inperspective

LIABILITY landscape

BY LINDA WILLIAMS, RN

The fluid and electrolyte balancing act

Dehydration is the most common fluid and electrolyte imbalance in the elderly, regardless if the person lives in the community or in a healthcare facility. Some risk factors for resident dehydration include:

- chronic cognitive impairment, such as Alzheimer's or other forms of dementia
- dependence in ADL functional status
- inadequate nutritional status, including the use of enteral feedings
- acute illness (e.g., vomiting, diarrhea, febrile)
- major psychiatric disorder, such as depression and/or use of psychotropics (e.g., antipsychotics, antidepressants, antiolytics)
- four (or more) medications and/or chronic conditions
- use of steroids
- purposeful restriction of fluids
- frequent laxative, enema, or diuretic use
- excessive urine output
- urinary incontinence
- cardiovascular accident
- diabetes
- repeated infections
- history of dehydration

Because there are so many factors to consider, it is imperative for caregivers to quickly identify residents who are at risk and then implement interventions accordingly. Please review the following situation and plan to make changes as appropriate in your facility.

The Situation

An 84-year-old woman, who lived alone, was admitted to a nursing facility following

hospitalization for treatment of back pain caused by a fall that she sustained in her home. While in the hospital, her daughter requested that she be placed in a nursing facility because she was no longer safe alone. The daughter wanted her mother to live nearby, so they selected a facility next door to the daughter's home. The woman's medical history included mild dementia, noninsulin dependent diabetes mellitus, hypertension, spondylolisthesis, and an ileostomy. Among her medications were two diuretics.

Unfortunately, the woman did not adjust well to her new environment. She became more confused and noncompliant to the extent that she stopped eating and taking her medications after a few weeks. When the staff and her daughter tried to persuade her to comply, they were met with hostile resistance. Throughout this period, the woman's physician was informed of the situation and he visited her every week for three weeks. Interventions that were ordered included various dietary supplements, a mood-altering medication, occupational therapy services, and pain medication. In addition, the staff discovered that the woman had a painful mouth lesion, so an antifungal treatment was ordered and given when the woman would allow it.

The woman's daughter diligently visited her mother daily and even assisted with some of her care. One day, the woman told her daughter that she felt ill and then began to vomit. The daughter alerted the nursing staff who assessed her and notified her physician. At her physician's directive, she was immediately transferred to the hospital.

At the hospital, the emergency room physician determined that the woman had aspiration pneumonia, possible sepsis, and marked hypotension and hypoxemia. The daughter was informed that her mother was severely dehydrated, which probably led to her dangerously low blood pressure. The woman was transferred to the intensive care unit for aggressive treatment of her blood pressure. Despite the hospital staff's efforts, the woman's body began to shut down, necessitating that she be intubated and placed on a ventilator. The physician talked to the woman's daughter about her poor prognosis, and she asked that her mother not be resuscitated. A few hours later, the woman died.

The daughter was devastated and sought the counsel of an attorney. Together, they agreed to file a lawsuit against the facility alleging wrongful death due to severe de-

hydration. The daughter alleged that the emergency room physician told her that her mother was critical because of "poor management by the facility." After her mother had passed away, the daughter stated that the same physician told her that her mother's blood had "jellied" from severe dehydration and that her heart could not pump it. The daughter also alleged that the facility failed to properly care for her mother by not assessing her for obvious signs and symptoms of dehydration, even though she was at high risk for the condition.

During his deposition, the emergency room physician denied making the alleged statements to the daughter and said he would never use the term "jellied." While he testified that the woman was very dehydrated when she came to the hospital, which contributed to her low blood pressure, she also suffered from numerous other problems that could have contributed to her condition as well.

Although the hospital lab values indicated severe dehydration, the woman's death certificate stated that she died from pneumonitis due to inhalation of food or vomitus.

As to the allegation of poor care, the facility's attorneys argued that the staff had kept the physician informed of her condition and together they implemented several interventions to address the woman's overall condition, which was complicated by her noncompliance. They surmised that the woman was living the best life that she would allow herself to live, but she unfortunately aspirated—an unavoidable event that could neither be anticipated nor prevented. Mediation was held between the parties and a settlement was reached.

Protecting Your Residents and Facility

One of the biggest problems in this situation was the fact that the woman had many risk factors for dehydration, yet neither the staff nor her physician knew that she was severely dehydrated until the condition was confirmed by the hospital's lab report. The woman was at the nursing facility for only 24 days, so it is unknown if she was dehydrated upon admission or if the condition occurred gradually with her use of diuretics, refusal of hydration, and other risk factors.

At any rate, it is important for nursing staff to assess all residents on a continuous basis for dehydration through food and fluid intake monitoring, known risk factors, signs and symptoms, and good nursing observation. Some objective signs and symptoms of dehydration to be aware of include:

- decreased saliva and dry, pale mucous membranes—may need to remove dentures to check
- dry, coated tongue (longitudinal furrows)
- change in skin turgor of the breastbone or forehead
- sunken eyeballs
- decrease in blood pressure and/or orthostatic hypotension
- increased heart rate (10% to 20%)
- decreased urinary output (<800 cc/day)
- concentrated and odorous urine (dark yellow or greenish brown in color)
- speech difficulties
- acute onset of confusion
- muscle weakness in upper body control
- acute decrease in weight
- lab changes of increased hematocrit, BUN/creatinine ratio, serum osmolality, serum sodium, urine osmolality, and urine specific gravity

It is important to remember that although clinical impression is a very important factor, signs and symptoms of dehydration may not always be conclusive except in severe cases. Caregivers should always report their concerns to the physician who should make the determination whether a resident is clinically dehydrated. However, interventions should be initiated as preventative measures for all residents suspected as being at risk of dehydration per nursing assessment and judgment. By heeding these precautionary measures, you can protect your residents and facility now and into the future. ■

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The GuideOne Center for Risk Management is dedicated to helping churches, senior living communities, and schools/colleges safeguard their communities by providing practical and timely training, and resources on safety, security, and risk management issues. For more information, phone (877) 448-4331, ext. 5175, e-mail slc@guideone.com, or visit www.guideone.com. *To send your comments to the author and editors, e-mail williams1207@nursinghomesmagazine.com.*