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CONTINUING EDUCATION FOR NURSES

Fraud and Negligence in Home Health Care:

What Healthcare Professionals Need to Know

It seems that home care always has something new for home care professionals to worry about, for example, PPS, OASIS OBQI, the Quality of Care Star Rating system, etc. While the importance of these issues should not be minimized and are especially important for Medicare Certification, it is equally important for everyone caring for patient/clients in the home to remain mindful of some basic concerns. Legal issues are fundamental concerns that every healthcare professional faces and which always remain of great consequence throughout one's professional career. Even in the midst of advancing technology and changing regulations, attention to the legal implications of one's actions must remain uppermost in our minds. The significant legal issues a home health professional faces are generally related to two areas of concern: negligence or fraud.

Learning Objectives:

Upon completion of this program the learner will be able to:

1. Define "standard of care";
2. List and define the four elements of negligence;
3. List the four most common negligence-related risks in home health care;
4. Discuss the Five Rights of Delegation;
5. List five common sense approaches to avoiding negligence-related risks in home health care;
6. Give an explanation of eight common documentation mistakes; and
7. Implement a minimum of ten good documentation practices.

Negligence

"Standard of Care" is defined as what a reasonable healthcare professional (nurse, physical therapist, etc.) would do for a patient/client under the same or similar circumstances. In other words, it dictates the healthcare professional carry out their responsibilities and conducts themselves using a degree of care or prudence in a manner in which healthcare professionals of the same training and experience would use under similar circumstances. Clinical documentation must clearly demonstrate that the healthcare professional adhered to standards of care.

Standards of Care are consistent with minimum, safe, professional conduct as determined by professional organizations. Examples of professional written standards of nursing practice include but are not limited to the following:

- Federal requirements for agencies receiving Medicare and Medicaid (i.e. Conditions of Participation)
- State law and regulation
- Institutional policies and procedures
- Nurse Practice Act
- Standards of national nursing organizations and sub-specialty groups (e.g. American Nurses Association (ANA), Infusion Nurses Society (INS), Wound Ostomy and Continence Nurse Society (WOCN), American Physical Therapy Association)
- Accrediting organizational standards (e.g. The Joint Commission, Community Healthcare Accreditation Program (CHAP), Accreditation Commission for Health Care (ACHC))
- Center for Disease Control (CDC) Guidelines

Negligence is the failure to provide a patient/client with the standard of care that a reasonably prudent healthcare professional would have provided under the same or similar circumstances.

Four Basic Elements of Negligence

1. **Duty:** The first element is establishing the presence of a duty owed by one person to another. People have a duty to act in a reasonable manner towards others.
2. **Breach:** The second element is a breach of duty owed by one person to another. A person breaches their duty by failing to act in a reasonable manner toward another person.
3. **Causation:** The third element is when the breach of duty becomes the direct cause of another person's injuries. The type and severity of injuries must be related to a failure to act in a reasonable way.
4. **Damages:** The fourth element is when legally recognized harm or injury occurs to the person to whom the duty of care was owed.

Negligence occurs when an applicable standard of care exists, **AND** the healthcare professional fails to act in accordance with the standard of care, **AND** a medical injury results directly related to the failure to act within the standard of care.

Negligence-Related Risks in Home Health Care

Some of the more commonly encountered negligence-related risks in home health are associated with:

- Autonomy. The healthcare professional (e.g. nurse, physical therapist) practices without direct supervision in the home health setting and is expected to make on-the-spot decisions. Because the healthcare professional is alone in the field, the clinical manager or home care supervisor should be only a phone call away if the healthcare professional needs help. It is important for the healthcare professional to know the chain of command and the agency's policies and procedures for dealing with emergency and non-emergency situations, as well as to understand when it is the right thing and time to call, even for a second opinion.
- Patient/Client Teaching. Patient/client education is a vital part of care in the home, but it can also put the healthcare professional at legal risk. For example, the patient/client might claim he or she was harmed because the healthcare professional's teaching was inadequate. The

healthcare professional can protect himself/herself by making sure that all aspects of individual patient/client self-care is taught, learning is assessed (e.g. teach-back method) and documented. The healthcare professional must be sure to document everything taught to the patient/client and family member/caregiver, including how the learning was assessed, whether a family member/caregiver was present, and if any educational materials were left behind. It is responsible and desirable for the healthcare professional to involve family members/caregivers in the management of the patient/client's care, but never to abdicate the responsibility for monitoring the patient/client while they remain under care of the home care agency. We are in an age of better-informed consumers, and better-informed consumers have an expectation of a certain level of care and are better able to recognize insufficient or inappropriate care.

