Taking The Guess Work Out Of Change Of Condition In Nursing Home Residents

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Disclosure

I have no relevant financial relationships to disclose.

Objectives

Participants will be better able to:

- Manage nursing facility phone calls through focused "change of condition" evaluations
- Review methods of improving physician communication skills in transitions of care
- Discuss the differential diagnosis of common condition changes in frail geriatric patients
- Describe how to reduce avoidable transitions to acute care facilities and manage condition changes within the nursing facility
- Identify the appropriate time frames and means of follow-up after nursing home treatment for acute changes in condition

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Background

- Nursing home practitioners get A LOT of notifications of acute changes in condition
  - Faxes
  - Telephone calls
  - Pages
  - Texts
  - Emails
- Job satisfaction diminishes with frequent middle of the night nursing home phone calls
- Phone calls can be time consuming if not approached in a methodical manner

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Telephone Medicine Can Be Challenging

- We are trained to see people "face to face".
- How to "trust" the information we get over the phone?
- Aging of America and little to no geriatric training of practitioners
- How many phone calls? How to balance the need to "follow-up" with the rest of our lives…why aren't the nights and weekends family time?
- You need a system…

Factors Contributing to the Hospitalization of LTC Residents

- Lack of continuity care
- Infrequent LTC visits
- Increased complexity of patients
- Heterogeneity of in house capabilities to manage acute change of conditions
- Nursing staff capabilities (RN presence in facilities is limited)
- When in doubt – "Transfer to the ER" Right?

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Make a System

- What patients are you covering for?
  - Just your own?
  - Other physicians you work with on a daily basis?
  - Part of a large call group?
- What type of "sign-out" do you get?
  - The procedures you had as a resident may still work in the nursing home
  - Calls that you know are coming are less time consuming and easier to give the RIGHT answer the FIRST time
- Which facilities are you covering?

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Barriers to a System

- Off-site physician lacks physical access to the patient and their chart
  - Compounding the physician's unfamiliarity with the patient's clinical history[5]
- Information provided by the on-site nurse strongly influences physician orders for patient treatment
- Frequently patient information is conveyed by telephone – up to 50 phone calls per patient per year.

Here Comes The Call

- Which LTC facility is calling?
- Who (RN, CNA, family request) *initiated* the call?
- What is the patient's goals of care?
  - More than just code status
- Is family aware of the call?

Need to Know-
What Can the Facility Offer

- Long term care facility services vary
  - Does the facility have the ability to do diagnostic testing? (stat labs, mobile x-ray, etc.)
  - Does the facility have APRN (Advanced Practice Registered Nurse) Services? How often?
  - Does the facility have nursing interventions available? (IV services, hypodermoclysis, O_2 management, nebulizer treatments, 1:1 sitters, etc.)
  - What medications are available (i.e. E-box) while you wait for medication to be delivered from pharmacy?

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Case #1

- Nursing calls physician to notify of acute change of condition
  - 89 y/o female complaining of abdominal pain x 24 hours
  - One episode N/V
  - Admitted 10 days ago to skilled nursing for rehabilitation s/p hip fracture & repair

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Case #1

- Physical data to receive
  - Vital signs
  - Abdominal evaluation including tenderness, pain, bulging, distension upon palpation, and bowel sounds upon auscultation
  - Digital rectal evaluation, including any tenderness, mass, or hard stool
  - Vomiting - contents, quantity, and (if presence of blood) hemoccult
  - Type of pain (dull, sharp, stabbing, burning, and rating of pain on scale (including whether pain is consistent or intermittent)
  - Alleviating factors or aggravating factors

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Case #1

- Medical history to receive
  - Onset, duration, frequency, and severity of symptoms
  - History of related gastrointestinal conditions (prior surgery, history of peptic ulcers, diverticulitis, etc.)
  - Approximate frequency of bowel movements, last bowel movement and any associated problems

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Case #1

- Medical history to receive
  - Current medications, including any recent changes
  - Recent food and fluid intake patterns, including any recent changes (Ability to tolerate PO)
  - Current diet (regular, restricted, etc.)
  - All current diagnoses
  - Any recent lab or diagnostic test results

Case #1

- Drill it down
  - Any viral infection in facility?
  - And change in mental status (lethargic)?
  - Any fever?
  - If on a SNF Med A stay, why? (e.g. post-op recovery)
  - Recent bowel history
  - Bowel sounds
  - Abdominal tenderness to palpation
  - Describe location and type of pain, radiation
  - LABS on file: CBC, CMP, UA, C&S
  - Evaluate hydration status

Case #1 – General Diagnoses to Consider

- Constipation (#1)
- UTI (#2)
- GERD (#3)
- Abdominal wall hernia
- Appendicitis
- Ascites
- Infectious diverticulitis
- Obstruction / ileus
- Pancreatitis / Gall stones /Peptic ulcer disease
- Renal stones
- Scrotal pain – consider prostatitis / strangulated hernia

*Geriatric caveat – frail seniors exhibit vomiting and lethargy as a sign and symptom of pneumonia

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Now what to do?

