LNP 276
The Vulnerable Elderly in Nursing Homes
Donna Denert

Pat: Hi, this is Pat Iyer with Legal Nurse Podcast. Today we're going to be talking about long-term care and long-term care liability. You might be a long-term care expert witness like our guest Donna Denert or you might have a family member in long-term care. You might think in the future you might have a family member in long-term care. Or you might be helping attorneys as a legal nurse consultant with long-term care, nursing home, or assisted living cases.

I met Donna at the National Nurses in Business Association. She's been involved in healthcare since the age of 16. She's a third-generation nurse and she's worked in numerous nursing capacities, currently in long-term care for the last 17 years. She is a nurse consultant with the Middletown Connecticut Health Department and a board-certified legal nurse consultant. Donna is also interested and trained in clinical aroma therapy.

My favorite type of aroma therapy is baking chocolate cake, Donna. I have to say that's probably not the kind of aroma therapy that you think about.

Donna: It works, right.

Pat: Welcome to the show, Donna. I'm so glad that you could join us today.

Donna: Thank you very much Pat, for the opportunity.

Pat: Take us back to when you were 16-years-old. I'm assuming you were still in high school at that time. Did you get a job in a nursing home at that point?

Donna: I did. I started out in 1975. I was 16-years-old and we weren't certified back then, that came years later. The first day I showed up for the 3:00 to 11:00 shift and I hadn't even been oriented. The nurse in charge asked the CNA that I was working with, "Has Donna ever

performed postmortem care?" "No," so right off the bat I learned about postmortem care.

Back then, we were taught on the job. We were taught how to pass linens, how to feed, dressing people with strokes, transferring people from the bed to the toilet to the chairs. We had the old Hoyer lifts with the pump handle and the chains, and you had to be very careful not to get your fingers caught in the chains. We gave bed baths, which although were very time consuming were beneficial to the patients. They helped them with their sleep. They helped them with their pain issues. That's one thing that's actually not done anymore is the bed baths.

The fun part is that we didn't wear gloves. We had buckets to wash everything with bleach, the ringer and the scrub brush. That was quite interesting. We had people in their wheelchairs, but we had chest restraints to keep them upright in their wheelchair. We took the patients for walks, which is another dying art. People got fresh air and sunshine. Even the aides got to relax a little bit just by going out and spending time with a patient.

The term Alzheimer's wasn't known then. Back then it was called "Senility". The nursing homes were smaller. They were mostly privately owned. There were Victorian homes with beautiful porches where everybody could just sit out in the sun and everything. Basically, the nurse's aides were given a job and we did the jobs. It was a lot different then.

One thing I do want to mention is that years ago there was the stigma of the nursing homes. The nursing homes weren't exactly the nicest smelling places and if you were there in a nursing home, you were there for a long time and basically that was the nursing home way back when.

Pat: When you were talking about nursing homes being in Victorian mansion, my mind immediately went to "Victorian ranches were not ranch-style houses," so that meant there were stairs and people could fall down stairs.

Donna: Yes.

Pat: What did they do about that risk?

Donna: I'm not sure because the facilities that I worked with were one-story buildings and they were brick. By then they had the elevators if you wanted to go from one floor to another. The facility that I'm at right now does have a staircase, but the doors are locked. I have not seen any residents going down any staircases, so that's one big thing is that there are elevators and the residents don't really go up and down the stairs anymore.

Pat: That sounds like a good thing. Some of the things that you're describing brought me back to when I worked in a nursing home when I was in nursing school. I worked there for six weeks so I could save money to go on a trip to Colorado to see my best friend. I remember being given a list of each resident's preferences when each resident wanted to go to bed. One lady was really put out with me because she was 30 minutes late getting into bed because I was behind.

I would imagine that some of those things have not changed and yet today nursing home care is different than it was when you were 16 and when I was 19. What are some of the big changes that you have seen?

Donna: There's been a lot of changes. The facilities now are a lot busier. Instead of being called convalescent or nursing homes, you have to have health care, rehab, short-term care in their names. There are a lot of needs. There's physical, emotional, mental and behavior needs. The population is younger. We have many patients coming in who are in their 50s for short-term rehab. There's a lot of input from the administration. We have the social workers. We have the x-ray and lab people coming in. For example, what used to be if someone had a fall they used to be sent out and now the x-ray people come in, so that's a good change. We get the x-rays done right then and there.

