APPROACH TO THE MONTHLY VISIT

The approach to any medical encounter should be directed toward accomplishing the goals for the visit. While a goal for a scheduled nursing home visit is to meet regulatory imperatives, this is the minimum standard. A more thoughtful consideration of goals will contribute to a visit more beneficial to the resident and the facility and more rewarding for the physician, nurse practitioner, resident physician or geriatrics fellow.

The general goals for nursing home visits are to: 1) provide a safe and supportive environment for chronically ill and dependent persons, 2) maximize individual autonomy, functional capacities, and quality of life, 3) stabilize and delay, if possible, the progression of chronic illnesses, and 4) prevent subacute and acute illnesses (Ann. Intern. Med. 1994;121:584–92).

Adapting these goals to the individual nursing home patient requires careful consideration of each resident's unique medical, psychological, and personal circumstances. This need for holistic evaluation creates stimulating intellectual, emotional, and ethical challenges for the physician that reach far beyond mere regulatory compliance.

The following is a structure for routine nursing home visits according the formula: Record Review, Vital Signs, Eyes-Ears-Teeth-Feet, Bowel and Bladder, Skin, Diagnoses, Administrative Concerns, Orders.

Record Review

Begin by reviewing the medical record, paying particular attention to problems or changes that have occurred since the last regulatory visit. Look for orders called in by covering providers, and review recent lab results. Look for documentation of personal changes that may affect the patient's mood, such as a room change, death of a roommate or family member, visits from distant relatives, or winning a recent Wii bowling tournament in the facility.

Review the patient's code status and formal advance directive. Be sure you are aware of whether the patient or a surrogate is the legal decision maker.

Examine the medication list, looking for opportunities to manage polypharmacy. Note whether PRN medications are being used, and if so, how often and with what benefit.

Note issues raised by interdisciplinary team (IDT) members.
Responding to IDT concerns now is more productive and efficient than responding to faxes later.

Lastly, review the diagnosis list. Record review will help prioritize your examination of the patient. If the record lacks needed information, ask for it now so it may be obtained while you are examining the patient.

**Vital Signs**

As in most medical encounters, the first step of the exam is assessing vital signs. The most important vital sign in chronic disease management is weight and its change over time. Ideally, trend data for all vital signs will be available. I take vital signs myself only when the reported vitals seem not to make sense. Every medical specialty has an “extra” vital sign. In the case of nursing home medicine, there are two: a measurement of pain and pain trends (is your patient flagging for pain on the Minimum Dataset [MDS]) and formal assessment of cognitive status. For cognitive evaluation over time we use the Mini Cog which can be found in the instruments section of this site. You can also use the MDS PHQ-9 which should be recorded in the MDS.

**Eyes-Ears-Teeth-Feet**

Assessments of vision, hearing, speech, chewing and swallowing, ambulation, and fall risk are important. Successful medical management of deficits in these areas can preserve function and enhance quality of life. Are the resident's glasses on and clean? When was visual acuity last checked? Macular degeneration and blepharitis are easily overlooked; consider these two common diagnoses at every visit.

Are there hearing aids, and if so are they in place and functioning? Do you need to use a voice amplifier to successfully communicate with the patient? Are the ears free of obstruction? A common nursing home procedure is removal of ear wax, a humble but important task so don’t forget your otoscope.

When examining the mouth, look for unaddressed dental needs and assess hydration status. If there are concerns about swallowing, test the patient at the bedside. If the results are problematic, consider a more thorough speech evaluation. Be particularly attentive to oral issues when your patient is flagging for weight loss.
Looking at the feet reminds me to ask the patient or nurse about walking ability and whether there have been recent falls. Of course, having the patient demonstrate his or her transfer and walking skills is better than just asking. Assessing foot hygiene and nail care is an effective quality assurance activity. Good foot and nail care generally reflects attentive personal care overall. If the nails or calluses are difficult to care for, consider a podiatry consult with your attending.

**Bowel and Bladder**

Is the patient continent? Incontinence is obviously a nursing concern and a resident dignity issue and needs to be addressed at every visit. Is a urinary catheter present? Is it needed chronically for urinary retention, or can it be safely removed? Is an adult incontinence product being used? Is the patient wet or soiled at the time of your visit?

**Skin**

Skin integrity is a major issue for patient comfort and appearance. I assess skin immediately after assessing bowel and bladder, recognizing that incontinence is a major contributor to pressure sores and other skin problems in the perineal area.

Doing a full skin exam is logistically difficult and may require a nurse or CNA to help disrobe the patient and serve as a chaperone. Are there any lesions worrisome for skin cancer? If so you may need to consult Dr. Usatine or the patients dermatologist of choice.

**Diagnoses**

This is the part that physicians and nurse practitioners do instinctively. The length of the medical problem list can make this task daunting. Fortunately, at most visits, most problems are stable.

The extent of the physical exam is dictated by the need to perform and document areas relevant to the patient’s medical problems. Patients with congestive heart failure are carefully assessed for weight gain, rales and edema; those with osteoarthritis, for symptomatic joint findings; patients with dementia for progression on the FAST scale or Mini Cog, depending on your attending.

**Administrative Concerns**
Now that the assessment is nearly complete, ask yourself, What might come up before your next monthly visit? Are the patient's goals and family's expectations compatible with the nursing home care plan? If your patient with advanced dementia is full code, is it time to readdress code status with the surrogate decision maker? Is it time to transition to an explicit palliative care plan?

This outline is also useful in caring for residents of assisted living facilities. The biggest administrative concern for any checkup in that setting is determining whether the level of care is still appropriate. If not, does the resident need additional in-home services, or is it time to move to a higher level of care?

Orders

Lastly, review and sign the orders. The words to write at this point are, “Orders are reviewed and renewed with the following change(s).” Provide a summary of the reasons supporting any change.

The predictability of this outline keeps me on track for nursing home, assisted-living, and home visits, and it lets staff know what to expect and how to provide assistance. The outline is also helpful for admitting and annual exams. At admission, the physical will be more comprehensive and the orders must address transition of care issues. For the annual exam, the patient should be gowned and in bed, with a chaperone available, so you can complete a thorough exam. This is also the time to consider whether the goals for each medical issue are still appropriate, and to evaluate the utility of preventive medicine interventions.

This outline is not useful for acute visits. If we are asked to see a patient because of an elevated temperature or a change in mental status, our actions should be driven by the chief complaint. A comprehensive assessment is not necessary. When an acute problem is discovered during a routine visit, one essentially must do two visits: one assessing the patient's overall status as outlined above, and the second focusing on the acute issue.