



PROPER NOURISHMENT HELPS TRIM RISK

Everyone knows that proper nutrition is a key to health. But eating is about more than consuming the nutrients our bodies require. Meals also satisfy

– or should satisfy – other basic human needs, such as sensory enjoyment and social interaction. For residents of long term care (LTC) facilities, meals are more than functional – they are often the high points of the day.

Because it is central to the total health of residents, mealtime is a significant source of risk for LTC organizations. A look at CNA HealthPro claim files shows that many LTC claims include allegations of malnutrition or dehydration. Plaintiff attorneys are quick to suggest that these problems are caused not by disease or aging processes, but rather by failure to provide proper feeding assistance to resi-

you can also enhance residents’ and families’ satisfaction levels, and smooth some of the seemingly minor frictions that may otherwise snowball into complaints and legal action.

Ensuring that residents are well-nourished, physically and otherwise, is what good care is all about. This issue, with its convenient risk assessment tool, will make it easier for your facility to give residents the particular support they need.

Nutritional Safeguards: Key to Reducing Malpractice Exposure

Malnutrition and dehydration lower the quality of residents’ lives in many ways, including decreased immunity to bacteria and viruses,

dents, or to address medical or dental conditions that make eating painful or difficult.

This issue of *CareFully Speaking* discusses five common types of malnutrition-related negligence claims, ranging from mealtime understaffing to untreated oral problems. All of these potential hazards can be substantially mitigated through sound, well-executed risk management strategies that emphasize proper staffing, vigilant monitoring of malnutrition trouble signs, frequent nutritional assessment, ongoing staff education on diet and feeding issues, and accurate and comprehensive documentation.

The measures described here can help protect your residents from the many health risks posed by inadequate dietary intake, and your organization from the threat of litigation, sanctions and damaging publicity. But we should remember that food is an important emotional and psychological issue, as well as a physical one. By working to make mealtime at your facility a consistently positive experience,

greater susceptibility to pressure ulcers, and muscle weakness leading to immobility and falls. Malnutrition can occur for a variety of reasons, some of which are beyond the facility’s control. Preventing malnutrition is a key responsibility of all LTC facilities, and the failure to do so can have a significant negative impact on an organization, including higher costs of care, state investigations, exposure to litigation and a damaged reputation.

Many lawsuits instituted against LTC facilities include complaints related to malnutrition and dehydration. (See “Malnutrition and Dehydration: A Claims Perspective,” p. 5.) Protecting your organization against such allegations requires not only a commitment to assessing and meeting the nutritional needs of all residents, but also thorough documentation of preventive measures taken. This article discusses some common allegations of nutrition-related negligence and offers practical interventions to help your facility reduce its exposure.

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Allegation 1: Failure to employ an adequate number of staff to sufficiently feed residents.

LTC experts have long called for nationwide minimum-staffing requirements to ensure that residents get the assistance they need at mealtime, including close monitoring for possible dental problems or medical conditions that can impede proper nutrition. In 2003, the Centers for Medicare and Medicaid Services (CMS) published a rule aimed at helping LTC facilities alleviate this problem by allowing them to hire part-time workers to help feed their residents. (The final rule may be accessed at <http://www.cms.hhs.gov/providerupdate/regs/cms2131f.pdf>.)

According to the rule, a paid feeding assistant:

- must be at least 16 years old
- can work elsewhere in the facility, such as laundry, housekeeping or clerical
- may assist only those residents who do not have feeding complications, such as difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings
- cannot provide nursing or nursing-related services beyond the activities of eating and drinking
- must complete a state-approved eight-hour training course

While the CMS rule does not require a competency test to measure feeding assistants' skill level and working knowledge, it is a prudent risk management practice to observe trainees at work, and to initial and date your observations to verify their performance. Not all states permit feeding assistants. Therefore, it is necessary to consult your state's applicable laws to determine if your facility can administer a feeding assistant training program.

Whether or not your facility has a formal feeding assistant program, we recommend that you adhere to the national guidelines listed above. When selecting and educating mealtime caregivers, the following knowledge and skills are paramount:

- feeding techniques for residents of differing abilities
- communication and interpersonal skills
- appropriate responses to resident behavior
- safety and emergency procedures, including the Heimlich maneuver
- infection control and prevention of food-borne illness
- resident rights, especially regarding tube feedings
- knowing how to recognize changes in residents and report these changes to the nurse

For more information on training staff in feeding assistance and providing annual education on this topic, you may wish to consult these curriculum models:

- *Assisted Dining: The Role and Skills of Feeding Assistants*, by the American Health Care Association at www.ahcapublications.org.
- *Eating Matters: A Training Manual for Feeding Assistants*, by the American Dietetic Association at www.eatright.org.

