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## Guiding Clinical Practice: Prevention and Screening Recommendations for Adult Nursing Facility Patients

Michele Friedman DNP<sup>#</sup>

<sup>#</sup>Department of Nursing, Allen College, UnityPoint Health, Iowa, USA

<sup>#</sup>**Corresponding author:** Michele Friedman DNP, Department of Nursing, Allen College, UnityPoint Health, 1825 Logan Ave. Waterloo, Iowa 50703, USA

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### Abstract

There is a lack of specific recommendations for prevention and screening recommendations for nursing facility patients. Numerous sources were reviewed and the prevention and screening guidelines as they relate to the adult nursing facility patient were summarized. As a result, it is recommended to individualize patient prevention and screening recommendations, while considering life expectancy. The summarization of these recommendations is significant for providers who provide primary care services to nursing home patients.

**Keywords:** Nursing facility, prevention and screening, guidelines

### Introduction

Patients who reside in nursing facilities require providers to consider multiple variables while providing medical care. The provider must consider overall health status, current conditions, and patient wishes. Clinical guidelines help providers decide when to start screening, but rarely speak to when to discontinue. Nursing home residents are often debilitated in one way or another. This could include mental or physical limitations. Often residents reside in a facility because they are unable to care for themselves. Residents are not only elderly, but also younger residents with born with neurological conditions, acquired brain injuries, or other conditions that have limited their ability to live independently.

Screening for medical conditions in patients is often a requirement and a clinical responsibility. Many health providers complete Medicare's Adult Wellness Visits (AWV). The adult wellness visit is a specific visit to address needed screening and prevention measures, among other things [1]. The AWV is a way to focus time and energy on screenings and prevention. Payor sources, including Medicare will incentivize screening and prevention through pay for performance [2]. Screening and prevention measures in a young, healthy individual are clear and relatively straight forward. However, when providing screening and prevention for a chronically ill, institutionalized patient, who is of advanced age, screening requires thoughtful evaluation of individual needs. Prevention is key to keeping healthy patients healthy and preventing the chronically ill patients from further insult.

Similar to patients in the community, nursing facility patients require screening and prevention measures. There are multiple screening recommendations. Each must be addressed individually. This may require discussion with patient, family, guardians, or even the legal system. Screenings and preventative treatments might include immunizations, screening exams, screening labs, and screening diagnostic tests.

Various sources were searched to find a concise recommendation for prevention and screening recommendations that were specific to nursing facility patients. Key words, "nursing home patients screening and prevention guidelines" and "geriatric screening and prevention guidelines" were searched within the Primo database. Though there are many individual guidelines for screening and preventative care for adult patients, there is not a summative of the recommendations as they pertain to nursing facility patients. This paper will discuss common screening and preventative recommendations for adult patients who reside in a nursing home. The summary of recommendations as they relate to adult nursing home patients and considerations for their use are summarized in (Table 1).

Immunizations	Recommendation	Source	Considerations
COVID	Evolving, eval yearly	[3]	
Hepatitis B	2 doses given 2 months apart Age 19 through 59 60 years or older with risk factors for hepatitis B infection. Adults who are 60 years or older without known risk factors for hepatitis B may also receive hepatitis B vaccine.	[3]	
Influenza	Yearly inactivated or recombinant only after age 50 MenACWY vaccination for: adults at increased risk for meningococcal disease MenB vaccination for: People 10 years or older at increased risk for meningococcal disease	[3]	
Pneumococcal	PCV15 or PCV20 for those who have never received any pneumococcal vaccine for adults 65 years or older and Adults 19 through 64 years old with certain medical conditions/other risk PPSV23 Adults 19 years or older who received PCV15 (not indicated for those who have had PCV20)	[3]	
Tdap	Every 10 years	[3]	
Zoster	2 doses of Shingrix, 2-6 months between doses. If missed 2nd dose, give ASAP, do not restart series	[3]	Can give if history of Zoster, wait until lesions are healed
<b>Screening Exams</b>			
Dental	Regularly	[4]	Cooperation with exam
Diabetic Foot	Yearly for diabetic patients	[5]	
Vision	Every 1-2 years	American Academy of Ophthalmology [6]	Cooperation with exam
<b>Screening Labs/ Diagnostics</b>			
Bone density DXA	Every 2 years >65 or if post-menopausal with risk factors	USPSTF [7]	Able to transfer to a table with or without assistance, and lay flat on back
Hepatitis C	At least once in a lifetime for all adults aged 18 years and older Routine periodic testing for people with ongoing risk factors and people with selected medical conditions, including dialysis	[8]	
Hemoglobin A1C	>45 years old: every 3 years. Diabetic patients: twice yearly. If uncontrolled DM, more frequently	[5]	Avoid tight control in elderly or with decreased life expectancy
Lipid profile	Young Adults (Men Aged 20-45 Years, Women Aged 20-55 Years): every 5 years Middle-Aged Adults (Men Aged 45-65 Years, Women Aged 55-65 Years) In the absence of ASCVD risk factors, screen middle-aged individuals for dyslipidemia at least once every 1 to 2 years. More frequent when multiple global ASCVD risk factors are present Older Adults (Older Than 65 Years) Annually screen older adults with 0 to 1 ASCVD risk factor for dyslipidemia Older adults should undergo lipid assessment if they have multiple ASCVD global risk factors	[9]	Screen only if planning to treat. Benefit vs. risk Greater than 65 year old: lipid level do not change very much Discontinue when life expectancy is less than 10 years [10].
Low dose computed tomography	Yearly People who— Have a 20 pack-year or more smoking history, and Smoke now or have quit within the past 15 years, and Are between 50 and 80 years old.	[11]	Stop screening when: Turns 81 years old, or Has not smoked in 15 or more years, or Develops a health problem that makes patient unwilling or unable to have surgery if lung cancer is found USPSTF [12].

