

October 5, 2003

OPERATION GUARDIANS

Department of  
Medicine

CLINICAL FINDINGS

General Internal  
Medicine

Between July 1, 2000 and April 1, 2003, board certified geriatric medicine faculty members from the Section of Geriatric Medicine, Keck School of Medicine of the University of Southern California have been part of the Medical Team of Operation Guardians. During this time span, these faculty members have taken part in over 150 visits to skilled nursing facilities throughout the State of California. There have been many fine facilities; others, however, had significant failings in the clinical care and environment they provided to their elderly and dependent adults. Below are some of the more important general clinical findings, based on these visits. Areas covered include staffing, charting, appearance of the residents, environment, nutrition, hydration, pressure ulcers, falls, psychiatric problems, medications, the physician and the medical director.

I. Staffing - Both the number and quality of staff at the skilled nursing facilities (facilities) visited made a significant difference in resident care and the development of problems in the residents. There is no question that the director of nursing (DON) sets the overall tone of care for the facility. A good DON instills a sense of mission in the staff and provides, through example, in-services and employee recognition of the importance of conscientious observation and care of the residents, communication with licensed nursing personnel, physicians, the families and administration, and accurate charting of clinical findings. Where the DON is not as effective, there are more problems noted in resident care issues and resident morbidity.

It appears from the Operation Guardians visits that the certified nursing assistants (CNA) play the key role in providing resident care and noting onset of problems. When CNA's are well trained and have a sense of the importance of their roles, resident care is significantly better, there are fewer clinical surprises noted (such as suddenly noting a Stage IV sacral decubitus ulcer), and there is less resident morbidity. In such facilities there are fewer pressure ulcers, fewer falls and fewer infections. In facilities where CNA's are not well trained and do not have a sense of importance of their roles, resident care problems are more frequent. Where the number of CNA's is insufficient for both the resident number and acuity, there is more resident morbidity, more care problems, and

more family dissatisfaction. The thoughtful development of training programs and continuing education programs for CNA's leads to a greater sense of importance of their roles as key caregivers.

It is apparent from the 150+ visits made by the Medical Team, that it is crucial that the facilities select well-trained and thoughtful therapists, speech pathologists, and dieticians. In many instances we observed these professionals simply chart resident decline without themselves intervening by notification of nursing and physician staff. This problem is particularly crucial in dietary care. The Team has noted multiple instances where the dietician has noted weight loss or increasing dehydration without effecting any change in the resident's diet or fluid intake. These professionals must make assessments and *advocate change in care, which will benefit the resident.* Where therapists and dieticians have made thoughtful recommendations, resident care has significantly benefited.

II. Charting - The careful documentation of assessments of residents at time of admission and during their stay at the facility must be thorough and accurate. *Successful charting is the job of all care providers, including the physician, consultants, pharmacist, nursing, CNA's and therapist.* Inaccurate charting or incomplete charting gives a false impression of the resident's physical and mental status and care needs. *Mischarting can place residents in imminent danger of harm.* The importance of accurate charting must be stressed to employees and other caregivers at frequent intervals. Furthermore, caregivers need to be aware of what others are charting at the same time. The Team has seen multiple problems due to charting deficiencies or lack of communication of individuals charting contemporaneously. Examples abound. In one instance, the CNA reported resident food intake of 20-30% of meals, while licensed nursing notes state - "resident eating well." In another instance, the licensed nurse's notes state "dependent resident turned q2 hours for skin integrity and comfort." While the ADL sheet for the time period lists "I" (meaning resident turned self in bed.) These findings are all too common. Other examples include fluid intake sheets for one month, obviously having all entries made at one time; noting acute shortness of breath on May 5 "send resident to the hospital " - however, review of vital signs taken daily show for four previous days the resident was breathing at 28 to 36 respirations/minute for three days had a fever, and for two days was not eating.

III. The Appearance of the Residents - On the whole, in facilities where the residents are well groomed, up early, in activities, socialized where possible, and highly interacted with, there are fewer unreported care problems and less morbidity. Such facilities have to have a good staffing ratio and a good sense of mission in the staff. The Team has visited multiple facilities where residents are still in bed at 11 a.m., unwashed, ungroomed and in some instances unfed. In these facilities, there are more pressure ulcers, more malnutrition and dehydration, and often more use of psychotropic medication, all

of which may reflect inadequacy by the employees of their assigned tasks. Thus resident appearance has become a predictor of what is to be found on the Operation Guardians visit.