- Equipment. Advances in technology require healthcare professionals to have knowledge of a variety of technologies and their capabilities, limitations and safety features. If the healthcare professional is unsure of how to use or troubleshoot certain equipment necessary for a patient/client's care, he/she is responsible to tell the supervisor and ask to be assigned to a different patient/client or request the additional education needed to expand their skills appropriately. Otherwise, the healthcare professional could be liable for negligence if the patient/client is harmed. If the healthcare professional is familiar with the equipment and can care for the patient/client using the equipment safely, it is important to show evidence of their experience and knowledge in the employee file. It is also important for the healthcare professional to have an understanding of agency policies and procedures for dealing with equipment malfunction should it arise.
- Delegation***.*** Delegation is the assignment of responsibility to another person to carry out a specific activity or task. When a task is delegated, it remains the healthcare professional's (e.g. registered nurse, physical therapist) responsibility to make sure that the employee (e.g. aide, PTA, LPN/LVN) providing the care of the task being delegated has been adequately prepared. The care being delegated must be within the employee's scope of practice and in compliance with state law and regulation. The healthcare professional must routinely review the care plan with the employee so that the employee understands their expectations (e.g. when to call the RN/PT, what should be documented, etc.) The healthcare professional or the person who delegated the task remains accountable for the outcome of the delegated work and could be liable if errors are made in carrying out the delegated task; therefore it is important for the healthcare professional to always consider patient/client safety as a priority when delegating tasks.

  Delegation is an essential skill and yet is one of the most difficult responsibilities as it requires sophisticated clinical judgment and final accountability for patient/client care. There are a number of essential concerns to consider when planning delegation of responsibilities. Those responsibilities are known as the **Five Rights of Delegation**:

  1. **The right task** – An assessment of the patient/client determines if an activity can be delegated to a specific member of the health care team. Knowledge of state practice acts and agency policies and procedures are essential when making decisions about what patient/client care tasks can be delegated.
  2. **The right person** – The skills and abilities of the employee is considered in making decisions about delegation of tasks. If the task is outside the scope of practice or skill level, additional training and competency demonstration must occur.

For example, an aide is caring for a patient/client who is quadriplegic and has an established bowel program in which the aide will be participating. The aide must receive training/instruction on digital stimulation and insertion of suppositories for this particular patient/client and return competency demonstration under the nurse's direct observation. The nurse must know the skill ability of that aide. The aide must be willing to learn and demonstrate competency performing the task prior to assignment.

3. **The right circumstances** – Assessment of the patient/client identifies the health care needs of a patient/client. Assessment and judgment can never be delegated! In order for a task to be delegated, it must have a predictable outcome, be routine for the patient/client's care, and must not require direct supervision during the task. Routine means that the task is routine for the patient/client--not clinically routine for the healthcare professional delegating the task.

   For example, a bowel program for a quadriplegic patient/client is a routine part of his/her care and has a predictable outcome. The aide performing this task does not require direct supervision each time the task is being performed.

   Examples of common, routine and predictable tasks that may be delegated to a home care aide are:

   - Non-sterile wound care,
   - Inserting suppositories and or fleets enemas,
   - Oral suctioning,
   - Gastrostomy Tube feeding; and
   - Applying topical medicated ointments.

   Appropriately delegated tasks cannot pose any harm to the patient/client and must be within the scope of practice and skill level. Tasks requiring repeated assessment during the task cannot be delegated. Examples of tasks that should NOT be delegated to a home care aide are:

   - Performing sterile procedures;
   - Application of heating pads;
   - Nail trimming for diabetic patient/clients; and
   - Insertion of indwelling tubes.

