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The Role of the Physician Order

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INTRODUCTION

Medical care is the primary focus when an individual becomes acutely ill and is hospitalized. A home-like environment and personal choices are often sacrificed, temporarily, in efforts to treat acute medical illnesses and exacerbations of chronic illness. A hospital bed, vital signs in the middle of the night, a medication pass at 6am and a medicalized diet are not just accepted, but sometimes expected by the individual. These personal sacrifices are made with the expectation that by focusing all efforts on medical care, the individual will begin to improve and return home. Over time, nursing homes have begun to resemble small hospitals. While it is clear that nursing home residents have become more medically complex, the fact remains that the nursing home is not a hospital. Rather, it is and should be an individual's home, where one should not be asked to sacrifice creature comforts and personal choice; a place where the focus should be on "living" and where good medical and nursing care supports the individual, rather than dictate routine. Person-directed care makes this happen by placing value on individualized care, personal choice and the creation of community and relationships. As stated in the *Values and Principles of the Pioneer Network*: "Know Each Person", "All elders are entitled to self-determination wherever they live", "Community is the antidote for institutionalization" and "Relationship is the fundamental building block of a transformed culture." [1]

As medical directors and clinicians, we realize that most, if not all, residents who reside in nursing homes have complex medical needs. To ignore this fact would be foolish. As nursing homes strive to change their culture and provide individualized care, it is imperative that medical directors and clinicians take a prominent role to ensure that quality of care is maintained. Residents can be allowed to eat what and when they want. They can choose when to go to bed and when to wake up. These choices are the foundation of individualized care, but adopting this culture can be challenging for the nursing

home staff. Potential concerns include residents with out of control diabetes and/or congestive heart failure due to liberalization of their diets; an increased risk for survey deficiencies due to breaks in institutional routine; residents losing weight and developing pressure ulcers due to sleeping too long; and a chaotic medication pass when residents determine their own sleep-wake times. Yet, if individualized care is done correctly, most residents will thrive. When good nursing and medical care support this culture, the residents who are at risk for these potential adverse outcomes are easily identified and their plans of care may be adjusted to meet their unique needs.

MEDICALIZED DIETS

A diet order is required for all residents admitted to the nursing home. This dates back to the 1960's and was part of the initial criteria for participation in the Medicare program. There is no obvious justification given in the current Medicare regulations to support this practice for all residents, nor is there justification in the medical literature. Diet modification has been mentioned as a potential option in the treatment of chronic medical illnesses including hypertension, heart failure, diabetes mellitus and hyperlipidemia. One example is a two gram sodium diet that is often recommended for individuals with hypertension. This diet has been shown to reduce systolic blood pressures, on average, by 5 mmHg, and diastolic blood pressures by 2.5 mmHg. While often recommended and clearly beneficial in reducing blood pressures, this diet's effect on blood pressure is modest at best and has not actually been shown to improve cardiovascular outcomes in the nursing home resident[2]. In addition, guidelines for blood pressure targets in the elderly differ from those for younger patients. In the elderly, current literature supports intervention, with medication and/or diet, only for systolic blood pressures over 160 mmHg and targets a systolic blood pressure of less than 150mmHg[3]. There is also evidence to show that lowering systolic blood pressures below 120 to 130mmHg and diastolic pressures below 65mmHg may increase mortality in the elderly[4]. Limiting salt intake in individuals with congestive heart failure is also

felt to be of benefit by limiting fluid retention, but our clinical experience shows that this is necessary in only a minority of nursing home patients, usually those who are salt sensitive and often have advanced disease.

