Nutrition Is No Secret

How one facility paid the ultimate price for not sharing its nutrition management ideas with a resident's family

BY LINDA WILLIAMS, RN

Maintaining acceptable parameters of nutritional status among nursing home residents is a serious issue. Dr. Eric Tangalos, head of Geriatrics at the Mayo Clinic in Rochester, Minnesota, stated, "Sixty percent of all residents are susceptible to malnutrition because most have one or more conditions that interfere with eating." Statistics compiled by the government show that 25 to 30% of all nursing home residents are underweight, with 10 to 14% experiencing significant weight loss. At least 47% of nursing home residents need some assistance with eating, and of those, 21% are totally dependent. Dr. Tangalos further found that it is not unusual for one heavy-care resident to require a full 90 minutes to eat a 600-calorie meal. Given these facts, it's not surprising that lawsuits concerning resident weight-loss issues are on the rise.

The following is a summary of a case against a nursing home concerning alleged improper nutritional care of a resident, resulting in a multimillion-dollar judgment.

The Situation

An elderly man with end-stage Alzheimer's was admitted to a nursing home. In the 29 months prior to his admission, he had been losing weight at an average of 0.6 pounds per month. As with many residents suffering with this terminal illness, the resident's appetite was poor, and he continued to lose weight at an average rate of 0.7 pounds per month. Nursing home staff members encouraged him to eat and provided appropriate supplements, but to no avail. The nursing staff requested that a feeding tube and IV be inserted to supplement the resident's oral diet, but the resident's wife refused as long as the resident was still capable of eating something.

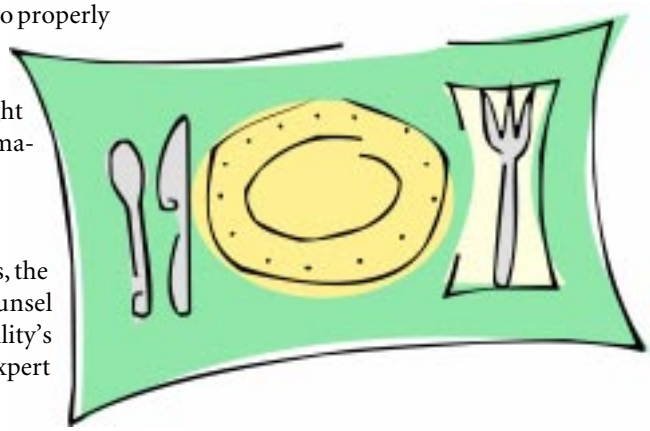
As a result of inadequate nutrition, the resident began to develop decubitus ulcers. Some of them healed but others deteriorated. As the resident's condition worsened, his wife still refused the feeding tube and IV because he could still accept some nutrition orally. When he was transferred to a hospital for treatment of the decubitus ulcers, the hospital staff inserted an IV. But when his wife arrived at the hospital, she insisted that the nurse remove it. Shortly thereafter, the resident was transferred back to the facility, where he died within two weeks.

Two months later, the former resident's wife filed suit against the nursing home alleging that the facility failed to properly care for her husband by not providing adequate nutrition, which caused subsequent weight loss, contributing to the formation of decubitus ulcers.

The Trial

Through the discovery process, the nursing home's defense counsel questioned many of the facility's staff members, as well as an expert witness. Their statements showed that, given the progression of the Alzheimer's and lack of proper nutrition and hydration (because of the wife's refusal of the feeding tube and IV), the decubitus ulcers could not have been prevented or healed. During pretrial negotiations, however, the plaintiff would not drop the demand for $2 million, so the case went to trial.

During the trial, the deceased resident's spouse testified that she didn't think her husband needed the feeding tube or IV because "he was eating so well." When the resident's medical records were examined, the plaintiff's attorney showed the jury a food consumption sheet that stated the resident had been eating 100% of his meals, despite the witnesses' statements to the contrary and the fact that the resident weighed only 84 pounds at the time of his death. In addition, photographs of the emaciated resident were shown to the jury. After substantial deliberation, the jury awarded the plaintiff $580,000 in actual damages and $2.4 million in punitive damages. It was evident that the jury members had been upset by the lack of communication between the nursing home staff and spouse, as well as the misleading documentation in the resident's record.



