

# in perspective

## LIABILITY landscape

BY LINDA WILLIAMS, RN

### Is your staff prepared to handle a diabetic crisis?

According to the National Diabetes Information Clearinghouse (NDIC), 10.3 million people age 60 years or older in the United States have diabetes. While the majority of nursing facility residents with diabetes are diagnosed before entering the facility, some residents develop the disease afterward, since the risk of type 2 (late-onset) diabetes increases with age. In fact, the National Center for Health Statistics estimates that one in three Americans will develop this potentially debilitating disease during his or her lifetime.

Some serious complications of diabetes include heart disease and stroke, high blood pressure, blindness, kidney disease, nervous system disease, peripheral vascular disease, and dental disease. The prevalence of functional disability and multiple comorbid conditions in the long-term care population increases the complexity of diabetes management. The American Medical Directors Association (AMDA) reports that hyperglycemia impairs cognition and, when untreated, may contribute to further functional decline in residents with dementia, as well as decreased pain thresholds, impaired vision, and increased risk for falls. Frail elderly people with diabetes also are at higher risk for hypoglycemia, which can lead to falls or permanent neurological impairment. In addition, symptoms may be atypical for this population.

Overall, the risk for death among people with diabetes is about twice that of people without the disease of similar age. It is an urgent problem that nursing home caregivers need to be prepared to handle. Please review the following situation in which a caregiver was suddenly confronted with a diabetic crisis. Plan to make changes as appropriate in your facility.

#### The Situation

A 79-year-old woman was admitted to a nursing home with congestive heart failure. In addition, she had diabetes mellitus and was insulin-dependent. Her daughter lived nearby and visited her frequently, assisting her as needed. The daughter had a slight hearing impairment, but nevertheless interacted well with her mother's caregivers.

Two years went by and the woman became increasingly frail, to the point that she was totally dependent on others to meet her needs. The resident slept a lot and did not eat well; consequently, she began to lose weight. Her blood sugars were monitored daily and often remained on the low side within her parameters of 70 mg/dL to 200 mg/dL. The woman's physician had issued sliding scale orders for additional insulin administration if her blood sugars rose beyond the 200 mg/dL parameter, but did not address what to do if her blood sugar levels fell below 70 mg/dL. So, the nursing staff wrote on the woman's Medication Administration Record (MAR) to simply "call the doctor" if that should happen.

On New Year's Eve night, a nurse who was new to the facility walked into the woman's room and found her shaking and moaning. The woman's skin was pale and diaphoretic, so the nurse immediately tested the woman's blood sugar, which read 48 mg/dL. In response, the nurse obtained and administered glucagon from the facility's emergency medication box. After 20 minutes, she checked the woman's blood sugar again and found it to be 68 mg/dL. The woman appeared to be resting comfortably

and her skin color had returned to normal. The facility did not have a hypoglycemia crisis protocol and so the nurse decided to check the woman frequently and test her

blood sugars four more times throughout the night. The woman's countenance did not change, and her blood sugars hovered in the 60s until her last check at 4:00 a.m., which read 72 mg/dL. At 4:20 a.m., the nurse entered the woman's room to check on her again and found her unresponsive, without a pulse.

The woman had a "Do Not Resuscitate" (DNR) order, so the nurse called her daughter to notify her of her mother's death.

Since the nurse was new, she had never met the woman's daughter and did not know that she had trouble hearing. Unfortunately, the nurse spoke softly and she was not fluent in English; therefore, the woman's daughter could not understand what she was trying to tell her on the phone. Finally, out of sheer frustration, the nurse blurted out, "Your mother is dead, dead, dead." The daughter was stunned and quite upset.

The cause of the woman's death was later listed as Chronic Obstructive Pulmonary Disease (COPD) and respiratory insufficiency, with contributing factors of diabetes and congestive heart failure. The daughter remained very upset about her mother's death and the way that she had received the news. She hired an attorney to review her mother's medical records. Soon a lawsuit was filed against the facility for failing to provide adequate and appropriate care for the woman, specifically alleging negligence for not notifying her physician or family in



a timely manner of her significant change in condition. In addition, there were several documentation problems, including gaps when blood sugars were supposed to be checked but weren't, and other instances where results were beyond the listed parameters, yet nothing was done. It was further noted that the staff had not routinely tested the glucometer machine, as directed by the manufacturer, so the accuracy of readings was questionable. To settle the lawsuit, the daughter sought \$350,000. A mediation was eventually held and both parties agreed to a settlement for half that amount.