In the treatment of diabetes, a "no concentrated sweets" and a liberal diabetic diet have been used. However, these diets have not been shown to improve glycemic control in nursing home residents[5] and therefore should not be used. A more effective approach is to provide an individualized regular diet that is well balanced and contains a variety of foods and a consistent amount of carbohydrates[6]. Recent studies have failed to show that tight glycemic control prevents heart attacks and strokes in diabetes and may in fact worsen outcomes[7]. Tighter control may prevent long term complications of diabetes such as retinopathy, neuropathy and nephropathy in newly diagnosed diabetics[8] but these conditions take years to develop and few, if any, nursing home residents would benefit from this approach. *Given the lack of clear evidence to guide treatment in the elderly, The American Medical Directors Association (AMDA) recommends individualizing the treatment plan based on a resident's underlying medical condition and associated co-morbidities.* A target hemoglobin AIC between 7 and 8 is reasonable[6].

For treating elevated cholesterol, low cholesterol and low fat diets have been used. The effects of these diets vary greatly and, at most, will decrease lipids by only 10-15%. If aggressive lipid reduction is appropriate for the nursing home resident it can be more effectively achieved through the use of medication that provides average reductions of between 30 and 40% while still allowing the individual to enjoy personal food choices.

Although limited evidence supporting a medicalized diet in select residents does exist, it is also important to note that these diets are often less palatable and poorly tolerated and can lead to weight loss[9]. Weight loss is a far greater concern to the often frail nursing home resident and easily outweighs

the potential modest benefits a medicalized diet can only sometimes offer. Weight loss is common in the nursing home and associated with poor clinical outcomes such as the development of pressure ulcers, increased risk of infection, functional decline, cognitive decline and increased risk of death[10]. Given that most nursing home residents are at risk for malnutrition and may in fact have different, therapeutic targets for blood pressure, blood sugar and cholesterol, a regular or liberalized diet which allows for resident choice is most often the preferred initial choice. As with any medical issue, residents should be monitored for desired outcomes as well as for potential adverse effects.

Another method of altering the resident's diet is to change the consistency. The most common reason for prescribing an altered consistency diet is due to dysphagia or swallowing difficulties. The lifetime prevalence of swallowing problems among community dwelling elders was 38% in a recent study[11]. Given that those in long term care are often more debilitated and frail, the prevalence is much higher. Dysphagia is not a diagnosis; rather it is a symptom commonly associated with conditions such as stroke, dementia or Parkinson's disease.

To understand the scope of the problem it is important to review the anatomy and physiology. The oral pharyngeal phase of swallowing requires a complex interplay of mastication (chewing), food bolus formation, and push of the bolus to the back of the throat for the process of swallowing and movement to the esophagus and stomach. Multiple facial and oral muscles, including the tongue, are responsible for this initial phase. The most common cause of oral pharyngeal dysphagia is stroke, with up to 45 percent of stroke patients demonstrating acute swallowing problems[12]. Other chronic neurologic processes such as Parkinson's disease, multiple sclerosis and Alzheimer's disease, may also be responsible.

Once the food bolus is to the back of the throat a series of muscular contractions occurs to move the bolus into the esophagus and away from the airway. The airway is temporarily closed as the

food bolus is pushed past the tracheal opening and into the esophagus. The food bolus then makes its way to the stomach through another series of coordinated muscular contractions within the esophagus. Disease states that can affect the ability of the food bolus to successfully pass from the esophagus to the stomach include pathology of the esophagus and or the gastric esophageal junction such as diffuse esophageal spasm, presbyesophagus, and achalasia (abnormal tightening of the muscle at the gastroesphogeal junction).

Disease states which affect muscle strength and coordination alter the ability for one to successfully complete a swallow and/or protect the airway. The results may be: 1) choking, where food partially or fully obstructs a resident's airway; or 2) aspiration or inhalation of food/liquids, oral secretions or gastric secretions into the airway and lungs. Aspiration may result in an infection called aspiration pneumonia, caused by the inhalation of oral bacteria into the lung. Alternatively, gastric secretions may be inhaled without bacteria causing an inflammation of the lung tissue called aspiration pneumonitis[13]. It is important to understand that individuals with weakened ability to control their swallow and protect their airway will aspirate not only food or fluids that are introduced into the mouth but also their own saliva or any gastric secretions, which may be refluxed into the airway.

