Legal Issues in Home Care: Current Trends, Risk-Reduction Strategies, and Opportunities for Improvement

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Home health nurse malpractice litigation and judgments are increasing. The legal and home health practice environments are evolving in streams of tumultuous change. The legal view of nurse practice lags behind the realities of nurse practice. Evidence-based practice is evolving and becoming the expected standard of practice. This article summarizes the current home health malpractice trends and identifies current factors affecting change in both the legal and home health environments. Strategies and resources to reduce nurse malpractice risk in home care are discussed.

Patient quality of care and safety have received increasing scrutiny in recent years. Although malpractice claims in home care remain low when compared to acute and long-term in-patient care, they are increasing, and this trend is expected to continue. Benchmarking of quality outcomes is occurring, and increased use of evidence-based guidelines in practice standardization has occurred across provider settings. The consumer public has increased savvy regarding minimal quality-of-care standards and prevention of medical errors and avoidable complications. The term *adverse events* is becoming well known across provider settings. Avoidable or preventable adverse events are now closely scrutinized by both regulators and accrediting bodies. This article addresses the current home care practice environment as it relates to the changing legal environment and increasing home care litigation. Resources and practices to reduce risk are identified and discussed, focusing on the populations at risk or already with complex wounds.

COMPLEX POPULATIONS

The growing, complex populations of chronically ill and elderly have yielded clinically complex discharges to the home care practice setting. In addition, community referrals to home care are yielding admissions with increasingly complex care management needs without prior hospital admission. Reduced availability of competent home care staff and unpaid caregiver availability is an issue complicating care management with the growing, complex, chronically ill and elderly populations. Health care market evolution varies geographically and affects home health agencies (HHAs) economically at a local level.

Increased industry competition and consolidation has occurred with the implementation of the Medicare Prospective Payment System (PPS) and mandated data collection. Much of the home care data collected is standardized via the mandated use of a minimum data set (MDS), Outcomes Assessment Instrument Set (OASIS), mandated by the Centers for Medicare and Medicaid Services (CMS). Outcome-based quality improvement (OBQI) is now driven by benchmarked reports provided by CMS (adverse events and case-mix reports). Benchmarked outcome reports were made

Key Words: nursing malpractice; National Practitioner Data Base; risk-assessment tools; evidence-based practice; disease management

Home Health Care Management & Practice / February 2005 / Volume 17, Number 2, 93-100
DOI: 10.1177/1084822304270025

available to the public on the CMS web site (www.cms.gov) in November 2003. In addition, some agencies have the capability to generate more timely OASIS-based reports for internal performance-improvement (PI) initiatives. Nonetheless, changes in standards of practice mandated by law often lag behind practice standards and practice reality. Home care nurses not only need to understand current laws and practice standards but must develop and employ successful strategies to manage risk. This applies to both themselves and their organizations in this changing environment.

Malpractice litigation has increased overall. Home care litigation has historically been a small percent of overall health care litigation. Croke (2003) reported a 2% rate of malpractice litigation in a study across practice settings for the HHA setting where nurses were defendants in a civil lawsuit as a result of unintentional action (no criminal act alleged). Acute care and skilled nursing facilities (SNFs) accounted for the majority of the cases. This retrospective study was done by pulling data from multiple legal sources for cases during the period from 1995 to 2001. Although the majority of nursing malpractice claims still arise from acute care and SNFs, the percentage of care claims is rising and will continue to do so as patients are increasingly cared for in the home (Croke, 2003).

Nursing malpractice can include negligence related to an action or failure to act resulting in patient injury. The question posed in all such cases is, "Was the nurse's conduct reasonable under the circumstances?" Stated another way, "Did the nurse comply with accepted standards of nursing conduct?" Although the standard of care often is amorphous and difficult to define, standards of practice exist in multiple sources (e.g., State Nurse Practice Acts, accrediting and licensing agencies/bodies, certification entities and professional organizations, and institutional/agency standards in practice settings via standards/policies and procedures). As consensus increasingly develops in nursing care, variations from the consensus will be less defensible.

