The First Visit: A Fact-Finding Mission

The initial visit is the best way to paint a complete picture of the client and his or her needs. This fact-finding mission assists in assigning the right caregiver and developing the plan of care.

Begin Your Assessment

Here's a look at each of the tasks on Diane's to-do list in finer detail.

Assess the Client's Current Health Status.

- Gather baseline vital signs—temperature, heart rate, blood pressure, respiratory rate, and pulse ox.
- Perform a head to toe assessment—listening to lungs, heart, and bowel sounds.
- Check skin for any sores, wounds, or pressure ulcers.
- Ask about any relevant past medical history.

Assess the Client's Functional Status.

- Assess the client's level of ability to function (walk, bathe, cook, etc.) independently in the home.
- Check for safety issues, such as dimly lit hallways or trip hazards.
- Perform a fall risk assessment. Use your agency's standardized fall risk assessment tool. If no tool is available, use the Morse Fall Scale. While no tool can perfectly predict accidental falls, the Morse Fall Scale is proven to be valid and reliable.

Assess the Client's Cognitive Status

- Use your agency's cognitive assessment tool. If no tool is available, use the Mini Mental State Exam or the Mini-Cog.

Check Risk for Re-admission

- Use your agency's risk assessment tool. If no tool is available, use the LACE Index Scoring Tool for Risk Assessment of Hospital Readmission.

Reconcile Medications

- Identify all medications the client takes (both prescription and non-prescription), along with dose, time of administration, and route.
- Evaluate each medication for possible side effects or drug interactions. Your agency should have a policy that guides clinical staff regarding when a concern about a client's medication should be reported to the physician.
- Any reportable concerns should be discussed with the client's family and physician.

Client/Family Education

- Make sure the client and family caretakers know how to reach the agency during and after hours.
- Review advance directives.
- Identify strengths, goals, and care preferences.
- Discuss the plan of care and frequency of visits.
- Go over red flag symptoms related to the client's diagnosis.