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HOME CARE BRIEFING®

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Client Selection: Comprehensive Screening and Assessment Can Help Optimize Home Care, Limit Risk

According to the Federal Interagency Forum on Aging Related Statistics there will be 74 million Americans age 65 and over by 2030, representing almost 21 percent of the total U.S. population – up from 15 percent in 2014. As the senior population increases, so too does the number of individuals hoping to remain in their home and "age in place." In response to this growing consumer demand, many personal care and home care providers are increasing staff and expanding service offerings. However, as services change or expand, new exposures may arise from both a regulatory and professional liability perspective. To diminish their potential impact, providers must ensure that services comport with state practice regulations, as well as the rules and regulations of the state nursing board. In addition, providers should thoroughly evaluate prospective clients for their care requirements and prepare detailed service plans based upon their medical condition, degree of orientation and functional capability.

Comprehensive guidelines for client screening, assessment and service planning help ensure that personal and home care organizations comply with statutory and regulatory mandates, while also demonstrating their capability to provide the necessary physical and human resources, staff expertise and range of services that clients require. This issue of *Home Care Briefing*® examines the elements of a prospective client screening and assessment procedure, and offers a number of suggestions to help strengthen documentation in these areas. The resource also reviews related issues, including service planning essentials and requirements for ongoing client monitoring.

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Client Screening. An effective screening procedure reduces the risk of inappropriate client selections by ensuring that prospective clients are suited for personal or home care services and that their needs do not transcend the services, capabilities and resources of the organization. The goals of a pre-admission screening are threefold: 1) To determine an applicant's medical and non-medical service needs, 2) assess their suitability for the home care/personal care setting and 3) initiate the care-planning process.

Providers should thoroughly evaluate prospective clients for their care requirements and prepare detailed service plans based upon their medical condition, degree of orientation and functional capability.

The screening process commences with an interview of the prospective client and the family or primary caregiver(s). An experienced staff member who is knowledgeable about the services the organization is capable of providing should conduct the interview *prior* to contracting for services. The screening process should focus on the following areas, among others:

- **Medical and cognitive status,** including medical diagnoses, allergies, presence and stage of Alzheimer's disease/dementia, behavioral patterns, recent surgeries/hospitalizations, presence of indwelling devices (e.g., catheters and endotracheal tubes), standing physician orders, ability to comprehend information and instructions, and existence and level of pain.
- **Fall risk and fall history,** including near falls and those with and without injury.
- **Physical limitations,** including limits on activities of daily living, bladder and bowel continence, toileting assistance requirements, ambulation/transfer needs, assistive devices and tele-monitoring equipment used, extremity weaknesses and deficits to vision, hearing or speech.
- **Medications,** including the current drug regimen, medication self-administration abilities or assistance needs (e.g., pill crushing, injections) and requirements for monitoring drug dosages and/or their effects.
- **Skin integrity,** including a detailed description of wounds or other skin-related issues and notation of any specific wound care needs.
- **Nutrition needs,** including prescribed or special diets, feeding abilities, the presence of feeding tubes and any associated care requirements, and meal planning and preparation directives.
- **Safety of the home environment** and necessary modifications for client/caregiver safety and functionality.
- **Medical instructions** in the form of a durable power of attorney for healthcare, advance healthcare directive, physician's order for life sustaining treatment and/or conservatorship papers.

Interviewers also should ascertain prospective client and family expectations and desired services, while imparting caregiver limitations and support capabilities in an honest and forthright manner.

The following strategies can enhance client selection screening and documentation:

1. **Cast the screening process in a positive light.** When initiating screening with prospective clients, focus on how effective screening ensures an appropriate match between client needs and available services and resources.
2. **Expand the number of interviews.** By talking with family members or primary caregivers and current and former medical providers, screening staff can gain a more complete and accurate analysis of the prospective client's deficits and treatment or support needs. Prior to conducting interviews with third parties, request permission from the prospective client. Explain that all information obtained in the screening process remains a part of the application record and is not shared with unauthorized individuals.
3. **Conduct face-to-face interviews.** Every effort should be made to conduct in-person interviews with prospective clients, as well as family members and other supportive individuals. Although telephone interviews may save time, they lack the personal observation which often provides a clearer understanding of the client's needs, and may also create an impersonal first impression.
4. **Record the names of all parties interviewed,** including the prospective client, family members, designated healthcare agent and supportive individuals. Note the relationship of third parties to the client and include current contact information for each individual. Records also should include the name of the staff member conducting the screening interview, as well as the date and time of all interactions.

Client assessments. After screening but prior to commencement of services, assign a qualified staff member to visit the client's home in order to complete a comprehensive initial assessment, determine care needs, identify home environment limitations and concerns, verify the client's suitability for services and obtain information necessary for developing an individualized service plan. A reassessment should occur at least every six months or anytime that the client's condition or needs change. All assessments and reassessments must be documented, including the names of the assessor and individuals participating in the screening/assessment process, as well as the date of completion.

After the screening process and in-home assessment are complete, the information compiled should be reviewed by an admissions team in order to determine if the organization can safely meet the identified needs and expectations from both a medical and non-medical perspective. Before rendering a decision regarding selection, careful consideration should be given – and documented – to organizational capabilities, regulatory compliance, staff availability, competency and training.

Service planning. The prospective client screening process is an opportune time to initiate service planning. Data compiled during the screening and assessment phases serve to identify the specific interventions needed to improve a client's quality of life. Once selected, personal/home care staff can develop a service plan in collaboration with the client and the family, building on the issues, needs and goals previously identified.

More specifically, a service plan should delineate goals and objectives, services to be provided and client monitoring guidelines. It should reflect care that is consistent with the client's advance healthcare directives, and include both the name and contact information of the designated healthcare agent. Changes in a client's condition should elicit a revision to the service plan. A commitment to ongoing, open communication among all parties helps ensure that client and supportive individuals are kept informed of the services being provided, as well as any changes in the client's condition that may necessitate a revision of the service plan.

Ongoing monitoring of services provided. Regular reviews should be conducted to monitor staff compliance with service plan elements. Reviews should encompass an evaluation of the service plan as well as supporting care documents. Unannounced visits to the client's residence by supervisory staff also should be conducted, both during and after personal/home care visits. Inquiries should be posed to the client and the family related to satisfaction with services being provided and any changes to the client's condition or needs.

If it becomes apparent through review activities that the client's needs and/or expectations can no longer be met by the organization, for any reason, the client and the family should be informed of the need for an alternate care provider or a higher level of care. In that event, steps taken to either discharge the client from the organization or transfer him/her to an alternate service provider or facility should be thoroughly documented in the service plan and client care record.

A thorough pre-admission screening and comprehensive assessment process is critical to ensuring proper client selection and care planning. Screening and assessment activities, coupled with careful planning and ongoing monitoring, can help protect clients from unnecessary harm, while promoting quality care and minimizing organizational liability.

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