Historically, nursing liability was limited to failing to follow physician's orders. Because nursing was not viewed as requiring independent judgment, nurses could not be held liable for malpractice or professional negligence. The nurse could be held accountable, as any other employee, for not following orders but had no duty to exercise independent judgment. There really was no nursing malpractice noted, as nurses were seen in a dependent role where they were to follow MD orders. Newfield (2003), a defense malpractice lawyer, noted in a lecture that the traditional view of nurses was "that of passive, servile employee." This is no longer the case.

The law now recognizes that nurses are responsible for and make health care judgments, and it holds nurses liable for decisions that depart from accepted standards in the community. Nonetheless, public perception and the law lag behind the realities of practice in home care where the nurse is more autonomous and often drives care management. Although responsible for making nursing assessments and judgments, a physician's order continues to insulate greatly a nurse from liability; unless it is so contraindicated, it could not be followed by any reasonable person. Newfield (2003) has related that the role in the legal environment is evolving. Newfield noted that the current legal view of a nurse's role does include an expectation of exercising judgment and discretion while still following physician orders. Only in extreme circumstances is there a legal expectation that the nurse must not follow the physician order. In that circumstance, the nurse is obligated to challenge that order to prevent culpability in malpractice litigation (Newfield, 2003).

In multiple legal presentations to nurses over the years, common pitfalls leading to home care risk that have been identified include:

- unsafe admissions;
- rushed or incomplete assessments;
- incomplete or missing documentation;
- following orders blindly by failing to clarify or question unclear orders or orders out of the norm;
- lack of attendance in continuing education programs, reading of nursing/medical journals, and participation in professional organizations;
- failure to look up unfamiliar medications or doses; and
- rushed procedures or failure to follow steps laid out in standards.

RESEARCH AND CURRENT TRENDS

Croke's (2003) research provided insight into current trends. She noted six major categories of negligence that result in malpractice lawsuits based on a review of 350 trial, appellate, and Supreme Court case summaries:

- failure to follow standards of care (e.g., perform complete admission, adhere to standardized protocols, or follow physician orders),
- failure to use equipment in a responsible manner (e.g., follow manufacturer recommendations, check equipment for safety, receive training/learn proper equipment functions/use),
- failure to communicate clinical status (e.g., notify MDs in a timely and accurate manner of changes in patient status or follow-up on patient complaints),
- failure to document (e.g., complete assessment, appropriate follow-up to injuries, medical orders, details and time of interdisciplinary communication and follow-up),
- failure to assess and monitor (e.g., complete assessment, interpret a patient's signs and symptoms, and implement a plan of care), and
- failure to act as a patient advocate (e.g., question incomplete medical orders or challenge a discharge order when the patient condition warrants it) (Croke, 2003, p. 57).

Croke also reported on the data available in the National Practitioner Data Base (NPDB) from 1998 to 2001 by nursing category: nonspecialized RNs, nurse anesthetists, nurse midwives, and nurse practitioners. This database provides detailed judgments in nursing malpractice suits including settlement, disciplinary actions resulting in license revocation, or privilege limitation or monetary damages. The NPDB was established in 1986 and is regulated by the Bureau of Health Professions, the Health Resources and Services Administration, and the U.S. Department of Health and Human Services (Croke, 2003).

NURSE'S ALLEGED FAILURE TO REPORT, DIFFERENTIATE, OR SCREEN

In home care settings, litigation frequently stems from the nurse's alleged failure to advise a physician of clinically significant findings or changes thereby resulting in delayed diagnosis or treatment. Unlike in acute care settings where physicians' direct involvement in care is more frequent and predictable, in home care, the physicians rely more extensively, and at times exclusively, on nursing judgments and often are insulated by the nurses' alleged failure to report. Should problems arise, litigation will often focus more on the nurse's judgment than the physician's duty to monitor and manage the patient's care.

