**Elder Abuse Cases Involving the Diabetic Resident: Responding to the "Natural Progression" Defense**

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In 1992, the California Legislature recognized the need to expand the remedies available to the elderly victims of nursing home neglect and abuse. The Elder Abuse and Dependent Adult Civil Protection Act (EADACPA) resulted in nationwide, consumer-driven litigation designed to hold nursing homes accountable for their reckless neglect of the elderly.

Attorneys who handle these cases know that skilled nursing facilities ("SNFs") and other extended-care facilities often use the defense that the injury sustained by the patient is non-tortious because it was "part of the natural progression of the disease." For example, in the case of the diabetic patient who develops an infected pressure sore and must have a partial-limb amputation, the "natural progression" defense is inevitable. Attorneys practicing in the elder abuse arena are well aware of the hurdles that must be overcome to satisfy the EADACPA’s requirements of "reckless negligence," as well as the distinction made between medical malpractice claims that fall under MICRA and those that fall under "custodial neglect" as defined by EADACPA. (See Garcia and Bamberger’s June 2002 *Forum* article for an excellent discussion of the legal issues regarding elder abuse cases against SNFs; please note that although this article refers specifically to SNFs, much of the material may also apply to elder care provided by Residential Care Facilities for the Elderly as well as acute care hospitals.)

The purpose of this article is to offer guidance to the consumer attorney who must meet defense arguments about "natural progression" of disease processes. Consumer attorneys must be prepared to scrutinize elder care practices in a variety of settings in order to establish "recklessness" under EADACPA. Of course, this article cannot and should not replace the necessary assistance of a competent medical consultant.

One particularly challenging disease process affecting many elderly residents in custodial care settings is diabetes. With regard to this and many other chronic conditions, defense attorneys want us to believe that SNF’s only exist to maintain an elderly person at the condition they were in at admission. In fact, pursuant to federal and state statutes and regulations, SNF’s must assist their patients to "attain or maintain the highest practicable physical, mental and psychosocial well-being." (C.F.R., § 483.25.) As the average age of the U.S. population increases, consumer attorneys have the opportunity to hold elder care institutions to a standard that will improve the lives of our older citizens and decrease the unnecessary expenses that society incurs as a result of failures of medical and nursing management. There is sufficient information available to allow better management of the aged: they are not lost causes, there is much that can be done to improve their quality of life in and out of medical facilities. This article will hopefully aid you in dealing with experts and formulating discovery.

**Overview**

Diabetes Mellitus is increasingly prevalent in the older population. The Center for Disease Control estimates that at least 12% of the population older than 70 have diagnosed DM and 11% of those over 60 have undiagnosed DM. An older person with diabetes is twice as likely to be admitted to a nursing facility as one without this disease. Diabetics have a higher rate of several geriatric syndromes including depression, cognitive problems, urinary complications of DM are attributable to poorly treated chronic hyperglycemia. In young adults to the middle aged, tight glycemic (blood glucose) control to normal levels is the standard of care, justified by large studies that have shown a significantly reduced risk of diabetic eye, kidney and nerve disease. No studies have yet looked at tight glycemic control in the elderly. However, good, if not perfect, control of chronic hyperglycemia is still a reasonable goal for the elderly patient. Maintaining the aged patient close to normal glucose levels can not only reduce the risk of several complications; it gives the patient an overall sense of well-being, energy and the desire to remain active.

**Types of DM**

There are two main types of DM. Type 1 DM typically presents in early life and is usually caused by a deficiency in insulin secretion due to destruction of insulin-producing cells in the pancreas. A type 1 diabetic will always need insulin supplementation. DM Type 2 is far more common and develops in middle and later age. It is caused by impaired insulin secretion by the pancreas coupled with a resistance to the transporter action of insulin on blood glucose. In the mildest cases of Type 2 DM, dietary modification and exercise may be all that is needed to bring and maintain normal to near-normal glucose levels. Where lifestyle changes alone fail, oral anti-hyperglycemic medications such as metformin hydrochloride (Glucophage®) and the family of drugs known as sulfonylureas are additionally employed. A last resort is insulin via injection (it cannot be taken as a pill) with a syringe or insulin pen, usually into the fat of the abdomen. Insulin pumps provide a far smoother delivery of insulin directly into the blood stream, but their expense has hindered widespread use, particularly in the elderly.

Insulin is classified based on how soon it begins to take effect on blood sugar levels, when it reaches its peak effect, and how long its effect lasts. Based on blood glucose monitoring results, a physician will prescribe daily mixes and dosage ranges of one or more types of insulin. This determination of the appropriate combination of medications and dosages to produce a maintenance schedule is called "titrating the patient." Until the patient has achieved a documented stable blood glucose level, levels must be checked at least 3 times a day. Many Type 2 patients who need insulin injections begin with one dose per day. Insulin comes into play as glucose enters the blood from a meal so insulin injections should be timed according to the meal schedule. In the SNF setting, the physician’s medication orders should designate when doses are to be administered, and the nurse’s medication records should document the time of insulin administration relative to the meal. If a SNF diabetic patient is not eating regularly or well, that will have a profound effect on blood glucose levels and insulin dose. It is therefore very important that care be taken to ensure that diabetic patients eat regularly and well.