- A: To the ER
- B: Stay in the Nursing Home

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Case #1 – Can They Stay or Do They Go?

- **Keep in facility if**: non-emergent and facility can meet patient needs
- **Transfer to ER if**: hemodynamically unstable (tachycardia, tachypnea), ileus, abdominal exam shows signs and symptoms of peritonitis (guarding, rigidity, rebound tenderness), fever with vomiting, change in mental status (lethargic), vomiting not relieved with antiemetics, tarry black stools, hypotensive (systolic blood pressure less than 90), concerned with obstruction, positive X-ray for obstruction
  - And consistent with patient's goals of care (i.e. patient does not have a "do not transfer" order)

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Case #1 – Can They Stay or Do They Go?

- Is there something the hospital/ER can do for the patient that cannot be done at the nursing home?
- Initial treatment of constipation
- Follow-up by nursing staff in 6-8 hours
- How long would it take to get an x-ray to determine obstruction / other pathology?
- IV fluid vs. hypodermoclysis administration
- IV vs. oral nausea medications

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Case #1 – If Staying, What Do I Do?

- Constipation
  - rectal treatment (enema, suppository, etc.)
  - oral treatment (magnesium hydroxide suspension, senna, sorbitol, prune juice, polyethylene glycol laxative, etc)
- Symptomatic treatment of emesis
- Consider bowel rest and antiemetics if needed
- Avoid pain medications if possible — may mask pain
- Treat dehydration
  - encourage oral hydration (i.e. order 1-2 liters in 24 hrs)
  - IV fluids vs. hypodermoclysis administration
- Judicious use of antibiotics

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Case #1 – Follow-Up

- **Within first 24 hours:**
  - If the patient's X-ray shows fecal impaction, make sure that patient has bowel movement. Check on patient's hydration status, X-ray and labs. Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives. Antibiotics if indicated.
- **Next business day:**
  - Check the labs, manage pain, manage symptoms, and look for worsening or improvement of symptoms. Make next treatment/management decisions based on this information.
- **Next scheduled visit:**
  - Follow up and make decisions on whether or not to continue any medications started for this recent problem, especially for peptic ulcer.

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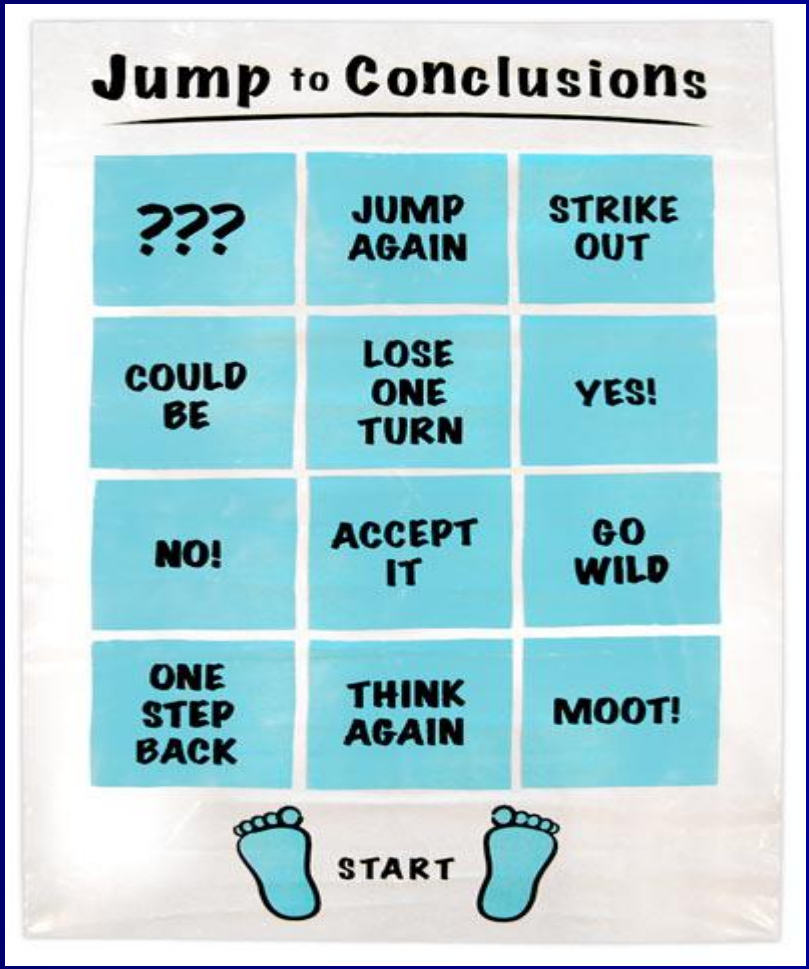
Ask the Questions…
Don't Jump to Conclusions



