

Long Term Care Highlights



North Dakota Department of Health
Division of Health Facilities

October 2009



“DIRTY MOUTH? CLEAN IT UP . . .” POOR ORAL HYGIENE IN LONG TERM CARE

By Corrie Tivis, Health Facilities Surveyor

“An institutionalized man with severe mental disability and cerebral palsy, admitted from the Emergency Department (ED) with suspected aspiration pneumonia, died after a long struggle with respiratory difficulties. The cause of death was determined to be asphyxia resulting from a complete obstruction of the posterior pharynx and upper larynx by thickened oral and nasopharyngeal secretions. Although airway obstruction is common in people with motor or neurologic disorders and in those who are chronically debilitated or institutionalized, food and foreign matter are not the only culprits. This case serves to remind clinicians that a failure to provide good oral care and adequate hydration is not only poor practice but can result in death.”

Although the case mentioned above is rather extreme, it serves to prove a very serious point: oral care needs to be a priority in caring for vulnerable populations. In addition to suctioning, feeding tubes, confinement to bed, swallowing difficulty and feeding

dependency, inadequate oral care is one of the factors known to increase the risk of aspiration pneumonia in nursing home residents, not to mention contribute to a multitude of other health conditions, including in part: diabetes, stroke, hypertension, myocardial infarction, periodontal disease, cavities, halitosis and bleeding gums.

Providing oral hygiene is as much a part of basic nursing care as providing food, water, toileting and cleanliness, but sadly, residents often receive little of it. For example, in a 2006 study that examined the oral care given to nursing home residents, only 16 percent of residents received any oral care, with an average tooth brushing time per resident of only 16.2 seconds. Although this is inadequate, it pales in comparison to the fact that none of the nursing assistants wore clean gloves while performing oral care, and they often brushed or swabbed residents’ teeth immediately after cleaning the perineal area or changing soiled garments.



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Recommendations to address the problem of poor oral health in long term care facilities and give residents that “just brushed clean feeling” include:

- Training and education:
 - The provision of oral hygiene supplies
 - The provision of forms for daily documentation of oral care
 - Education on oral diseases
 - Instruction on oral assessment
 - Education on the importance of oral care
 - Hands-on training for delivery of oral care, particularly to care-resistant patients
 - The provision of sufficient staff and time to provide adequate oral cares
- Handling resistance to care when brushing teeth:
 - Tooth brushing is the gold standard of oral hygiene and advised for residents who are able to do so. Residents exhibit less resistance when caregivers encourage them to perform their own oral care.
 - Cognitively impaired older adults may be cued to remember tasks learned in early childhood. Placing a toothbrush in the dominant hand of the resident and providing nonverbal cues, such as pictures, modeling, and pantomiming, can be an effective strategy for overcoming resistance.
 - Using an egg timer and setting it for gradually longer intervals (30, 60, 90, and finally 120 seconds) may promote adequate brushing time.

- Independent brushers should be supervised and encouraged daily.
- *Modified or specially designed toothbrushes are recommended for use in special-needs populations:*
 - Soft bristles prevent oral injury and reduce discomfort,
 - A child’s brush is preferable for use in a small oral cavity or limited opening capacity.
 - Bending back the toothbrush handle approximately 45 degrees may improve access.
 - The Collis Curve toothbrush has curved bristles of differing lengths to clean all tooth surfaces simultaneously.
 - Spin brushes, electric toothbrushes and suction toothbrushes may benefit more debilitated residents.
 - A small (pea-size) amount of fluoride toothpaste is recommended for use in most residents. Toothpaste should be avoided with residents who have severe disabilities and are prone to choking and gagging. Instead, the toothbrush can be moistened with a minty mouthwash.



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• *Toothbrush Alternatives:*



- A foam stick (such as a Toothette) soaked in alcohol-free mouth rinse, can be used to swab the outer and inner surfaces of the teeth for at least two minutes.
- For dry mouth in severely debilitated residents, an atomizer or spray bottle can be used to mist the oral tissues with water or a water-based rinse; in addition, a moisturizing gel may be applied to the oral mucosa. A tongue blade wrapped with gauze and soaked in chlorhexidine can be used to remove excessive nasal or oral secretions.

