Mrs. S is an 85-year-old woman who moved into the nursing home five years ago when her husband could no longer provide care for her due to his progressive weakness and failure to thrive. She has a history of Barrett’s esophagus and significant reflux and subsequent dysphagia, a long history of depression, allergic rhinitis, dementia with a Brief Interview for Mental Status (BIMS) score of 12, basal cell carcinoma, insomnia, iron deficiency anemia, and a pneumothorax due to aspiration. She is oxygen dependent.

Her medications include mirtazapine, 30 mg daily; nortripryline, 80 mg daily; melatonin, 3 mg daily; omeprazole, 40 mg daily; ferrous sulfate, 325 mg daily; vitamin D3, 2,000 units daily; and polyethylene glycol 3350 and senna daily. Over the years her diet has decreased to include mostly just soft or liquid intake such as supplements, ice cream, yogurt, and milkshakes. She has generally maintained her weight. A month ago, she was noted to have loose stools, and the nurses immediately stopped the polyethylene glycol 3350 and senna. The loose stools continued, and she was noted to have less appetite and started to lose some weight.

A complete blood count and comprehensive metabolic panel were obtained, and a stool was sent for *Clostridioides difficile* testing. Her white cell count was up to 17.3 x 109/L, hemoglobin down to 9.6 g/dL; hematocrit 32.9%; total protein 5.5 g/dL, and albumin 2.3 g/dL. All other tests were within normal limits. The stool specimen tested positive for *Clostridium difficile*, and she was started on vancomycin, 125 mg orally four times a day for 10 days.

At the end of the 10-day period she was still having at least a few episodes of loose stools daily, and she had a 14-pound weight loss over the past 6 weeks. The team is asked to discuss best ways to facilitate care for Mrs. S.

**Interdisciplinary Team Case Studies**

By Barbara Resnick, PhD, CRNP, and Paige Hector, LMSW

**Clostridioides Difficile Management in a Patient With Barrett’s Esophagus**

Mrs. S is experiencing persistent loose stools. In addition, oral vancomycin could have added to her reduced appetite as it has known to cause dysgeusia.

In addition to the vancomycin, tricyclic antidepressants such as nortripryline also affect taste. This is noteworthy in light of her weight loss, and obtaining her nortriptyline levels also should be considered (the specimen should be collected >12 hours after the dose).

**Activities Director**

Diane Mockbee BS, AC-BC

Ms. Mockbee is an activity consultant, educator, and trainer.

I would review infection control precautions with the staff of the activities department. I would talk with Ms. S to identify what activities would be meaningful for her while she is being isolated for her infection. Possible activities may include playing her favorite music, singing to (or with) her, gentle massage with lotion (the person providing the massage should be wearing gloves), soothing lighting, and reading to her. I would reassess her spiritual needs and preferences and help ensure those are met. The activities department can help support her nutritional needs by offering nutritious snacks such as milkshakes and yogurt. Until the *C. difficile* infection has resolved, we need to avoid the use of any activity aids or supplies that are difficult to disinfect. Instead, we would encourage her husband to supply such items if she requests them.

**Social Worker**

Paige Hector, LMSW

Ms. Hector is a social work expert and a coeditor of this column.

Physically, mentally, and emotionally, Mrs. S has endured significant life challenges, and her current health changes are presenting her with more: declining health, loss of independence, depression, oxygen dependence, and now an illness that impacts her overall well-being, comfort, and appetite. Added to all this is diarrhea, which necessitates frequent pericare and infection control precautions in which she is only touched by staff wearing gloves and gowns. She can only have soft foods or liquids because

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she chokes. Her cognition is changing as well — either because of depression, dementia, trauma, or a combination of all three. The move from her home where she had created a life with her husband may not be “new,” but the effects of that move and all the other changes have not gone away simply because she has grown older or time has passed. Indirect screening for trauma means that staff need to know the signs and symptoms of delayed (or current) response to trauma. With a trauma-informed lens, we consider the cumulative effect of all these events on Ms. S’s well-being.

Consider that the definition of psychological trauma includes “any situation that leaves you feeling overwhelmed and isolated can result in trauma, even if it doesn’t involve physical harm” (HelpGuide, Feb. 20, 2020; http://bit.ly/2P03cWy). It would be easy to discount the potential impact of trauma because Ms. S’s situation is not uncommon, and staff are accustomed to seeing it regularly in the post-acute and long-term care setting. One of the biggest barriers to incorporating a trauma-informed care approach is an incorrect assumption that “common” events are not traumatic, individually or cumulatively. Another challenge in recognizing trauma is that dementia and post-traumatic stress can make accurate diagnosis difficult and the “behaviors” are often similar.

With Mrs. S’s change in condition, this would be a good time to review her advance directives, but more importantly to engage in advance care planning discussions with her (to the degree she is capable) and her husband to learn what they understand about this current illness and her overall well-being. What are her values and wishes that would inform the type of care she would want should her condition continue to decline? It is also important to educate her husband on C. difficile infections to help prevent transmission yet still allow compassionate and caring visits with his wife.