Allegation 2: Failure of staff to adequately assess a resident in need of feeding assistance.

All LTC caregivers should be trained to understand the risks of malnutrition and dehydration among the elderly, and to recognize danger signs. Preventive measures should be taken from the moment a resident is admitted. The following indicators signal a potentially high-risk resident and warrant further assessment and immediate intervention:

- has a cholesterol level of less than 160 mg/dL
- has an albumin level of less than 3.5 mg/dL
- leaves 25 percent or more of food on plate at two-thirds of meals over seven days
- loses 5 percent of body weight in 30 days or 10 percent in 180 days
- coughs or chokes during eating
- requires assistance in eating or drinking
- suffers from mouth pain, frequent vomiting, diarrhea or fever
- has a dry mouth, cracked lips, dark urine or sunken eyes
- suffers from one or more chronic diseases, such as diabetes, chronic obstructive pulmonary disease, cancer or HIV
- appears profoundly sad
- has a history of alcoholism or substance abuse

A well-documented nutrition and hydration initial assessment should include a review of the physical, emotional, social and environmental factors that can cause a resident to eat poorly. It is especially important to have a complete baseline profile on record for every resident, which may refute later allegations of negligent treatment by showing evidence of pre-existing conditions. To assist your staff in identifying risk factors that may predispose a resident to malnutrition and dehydration, this issue includes a Resident Risk Assessment Tool for your organization's use. (See p. 6.)



All LTC caregivers should be trained to understand the risks of malnutrition and dehydration and to recognize danger signs.

Allegation 3: Failure to properly educate staff about measuring nutritional intake.

The federal government requires LTC facilities to assess the nutritional status of residents at the time of admission and every three months thereafter. The standard of care requires your facility to check caloric intake, fluid intake and output, and bowel and bladder activity. Failure to monitor these parameters may constitute evidence of neglect. Sodium, potassium, calcium, albumin and other electrolyte levels should also be checked at prescribed intervals, such as every six months, and whenever symptoms arise suggesting possible dehydration or malnutrition. When an unexpected rise occurs, your staff must understand the importance of reacting quickly and implementing preventive measures (such as a special diet or assistance with feeding) to minimize further risk.

It is also essential to train care providers to adequately and consistently measure residents' food and drink intake – i.e., whether they are eating less than 75 percent of most meals. Careful consideration should be given to the degree of precision that can be reasonably expected in food and nutrient calculation. Traditional estimation and documentation methods involve pre- and post-meal photographs, tray diagrams or point scales, all of which require a well-trained observer to implement. More practical food and fluid estimation programs use the resident meal ticket and have the following characteristics:

- *Pictures of food groups are printed on the back of the meal ticket*, one for breakfast and one for lunch and dinner.
- *One of five consumption levels is indicated for each picture*, using partial-to-full shading (i.e., 0, 25, 50, 75 or 100 percent consumed).
- *Instructions for completing the measurement tool are printed on the meal ticket* in English and other languages to meet the needs of your resident population.
- *Staff members mark the measurement* while the tray is still in view.
- *Food and fluid intake are estimated for each resident individually*, not as a group.
- *The overall meal intake is calculated by trained dietary professionals* to ensure proper measurement.
- *Common foods are pre-weighed* to provide a consistent baseline for nutrient calculations.

Allegation 4: Failure to properly supervise employees who provide nutritional services.

The responsibility of ensuring that residents eat a balanced, nutritious diet lies primarily with the professional staff in your dietary services department. Failure to adequately supervise dietary services staff can be a dangerous misstep, both for residents and your facility. It is important to establish written parameters governing dietary consultation, as well as educational efforts for residents and staff about the importance of adequate nutrition. You can protect your organization by regularly reviewing dietary policies and procedures, and by ensuring that your food service program includes, at a minimum, the following:

- *Well-balanced, palatable meals are served* at the proper temperature and presented in an appetizing manner.
- *Dining areas foster as home-like an atmosphere as possible* in terms of service, lighting, décor, etc.
- *Dietary staff members are given checklists* of food and water distribution times as reminders.
- *Residents who refuse served food are offered substitutes* of similar nutritional value.
- *All residents have sufficient time* to eat their meals.
- *A variety of nourishment forms and textures are offered*, including smoothies, pureed and soft foods.
- *Residents' dining companion preferences* are taken into consideration.
- *Disruptive residents are separated* from others during mealtime.
- *Agitated residents or those with dementia are offered finger foods* if they cannot sit through a meal.

