Nurse Spotlight: Home Care

Nurses Service Organization (NSO), in collaboration with CNA, has published our 4th Edition of the NSO/CNA *Nurse Liability Claim Report*. It includes statistical data and case scenarios from CNA claim files, as well as risk management recommendations designed to help nurses reduce their malpractice exposures and improve patient safety.

You may access the complete report, and additional Risk Control Spotlights, at: www.nso.com/nurseclaimreport.

The home care environment presents numerous safety, injury and liability concerns for patients, nurses and healthcare business owners. This Spotlight provides an overview of common liability exposures in the **home care** setting, as well as risk control recommendations and mitigation strategies designed to enhance nurse and patient safety and minimize potential loss.

The 4th Edition of NSO and CNA's *Nurse Liability Claim Report* revealed a notable increase in the proportion of home care closed claims, including claims involving insured nurses working in home health, hospice and palliative care. As depicted in **Figure 1**, **home care** closed claims against nurses increased from 12.4 percent of the total claim count in the 2015 claim analysis to 20.7 percent of the total claim count in the 2020 claim report. The increase reflects the overall shift in patient care locations. This escalating transition of patient care from the hospital to the home probably will continue as technology, such as telehealth and other virtual healthcare tools, improves and its use is adopted by third-party payors.

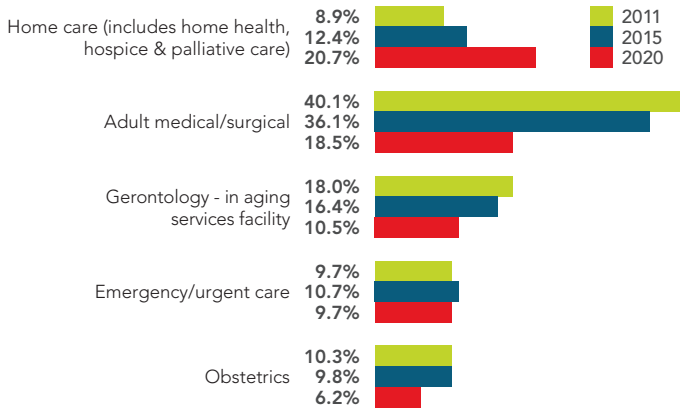
An analysis of closed claims involving nurses working in home health, hospice and palliative care reveals that the majority of allegations, 52.1 percent, are related to **treatment/care management** (**Figure 2**). These allegations reflect a failure to fulfill core nursing responsibilities, duties and expectations. Examples include allegations of improper management of treatment resulting in pressure injuries and improper performance of treatment/care resulting in the patient sustaining severe burns. These claims are often compounded by lack of thorough, complete documentation.

A substantial proportion of home care closed claims involve allegations relating to **patients' rights/abuse/professional conduct** (17.0 percent). These claims often involve allegations of a failure to maintain a safe environment resulting in patient falls. Examples include allowing a patient who requires the use of a walker to stand unattended, and transferring a patient from the bed to the wheelchair without the use of prescribed lifting devices.

In addition to professional malpractice lawsuits, state licensing board complaints represent another source of liability for nurses working in home care settings. For more information about license protection matters, please refer to the *Nurse Professional Liability Exposure Claim Report: 4th Edition*, as well as the Nurse Spotlight: Defending Your License. An example of a license protection matter involving a home health nurse follows.

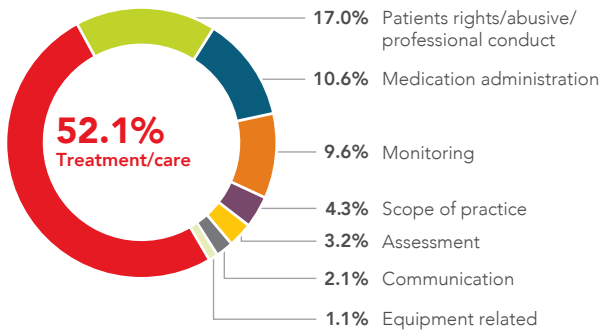
1 Comparison of 2011, 2015, 2020 Closed Claim Count Distributions by Specialty

Closed Claims with Paid Indemnity of ≥ $10,000



2 Home Care Closed Claims by Allegation

Closed Claims with Paid Indemnity of ≥ $10,000



License Protection Scenario: Failure to maintain professional boundaries

This scenario involves an insured registered nurse providing in-home nursing care to a male patient over a period of approximately nine months. At the time the nurse began providing in-home care for the patient, the patient had a friend and former co-worker who assisted him with a multitude of errands. Over time, the friend and co-worker were less able to assist the patient, so the nurse began performing a number of tasks to help the patient. The nurse began by purchasing groceries for the patient and receiving partial reimbursement from the patient. Then, the nurse began paying bills for the patient out of her own checkbook, and the patient would reimburse her for the expenses. Shortly thereafter, the patient gave the nurse his ATM card and personal identifying number (PIN), requesting that she make cash withdrawals for him and bring him the cash and a receipt for the transactions. The nurse used the patient's ATM card and made cash withdrawals on several occasions.

