**Home Visit Policy**

**Sunniside Practice**

**Document Control**

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# Introduction

## Policy statement

The purpose of this document is to ensure all personnel at Sunniside Surgery fully understand the organisation’s system for the triaging and prioritising of home visits thereby ensuring that patient safety is not compromised.

This policy should be read in conjunction with [CQC GP Mythbuster 71: Prioritising home visits](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-71-prioritising-home-visits). Additional reading can be found at [Section 2.9](#_Further_reading).

## Status

The organisation aims to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the [Equality Act 2010](https://www.legislation.gov.uk/ukpga/2010/15/contents). Consideration has been given to the impact this policy might have regarding the individual protected characteristics of those to whom it applies.

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment. Furthermore, this document applies to all employees of the organisation. Other individuals performing functions in relation to the organisation, such as agency workers, locums and contractors, are encouraged to use it.

# Policy

## Home visit requests

Requests for home visits are received via telephone (usually between 0800 and 1100). They are triaged by a clinical member of the team and recorded on the clinical system. Requests received outside of these times are to be referred to the duty doctor.

When discussing with the patient their condition, it is essential that the following are confirmed:

* Patient’s full name (if not the patient, full name of the person calling, relationship to patient and that consent has been provided)
* Date of birth
* Address
* Contact telephone number
* Named GP
* Known existing medical conditions
* Reason for calling/duration of symptoms
* The patient or carer is to be reminded that staff are not to be unduly exposed to risks.

Risks may include:

* + Moving throughout the premises
  + Animals
  + Second hand (or passive) smoking
  + Any other obvious risks that may cause harm to the employee

In addition, the name, address and telephone number of the next of kin, a family member or nearest keyholder should also be considered in case of a failed visit.

## Home visit justification

Home visits are at the discretion of the GP who will determine if the visit is clinically necessary. Visits are reserved for patients who are genuinely housebound, including those in nursing and residential homes, and terminally ill patients.

A healthcare professional from the organisation may conduct a home visit if they believe the patient’s condition:

1. Prevents them from travelling to the organisation, or
2. The condition may deteriorate as a result of travelling to the organisation

Home visits will not be authorised because of:

1. A lack of transport
2. The patient’s financial situation
3. Childcare issues
4. Poor weather conditions
5. Any other situation deemed inappropriate by the clinician

This organisation will also consider whether alternative ways of assessing the patient are appropriate such as either a video call or a telephone call or, if in a care home, the use of a virtual ward.

Following confirmation that a home visit is required, the delegating GP will ensure that the attending clinician has the necessary skills, knowledge, competence and training to deliver the home visit. Furthermore, appropriate supervision and support will also be provided by the organisation and/or delegating GP.

## Patient obligations and managing risks on a visit

This organisation has an obligation to our staff when visiting any patient’s home and would expect that they are not exposed to risks. While there is no law to protect anyone working in a patient’s home, the organisation would rely on their understanding and goodwill to ensure that the healthcare professional is not unduly exposed to risks during their employment. Not being exposed to risk is an absolute right and should the staff member feel compromised, then this organisation will fully support their decision in all circumstances.

Following any visit, should the staff member be concerned, or have highlighted that the patient’s home is potentially hazardous to their own or others’ health or safety, then a patient contract can be raised to formalise the arrangement. A template contract is available as an annex within the [Dealing with Unreasonable, Violent or Abusive Patients Policy](https://practiceindex.co.uk/gp/forum/resources/dealing-with-unreasonable-violent-and-abusive-patients-policy.1638/).

Expectations would be that the consultation area is smoke free, there is a space to safely enable the clinician to undertake their role, or that any animal that is likely to cause a nuisance is not in the same room for the duration of the visit.

Any risk and mitigating actions are to be recorded using the template at [Annex A](#_Annex_A_–_1).

Details of any contract, risk management or significant event should be detailed within the clinical system, enabling any visiting healthcare professional to view potential risks.

Should there then be non-compliance with this agreement, then the member of the team will need to determine how to proceed on the day. As this organisation has a duty of care to both patient and staff, the ICB is to be consulted to discuss the next steps. This may include requesting that any visits are conducted at an alternative venue. The Defence Union and/or LMC may also be contacted for advice.