Given the complexity of the swallow mechanism and the multitude of problems that can arise, it is essential that the physician is involved in the evaluation of swallowing disorders. A thorough history and physical examination is required to determine potential causes of the swallowing dysfunction. While the most common processes causing dysphagia in long term care are related to identified co-morbid conditions, it is important to consider other disease states or pathology such as previously undiagnosed mass lesions, gastroesphogeal reflux, or cancer. Therefore, it is important to have the primary care physician direct the workup of this problem. Two common tests ordered to further evaluate dysphagia are the bedside swallowing evaluation and the videofluoroscopy swallowing study,

commonly referred to as modified barium swallow. The bedside swallowing evaluation is done by the speech language therapist and consists of evaluating the resident's swallowing function by observing the resident's positioning, posture, and the strength and movement of the muscles involved in swallowing including the tongue. A videofluoroscopy swallowing test consists of having the resident swallow different consistencies of food and fluids containing barium while the processes of chewing and swallowing are observed with a scanning x-ray. The main use of this procedure is to show the dynamics of the swallow and to determine the reasons for dysfunction if these cannot be determined from clinical examination alone[14].

The use of videofluoroscopy in long term care should be used only when clinically indicated and not as a knee jerk reaction to a resident who coughs when eating. When used appropriately, the modified barium swallow can provide useful information about where problems are arising and potential modifications that may be of assistance to the resident. The results of this test should be used in assisting the interdisciplinary team in discussing further options with the resident and or their family/Power of Attorney (POA). If the testing will not add new information or aid in adjusting the resident's plan of care then the value of the additional test needs to be reconsidered.

Modification of the diet and/or fluid consistency is a potential intervention for residents with dysphagia. The solid foods may be ground or pureed and liquids thickened to nectar or honey thickness. The anticipated outcome of these diet modifications is improvement in oral intake and a reduced risk of choking and/or aspiration. Unfortunately, data on the effectiveness of these interventions is inconsistent. First, all residents with dysphagia do not aspirate or choke and second, not all aspiration results in pneumonia. In addition, while a modified barium swallow may show that thickened liquids reduce the risk of aspiration acutely, there is little to no long term evidence that this intervention prevents aspiration pneumonia[15,16,17]. In fact, there is a growing body of literature showing daily oral

care is more effective in reducing the risk of aspiration pneumonia than a modified diet.[18]. Recent information also raises the concern that these at risk residents become more at risk for dehydration and malnutrition caused by the unpalatable and visually unappealing modified diets[19].

Rather than approaching all cases of dysphagia as an isolated problem for the speech therapist, the interdisciplinary team should assess the dysphagia in the context of the whole individual. It is essential to understand who the resident is, and how he/she is doing medically, functionally and psychosocially[24]. If the medical evaluation identifies oral pharyngeal dysphagia as the primary concern, the speech therapist may be consulted to perform a bedside swallow evaluation. This evaluation may provide valuable information regarding how the resident is processing food but the information must be used in context to how the resident is doing overall. The interdisciplinary team, speech therapist included, can then begin to review potential interventions based on concerns that have been raised and based on discussion with the resident and/or their family/POA regarding risks and benefits. Once a plan is agreed upon, it must be monitored for desired outcomes. This is, if nothing more, the essence of proper individualized care. The AMDA Clinical Practice guideline for Alteration in Nutrition summarizes this issue: "Provide foods of a consistency and texture that allow comfortable chewing and swallowing. A resident who has difficulty swallowing may reject pureed or artificially thickened foods but may eat foods that are naturally of a pureed consistency, such as ice cream, mashed potatoes, oatmeal, peach nectar, puddings, tomato juice and yogurt"[9]. To the extent possible, a facility must tailor changes in food consistency to the resident's preferences and tolerance; finely chopped foods may retain their flavor and be equally well handled[9].