When the nurse's employer learned that she had been conducting financial transactions on behalf of the patient, the employer conducted an internal investigation. The investigation revealed other professional boundary violations, including the nurse permitting the patient to give her son a parcel of land. The nurse's husband also had taken the patient's tools and toolboxes, which the patient had accumulated over 40 years of working as a machinist, supposedly to sell on his behalf.

After conducting an internal investigation, the nurse's employer terminated her employment and then filed a complaint with the State Board of Nursing ("the Board"), asserting a violation of professional boundaries. The nurse and her counsel submitted materials to the Board demonstrating her character, such as reference letters and certificates of completion for courses on professional boundaries in nursing. The nurse also tried to explain her actions to the Board. She acknowledged that her actions may have been perceived as serious boundary violations. Nevertheless, she maintained that she was trying to assist the patient and act in his best interests because he had no one that could help him. The nurse also insisted that the patient voluntarily gifted her son with the parcel of land and requested that her husband sell his tools on the patient's behalf. The nurse adamantly disputed exercising undue influence over the patient by giving her access to his ATM card or giving gifts to her family members.

The Board was neither persuaded by the materials the nurse submitted, nor her testimony. The Board concluded that despite the possible intentions of the nurse, her repeated and various boundary violations over the course of nine months of caring for the patient demonstrated a troubling fact pattern. The Board noted that the public expects nurses to maintain professional boundaries, especially in the area of home care, where the patient population served is especially vulnerable and isolated. The Board suspended the nurse's professional license for two years and issued a $4,000 civil penalty.

Following the penalty issued by the first State Board of Nursing, a second state where the nurse also held a professional license began its own investigation into the nurse's actions. The second State Board of Nursing initiated its investigation after being notified of the action taken against the nurse in the first state via a reciprocal licensing agreement between the two states. At the conclusion of its investigation, the second State Board of Nursing placed the nurse on probation for one year.

Allegations of boundary violations can be difficult to defend. As licensed professionals, nurses are responsible for maintaining professional boundaries with patients. Nurses should make their employer aware of patient requests that are outside of the scope of their license or job description, so that a social service and/or case management referral can be appropriately made. To avoid the appearance of abandonment, thoroughly and carefully document the requests in the patient's healthcare information record, describing in detail the patient's actions, history, psychosocial needs and referrals to the appropriate services.

Nurse Spotlight

For risk control strategies related to:

- Defending Your License
- Communication
- Documentation
- Medication Administration
- Depositions
- Liability for Nurse Managers

Visit nso.com/nurseclaimreport

Risk Management Recommendations: Home Care

The following guidance is designed to assist nurses and their employers in evaluating risk control exposures associated with their practice in home health care settings. For additional risk control tools, or to download the *Nurse Liability Claim Report: 4th Edition*, access Nurses Service Organization or CNA Healthcare.

Standard of care and scope of practice. Home care nurses must render care that meets applicable standards and licensure requirements and is commensurate with care provided by other similarly trained and credentialed nurses, irrespective of setting. Fulfilling the standard of care involves adherence to the following laws, regulations and expectations:

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

Patient screening. 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 that the organization is capable of providing should conduct the interview *prior* to contracting for services. The screening process should consider focusing 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, and any non-prescription medications or supplements that the patient may be taking.
- **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.
- **Presence of other occupants in the patient's dwelling,** including their relationship to the patient and whether or not they are caregivers to the patient. Exercise caution when providing care instructions to family caregivers until a level of confidence is ascertained. Document your instructions and education, educational materials, resources, or references provided, as well as the caregiver's questions, returned demonstration, and comfort level with the instructions.

For more information on educating family caregivers, please refer to the following resources:

- AARP Public Policy Institute: Home Alone Alliance℠
- American Journal of Nursing (AJN): *Resources to support family caregivers*
- Supporting Family Caregivers in Providing Care. Chapter 14 in: *Patient Safety and Quality: An Evidence-Based Handbook for Nurses (2008)*. Available from: https://www.ncbi.nlm.nih.gov/books/NBK2665/

Patient assessments. After screening but prior to commencement of services, a qualified staff member should 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. **This protocol is critical as not all patients who wish to have home care, or for whom it is ordered, are appropriate.** A reassessment should occur at least every six months or at any time 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, realistic, and achievable goals should be established in collaboration with the patient and designated primary family member/caregiver, supported by precise documented monitoring of the patient's response to treatment, care, and therapy. Data compiled during the screening and assessment phases serve to identify the specific interventions required to improve a patient's desired and realistic care outcomes to support improved quality of life. 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 the patient and supportive individuals remain 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.