Instead of the nurse and the doctor making the decisions, we have the APRNs calling in or helping us with the decisions. Years ago, if we were to call for an order, we would get the on-call doctor to be very quick. Now when you make an order if you want to get the doctor's input on something, we have to go through a much larger exchange with many more people involved. You may not even know who the APRN is who's going to be giving you the order, so that's one thing.

Another thing is that a lot of things are computer generated. Some people love computers, but in my capacity, I go to many different facilities. I have to know the particular computer system. I have to know the facility password and then I have to know my own password. Sometimes the computers for third shift are shutdown between 2:30 to 5:00 in the morning for example. Patient needs and nursing documentation does not shutdown, so that was the big dent in my time where I had to stay late just to put in all the information that I needed much earlier.

That's another change is the computer. Some people love them and I'm getting used to them, let's put it that way.

Pat: I know that computerized medical records have certainly changed documentation with a strong focus on trying to become more efficient, to be able to share information more effectively. Nursing homes can be owned by county facilities, by private organizations and by public organizations. In the nursing home world, the non-profit direction is strong, but the for-profit ownership is also a big component.

When we talk about for-profit nursing homes, we're talking about owners who want to make a profit (that's their goal) on the care that's being delivered to residents. Sometimes that profit is modest and sometimes that profit is very big. Plaintiff attorneys in particular focus on the for-profit chains that have a very strong temptation to reduce services, nutrition or staff to the residents in order to be able to make more money.

From your perspective as a long-term care nurse, what do you see about the care being delivered in for-profit facilities versus not-for-profit? Is there a difference?

Donna: A big difference. Years ago, we used to know the owners. The owners would come in and they would know the patients. Now we have the large corporations who might be four states away. The owners of the facilities might come in if there's a problem. For example, one time I came in 3:00 to 11:00 and it's like what's going on? "The owners from Philadelphia flew in because of an incident that happened."

The ownership of a facility can greatly impact patient care and we don't want to think that everybody wants to make a profit, but those

profits should not be taken out of direct patient care, for example in staffing. Staffing is a big issue. They will come in if there's a problem, but do they know the residents, do they know the needs of the facility?

No, they see the bottom dollar and they don't come in and associate with the staff. They don't know the residents. They may not know the day-to-day operations, and this is one of the biggest things about the facilities being owned by big corporations. They don't know the day-to-day needs of the facility. Also, whereas years ago the facilities used to be smaller and were like maybe 50- to 100-bed, now these places are getting pretty big where they are at least 150-bed facilities. That also has a change to it.

Pat: I remember working on a case involving an owner's daughter. This was a man who tended to grab food off the trays of other residents. He was in an unsupervised dining area. There were supposed to be staff present, but the aides were off at lunch and there was nobody in the room. He grabbed a piece of deli ham off of somebody else's tray, put it in his throat and he choked on it.

Donna: Not uncommon.

Pat: Yes, and he fell to the floor. The staff did obstructed airway maneuvers on him and called in the rescue squad. The rescue squad had a device, forceps, went into his throat and grabbed this piece of deli ham and pulled it out. They sent him off to the hospital with a piece of deli ham in a plastic bag on the stretcher where the ER staff completely ignored the deli ham and threw it out, which became a piece of evidence in the case.

What was remarkable was that he did end up dying from his anoxic brain damage as a result of having this meat in his throat, but the owner tried very hard to convince all the investigators that that wasn't a piece of deli ham, it was a piece of curdled strawberry Ensure. It made no sense that you could be able to grab Ensure with forceps and remove Ensure from a throat. She was not a healthcare provider. She was the daughter of the owner and got adamant that this is not what the EMTs and paramedics documented it was, it was actually something entirely different that was innocent in comparison to the fact that this man was unsupervised.

The case ended up settling. I was an expert witness on it. I remember vividly that my deposition started at 9:00 in the morning and ended at 7:00 at night. It was the worst and longest deposition that I had ever gone through, and it was a relatively simple case. It was a piece of meat stuck in this guy's throat that shouldn't have been accessible to him.

That's an example of like a private family getting involved in an investigation, offering theories or opinions which had no medical basis for but were rooted in wanting to repaint the picture of what happened.