Pap smear	Age 25- 65; primary HPV test* every 5 years. If primary HPV testing is not available, screening may be done with either a co-test that combines an HPV test with a Papanicolaou (Pap) test every 5 years or a Pap test alone every 3 years. Over 65, if routine screenings in the past 10 years with normal results and no history of CIN2 or more serious diagnosis within the past 25 years should stop cervical cancer screening.	[13]	Cooperation with exam Positioning for exam Wishes and goals
PSA	Age 50 and older if greater than 10-year life expectancy Age 45 and older for high risk (African Americans, first degree relative with prostate CA prior to age 65) Age 40 for men at even higher risk (those with more than one first-degree relative who had prostate cancer at an early age).	[14]	Life expectancy at least 10 years Wishes and goals
TSH	The ATA recommends beginning TSH screening in all adults at age 35, with repeat tests every 5 years. American Thyroid association, 2001 The AACE recommends routine TSH screening in older patients, with no specified age. The USPSTF continues to recommend against routine screening for thyroid disease among nonpregnant adults. USPSTF. 2015	[15,16]	Screening for those with psychiatric illness or on high-risk medications (amiodarone, antipsychotics)
Urine Microalbumin	Yearly for diabetics	[5]	Ability to obtain sample
Mammogram	Women between 40 and 44 have the option to start yearly. Women 45 to 54 yearly. Women 55 and older every other year, or they can choose to continue yearly mammograms.	[17]	Positioning for mammogram Life expectancy at least 10 years Wishes and goals
Colon cancer screening Tests: fecal immunochemical test annually; high-sensitivity, guaiac-based fecal occult blood test annually; multitarget stool DNA test every 3 years; colonoscopy every 10 years; computed tomography colonography every 5 years; and flexible sigmoidoscopy every 5 years.	45 years and older with an average risk of CRC screening with either a high-sensitivity stool-based test or a structural (visual) examination. Average-risk adults in good health with a life expectancy of more than 10 years continue CRC screening through the age of 75 years. Individuals aged 76 through 85 years based on patient preferences, life expectancy, health status, and prior screening history; and discourage individuals older than 85 years from continuing CRC screening.	[18]	Wishes and goals Life expectancy
AACE (American Academy of Clinic Endocrinologists), ACE (American College of Endocrinology), ACS (American Cancer Society), ADA (American Diabetes Association), CDC (Center for Disease Control), USPSTF (United States Preventative Services Task Force)			

**Table 1:** Summary of Screening and Prevention Recommendations.

### Immunizations

Immunizations are important to the prevention of disease. The Center for Disease Control provides recommendations for immunizations. There are very few contraindications for immunizations. With the recent pandemic, health care providers and patients are even more attuned to the availability of immunizations. Additionally, the pandemic has brought about many new vaccines that are evolving routinely. As of the writing of this paper there are still frequent changes to the recommendations for COVID.

It would seem easy to make a clinical decision regarding vaccinations for patients. However, there are considerations. First, is the vaccine appropriate? Do the benefits outweigh the risks? Is there a contraindication? Next, Is the patient willing and accepting of the immunization. One of the common issues encountered in practice is not having an accurate immunization record.

## Screening Exams

Some nursing facilities offer special services within the facility to provide exams for vision, dental and foot exams. State and federal regulations require nursing facilities to provide dental care by the nursing facility [19]. Routine dental exams are important due to the consequences of poor dentition: pain, infection, poor dentition, and chewing ability. The American Dental Association recommends regular screenings [4]. Vision screening is recommended every 1-2 years by the American Academy of Ophthalmology. A vision exam can screen for common conditions that affect the aging [6]. Diabetic foot exams are recommended to be done yearly. Diabetic foot exams are important in the prevention of diabetic ulcers and amputations. The American Diabetes Association recommends a “comprehensive foot evaluation at least annually to identify risk factors for ulcers and amputations” [5]. Barriers to completing recommendations are cost to the patient and/or facility, transportation, and limited specialty resources.