Caregivers should communicate with residents when providing oral care. Smiling, praising and encouraging may help to promote cooperation with resistive residents. Talking, singing, playing music and providing a rummage box or busy board as distractions, also may decrease resistance. Positioning also is an important factor in providing oral cares. If possible, the resident should be sitting upright to prevent aspiration. Caregivers should not attempt to restrict the resident's movement because that may cause further agitation. Instead, the caregiver should go with the movement and provide frequent breaks. If the resident refuses to open the mouth, brushing the front of the teeth is far better than abandoning oral care altogether.

Because of strong evidence that improved oral hygiene decreases the incidence or progression of respiratory diseases, nursing staff in long

term care facilities should be diligent in making the completion of oral cares a priority in the provision of care for the residents they serve” “For a good clean feeling, no matter what”.

References:

Prahlow, J. A., Prahlow, T. J., Rakow, R. J., Prahlow, N. D. (2009). “Case Study: Asphyxia Caused By Inspissated Oral and Nasopharyngeal Secretions”. American Journal of Nursing, 109 (6): 38-42.

Stein, P. S., Henry, R. G. (2009). “Poor Oral Hygiene in Long Term Care”. American Journal of Nursing, 109 (6): 44-49

Dysphagia

By Bobbie Houn



Dysphagia, also known as a swallowing disorder, can cause food or drink to enter the airway. It is estimated that six million people have swallowing difficulties secondary to traumatic brain injury, stroke, cerebral palsy, infection, cancer, degenerative disorders and/or surgical procedures. The prevalence of dysphagia increases with age and poses particular problems in the elderly. Approximately 30 percent to 75 percent of residents in nursing homes have a diagnosis of dysphagia.

As a result of having a swallowing disorder, residents may:

- Have poor nutrition.
- Become dehydrated.
- Have weight loss.

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- Be at risk for aspiration which can lead to pneumonia.
- Have less enjoyment at mealtime.
- Be embarrassed in social situations.
- Isolate themselves.

After receiving a referral, the speech pathologist will assess and treat residents who are experiencing problems eating and/or drinking. The assessment often will include a clinical bedside and/or an instrumental evaluation such as a video-fluoroscopy or fiber-optic endoscopy. Studies have found these evaluations to be highly sensitive in diagnosing dysphagia.

When should a caregiver make a referral to the speech pathologist? What are the signs and symptoms of a swallowing disorder?

- Throat clearing
- Coughing or choking during or right after meals
- Wet or gurgly sounding voice during or right after meals
- Extra effort or extra time needed to chew and/or swallow
- Drooling; food or liquid leaking out the front of the mouth
- Pocketing; food in the mouth long after the resident has finished eating
- Chest congestion after meals
- Recurring pneumonia
- Weight loss
- Dehydration

Treatment recommendations will depend on the cause, symptoms and type of swallowing problem. Treatment approaches may include specific exercises to improve muscle movement, positions or strategies that may help the resident to swallow more effectively, or a specific food or liquid texture that is easier and safer for the resident to swallow.

Efficacy studies have shown treatment approaches improve nutritional status, hydration and reduce morbidity.



The speech pathologist can provide interventions that help contain medical costs by reducing the length of hospital stays, decreasing expenses associated with pulmonary complications, decreasing the need for non-oral (tube) feedings, and reducing nutritional problems.

How does the treatment of residents experiencing symptoms of dysphagia relate to the survey process? When surveyors enter a facility and choose sampled residents to observe, they may focus on residents who are experiencing problems swallowing, have weight loss, are dehydrated or are tube fed. As a reference, tags F310, F311, F312, F322, F325, F327 and F373 all address specific issues relating to dysphagia. The intent of these regulations is to ensure residents receive the care and services necessary to maintain their highest practical level of function.