Case #2

- Nursing calls physician to notify of acute change of condition
  - 78 y/o female is more lethargic than normal
  - Not eating well for past 2 days
  - No complaints other than feeling weak…
  - Vitals: BP 89/44 HR: 115 RR: 18 Pulse ox 88%
  - She is legally blind and hard of hearing unless shouted into her right ear

Now What Do I Do?

- Nurse reports patient's families goals of care are for DNR/DNI but transfer to hospital for any acute change in condition
- To the ER…..
- What communication does the ER need?

ER Communication

- The patient has a history of being combative if she is touched by staff she does not know and if she does not know what they are doing
- Communication to EMS: patient tolerant of IV placement
- Communication to ER staff: May prevent patient being chemically / physically restrained from agitation that is actually vision / hearing impairment

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Case #3

- Nursing calls physician to notify of acute change of condition
  - The evening LPN calls the on-call physician and states, "Mrs. J is very confused and yelling out. We contacted the nursing supervisor and she wants patient sent to hospital for evaluation."
  - 85 y/o female with history of recurrent UTI is yelling out loudly and refusing cares (i.e. dressing, toileting).

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Case #3- How Do you Respond?

- What is the situation?
  - When did the problem start, what makes it worse or better, did the nurse try interventions?
- Ask for the following:
  - Vitals, pain evaluation, hydration status, GI changes like nausea, vomiting, diarrhea, constipation, distension, reduced urinary output; signs of motor weakness, facial weakness, lethargy, or significant change in function; signs or symptoms of acute infection (fever, chills, changes in urinary pattern, etc.); signs of injury; full description of behavior compared to usual behavior; all current medications, including any recent changes; any history of acute or chronic psychiatric disorders; advance directives; recent labs.
  - What else?

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Case #3- Drill it Down

- Past Medication history
- Is she here for skilled nursing rehabilitation;
  - if so, why? (i.e. suspect delirium if patient s/p recent surgery or hospitalization)
- Check finger stick glucose, if diabetic

Case #3- Drill it Down

- Any new focal neurological findings?
  - unilateral weakness-suspect CVA
- Any change in MS?
  - lethargic-suspect infection or electrolyte imbalance
- Any signs or symptoms of infection?
- LABS: CBC, BMP, UA

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Case #3- How Do you Respond?

A: To the ER – no further work-up/evaluation in the SNF

B: Call and talk to the family – see what they want to do?

C: Further work-up evaluation in the nursing home

D: Tell the nurses she will fall asleep eventually and to ignore her

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Case #3-
How Do you Respond?

Next…consider
the possible differential diagnosis
in your mind…

Case #3 – Diagnoses to Consider

- Advancing dementia
- Arrhythmias
- CHF
- Constipation / urinary retention
- CVA
- Delirium (lethargy, change in MS)
- Dehydration / electrolyte imbalance
- Hypoglycemia (if diabetic)
- Hypotension
- Hypoxia
- Infection (UTI, pneumonia, sepsis)
- Medication S/E
- Medication changes, recent
- Pain (especially in persons with dementia)
- Sleep loss, change in environment / sensory deprivation or overload
- Sundowning (persons with dementia)

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Case #3- Do they Stay or do they Go?

- **Keep in facility if**:
  - Dehydration / fluid electrolyte imbalance and can be managed in LTC facility
  - Infections
  - Pain
  - Medication side effect
  - All non-emergent conditions/situations
- **Transfer to ER if**:
  - patient is unresponsive
  - New focal neurologic finding

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Case #3 – Does she have to Go?

- What would the ER do?
  - IV fluids
  - Lab tests (CBC, CMP, UA, Urine Culture)
  - Chest X-ray
  - Face-to-face physical examination
- How fast can the nursing home do the same?
- Risk of transfer – HIGH risk of delirium, worsening dementia, de-conditioning due to hospitalization
- Risk of not transferring – patient's family requests aggressive intervention that cannot be done timely in the nursing home (or cannot be done at all) and patient has an adverse outcome.

Case #3 – Follow-Up

- She stays at LTC facility
- LTC facility has labs, x-ray and IV fluids available within 6 hours
- On-call physician instructs LTC staff to call physician with update in 12-24 hours
- On-call physician wonders… if the time to obtain tests results at nursing home, the patient could have be evaluated in ER and sent back…

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Transfer When Medically Appropriate not When it is the EASY Thing to Do

Case #4- Abnormal Labs

- Nursing calls physician to notify of acute change of condition
  - Nurse notifies you of several abnormal laboratory results and inquires about any new orders
- Things that should come to your mind:
  - Why are you being called about this test?
  - What prompted the ordering of the test?
  - How is the patient now?
  - What has changed or is different from baseline?

