LIABILITY
landscape

BY LINDA WILLIAMS, RN

Understanding the pros and cons of using feeding tubes

Artificial hydration and nutrition (AHN) through a feeding tube is frequently used in elders with advanced dementia when they lose 15 to 20% of their body weight and are unwilling or unable to take in adequate nutrition orally. Medical indications for this type of intervention typically include an acute event (e.g., trauma or surgery) from which recovery is anticipated, uncomplicated dysphagia, or a stroke with unimpaired consciousness.

According to a report published in *The Journal of the American Medical Association*, "About one third of U.S. nursing home residents with advanced cognitive impairment have feeding tubes. In this setting, such tubes can cause discomfort and have no demonstratable health benefits" (JAMA, July 2, 2003, pp. 73-80). The researchers found that residents were more likely to be given a feeding tube if they were younger, nonwhite, male, or divorced. Other risk factors included the absence of an advance directive, a recent decline in functional status, and the lack of an Alzheimer's diagnosis.

With such an increasing need for AHN in elders, nursing home providers need to be prepared to address the special challenges that arise when they are asked to care for residents with feeding tubes. The following is a summary of a lawsuit against a nursing home that had not fully prepared or anticipated the needs of a resident with a feeding tube. Please take the time to review the circumstances surrounding this case and make changes as appropriate at your facility.

The Situation

A 72-year-old man was admitted to a nursing home following a two-month hospital stay during which he had undergone a triple coronary artery bypass graft surgery that resulted in a stroke. His medical history included coronary artery disease, hypertension, insulin-dependent diabetes mellitus, hyperlipemia, obesity, jejunostomy, tracheostomy, and dysphagia. In addition, the man had postsurgical pneumonia and a urinary tract infection, which created increased confusion and restlessness. While in the hospital, the man pulled out both his trach and feeding tubes and had to be physically restrained.

A day after entering the nursing home, the man again pulled out his trach tube and was temporarily readmitted to the hospital for emergency care. Upon his return to the nursing facility, he continued to have intermittent bouts of restlessness and managed to again pull out his feeding tube. The LPN on duty discovered the incident and observed the tube lying on the bed with formula still flowing from it. She quickly disposed of the tube and asked the aides to bathe the resident before reinserting a new jejunostomy tube. The resident tolerated the procedure well.

The following month, the resident was readmitted to the hospital with swallowing difficulties. While there, he again pulled out his feeding tube and a new one was reinserted. Once stabilized, the resident returned to the nursing home for another month before finally being discharged to his home, accompanied by his wife.

The man's first weekend at home was during a holiday, so his family held a big celebration. That Saturday evening, he became seriously ill, expressing severe stomach discomfort. An ambulance was summoned, and he was transported to the hospital, where x-rays were taken. The x-rays were not read for two days because of the holiday weekend, and the radiologist offered no remarkable comments after finally studying them. Throughout the following days, the man continued to experience severe abdominal discomfort, which eventually required the physician to perform exploratory abdominal surgery. During the procedure, the surgeon discovered a 22-cm piece of tubing that had been left in the man's small intestine and had perforated his colon wall. The tubing was removed, but an infection had already developed in the man's bloodstream and he died shortly thereafter. The cause of his death was sepsis from the perforated colon.

The man's family was extremely upset with the events leading to their loved one's death and filed a multiparty medical malpractice lawsuit against the radiologist, ER physician, and nursing home, alleging wrongful death, pain and suffering, mental anguish, loss of consortium, etc. Their demand to settle the claim was $1.9 million.

When the LPN was deposed, she testified that she had not received any instruction regarding the insertion and management of a feeding tube while in nursing school. She had attended an in-service training session at the facility regarding how to reinsert a feeding tube, but it did not include a discussion of possible dangers associated with the procedure.

The piece of tubing found in the resident's colon was from a regular gastric tube, like the one inserted in the hospital before the resident was initially transferred to the nursing home. All the other tube insertions involved a smaller jejunostomy tube. The LPN had not noticed that the original tubing was longer than the tube used at the facility. She assumed that all tubing was the same size and promptly discarded it without checking to see if the end was intact or broken off (with a section remaining in the resident's body). The LPN believed that she had not done anything wrong and that someone at

the facility should have advised her of the difference in tubes during the in-service.

The plaintiff's expert physician testified that, to a reasonable degree of medical certainty, the resident would be alive today if:

- the LPN had notified her appropriate supervisors of the situation;
- the nursing home had not allowed the LPN to replace the feeding tube; and
- the radiologist had reported and notified the ER physician of the dislodged feeding tube.

The radiologist testified that he was saturated with work on the Monday in question because he had received all the films from the preceding holiday weekend. He stated that he might not have seen the tube when he examined the film, but was sure that he had. However, he could not explain why he did not put that in his radiology report.

The plaintiff's expert radiologist testified that a comment about lines and/or catheters should always be included in a radiologist's report. That information should have been available to the ER physician for clinical correlation in a timely manner. He felt the actions that were taken were clearly a deviation from the standard of care.

The case against the nursing home was settled for $400,000, and the facility no longer allows LPNs to replace feeding tubes. The cases against the radiologist and ER physician were settled later for an undisclosed amount.

Proactive Steps to Protect Your Facility

Had this facility made better decisions regarding which residents to accept, what training to provide to staff, and the responsibilities their staff should assume—before agreeing to admit the resident—perhaps the outcome of this case would have been better. Hence the importance for nursing homes to establish a clear understanding of the type of care they are willing to provide and to focus all interventions, interactions, and programming around that standard before the first admission agreement is made. If a facility chooses to accept residents with feeding tubes, they should heed the following proactive risk management steps:

1. The facility should have a clear understanding of the type of care that a resident with a feeding tube requires and should develop policies and procedures that will assist staff to adequately meet the resident's needs, even if unplanned complications arise.

2. Staff members should only be allowed to perform tasks within the scope of their license or certification. Providers need to ensure that employees are knowledgeable and competent to do the tasks required of their position. One way to determine this is to use a preemployment survey that lists different skills and requires applicants to indicate whether they are knowledgeable, comfortable, or proficient with each skill.

3. All caregivers should be trained in the care and management of residents with feeding tubes, as it pertains to their particular job function. The training should include a discussion on potential risks and how to respond to them. Competency testing should be required on all practices that are used within the unit in which a caregiver is working.

4. An RN should perform an on-site assessment of a resident to identify acuity needs before an admission agreement is made. All progress notes should be reviewed for indications of prognosis. If there is no clear indication, the physician should be contacted.

5. If the use of physical restraints is a consideration, based on past noncompliant behavior, staff should be prepared to accept the risk before agreeing to admit the resident. Restraint alternatives should always be considered first—such as providing adequate pain control, camouflaging or covering the ostomy site, etc. Government requirements mandate that physical restraints be used only when nonrestrictive alternatives are ineffective and when protecting the resident and caregiver from serious harm. Nurses must document the resident's medical need for the restraint and follow approved clinical protocols.

6. If a family is faced with the decision on whether to have a feeding tube placed in their loved one, they should be educated about the disease process and the expected progression of the illness, both with and without intervention with a feeding tube. Additionally, staff should assess the family's knowledge and understanding of the AHN process. Do they know the potential risks that accompany the use of a feeding tube? Do they understand the process involved? Information should be provided, as needed, so families can make informed decisions. Once their decision is made, it should be supported and nursing measures implemented accordingly.

Proactive risk management in a long-term care setting is an ongoing challenge, but all of the time and trouble is definitely worthwhile if incidents such as this can be avoided. ■

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