In some circumstances, the resident will continue to experience dysphagia and, despite agreed upon interventions, may still lose weight and/or experience aspiration. The placement of a tube for maintenance of enteral nutrition and hydration may be discussed. Again, a holistic approach to the

resident is essential and a discussion with the resident and/or family/POA concerning goals of care is critical at this juncture. Feeding tubes have not been shown to reduce the risk of aspiration or prolong survival in residents with end stage dementia[20]. Oral secretions and/ or gastric content are often the source of aspiration pneumonia or pneumonitis and thus will not be resolved with the placement of a tube. Arguments for placing a tube for feeding include improving nutritional status. Studies in the elderly with dementia have shown little to no improvement in weight. In situations when there was improvement in weight, there was no improvement in clinical outcome for the residents[21,22]. Enteral feeding is also considered for wound care as a means to improve wound healing. Data over a 6 month follow up has shown no impact on pressure ulcers or on infections such as cellulitis associated with wounds[21,22]. PEG tubes do not improve a resident's quality of life. There are associated physical and psychosocial discomforts related to the feedings themselves such as abdominal distension, diarrhea, and restriction of free movement if attached to an infusion device. Additionally, the resident is deprived of the social experience of mealtime that is valued by many. Placing a PEG tube in residents with advanced dementia should be strongly discouraged, and placement in other individuals should take goals of care into account.

Choice of food has a tremendous impact on quality of life. Some might say it defines quality of life. The medical director should work closely with the dietician, director of nursing and the director of food services to develop a system promoting resident choice while maintaining quality of care. This system should include policies that promote routine use of a regular diet while maintaining opportunities for discussion of the risks and benefits of diet choices that are felt, by convention, to place the resident at risk. The facility must provide evidence of the education that was offered to the resident and the family as well as documentation of the discussion of the risks. A periodic review of the risks associated with the resident's choices should be conducted with the resident and his/her family. It is imperative the resident's physician be involved in these discussions. The facility should attempt to

offer less risky alternatives to food choices the resident may request. Offering ice cream instead of a cookie may satisfy the desire for a dessert while maintaining a safer consistency. The facility must plan for the resident's choice, noting ways to monitor and provide for safety, such as offering to cut meat into small pieces at meals, recognizing the resident's ability to decline the offer. An informed consent by the resident does not mitigate the facility's responsibility to keep the resident as safe as the resident and his/her family allow based on informed choices.

In addition, homes may have general stores and small dining areas such as a "bistro" run by other residents or volunteers. These non-institutional additions provide challenges to strict adherence to a resident's dietary restrictions. If a resident chooses to visit the store or "bistro", who has the responsibility for assuring the resident is making an appropriate choice? This should be addressed during discussions with the resident and his/her family about dietary issues and resident choice.

It is important to note that only a minority of residents will clearly benefit from a medicalized diet, and thus it is far more prudent and effective to liberalize the diet for all and modify for the few when clinically appropriate. It is recommended that CMS remove the requirement of a diet order on admission to the nursing home, allowing the physician, dietician and nurse to monitor and ensure that the regular diet is meeting the resident's needs, and make adjustments accordingly. Most importantly, the use of medicalized diets should be carefully scrutinized by the interdisciplinary team, and an order for every medicalized diet should be accompanied by proper documentation supporting its use and demonstrating adequate monitoring for adverse effects.