4. **The right communication** – Communication is key….specifically what, how, and by when delegated tasks are to be accomplished. Communication includes the purpose and goal of the task, limitations and expectations for reporting. The employee receiving the delegated task must receive training/instruction on specific tasks for specific patient/client and provide return demonstration of such tasks under the healthcare professional's (e.g. RN, PT) direct observation. The healthcare professional must give clear and specific direction both orally and in writing regarding the task. It is important that the employee clearly understands their parameters and responsibility, as well as who to call and when.
5. **The right supervision** – The healthcare professional monitors and evaluates both the patient/client and the employee's performance of delegated tasks. The complexity of the

delegated task(s) affects the determination of the required frequency for supervision. However, supervision must never be less than the applicable state, federal or agency requirement. Case supervision allows for specific feedback from the patient/client or family member/caregiver regarding the employee's performance of the delegated task. It also offers an opportunity to intervene on behalf of the patient/client as necessary and provide immediate employee feedback to increase competency in delegated task performance. Patient/client satisfaction surveys and patient/client complaint reports are also a way to indirectly supervise by identifying and responding to any negative trends that might be related to the delegation of routine tasks.

Managing the Inherent Risks

The above-mentioned risks are inherent in the nature of home health care. However, potential liability can be reduced by using caution and common sense, providing oversight and supervision, and maintaining a heightened awareness of his/her legal responsibilities as described below:

Maintain open, honest, respectful relationships and communication with patient/clients and family members/caregivers.

- Patient/clients are less likely to sue if they feel that a healthcare professional has been caring and professional and has involved the patient/client in his/her own care.
- Don't offer opinions when a patient/client asks what you think is wrong with him—you may be accused of making a medical diagnosis. Refer the patient/client to their physician.
- Don't make a statement that a patient/client may interpret as an admission of fault or guilt. It is acceptable to apologize for any inconvenience or distress that the patient/client may have experienced.
- Don't criticize or offer opinions regarding other health care providers regarding their actions when you are with patient/clients.
- Maintain patient/client confidentiality.
- Do not discuss issues from your private life with the patient/client or family members/caregivers.

Maintain competence in your specialty area of practice.

- Attend relevant continuing education classes.
- Attend relevant agency in-service programs.
- Expand your knowledge and technical skills as relevant to the kinds of patient/clients you care for.

Know legal principles and incorporate them into everyday practice.

- Keep up to date on your state's Practice Acts.
- Keep up to date on agency policies and procedures.

Practice within the bounds of professional licensure.

- Perform only the skills allowed within your scope of practice and that you are competent to perform.
- Delegate only those tasks allowed by your state law and regulation.

Know your strengths and weaknesses.

- Don't accept a clinical assignment you don't feel competent to perform or manage.
- Document all care accurately and as soon as you can after delivery of that care. If care is not documented, courts assume it was not done.
- When documenting care in the patient/client's record, use the FACT mnemonic: be **f**actual, **a**ccurate, **c**omplete, and **t**imely.

Fraud

Healthcare fraud is an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party. As it applies to healthcare professionals in home health care, the most common fraudulent activity is representing the delivery of services one way, when it was actually delivered in another way or not delivered at all. The patient/client's record and/or billing records are the most common places where evidence of misrepresentation (fraud) may be found. Any occurrence of fraud is managed with serious disciplinary action up to and including termination. In extreme cases that involve the care of patient/clients who receive Medicare or Medicaid payments, the healthcare professional may be prosecuted and can be excluded from work in any home care agency or health facility.

Documentation

Often when concerns arise related to either negligence or fraud, the root cause of the problem may not be the actual care provided or the practices of the healthcare professional but rather how that care or practice was documented in the patient/client record.

Whether computer-based or handwritten, the patient/client record provides legal proof of the care the patient/client receives. It may become the focus of inquiry in personal injury, professional malpractice or product liability claims, as well as in workers' compensation, child custody, and employment disputes.

Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based practice. Healthcare professionals have a legal duty to maintain the patient/client record in detail by documenting all care delivered and according to standards of practice. Documentation is objective evidence that actions or tasks have been performed. Inadequate documentation of the care provided may result in liability or no payment by third-party payers. In fact, documentation of care has become synonymous with care itself, and failure to document implies failure to provide care. *"If it isn't documented, it hasn't been done."*

Common Mistakes of Documentation

1. Failing to record pertinent health or drug information

If the patient/client has an allergy or a disease (such as diabetes, hemophilia, or glaucoma) that the care team needs to know about, it is important to record this information in the patient/client's record for reference by all healthcare team members. For example, if the nurse forgets to record the allergy or disease in the patient/client record; the nurse and the agency could end up in a legal proceeding like the trial situation described below.

