Nurses Service Organization
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# RISK ADVISOR

## FOR HEALTHCARE BUSINESS OWNERS

## Healthcare Spotlight: Home Care in the Time of the Novel Coronavirus (COVID-19)

As of April 3, 2020, approximately 311 million Americans live in an area where they are being directed to stay at home and “shelter in place” and only leave their homes for essential needs. Under these orders, businesses such as grocery stores, healthcare facilities, pharmacies, gas stations, and laundromats are designated as “essential”, but questions remain about how healthcare offices and providers should respond to these orders.

According to guidance issued by the Centers for Disease Control and Prevention (CDC), healthcare facilities and clinicians should prioritize urgent and emergency visits and procedures for the foreseeable future. Taking these actions can ensure staff and patient/client safety; conserve critical resources, including healthcare staff, personal protective equipment, and patient care supplies during the COVID-19 pandemic. The CDC recommends that clinics and healthcare facilities:

- Delay all elective ambulatory provider visits
- Reschedule elective and non-urgent admissions
- Delay inpatient and outpatient elective surgical and procedural cases
- Postpone routine dental and eye care visits

The CDC recommendations offer good overall guidance to healthcare providers on how to minimize the spread of COVID-19. During the COVID-19 pandemic, healthcare providers must decide if each of their patients would be a good candidate for healthcare services via telehealth/telemedicine, if a patient’s therapy can be delayed, or if the patient would be a good candidate for healthcare services in the home. Healthcare providers are in the best position to know what is best for their patient, his or her overall health and how well their conditions are managed (see CDC, Healthcare Professionals: Frequently Asked Questions and Answers, updated March 30, 2020). While each situation should be handled on a case by case basis, healthcare providers should work with their patients to manage their underlying condition to the best of their ability. If the patient insists on an in-patient appointment, the healthcare provider should explain to the patient the consequences and foreseeable risks (informed refusal/refusal of care) of an in-person appointment.

During this public health emergency period, some healthcare providers and healthcare business owners may be considering expanding service offerings to include healthcare services in the patients' homes. However, as services change or expand, new exposures may arise from both a regulatory and professional liability perspective. The home care environment presents a wide array of injury and liability concerns for patients, healthcare providers and healthcare business owners. A comprehensive risk control program that identifies and addresses common exposures is essential to enhance worker and patient safety and minimize potential loss.

## Establishing Home Care Services

To diminish potential risk exposures, healthcare providers must ensure that services provided in the patient's home comport with state practice regulations, as well as the rules and regulations of applicable state licensing or certification boards. In addition, healthcare providers and healthcare business owners should thoroughly evaluate prospective patients for their care requirements and prepare detailed service plans based upon their medical condition, degree of orientation and functional capability. Comprehensive guidelines for client screening, assessment and service planning help ensure that personal and home care organizations comply with statutory and regulatory mandates, while also demonstrating their capability to provide the necessary physical and human resources, staff expertise and range of services that clients require. For more detailed information specific to providing healthcare in the home care setting, please refer to the following resources as a starting point:

- The U.S. Centers for Medicare & Medicaid Services
- The Joint Commission
- National Association for Home Care & Hospice (NAHC)

**Policies and procedures.** Written employment policies are intended to establish behavioral expectations and delineate the consequences of noncompliance. Employment policies should address the following areas, among others:

- **Delegation and supervision:** Special attention should be given to delegation of duties by licensed healthcare staff, in order to ensure that unlicensed assistive personnel do not provide clinical care beyond their training or regulatory limits.
- **Monitoring:** Supervisors should make periodic unannounced telephone calls to patient homes and conduct documented in-person interviews with patients and family members. Questions should focus on care issues, finances, and evidence of undue provider influence or inappropriate actions.
- **Boundaries:** Healthcare providers should be educated about professional boundary issues and should avoid any activities with patients that fall outside of professional standards and the plan of care. Healthcare should be conducted in an open and straightforward manner, and providers

should avoid multiple relationships with patients, their significant others and their family members. Both providers and business owners should be alert to the following red flags:

- Assuming a dual role.
- Extracting inappropriate fees.
- Engaging in inappropriate activities with a patient.
- Accepting gifts, tips, or valuables from patients, or giving gifts to a patient.
- Becoming business partners with a patient.
- Connecting inappropriately with a patient on social media.

