

UNIT NO. 3

PRINCIPLES OF HOME ASSESSMENT

Contributors: Dr Ng Wai Chong, Dr Tham Weng Yew, Dr Ng Yuen Yuen

PREVIEW

This unit outlines the objectives and procedural aspects of making a home visit..

OBJECTIVES

At the end of this unit, the course participants should be able to describe:

1. the need for home visits
2. the differences between home and clinic assessments
3. the indications for a home visit
4. the preparation for a home visit
5. the presentation of problems in frail and homebound older persons.

1. Why Home Visits?

- a. One of the central goals of health care for older people is to optimize their general health, functional capacity and quality of life. This requires the identification and skillful management of psychosocial and environmental problems, in addition to the medical problems. A narrow approach to the diagnosis and treatment of medical problems alone may not suffice, if the other issues are neglected. For the home bound frail older person, psychosocial and environmental factors that confound therapeutic efforts are likely to originate and manifest in the patient's home. Therefore, an understanding of the home environment may prove critical to providing effective care.
- b. It is not easy for the physician to obtain a good mental picture of the patient's home environment based on the history obtained during the patient's visit to the clinic. Important details are often found wanting, especially if information offered by the patient or the accompanying relative may not always be reliable. The information may be biased at times and the informants may not always

recognize the presence of serious problems (eg. environmental hazards) in the home. Some issues may not be readily picked up at clinic interviews, such as the dynamics of the relationship between the patient and the other members of the household. A visit to the patient's home will expand the scope and enhance the quality of a comprehensive patient assessment.

- c. The major goal of a home assessment is to gain an understanding of the patient's
 - κ health and functional status
 - κ physical and social environment (including support systems) and the interaction between these factors.

2. Comparison between home and clinic assessments

- a. Opportunities

An assessment in a clinic visit is usually focused on the more traditionally defined medical problems. Home visits provide the clinician with opportunities to

 - κ inspect the home environment
 - κ interview household members
 - κ observe the patient's functional skills and interpersonal interactions and evaluate the characteristics of the neighbourhood.
- b. Challenges

Unlike office consultations, home assessments pose challenges such as:

 - κ limited availability of equipment and resources
 - κ limited control over the setting for assessment eg. adequacy of lighting, space to maneuver, bed height, noise and heat
 - κ need to travel to the patient's home
 - κ patients may not be accessible eg. not at home or no one to open the door.

3. Indications for a Home Visit

- a. The house call is the most common type of home visit made by primary care physicians. However, house calls are often made for acute medical problems and the focus during such visits is the diagnosis and treatment of specific illnesses in the traditional medical model. Therefore, over and above the occasional house call, the physician could avail himself/herself of other opportunities to perform home visits.
- b. Home visits could be made for the following reasons:
 - κ Assessment
 - κ Acute problems
 - κ Review
 - κ Maintenance
 - κ Procedures: diagnostic and therapeutic.
- c. Assessment visits
Assessment visits are made when a patient has been referred upon discharge from hospital or when on-going problems (eg. recurrent falls) are detected by family members, health care personnel (eg. the community nurse) or social workers.
The aim of the assessment visit is to:
 - κ Identify the needs of the patient and care giver(s)
 - κ Determine if the patient is suitable for home care
 Because of the multifarious issues involved in some cases, it may take a few visits to complete the assessment.
- d. Acute problem visits
These visits are usually initiated by the patient or the care-giver because of complaints which have developed acutely. The focus is on the diagnosis and treatment of the medical condition. The physician has to decide if admission to hospital is necessary or if treatment can be instituted in the home.
- e. Review visits
Acute conditions need to be reviewed after treatment has been instituted eg. pneumonia or

urinary tract infection which has been treated with a course of antibiotics. Likewise, subacute problems such as depression, recurrent falls, or care giver stress need to be reassessed after a trial of intervention. Review visits are also made to obtain an update of patient status after major events eg. surgery or a period of prolonged hospitalization.

- f. Maintenance visits
These visits are directed at regular maintenance follow-up of chronic illness such as hypertension and diabetes mellitus. The physician could also use these interval follow-ups to screen for unreported early problems such as constipation, depression, and changes in cognitive status.
- g. Visits for procedures
Home visits could be scheduled to carry out a variety of procedures including:
 - κ Nursing procedures eg. change of urinary catheters, nasogastric tubes and wound dressing
 - κ Bedside surgical procedures eg. wound debridement, incision and drainage of abscess, toilet and suture of lacerations
 - κ Diagnostic procedures eg. venepuncture for collection of blood specimens, recording a 12-lead ECG
 - κ Communication and counseling eg. communication of care plans, patient and care-giver education and training
 - κ Forensic procedures eg. disability or death certification.

4. Preparation for the Home Visit

Adequate preparation prior to conducting the visit helps to ensure efficiency so that optimum results could be achieved by the visit and repeat visits for unaccomplished tasks are minimised.

