The Medical Director's Role: Neglect in Long-Term Care

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Elder mistreatment is a significant problem in nursing homes. Analysis of databases generated from annual state surveys and formal complaints showed that more than 30% of the nursing homes in the United States were cited for abuse violations that had potential for significant harm to residents.[1] Many frail elders are fearful of residing in facilities because of concerns involving mistreatment. Allegations of neglect constitute a significant portion of elder mistreatment. In general, neglect of a resident typically involves the failure to provide life essentials such as food, water, medication, comfort, safety, personal hygiene, clothing, and other necessities as required by the individual's physical condition.

The US Code of Federal Regulations establishes requirements for care of long-term care residents (42 CFR Part 483).[2] These requirements include the charge to maintain a resident's functional status and to prevent medical problems that are commonly present in cases of neglect. In the nursing home, poor care or care below accepted medical standards may result in signs and symptoms of neglect. Signs of neglect may include dehydration, malnutrition, pressure ulcerations, poor hygiene, and contractures.

For the year 2004, complaints of gross neglect reported to the National Ombudsman Reporting System (NORS), made up 0.9%, or 2056 of 227,721 complaints.[3] Twenty-nine percent, 65,075 of 227,721, of the complaints under the "resident care" category, included improper handling, delayed assistance, care planning, contractures, pressure sores, and unattended symptoms.[3] Some of these complaints could also qualify as neglect. Incidents of neglect are underreported, especially given the difficulties inherent in defining and recognizing this type of mistreatment.

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THE MEDICAL DIRECTOR'S ROLE

As a clinical leader who oversees the coordination of medical care, the medical director must understand the ramifications of elder neglect. First, nursing home residents experience increased morbidity and mortality. Families and staff undergo increasing concern and stress when a resident deteriorates. The health care providers and nursing facility may also be subject to legal recourse, both civilly and criminally. The medical director is an advocate for all parties, and is most effective when the focus is placed on the care of the patient. The medical director must be visible and available to patients, families, and staff for questions relating to patient care.

Title 42 (483.75) describes the function of the medical director in 2 major categories, the implementation of resident care policies, and the coordination of medical care. In the past, medical directors, in many cases, lacked authority within the facilities or over attending physicians to enforce policy.[4] Expert guidelines have been updated to clarify medical directors' roles and responsibilities.[5,6] Familiarity with investigative protocols that guide nursing home surveyors may be helpful in defining one's role with facility staff and administration, and assessing the extent of a medical director's accountability.

Addressing elder and dependent adult neglect includes prevention, reporting, and preparedness in response to allegations. Preventing neglect is the first priority. Certain facilities appear to be at higher risk for allegations of neglect. A recent elder abuse litigation study in California revealed that nursing home facilities with poorer records of care were subject to the most civil lawsuits. In fact, 10% of facilities were associated with 47% of the lawsuits.[7] Facilities with higher citation rates had more complaints of neglect and were subject to more lawsuits. Therefore, addressing factors that contribute to poor care may afford medical directors an opportunity to prevent future cases of neglect.

Also, awareness of recent civil proceedings may alert administrators to the potential liability that providers may face. For instance, in California, the passage of the Elder Abuse and Dependent Adult Civil Protection Act has formed the basis for recent civil proceedings[8] against a physician for neglect. There have been criminal prosecutions of facilities, staff, and physicians under the statutes of elder abuse laws.[9] Federal regulations also mandate that appropriate reporting procedures are followed for suspected cases of elder mistreatment. Many states now have criminal statutes relating to reporting.[6] Understanding proper reporting procedures can reduce the risk of government sanctions and criminal penalties for those working in nursing homes. In a recent landmark case, a licensed nursing home administrator was convicted for failing

to report dependent adult physical abuse by one of the facility's own staff.[10]

Medical directors have the opportunity to set standards for addressing allegations of neglect. Providing documentation that demonstrates an awareness of the resident's baseline functional deficits and medical conditions is critical. In addition, charting that reveals timely responses to change in conditions and the progress of a medical complication will afford the opportunity to show that, despite diligent care, a resident's condition was inevitable.