For more information regarding managing professional boundaries and addressing boundary violations, refer to the CNA and NSO/HPSO Healthcare Perspective, Professional Boundaries: Drawing Lines That Cannot Be Crossed.

- **Incident response:** Policies and procedures should address expected staff response to medical emergencies, falls or other injuries, and allegations of theft or abuse. An incident report should be filed whenever an unexpected event occurs. The rule of thumb is that any time a patient makes a complaint, an error occurs, a device or equipment malfunctions, or anyone—patient, staff member, or visitor/family member—is injured or involved in a situation with the potential for injury, an incident report is required.
- **Non-owned vehicles:** Providers should be prohibited from transporting patients in their personal vehicles. To help further minimize driving-related risks, only authorized drivers should be allowed to use personal vehicles for business purposes. Require proof of personal automobile insurance and ensure that insurance policy limits meet state coverage requirements.

To promote compliance with evolving rules, regulations and laws, staff should undergo a refresher course on policy and procedure annually, or more frequently if indicated. Promptly alert staff to all new or revised policies, procedures and protocols, and answer any questions that arise. For more information regarding policy and procedure development and review, refer to the CNA and NSO/HPSO Healthcare Perspective, A Guide to Developing, Reviewing and Implementing Written Policies and Procedures.

**Standard of care**. Home care providers must render care that meets applicable standards and licensure requirements and is commensurate with care provided by other similarly trained and credentialed providers, regardless of setting. Satisfying the standard of care involves adhering to the following laws, regulations and expectations:

- Professional licensure requirements.
- Federal and state statutes.
- Medicare regulations.
- Professional association standards, including those of the NAHC.
- Other applicable regulations and standards used to determine negligence in the event of litigation.

**Scope of practice**. Note that state practice acts and regulations vary from state to state and may evolve over time. To maximize compliance, healthcare providers must be aware of and regularly review applicable regulations and state practice acts, as well as organizational policies governing delegation and scope of practice. All staff should receive extensive and documented training on standard of care and scope of practice issues.

## Patient Screening and Assessment

Comprehensive guidelines for patient screening, assessment and care/service planning help ensure that personal and home care organizations comply with statutory and regulatory mandates, while also demonstrating their capability to provide the necessary physical and human resources, staff expertise and range of services that patients require.

**Patient Screening**. An effective screening procedure reduces the risk of inappropriate patient selections by ensuring that prospective patients are suited for personal or home care services and that their needs do not transcend the services, capabilities and resources of the organization. The goals of a pre-admission screening are threefold: 1) To determine an applicant's healthcare and non-healthcare service needs, 2) assess their suitability for the home care/personal care setting and 3) initiate the care-planning process.

The screening process commences with an interview of the prospective patient and the family or primary provider(s). An experienced staff member who is knowledgeable about the services the organization is capable of providing should conduct the interview *prior* to contracting for services. The screening process should focus on the following areas, among others:

- **Healthcare and cognitive status**, including medical diagnoses, allergies, presence and stage of Alzheimer's disease/dementia, behavioral patterns, recent surgeries/hospitalizations, presence of indwelling devices (e.g., catheters and endotracheal tubes), standing provider orders, ability to comprehend information and instructions, and existence and level of pain.
- **Fall risk and fall history**, including near falls and those with and without injury.
- **Physical limitations**, including limits on activities of daily living, bladder and bowel continence, toileting assistance requirements, ambulation/transfer needs, assistive devices and tele-monitoring equipment used, extremity weaknesses and deficits to vision, hearing or speech.
- **Medications**, including the current drug regimen.
- **Skin integrity**, including a detailed description of wounds or other skin-related issues and notation of any specific wound care needs.
- **Safety of the home environment** and necessary modifications for patient safety and functionality.

**Patient assessments**. After screening but prior to commencement of services, assign a qualified staff member to visit the patient's home in order to complete a comprehensive initial assessment, determine care needs, identify home environment limitations and concerns, verify the patient's suitability for services and obtain information necessary for developing an individualized service plan. A reassessment should occur at least every six months or anytime that the patient's condition or needs change. All assessments and reassessments must be documented, including the names of the assessor and individuals participating in the screening/assessment process, as well as the date of completion.

