DeAR DR. JEFF
Jeffrey Nichols, MD, CMD

One Bourbon, One Scotch, One Beer

DeAR Dr. Jeff:

One facility has one resident who routinely consumes large quantities of alcohol in his room. Usually his booze is brought in by “friends,” who sometimes drink with him, but at times his brothers bring him his booze. Once, when no one was available to visit, he called out for a delivery from a local liquor store! Nursing staff is concerned that he be made to understand that his problem resident is an efficiency citation. They want to confiscate his bottles and bars available to him alcohol. The social worker says that his drinking is his right and we can’t interfere. What do you think?

Dr. Jeff responds:

Alcoholic liquids served for pleasurable consumption are often referred to as “legal beverages.” There may be age restrictions on who may consume them and regulations regarding public vs. private consumption or which restaurants and stores can sell them, but the point is that they are legal to consume. The phrase was intended to distinguish them from ethanol-containing liquids used for medicinal purposes which can, of course, be prescribed without age limitations and dispensed by pharmacies without a required liquor license. But, assuming that your problem resident is an adult, he is indeed within his legal rights to consume alcoholic beverages within his room, whether alone or with other adults.

Phase 1 of recent revisions to the Requirements of Participation from the Centers for Medicare & Medicaid Services have highlighted a new emphasis on resident rights. New introductory language reinforces a resident’s right to dignity, self-determination, and person-centered care. A new section (483.10(h) Exercise of Rights) adds new language expanding these concepts with a new right to be supported by the facility in the exercise of these rights. The potential for a deficiency citation would certainly exist if a resident were arbitrarily denied access to a beverage that he could legally access, which would be a violation of self-determination. Alcohol is such a marker of adult status that young adults often celebrate the attainment of legal drinking status as a major life event; denying this resident’s right to drink essentially violates his dignity by treating him as a child. Furthermore, prohibition of an element of the resident’s usual socialization and lifestyle could be characterized as a failure to provide person-centered care.

Resident rights, however, are not unlimited. You describe behavior that is confined to the resident’s room and not disruptive to other residents or interfering with routine care delivery. However, he would have no right to schedule wild parties in the day room or invite other residents to share his liquor cabinet to the detriment of their medical care — or even to become drunk and abusive to other residents or staff.

Facility Prohibitions

Facilities do have the right to create and enforce regulations that potentially limit otherwise legal resident activities. The risks of secondhand smoke and the general public health interest to limit or eliminate tobacco use has allowed increasing numbers of facilities to declare themselves smoke-free. This is quite different from the 1980s and 1990s when state surveyors, at least in New York, routinely told facilities that they needed to make arrangements to accommodate smokers.

Facilities sponsored by religious entities that forbid alcohol consumption could adopt a policy to forbid its use within their facilities. This could include Muslims, Jews, Sikhs, members of the Church of Latter Day Saints, and many Methodists, Baptists, and Pentecostals. Potential residents would need to be informed of such policies prior to admission; they cannot be applied retroactively to those for whom the facility is already home. The Supreme Court decision in the Hobby Lobby case may support this religious exemption to extend to facilities owned by an individual or a closely held, corporately owned facility whose owners hold these religious views.

Many religions incorporate alcohol for sacramental purposes, including, of course, Roman Catholicism during Mass and Hinduism’s use of alcohol in Ayurvedic healing. Shintoism and Judaism not only permit the use of alcohol but have religious ceremonies in which some religious authorities endorse drunkenness. Noah was a vintner, and the Book of John reports that Jesus’ first public miracle was the transformation of water to wine when a marriage feast’s supply was depleted. The ancient Greeks and Romans actually had a god of wine (Dionysus or Bacchus), and the Dionysian cults reportedly enjoyed not only overindulging in wine but also the behaviors that typically followed. Although I do not believe that federal code requires your activities department to coordinate Dionysian orgies, reasonable respect for the beliefs of your residents would require a facility to accommodate alcohol use in accordance with religious practices.

But your letter raises concerns regarding the quantities that this resident is consuming and the potential consequences for his health. Moderate consumption of alcohol in general does not seem to pose a health risk. I have worked at religiously sponsored facilities that incorporated a cash bar in the basement. Friends and families were encouraged to drop by after work and socialize just as they had done when the resident lived in the community. Residents from different units could interact socially during happy hour. A glass of dry sherry or other bitter alcoholic beverages such as gin may stimulate the appetite (the evidence, although slightly contradictory, leans in that direction), an effect that seems to correlate with the quantity ingested. A glass of Dubonnet, which was deliberately formulated with quinine, will also help protect you from malaria — better safe than sorry.

The National Institutes of Health recently announced a $100-million study to determine whether moderate alcohol intake will protect against heart disease. The funding comes primarily from alcohol industry corporate donations. There is considerable evidence that moderate alcohol consumers live longer than either chronic alcoholics or total abstainers. Worldwide clusters of extremely long-lived persons include some where alcohol consumption is routine and some communities where complete abstinence is the norm.