IV. The Environment - Most are sun-like, have good lighting, have home-like furnishings, are clean, and staff appears friendly and helpful. In other facilities, it is dingy, lighting is poor, often there are lingering odors, and staff appears indifferent. In this latter group of facilities, the Team would usually find more care problems in their residents such as in hydration, nutrition, depression, and the development of pressure ulcerations. Again, environment appeared as a predictor of what would be found on the visit by the Medical Team.

V. Nutrition - In each visit, the Medical Team focused on resident nutrition and significant recent resident weight loss. In most facilities, weight loss could be explained by recent acute illness and hospitalization, e.g., recent cancer surgery with the resident not eating for several days, order diuresis of excess fluid in individuals with congestive heart failure, or the removal of a leg cast. However, in some facilities weight loss was documented and little insight was given in the chart as to what was occurring. In some instances, weight loss was short lived - i.e. adjustment to the new environment and new diet in recently admitted residents. But in many instances the weight loss was consistent and profound. In such individuals, charting was often inconsistent, e.g., resident eating lunch well but that same meal was reported as 20% eaten. Problems in nutrition identified by the Team include: failure to weigh accurately, failure to assess and adequately treat depression; failure to assess and treat dental abnormalities or replace lost dentures; failure to provide types of food which the resident preferred; failure to assess swallowing abnormalities; failure to provide the right consistency of diet which the resident could eat; failure to provide alternative dietary choices or nutritional supplements; failure to assess a resident for a feeding tube. All of these noted areas were seen on multiple occasions. It is crucial that a well trained, thoughtful dietician work with the facility staff, physician, and family to establish a diet which is adequate given health problems (more protein and caloric needs to heal pressure ulcers and broken bones of the residents, pleasing and can be eaten.) All too often a diet is given to frail seniors with pressure ulcers, which is insufficient in both calories and protein to ever allow for healing of these skin lesions.

VI. Hydration - Findings in the medical literature show that healthy seniors have a decreased sense of thirst, and this problem is even worse in residents of skilled nursing facilities who are demented or who are dependent. Such individuals rapidly become dehydrated unless offered fluids frequently and many need to be helped in drinking the fluids. The Team has seen many problems that lead to residents' dehydration. In several facilities there was no water available at the resident bedside such that it was unlikely the residents would drink by themselves. Water must be available at all times. Because of staffing shortages, fluids were not offered frequently. Dinner trays were present

with only a small cup of juice as the total liquid available. The dietician must play a role in assuring that residents be given adequate fluids. In some facilities visited, the dietician would estimate fluid needs of the residents. Under normal circumstances, a resident requires 500-700 cc of water just to keep up with insensible water loss (from skin, from breathing, etc.). In addition, fluid is needed to perfuse the kidneys, allow bowel contents to move and keep up blood volume. Seniors need more fluids if they are infected or febrile; if they are taking a diuretic; if they have open pressure ulcers; if the ambient temperature rises or the humidity falls; or if they have diabetes out of control. It is incumbent on the dietician, the nursing staff, and the physician to see that these hydration needs are met. Unfortunately, in many frail seniors and dependent adults, the Team has noted that these needs are not met.

VII. Pressure Ulcers - The Team noted many facilities in which pressure ulcers were rare or when they occurred healed rapidly. Pressure ulcers occur most frequently in debilitated, dependent individuals. Hallmarks for development of these painful lesions are: dehydration, malnutrition, skin shear, pressure point skin deterioration, failure to move, incontinence of bowel and bladder. Facilities which have few pressure ulcers usually have good staff ratios, have frequent in-services about skin care, have at least one nurse considered a skin-care expert, turn residents frequently, use pressure relieving devices (heel protectors, low air loss mattresses, etc.), provide residents with good nutrition, hydration and pericare. In facilities where issues are not taken care of from the beginning, pressure sores develop and can escalate into a disaster for the resident with multiple infected ulcers, osteomyelities, gangrene and constant pain. Usually pressure ulcers are preventable by following the above precepts, being proactive and having adequate staff and good dietary backup.

