Poll Question

Which of the following was not one of the major categories of adverse events that was reported by the office of inspector general report of 2014?
Poll Question

The most common adverse event that occurs in SNF’s as cited by the O.I.G. report was

<table>
<thead>
<tr>
<th>Types of Adverse Events</th>
<th>Percentage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Events Related to Medication</td>
<td>37%</td>
</tr>
<tr>
<td>- Medication-induced delirium or other change in mental status</td>
<td>12%</td>
</tr>
<tr>
<td>- Excessive bleeding due to medication</td>
<td>5%</td>
</tr>
<tr>
<td>- Fall or other trauma with injury secondary to effects of medication</td>
<td>4%</td>
</tr>
<tr>
<td>- Constipation, obstipation, and ileus related to medication</td>
<td>4%</td>
</tr>
<tr>
<td>- Other medication events</td>
<td>14%</td>
</tr>
<tr>
<td>Events Related to Resident Care</td>
<td>37%</td>
</tr>
<tr>
<td>- Fall or other trauma with injury related to resident care</td>
<td>6%</td>
</tr>
<tr>
<td>- Exacerbations of preexisting conditions resulting from an omission of care</td>
<td>6%</td>
</tr>
<tr>
<td>- Acute kidney injury or insufficiency secondary to fluid maintenance</td>
<td>5%</td>
</tr>
<tr>
<td>- Fluid and other electrolyte disorders (e.g., inadequate management of fluid)</td>
<td>4%</td>
</tr>
<tr>
<td>- Venous thromboembolism, deep vein thrombosis (DVT), or pulmonary embolism (PE) related to resident monitoring</td>
<td>4%</td>
</tr>
<tr>
<td>- Other resident care events</td>
<td>14%</td>
</tr>
<tr>
<td>Events Related to Infections</td>
<td>26%</td>
</tr>
<tr>
<td>- Aspiration pneumonia and other respiratory infections</td>
<td>10%</td>
</tr>
<tr>
<td>- Surgical site infection (SSI) associated with wound care</td>
<td>5%</td>
</tr>
<tr>
<td>- Urinary tract infection associated with catheter (CAUTI)</td>
<td>3%</td>
</tr>
<tr>
<td>- Clostridium difficile infection</td>
<td>3%</td>
</tr>
<tr>
<td>- Other infection events</td>
<td>5%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

*The percentages for conditions listed within the clinical categories do not sum to 100 percent because of rounding. See Appendix F for a complete listing of all adverse events identified by the reviewers. Source: GAO analysis of SNF stays for 653 Medicare beneficiaries discharged in August 2011.
Action Point Review

• Consider formatting your QA reporting to quantify adverse events in the same way that the O.I.G. did in their report.
• Collect data to reflect percentage of admissions that your facility receives after hours, on Friday, and on weekends.
• Determine how the outcomes for these admissions differ from those that are admitted earlier in the day and week.

Action Point Review

• Investigate the ability of your facility to rapidly obtain serum lactate levels and other biomarkers of sepsis.
• Have strategic discussions with your LTC pharmacy provider regarding timely delivery of “Vital” medications.
• Since sepsis is so common in LTC, consider making analysis of sepsis occurrence in your facility an organized quality initiative.
Action Point Review

• Initiate a QA process that tracks your warfarin management looking at time in therapeutic range.

• One More Thing (regarding QAPI)
  – In a recent ruling, the Supreme Court of West Virginia ruled that QAPI reports are not “protected” reports. Be certain that you follow law changes pertinent to New York State regarding status of QAPI documents.
Sepsis and Septic Shock Is Caused By Nursing Home Abuse and Neglect

January 23, 2013

Sepsis describes a bacterial infection of the blood which can become fatal without treatment. The elderly often present a high risk for developing sepsis due to having weak immune systems especially if they have also pre-existing medical conditions. Improper or neglectful nursing home care of residents with bed sores, surgical or slow healing wounds, or using intravenous lines or catheters can result in a septic infection says California Nursing Home Abuse and Neglect Lawyer Steven Peck.

Cause of Sepsis:
Sepsis is caused by bacterial infection which spreads from any vulnerable point of the body into the bloodstream. Some symptoms of sepsis include irregular body temperature, and respiration, nausea, vomiting, seizures and body pains.