Donna: Unfortunately, residents choking is not unheard of. I know of four instances when there's been choking. A visitor comes in and gives someone a piece of candy or a piece of dessert not knowing what diet this person is on. Unfortunately, that was one of the incidents that happened. The staff was in the area, but they did not see this visitor come in and give the patient a piece of cake or something that the patient did end up choking on and didn't make it.

Before I continue, I need to share details of online training that directly addresses the setting of this case.

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Let's return to the show.

Pat: Tell us about who staffs nursing homes. Do we have RNs on the floor? Do we have LPNs? Do we have RNs in the building? How does that all work?

Donna: The nurses in general, many are getting older. They're my age and they're looking forward to retiring. We have LPNs who are charge nurses and they're absolutely wonderful. We have the Director of Nurses who are RNs and then we have the CNAs. The whole thing is that we need to make sure that we have enough adequate staffing on the floors for safety reasons and this is one of the biggest things just to make sure that everybody is safe. When you cut costs and you want to cut staff and you don't want to replace someone who is called out, that is one of the biggest things that's going on.

We then also have new graduates who might have a BSN, but they don't have the floor training. This is not to say that there aren't good schools, but for my experience the hospital experiences are getting short changed. I had in home care two nurses and they were going to be graduating in two weeks. Neither one of them had done any wound care. In home care you need to have the basic skills because you're going to be making calls. They have never seen an infection, so I was surprised when they said that their experience with two weeks to go before graduation had not been taught any wound care.

The practical things to be able to hire the nurses is what do they need to carry out their nursing duties. Also, the physicians are not always present. In the long-term care facility, the doctor may come in once a week to sign orders. He may come in once a week to check on the residents and so we don't have the doctors on the floor like they do in a hospital. Nurses need to be extra careful about doing their assessments to keep everybody safe and to really tell the doctor what is going on with a patient.

The other thing is that the nursing home workload is very tiring. We have patients who come in and they're overweight. They may be bariatric patients, so the nurses need to know it's not a walk in the park when you have long-term care. There's safety and there are people who need to be repositioned. The older nurses are retiring in general. We need to mention the new nurses coming in because years ago they used to work in the hospitals before they went to long-term care and now, they don't have that experience. The long-term care setting might be their first job as a nurse.

Pat: Let's go back to the piece about the obese patients and the staffing because one of the things that comes up in long-term care is the need to prevent pressure sores. You know the old rule of repositioning and turning patients every two hours, and I'm thinking about obese elderly people and the level of staffing in nursing homes. Tell me, is that happening? Are there any solutions to reducing pressure sores in obese people in long-term care?

Donna: Yes. When we accept bariatric patients, do we have the equipment to take care of them? Do we have the extra-large bed?

Sometimes if the patient lands on the floor, for example, and they're obese, we've had to call the fire department to come lift the patient up. Now we have the special beds. We have special mattresses, but we still need the staffing to reposition because even though they're on a special mattress the linens get sweaty because of all the heavy duty sweat of the obese patient. We do need to change them. We do need to reposition them. We need to have them help themselves to help the staff to change their position.

Even if it's not an obese patient, we have the patients who are cognitively impaired who can't reposition themselves, so no matter what if it's bariatric or if it's a little old lady, if it's a hospice patient, repositioning is one of the major things that we need to think about. The staff needs to know why they need to reposition because the aide says, "Well, you know I repositioned them two hours ago". It may be three hours. We need to be diligent about repositioning patients if they're bariatric or if they're cognitively impaired. This is one issue that we need to take care of.

Pat: I know that a lot of that depends upon staffing, that the people who are giving the hands-on care are people who have gone through a course, a CNA course. Some of the issues that I think that we run into in long-term care is the level of education of level preparation for the hands-on staff.

What is it like to try to staff a facility with people who have gone through a course who may have transportation issues, who have to live near a bus line who may not speak English as their primary language? I would imagine that poses challenges and I wondered what challenges you see that are related to the quality of care with people who are in that CNA level.

Donna: That's a very good question because if I can't understand as a nurse what my CNA is trying to talk about that's one issue and I have to keep saying, "Can you repeat that again?" Then if you are a patient and your needs are not being met that's another issue. If you're in a hurry and you need to find out the information right now and you can't understand them, or the patient is getting agitated because they can't understand, that's two strikes against the language. When you're cognitively impaired, that might cause a lot of aggravation or aggression in a patient.