Infections and other stresses can also increase insulin resistance leading to hyperglycemia. If nursing personnel are not sufficiently vigilant to the effects of such stresses, the elderly patient’s diabetic state can rapidly deteriorate when the patient is sick from other causes. During illness, blood sugar should be checked every 3-4 hours.

**Monitoring DM Care**

Although blood samples sent to a lab are the "gold standard" for blood glucose measurement, electronic devices called "glucometers" that require only minute amounts of blood for testing, are in wide use today. In a facility setting, there should be at least daily glucose tests in a patient already demonstrated to be in good control (*vide infra*). Doctors’ orders should include instructions specifying insulin dosage for a given range of glucose levels, and naming the critical value that should prompt a call to the physician.

Concern is warranted when blood glucose levels are consistently higher or widely fluctuating during the day (obviously to know the latter, levels should be checked in the morning and evening until stability is documented).

An extremely important, but frequently neglected, measurement of diabetic management is a blood test known as "glycosylated hemoglobin" or Hemoglobin A1C ("A1C"). If a daily blood glucose level is a student’s grade on a single test, then the A1C is the grade point average over a semester. Each has its own utility, the former tells a one-time short story, the latter reveals how well the blood sugar has been managed in the preceding three months. In a patient receiving reasonable medical care, the A1C should be checked every three to six months.

In evaluating the care of an elderly diabetic nursing home resident, the first question should be: "Was Hemoglobin A1C checked in the last three months, and if it was high, what was done about it?" A couple of reasonably "normal" blood sugars in an elderly person does not mean management has been optimal; this unfortunately is the approach taken by many nursing facilities; they never seek a previous A1C level or order a new level. For a diabetic patient expected to be in a SNF for more than one month, a failure to either test for or to seek previous A1C values suggests that the facility does not take the patient’s diabetic status seriously. An elevated A1C immediately suggests that the patient’s diabetes has not been closely or successfully managed and therefore has a high likelihood of diabetic complications that must be addressed or prevented.

**Managing Blood Sugar Is Never Enough**

Controlling blood sugar should be considered the minimum requirement in the care of the elderly diabetic.

Diabetics are at an increased risk for cardiovascular events and studies have shown that aspirin use is associated with a reduction in heart attacks (myocardial infarction) and mortality from such events. All older diabetics should be on aspirin therapy unless they are on another anticoagulation (anti-clotting) agent or have a record of adverse reaction to aspirin.

The importance of careful examination and management of the diabetic foot in the SNF cannot be overemphasized: The risk of amputation of a lower extremity in the diabetic is at least 10 times greater than in the non-diabetic; this usually follows a gangrenous and/or pressure ulcer infection in a foot. Since pressure ulcers are rarely listed as a cause of death on death certificates, many researchers in the field believe the reported rate of 6% as a primary cause of death is underestimated. A fallacy persists in the medical community that pressure ulcers primarily develop over a long period in bedridden patients. To the contrary, many ulcers are acquired in the first 2 weeks of an acute hospital admission, not uncommonly in relatively ambulatory diabetics. The patient is then transferred to a skilled nursing facility where the ulcer is not appreciated or inadequately managed leading to dire consequences that could have been avoided or mitigated.

Because many elderly diabetics have decreased sensation in their feet due to damage of the peripheral nerves, suffer visual impairment, and take some medications that can impair balance, they are at a higher risk for injurious falls than age-comparable persons. One study of 32,000 postmenopausal women showed that Type 2 diabetics had a 70% greater risk of a hip fracture than women without diabetes. SNF intake histories should carefully screen for past history of falling or fractures. All elderly diabetics should be considered at increased risk for falls unless they have been carefully evaluated for stability and visual competence. Such direct observation should be documented in the medical records as soon as the patient is ambulating. If any degree of instability is noted, then precautions to protect from falling must be made both in the patient’s room and bathroom as well as in the hallways.

**Conclusion**

In summary, proper care of the elderly diabetic in a skilled nursing facility boils down to: 1) designating the elderly diabetic as a high risk patient from the time of admission; 2) identifying each patient’s specific risk profile; 3) focused management of the risks identified; 4) careful monitoring; 5) appropriate documentation and follow-up. Even in those patients where a diabetic complication did not have its onset at the SNF level of care, rational nursing and medical management strategies to mitigate their impact are available; it is the responsibility of the facility to deal aggressively with those complications. Contrary to the arguments used by nursing facilities in elder abuse cases, many complications need not be a "natural progression of the disease." Such facilities need to be held accountable for meeting accepted standards of care of our elderly diabetics.

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