The nurse admitting the patient neglected to record the patient's penicillin allergy in the admission documentation. Because another nurse caring for the patient didn't know the patient was penicillin-allergic, he gave the patient a penicillin injection. The patient, who was incoherent and couldn't tell the nurse about the allergy, went into anaphylactic shock and suffered irreversible brain damage. At the trial, the court found the admitting nurse guilty of negligence.

A nurse must ask every patient/client about food and drug allergies, diseases, and chronic health problems, and record the information on the admission assessment, and as appropriate in the nurses' notes and in the Plan of Care to ensure that the information is known and considered by all member of the care team.

2. Failing to record nursing actions
It is imperative that all care delivered for a patient/client is documented in the patient/client record as soon as possible after the care is provided.

Suppose the day shift nurse observes heavy drainage from around the patient's G-tube, and she changes the dressing several times; but she forgets to record the dressing changes before she leaves.

The evening shift nurse has never cared for this patient before. She also notices heavy drainage from around the G-tube. She checks the day nurses' notes and finds no evidence that the dressing was changed. She considers the amount of drainage for the shift to be normal. She changes the dressing, and like the previous nurse, she doesn't document the amount of drainage.

Is the condition getting more serious? Is the patient's well-being in jeopardy? No one knows because nothing is being documented.

3. Failing to record medications timely
Another "must-do" is recording every medication when it's given--including the dose, route, time, and patient/client's response.

Suppose a day nurse gave a patient a 4:00 pm scheduled dose of heparin by intravenous push just before she went off duty, but didn't have time to chart it. An hour later, the evening nurse saw the order for heparin--but no indication that it had been given. So she gave the patient the same dose. The patient began to hemorrhage and went into hypovolemic shock. He did recover.

Both nurses made mistakes. The first should have recorded that she'd given the dose. The second should have been suspicious when she saw the order for heparin but no evidence that it had been given. She could have:

- asked the patient if he'd received the medication;
- called the pharmacy to see if the dose had already been furnished; or
- called the first nurse at home to verify if the dosage had been given.

A*lways* investigate when you suspect a medication may have been given but not recorded.

Here's an example of a problem that may occur if you record a medication BEFORE it is given.

The nurse covered the night shift for a pediatric patient at home. The patient always received the same medications at the same time every night, 12:00am and 6:00am. To save time, the nurse would prepare and document the medications as soon as she arrived at the patient home; then she would administer them at the appropriate time. One night the patient arrested and was rushed to the hospital at 3:00am. Needless to say that the nurse did not administer the patient's medications at 6:00am, but having them documented as given gave the appearance of fraudulent documentation by the nurse.

4. Recording on the wrong patient/client record
You can't be too careful in any situation that might lead to confusion between two patient/clients, such as a same last name, same condition, or same doctor.

Mrs. B. Moyer and Mrs. C. Moyer were patients of the same home care nurse. Mrs. B. Moyer was being treated for severe hypertension; Mrs. C. Moyer, for acute thrombophlebitis. Mrs. B. Moyer's doctor ordered Lasix for her.

The nurse mistakenly transcribed the Lasix order onto Mrs. C. Moyer's patient record and administered the Lasix. Mrs. C. Moyer became dehydrated.

When two or more patient/clients have the same name, be sure to implement a process that will identify each patient/client uniquely to you and to other healthcare providers caring for the patient/client.

5. Failing to document a discontinued medication
When a patient/client has a medication discontinued by the physician, the nurse must document that order promptly. Below is an example of a problem with not documenting physician orders promptly.

A doctor suspected that his patient, who was taking high doses of aspirin for arthritis, had developed an ulcer. So when he spoke with the nurse about the patient he discontinued the medication. Although the nurse mentioned the discontinued order to the patient, the nurse did not record the order. By the time she next spoke with the patient's family, she had forgotten about the order. The patient was not reliable in retaining this kind of information either. The patient's family continued to administer the aspirin, the ulcer bled, and the patient eventually underwent a partial gastrectomy because her condition deteriorated.

6. Failing to record drug reactions or other changes in the patient/client's condition
Monitoring a patient/client's response to treatment is important; however the nurse must also be able to *recognize* an adverse reaction or a worsening of the patient/client's condition and *intervene* before the patient/client is seriously harmed.