Nursing Home Administrator
Nigel Santiago, MBA
Ms. Santiago is the executive director of Haven of Phoenix in Arizona with 12 years’ experience in long-term care. He holds an MBA from the University of Arizona.

When a resident has a contagious infection like C. difficile, we still must uphold the resident’s rights, but they may have to be temporarily modified under the circumstances to decrease the risk of transmission. Together with the director of nursing, I will review the resident’s care plan and the interdisciplinary documentation to make sure we are following the facility’s policies, meeting the regulations, and providing the best resident care possible. We should identify how staffing responsibilities need to be modified to accommodate the extended time it requires to care for someone with C. difficile and the additional supplies the staff will need to care for Ms. S. Some staff may require education and training on C. difficile.

In the morning stand-up meeting, the interdisciplinary team (IDT) will discuss how we are meeting Ms. S’s needs medically, socially, and emotionally and how we can best support her husband so that their mutually supportive visits continue.

Director of Nursing
Judi Kulus, MSN, MAT, RN, NHA, RAC-CT, DNS-CT
Ms. Kulus has been a certified AANAC RAC-CT Master Teacher since 2004.

With Mrs. S’s change in condition, we have an opportunity to re-examine her resident’s care plan and the interdisciplinary team (IDT) will discuss how we are meeting Ms. S’s needs medically, socially, and emotionally and how we can best support her husband so that their mutually supportive visits continue.

To learn more about emotional and psychological trauma, go to http://bit.ly/2P03cWy.

For access, go to gapna.org/DCS

The overall goal of this course is to provide Nurse Practitioners with knowledge necessary to provide high quality dementia care management.

9.00 contact hours available
Member Price: $39.00
Standard Price: $59.00

The John A. Hartford Foundation
The overall goal of this course is to provide Nurse Practitioners with knowledge necessary to provide high quality dementia care management.
intake to maintain and improve Mrs. S’s weight, monitor her fluid balance due to the diarrhea, continue management of the loose stools, and assess and monitor her depression, which might be exacerbated by the illness and isolation. Additionally, efforts should be made to replenish Mrs. S’s normal gastrointestinal tract flora, which naturally will be depleted from antibiotic therapy and C. difficile infection. Even with a BIMS score of 12 (“moderately impaired”), Mrs. S may be able to participate in her recovery plan and share her food-related likes and dislikes, which may help to increase her appetite and intake.

The Significant Change of Status Assessment (SCSA) Minimum Data Set is required when a resident has two or more changes in condition that will not normally resolve in about two weeks. In the case of Mrs. S, this may apply to the diagnosis of C. difficile, the loose stools, and the weight loss. Staff should monitor her condition to determine whether an SCSA will be necessary.

Nutritionist
Rebecca Myrowitz, MHS, RDN, CSOWM, LDN, CPH
Ms. Myrowitz is a registered dietician who currently provides dietary consultation in a continuing care retirement community.

In caring for Mrs. S, the dietitian should perform a physical assessment to determine if fat or muscle losses are evident because these help to classify the severity of malnutrition. Some weight loss may be expected due to lack of appetite, antibiotic therapy, and a prolonged period of loose stools, but I would recommend close monitoring of weekly weights with a goal of no further weight decline. Mrs. S should be encouraged to have small, frequent meals. She may find it easier to incorporate fortified foods to increase energy density. Hydration should be a consideration as well, and she should be encouraged to replete electrolytes with broths, Gatorade, or a clear liquid supplement. Due to the continued loose stools, I would encourage Mrs. S to pick fewer milk-based foods and incorporate more soluble fiber such as oatmeal.

Additionally, it is imperative that the team be aware of her advance directives and whether Mrs. S chooses to receive intravenous fluids or enteral nutrition, should it be suggested. She may benefit from a nocturnal meal to help support her oral intake and meet her estimated nutrition needs. Because Mrs. S has a history of dysphagia and aspiration, and is tending toward softer or liquid foods, the team may consider a speech consultation to assess her swallowing ability. If she has dentures, she may want a dental consultation because weight loss can contribute to ill-fitting dentures. Due to her history of depression coupled with her current lack of appetite and the contact isolation, I would recommend a behavioral health referral.

The team may consider adding a probiotic like Florastor to restore her gut flora, and vitamin C with the ferrous sulfate to aid absorption. If the ferrous sulfate is causing nausea, she may want to take it with food.

Dr. Resnick is the Sonya Ziporkin Gershovitz Chair in Gerontology at the University of Maryland School of Nursing in Baltimore. She is also a member of the Editorial Advisory Board for Caring for the Ages.

Ms. Hector is a clinical educator and professional speaker specializing in clinical operations for the interdisciplinary team, process improvement and statistical theory, risk management and end-of-life care, and palliative care, among other topics. She is a member of the Editorial Advisory Board for Caring for the Ages. She is passionate about nursing homes and supporting staff to care for the most vulnerable people in their communities.