The NPDB allows eligible entities, including HHAs, to screen prospective applicants. In a current search of the database, the author noted additional nursing categories: advanced practice nurse, clinical nurse specialist (CNS), and licensed practice nurse. Physician reporting is mandated by law, so the physician data are more complete than the voluntary nursing data reported. Because reporting of nursing data is voluntary, there are missing nursing data. Recent, rare, criminal nurse cases with multiple patient deaths have affected changes in regulation in New Jersey, and there may be more pressure to mandate nursing data to provide for patient safety. A plaintiff's attorney has access to the NPDB as well as the defendant practitioner. The web site for the NPDB is www.npdb-hipdb.com.

Increased malpractice activity has been noted in the area of wound care complications (morbidity and mortality) and adverse events such as pressure ulcer development across practice settings. Patient admission requiring complex wound care and patients at high risk for pressure ulcer development are occurring in home care. Wound case prevalence volume rates are high and do vary by HHA. Home care referral data for cases requiring wound care have been reported at 15% to 20% and census prevalence at 25% across payers (Dailey, 2001). It is expected that this trend will continue as hospital length of stays (LOS) shorten. Prevention of avoidable pressure ulcers and worsening of existing wounds is considered a current standard of practice. Wound categorization, wound care treatment goals (identified as curative or palliative), and an appropriate treatment plan including prevention are important for good care management. If not done, nurses and their agencies will be held to a standard that may not be possible or intended. Documentation of the appropriate referral intake process, admission, and ongoing care management is key to reducing litigation exposure. Appropriate screening for an admission, discharge, or transfer to the appropriate practice setting is essential to reduce risk and adverse events.

Admission of cases requiring more resources than can be safely provided in the practice setting should not occur. Education of home care nurses as to how to stratify cases for admission rejection in both the intake process and during the admission visit is crucial to reducing risk for both the practitioner and the HHA. A mutual care agreement spelling out the caregiver responsibilities to ensure follow-up to the physician care plan and maintenance of a safe environment is an excellent tool to be employed appropriately. Often psychosocial or caregiver adherence issues may be

revealed in the intake process. A mutual care agreement can be utilized when appropriate versus outright rejection of the patient for home care services. A multidisciplinary approach involving the patient and caregiver works best in employing mutual care agreements in a face-to-face meeting prior to discharge. Attorney Randall (1995), with expertise in home health, noted that the appropriateness of rejecting unsafe referrals in the intake and admission process is essential to reducing risk and avoiding accusations of harm or citations regarding abandonment for home care discharge related to unsafe conditions or nonadherence. Similarly, state and federal regulations make it difficult or impossible to discharge patients once admitted regardless of patient nonadherence or unsafe conditions. For example, absent extraordinary circumstances such as physical abuse of staff, Medicaid patients cannot be discharged without a fair hearing or a physician's order approving a discharge. In addition, Randall noted that if multiple agencies are contributing to care or an HHA is responsible for only some aspects of care management, this should be spelled out in the admission agreement signed by the patient and/or caregiver as appropriate (Randall, 1995).

PRACTICE REVISIONS

HHAs have revised wound care policies, procedures, and standards to reflect current evidence-based practice to promote positive clinical and financial outcomes and reduced regulatory and legal exposure. It is key that the HHA staff be educated, updated, and cued appropriately to provide a minimum standard of practice to meet these standards of the HHA. Education and expertise regarding appropriate documentation, screening for complex case management for high-risk cases, and patient advocacy are keys to success in reducing litigation risk and improving outcomes. Current newscasts, such as *Sixty Minutes* (2003), have reported on the critical nursing shortage. The nursing shortage has affected HHA recruitment efforts and is increasing competition for the experienced RNs. Experienced home care nurses are retiring in larger numbers as the workforce ages. Programs recruiting new graduates into home care are being implemented to close the recruitment gap. Thus, the experience, competency, and knowledge level of available home health recruits provides unique challenges. HHAs are providing opportunities for expert consultation on complex cases such as telehealth consults by CNSs for high-volume populations (e.g., cardiopulmonary; diabetes; oncology; and wound, ostomy, and continence nursing [WOCN]). The CNSs cue evidence-based practice and provide clinical consultation regarding complex care management modalities. Evidence-based practice standards are based on published guidelines compiled from current research and that adhere to certain standards (e.g., standards are listed on the Agency for Health Research and Quality Guidelines Clearing House, www.guideline.gov, or linked via www.ahrq.gov; they are also available via professional nursing societies such as the WOCN Society at www.wocn.org). Evidence-based practice standards reduce practice variance and promote quality outcomes. Motta (1995) noted that a wound documentation tool or standardized assessment with pertinent cues is essential to reducing legal risk. Regardless of the format of documentation, Motta also noted that appropriate, timely reporting of acute wound changes (e.g., signs or symptoms of infection, increased necrotic tissue or size, or new wounds) is critical to reducing risk.