During a home care visit a patient complained to his nurse of nausea, dizziness, abdominal pain, and itchy skin shortly after starting a course of nitrofurantoin macrocrystals (Macrodantin). His nurse recorded the complaints in the patient record but did not call the physician. By the next day, he was vomiting and had a high fever, urticaria, and early symptoms of shock. He was obviously continuing to experience the drug reaction that started the day before.

The fact that most patient/clients don't have adverse reactions to certain drugs shouldn't lull the nurse into carelessness; most drugs can cause problems in some patient/clients who take them. It is the responsibility of the nurse to observe patient/clients closely, consider the possibility of adverse reactions when a patient/client reports new symptoms, and follow up appropriately.

7. Transcribing orders improperly or transcribing improper orders
If the nurse transcribes orders in the wrong patient/client record or transcribes the wrong order, the nurse can be held liable for any resulting injury. The nurse can also be held liable if transcribing or carrying out an order as it's written while knowing or suspecting the order is wrong. The nurse should be familiar enough with the medications, procedures, and activities of home care to know when something isn't right.

A home care supervisor wrote a verbal order for 20 mg of morphine for a post-surgical patient. The supervisor meant to write 2.0 mg, but he didn't write the decimal point clearly. The field nurse administered the order as 20mg, although she didn't think it seemed right. She decided the doctor knew best and didn't check the dose before administering it.

Anytime the nurse is unsure about a drug or treatment order, it is important to check it with the prescribing doctor. And if the nurse is sure the order is wrong, tell the doctor why it can't be administered, and then notify the nursing supervisor.

8. Writing illegible or incomplete records
Jokes about physicians and healthcare professionals and their handwriting are common, but in truth, legibility is a serious issue. These mistakes cause difficulty for others who must have access to the patient/client's record, and they can cause problems in case of legal action. Additionally, as an employee, the healthcare professional risks damage to his/her professional reputation if the supervisor must call the healthcare professional repeatedly to clarify documentation or to inform the healthcare professional that the information recorded is incomplete.

Good Documentation Practices

DO'S

- Write legibly. Print if your handwriting is difficult to read.
- Write at least your initials somewhere on every page where you've documented.
- Record every nursing action as soon as possible after you've finished it.
- Make sure your documentation reflects the nursing process and your professional capabilities. Write enough to convince a reader that the patient/client was adequately cared for.
- Document often enough and in enough detail to tell the whole story.
- Document patient/client care at the time you provide it.
- If you remember an important point after you've completed your documentation, document the information with a notation that it's a "late entry." Include the date and time of the late entry as well as your initials.
- Sign your full name and title.
- Check that you have the correct patient/client record before you begin writing.
- When you administer a medication to a patient/client, document the full name of the medication, the dose, time you gave the medication, administration route, and the patient/client's response.
- Document precautions or preventive measures used, such as instructions in safety measures or what you did to make the patient/client's environment safer.
- Record each phone call to a physician or other healthcare team member, including the exact time, message, and response.
- Document a patient/client refusal to allow a treatment or take a medication. Be sure to report this to your supervisor and the patient/client's physician and document this communication in the patient/client record as well.

DON'TS

- Don't leave blank spaces, lines, or boxes on a patient/client record. If you don't use the space, draw a line through it or write N/A (not applicable).
- Don't use abbreviations that aren't on your agency's approved list of abbreviations. Chances are someone could misunderstand your abbreviation, and years later, you may not even remember what it meant.
- Don't document a symptom, such as "complains of pain," without also documenting what you did about it and how the patient/client responded.
- Don't alter a patient/client's record--this is a criminal offense.
- Don't write imprecise descriptions, such as "bed soaked" or "a large amount."
- Don't give excuses, such as "Medication not given because not delivered by the pharmacy."
- Don't document what someone else said, heard, felt, or smelled unless the information is critical. In that case, use quotations and attribute the remarks appropriately.
- Don't document care ahead of time--something may happen and you may be unable to actually give the care you've documented. Documenting care that you haven't done is considered fraud.
- Don't use white-out to correct an entry.

SUMMARY

Given the litigious nature of our society, every professional faces the risk of legal action. Healthcare professionals in particular are at risk as mistakes or omissions can seriously jeopardize a human's life. However, you can better protect yourself, the company you work for and your patient/clients by following these few guidelines.

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