### Protecting Your Residents and Facility

One of the biggest differences between the care provided in a hospital setting and that which is provided in a nursing home is that the patient in a hospital usually leaves once care has been received, whereas the care provided in a nursing home setting is ongoing, generally for the remainder of the recipient's life. That is why the term "resident," instead of "patient," is used to describe the recipient. If lawsuits were filed simply because a resident dies, the judicial system would be hopelessly jammed and nursing homes could not exist. Fortunately, a resident's death is rarely the sole motivating factor for suing a nursing home. Instead, the spark that typically ignites a lawsuit comes when families perceive staff indifference or a lack of concern or caring. Certainly, that was the case in this situation, when the daughter was told that her mother was "dead, dead, dead."

Undeniably, a lack of good communication was the key factor in this case—and it could be a problem in your facility. The following are some commonsense steps that you can take to clear the roadblocks of communication that your staff, residents, and families may encounter when dealing with a diabetic crisis or similar situation.

**Communicate special needs.** One key piece of information that staff obtain during a resident's admission process is the phone number of who to call in case of an emergency. When asking for the number,

also inquire about any special calling instructions. Sometimes families have alternative numbers depending on the day of the week, other times they may not want to be disturbed during specific hours unless an emergency truly exists. In this situation, it would have been helpful for the new nurse to know that the daughter was hard of hearing so the language barrier could have been compensated in more effective ways.

**Communicate individualized blood sugar parameters on the MAR.** Problems can arise when individualized parameter orders are not received from the physician and/or they are not placed in an easily accessible location, such as the MAR. In addition, the physician and nursing staff, with input from all disciplines, should develop a diabetes management care plan that addresses glucose monitoring, meal plan, activity, foot/wound care, pain management, etc. The AMDA recommends that the interdisciplinary team establishes both short- and long-term goals that address the resident's disease severity, cardiovascular risk factors, and overall prognosis. The resident and/or family member should be involved in this process to ensure that their wishes and values are incorporated into the care plan.

**Communicate emergency standing orders.** Simply writing "call the doctor" on the MAR is not enough information during a time of crisis. Obviously, certain emergency situations require the nurse to act quickly to save a resident's life, and calls should be made soon after the resident is more stable. It is prudent for administrative staff to discuss these types of situations with their medical director so that emergency standing orders can be developed and training can take place to equip staff for a crisis. These standing orders should be kept in an easy-to-reach spot for quick access. Additionally, keeping hypoglycemia/hyperglycemia checklists to provide education and procedural guidelines in the identification and treatment of low or elevated blood sugars is helpful.

**Educate staff on current information regarding the care of a diabetic resident.** Usually there are several clinical educators

within a community who can provide this service, along with updates on new types of insulin, onset peaks, and duration of effect.

**Educate families and responsible parties on the condition, diagnosis, prognosis, and treatment options.** Education should begin at the time that residents are first identified as being at risk, before an actual problem develops. Further education is needed as conditions change. In this case, the woman was rapidly declining with her decreased energy, appetite, and ability to function. Perhaps hospice should have been considered. At any rate, the staff might have helped the daughter to better prepare for her mother's inevitable death.

**Remember that documentation is an essential form of communication.** That is why it's imperative that facilities have an audit system to monitor and ensure that there are no gaps in a resident's records and that interventions, such as responding to abnormal glucometer readings, are addressed. In addition, logs should be audited to ensure that safety alarms, glucometers, and other devices are tested according to the manufacturer's recommendation.

By taking these precautionary steps, you can protect your residents and facility. ■

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Linda Williams, RN, is a Registered Nurse and Long-Term Care Risk Manager for the GuideOne Center for Risk Management's Senior Living Communities Division. She previously served as Director of Nursing in a CCRC and as a nurse consultant for two corporations with numerous long-term care facilities in Iowa.

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, call (877) 448-4331, ext. 5175; e-mail [slc@guideone.com](mailto:slc@guideone.com); or visit [www.guideone.com](http://www.guideone.com).

### Suggested Reading

American Medical Directors Association. Managing Diabetes in the Long-Term Care Setting. Clinical Practice Guidelines. Columbia, Md.: American Medical Directors Association, 2002.