- a. Building up rapport with the patient and care-giver.
This is done even before the physician makes the

home visit. Initial communication of purpose, roles and administrative details are usually necessary. This may include explanations of the purpose of the visit, what the physician can and cannot provide, expected charges to be incurred, and means of contacting the physician. This initial communication also gives the physician the opportunity to listen to the concerns of the patient and care givers, and their expectations. A good initial impression made by the physician on the patient and care givers goes a long way to making the ensuing home visit effective, fruitful and enjoyable.

- b. Knowing the purpose of the visit
Before the visit is made, the physician must be clear about the purpose of the visit:
 - κ Why is there a need for the assessment?
 - κ Is there an acute problem?
 - κ Have there been recent problems that need to be reviewed?
 - κ Is it time for a maintenance visit?
 - κ Is there any diagnostic or therapeutic procedure to be performed?
- c. Knowing what to bring for the visit
The contents of the familiar black bag that the doctor brings along during the home visit should be checked and maintained regularly. Not everything needs to be packed all the time and the physician should anticipate what would be required for a particular visit he/she makes. Suggestions for items to be included in the home visit bag are given in Table 1.
- d. Making an appointment with the patient and care-giver
An appointment must be made with the patient and the care giver before the home visit. It is sometimes important to request for the presence of certain key family members (eg. those who are able to provide the relevant history or persons who are key decision makers) during the visit.

Table 1: Equipment to be brought for the home visit

For Clinical Assessment	
o Stethoscope	o Vaginal speculum (disposable)
o Sphygmomanometer	o Lubricant gel
o Thermometer	o Latex gloves (disposable)
o Tendon hammer	o Glucometer and strips
o Pen-torch	o Urine reagent strips (for protein, leucocytes, nitrite, blood)
o Ophthalmoscope and Otoscope set	o ECG machine
o A pocket Snellen's Chart	
o Proctoscope (disposable)	
For specimen collection	
o Syringes and needles (disposable)	o Blood specimen collection tubes
o Tourniquet	o Urine and stool bottles
o Alcohol swabs	
For therapeutic procedures	
o Scalpel (disposable)	o Naso-gastric tube
o Basic dressing set (disposable)	o Chlorhexidine solution
o Sterile gauze and swabs	o Normal saline solution
o Paper towels	o Hydrogel / hydrocolloid dressing
o Mask and Apron (disposable)	o Transparent dressing
o Crepe bandage	o Micropore tape
o Urinary catheter	o Container to collect sharps
o Urine bag	
Drugs	
o Bisacodyl / glycerin suppositories	o Analgesics
o Phosphate enema	o Antiemetics
o Antibiotics	o Antihistamine
Stationery	
o Prescription pad	o Laboratory request forms
o Memo pad	o X-ray request forms
o Death certificate	
References	
o Drug formulary	o Important telephone numbers
o Therapeutic manual	
o Geriatric assessment instruments	

5. Presentation of Problems in Frail and Homebound Older Persons

Disease presentation could be somewhat different in older persons. It is usually characterised by:

- a. Under-reporting of symptoms
Older people and their family members tend to attribute many disease symptoms to ageing. Hence problems are ignored until they become quite severe. It has been reported that hypochondriacs are less common in the elderly than in the middle-aged
- b. Multiple pathology
Most studies reveal an average of 3 to 4 major problems per person older than 65 yrs. The clinician has to be aware of disease-disease and disease-treatment interactions in older persons
- c. Functional loss
Older people are likely to present with a deterioration of function rather than specific symptoms of disease. Functional decline is the final common pathway in disease manifestation. A given functional loss may result from one or more different pathologies
- d. Non-specific presentation of diseases
Ageing restricts the capacity to maintain homeostasis. Perturbation by disease, trauma or drug toxicity will manifest in the most vulnerable organ. For example, a urinary tract infection could present with congestive cardiac failure and confusion
- e. Altered presentation of diseases
Atypical presentations are quite 'typical' of older people eg. painless acute myocardial infarcts and apathetic thyrotoxicosis

- f. Alert flags that the home care physician needs to watch out for include:

- κ Recurrent falls
- κ Medications discrepancies
- κ Deterioration in function
- κ Increased hospital attendance
- κ Increased anxiety/ hypochondriasis in a previously stoic elderly.

RECOMMENDED READING

Besdine R.W. Clinical Approach: An Overview, in Geriatric Medicine, Spring Valley, New York, 1997. Pages 155-68.

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5. Kane RL, Kane RA (ed). Assessing Older Persons, Oxford University Press, 2000.
6. Ramsdell JW. Geriatric Assessment in the Home, Clinics in Geriatric Medicine, 1991; 7:677-93.
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KEY POINTS

- κ **Each home visit should be purposefully made through careful planning and preparation. This will help to minimise wasted time and trips.**
- κ **Disease presentation could manifest differently in frail older people. One should look beyond the typical signs and symptoms and pay particular attention to changes in physical and mental function.**