The Continuity Approach to the Follow-Up Visit in LTC

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SUBJECTIVE*

- Current Chief Complaints:
  Review with the nurse, patient, and the patient's family/guardian/DPOA/proxy (if present)
- New issues since the last routine visit:
  Review the Doctor's orders written since the last routine visit
  Review the Nurses' notes written since the last routine visit
  Review the Consult's notes written since the last routine visit
- Follow-up from the last routine visit:
  Review the Progress notes written from the last routine visit (the A/P should be kept updated from month to month)
  Review the labs and x-ray sections .
  Review the UT Medicine Nursing Home Communication Book.
- Review of Systems:
  Collect from nurse, patient, and the patient's family (if present)
  If the patient has dementia list this as a reason under ROS for not getting information from the patient
- Social History:
  Collect from the Demographics sheet (face sheet), prior H&P's, 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)
  Review Doctor's orders back to the date of the consolidated orders being printed
  Review stop dates for medications, coumadin, plavix, and antibiotics (remember to dc IV's including PICC lines)
  Wean medications as deemed appropriate for the patient
  Order medication appropriate labs
  Leave hold parameters that you would like medications to be held for
- Treatments:
  Review the Doctor's orders back to the date of the consolidated orders being printed
- Wound Care:
  Review the Doctor's orders back to the date of the consolidated orders being written
- Functional level:
  Review with the nurse, physical therapist, and/or the occupational therapist and/or the speech therapist
  Be aware of patient's one-person/two-person assist status before assisting patients in and out of bed.
  Include rehab potential comment, i.e. good, fair, poor.

- 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)
  Review with the nurse, patient, and the patient's family (if present)
  Speak with the guardian/DPOA/POA for health care directives when appropriate
- Diet:
  Review the Doctor's orders back to the date of the consolidated orders being written. In dementia patients ask the nurse/aide if patient has had any problems with coughing while eating.
  If patient is no longer safe to eat or patient has had a significant decline and is not eating, address artificial feedings and hydration with the patient/DPOA/guardian. If artificial feeds/hydration are
  Declined, document this in the chart. Order a MBSS when indicated.
- Infectious diseases:
  Be aware of isolation policies such as MRSA and C. Difficile, i.e. active treatment patients must be placed in private rooms while post-treatment patients must be cohorted. Ask the nurse/DON for assistance, if needed.
- Stooling History:
  Last BM (usually listed on the aide data collection sheet)
  If the patient is placed on a opioid-like drug, order a prevention and treatment plan for constipation on the chart
- 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.
  Include TB skin testing status and vaccinations for pneumonia and influenza
- Past Medical History:
  Review problem list on the consolidated orders, previous progress notes, and previous history and physicals

*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 Protocols sheet, as well as the patient's care plan

OBJECTIVE

- Vital signs including the O2 saturation on percentage of O2 being delivered (most recent are usually found in the nurse's notes, the MARS, or the monthly is found on the Nurse's Monthly Assessment sheet
- Pain, function, and cognitive assessment
- Leave parameters that the MD should be notified for
- 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
- Physical Exam:

General exam and assessment of wounds, IV sites, PEG sites, Foley sites (If tubes need to be reinserted, replaced, or dc'd please contact the physician placing the tube(s) and address this issue before proceeding. Some tubes i.e. PEG tubes must have special visualization for placing and validating position).

ASSESSMENT/PLAN

- List the top 4 problems that you are working with, starting with the one you spent the most time with and descending. (if the patient is stable and there are no new issues, list any issues addressed since the last visit and consider listing problems addressed by 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 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.) Confirm that booster TB skin testing has occurred and has been documented. Confirm that vaccinations for influenza and pneumonia have been offered and when given have been documented.
- Advanced Directives (offer hospice services when indicated)

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