For passive smoking concerns, the Royal College of Nursing has produced [Protecting community staff from exposure to second-hand smoke](https://www.pi.nhs.uk/smoking/Final%20RCN%20SHSdoc.pdf) providing guidance for staff and managers.

## Home visit management system

The flow diagram at [Annex B](#_Annex_B_–_1) illustrates the processes that are to be adhered to for home visit requests.

## Lone working

Clinicians will be required to attend patients’ homes on their own and this has been considered and added to the risk assessment at [Annex A](#_Annex_A_–_1). For detailed guidance, see the organisation’s [Lone Working Policy](https://practiceindex.co.uk/gp/forum/resources/lone-working-policy.861/).

## Recording information

The form at [Annex C](#_Annex_C_–) is to be used to record any relevant information during a home visit with the intention that this information supports the organisation’s Quality Outcomes Framework (QOF) aspirations.

## Other clinicians and home visits

At this organisation, suitably qualified clinicians are permitted to undertake home visits and are to follow the process detailed below.

Home visit consultations are to be structured just as if the consultation had taken place in the organisation. The preferred format for home visit consultations is illustrated below.

|  |  |
| --- | --- |
| Complains of (C/O) | The reason the patient has requested the home visit |
| History (Hx) | Onset, exacerbating or relieving factors |
| Past medical history (PMHx) | Record any other medical conditions the patient has |
| Family history (FHx) | If relevant, gather information about the patient’s family history |
| Social history (SHx) | Consider patient background if they are a carer or have carers. Include smoking and alcohol status, consider mood, mobility, nutrition, etc. |
| Drug history (DHx) | Record current medication |
| On examination (O/E) | Conduct an assessment of the patient which must include BP, PR, RR, temperature |
| Diagnosis (Δ) | Document initial diagnosis |
| Treatment (Tx) | Document treatment provided during visit |
| Prescription (Rx) | State (if applicable) what medicines have been prescribed, detailing dosage and frequency |
| Plan | Explain (and document) plan, to include follow-up, advise given, etc. |

The visiting clinician must ensure that the notes made during the home visit are entered on the clinical system in the individual’s healthcare record as soon as they return to the organisation.

## Equipment and medication

Any equipment taken to a home visit is to be visually checked to confirm that it is fit for purpose, i.e., calibrated, serviceable, any package intact and within any expiry date.

# Failed visits process

## Overview

A failed visit is when there is no access to or contact with the patient at a planned or agreed visit and is a priority situation. The time taken to resolve a failed visit may have an adverse or fatal consequence for a patient. There is often a simple explanation when a patient has forgotten the appointment and has gone out. However, a failed visit can also be indicative of a serious incident or issue.

## Responsibilities

All clinicians have a responsibility to act if a patient does not answer their door and the actions required will depend on the role of the clinician. It is advised that the failed visit should be discussed with a more senior member of staff where appropriate to gain support and advice before leaving the patient’s home address.

All staff members must be satisfied that the situation has been seen through to resolution before ceasing to act and this should be documented within the patient’s medical record on return to the organisation.

## Action

If there is no access to or contact with the patient at a planned or agreed visit the following checks should be undertaken:

* Give the person time to come to the door
* Ensure that the correct address for the patient has been provided
* Knock on the door again and (if possible) windows
* Check doors and windows for signs of the patient or any distress
* Speak and look through the letterbox checking for internal signs or smells of any concern, post, milk or paper deliveries, drawn curtains
* Listen for the sound of the television or radio
* Attempt to contact the patient by telephone
* Check with any neighbours as to whether they have seen the person or have any information on the person’s whereabouts
* If undertaking all the above does not resolve the issue within 15 minutes, contact the reception team to confirm that the checklist has been completed. Furthermore, ask them to review the medical records for any relevant information that may give rise to their whereabouts such as a hospital admission

If the patient lives in sheltered accommodation, then the clinician should locate and work with the on-site staff.

## Escalation

If a clinician suspects the person is at risk of serious harm, is critically unwell or that a crime has been committed then they should call 999 immediately and, depending on their role, inform their direct line manager/supervisor.

The clinician should explain the situation and request that the police carry out an immediate welfare check to the property. An indication of the response time should be provided by the police and the clinician should remain at the property to meet the police.

The police will decide whether a forced entry is appropriate based on their own risk assessment. If the person is found within the property, they can assist with providing emergency care, if appropriate, and informing the next of kin.

