CP 4.1: Home Visits

Updated:
Reviewed:

Purpose

- To outline the standardized procedure for all home visits performed by the Community Paramedic
- To describe the difference between initial and repeat visits for the same diagnosis
- To describe the difference between medical and non-medical/educational visits

Policy Statements

The Community Paramedic (CP) will provide home visits for patients in response to a Request for Service from a primary health care provider or a Health Authority.

The Request for Service form must be received from an appropriate referral source and contain requests for appropriate services to be provided by the CP based on the CP's scope of practice and permitted services.

The referral will include the patient's name, date of birth (DOB), contact information, diagnosis, reason for visit, the requested services to be provided by the CP and the reporting expectations based on the results founds.

Procedure

1. **REVIEW** the patient's health history, care plan, lab results, list of current medications and any other pertinent information as provided by the referring agency or health care provider. *NOTE: It is important that the CP become familiar with the patient's condition and needs as much as possible prior to the first visit.*
2. **SCHEDULE** the CP visit with the patient within the first 24 hours. Suggested verbiage for the encounter is, "Your physician has requested that I stop by your home and check in on you, what time would be convenient?"
3. **ARRIVE** at the patient's home in a marked vehicle.
4. **ARRIVE** at the visit wearing an official BCEHS uniform and official BCEHS identification.
5. Upon arrival, **EXPLAIN** the purpose of the visit and **OBTAIN** verbal consent.
6. **PERFORM** a home safety screen in conjunction with a falls risk screen on initial visit and report any concerns to health care team.
7. **COMPLETE** the initial assessment screen as outlined on the Community Paramedicine Initial Assessment Screen form. The screen and accompanying assessments may be conducted over a few visits based on patient's tolerance, time and condition.
8. **PERFORM** head-to-toe assessment and **OBTAIN** a set of vital signs (HR, RR, BP, T, SpO_2) and any additional assessments (e.g. weight, glucometer reading, cap refill, pain score, etc.) as requested on Request for Service form/careplan.
9. **PROVIDE** treatment, care and/or other assessments as outlined on the Request for Service form/careplan.
10. For initial Non-Medical/Educational Visits: **FOLLOW** the same procedures as medical visits without vital signs, physical assessment or treatment services. In consultation with the health care team, the CP may suggest adding more services if indicated after the initial assessment is completed.
11. **COMPLETE** services as requested. If more services are indicated, **CONTACT** the primary health care provider to obtain additional direction.
12. **SCHEDULE** follow-up visit(s) as necessary or as per primary care provider direction.
13. For subsequent visits under same referral, **PERFORM** focused assessment based on findings from previous visit(s) and **COMPLETE** services as requested or as per care plan.

Documentation

DOCUMENT on appropriate records:

- Initial health assessment screen on Community Paramedicine Initial Assessment Screen form

- Head to Toe assessment on Physical Assessment form
- Vital signs can be plotted on vital sign graphic record if trending of vital signs is desired
- Arrival time, departure time, visit summary, care provided, any additional assessments or services provided and who/when notified of any concerns on Community Paramedicine Client Visit Progress Notes

References

1. Eagle County Paramedic Services. Community Paramedic Protocols Manual. 2013. [Link]
2. Tri-County Health Care Emergency Medical Services. Community Paramedic Policy & Procedure Manual. 2016. [Link]
3. Vancouver Coastal Health. Vancouver Community AOA Practice Guidelines. Initial Assessment Tool – Guidelines for Use. March