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David R. Hoffman (dhoffman@dhoffmanassoc.com) is President at David Hoffman & Associates in Philadelphia, PA.

Ilene Warner-Maron (aldengeriatrics@gmail.com) is an Assistant Professor in the Department of Geriatrics and Palliative Medicine at the Philadelphia College of Osteopathic Medicine.

Utilizing the MDS as a resident's rights and risk-reduction strategy in long-term care

By David Hoffman, JD FCPP; and Ilene Warner-Maron, PhD RN NHA FCPP

The frailty syndrome is an emerging concept for providers who care for individuals with significant comorbidities, advanced age, or a decline in functional or cognitive status; the more typical resident receives services in a long-term care facility. In general, frailty is a concept that residents or their families do not understand well. The sequelae of frailty are often underrecognized and minimally addressed by the interdisciplinary team, including the attending physician and physician extenders.

The Minimum Data Set (MDS) can be an effective tool in identifying residents with physical and cognitive decline related to frailty, sarcopenia, and failure to thrive.[1] Residents and family members often have minimal understanding of the effects of these conditions on weight loss, falls, the development of pressure injuries, and related issues that have become the major foci of regulators and malpractice litigation.

An effective ethics and compliance program seeks to integrate clinical outcomes with regulatory compliance. Importantly, setting expectations for a resident's care goals, and what can or cannot be addressed by nursing care, assists in compliance with the mandated nursing home informed consent provisions. The chief ethics and compliance officer should work collaboratively with leaders in clinical operations to improve the understanding of clinical decline by families of residents most impacted by these diagnoses and syndromes. This collaboration should include identification of communication strategies for meaningful, documented care plan conferences, during which the resident and responsible party are apprised of the implications of frailty.

Case study

Shirley was an 88-year-old woman with diabetes, hypertension, hyperlipidemia, hypothyroidism, osteoarthritis, osteoporosis, and dementia who fell at home and fractured her left hip. Due to her advanced age, the orthopedic fixation of her fracture was deferred, and she was discharged to the community with home health services. Her daughter sought a second opinion from a tertiary care hospital's orthopedic department, which agreed to perform an internal fixation of the left trochanteric fracture. Postoperative, Shirley was transferred to the intensive care unit, transfused, and given medication (pressor agents) to support her blood pressure. During her hospitalization, she developed several minor pressure injuries, which were present upon her discharge to a skilled nursing facility. While in the nursing home, Shirley lost 10% of her weight due to an average oral intake of 25%–50%. The speech therapist noted Shirley had little energy for chewing, even demonstrating difficulty

sucking up fluids with a straw; this condition had progressed when she lived in the community. Her attending physician repeatedly observed in progress notes that Shirley's prognosis was "guarded;" however, there was no documentation of any discussions about the likelihood of decline with the resident or her family. Shirley died six weeks after her admission to the skilled nursing facility. Her family filed suit six months after the death, alleging neglect stemming from the facility's failure to prevent weight loss and the deterioration of her wounds, which became larger and necrotic.

Frailty

Frailty is a condition characterized as increased vulnerability to the adverse outcomes of geriatric syndromes such as falls, disability, delirium, pneumonia, urinary tract infections, COVID-19, and the failure to return to baseline following a stressful physical or psychological event.[2] Residents may also experience weight loss greater than 8–11 pounds or more than 5% in one year (see FRAIL-NH Scale). An observed decrease in activity and generalized weakness evidenced by low grip strength are commonly seen in older adults with frailty syndrome. In turn, frailty leads to delirium, weight loss, falls, recurrent hospitalizations, malnutrition, fractures, polypharmacy, and increased healthcare costs. These issues contribute to the risk of institutionalization. Still, despite the myriad medical, nursing, and psychosocial issues, residents and families have little understanding of these conditions or the limitations of medicine in ameliorating frailty-related impairments. (*See FRAIL-NH Scoring on page X)*

Many risk factors identified in the case study, including advanced age, cognitive impairment, and medical comorbidities, are common in nursing home residents. Additionally, polypharmacy, the lack of regular activity, poverty, undernutrition, and isolation contribute to the frailty cycle in which malnutrition and weight loss lead to sarcopenia, i.e., the loss of muscle strength and mass further contributing to the individual experiencing falls, fractures, and head injuries causing disability and death. Sarcopenia causes decreased strength leading to falls, disability, and reduced activity before the cycle begins again.