Medication administration. Medication safety and patient adherence are prominent issues, as national patient safety initiatives have focused practitioners' attention on the need to improve medication management and error reporting processes. However, dispensing and administration lapses, which are often difficult to defend in the event of a malpractice claim, continue to occur. Nurses can help to reduce liability associated with medication errors by following suggested actions, such as:

- **Compliance with policies and protocols** related to medication administration.
- **Understanding why the patient is taking a medication**, as well as interactions, side effects or adverse reactions that may occur.
- **Consistent use of the "six rights"** when administering medication to patients: right patient, right drug, right dose, right route, right time, and right documentation.
- **Eliminating sources of distraction** and interruption as much as possible when administering medication.
- **Listening to patient concerns.** If a patient questions the need for a medication or treatment, listen to these concerns and verify the order in the electronic medical record (EMR) and/or with the ordering practitioner.

For more medication risk control recommendations, see the Nurse Spotlight: Medication Administration.

Documentation. Documentation is a critical requirement for the planning and provision of healthcare services, communication among providers, patients and family, and demonstration of compliance with federal, state, third-party payer and other regulations. Patient care assessments, observations, communications and actions should be documented in an objective, timely, accurate, complete, appropriate and legible manner. As clinically appropriate, documentation in the EMR should include:

- Patient's chief complaint and review of current problems or symptoms.
- Review of clinical history, including relevant social and family history.
- Documentation of each visit or encounter, documenting the date and time, implementation of the plan of care, changes in patient status [physical, emotional and psychological], 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 evaluations and convey any problems to the primary provider.
- Educational materials, resources, or references provided to the patient.
- Encounters with other providers, including those via telephone, facsimile, and email, including a summary of the discussion and any subsequent actions taken.
- Documentation of reexaminations, including data from repeated or new examination elements, to provide a useful context for evaluating progress and help inform plans to modify or redirect interventions.
- Documented use of approved medical translators as needed, including sign language and non-English language translation.

For additional documentation-related risk control recommendations for nurses, see NSO and CNA's publications, Nurse Spotlight: Documentation, and Home Care Documentation: A Checklist of Essentials.

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 competency, knowledge, training, or regulatory limits. Some key risk control recommendations related to delegation and supervision include:

- **Know your State Nurse Practice Act and employer's policies and procedures** related to clinical practices and delegation. Lack of knowledge about established policies and protocols is not a defense.
- **Those in a supervisory role should conduct routine audits of staff** assessment procedures and documentation practices to verify competency and adherence to procedures.
- **Prior to delegating tasks, be cognizant of the knowledge and skills**, training, formal certification, diversity awareness, and experience of the individual to whom you are delegating elements of care. Use sound clinical judgement, which includes considering the complexity of the patient's condition, as well as the availability and competence of the unlicensed assistive personnel, prior to delegating patient care.
- **Monitor implementation of the delegated task**, as required, to the overall patient plan of care.
- **Evaluate overall patient condition** and the patient's response to the delegated task.
- **Evaluate and document the skills and performance of unlicensed assistive personnel** and provide feedback.

For additional information regarding nursing delegation, it is recommended that nursing professionals review the National Council of State Boards of Nursing (NCSBN) and American Nurses Association (ANA) National Guidelines for Nursing Delegation

Reducing Exposure to Common Health and Safety Threats in Home Care

Home care hazards, including hostile animals and potentially violent situations, compromise patient care and subject staff to more frequent and severe injuries, as compared to nurses who work in more controlled healthcare environments. Moreover, the inability of nurses to ensure a healthy and safe environment presents certain risk exposures in the form of physical and structural impediments that may result in patient falls, equipment malfunction, infectious disease exposures, and nurse staff injuries. In an effort to promote the safety and security of nurses working in a home care setting, and to promote the health and safety of their patients, common hazards and strategies to minimize their impact are presented.

Health and Safety Threats in Home Care

- Falls
- Infections
- Professional Boundary Violations
- Hostile Animals
- Violent Situations

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 causing serious injury, such as broken bones or a head injury. Falls also represent a common source of professional liability litigation. Therefore, reducing the incidence and consequences of falls is a risk control priority. Fall prevention and reduction programs for home health care should consider including 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, clutter, and pets.
- **Document all mitigation measures taken** and the rationale for their implementation.
- **Reinforce fall risk reduction tactics with patients and family.** Document 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** to supervisor, treating provider, and the patient's family, in a clear and timely manner, as necessary/appropriate.
- **In the case of a fall, report the incident** to a supervisor, treating provider, and the patient's family, and document the incident objectively in the EHR. An incident report should also be completed according to organizational policy. For more information on completing incident reports, refer to NSO's article, Are You Filing Incident Reports Properly?
- **Document patient non-acceptance of recommendations,** such as recommendations to move furniture or to use an assistive device to ambulate.