References:

www.asha.org
State Operations Manual; Centers for Medicare & Medicaid Services





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Resident Assessment Instrument (RAI)

Discharge and Reentry Tracking Forms: Untangling the Process

By Carol Maher, RN-BC, RAC-CT

The RAI process of tracking resident discharges and readmissions can be confusing. Understanding when a discharge or reentry tracking form is needed is just the first step in the process. The second step is deciding which form to use when one is required.

Let's start with when **NOT** to do a discharge tracking form. Discharge tracking forms are **NOT** completed when:

- The resident leaves the facility on a temporary visit home, or on any other type of therapeutic or social leave (no matter how long).
- The resident is in a hospital outpatient department for an observational stay of less than 24 hours and the resident is not admitted for care as an inpatient (example, an ER visit of less than 24 hours).

When the observational stay goes beyond 24 hours or the resident is admitted for acute care, then a Discharge Tracking form must be completed within seven days. The discharge date entered at R4 would be the date the resident actually left the facility, not the date he was admitted to the hospital. (Example: The resident left your facility at 2 p.m. on Tuesday, June, 1 and was admitted to the hospital at 1 a.m. on Wednesday, June 2. June 1 would be the correct date to enter in Item R4).

Once the requirement for a Discharge Tracking form is met, you must decide which form to use. There are three types of Discharge Tracking forms:

- Discharged-return not anticipated (Reason for assessment AA8a=6)
- Discharged-return anticipated (Reason for Assessment AA8a=7)
- Discharged prior to completing initial assessment (Reason for Assessment AA8a=8)

All Discharge and Reentry Tracking forms must be transmitted within 31 days of completion. Discharge and Reentry Tracking forms must be copied and brought forward upon readmission as part of the 15 months of MDS data required to be on the resident's medical record.

Keep a copy of the MDS 2.0 Discharge and Reentry flowchart found on page 2-26 of the RAI manual posted near your computer. It is a great visual tool to help you successfully navigate through this process and stay on track.

Discharge and Reentry Tracking Forms in North Dakota

By: Joan Coleman, State RAI Coordinator

If a resident is discharged with return anticipated, AA8a=7 and you later discover that the resident will not be returning to the SNF or has died, in North Dakota it is necessary to complete another discharge tracking form, AA8a=6, Discharged return not anticipated.

In North Dakota, bed hold status DOES affect the type of discharge tracking form to be completed. If the Admission Assessment was **NOT** completed and the resident is on bed hold status, you would NOT complete a Discharged prior to completion of the initial assessment, AA8a=8. Rather, in our state for payment purposes, if a resident is on bed hold status the correct discharge tracking

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form to complete would be a Discharged – return anticipated, AA8a=7.

If the resident’s family does not choose to hold the resident’s bed upon discharge to the hospital but the resident is expected to return to the facility after hospitalization, the Discharge-return not anticipated, AA8a=6 is the correct form to complete.

If you have any additional questions on discharge and reentry tracking forms in relationship to Case Mix, please contact the Department of Human Services, Medical Services Division at 701.328.2321.

ANNOUNCING A NEW DIVISION

During the 2009 Legislative Session, two new positions were approved for the Department of Health to conduct onsite inspections of new construction and remodeling in health-care facilities licensed by the Division of Health Facilities. Monte Engel was assigned this added workload in addition to his previous responsibilities.

Due to specialized and complex technical nature of the work and the added workload, the Division of Life Safety Code and Construction was created to respond to these statewide responsibilities. Monte was assigned to serve as the director of this new division. As the Life Safety and Construction Division Director, Monte also has been assigned the lead for the Life Safety Code Business Process Reengineering Workgroup.

CERTIFIED NURSE AIDE REGISTRY UPDATE

*By Cindy Kupfer and
Rocksanne Peterson*

Reminder -

If you would like to change your name / address or renew your certification, you can use our on line web site:

www.ndhealth.gov/hf/registry/renewal-search.aspx

QUOTE:

"Even if something is left undone, everyone must take time to sit still and watch the leaves turn."

- Elizabeth Lawrence



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