should lead with the uninvolved leg, placing the cane on the step and then moving the leg up to the same step. This is repeated until the top of the stairs is reached. When going down steps where there is a railing, the patient leads with the involved leg; however when no railing is present, the patient should lead with the cane on the uninvolved side. [Gingerich, 2003, Ellis, 1996] A cane use procedure, including stair climbing, sitting and standing is available at www.hhcis.com.

Similar procedures should be put into place for other patient assistive devices, and both patients and staff should be instructed in these procedures.

Patient Care Equipment - All staff should be provided education on each piece of patient equipment that they will use in the provision of care. Most organizations choose to evaluate and instruct staff on equipment at the time as orientation. Some organizations also integrate this evaluation and instruction into their annual competency evaluation program. When new equipment is introduced for patient care throughout the year, an inservice and/or just in time approach to education is used in order that staff are safe to use the equipment before it is placed in use in the care setting. Staff need to know how to use equipment and should make certain that equipment is in good working condition before use.

Equipment Maintenance Plan - As part of the organization's Equipment Maintenance Plan, equipment that requires calibration should have a specified calibration procedure that is adhered to by the organization. When equipment is purchased, it is assigned a tracking number and logged into the organization's records. Once this process is complete, the organization should continue to note where the specific piece of equipment is located. This can be accomplished through the use of an Equipment Tracking and Maintenance Log. This log can be used for several purposes including finding equipment that is recalled, assuring that equipment has been cleaned and serviced and validating that annual maintenance and calibration are current.

By using this approach to equipment management and safety, when notices regarding hazards and recalls come into the organization, the recall can be checked against the Tracking and Maintenance Log and equipment immediately removed from service. In order to avoid interruptions to care and treatments, back-up equipment items should be available for use by staff. It is recommended that any equipment related incident reports be included in the organization's quality improvement plan and that the equipment reports be aggregated, trended and analyzed for patient safety concerns. In the event that equipment either fails to function or malfunctions and there is suspected harm to the patient, the organization is expected to follow the Federal Food and Drug Administration (FDA)'s reporting guidelines. The FDA is to be notified at 1-800-FDA-1088,

A sample Equipment Tracking and Maintenance Log includes the following information.

EQUIPMENT TRACKING AND MAINTENANCE LOG (Part 1 Excerpt)

Equipment Item			Number			
Manufacturer			Purchase Date			
Manufacturer Contact			Cleaned		Maintenance	
Date Placed	Location	Date Returned	Date	Initials	Date	Initials

EQUIPMENT TRACKING AND MAINTENANCE LOG (Part 2 Excerpt)

Date	Maintenance Performed	Failure/Malfunction FDA Report, Date, Initials

Adapted from: Gingerich, Safety Manual for Home Care Organizations, 2006.

24 hours per day, 7 days per week and a FDA Medical Products Reporting Program form must be completed and mailed to the FDA. This is usually one aspect of the organization's Medical Related Device Reporting Plan. For a sample Medical Device Reporting Protocol please go to www.hccis.com.

Summary

Educating patients, their family and caregivers, as well as patient care staff, in the safe use of equipment is a critical component of the organization's overall safety program. This cannot be a "once and done" approach, but rather an ongoing educational program that encourages staff participation and communication. The home care staff are often the first individuals to know that a new piece of equipment is being used in home care delivery. They also will be the first to know that a specific patient has new and/or different equipment. By including an annual equipment update as part of the organization's inservice schedule, staff will have the opportunity to discuss equipment safety and concerns, as well as report on new equipment they are finding in the home. ♥

Loss Control Resources

www.hccis.com

Hospice and Community Care Insurance Services has recently completed production of an educational DVD titled, ***"Zero Tolerance: Abuse Prevention and Reporting."*** An order form can be downloaded from our website under the Training and Education tab. Additional titles include:

- ***Patient Transfer Safety***
- ***Driver Safety: Do No Harm***
- ***Employment Practices Liability Program***

In addition to training program materials, the website also includes references and resources on topics such as Documentation, Fall Assessment and Home Safety, Medication Competency, Patient Visitor Incident Reporting, Safe Driving, and all past issues of our newsletter.

Also under the Training and Education tab, you may register for "My Community Workplace." This resource offers useful tools such as analysis of EEOC data, employment practice training programs and model policies, along with an extensive database of employment practice topics. The site allows you to print out training certificates for employees who have completed a training module.

It is our goal to provide timely and topical loss control resources for the hospice and home health care industries. Please let us know if you are interested in more information on these valuable resources.♥

Who to Contact

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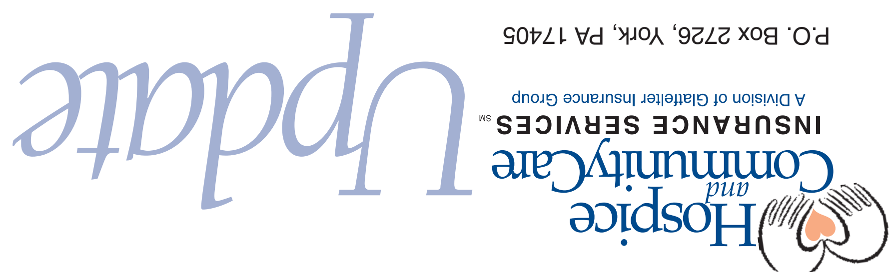

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