Home Health and Assisted Living Self-Assessment

ProAssurance
Treated Fairly

This self-assessment is intended to help evaluate systems and processes that may improve patient safety and potentially reduce professional liability.

A-Always, S-Sometimes, N-Never, NA-Not Applicable		A	S	N	NA
General Patient Care					
1.	Identify risks to the organization using multiple sources such as: claims; adverse events or suboptimal outcomes; incident reports; reports of near misses or other concerns; patient and employee satisfaction surveys; complaints; retrospective chart reviews; self-assessments; discussions with staff.				
2.	Complete periodic review of outside resources (e.g., ECRI Institute, professional associations, quality improvement organizations, centers for home care research) to improve the quality and safety of home care.				
Admission and Patient Expectations					
3.	Utilize patient admission criteria.				
4.	Have patients and family members document their review of services and level of care available, including services that are not provided.				
5.	Review all materials for unsupported promises or other problematic language implying an unreasonable warranty or guaranty of care. Examples of materials include brochures, website, telephone-hold messages, etc.				
6.	There is a process for addressing patient and family concerns. Describe process or give examples: _____ _____ _____				
Assessment and Care Planning					
7.	Changes in condition are clearly and completely documented.				
8.	Changes in condition trigger a review of the care plan.				
9.	There is a reliable method for communicating changes to the care plan to all relevant staff. Describe the method or give examples: _____ _____ _____				

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Patient Education and Engagement					
	Patient and family education documentation includes:				
10.	Patient care expectations.				
11.	Patient and family responsibilities for self-care and patient safety.				
12.	Signs and symptoms to watch for, including mistreatment/abuse recognition.				
13.	What the patient and family should do in the event of each sign or symptom.				
14.	Instructions for use and maintenance of devices and equipment provided by the organization.				
15.	A copy of all educational materials provided to the patient and family.				
16.	Confirmation of patient understanding (e.g., using teach back).				
Mistreatment/Abuse					
17.	Staff training includes mistreatment and abuse recognition at orientation and annually.				
18.	Annual staff training includes reporting processes for suspected mistreatment/abuse consistent with state guidelines and investigation of all allegations.				
19.	Document that residents and family members receive orientation regarding mistreatment/abuse recognition and reporting to the organization and state agencies, including contact information.				
Falls Prevention and Management					
	Falls prevention and education documentation includes:				
20.	Home safety assessment.				
21.	Results of home safety assessment are used to perform safety education for patients and family.				
22.	Informing patients and family members of the importance of reporting falls.				
23.	Training and guidelines on preventing falls for all relevant staff members.				
24.	Comprehensive post-fall assessments.				
25.	A post-fall observation of patients performing activities of daily living.				
26.	Contributing factors and post-fall interventions after a fall occurrence, including a revised care plan as needed.				
27.	Staff training on the reporting of falls and near misses.				
28.	Fall reports include number of falls, severity of falls, follow-up care needed, and modifications.				
29.	After a fall occurrence, the frequency of visits is reviewed to monitor the patient's status.				
30.	Falls are analyzed at the patient, agency, and corporate levels.				
Pressure Ulcer Prevention and Treatment					
	Staff education documentation includes:				
31.	Risk factors for pressure ulcer development.				
32.	The organization's available tools and procedures for pressure-ulcer risk assessment, prevention, and treatment.				
33.	Staff follows evidence-based guidelines for pressure ulcer treatment and prevention.				
34.	Staff teaching of how to recognize signs of skin breakdown to patients and family caregivers is documented.				
35.	Staff documents any help given to identify devices that may make it easier for family caregivers to reposition the patient.				

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Prevention of Unnecessary Hospitalizations					
36.	The organization has a program to prevent unnecessary hospitalizations.				
37.	The program addresses multiple factors (e.g., patient self-management of medications, patient understanding and engagement, physician follow-up, red flags).				
38.	Staff education addresses risk factors for hospitalization.				
Environment of Care					
	Safety education for patients and family members is documented and addresses:				
39.	Falls-prevention strategies.				
40.	Fire safety (especially if portable oxygen is used).				
41.	ALF resident participation in annual fire drills.				
42.	Hand hygiene and infection control.				
43.	Other home safety and ALF security topics (e.g., weapons).				
44.	All staff are trained on security measures (e.g., not leaving personal or work items in the car).				
45.	Electronic security policies have been implemented (e.g., device encryption, remote deletion, etc.).				
46.	Staff education and training on security measures and policies is documented.				
Medication Safety					
47.	There is a system for reporting and classifying medication errors and near misses.				
	Medications are reconciled:				
48.	On admission to home care.				
49.	After return from a hospital or other healthcare facility.				
50.	Upon any other applicable changes in condition or treatment.				
	Patient medication profiles include:				
51.	A list of the patient's medications.				
52.	Reasons the patient is taking each.				
53.	Information on dosing, administration, and side effects.				
54.	Notes on medication changes.				
55.	Documentation of communication between staff and patients.				
56.	A staff check for medication changes during each visit is documented.				
57.	Patients with strength or coordination problems that interfere with taking medications are referred to occupational therapy (if applicable).				
58.	Teach back is documented to check for understanding, when appropriate, regarding medication administration.				
59.	The patient response to education is documented.				
60.	Other strategies to improve medication self-management are considered. Examples include visual medication cards, medication diaries, pillboxes, etc.				
61.	Federal, state, and local requirements regarding drug disposal are reviewed.				
	Policies and procedures on drug disposal address:				
62.	Staff and patient education.				
63.	Collection and disposal of unused drugs if they are no longer needed.				
64.	Documentation of drug disposal.				
65.	Assessment for potential diversion.				
66.	An individual (e.g., home care nurse, family member) is designated to be responsible for disposal in accordance with state or local guidelines.				
67.	Staff training includes what to do if a patient or family member refuses to destroy drugs (e.g., document the situation, notify authorities if necessary).				

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Infection Prevention and Control					
68.	The organization follows applicable guidelines on infection prevention and control.				
69.	Fiscal resources have been designated for infection control.				
70.	Responsibility for infection control has been assigned to a staff member.				
71.	The organization has processes for communicating patient infections to staff. Describe process or give examples: _____ _____ _____				
72.	There is a policy addressing precautions for patients colonized or infected with multidrug-resistant organisms (MDROs).				
73.	The organization has a readily apparent method of communicating patient MDRO status.				
74.	Staff training in infection-control policies and procedures is documented annually.				
75.	Staff education addresses what and how to teach patients and family members.				
76.	Education for staff, patients, and family members addresses cleaning and disinfection of the home, patient care equipment, household supplies, and linens (if necessary).				
77.	Staff adherence to standard and contact precautions is monitored.				
	Total Always				
	Percent Always				

Assessment completed by: _____ Date: _____

Item No.	Action Required	Responsibility	Target Date	Date Completed	Initials