

The Admission Visit in LTC: A Detailed Guide

M. Rosina Finley MD, David Espino MD, Dr. Robert Parker MD, Liliana Oakes MD, Kathleen Owings MD, TK NP, Dianne Rudolph NP

SUBJECTIVE*

- **Current Chief Complaints:**
Review with the nurse, patient, and the patient's family (if present), and the ACH transfer information packet
Review weight bearing status (for patients with orthopedic conditions) and write activity orders with this as a reference
Review transfer information packet to identify specialist/PCP f/u visits and write orders for the patient to attend the visit
Review the labs and x-ray sections from the ACH transfer information packet (make a plan for needed f/u labs, etc.)
- **Review of Systems:**
Collect from nurse, patient, and the patient's family (if present). If the patient has dementia and is unable to provide this information list this as a reason under the ROS.
- **Social History:**
Collect from the Demographics sheet (face sheet), prior H&Ps, nurse, patient and the patient's family (if present)
- **Medications:**
Each medication must be accompanied by a diagnosis (please write a clarification order on the physician's order sheet if you do not find a diagnosis for each of the medications). Leave parameters that you would like to be called on.
Review Doctor's orders back to the date of the consolidated orders being printed (if patient is a readmission)
Review stop dates for medications, coumadin, plavix, and antibiotics (remember to dc IV's including PICC lines). If any tubes including PEG tubes need to be reinserted or removed, first contact the physician placing the tube and ask for any special considerations before reinserting or removing the tubes. Some tubes such as a PEG tube must not be reinserted within a certain time of placement without direct visualization and confirmation of placement.
Wean medications as deemed appropriate.
Get a list of the patient's home medications as soon as possible after the Admission. Compare this list to the admission list to see whether the patient should be on the home medication during their nursing home stay.
- **Infectious diseases:**
Patients with infections such as MRSA and C.Difficile must be in private rooms (active treatment) or cohorted (post treatment). Ask the nurse or DON for guidance in this area if you are unsure.
- **Treatments:**
Review the Doctor's orders back to the date of the consolidated orders being written (if patient a readmission).
- **Wound Care:**

Review the Doctor's orders back to the date of the consolidated orders being written (if patient a readmission)

- **Functional level:**
Review with the nurse, physical therapist, and/or the occupational therapist and/or the speech therapist. If the patient is considered a one or two-person lift please ask for assistance if a two-person or greater is deemed the safest route of assisting a patient and you are needing to assist them to or from bed. Also, include rehab potential comment, i.e. good, fair, poor.
Use of side rails for assistance with mobility in bed must have an order written to clarify this use.
- **Cognitive level:**
Review advanced directives, guardianship/DPOA/POA, Acute Care Hospital of choice information (note these on your note, i.e. DNR/DNI/DNH and DPOA/POA). Speak when appropriate to guardians and DPOAs and document your conversations in the progress notes. Some physicians notify the nurse and ask that the nurse record this information on the chart for them, i.e. Dr. X called to report that he/she had reviewed the following information with the Guardian/DPOA, etc.
Review with the nurse, patient, and the patient's family (if present)
- **Diet:**
Review the Doctor's orders back to the date of the consolidated orders being written if patient a readmission (review MBSS information and necessary changes in diet)
- **Stooling History:**
Last BM (usually listed on the aide data collection sheet and/or the nursing admission record). If the patient is on opioid-like drugs you must order a bowel regimen for preventing and treating constipation.
- **Health Care Maintenance:**
This is negotiated between the MD/NP and the patient or the patient's DPOA/proxy. Document declines in HCM in the progress note. (Address as indicated for short stay patients).
Include TB skin testing status and vaccinations for pneumonia and influenza.
- **Past Medical History:**
Review problem list on the consolidated orders (for readmissions), previous progress notes, previous history and physicals, patient, and patient's family (if present).

*Information can also be gathered from the nurse's admission data sheet, the nurse's monthly assessment sheet and/or the Minimum Data Set and Resident Assessment Protocol sheet as well as the patient's care plan and transfer packet information

OBJECTIVE

- Vital signs, including the O2 saturation on percentage of O2 being delivered (most recent are usually found in the nurse's notes or the MARS or the monthly is found on the Nurse's Monthly Assessment sheet. Leave parameters that you would like to be called on.

- Pain evaluation, function evaluation, cognition evaluation
- Note if patient on home O2 and if patient may need BPAP or CPAP during their nursing home stay.
- This month's weight, last month's weight and previous months' weights if not stable (will be in the monthly/weekly weights book and the monthly vitals signs sheet found on the patient's chart)
- Accucheck's (usually listed on the MARS)
- Labs/X-rays (usually in transfer information packet)
- Physical Exam:
General exam and assessment of wounds, IV sites, PEG sites, Foley sites

ASSESSMENT/PLAN

- List the top 4 problems that you are working with, starting with the one you spent the most time with and so on. If the patient is stable and there are no new issues, consider listing any issues addressed since the last visit via telephone and the ones that you are following up on from previous visits)
- Health Care Maintenance: Always offer the standard of care and let the patient and/or their DPOA/family accept and/or decline it. Keep in mind the patient's overall health and where they are in the spectrum of each illness when offering the standard of care. Some MDs/NPs chose the first visit after the patient's birthday as their HCM visit while some perform the HCM visit during the first three months of the patient's stay in the nursing home.
- Advanced Directives (offer hospice services when indicated.)

1/08/2007

2/28/07