**Care planning**. Individualized, realistically achievable goals should be established for each patient, supported by thoroughly documented monitoring of the patient's response to treatment, care and therapy. The prospective patient screening process is an opportune time to initiate care or service planning. Data compiled during the screening and assessment phases serve to identify the specific interventions needed to improve a patient's quality of life. Once selected, the healthcare provider can develop a care plan in collaboration with the patient, building on the issues, needs and goals previously identified. Care planning must comply with regulatory requirements and reflect billed charges.

More specifically, a care/service plan should delineate goals and objectives, services to be provided and patient monitoring guidelines. Changes in a patient's condition should elicit a revision to the service plan. A commitment to ongoing, open communication among all parties helps ensure that patient and supportive individuals are kept informed of the services being provided, as well as any changes in the patient's condition that may necessitate a revision of the service plan.

**Documentation**. Documentation is a tool for the planning and provision of healthcare services, communication among providers, and demonstration of compliance with federal, state, third-party payer and other regulations. Inadequate documentation may not only impede the quality of patient care, it can also hinder the healthcare provider's legal defense in the event of a malpractice lawsuit and can even lead to a state licensing board license complaint. Patient care assessments, observations, communications and actions should be documented in an objective, timely, accurate, complete, appropriate and legible manner**.** Documentation should support the treatment plan and satisfy board regulatory and third-party billing requirements. At minimum the record should include:

- Patient's chief complaint and review of current problems or symptoms.
- Review of clinical history, including relevant social and family history.
- Patients' acknowledgment that they agree to the treatment to be provided and are aware of the expected treatment outcome.
- Documentation of each visit or encounter, documenting the date and time, implementation of the plan of care, changes in patient status, and progressions of specific interventions used.

- Evaluation of the patient's wound condition, skin integrity, neurological status, and ability to perceive pain or discomfort, if applicable. Document this evaluation and convey any problems to staff.
- Educational materials, resources, or references provided to the patient.
- Telephone encounters (including after-hours calls), documenting the name of the person contacted, advice provided, and actions taken.
- Encounters with healthcare providers, including those via telephone, facsimile, and email, with a summary of the discussion and any subsequent actions taken.
- Documentation of reexaminations, including data from repeated or new examination elements, to provide useful context for evaluating progress and helping inform plans to modify or redirect interventions.
- When indicated, document revision of goals and plan of care.

For more documentation-related risk control recommendations for healthcare providers, see NSO/HPSO and CNA's publication, Home Care Documentation: A Checklist of Essentials.

**Ongoing monitoring of services provided**. Regular reviews should be conducted to monitor staff compliance with service plan elements. Reviews should encompass an evaluation of the service plan as well as supporting care documents. Unannounced visits to the patient's residence by supervisory staff also should be conducted, both during and after personal/home care visits. Inquiries should be posed to the patient and the family related to satisfaction with services being provided and any changes to the patient's condition or needs.

## Reducing Exposure to Common Health and Safety Threats in Home Care

Home care hazards compromise patient care and subject staff to more frequent and severe injuries, as compared to other providers who work in more controlled healthcare settings. The inability of providers to ensure a healthy and safe environment presents certain risk exposures in the form of physical and structural impediments that can lead to falls, equipment malfunction, infectious diseases, hostile animals and potentially violent situations. In an effort to promote the safety and security of healthcare providers working in a home care setting, here we examine these common hazards and offer strategies to minimize their impact.