Documentation is usually a mixture of electronic and paper formats in most HHAs today. Automated documentation systems are rolling out, but often major documentation pieces remain in paper format. Typically, the prior nurse's complete documentation is not available to the covering nurse on the next visit. Effective and efficient verbal communication remains inherent in maintaining continuity of care and documentation in home care. Documentation consistency in wound type and description, adherence to the MD-ordered plan of care, and timely reporting of significant clinical findings to the MD are current standards and important to reduce risk. As communication capabilities and documentation systems evolve, increased expectations for improved coordination and follow-up will occur.

Upstream data accuracy in the referral process and appropriate wound categorization by the MD are key to success. This facilitates the initiation of comprehensive and consistent patient assessment and evidence-based care documentation. Referral data forms or electronic screens should include a comprehensive wound category choice (not only OASIS-tracked surgical, stasis, and pressure categories). When the referral forms/screens include appropriate choices (e.g., neuropathic, arterial, etc.) in addition to OASIS-tracked wound categories, accurate wound categorization and appropriate evidence-based care are facilitated. If the wound category or etiology is unknown upon referral and it is not

feasible to have testing done prior to home care admission, the unknown categorization is a flag to cue timely MD-RN collaboration. This facilitates evidence-based care management and positive outcomes. Dailey (2001) noted that wound categorization is essential to utilizing an effective and efficient disease/population management model in wound care. Upstream data comprehensiveness and accuracy are important across primary and secondary diagnoses for all populations.

DISEASE-BASED POPULATION MODEL OF CARE

A disease/population-based model of care management facilitates evidence-based practice and standardized referral processes and care-management documentation as well as the reduction of risk. Agency-specific, evidence-based tools cue staff to essential care management so that standardized protocols are followed. These tools can be a hard copy or available via electronic prompts in an electronic documentation system. HHAs facilitate consistency in evidence-based practice by providing orientation and educational updates, CNS consults, and user-friendly tools. Comprehensive and accurate assessment, choosing appropriate interventions based upon the assessment, contacting the MD for changes in orders, and appropriate clinical intervention and follow-up are needed. Reduction in avoidable emergency room use and rehospitalizations are the current quality outcome expectations by regulators, accrediting bodies, and managed care payers. Establishing systems to ensure effective communication with physicians reduces risk exposure and good care management. Disease management standards are available at the Disease Management Association of America's (DMAA's) Web site: www.dmaa.org.

ASSESSMENT TOOLS

Reliable and valid risk-assessment tools focus clinician interventions on evidence-based practice. These tools can be used in a hard copy or electronic format and should be linked to the appropriate intervention tool based on evidence-based guidelines. For instance, the ordering of support surfaces for the bed bound or chair bound, the highest risk population for pressure ulcers, would be linked to the support surface algorithm tool, which cues a WOCN consult for more complex patients. Olshansky (1998) noted that caregiver compliance with evidence-based protocols is another area of risk assessment. He noted that the incidence of pressure ulcers is related to caregiver follow-through with evidence-based, pressure-relieving standards. Ferrell, Josephson, Norvid, and Alcorn (2000) noted that pressure-relieving devices in home care are often underutilized and indiscriminately applied. Thus, assessment of risk must be combined with provision and documentation of evidence-based care management following federal, state, and agency standards of care or protocols. CNSs are content experts to partner with operations, quality management, and other disciplines in setting HHA protocols and standards and PI initiatives. They can also be strong allies in ensuring implementation of necessary treatment.