CASE

Mrs H was a petite 84-year-old female with advanced Parkinson's disease, and a history of a right cerebrovascular accident with a resultant mild left lower extremity weakness. She was moderately demented but retained the ability to carry on conversations and express her needs to caregivers. She moved to a skilled nursing facility 4 years ago after falling in the adjacent assisted living facility. After admission, she began to experience hallucinations that were very upsetting to her. Citing a medication effect, her physician discontinued the dopamine agonist that she was taking to control her tremors. The hallucinations ceased, but she began experiencing worsening tremors, affecting her ability to feed herself and to ambulate. She began using a wheelchair because of increased fall risk.

Two months later, she developed a stage II pressure ulcer on the sacrum. Wound treatment, including frequent repositioning, was ordered and the pressure ulcer resolved without complications. However, 6 months afterwards, a 5-cm stage IV decubitus ulcer, extending to the underlying bone, was discovered on the sacrum. Upon cleansing the wound with normal saline, the central area was discovered to be embedded with dry, crusted feces.

A review of the medical chart indicated that Mrs H had been bathed earlier that day. No mention of the ulcer was made in the nursing notes. The nurse supervisor was unaware of the ulcer. She reported that there had been a series of certified nursing assistant (CNA) changes for Mrs H over the previous month because of staffing issues. Experienced CNAs had left the facility for a new skilled nursing facility a few blocks away.

Aggressive wound treatment was ordered as well as serum laboratory studies. Several days later, Mrs H's condition worsened. Her temperature rose to 101.5°F. She experienced tachycardia, with an alteration of mental status. She was transferred to the hospital. Her blood cultures grew *Escherichia coli*, a bacteria seeded by the stool in the ulcer. Despite appropriate treatment, Mrs H became septic and died.

The hospital social worker reported an allegation of neglect to the ombudsman, who notified local law enforcement. Unfortunately, the investigation revealed no documentation of the recurrent pressure sore. There was documentation of a call to Dr N about a "diaper rash" 3 weeks prior. It was described only as a "red" area and a barrier cream was prescribed. He also advised a medical evaluation within 48 hours. The nurse supervisor was unaware of this order. There was no relevant documentation after this, and this coincided with staff changes affecting Mrs H. Because of the presence of an advanced pressure sore with crusted feces in the center, and the bacteremia, or spread of infection, which ultimately caused death, the allegation of gross neglect was confirmed.

DISCUSSION

How could the neglect that Mrs H experienced have been prevented? Care of patients includes the dynamic interaction between residents, staff, and providers. Analysis of this triad often reveals multifactorial causes. For instance, risk factors for abuse and neglect can often be identified in the residents or staff members of a long-term care facility. By identifying these risk factors, medical directors can target prevention strategies.

Patient characteristics that increase the risk of abuse and neglect include cognitive impairment, behavioral problems, and physical dependency.[11] Mrs H suffered from cognitive impairment and physical dependency. When Mrs H experienced a change in physical condition, she was less able to ambulate and feed herself, and thus was at higher risk for the development of pressure sores and malnutrition. In addition, she had been treated for a previous ulcer, and was clearly at risk for another ulcer. She could easily be identified as someone requiring increased monitoring for feeding, skin checks, and deconditioning. Routine screening for risk of skin breakdown is often performed using an assessment such as the Braden scale. Finally, she had no personal advocates, family, or friends, to monitor her welfare.

Staff risk factors for abuse include caregiver burden, inadequate training or knowledge base, inadequate staffing ratios, and criminal background.[11] Advocacy of adequate staffing ratios and education requirements at federal and state levels will improve the overall care. Nursing home residents, and especially subacute care residents, have increasingly complex medical problems, so ensuring that one's staff has adequate training is essential to improve both the comfort level and competence of staff.