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Case #4- Elevated drug Levels

- Antibiotics
  - vancomycin
- Carbamazepine
- Digoxin
- Lithium
- Phenobarbital
- Phenytoin
- Potassium
- Theophylline
- Valproic Acid
- Warfarin (INR)

What do I ask for? What do I need the facility to do?

- Current medication administration list
  - Medication dose changes
  - Recent medication discontinuation/addition
  - Review 'PRN medication' as well
  - Ask about OTC/herbal medications
- Current patient status
  - Associated symptoms (i.e. elevated INR requires evaluation of signs of bleeding)
  - Recent change of condition

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What Do I Do?

- Evaluate for potential drug-drug and drug-disease interactions
- Confirm medication dose appropriate for renal and hepatic insufficiency
- Determine frequency of follow-up laboratory tests
- Elevated INR – hold warfarin; consider oral vitamin K (5-10 mg once)

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What Do I Do?

- **Keep in Facility**:
  - For mild elevated drug level. Nursing facility staff monitors vitals and mental status
- **Send to ER:**
  - If presented with acute toxicity (loss of consciousness, arrhythmias, bleeding, toxic levels or respiratory distress)

When do I follow up?

- Depends. Consider if any symptoms and frequency of follow-up laboratory tests

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Case #5

- Nursing calls physician to notify of acute change of condition
  - 72 y/o male fell while transferring from toilet to wheelchair. Patient refuses to stand up to assess weight bearing
  - Patient at skilled nursing for rehabilitation s/p CVA with hemiparesis
  - Nurse requests physician order to transfer patient to ER. Family is present and demanding trip to ER to evaluate for fracture. Family has never met you-the physician

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Case #5

- Nurse assessment/evaluation:
  - Patient does not complain of pain with passive motion of any joints while in bed
  - Has some bruising over right hip
  - No external rotation
  - Full ROM
  - Patient able to accurately describe painful stimuli
- Determine LTC Facility mobile X-ray availability
  - In few hours? In 24 hours? Next business day?

Does patient go to ER at family request?

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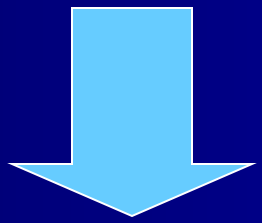
Case #5 – Does He Stay or Does He Go?

- A: To the ER
- B: Stays in the facility

Case #5 – Medical/Legal Issues

Medical appropriateness vs. family wishes



Medical futility vs. potential medical liability for going against family wishes

Family Communication Skills

- Importance of family communication skills
- "Top 3 goals of Care"
  - duration of life, quality of life, pain, sleep, mobility, independence, ability to eat
- Phone communication is more likely to be successful if the family has previously met you in person
- Communicate at regular intervals to provide updates. Not just when it's bad news

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Communication Documentation

- LTC Physicians do a lot of talking
  - Communication with ER physicians
  - Communication with families
  - Communication at end of call coverage to other physicians
- Do we write what we said?
  - Progress notes at home & fax to facility
  - Electronic options

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Why not ALWAYS Send the Patient to the ER?

- Myths:
  - "I'll stay out of court if I always send the patient out."
  - "The patient will get all the diagnostic testing they need in the ER."
  - "The ER doctor can communicate everything to the family."
- Reality: Communication and documentation will keep you out of court more than frequent trips to the ER

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The ER is Not Always the EASY Way Out

- If at all possible, avoid the transition!
  - Frail seniors have poor outcomes associated with hospital transfers including:
    - delirium, inadequate nutrition, serious infections, skin breakdown, adverse drug reactions…
  - Much more work on everyone's part when transferring when not necessary
  - Medication reconciliation on return to SNF

Follow-Up Communication Systems

- Keep and follow-up on your promises
  - the patient, family, or facility
- Communication with other medical practitioners
- The record should reflect resolution of the problem
- Remember – you get paid for 'medically necessary' visits. If you receive phone calls over the weekend about a patient, then, the face-to-face visit is medically necessary

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Summary

- Diagnosis and treatment over the telephone is a crucial skill for Nursing Home Physicians.
- An organized system for communication between nursing, families, other providers and outside facilities is important for appropriate decision making.
- It helps before taking the call, knowing what the facility can do and how fast they can do it.
- If a resident is staying in the facility to receive care for their acute change in condition, be specific as to the follow-up needed for all disciplines.

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