It's the language and then we have the child care issues where the transportation like you said is an issue. The taxi may not come. They rely on their rides. They rely on babysitters, "I can't come in because my babysitter." The staffing issues are definitely there.

Pat: I know that CMS just announced recently that they plan to do more surveys on weekends and off shifts because of concerns about the quality of care being delivered at times that are not Monday through Friday, 9:00 to 5:00. Do you see facilities that are reducing their staffing on the weekend and not affecting quality of care?

Donna: Yes, because of course everybody wants to have the weekend off and when we have callouts the callouts impact everybody. It causes everybody to do more work with less staff. For example, the facility needs to make sure that they hire enough people to staff the whole building plus more. Some of the callouts that I've had, I may get an hour's worth of callout time. Now they have automated computers where you dial in a button and the call goes out to everybody, "Can

you come in," but you may not get a response for a number of hours so you still don't know if you're going to have enough coverage for the shift. What happens is if you have a nurse, a RN, who is the supervisor, she's done her floor, and then the 7:00 to 3:00 staff might call out, the supervisor might have to cover a whole other shift after doing her whole floor and everything.

With the staffing, the facilities also want to cut down on overtime. Okay, overtime can be expensive, but the thing is that when you have to do more with less staffing it just makes it harder on everybody. Management needs to think, "What happened to keep this nurse overtime, what happened during the shift?" Calls, falls and other issues have happened prior to the hour change of shift.

One thing that has to be done to keep a nurse overtime is charting. That's another issue. Okay, you don't want to pay overtime, but if the work happens, for example, at a quarter to the hour we have had low blood sugars at the last hour and this is a real case example. We have had a blood sugar of 58. We have a hospice patient who is dying at that time. We have an IV patient whose alarm is going off. We have had a recent fall at the same time. All of these issues happen, and it was in the last hour of work that its happened. Well then, we need to stay late, and it may be another two hours.

Those are the kinds of things that impact the staffing. We also have the increasing patient care issues, so not only do we have regular needs, but we also have increasing complexity of the care that all impact the safety of the patient. We then have the unrealistic workload. This is where I was talking earlier about one trend is if there's a callout for 7:00 to 3:00.

You have the RN supervisor. If the 7:00 to 3:00 regular nurse calls out and they can't find coverage, the nursing supervisor has had to take over a floor in addition to doing her regular supervisory duties. This isn't a good idea because the floor nurses have a very complex workload. For example, we have to do a very long med pass. We have to handle the phone calls that come in. We have to handle the safety issues. To have a nursing supervisor, any shift, take over a floor in addition to handling her supervisory role, it doesn't really work that well for patient safety. The supervisor does many things, helping out the whole facility. For example, when I was a supervisor for larger

facilities, there were four floors that I was in charge of. When I had to take care of a floor, who's watching the house, who's helping the other floors take care of what their needs were?

In essence if the supervisor is taking care of a floor, she's not being able to take care of her issues for the rest of the house including doctors' phone calls. Now one thing that I like to do is to empower the floor nurses to take care of their own floors and then if there are issues have the supervisor help out, not the supervisor taking care of all the floors. We're there to assist, to make sure that everyone is safe, and everything is done, not to do everybody's work. I like to encourage the floor nurses to do their own work and then call the supervisor to make sure that everything is done correctly.

Pat: I think you have given us some great insight Donna into the complexities of long-term care. How can our listeners find out more about you?

Donna: I'm on a LinkedIn page and I also am on a website www.forthehealthofitCT.com. My telephone number is (860) 801-3840 and I also have the website www.forthehealthofitCT.com.

Pat: Okay, so that website address is www.forthehealthofitCT.com. Is that correct?

Donna: Yes.

Pat: We've been talking with Donna Denert. Donna provides expert witness services in long-term care and is available to consult with legal nurse consultants and attorneys. Donna, thank you so much. I know that we could have gone into much greater depth in the short period of time that we had to talk together today. You have brought up some really good points to help us think about the atmosphere, the environment in long-term care where many vulnerable patients are receiving care. Thank you for being on the show.

Donna: Thank you.

Pat: You're welcome.

Donna: Okay thanks Pat.

Pat: This has been Donna Denert and Pat Iyer with Legal Nurse Podcast bringing you our weekly show with interviews to help increase your knowledge, give you different perspectives and fresh insights about legal nurse consulting. We will be back next week with another show.

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