Allegation 5: Failure to correct oral deficiencies leading to malnutrition and dehydration.

To ensure that all residents receive the vitamins, minerals, protein and calories they need, your facility must address oral problems that may interfere with proper eating. One of the most prevalent changes in the oral status of older patients is a decrease in saliva production. This condition is usually caused either by a systemic disease or by one of the hundreds of drugs reported to cause dry mouth, such as tricyclic antidepressants, sedatives and antihypertensives. Saliva provides important chemical as well as physical decay-fighting effects. Its reduction, combined with the gum recession that often occurs among older adults, leaves patients susceptible to extensive and rapid tooth decay, particularly on exposed root surfaces. The decay

Malnutrition and Dehydration: A Claims Perspective

Many CNA HealthPro LTC claims include allegations of malnutrition and/or dehydration, contributing to a resident's injury or death. Often these are secondary complaints, included by the plaintiff's attorney along with other assertions of negligence. Sometimes, they are the primary allegation. Such paid claims in the files of CNA HealthPro have recently resulted in settlements or awards ranging from \$50,000 to \$735,000.

If this allegation is made against your organization, you can strengthen your defense by establishing a baseline for all laboratory blood test results. By demonstrating that the resident's metabolic profile has not changed significantly since admission, your defense team may contend that long-term disease processes or aging caused the adverse event. This will serve to counter the plaintiff's allegation that the resident experienced recent-onset malnutrition due to caregiver neglect.

In the event of a legal action, you should anticipate that the plaintiff's attorney will attempt to place the blame for malnutrition on your facility's failure to provide an adequate diet or to assist in resident eating. To protect yourself, revisit your routine blood testing policy. Make sure that every resident is tested upon admission and as needed thereafter, and that all lab results are scrutinized, acted upon and carefully documented. Remember, too, that thoroughly documenting dietary and assistance needs on resident care plans can improve your defense against allegations of malnutrition.

can lead to pain while chewing and an over-reliance on liquid supplements to meet dietary needs.

Inform staff that residents with arthritic hands cannot brush or floss their teeth easily. In these cases, dental plaque and tartar can build up, increasing the risk of dental caries (i.e., decay) and periodontal disease. Therefore, it is essential to identify appropriate oral hygiene aids. Routine oral cavity checks by staff should also document loose fillings, crowns and other prostheses. Over time, decay can occur around fillings and crowns, which may cause the bite relationship to collapse. Dentures that do not fit properly can cause additional problems. If the resident wears ill-fitting dentures, they may cause mouth sores and pain, or preclude proper chewing. Typically, the resident refuses to wear them, and as a result prefers drinking to chewing, which invites nutritional deficits.

Staff should be initially trained to conduct oral assessments and routinely evaluated thereafter for proficiency. These simple risk-reduction interventions by your staff can make the difference in promoting optimal oral health among your resident population:

- Offer an *electric brush* to residents with painful arthritic hands.
- Recommend that *soft, sticky foods be consumed at mealtime*, not as a between-meal snack.
- *Clean debris from teeth* as soon as possible after mealtime.
- *Do not allow residents to eat without brushing* before retiring for the night.
- *Ensure that toothbrushes are in good condition* and appropriate for the resident.
- *Encourage residents who grind their teeth* to see their dentist for fabrication of occlusal bite guards.

The following additional interventions should be considered when coordinating professional dental services on behalf of your residents:

- *Change routine dental checks* from six-month intervals to every three months.
- *Consider using decay-fighting topical fluoride* as an adjunct to daily oral hygiene.
- *Document special oral hygiene needs* in resident care plans as recommended by a dentist.
- *Evaluate dentures at least once a year* and reline on a periodic basis.

Eating should be a source of pleasure, not pain, for everyone. But that is not always the case for LTC residents. Protecting your residents' well-being and your organization from a nutrition-related lawsuit requires vigilance on the part of caregivers, as well as the knowledge and skill to address the underlying medical and dental conditions that create eating problems. You can help reduce the risk that malnutrition poses to your residents and to your organization by maintaining adequate staffing levels, paying close attention to residents' oral health and monitoring dietary services. Most of all, it is essential to ensure that caregivers have the solid initial training and ongoing education they require to help residents meet their nutritional needs.