Bed Sores and Skin Ulcers:
Bed ridden or incapacitated residents are vulnerable to skin ulcers or bed sores. Some treatments include relieving pressure in affect areas, antibiotics, and cleaning and covering of wounds. Without treatment these wounds can blister, break open, and become infected. The infection can eventually develop into sepsis indicates Elder Abuse Attorney Peck.

Surgical and Slow Healing Wounds:
Residents recovering from surgical or slow healing wounds may require antibiotics, regular cleaning and changing of bandages to help reduce possibility of infection. Improper or neglectful attention, to these residents, can increase potential for a bacterial infection which can spread from the wound to surrounding tissue and into the bloodstream causing sepsis.
Intravenous Lines (IV Lines):
Intravenous treatments carry a risk of infection due to direct contact into the bloodstream through the vein. It is an aseptic procedure which requires regular changing and cleaning of the insertion site. However, improper care can lead to bacterial infection from foreign objects within the line and contaminated equipment. Accumulation of moisture around the insertion site, can also result in an infection which can grow into sepsis.

Treatment:
Treatment for sepsis includes aggressive intravenous antibiotics to kill the infection. A more severe case may require ventilation for respiratory failure, vasopressor treatment to stabilize blood pressure, painkillers, and medications to control blood sugar and immune response. Invasive surgical procedures may also be required to drain or remove the source of infection.

Prevention:
Nursing home attendants can help reduce risk of sepsis through regular bathing of incapacitated residents, proper attention and cleaning of surgical wounds and bed sores, and regular changing of IV lines.

Discipline: Peck Law Group LLC (Nursing Home Abuse & Neglect Lawyers)

- Respiratory Infection
- Urinary Tract Infection
- Recognition & Response
  - Nursing Home Abuse
  - Nursing Home Neglect
  - Inadequate wound cleansing
  - Inadequate pressure reduction
  - Insufficient dressing changes
  - Antibiotics not prescribed

- Co-morbid Medical Conditions
- Weak Immune Systems
- I.V. Lines
- Indwelling Catheters
- Bed-ridden/ Incapacitated

- Elderly
- High Risk Population

- Infection Control
- Skin & Soft Tissue Infection

Acute Care Transfers Diagnosed with Sepsis

- Surgical Wounds
- Slow Healing Wounds
- Bed Sores
- Moisture around IV insertion site
- Regular cleaning Of IV site
- Regular changing Of IV lines
- Inadequate Bathing

- I.V. Lines
- Indwelling Catheters
- Bed-ridden/ Incapacitated
- Elderly
- High Risk Population
### Recommended INR-Based Warfarin Dose Adjustments for Patients Who Are Not Bleeding

**Target INR:** 2.0–3.0

- **INR < 2.0:**
  - Increase by 10–15%* if INR c.1.5

- **INR 2.1–3.5:**
  - Decrease by 0–10% if INR < 2.0
  - Hold 0–1 dose if INR > 2.5

- **INR 3.6–4.0:**
  - Decrease by 10–15% if INR < 3.1
  - Hold 0–2 doses if INR > 3.5

- **INR 4.1–4.9:**
  - Decrease by 10–15% if INR < 4.1
  - Hold 2 Doses Vitamin K 2.5–5 mg po

- **INR > 5.0:**
  - Decrease by 10–15% if INR < 4.1
  - Hold 2 Doses Vitamin K 2.5–5 mg po

- **INR > 9.0:**
  - Decrease by 15–20% if INR < 4.1
  - Repeat INR within 2 weeks

