AMERICAN MEDICAL DIRECTORS ASSOCIATION
HOUSE OF DELEGATES
RESOLUTION B91

SUBJECT: **Role of the Attending Physician in the Nursing Home**

INTRODUCED BY: **AMDA Board of Directors**

INTRODUCED ON: **December, 1991**

The attending physician should:

1. Comprehensively assess each resident and coordinate all aspects of medical care.

2. Implement specific treatment/services to enhance and/or maintain physical and psychosocial function.

3. Participate in the development of individual care plans and review and revise such plans periodically in conjunction with the health care team.

4. Review progress of each resident relating to individualized therapy (i.e. speech, Development, PT) and, in concert with the appropriate therapists, approve continued use.

5. Evaluate the need for rehabilitative services. Order appropriate measures and assistive devices to reduce the risk of accidents.

6. Evaluate the need for physical and/or chemical restraints, minimizing their use whenever possible.

7. Periodically review all medications and monitor for both continued need based on validated diagnosis or problems and periodically review for adverse drug reaction. Jointly review and develop recommendations of the residents' medication profile in conjunction with consultant pharmacists.

8. Physically attend to each resident in a timely fashion consistent with established state and federal guidelines. Document progress and changes in care plans. Arrange for appropriate back-up or alternate coverage.

9. Respond in a timely fashion to medical emergencies.

10. Facilitate information transfer between acute and long term care facilities.

ROLE OF THE ATTENDING PHYSICIAN IN THE NURSING HOME

1. Comprehensively assess physical, functional and health status of each resident, identify care plan priorities and coordinate all aspects of medical care. Implement specific treatment/services to enhance and/or maintain physical and psychosocial function.

2. Participate in the interdisciplinary development of individual care plans and review and revise such plans periodically in conjunction with the health care team.

3. Review progress of each resident relating to individualized therapy (i.e., speech, OT, PT) and, in concert with the appropriate therapists, evaluate the need for rehabilitative services. Discuss the integration of rehabilitative strategies into the daily care of the resident to the extent possible. Order appropriate measurea and assistive devices to reduce the risk of accidents.

4. Evaluate the need for physical and/or chemical restraints; minimizing their use whenever possible.

5. Periodically review all medications and monitor for both continued need based on validated diagnosis or problems and periodically review for adverse drug reactions. Jointly review and develop recommendations on the residents' medication profile in conjunction with consultant pharmacists. Recognize the need for cautious observation in prescribing new medications for frail elderly.

6. Physically attend to each resident in a timely fashion consistent with established state and federal guidelines. Document progress and changes in care plans. Arrange for appropriate back-up or alternate coverage.

7. Respond in a timely fashion to acute change in health status of resident.

8. Facilitate information transfer between acute and long term care facilities.

9. Inform residents of their health status and, whenever possible, optimize each resident's ability for self determination; determine each resident's decision making capacity while assisting in establishing advance directives. Discuss with the resident the role of the family in directing the resident's care. Need to interface with families when patient's condition acutely deteriorates or transfer is considered. Initiate, document, and communicate

the process of determining appropriate treatment intensity plans, including but not limited to issues of resuscitation, based upon discussions with the patient) or the appropriate surrogate) and the physician's best judgment of the overall prognosis for the resident.

10. Seek participation in the essential committees of the nursing home; i.e., quality assurance, infection control, pharmacy, etc.

Prior to admission

- personally approve a resident's admission to a facility, and the level of care
- advise the facility if you know that a mentally ill or mentally retarded prospective admission has not been appropriately screened by a state mental health agent prior to admission

On admission

- assess the resident, and write admission orders
- indicate whether the individual has discharge potential
- place a medical assessment on the chart within 48 hours of admission, which includes a medical review of past history and current status, and an evaluation of physical and psychological condition and functional status;
- advise the staff about a resident's decision-making capacity
- help ensure that the resident is informed of his health status, including medical condition, in a comprehensible language
- certify when residents are incapable of self-administration of medications
- help other staff understand the relationship of the medical plan of care with those of other professional disciplines
- write admission orders which reflect an individual's physical and psychological needs, and wishes, as much as possible;
- designate an activity level consistent with condition and prognosis, as well as specify pertinent limitations to, or precautions for, such activities
- advise the facility about whether the resident should receive Pneumovax or flu vaccine.

Physician visits

- arrange, or provide for, alternative coverage in case you are unavailable
- at each visit, review the resident's total care plan, including medications and treatments, and write, sign, and date a progress note
- visit a resident at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter
- make scheduled visits within 10 days of the scheduled date
- make the initial visits personally
- arrange, where desired, for alternate visits to be made by an appropriately supervised physician assistant or nurse practitioner

During the resident's stay, as needed

- perform or request an appropriate assessment of functional levels and rehabilitation potential, and request or approve specific rehabilitative services
- encourage the limited and judicious use of restraints, protective devices, and psychotropic medications, and document periodically the reason for their continuation
- consider and order, as indicated, specific treatments or services that may help the staff maintain or enhance a resident's quality of life and self-determination
- prescribe activity levels consistent with a resident's needs, condition, and interests
- order appropriate measures to try to prevent and manage declines in ADL function
- order appropriate treatment and assistive devices to try to maintain vision and hearing capabilities
- order appropriate measures to prevent or treat pressure sores