VIII. Falls - Residents who are frail or dependent may be at risk for falls in skilled nursing facilities. There is always a balance between allowing resident independence and preventing falls in the more disabled residents. The Medical Team concentrates on falls, recurrent falls and fall frequency in its facility visits. Each resident on admission is supposed to be assessed for falls. This does not always happen. Falls occur more frequently when staffing is low (so that residents try to go the bathroom by themselves despite gait problems); when they are disoriented (no night light, psychotropic or sleeping medications being given, dementia or delirium); when they start new blood pressure medications; when they are dehydrated or recently suffered loss of blood; when they have arthritis of the lower extremities; when they have muscle wasting from malnutrition or acute disease, and when they have been bed-bound for some time. Falls can be prevented by toileting residents frequently, assuring adequate hydration and nutrition, monitoring their gait when walking, giving physical therapy, reviewing their medications, assisting their ambulation or in some instances by using restraining devices with permission of the physician and the caregiver. When so restrained, residents need frequent monitoring and

assessment. Not all falls are preventable, but most are. Falls result in fractures (especially hips, subdural hematomas and even death).

IX. Psychiatric Problems - Many seniors and dependent adults seen in the facilities visited have psychiatric problems. The most common are depression and dementia. However delirium, anxiety, agitation and psychosis are also common. In some facilities, the primary care physician, with nursing input, treats these problems – often with psychotropic medications. In some facilities, these problems have been largely ignored and untreated. In some facilities such individuals have been over-treated and are basically in chemical restraint. Resident psychiatric care is best done in these facilities by a team approach. Calling in a trained geropsychiatrist earlier is essential. Often this is not done. Instead, in many instances, the Team has seen the primary care physician try to treat the problem. Often choices of medications and approaches work, and sometimes they do not. A team consisting of the nurse, CNA, social services, pharmacist, physician and consultant psychiatrist working in concert will provide the best hope for care of the resident's mental health problems.

X. Medications - Twenty percent of seniors are hospitalized primarily due to medication problems. Facilities having the most problems with medications in their residents were ones where: there were many prn (as needed) medications ordered; where there was little input from the consulting pharmacist; where there was a significant use of psychotropic and sleeping medications; where consulting psychiatrists were not called in; where the patients treated with psychotropic drugs were also dehydrated and malnourished. Places that had the fewest problems overall had less resident medication use, an active clinical pharmacist team, and a team approach to resident care. Instances of chemical restraints from medication use were not rare. Furthermore, there were multiple instances in which residents were given multiple medications of the same type (two antidepressants) or medications, which interact badly when given together. Seniors often have different side effects to medications than do younger individuals. Often these senior specific problems are unknown to the physician and nursing staff. The role of the consulting pharmacist is key in these situations. When psychotropic medications are used in these facilities, it is required that informed consent is obtained from the resident or appointed responsible individual. The Team has found instances where this has not been done.

XI. The Physician - The primary care physician (PCP) is responsible for the resident's care. The PCP must be available to handle questions from nursing or the family about the resident, supervise care and write orders. The physician must visit and examine the resident at least one time per month. In several facilities visited, the PCP's did not even come in to see the resident, did not sign orders, did not examine the resident, did not pay attention to concerns

of the nursing staff, the dietician, or the family. Most PCP's provided good care for the residents and worked with nursing and other care providers. Those who did not had greater morbidity noted in the residents for whom they provided care. In some facilities, monthly physician notes were one line long, e.g., no change noted this month. Each year a resident in a facility needs a new history and physical examination. This must be performed. Some physicians failed to do this or did so in a perfunctory way, e.g., "H & P the same as last year." Such charting is unacceptable.

XII. The Medical Director - Each facility must have a medical director (MD). The MD may also follow patients at the facility. Such an individual has, however, the role of working with nursing to assure good patient care is provided by other physicians as well as the MD. The MD further reviews all falls, medication errors, and skin lesions occurring in the facility at least on a monthly basis. If the PCP is not performing adequately by not seeing the resident in a timely manner or not being responsive to the resident's needs, the MD is expected to step in and advise the PCP of the problems or even take over resident care. In several facilities visited by the Team, the MD failed to fulfill the required role. In several instances, the MD was the PCP, who was not providing adequate resident care and oversight. This latter problem presents a dilemma to the facility and to the MD.

The above-cited findings present a general overview of what was found by the Medical Team of Operation Guardians.

Submitted by:

Loren G. Lipson, M.D.  
Chief, Section of Geriatric Medicine and  
Associate Professor of Medicine,  
Gerontology, Clinical Pharmacy, Medical  
Dentistry and Public Health, Occupational  
Science and Occupational Therapy - all at  
University of Southern California