SLEEP-WAKE TIMES AND MEDICATION PASS

Another essential component of person-directed care is allowing the resident to choose their own sleep and wake times. Yet, this common sense practice can create potential concerns for the clinical staff. The three most common potential concerns or worries include the development of pressure ulcers from extended time in bed; weight loss in those who sleep through breakfast; and creation of a chaotic medication pass due to variation in wake times between individuals. It is important to validate these staff concerns and empower them to help develop solutions. In one community on the culture change journey, the director of nursing and dietician were on the verge of leaving their jobs because they felt disempowered and disrespected. Their issues were not with change, per se, and they were not resisting just to be difficult, but they were accustomed to doing things in a certain way, an institutional way, a way they felt offered good care and yielded positive clinical outcomes. While the positive clinical outcomes may have kept the facility in regulatory compliance, these institutional processes did not allow resident choice and negatively affected quality of life. Staff needed help in understanding that allowing choice would not impair quality of care if completed in a way that is thoughtful, involves staff in its creation and implementation, and is monitored carefully for negative outcomes. This community moved forward carefully, initially piloting some of these programs in a single neighborhood (or unit). The approach allowed for resident choice while maintaining desired clinical outcomes and the director of nursing and dietician are still there today and in fact two of the staunchest defenders of the changes.

Much like the goal of providing a liberal diet for all and modifying only as necessary, the same approach is effective in dealing with pressure ulcer and weight loss concerns. In this case, allowing the resident to choose wake and sleep times should be the norm. Policy and procedure should ensure that each resident is assessed for risk of pressure ulcer development and weight loss and then monitored accordingly. Those residents who are unable to reposition or who stay in bed for excessive periods of time will need to have their sleep/wake times adjusted. Again, similar to the diet, the majority of

residents will do fine with being allowed to go to bed and arise when they want but clearly there will be some that need a modified plan of care to reduce their risk of negative outcomes.

The effect of sleep/wake choices on the medication pass is a more complex problem but certainly one that can be solved. Again, staff should be empowered to help create solutions. Typically and historically, the medication pass order was determined by nursing based on location of the resident's room. The only difference in incorporating resident choice in sleep/wake times is that the new order is determined by when the resident arises, not by when the nurse appears at the door, thus person-centered. The pass still includes the same number of residents and the same number of medications. The first step in adjusting the medication pass is a detailed discussion with staff. It is imperative to understand all the steps involved in the medication pass and anticipate what changes may occur with allowing resident choice in wake times while also being aware that issues may arise that were not thought of and as a team dealt with. After ensuring staff buy-in, the next step involves the medical director, director of nursing and consultant pharmacist working together to create policy and procedures that allow for medication pass safety and flexibility tailored to the daily routine of the resident. This should include defining daily medications as being given upon arising rather than at a specific time. Twice daily medications default to '"upon arising" and "before dinner". A similar schedule can be planned for medications given three and four times daily, although, with many once and twice daily alternatives to choose from, orders such as these should be minimized when possible. In addition to decreasing the medication pass for nursing, once and twice daily medications have the additional benefit of being easier regimens for the resident to follow. The policy should also account for circumstances that require time specific delivery of certain medications such as pain medications or antibiotics, achieved by writing an order specifying the exact time of administration such as 8am and 2pm, as opposed to twice daily which would default to "upon arising" and "before dinner". Once this process is established, it is essential to ensure that all providers and nurses are educated in the new

policy and procedure. Piloting the new medication pass in a single neighborhood can serve to avoid confusion and identify the "kinks" prior to implementing community wide.

The director of nursing should work with staff to accommodate differing resident wake times and to ensure that staffing is meeting the needs of the resident. This may necessitate a shift in staffing to accommodate when most residents wish to arise rather than mandating that night shift get the most time consuming residents up prior to change of shift. This does not mean more staff; it simply means reallocating staff to when the residents need the most assistance. For example, in a community of early risers it might mean reallocating more staff to night shift or starting day shift earlier to accommodate these residents. A community of late risers would mean less staffing on night shift, more on day shift. It will also require a system that ensures each resident is given their medications when they arise. This may involve the resident checking in with the nurse prior to breakfast, having the nursing assistant notify the nurse when a resident arises, or having dining room staff notify nursing when the resident arrives for breakfast. There is no one way to accomplish this task, but it is essential to involve the staff so as to better understand where problems may occur and how to work around these issues.