When should providers stop offering these screening exams? The provider must individualize the treatment recommendations. For example, if a patient is bed bound, does not open eyes, there would be no need for vision screening. Similarly, if a patient has advanced dementia with agitation, a dental screening would be difficult.

## Screening Labs/ Diagnostics

Screening for diabetes and complications of diabetes are important to patient care. Glycosylated Hemoglobin (Hgb A1C) is recommended to be routinely checked for screening and for treatment monitoring [5]. In those with established diabetes, urine microalbumin should be monitored. As mentioned above, diabetic foot exams are also highly recommended for prevention of complications from diabetes [5].

Cancer screenings are important for early detection of cancer. According to the American Cancer Society, women of adult age should be screened for cervical, breast, and colon cancer. Adult men should be monitored for colon cancer and prostate cancer. Colon cancer screening recommendations include evaluation with either fecal test or direct visualization [18]. Lung cancer is the leading cause of deaths by cancer. The CDC recommends low dose CT scan for those with risk [11]. Recommendations for cancer screening do include information about when to stop screening, but this could be subjective and is sometimes difficult to determine.

Other adult screening exams include lipids, TSH, Hepatitis C, and bone density exam. Thyroid disorder screening has guidelines provided by three different agencies. The ATA and the ACE have recommendations for screening, but not specific, and the USPSTF does not recommend screening. There are no recommendations regarding when to stop screening for osteoporosis, but the gold standard for screening is the BMD assessment by Dual energy x-ray absorptiometry (DXA). Hepatitis C testing is now recommended for any adult at least once in the lifetime, more frequently if risk factors exist. This is not an exhaustive list of all possible preventative and screening measures for nursing home residents. For completeness, fall prevention, infection prevention, skin screening assessments, cognition assessments, depression screening, pharmaceutical reviews and others should be routinely evaluated for nursing facility patients. And finally, the most important prevention is the goals of care conversation. This conversation prevents unwanted life sustaining measures. Documenting the patient wishes on a portable medical orders document (POLST) is important to communicate wishes across the continuum of care [20,21].

While evaluating current clinical guidelines, it became clear that the recommendations are not written specifically for nursing home residents. Therefore, this author recommends the provider should consider the following regarding screening and preventative services for nursing facility patients.

- What does the patient want? Is the family on the same page as the patient? Do you need to negotiate?
- Does the benefit outweigh the risk? (colonoscopy in patient with severe lung disease, risk for respiratory compromise)
- How will the patient complete the test? (Mammogram on a bed ridden patient)
- Will the results change treatment? (Lung cancer screening in patient who cannot have surgery or treatment)
- What is the life expectancy of the patient?

Life expectancy is presented in some of the guidelines regarding when to stop screening. However, there are no recommendations on how to calculate life expectancy. A Google search identified many calculators available, but a universally accepted life expectancy calculator is not identified. There are calculators for banking and insurance and there are also some very thorough calculators for health risk assessments. Ideally a government health agency or other organization would provide guidance on life expectancy. Identifying life expectancy is important not only for screening measures, but also in terms of discussing goals of care. Identifying a standardized tool for calculating life expectancy should be a health care priority for clinicians and administrators. The implications of utilizing a life expectancy calculator to exclude tests and treatments go far beyond the scope of this paper. This author recommends further research and guideline development for calculating life expectancy in the clinical practice setting.

Many barriers are identified when attempting to provide screening evaluations for patients. First, there are patients who verbally agree to a screening test or treatment, then refuse to have done the day of the planned test. Other barriers could include availability of medications or testing supplies, the skill and ability of staff to obtain a specimen or sample, and others. Patients who are incompetent to make decisions present a particular type of challenge. Ideally, decision making for these tests and treatments should be done in collaboration with the patient, DPOAHC, or guardian. Identifying the correct decision maker and communicating with them can be difficult as they are not often with the patient at the time of the provider visit.

Another issue that can arise is when a patient has inconsistent goals of care. For example, a patient who has been admitted to hospice, but still wants to have some testing done. This creates a conflict. Often this requires further education and discussion. Consider the patient who has dementia, does not speak, but does mobilize around the facility and seems happy. The patient was admitted to hospice after being weak from having COVID. Now it is time for influenza vaccines to be given at the facility. Should this patient be offered a flu vaccine? Cases like this are where clinic judgement and experience are valuable.

In conclusion, providing prevention and screening for nursing facility patients can be challenging. There are many variables to consider. However, incorporating a standard recommendation into practice could ease some of the difficulty. Screening and prevention are important for nursing facility patients, and it is important to individualize the recommendations to meet the needs of each patient.

### Author Note

I have no conflicts of interest to disclose

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