A review of the staffing available to Mrs H revealed that the staff-to-patient ratio was higher due to attrition. When newer, inexperienced staff assumed the care of Mrs H, the progression of the "rash" was neither communicated nor documented. In addition, a staff member responsible for bathing a resident would reasonably be expected to notice a large ulcer with feces embedded centrally. In this case, Mrs H's caregivers either ignored the ulcer, or were unaware that it was a serious medical problem.

How can the medical director advocate for resident care in this example? Developing and implementing protocols to ensure that changes in medical and functional status are recognized early is vital. Anyone caring for a patient must be encouraged to report new findings and changes in behavior. Caregiving staff must know that there are potential life-threatening ramifications associated with medical signs and symptoms. Clearly, staff should not assume any diagnosis for a condition or finding. Their responsibility is to report it to appropriate personnel for documentation and action. A red area assumed to be a "diaper rash" might be a developing abscess or pressure ulcer. Or, a sudden change in mobility may

herald an undiagnosed hip fracture and lead to contractures and pressure ulcers. It may be difficult to distinguish signs from outcomes that are unavoidable because of the resident's level of debility and stage of disease process, but these questions need to be addressed by trained professionals.

Notifying physicians in a timely manner is critical to appropriate medical care. Failure to attend to new symptoms and to notify others of a change in condition was the ninth most common complaint in the NORS database, making up 2.27%, or over 5000 complaints.[3] In Mrs H's case, the lack of communication about a progressing ulcer prevented the resident from receiving appropriate medical care. Policies should also detail protocols to be followed in cases where attending physicians are unavailable. If the medical director is visible and available, the staff will be more comfortable in addressing these issues.

Proper documentation is critical to standards of patient care. Not only does documentation improve care, but appropriate documentation would inform an ombudsman or criminal investigator that appropriate care was delivered. It is through the documentation that the communication between the staff, resident, and medical providers is discerned. Agreement between interdisciplinary notes strengthens the necessary communication for appropriate care. In Mrs H's case, the lack of documentation was consistent with the lack of care. When wounds are present, photographs are invaluable in documenting healing or progression.

Staff members should be encouraged to report concerns of care to their supervisor and be invited to participate as a member of the interdisciplinary team to address these concerns. Medical directors can use monthly quality assurance (QA) meetings to review cases of residents with possible signs of neglect. Facilities should review incidence and frequency of weight variance, pressure sores, and falls in their monthly QA meetings. By doing so, neglect may be prevented by appropriate interventions. By additionally tracking the progress of residents with contractures, changes in ambulatory status, and decline in general condition, patterns may emerge that would lead to the recognition of neglect. Additionally, medical directors can prevent neglect by making themselves available for staff to consult on residents most at risk.[12] A medical director can often intervene by contacting a physician or consultant if necessary before neglect occurs.

Once an allegation of neglect has been made, the medical director should review the facility's policies. The director should make sure that mandated reporting procedures were followed, and cooperate with investigating agencies. Investigators should be made aware of policies in place to prevent care deficiencies. Was the director notified of a problem with a resident's care? If not, why not? The director should be aware of resident care problems. Communication procedures should be clearly stated and disseminated. Again, awareness of surveyor guidelines will educate the medical director about an investigator's perspective.[4] Ultimately, it should be clear from policies and procedures that resident care is the facility's priority.

SUMMARY

For the medical director, the primary focus in addressing neglect is prevention. In many cases, neglect results from a fragmented patient, staff, and health care provider triad. Positive steps toward maintaining communication may range from systemic solutions such as increased staffing, education of staff, and adherence to documentation. Adherence to standardized protocols will decrease the variability between nursing homes, improve care for residents, and decrease the incidence of neglect. Strong leadership from medical directors is vital, because those who care for the most vulnerable elders must maintain the highest levels of care and compassion on a daily basis. The ongoing challenge to provide quality medical and custodial care to long-term residents will force standards of care.

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