Of course, the trick here may be to define “moderate” in terms of alcohol consumption. One wag defined an alcoholic as “someone who drinks more than their doctor.”

What is “Moderate”? Clearly, what is considered moderate drinking should vary based on age, body size, and metabolism. Although hepatic alcohol dehydrogenase function does not decline significantly with age in the normal liver, its rate might vary, depending on other factors such as drug-drug interactions and underlying liver disease. Because alcohol distributes in total body water, which tends to decline as a proportion of total body mass with aging, the same consumption over a lifetime may produce significantly higher blood alcohol levels in an 80-year-old than when he was in his 20s. The standard two pints at the pub or two martinis before dinner, which might have been described as moderate consumption, may produce dangerous blood alcohol levels with aging. Also, end-organ sensitivity may also increase with medication interactions (particularly warfarin, benzodiazepines, or nonsteroidal anti-inflammatory drugs) or comorbid conditions, particularly balance disorders, cognitive impairment, hypertension, congestive heart failure, and peripheral neuropathy.

Alcohol consumption is [the resident’s] autonomous right, but this does not mean the facility and the care team can simply ignore it. As with any other potentially risky behavior, the concerns must be addressed in his interdisciplinary care plan.

In your patient’s case, members of the interdisciplinary team have identified health concerns related to his alcohol consumption. Alcohol consumption is his autonomous right, but this does not mean the facility and the care team can simply ignore it. As with any other potentially risky behavior, the concerns must be addressed in his interdisciplinary care plan. This will probably require some attempt to quantify his actual consumption (self-report or marking the levels in bottles could be a measure, as could the number of empties or even blood alcohol level measurements), and to evaluate it within a person-centered plan regarding his individual needs and risks.

Risks in the Nursing Home

Alcohol consumption is associated with falls and other accidents in individuals of all ages, and because the care team has explicitly raised concerns regarding that possible complication, it should be addressed in his care plan. Fall risk may increase with consumption of 14 or more drinks per week (J Am Geriatr Soc 2004;52:1174–1179). Comprehensive evaluation of the overall effects of his behavior should be included within the overall plan for his identified medical, nutritional, social, recreational, and nursing needs.

For example, social alcohol consumption is frequently associated with food consumption. There is extensive anecdoctal literature suggesting that foods such as chicken wings and pizza are commonly consumed with beer and other alcoholic beverages. Should he be provided with low-salt or salt-free snacks

2 CARING FOR THE AGES OCTOBER 2017
LOS ANGELES — Endocrinologist Jane Weinreb, MD, has a message for long-term care facilities and clinicians about caring for people with diabetes: help them control their glucose, but don’t overdo it. In fact, a high HbA1C level — even nearly 9% — might actually be just fine, depending on the patient.

“We want to individualize our targets based upon the overall health status of patients and also based on personal and family desires,” said Dr. Weinreb, who spoke at the annual meeting of the California Association of Long-Term Care Medicine. “In some cases, we don’t need to achieve tight goals because no benefit will be derived.”

Dr. Weinreb, the chief of epidemiology of the VA Greater Los Angeles Healthcare System and a clinical professor of medicine at David Geffen School of Medicine at the University of California at Los Angeles, shared tips about care for patients with diabetes.

Be aware of how common diabetes is in this population.

An estimated 26.8% to 34% of nursing home patients have diabetes, and the cost of caring for these patients in U.S. long-term facilities was estimated at $19.6 billion in 2012 (Diabetes Care 2016;39:308–318; Diabetes Care 2013;36:1033–1046).

Consider checking C-peptide levels.

In some cases, a patient with diabetes who takes multiple daily insulin injections may seem to be doing quite well on the blood sugar front, based on his or her levels — but this scenario might be too good to be true, Dr. Weinreb cautioned.

Many patients with diabetes retain the ability to secrete insulin even though they take insulin, she said. “I encourage you to check their C-peptide level,” she said, referring to a test of blood levels of a peptide that provides insight into insulin production. “If it’s greater than 1, they’re making their own insulin and don’t need to consume rather than the salted nuts, potato chips, and pretzels that his friends might also bring? If inadequate dietary intake is a concern, might this provide an opportunity to get some additional nutrition into him?”

Should his interactions with friends from the community be regarded as emotional support and a resident choice of recreational activity? Or do they interfere with his social interactions with other residents and his ability to participate in other desired activities? Assuming that alcohol is not only his pleasure in life, should an attempt be made to schedule his friends’ visits around other events or activities?

Alcohol is a known depressant and can cause mood swings. Is there evidence that its consumption is interfering with his mood (as scored by the Patient Health Questionnaire 9 or through simple observation)? Is the resident also receiving hypnotics, sedatives, or anti-depressants where potentiation would heighten the high risk of suicide effects? Is there evidence to suggest nocturnal alcohol consumption is disrupting his normal sleep patterns? Is his alcohol use being addressed within an overall behavioral care plan?

