This one-page form can help improve care, keep visits patient-centered, and even save you some time.

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,"[1] 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 afflicting 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

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NURSING HOME DOCUMENTATION FORM

PATIENT: _____ **ROOM:**_____ **DATE:** _____

CODE STATUS: ☐ FULL | ☐ DNR / DNI | ☐ OTHER:
FAMILY CONTACT: POA:
ADMIT DATE: LEVEL OF CARE:
PREVIOUS FACILITY:

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

MEDICATIONS START DATE

ALL: ☐ NKDA

VACC	DATE
Td	
Zoster	
Pneu	
Flu	

SOCIAL
CURRENT ACTIVITIES:
FORMER OCCUPATION:
LIVING RELATIVES/FRIENDS:

CC / NEW CONCERNS

ROS / GERIATRIC SYNDROMES

FUNCTION (activities of daily living)

I = Independent S = With Supervision
A = Moderate Assist X = Max Assist

	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: _____
_____ Dentition: _____
PULM: _____
CV: _____
ABD: _____ **RECT:** _____
EXT & MS: _____
SKIN: _____
NEURO: _____
SIT → STAND: _____ Get-up & go: _____ Grip strength: _____
PSY: MMSE: _____ GDS: _____ CSDD: _____

OTHER DISCIPLINES / CARE PLAN

ASSESSMENT & PLAN

SIGNATURE: _____

Use back if necessary. ➤

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

visit, updating as necessary, and writing in a new exam, other disciplines/care plan, assessment, and plan at every follow-up visit. The time required to complete the form varies with physician and patient, but we found that this form helped our residents adjust to the needs of the nursing home patient much more quickly. Although the initial visit may be time-consuming when using this tool, the form helps drive a more patient-centered visit as opposed to one that is merely disease oriented, and the information added at the initial visit serves as a valuable database for subsequent visits.

The complexity and diversity of nursing home patients, coupled with the infrequency of physician visits to the nursing facility, creates the potential for missed diagnoses, undetected problems, relative neglect, problems with transitions of care, and polypharmacy. Most family physicians and internists doing nursing home care spend two hours or less per week rounding on patients.[2] According to a 2008 American Academy of Family Physicians' survey, the average family physician has 9.6 nursing home patients and visits 2.3 nursing home patients per week.[3] Some innovative changes in nursing home and geriatric care have helped to improve quality. The institution of the mandated minimum data set is one such change; physicians rarely review it, though. Our documentation tool is a useful reminder of the importance of the minimum data set and an aid to sifting through the complexities of the nursing home resident's care. The form has considerably improved the efficiency of our family medicine residents, and we believe that it can be widely used with the same benefit for all practicing clinicians who see patients in the nursing home. FPM

Send comments to **fpmedit@aafp.org.**

GERIATRIC SYNDROMES

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

1. McCullough D. *My Mother, Your Mother: Embracing "Slow Medicine," the Compassionate Approach to Caring for Your Aging Loved Ones.* New York, NY: Harper; 2008.

2. Katz PR, Karuza J. *Geriatric Review Syllabus: A Core Curriculum in Geriatric Medicine.* 6th ed. New York, NY: American Geriatrics Society; 2006:119.

3. American Academy of Family Physicians. Table 5: Average number of family physician visits per week and average number of patients in various settings, June 2008. In: Facts about family medicine. Available at: www.aafp.org/online/en/home/aboutus/specialty/facts/5.html. Accessed Jan. 16, 2012.

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.

About the Authors

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