PUBLIC POLICY AND KEY EVENTS

Wakefield (1998) noted that patient safety and minimizing error in health care has moved out of the health care arena and into the public policy-making arena. In November 2003, the Institute of Medicine (Page, 2004) published the nursing report relating factors contributing to medical error and removal of a blame mentality in PI. Wakefield related that the Advisory Commission for Consumer Protection and Quality in Health Care in their 1998 report to President Clinton noted that the Federal Agency Administration error-reduction model needs to be adopted in health care. This model removes the blame focus and encourages self-reporting and confidentiality to promote reduction in recurrence via prompt remediation and PI processes implementation (Ferrel et al., 2000).

The *Wall Street Journal* (*WSJ*) noted that PI and evidence-based practice are essential to improving outcomes, reducing error, and reducing excessive cost in health care (Landro, 2003). Key groups influencing progress in health care quality and safety were identified in this *WSJ* article, although unfortunately neither nurses nor a nursing organization was mentioned in the article. Tom Scully, the CMS director who recently resigned, was quoted in this *WSJ* article regarding the importance of aligning practitioner and payer incentives to promote increased use of effective disease management programs. The CMS request for proposals in April 2004 regarding models for testing to improve chronic disease management provided impetus for planning and implementing effective disease/population management in the Medicare populations. As PI and disease/population management gain financial incen-

tive across the continuum, integrated systems and information sharing with home care will improve. As these models increasingly are publicized, the law through regulation, disciplinary action, and civil actions will pressure further the health care system to follow these care-management principles. Increased public discussion and media coverage regarding health care PI (e.g., integrating evidence-based practice) and reducing preventable errors and adverse events are also factors driving changes in legislation, regulation, accrediting body standards, and the legal environment in malpractice.

SUMMARY OF IMPROVEMENT STRATEGIES

In addition to increased complex care-management needs, patients often have treatment plans involving complex, technical, care-management modalities in home care. Care management increasingly involves equipment requiring prior knowledge of functioning, precautions, and demonstrated competency in use (e.g., use of the efficacious vacuum-assisted closure for certain stratified wounds in home care). Stratification of patients by clinical, psychosocial, and technical complexity needs is prudent upon admission to ensure competent staff members are assigned and appropriate advanced nurse consultation (e.g., CNS) is obtained. Excessive acute care and SNF LOS can be avoided when patients requiring complex clinical care (e.g., advanced wound care) can be safely discharged home with competent home care staff and home caregivers. The quality of the referral is enhanced in complex discharges when home care staff can assess the patients on site before discharge. In addition, psychosocial and environmental aspects of care affecting case complexity should be identified in the intake process. This facilitates removal of care management barriers and ensures a safe discharge plan (Benedetto, Dailey, Farren, & Liota, 2003). Formularies provide PI opportunities by reducing cost and increasing the familiarity of the front-line nurses and ordering physicians with formulary products. Dailey, Jasper, and Regan (2000) noted the planning and implementation of a wound care formulary in a large community-based organization as a PI opportunity.

In the intake process, it is crucial that the physician appropriately identify the patient's care-management goals and accurate diagnoses/prognoses. Too often, the patient and/or caregivers have not been given or understand an accurate prognosis prior to acute care or SNF discharge. Newfield (2003) noted that discussion of treatment goals and challenges should be done in a supportive but frank and realistic manner so that the provider, patient, and family caregivers develop a common understanding of the patient's underlying conditions and the challenges these present. This will enable all involved to develop reasonable expectations concerning prognosis and outcome. For example, a palliative care patient may have a nonhealing wound with arterial etiology that cannot be revascularized. In that case, the prognosis and potential complications (e.g., amputation) need to be clear to all parties. Newfield reinforced that clarity, consistency, and precision in communication and documentation are important tools in reducing risk and reducing the likelihood of unrealistic or divergent expectations. It is understandable that not all pressure ulcers or amputations are avoidable or wounds curable. Some wounds can persist for extended periods of time despite optimum wound care and patient adherence. In developing care plans and communicating with patients, families, and providers, nurses should be sensitive and forthright about this without exaggerating potential risks. This is a difficult task but must be addressed by the nurse to effectively manage exposure.