### Warfarin Tracker

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>INR Result</th>
<th>Current Dose</th>
<th>On Antibiotic</th>
<th>MD Notified</th>
<th>Dose Change</th>
<th>Next INR Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/21/15</td>
<td>7:00A</td>
<td>1.6</td>
<td>4.5 mg</td>
<td>No</td>
<td>Yes</td>
<td>5.0 mg</td>
<td>3/26</td>
</tr>
<tr>
<td>3/26/15</td>
<td>7:00A</td>
<td>2.2</td>
<td>5.0 mg</td>
<td>No</td>
<td>Yes</td>
<td>5.0 mg</td>
<td>3/31</td>
</tr>
<tr>
<td>3/31/15</td>
<td>7:00A</td>
<td>2.4</td>
<td>5.0 mg</td>
<td>No</td>
<td>Yes</td>
<td>5.0 mg</td>
<td>4/7</td>
</tr>
<tr>
<td>4/7/15</td>
<td>7:00A</td>
<td>2.6</td>
<td>5.0 mg</td>
<td>No</td>
<td>Yes</td>
<td>5.0 mg</td>
<td>4/14</td>
</tr>
<tr>
<td>4/14/15</td>
<td>7:00A</td>
<td>2.5</td>
<td>5.0 mg</td>
<td>No</td>
<td>Yes</td>
<td>5.0 mg</td>
<td>4/28</td>
</tr>
<tr>
<td>4/28/15</td>
<td>7:00A</td>
<td>2.4</td>
<td>5.0 mg</td>
<td>No</td>
<td>Yes</td>
<td>5.0 mg</td>
<td>5/19</td>
</tr>
<tr>
<td>5/19/15</td>
<td>7:00A</td>
<td>2.6</td>
<td>5.0 mg</td>
<td>No</td>
<td>Yes</td>
<td>5.0 mg</td>
<td>6/15</td>
</tr>
<tr>
<td>6/15/15</td>
<td>7:00A</td>
<td>2.6</td>
<td>5.0 mg</td>
<td>No</td>
<td>Yes</td>
<td>5.0 mg</td>
<td>7/13</td>
</tr>
</tbody>
</table>
LABORED BREATHING IN A RESIDENT WITH A GASTRIC TUBE

An 89-year old male with moderately severe dementia and seizure disorder is transferred to the emergency room with labored breathing.

He had chronic contractures of all four extremities, was unable to make needs known, and had a long history of dysphagia with recurrent aspiration pneumonia.

He was given nutrition by a gastric tube and had an order that he was to have nothing by mouth.

His PEG was functioning properly and he was tolerating his feedings well.
Physical Findings

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen Saturation</td>
<td>92% on 50% oxygen by mask</td>
</tr>
<tr>
<td>Pulse</td>
<td>Varied from normal to tachycardia</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Fluctuated between 80/65 and 138/52</td>
</tr>
<tr>
<td>Rectal Temperature</td>
<td>104.5 F</td>
</tr>
</tbody>
</table>

The facility transferred him thinking that he had probable aspiration pneumonia with possible sepsis.

Poll Question

Was it appropriate to transfer this resident to the hospital based on the information given?
Emergency Room

- Blood cultures collected
- IV piperacillin and Zosyn administered
- Chest X-Ray confirmed pneumonia
- IV fluids resuscitation attempted
- He was admitted and transferred to the medical floor

Medical Floor

- His labored breathing continued over the next few hours and his oxygen saturation levels dropped as low as 80%.
- A 100% non-rebreather mask was applied and his saturation improved.
- As his saturation improved his breathing became less labored and his pulse improved.
- He became combative when attempts were made to provide oral suctioning, so they stopped.
Medical Floor

• He continued to have labored breathing with a respiratory rate in excess of 40, but in addition was now having periodic apnea.
• The nursing staff grew concerned over not being able to provide suctioning as they observed his oral cavity was extremely dry with visible intraoral secretions.
• Soon, his respirations became shallow and then he went into cardiac arrest.
• He was pronounced dead with presumed cause listed as sepsis caused by aspiration pneumonia.

Subsequent Events

• An anonymous call was made to the department of health with claims that this resident had been neglected and possibly abused at the skilled nursing facility.
• The coroner’s office was notified of the allegations and an autopsy was performed.
Autopsy Report

• The external examination established that the patient had upper- and lower- extremity contractures and no pressure ulcers.

• Oral cavity examination revealed the presence of abundant, white-yellow material adhering to the upper surface of his tongue and to his hard palate

Autopsy Report

• Internal Examination
  – the patient’s esophagus, esophagogastric junction, and stomach were normal, except for the presence of the gastric tube, which had no apparent problems.
  – On gross examination the lungs were unremarkable, though the thorax was deformed, with severe kyphoscoliosis.
  – The brain showed marked, diffuse atrophy
Autopsy Report

• An examination of the pharynx, larynx, and upper trachea revealed a significant amount of firm, gelatinous, white-yellow material completely occluding the posterior pharynx and laryngeal airway, encasing the epiglottis

• Microscopic examination suggested that the substance was an admixture of squamous cells, proteinaceous material, and mucus, with focal inflammatory cells and bacteria, consistent with inspissated (thickened) oral and nasopharyngeal secretions.

• The adjacent mucosa was histologically unremarkable.