**Fall Prevention.** According to the CDC, falls remain a leading cause of bodily injury in older adults. More than one out of four people aged 65 and older fall each year, with one out of five falls causes a serious injury such as broken bones or a head injury. Falls are also a common source of professional liability litigation. Therefore, reducing the incidence and consequences of falls is a risk control priority. Fall-reduction programs for home care should include the following elements, among others:

- Utilize a fall assessment tool to assess the patient's level of risk and identify potential contributing factors, including:
    - Fall history
    - Gait and balance disturbances
    - Weight loss and hydration.
    - Reduced vision.
    - Comorbidities and disabilities.
    - Cognitive impairment.
    - Bowel and bladder dysfunction.
    - Unmitigated pain.
    - Prescription and over-the-counter drug use.
    - Use of appliances and assistive devices.
    - Environmental hazards, such as furniture arrangements, floor surfaces, lighting, cords, rugs, and clutter.
- Document all measures taken and the rationale for their implementation.
- Prepare a written record of discussions with patients and family members regarding fall-related risks and preventive measures.
- Continually assess and monitor patients for changes in condition, comorbidities and other health-related risk factors.
- Report changes in condition and patient falls to supervisor, treating provider, and the patient's family (if applicable) in a clear and timely manner.
- Reinforce fall reduction tactics with patients and family.
- Document patient non-compliance with recommendations.
- Follow sound documentation practices.
- Supervisors should conduct regular audits of staff assessment procedures and documentation practices to verify competency and adherence to procedures.

**Equipment Safety**. Medical device errors are a relatively common source of harm for patients and liability for healthcare providers and healthcare business owners. Many malpractice claims include allegations of mechanical malfunction, as well as failure to properly use, test or maintain equipment.

The following measures can help reduce the risk of equipment malfunction or user error:

- Perform and document preventive maintenance on all equipment, per manufacturer guidelines.
- Inspect and/or test equipment prior to patient use, removing anything that appears to be broken, unreliable or unsafe.
- Regularly replace items with a short life expectancy.
- Ensure that the specific equipment needed for each patient is readily available and checked before each use.

- Sequester any equipment involved in patient injury, treating it as potential legal evidence.

**Infection Prevention**. The home care setting presents its own set of infection prevention and other safety challenges for both patients and healthcare professionals. The CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC) state that "Infection prevention must be made a priority in any setting where healthcare is delivered." Such occupational safety programs involve supplying staff with the tools needed to implement universal precautions, including hand hygiene products and personal protective equipment (PPE), i.e., gloves, gowns, and face and eye protection. For evidence-based resources and recommendations for infection control, visit: www.cdc.gov/infectioncontrol/tools.

For infection control recommendations specific to COVID-19, please refer to CDC recommendations for Health care Professionals and Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for Coronavirus Disease 2019 (COVID-19).

**Hostile animals.** Home healthcare workers often encounter hostile and unrestrained animals. An initial patient screening should specifically inquire about animals in the home that may be prone to hostile tendencies. If threats are detected, expressly state in written service agreements that animals are to be restrained prior to home care visits. When encountering a hostile animal during a patient visit, providers should:

- Remain calm and wait outside the home until the animal is restrained.
- Use a soft, soothing tone of voice.
- Reiterate to the patient that all animals are to be safely restrained during visits.
- Promptly advise the patient of the inability to provide services if an animal cannot be restrained and inform the home care employer so that alternate care arrangements can be made.

**Violent situations.** Because home care workers are primarily dependent upon their own skills to safely defend themselves from acts of violence and aggression, staff training on the identification and management of unsafe situations is essential, both upon hire and at regular intervals thereafter. Training sessions should focus on:

- Reinforcing the importance of remaining vigilant to signs of impending violence exhibited by patients or family members, e.g., verbal aggression, threatening body language, signs of drug or alcohol abuse, and/or the presence of weapons. Providers should always maintain an open pathway for a swift exit, if required.
- Knowing how to defuse anger, including speaking to patients in a calm and respectful manner, avoiding directives or orders, acknowledging patients' feelings of frustration, moving in a slow manner and keeping a respectful distance.
- Empathizing with the needs and issues of agitated individuals, including measures to de-escalate unusual or disruptive behaviors.

- Maintaining safe boundaries and immediate access to a cell phone, in order to summon 911 assistance, if necessary.
- Reporting violent occurrences and home-related hazards, such as unsecured weapons, signs of drug/alcohol abuse or other illicit activities.
- Trusting personal judgment and promptly removing oneself from a potentially dangerous environment.

Adherence to the recommendations presented in the resources noted above will help to guide your decisions regarding professional practice during this unprecedented pandemic.