- order appropriate evaluation and management of urinary incontinence
- appropriately assess behavior and mental status changes, and consider the possibility of treatable medical illness or psychiatric dysfunction as a cause
- order evaluation and treatment to try to maximize movement and prevent contractures
- order appropriate intervention, testing, and treatment to try to improve or maintain psychosocial functioning
- order appropriate evaluation, diet, or treatment to maintain adequate nutritional and hydration status
- order tube feedings appropriately and judiciously
- order appropriate measures and assistive devices to try to reduce a resident's risk of accidents
- order appropriate therapeutic diets, as indicated
- strive to order medications judiciously, and observe for untoward side effects and complications --especially regarding psychotropic medications
- monitor for possible drug complications in specific residents
- periodically review and sign off on an interdisciplinary care plan
- provide relevant medical information to other caregivers
- periodically reevaluate a resident's physical status and needs, psychiatric and behavioral status and needs; mobility; functional limitations; nutritional status; rehabilitation potential and needs; activity level; and oral status and needs
- request evaluations, consultations, or tests as needed to help clarify a resident's condition, prognosis, and potential to benefit from programs and services
- respond in a timely manner to notification of problems or changes in condition, and status, and order appropriate monitoring, tests, treatments or transfers
- consider the value of certain primary, secondary, and tertiary preventive measures which might improve function, reduce pain and discomfort, enhance autonomy, reduce morbidity and mortality, prevent the spread of communicable illness, reduce subsequent need for more costly and prolonged medical care, or permit a more comfortable dying process
- periodically review the resident's use of, and need for, PRN medications
- specify whether a resident will require medications during a short- or long-term leave of absence, and authorize appropriate supplies
- periodically review the resident's level of care, to ensure that the resident's needs are being met and the placement is appropriate for that level of care
- write necessary medical orders for: pads, mattresses, or cushions; splints or orthotic devices; protective devices; supplemental oxygen; respiratory therapy equipment, or suctioning
- write orders for appropriate special precautions, consistent with an individual's condition or illness

Moving the resident

- certify and document the medical necessity or appropriateness of admissions, transfers, and discharges
- provide an appropriate discharge summary, which includes information about: diagnoses, post-discharge rehabilitation potential, clinical course, current medical orders, and other information pertinent to the individual's care
- as necessary, make or facilitate transfer arrangements
- provide a pertinent and timely discharge summary.

General

- ensure that your orders comply with established policies and procedures, and are consistent with standards of appropriate geriatric care
- respond appropriately and in a timely fashion to questions or items raised by the pharmacist consultant
- provide appropriate orders for necessary laboratory and radiology testing, and follow up in a timely fashion on the results of these reports
- include pertinent assessments, medical care plans, and progress notes in the medical record
- review and cosign physician assistant or nurse practitioner notes and orders on subsequent visits, as required by law or regulations
- complete medical information on the death certificate, in accordance with legal requirements
- as needed, fill out and sign the medical portion of any appropriate incident reports or forms.

Special situations

- assist the medical director and facility in prevention, management, and reporting of significant infections and outbreaks
- order appropriate precautions, preventive measures, vaccinations, or treatment of actual infections, consistent with accepted standards of geriatric medical practice
- assist the medical director in informing staff caring for residents with potentially serious or reportable communicable illnesses
- ensure that the admission of any AIDS patient is consistent with applicable regulations, facility policy, and the capacity of staff to provide needed care
- assist the staff in dealing with difficult families, by providing adequate and timely information and support

Resident rights and ethical issues

- attempt to help other staff respect and enhance certain resident rights, including the right:

1) to know the identity of his primary attending physician
2) to information from a physician about his condition and prognosis
3) to know about procedures and who will do them
4) to refuse to be a research subject
5) to freedom from restraints, except as specified by a physicians for justifiable medical and psychiatric needs
6) to transfer or discharge only for medical reasons or personal welfare
7) to be involved in care planning and decisions about care and treatment
8) to exercise free choice of medical care
9) to preserve personal privacy and confidentiality

- inform the medical director if the resident's wishes, needs, or condition limit or restrict your ability to provide adequate and appropriate care
- offer the resident or family member appropriate information about care and treatment, or any changes in that care or treatment
- help ensure that the resident (unless incompetent or incapacitated) participates in planning care and treatment
- discuss the use of feeding tubes with the resident, or with family or other substitute

decision maker, as appropriate, before ordering them

- assist the facility's staff in managing the terminally ill resident, including understanding the condition, prognosis, and care plan
- upon admission, clarify the status of any resident with a known terminal illness or condition
- determine, or request a review of, the resident's decision-making capacity
- inform the facility staff if you are aware of the existence of any documents, such as durable power of attorney or living will, or other statements of the resident's or family wishes
- encourage the resident and family or other substitute decision maker to complete appropriate forms and documents to provide ample written evidence of their wishes and intentions
- order any appropriate medications to help relieve pain or make the dying process more comfortable
- help provide the resident, family, and facility staff with pertinent information about condition, prognosis, treatment options, and possible or likely outcomes of treatment
- consider whether the individual has previously expressed any treatment preferences, or issued any specific instructions for care
- present the treatment options to the competent resident, or to the substitute decision maker for the incompetent resident
- as necessary, inform the administration of any need for the facility's assistance in obtaining an appropriate substitute decision maker consistent with state law
- periodically review a DNR order after reassessing the resident's condition, to ensure that the order remains appropriate, and consistent with the resident's needs and wishes
- clarify any implications of the advance directives for specific treatments such as antibiotic usage or transfer to an acute care facility.