Autopsy Report

• Microscopic examination of the lungs showed no pneumonia or aspiration

• admission blood cultures, as well as blood and lung cultures taken after death, were negative.

• Cause of Death
  – Asphyxia resulting from upper airway obstruction by oral and nasopharyngeal secretions
Additional Investigation

• The patient had been seen in the hospital about 10 months earlier for respiratory difficulties.
  – At that time, two "decent-sized chunks of material" had been removed from the "back of the throat."
  – There was no mention of that visit in the recent skilled nursing facility notes

Discussion Points

• Risks for aspiration
  – Chronic debility from a variety of physical and neurologic deficits
  – Advanced age
  – Poor dentition (toothless or has dentures)
  – Use of sedatives
  – Institutionalization
  – Presence of disorders affecting either motor coordination or mental function
Discussion Points

• Reducing aspiration risk for the resident in this case (a man with severe and chronic disability)
  – Reduce risk of aspiration by providing nourishment through a gastrostomy or jejunostomy tube rather than by a feeding tube (feeding tubes are associated with higher rates of aspiration and dehydration).
  – Consider use of jejunostomy tube over gastrostomy tube in patients who have had pneumonia.

Discussion Points

• Risk factors for build-up of secretions
  – Dehydration (not uncommon in residents feed by tube)
  – Use of full-face mask for ventilation
  – Inadequate cough
  – Sedation
  – Inadequate humidification when receiving high flow oxygen for an extended period of time
  – NPO status
  – Reduced oropharyngeal motility
  – Impaired neurologic/ mental function contributing to poor oral hygiene
  – Inadequate oral care and suctioning
  – Being confined to bed
Discussion Points

• Barriers to Good Oral Care
  – C.N.A. are not taught the importance of good oral care, thus, do not make it a priority
  – Combativeness

• Pearls
  – it's essential to evaluate the mouth and upper airway of all patients with respiratory difficulties, particularly those at increased risk for aspiration.
  – Chronically debilitated patients requiring tube feedings are particularly vulnerable to complications stemming from inadequate hydration and insufficient oral and upper airway hygiene.

Poll Question

For this resident, which of the following would be true to determine how much free water he should be given every 24 hours?
Fluid Maintenance

- Fluid Replacement using the “8X8” rule
  - Adults lose 1.5 liters of fluid daily through their urine.
  - Additional fluids are lost through breathing, sweating, and bowel movements.
  - In general, lost fluids can be replaced by consuming 8 cups of fluids per day along with a normal diet.
- One gallon of water weights 8 pounds.

Assessing Hydration Status with Tube Feeding

<table>
<thead>
<tr>
<th>Fluid intake and output</th>
<th>Record all fluids losses from urine, liquid feces, vomitus, drainage from fistulas and wounds, fever, perspiration, and hyperventilation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine concentration</td>
<td>Utilize urine volume, color (ranging from dark amber to pale or colorless), and urine specific gravity.</td>
</tr>
<tr>
<td>Body weight</td>
<td>Weight gain of 1 to 1.5 pounds per week may be expected from receiving increased nutrients.</td>
</tr>
<tr>
<td>Edema</td>
<td>Gain or loss of edema.</td>
</tr>
<tr>
<td>Sensorium</td>
<td>Changes (up or down) in sodium can lead to changes in responsiveness and levels of consciousness.</td>
</tr>
<tr>
<td>Blood chemistries</td>
<td>Elevated sodium = consider giving more free water. Low sodium = consider fluid restriction. Look at BUN/Cr ratio; If &gt; 20:1 a fluid volume deficit is possible Elevated glucose may indicate a risk for osmotic diuresis</td>
</tr>
</tbody>
</table>
QUESTIONS

Clinical Case Study

A 79-YEAR OLD MALE WITH ALTERED MENTAL STATUS
A 79-year old male with moderate cognitive impairment due to dementia was noted to have altered mental status that was described as being “less responsive than usual”.