Glucose monitoring is another task associated with the medication pass and takes two to three minutes per resident. The time increases if the resident needs to be given sliding scale insulin. This time is not inconsequential. If a community has twenty-five diabetic residents, each of whom are written for glucose checks four times daily with insulin sliding scale, then it is estimated that nursing will spend almost 8 hours per day dedicated to this task. This is an enormous amount of time to spend, especially when considering there is no need to be checking blood sugars with this frequency in the majority of diabetic residents in the nursing home. This is compounded by the fact that there is little evidence supporting the use of sliding scale insulin as it is reactive in nature and fails to meet the physiologic needs of the resident[6]. The only benefit is in newly diagnosed diabetics where the clinician is attempting

to estimate daily dosage of insulin. For this reason, insulin sliding scale should be used sparingly if at all, and glucose monitoring should be done no more than once daily in stable diabetics, more frequently, albeit temporary, if actively adjusting the regimen.

MEDICATION MANAGEMENT

In addition to the steps above, it is imperative to ensure that residents are receiving only those medications that are absolutely necessary to maintain or improve their medical condition. While this may seem obvious, current estimates show that nursing home residents take an average of over seven routine medications per day, and over fifty percent of residents are taking at least one mood altering medication. This is not acceptable and highlights a breakdown of the principles of medication management. Not only can a careful review of each medication regimen potentially improve quality of life for nursing home residents, it can also reduce the medication pass time and leave more time for higher complexity nursing tasks. The principles of proper medication management are the foundation of federal Tag F 329 which includes ensuring that all prescribed medications have an appropriate indication at a proper dosage and duration. This does not mean looking at a list of diagnoses and simply trying to associate a drug in order to justify it. Rather, in a truly individualized way, it means the clinician has carefully evaluated the resident, discussed goals of care and only then chosen to prescribe. Many of these medications were started in the hospital setting and simply never re-evaluated. When a resident returns to the facility after a consultant visit or a hospital admission, it is essential that the primary care physician (PCP) compare the new medication orders with the medications the resident had been taking. This is called *medication reconciliation* and can prevent medication errors such as errors of omission, prescribing (dosing) errors, drug interactions, and duplicative therapy. This should be done after every transition of care. The medical team in the nursing home now has primary responsibility for the

resident and should practice accordingly. In fact, instead of searching for reasons to continue a medication, the focus should be on finding a good reason why a medicine should not be stopped.

The medication regimen must also be monitored for effectiveness as well as side effects. Side effects or adverse drug reactions are common in the nursing home and occur at a rate greater than 350,000 per year, half of which are felt to be preventable[23]. A major challenge in a nursing home resident is that a side effect may be subtle and masquerade as a new medical problem. These individuals are medically complex and often on a multitude of medications. Unlike younger, healthier adults who would start a new medication and immediately report if they felt poorly, these frail older adults may misinterpret their symptoms as another medical issue or, worse yet, may not be able to adequately communicate how they feel due to dementia. Often these adverse drug reactions manifest as several common nursing home syndromes such as weight loss, cognitive decline, functional decline, and falls. The astute medical team realizes that any symptom in a nursing home resident could be an adverse drug reaction and evaluates for such. The likelihood of a side effect increases if the new symptom is temporally related to the initiation of a new medication or increased dosing of an old one. Consideration should always be given to the possibility of a gradual dose reduction and the nursing home is an ideal setting for the close monitoring this requires.