Protective Measures

Unavoidable weight loss by a resident is a tragic situation that many nursing homes, like this one, have had to face because of the frailty and nature of many residents. As the case study demonstrates, a nursing home's response can lead to devastating consequences if the situation isn't handled properly and in the best interest of all parties involved. The following precautions are highly recommended:

1. Develop policies and procedures related to advance directives that address aggressive measures, such as feeding tubes. If the resident is capable of making his/her own decisions regarding end-of-life issues, it is important that his/her family understands them. The resident should sign an advanced directive that clearly states his/her wishes, and these actions should be documented in his/her chart for reference in future decision making.

2. Once a resident's physician has determined that a resident has a terminal prognosis and is expected to lose weight despite facility efforts, the resident's power of attorney (POA) designee for healthcare decisions must be contacted. If aggressive measures, such as parenteral or tube feedings, are an option, the POA must be given these choices. If these are refused, an advance directive should be initiated and signed by the responsible party and physician that clearly states the consequences of such action within the context of its risks and benefits.

The following recommendations apply more generally to nutritional management programs, and should at least prompt a facility to re-examine its policies:

3. Work with your medical director to develop policies and procedures for a resident weight-management program. Provide staff training on this program during orientation and periodically throughout the year, and make copies of the program readily accessible to staff.

4. Staff should perform a full nutritional risk assessment during admission, quarterly, and at the time of any significant change (as per the MDS). Other types of assessments that can be useful in identifying problems linked to weight loss include mental status scales, geriatric depression scales, and functional evaluations.

5. During admission, nurses should obtain a weight history from the new resident or responsible party. They should be especially attuned to an underweight individual who has weighed the same amount for years, with little fluctuation; this indicates a normal state for this resident, and that efforts to reach "ideal body weight" would be unrealistic and unachievable.

6. A nurse should check resident medication orders, as many drugs—such as antibiotics, anti-inflammatories, cardiovascular, pulmonary, CNS and GI agents, nutrient supplements, narcotics, and steroids—are associated with weight changes. Close attention also should be paid to lab values, especially serum albumin, pre-albumin, calcium, and cholesterol levels, as these are key indicators of nutritional status.

7. Weigh all residents according to a facility weight-management program. One example of this is weekly weigh-ins within the first month of admission or after a significant weight change.

8. If a resident has been identified as being at risk for weight loss, a plan of care should be implemented that lists specific interventions aimed at minimizing this risk. Options include providing:

- dietary supplements,
- therapeutic supplements (such as multiple vitamins, zinc, calcium, etc.),
- specialty foods for nibbling by dementia residents (such as finger foods, etc.),
- adaptive dishes and utensils,
- occupational or speech therapy evaluation to assess the resident's need for feeding assistance and presence of swallowing difficulties,
- physical assistance or cueing by staff while eating, and
- pain medications, as indicated, to help preserve appetite.

9. Staff members should record percentages of food and fluid consumption after meals, as directed by dietary standards. These records should be audited routinely for accuracy.

10. If a resident's eating habits or weight change, the nurse should observe and assess the resident for underlying factors. Following this assessment, contact the resident's physician and responsible party and follow through with any new orders. In addition, a full nutritional assessment may need to be completed and additional interventions recommended by the facility's dietitian.

11. Everything that is done on behalf of the resident should be documented in his/her chart, with revisions made to the plan of care, as needed. A new MDS assessment may need to be initiated. The RAP summary should list all of the interventions that have been attempted or considered and rejected so the reader is aware of the facility's ongoing efforts, whether successful or not, to minimize the weight loss. Palliative interventions should be implemented accordingly and listed on the resident's plan of care.

12. Hospice care should be considered, especially for support to the resident and family members. A private room may also be desired, if possible.

In summary, the lesson of this case is that, as with any resident condition or remedy, communication with the parties involved is of utmost importance. But communication must be backed by taking all necessary precautions to maximize resident well-being. **NH**

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