Medical History: Dementia, Hypertension, Chronic Constipation

**Vital Signs**
BP 100/58
Pulse 114/regular
Respiratory rate 20
Temperature 100.2 F

**Physical Exam**
In no acute distress
Less communicative than usual, uttering only a few words
Skin turgor poor with temporal tenting
Normal cardiac, lung, and GI exam

---

**Poll Question**

Based on the information given thus far, do you think this resident is getting adequate blood supple to all of his vital organs?
WBC 16,600
Hg 17.3 g/dL
Hct 51.9%
Platelets 554,000

Sodium 176 meq/L
Potassium 6.9 meq/L
Chloride 145 meq/L
BUN 212 g/dL
Creatinine 14.4 mg/dL

U/A
2+ protein
2+ blood
(+) leukocyte esterase
(+) nitrite
50 – 100 RBC’s
4+ Bacteria

Normal hepatic profile

ECG: Peaked T waves in the precordial leads
Chest X-Ray: No active disease
Decreased oral fluid intake over the past 4 days

He was transferred to the emergency room.

Initial Hospital Course

- Admitted to the ICU
- IV hydration provided with normal saline at 200 cc/hour
- Empiric IV Levaquin started @ 500 mg Q 12 hours
  - This was subsequently changed to Ceftriaxone 1 gm Q 24 hrs. when the urine culture grew > 100,000 E. coli
- Renal work-up ordered
  - Renal consult
  - Renal ultrasound
Subsequent Hospital Course

- Day 2
  - BUN improved to 110
  - Creatinine improved to 9.6
- Day 4
  - BUN and Creatinine back in normal range
  - Mental status starts to show improvement
- Day 6
  - Awake and alert
  - Non-verbal but responsive to cues
  - Tolerating chopped diet with thickened liquids
- Day 8
  - Transferred back to the skilled nursing facility

Back at the S.N.F.

- Three weeks later
  - Resident is found on a Saturday afternoon in his room with altered mental status (lethargy). The attending physician immediately orders a transfer back to the hospital to get stat lab work done.
  - Lab results
    - BUN 99 g/dL
    - Creatinine 7.6 mg/dL
    - No evidence of UTI
    - No evidence of pneumonia
  - Admitted to the hospital with dehydration
Hospital Course

• First 3 days
  – IV fluids and supportive care
  – Renal function gradually returned to normal
  – His level of alertness improved

• Day 4
  – A percutaneous gastrostomy tube placed
  – Tube feeding with free water flushed provided

• Day 5
  – Returned to the SNF

Discussion Points

1. Why did this resident develop acute renal failure?
2. Could it have been expected that his renal function could improve with conservative treatment?
3. What could the team have done to prevent the second episode of acute renal failure?
4. What could the SNF have done to protect this resident?
5. Was insertion of a feeding tube appropriate?
Acute Renal Failure

- The most likely cause was volume depletion that occurred due to poor oral fluid intake.
- He could also have had age related decline in renal function.
- The decrease in fluid intake could have resulted from the urinary tract infection that was found at the hospital.
- Decreased fluid intake could also have happened due to ongoing decline in cognitive level due to dementia with altered response to thirst.

Improving Renal Function Using Conservative Measures

- Complete recovery of renal function using conservative measures could not have been expected due to the following factors
  - Advanced age
  - The degree of renal dysfunction at start of therapy
- He demonstrated a recovery with return to normal renal function but it is would not have been realistic to anticipate his recovery when his creatinine was 14.4 and his BUN was 212.
Actions to Prevent a Second Episode of Acute Renal Failure

• Define cause of the first episode (determined to be volume depletion), then formulate a plan.
• Establish what the resident’s baseline was for food and fluid intake.
• Review how well the resident was eating and drinking fluids just prior to the first episode.
• Assess the resident’s ability to eat and drink and verify that this can meet caloric and fluid needs.

Continued

Actions to Prevent a Second Episode of Acute Renal Failure

• Discuss potential alternate methods of feeding.
• Review the potential need for artificial feeding and hydration with the family.
• Explain to the family that if nothing changed, it would be likely that this event could occur again.
Potential Safeguards To Protect the Resident

- Communication between the hospital staff, SNF staff, and family.
- Frequent evaluation by the medical staff to assess adequate intake and development of volume depletion.
- Frequent lab monitoring to assess renal function.
- Dietary assessment of caloric intake and needs.
- A comprehensive feeding plan involving all pertinent staff and family members.

Was the Feeding Tube Appropriate?

- This resident was not able to meet caloric and fluid intake needs, thus, an alternate feeding plan was required.
- Data regarding use of feeding tubes show that they do not prevent mortality in patients with advanced dementia.
- This case was different given the brisk response to treatment of the first episode of volume depletion.
Was the Feeding Tube Appropriate?

• Pros
  – The use of a feeding tube at an earlier time would have prevented hospitalizations and two episodes of renal failure that could have ended with death.