The team should not assume that the resident is necessarily aware of the health consequences of his habits. Many older drinkers believe that they are not at risk because their consumption has not changed throughout life, particularly if their intake is typical for their family or social circles. The general notion that “drinking is bad for you” is not the same as a careful review with the resident of his problem list and medication list with a frank and informed review of the health risks and benefits of alcohol on each of these — including transparency regarding some mild benefits, or simply no reliable information. The clinical pharmacy consultant must be involved with this process to ensure the resident receives the best current information. Alternatives, including alcohol-free beer, may be considered.

The resident may well refuse to change his habits. Nevertheless, the facility response cannot be “It’s your funeral.” Medication adjustments may be available to minimize interactions if the resident continues to insist on self-medicating with alcohol. Other needed care must still be provided.

The July 2017 issue of Caring included an excellent Legal Issues column by William C. Wilson, Esq., that reviews the legal and risk management issues with a “refusing resident.” First, residents can only be regarded as refusing our care if it is an informed decision by a resident with decision-making capacity. If this occurs, the team must take multiple steps to protect the resident and the facility. And, of course, as with almost everything else in 21st-century medicine, “document, document, document.”

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board.

Beware Overdoing Glucose Control in Elders

Randy Dotinga

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Understand the symptoms of low blood sugar.

Hypoglycemia presents differently in the elderly, she said. Whereas younger patients may develop sweating and palpitations, older patients might experience these symptoms plus headache, confusion, sleepiness, slurred speech, and bizarre behavior.

“We need to think of hypoglycemia when a patient isn’t acting like themselves,” she said, especially since the elderly may not be able to describe their symptoms. “They’re not going to tell us, ‘My heart is beating in my chest too fast, and I have a feeling of anxiety,’” she said. “They just say they don’t feel well.”

The elderly may also develop incontinence due to high production of urine. Heart attacks, seizures, and coma are also possible.

Don’t use candy bars to treat hypoglycemia.

Hypoglycemia (low blood sugar) can be dangerous, especially in the elderly. Dr. Weinreb recommended giving hypoglycemic patients 15 grams of rapid-acting carbs like fruit juice, regular soda, or low-fat milk. It’s also appropriate to use glucagon, an emergency treatment for hypoglycemia, if the patient has significant alteration of consciousness or ability to swallow, or squeeze some glucose gel into the patient’s mouth.

Candy bars aren’t appropriate because the fat makes it take longer for the body to absorb the sugar, she said. If the patient’s blood sugar doesn’t rise to at least 70 within 15 minutes, she said, give rapid-acting carbs again.

Adjust a patient’s regimen to stop nighttime lows.

It’s difficult to prevent nocturnal blood sugar lows, Dr. Weinreb said. If midnight lows are a problem, it can be helpful to replace long-acting regular insulin before dinner with a form that acts more quickly, such as isophane insulin. If you never check late-night blood sugars, you may not know of nocturnal hypoglycemia, so it is wise to check these periodically.

Keep in mind an A1C level of 7% isn’t always ideal.

A target A1C below 7.5% is appropriate for healthy patients with few coexisting conditions and intact cognitive and functional status, based on recommendations from the American Diabetes Association (ADA), Dr. Weinreb said.

In this group, the target fasting/preprandial glucose level is 90–130 mg/dl, and it’s 90–150 mg/dl at bedtime (Diabetes Care 2017;40[S1]:S101). That is not the profile of most nursing home residents, however.

Better control can lead to longer lives in healthier patients, Dr. Weinreb said. Research suggests that “you can decrease microvascular events in a matter of 3.5 to 4 years” with improved glycemic control, although macrovascular benefits may take decades to manifest, she said.

The ADA says a reasonable A1C goal is less than 8% in an intermediate group of patients with multiple coexisting illnesses, two or more instrumental impairments in activities of daily living, or mild-to-moderate cognitive impairment.

The ideal target fasting/preprandial and bedtime glucose levels are 90–150 mg/dl and 100–180 mg/dl, respectively. In light of the life expectancy in this population, the rationale for these levels is to avoid hypoglycemia, falls, and a high treatment burden.

Finally, an A1C level of under 8.5% is always ideal. The ADA believes, for patients with end-stage chronic illnesses, moderate-to-severe cognitive impairments, and two or more dependencies in their activities of daily living. The appropriate fasting/preprandial and bedtime glucose levels are 100–180 mg/dl and 110–200 mg/dl, respectively.

“These [adjustments] aren’t only for my elderly patients, but also my mentally ill, demented, and homeless patients,” Dr. Weinreb said. When there is limited remaining life expectancy in such patients, the goal is to avoid excessive treatment and the risk of hypoglycemia.