MALNUTRITION AND DEHYDRATION RESIDENT RISK ASSESSMENT TOOL

INDICATOR PREDISPOSING RESIDENT TO RISK	DATE INDICATOR PRESENT	INTERVENTION(S) (INCLUDE CARE PLAN ENTRY)	FOLLOW-UP ACTION AND DATE
Underlying Disease & Medication Effects			
Does resident have an underlying disease that can impede adequate nutrition, e.g., congestive heart failure, chronic lung disease, liver impairment or kidney disease?			
Are adverse drug effects such as nausea, vomiting, diarrhea, cognitive disturbances or sleepiness impeding adequate nutrition?			
Does resident suffer from food and drug interactions that decrease the ability of the body to absorb vitamins and minerals?			
Is resident clinically depressed, unusually sad or anxious?			
Has resident started taking any new medications?			
Does resident exhibit swallowing difficulties resulting from trauma to the head and neck, neuromuscular disorders, strokes, dementia and/or Parkinson's disease?			
Has resident recently lost teeth or have mouth sores, mouth pain or dentures that do not fit properly?			
Does resident have tremors, dementia or agitation that affects the ability to feed him/herself?			
Pre-existing Malnourishment			
Has resident informed you that he/she is losing weight?			
Are routine weight measurements on the decline?			
Do resident's clothes fit more loosely than usual?			
Are lips cracked or does mouth look pale?			
Has resident complained that dentures no longer fit?			
Has hair been thinning or growing sparse?			
Do wounds seem to take longer to heal?			
Does resident appear confused (unrelated to any known underlying disease)?			
Is skin breaking down or does it seem loose?			
Does skin look or feel drier than usual?			
Do resident's eyes look sunken?			
Oral & Dental Factors			
Does resident fail to have dental check-ups at 3-to-6 month intervals?			
Do arthritic hands interfere with careful cleaning of teeth?			
Does resident consume large amounts of soft, sticky or sugary foods?			
Does resident have gum recession and dentin exposure predisposing him/her to root decay?			
Does resident grind his/her teeth?			
Are fillings, caps and dental prostheses in poor condition?			
Does resident exhibit periodontal disease, i.e., are teeth mobile and spaced, and does breath have a foul odor?			
Are dentures loose and in need of relining or remaking?			

INDICATOR PREDISPOSING RESIDENT TO RISK	DATE INDICATOR PRESENT	INTERVENTION(S) (INCLUDE CARE PLAN ENTRY)	FOLLOW-UP ACTION AND DATE
Eating Patterns			
Has resident's family and/or healthcare surrogate been involved in the care planning and treatment process for nutrition and hydration needs?			
Has resident's family and/or healthcare surrogate been asked to help with eating?			
Does resident rely on others to feed him or her?			
Does resident eat only at a favored time of the day?			
Does it take an unusually long time for resident to eat?			
Is resident rushed through meals and unable to finish food or swallow without choking?			
Are special eating utensils helpful?			
Does resident seem to eat more when someone is there to assist?			
Does resident seem uninterested in food?			
Does resident verbalize dislike for the food in the facility?			
Can resident read the menu?			
Are alternative foods or beverages offered to resident when he/she does not like what is being served?			
Is resident on a special diet?			
Feeding Needs			
Does resident have complicated feeding needs, such as difficulty swallowing, recurrent lung aspiration, or tube or parenteral/IV feedings?			
Does resident require assistance (other than at mealtime) with snacks and drinks?			
Does facility provide feeding assistants (FAs) who have successfully completed a state-approved training program that is at least 8 hours long and that meets minimum curriculum criteria?			
Is an FA assignment based on the charge nurse's assessment and resident's latest assessment and care plan?			
Are feeding and assistance needs assessed regularly and FA assignments made frequently, based on changes in resident's condition?			
Does resident's FA work under the supervision of an RN or LPN?			
Environmental Factors			
Does facility have an adequate number of staff to assist residents who need help eating?			
Does resident's care plan include methods to stimulate the appetite, such as periods of exercise, exposure to fresh air, and sensory or mental stimulation?			
Has facility addressed malnutrition and feeding assistance through its staff education programs?			
Does resident's dietary plan include an over-reliance on liquid supplements?			
Are special diets prepared in an appealing fashion and is food served at the correct temperature?			
Does facility's dining room provide an attractive and calm setting?			
Does resident's dietary plan take into consideration cultural differences and include foods that the resident is accustomed to eating?			
Is resident properly positioned at meal time – i.e., able to reach food when sitting up and in an upright position when in bed?			



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