• Cons
  – The use of the feeding tube would not change the natural history of the patients overall medical condition.

• Family View
  – He has sufficient quality of life and should have the tube. They are not ready for him to die yet, so they don’t want to let go.
Using ECOG Performance Status (Eastern Cooperative Oncology Group)  _________

- **Score 0**
  - 0. Cancer
  - 0. Advanced COPD
  - 0. Stroke (with decreased function by at least 50%)
- **Score 1 point overall**
  - 0. Moderate renal disease
  - 0. Liver disease
  - 0. bone disease
  - 0. End stage renal disease
  - 0. Advanced cardiac disease – i.e., CHF, severe CAD, CM (LVEF < 25%)
  - 0. Advanced cardiac disease – i.e., CHF, severe CAD, CM (LVEF < 25%)
  - 0. Other life-limiting illness
  - 0. Other condition complicating cure
  - 0. Moderate congestive heart failure

### Disease Trajectory

Holley JL CJASN 2012; 7:1033-1038

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1. **Basic Disease Process**
   - a. Cancer
   - b. Advanced COPD
   - c. Stroke (with decreased function by at least 50%)
   - d. End stage renal disease
   - e. Advanced cardiac disease – i.e., CHF, severe CAD, CM (LVEF < 25%)
   - f. Other life-limiting illness

Score 2 points EACH

2. **Concomitant Disease Processes**
   - a. Liver disease
   - b. Moderate renal disease
   - c. Moderate COPD
   - d. Moderate congestive heart failure
   - e. Other condition complicating cure

Score 1 point overall

3. **Functional status of patient**
   - Using ECOG Performance Status (Eastern Cooperative Oncology Group)

<table>
<thead>
<tr>
<th>ECOG Grade</th>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Fully active, able to carry on all pre-disease activities without restriction.</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work.</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Capable of only limited self-care; confined to bed or chair more than 50% of waking hours.</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.</td>
<td>3</td>
</tr>
</tbody>
</table>

Score as specified below
4. **Other criteria to consider in screening**  
Score 1 point EACH

The patient:

- a. has unacceptable level of pain > 24 hours
- b. has uncontrolled symptoms (i.e., nausea, vomiting)
- c. has uncontrolled psychosocial or spiritual issues
- d. has frequent visits to the Emergency Department (> 1 x mo for same diagnosis)
- e. has more than one hospital admission for the same diagnosis in last 30 days
- f. has prolonged length of stay without evidence of progress
- g. has prolonged stay in ICU(s) without evidence of progress
- h. is in an ICU setting with documented poor or futile prognosis
- i. is not a candidate for curative therapy
- j. has a life-limiting illness and chosen not to have life-prolonging therapy

**TOTAL SCORE**

**SCORING GUIDELINES:**
- **TOTAL SCORE = 2**  
  Give patient Palliative Care information brochure
- **TOTAL SCORE = 3**  
  Consider Palliative Care consult; give info to patient
- **TOTAL SCORE = 4**  
  Palliative Care Consult recommended (requires provider orders)

** Would you be surprised if this patient died within the next 6 months?  
YES  NO**

If NO, consider Hospice referral.

---

**Palliative Care Checklist**

- Understanding of prognosis  
  Clinical issues of hospitalizations, code status, pain, anxiety, and depression management;

- Understanding of current and future symptoms  
  Weight monitoring, diagnostic testing, starvation vs. dehydration, & stopping inappropriate (potentially all) medications.

- Advance Directives/MOLST  

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**QUESTIONS**

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**Break #2**
A 62 year-old male with a long standing history of schizophrenia complained to the nursing staff of severe abdominal pain.

He had been getting laxatives for several days after telling the staff that he had not gone to the bathroom to pass stool in more than 2 weeks.

**Medications**
- Quetiapine 200 mg BID and 300 mg in the evening
- Clozapine 100 mg BID
- Bowel regimen per facility protocol

The attending MD was called and ordered an abdominal x-ray that showed abundant fecal matter within the lower abdominal quarters.
The following day the MD came in to see him and found that his belly had non-tender distention with no bowel sounds. No masses were felt. Feces was present in the rectal bowl.

He gave the following orders on the assumption that he was treating severe constipation:

1. Fibercon
2. Lactulose 30 ml PO BID
3. A fleets enema
4. Encourage additional intake of free water

That evening the resident refused to eat dinner and several hours later he was found unresponsive in his room and was pronounced dead.

