A Nursing Home Documentation Tool for More Efficient Visits

As baby-boomers grow old and live longer, family physicians will be at the front line of caring for our aging population in long-term care, and the care of the elderly in a nursing facility is substantially different from the care rendered in the hospital or in ambulatory practice. For this reason, nursing home care is now a required curricular activity in family medicine residencies. Our family medicine residency program has a nursing home educational and continuity experience that consists of a minimum of six visits by the resident over two years – long enough for the resident to witness the impact of interventions and the natural progression of frailty, dementia, and other disease states.

We found that our residents had difficulty shifting from practicing acute-care medicine to long-term care. To help organize their thoughts and shift their focus to “slow medicine,” we developed a standardized clinician documentation tool for nursing home care. Our goal was to better identify the needs, problems, and resources of patients residing in nursing facilities. Although the form was designed for family medicine residents, we think that it can easily be incorporated into the practicing physician’s routine and, if used at every visit, can help improve efficiency without compromising quality.

Our search of the literature, including the Family Practice Management Toolbox (http://www.aafp.org/fpm/toolbox), yielded no similar tools for physician documentation in the nursing home. Nursing documentation in this setting is typically limited to the minimum data set, resident assessment protocols, and tools for monitoring an isolated quality indicator (e.g., pain expression or urinary incontinence).

It can be helpful to think of nursing home residents as divided into three types – those with cognitive issues such as dementia, often with the accompanying behavioral problems; those with functional deficits due to physical disability such as gait disturbance with subsequent falls; and those with both cognitive and physical limitations. Recognition of the “geriatric syndromes” listed on page 21 as common but often overlooked conditions affecting older persons has allowed for more comprehensive evaluation and management strategies in geriatric care. The nursing home documentation tool that we developed incorporates the traditional SOAP components of the progress note, but with a focus on the geriatric syndromes.

Using the form

The form fits on one page for ease of use. Components are grouped in boxes, with special attention to the components with a geriatric focus, such as geriatric syndromes, function, and code status. The exam portion has some cues for assessments commonly used in geriatrics, such as the Folstein Mini-Mental State Examination, the Geriatric Depression Scale, and the Cornell Scale for Depression in Dementia. Since nursing home care relies heavily on the interdisciplinary team, an “Other Disciplines/Care Plan” box is set aside for information derived from nursing staff, physical therapy, and consultant input. When doing an initial assessment, the physician can fill in the static items (such as the code status, past medical history, medications, social history, and review of systems/geriatric syndromes) using this information from visit to visit.
# Nursing Home Documentation Form

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Room:</th>
<th>Date:</th>
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## Code Status:  □ Full  □ DNR / DNI  □ Other:  

- **Family Contact:** POA:
- **Admit Date:**
- **Previous Facility:**

## PMH:  HTN  |  HLP  |  CAD  |  DM  |  CHF  |  COPD  |  CVA  |  Dementia

## ROS / Geriatric Syndromes:

### Function (Activities of Daily Living)
- Bathing
- Dressing
- Toileting
- Transferring
- Feeding
- Continence

### Cognition:
- Mood: (Depression, anx, behav)
- Sensory: (Vision, hearing)

### Falls / Gait:

### Nutrition:

### Exercise:

## Exam

- Pain Scale: Wt: ↑ / ↓  
  - HR | BP

### Gen:

### HEENT:

### Pulm:

### CV:

### ABD:

### Rect:

### Ext & MS:

### Skin:

### Neuro:

### Sit
- Get-up & go:
- Grip strength:

### Psy:
- MMSE:
- GDS:
- CSDD:

## Medications

- **Start Date**
- **ALL:** □ NKDA

- **Vacc**  Date
  - Td
  - Zoster
  - Pneu
  - Flu

## Social

- **Current Activities:**
- **Former Occupation:**
- **Living Relatives/Friends:**

## CC / New Concerns

## Assessment & Plan

## Meds

- **Start Date**

## Other Disciplines / Care Plan

## Signature:  

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The tool incorporates the traditional SOAP components of the progress note, but with a focus on the geriatric syndromes.

The authors have developed a nursing home documentation form to improve the efficiency and quality of care. Completing the form may add time to the first visit but can streamline subsequent visits. Since most family physicians have relatively few nursing home patients, a tool like this can help manage the complexities of nursing home care.

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GERIATRIC SYNDROMES
- Dementia/cognition
- Depression
- Falls
- Functional decline
- Malnutrition/failure to thrive
- Frailty
- Pressure ulcers
- Urinary incontinence

Send comments to fpmedit@aafp.org.