SUMMARY

Some experts speak of a medical model of care in which the resident is viewed as having complex medical issues requiring complex medical systems to support them. Other experts speak of a social model where the emphasis is on home and comfort. Critics would point out that the medical model is flawed as it is too restrictive and impairs quality of life while the social model is overly simplified and ignores a resident's medical complexity and invites poor outcomes. The fact is that individuals who reside in the nursing home are medically complex and often frail yet they, too, deserve

choice and to enjoy the creature comforts of home. In our well intentioned attempts to meet their medical needs, we have created a system that imposes itself on these individuals from the day they are admitted. Many are ordered a medicalized diet before even being assessed. Residents are frequently awoken in the middle of the night for skin checks and monthly vital signs and asked to get out of bed for a morning medication pass that may begin as early as 6 AM. Worse yet, we often divide the resident into "parts" and assign members of the interdisciplinary team the responsibility of assessing and treating those "parts" without the benefit of understanding the "whole" resident or the benefit of collaborating with other team members. A resident with behaviors sees the psychiatrist; one who loses weight sees the dietician; one who has difficulty swallowing, the speech therapist; one who falls, the physical therapist; one who needs medications assessed, the pharmacist[24].

Person-directed care ensures a holistic approach, one that effectively utilizes the interdisciplinary team and incorporates resident choice as well as information from the clinical assessment. In fact resident choice is not just a part of person-directed care, it should drive it. While these choices may sometimes conflict with recommendations of the clinical team, the label of being "non-compliant" should be avoided. Usually, a careful discussion of risks and benefits with the resident and/or their family/POA will allow for resolution of this conflict and help to create an agreed upon plan of care that can then be monitored for desired outcomes and potential adverse effects.

Main Points:

1. Nursing home residents are medically complex.
2. Individualized plans of care can improve quality of life while maintaining quality of care.
3. Individualized plans of care can create tension for the clinical staff and this tension cannot be ignored.
4. Medical interventions in this population have the ability to both help and harm the individual.
5. Creating protocols that target the exceptions make for bad policies.

Recommendations:

1. Create policies that promote resident choice and protocol that monitors for desired outcomes.

2. Restrict choice only when medically necessary, reviewed by the interdisciplinary team, discussed with the resident and/or family/POA, and consistent with goals of care.

3. A liberalized diet is the preferred initial choice for all admissions to the nursing home. In fact, communities should consider changing their policy so that all residents admitted to the nursing home receive a regular diet. Those who require medicalized diets can be assessed by the dietician, physician and if necessary the speech therapist for appropriate individualized modification.

4. At the least, communities should continuously monitor the usage of all medicalized diets and ensure that they continue to be medically indicated, much the same way the usage of urinary catheters are monitored.

5. When potential interventions have the ability to both help and harm, such as medicalized diets and thickened liquids, the interventions should be reviewed by the interdisciplinary team in a holistic fashion and discussed with the resident and/or their family/POA prior to their implementation.

6. Residents and/or their families/POA should be educated regarding these interventions and the care plan monitored for both safety and effectiveness.

7. PEG tube placement in advanced dementia should be strongly discouraged.

8. Residents should be allowed to determine their own sleep and wake times.

9. Nursing home leadership must work closely with staff to address clinical concerns that arise from allowing resident choice and craft effective solutions that promote individualized care while ensuring quality of care.

10. Residents should be monitored to ensure that individualized sleep/wake times are not causing weight loss, pressure ulcers or behavioral issues.

11. The medication pass should support individualized wake times.

12. Increased scrutiny of the medication regimen will ensure that only medically necessary medications are being given.

13. Weight loss, falls, cognitive decline and functional decline should prompt a review of medications to rule out the possibility of an adverse drug reaction.

14. More than once daily blood sugars in stable diabetic patients should be discouraged.

15. Use of sliding scale insulin should be discouraged except for the short term in newly diagnosed diabetic patient.

Medical directors and clinicians must become clinical champions, demonstrating to nursing home administration and staff that providing person-directed care while maintaining clinical excellence is possible. To ensure success, these efforts must be supported by nursing home leadership and, more importantly, by regulations that emphasize individualized care rather than relying on antiquated, institutionalized practices which are often more invasive, restrictive and more likely to decrease quality of life for residents.

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