Even with proper care and effective communication, undesirable outcomes and patient dissatisfaction can occur. An interdisciplinary approach can be helpful in addressing this with the patient and legal counsel as a valuable resource for care providers in limiting exposure and potentially avoiding litigation. In particular, Newfield (2003) noted that legal consult can be invaluable in ensuring protection from quality-assurance investigation and reducing exposure from improper communication and documentation. If during the course of home care a patient's condition or caregiving situation changes to render the home care setting unsafe, timely, appropriate patient transfer needs to be initiated. If ethical concerns are a factor, then the home care bioethics committee can be a helpful resource. Other resources (e.g., Adult Protective Services) may also be needed when a patient's safety or the community safety is at risk.

Advanced technology has provided opportunities for improving communication and efficiency in practice. Thus, secure, internal e-mail systems and secure, remote, expert telehealth consults (e.g., WOCN, CNS wound consult) can occur to meet the Health Information Portability Accountability Act (HIPAA) confidentiality regulations. As with other parts of patient care, electronic communication and data (e.g., wound

images) should be appropriate, and standards of clinical record documentation must be followed. In addition, wound images need to demonstrate that appropriate infection control and patient labeling standards of the HHA were followed. Telehealth consultation needs to occur according to the HHA standards/protocols, and appropriate follow-up by the home care staff must occur. A CNS consultation sets an expectation for follow-up per evidence-based standards. CNS scope and standards of practice may not be spelled out in state board regulations as RN, licensed practical nurse, and nurse practitioner scope and standards are spelled out. However, certification board standards and American Nursing Association standards are available for consideration. Federal regulations must be followed regarding ordered plans of care and changes in the plan of care (MDs, doctor of osteopaths, and podiatrists). At this time, advanced practice nurses (e.g., CNSs) can recommend changes in the plan of care but cannot order changes in nonhospice home care; the referring physician still must agree and sign the change in orders. Thus, even if a specific support surface is recommended by a CNS, an MD order must first be obtained prior to ordering the support surface (even if indicated). Appropriate documentation, physician education, and effective communication help increase compliance with CNS recommendations. Regulatory changes such as increasing CNSs' authority regarding wound care decisions in appropriate situations could improve compliance.

CONCLUSION

Continued changes will occur in the health care market and via technology breakthrough. Employers will encourage increased employee participation in health care choices. Herzlinger (2002) foresaw a health care revolution in terms of consumer pressure to improve health care quality and reduce cost increases. She noted that consumer demands would spur:

- integrated care via focused, effective, and efficient "factories" to treat populations with conditions or diseases (including complications);
- integrated information records that consolidate patient information; and
- personalized medical technologies that are designed to individualize patient treatment (integrating genetic makeup and self-care innovation) to promote improved care management and outcomes with reduced adverse effects. (Herzlinger, 2002)

As practice changes, malpractice liability will also continue to evolve. Increased consumer, payer, employer, and legislative participation in PI are spurring efforts to improve health care quality and reduce cost. The expectation of employing effective and efficient disease/population management models, systems to reduce human error, and personalized care management will enhance quality outcomes and reduce cost and malpractice liability. It is expected that evidence-based practice will be increasingly embraced by the legislative and legal malpractice arenas. Reduction in practice variance and improved patient outcomes will help to reduce malpractice liability exposure both for home care nurses as it will for other health care team professionals. Nurses, the largest group of health care providers, are uniquely positioned to affect improved outcomes. Home care nurses have expertise in the disease/population approach to PI thereby promoting patient/caregiver adherence and complex care management. Furthermore, technology is being effectively harnessed in home care with expert cueing (e.g., CNS consults) to promote efficient and effective evidence-based care. Thus, home health nurses are uniquely prepared to promote improved care outcomes thereby reducing costly legal exposure, preventable rehospitalization, and emergency use; other adverse events; and premature or preventable long-term care institutionalization.

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