INFECTION RISKS AND 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 required tools to implement standard precautions, including hand hygiene products and personal protective equipment (PPE), i.e., gloves, gowns, and facemask, filtering facepiece respirators, and eye protection. For evidence-based resources and recommendations for infection control, visit: www.cdc.gov/infectioncontrol/tools.

MAINTAINING PROFESSIONAL BOUNDARIES. Nurses should avoid any activities with patients that fall outside of professional standards and the plan of care. Home health services should be conducted in an open and straightforward manner, and nurses should avoid multiple relationships with patients, their significant others and/or their family members. Both nurses and business owners should be alert to the following red flags:

- **Assuming a dual role of providing services** which are social support in nature versus home health care services which have been ordered and established. Examples of some social support services which should be avoided include activities such as running errands, driving a patient to appointments, or taking care of pets.
- **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 additional information regarding managing professional boundaries and addressing boundary violations, refer to the CNA and NSO Healthcare Perspective, Professional Boundaries: Drawing Lines That Cannot Be Crossed.

HOSTILE ANIMALS. Home healthcare workers often encounter hostile or unrestrained animals. An initial patient screening should expressly 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 must be restrained prior to home care visits and remain restrained for the duration of the care visit, including birds and reptiles. When encountering a hostile animal during a patient visit, nurses should:

- **Remain calm and wait outside the home** until the animal is restrained.
- **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.
- **Establish boundaries regarding pet care** such as feeding, watering, and or walking animals unless agreed upon at the outset of the engagement.

VIOLENT SITUATIONS. Home health care workers are dependent upon their own skills to safely defend themselves from acts of violence and aggression. Therefore, knowing how to identify and manage unsafe situations is essential:

- **Assess the environment for quick egress routes** in case of sudden violence or danger.
- **Remain 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. Nurses always should maintain an open pathway for a swift exit, if required.
- **Know how to defuse anger,** including speaking to patients in a calm and respectful manner, avoiding directives or orders, acknowledging feelings of frustration, moving in a slow manner and maintaining a respectful distance.
- **Empathize with the needs and issues of agitated individuals,** invoking de-escalation measures when presented with unusual or disruptive behaviors.
- **Maintain safe boundaries and immediate access to a cell phone,** in order to summon 911 assistance, if necessary.
- **Report violent occurrences and home-related hazards,** such as unsecured weapons, signs of drug/alcohol abuse or other illicit activities.
- **Implement a violence alert flag in the EMR** and consider modifying staffing to ensure safety.
- **Trust personal judgment** and promptly remove oneself from a potentially dangerous environment. To avoid allegations of patient abandonment, refer to the state Nurse Practice Act provisions related to abandonment. Often, an individual nurse must decide whether or not it is possible to continue providing safe patient care. If not, the nurse should notify the supervisor of the decision, and document every reason in detail.
- Regularly review training on de-escalation and avoiding unsafe situations.

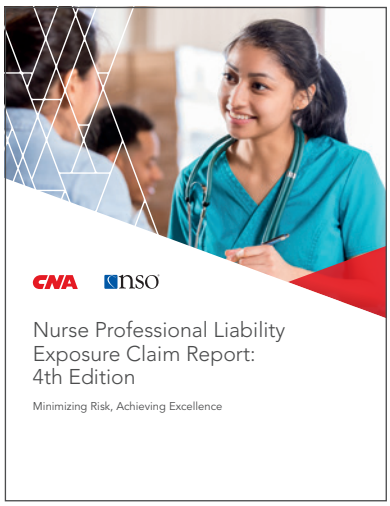
For more information, review OSHA's Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers, which includes the agency's recommendations for reducing the risk of workplace violence to workers in healthcare, including home healthcare.

INCIDENT RESPONSE: Policies and procedures should address expected 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. For more information on completing incident reports, refer to NSO's article, Are You Filing Incident Reports Properly?

Adherence to the recommendations presented will help to guide your decisions regarding professional practice. For additional 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)
- Occupational Safety and Health Administration (OSHA): Home Healthcare

This information is designed to help nurses evaluate risk control exposures associated with their current practice. It is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the tool to suit your individual practice and patient needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.



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In addition to this publication, CNA and Nurses Service Organization (NSO) have produced numerous studies and articles that provide useful risk control information on topics relevant to nurses, as well as information relating to nurse practitioner professional liability insurance, at **www.nso.com**. These publications are also available by contacting CNA at 1.888.600.4776 or at **www.cna.com**.

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