Autopsy Report

- External Exam
  - Increased abdominal volume

- Internal Exam
  - Pulmonary Edema
  - Congestion of the arterial supply to the small and large intestine
  - Distention of the transverse and descending colon
## Autopsy Report

- **Stomach contents**
  - Dark fluid that had the appearance and odor of feces

- **Liver**
  - Enlarged, congested and fatty

- **Histologic Exam**
  - Sub-endocardial fibrosis with fatty infiltration of the right ventricle
  - Non-specific chronic inflammation of the intestinal walls

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## Autopsy Report

- **Toxicology Report**
  - Traces of quetiapine within the blood and urine
  - Clozapine present in the blood and urine

- **Serum potassium level was elevated**

- **According to facility records, the resident’s last ECG showed a right bundle branch block with slight prolongation of the QT interval**
Autopsy Report

• Cause of Death
  – Sudden cardiac arrest
  – Due to or as a consequence of an electrolyte disorder, specifically hyperkalemia
  – Due to or as a consequence of a paralytic ileus

Discussion

• The resident had been stable on a combination of Clozapine and Quetiapine for more than 10 years.
• Both of these medications, in the class of second generation antipsychotics, are known to cause
  – Constipation
  – Prolonged QT intervals that can eventually lead to fatal ventricular arrhythmias
Discussion

• QT prolongation due to antipsychotics
  – QT prolongation was a concern with use of 1st generation antipsychotics.
  – When 2nd generation antipsychotics were introduced it was thought that QT prolongation would not be a risk with their use.
  – Post-marketing reports confirmed cases of QT prolongation.

Discussion

• Constipation due to antipsychotics
  – Studies indicate constipation rates of 9 – 12% in those treated with antipsychotics
  – Constipation, if not adequately treated, can lead to a block of peristalsis and in severe cases a potentially fatal paralytic ileus.

Discussion

• Clinical practice considerations when prescribing antipsychotics
  – A baseline ECG should be obtained when therapy is initiated.
  – Subsequent ECG monitoring should be done at the discretion of the attending physician
  – Special attention should be paid to residents with specific cardiovascular risk factors
  – Bowel monitoring should be regularly conducted and changes in bowel regularity should be managed aggressively

QAPI

“PRIVILEGED & CONFIDENTIAL” STATUS AT STATE LEVEL
IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

January 2014 Term

FILED
June 13, 2014
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SUPREME COURT OF APPEALS
OF WEST VIRGINIA

No. 13-0470

MANOR CARE, INC.; HCR MANOR CARE SERVICES, INC.;
HEALTH CARE AND RETIREMENT CORPORATION
OF AMERICA, LLC;
HEARTLAND EMPLOYMENT SERVICES, LLC;
JOHN DOES 1 THROUGH 10; AND
UNIDENTIFIED ENTITIES 1 THROUGH 10
(AS TO HEARTLAND OF CHARLESTON),
Defendants Below, Petitioners,

V.

TOM DOUGLAS, INDIVIDUALLY,
AND ON BEHALF OF
THE ESTATE OF DOROTHY DOUGLAS,
Plaintiffs Below, Respondents.

FACTUAL AND PROCEDURAL HISTORY

On September 4, 2009, Dorothy Douglas (hereinafter "Ms. Douglas") was admitted to Heartland Nursing Home in Charleston, West Virginia. Although Ms. Douglas was eighty-seven years old at the time of her admission to Heartland Nursing Home, and she suffered from Alzheimer's dementia, Parkinson's Disease, and other health issues, she was, nevertheless, able to walk with the use of a walker, able to recognize and communicate with her family, well-nourished, and well-hydrated. After spending nineteen days in Heartland Nursing Home, Ms. Douglas had become dehydrated, malnourished, bed ridden, and barely responsive. In addition, she had fallen numerous times, sustained head trauma and bruises, and suffered from sores in her mouth and throat that required the scraping away of dead tissue and debris. Following her nineteen-day stay at Heartland Nursing Home, Ms. Douglas was transferred to another nursing facility, then to Cabell Huntington Hospital, and ultimately to a Hospice care facility where she passed away eighteen days after leaving Heartland Nursing Home. According to her treating physician at Cabell Huntington Hospital, Ms. Douglas died as a result of severe dehydration.
Evidence presented at trial demonstrated that Heartland Nursing Home had been chronically understaffed. There had been numerous complaints from residents and their families, as well as by Heartland Nursing Home employers. At least one employee who complained of understaffing was reprimanded for her complaint, and the complaint was apparently removed from Heartland Nursing Home records. Additionally, and notwithstanding attempts to conceal the understaffing, surveys by the West Virginia Department of Health and Human Services documented Heartland Nursing Home's understaffing and improper records pertaining to staff that occurred prior to Ms. Douglas' admission to that facility. Nevertheless, Heartland Nursing Home remained understaffed and, as a result, Ms. Douglas did not survive the adverse effects of her stay there.

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Addendum Remark

According to the record, when Ms. Douglas was admitted to Cabell Huntington Hospital, she was suffering from severe dehydration and was totally unresponsive. She was administered IV fluids, which restored her to a normal level of hydration, but she remained largely unresponsive. The use of an NG tube temporarily, or a PEG tube more permanently, to administer nourishment to Ms. Douglas was discussed with her family. The family did not believe these treatments were something Ms. Douglas would want; therefore, they declined these procedures. According to the testifying physician, an NG tube is a nasogastric tube that goes down through the nose into the stomach. It can be used only temporarily because it will cause the nasal passage to erode. A PEG tube is a percutaneous endogastric tube which goes through the abdominal wall into the stomach.
Legal Matters

Court: HCR ManorCare QAPI reports must be turned over

A ruling by the West Virginia Supreme Court as to which nursing home internal documents are fair game in lawsuits has providers around the country sitting up and taking notice. That court ruled that Quality Assurance and Performance Improvement Program reports are not protected by state law. At issue is a wrongful death lawsuit brought by a former resident's family against HCR ManorCare's Heartland Charleston facility, located in Charleston, WV.

ManorCare claimed in court proceedings that the reports were meant solely for the company's Quality Assurance and Performance Improvement Program, and were excluded from discovery. But West Virginia's highest court disagreed. It upheld a lower court ruling that found ManorCare did not prove that the reports were submitted, or were intended to be submitted, to a peer review committee. This means they weren't barred from discovery by the state's peer review privilege law, the court wrote.
Legal Matters

Court: HCR ManorCare QAPI reports must be turned over

Plaintiff’s attorneys for Sharon Hanna's family wanted access to the reports to counter an assertion by HCR ManorCare attorneys that it had not acted improperly.

The court, however, spared the nursing home chain from having to produce board of director briefing packets, citing attorney-client privilege as a guarding factor.

JULY 2015 ISSUE OF MCKNIGHT’S LONG TERM CARE NEWS

Court of Appeals of New York.

IN RE: SUBPOENA DUCES TECUM TO JANE DOE, Dated April 25, 2001 and Four Other Subpoenas Duces Tecum. Park Associates, Inc., et al., Appellants; New York State Attorney General, Medicaid Fraud Control Unit, Respondent.

Decided: February 25, 2003

Connors & Vilardo, LLP, Buffalo (Terrence M. Connors and Vincent E. Doyle III of counsel), for appellants.


OPINION OF THE COURT

In this appeal, we are asked to determine if certain nursing home records are immune from disclosure in response to subpoenas issued by a grand jury conducting a Medicaid fraud investigation. We conclude that federal law protects from disclosure those records created or generated for quality assurance purposes at the facilities.

As part of an investigation into resident care initiated by the Medicaid Fraud Control Unit of the Attorney General’s office (MFCU), an Erie County grand jury issued a series of subpoenas seeking records from three nursing home facilities: The Waters of Orchard Park, The Waters of Salamanca and The Waters of Aurora Park. The subpoenas sought 59 categories of documents and reports involving various aspects of facility management and resident care and treatment. Petitioner The Park Associates, Inc., a nursing home consultant retained by the three facilities, moved to quash portions of the subpoenas on the basis that certain records were protected from disclosure under New York State Public Health Law § 2801 et seq. and the Federal Nursing Home Reform Act, codified in 42 USC § 1396r.

Five categories of documents were in dispute before Supreme Court: incident/accident reports, monthly skin condition and pressure sore reports, monthly weight reports, infection control reports and lists of any facility-acquired infections. Petitioner asserted that the records and reports at issue were generated by the facilities’ quality assurance committees and therefore the nursing homes were entitled to rely on the privilege extended to quality assurance committee work product under state and federal law.
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