If the whereabouts of the patient remain unknown, then the clinician should be satisfied that they have undertaken all available measures before ceasing to act any further.

Should any clinician or member of staff have cause for concern that actions are not being taken to locate or safeguard a vulnerable adult then they should escalate this to organisations safeguarding lead.

# Annex A – Home visit risk assessment

|  |  |  |  |
| --- | --- | --- | --- |
| **Risk assessment title** | **Lone working** | **Date of assessment** | **30/05/2024** |
| **Assessment conducted by** | **L H Jones (Ops Mgr)** | **Date of next review** | **29/05/2025** |
| **Contributors** | **P O Smith (PM)** | **Risk reference** | **12/24** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| What are the potential hazards? | Who is at risk of being harmed and how? | What are you already doing to control the risks? | Risk rating | Additional control measures required | To be implemented: by who, by when? | Residual risk |
| Interacting with patients, and their families during home visits increases lone worker vulnerability | Staff members may be assaulted by violent/aggressive/ abusive patients or their relatives | Staff frequently undertake this activity alone; however, there have been no reported assaults to staff in the last 12 months  The organisation has a Home Visit Policy, a Lone Working Policy and a Dealing with Abusive, Aggressive and Violent Patients Policy.  All staff receive conflict resolution training every three years.  All staff are provided with personal alarms. | 9 | Ensure adequate training is provided to all staff on de-escalation techniques and lone working.  Ensure policies are reviewed annually or sooner if required.  Monitor training compliance  Remind staff to test functionality on a regular basis | Ops Mgr – 05/08/2024  PM –  29/05/2025  Ops Mgr – Ongoing  Ops Mgr - ongoing | 6 |
| Theft of equipment | Staff members may be assaulted should a patient, a relative or other person attempt to steal equipment. | All staff maintain close supervision over their equipment during home visits. There have been no thefts of equipment within the last 12 months. |  | Remind staff of the potential of thefts during home visits. | Ops Mgr – ongoing |  |
| Risks or hazards existing in the premises where the visit is taking place | Staff may be a risk of illness or injury due to unknown hazards that exist in the premises where the visit is being carried out. | All staff are aware of the importance and requirement to report any identified risks so either an agreement can be put in place or actions taken to mitigate the risk(s). |  | Remind staff of the importance of identifying, recording and reporting and potential risks. | Ops Mgr – ongoing |  |
| Allegation of inappropriate behaviour | Staff must be mindful of conduct during homevisits | Staff know not to be alone with a vulnerable adult or child during a home visit. |  | Refresher training to be provided on dealing with vulnerable adults and children during visits. | Safeguarding lead – 31 July 2024 |  |

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|  | | **Likelihood** | | | | |
| 1  Rare | 2  Unlikely | 3  Possible | 4  Likely | 5  Almost certain |
| **Consequence** | 5  Catastrophic | 5  Moderate | 10  High | 15  Extreme | 20  Extreme | 25  Extreme |
| 4  Major | 4  Moderate | 8  High | 12  High | 16  Extreme | 20  Extreme |
| 3  Moderate | 3  Low | 6  Moderate | 9  High | 12  High | 15  Extreme |
| 2  Minor | 2  Low | 4  Moderate | 6  Moderate | 8  High | 10  High |
| 1  Negligible | 1  Low | 2  Low | 3  Low | 4  Moderate | 6  Moderate |

# Annex B – Home visit management system – flow diagram

Call received requesting home visit

Arrange an appropriate appointment based on clinical need **at the practice**

No

Yes

Yes

No

Is the patient housebound or terminally ill?

No

Yes

Arrange a timely home visit

Arrange the transfer of the patient to secondary care or advise 999

No

Yes

Is the condition acute or of such a serious nature it merits immediate referral?

Clinician advises patient and issues prescription if required

Can the request be managed by telephone?

Is it feasible to expect the patient to travel to the practice?

# Annex C – Data capture sheet

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient name** |  | **Date of birth** |  | **Patient ID** |  | **Date of visit** |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Blood pressure** | **Blood test arranged (specify, i.e., FBC, HBA1)** | **Cervical screening** | **FEV** | **Smoking status** | **Smoking cessation offered** | **Alcohol intake (units per week)** | **Alcohol advice given** | **Referral to structured education programme** | **Foot examination** | **Influenza and or COVID vaccine** |
| **Chronic heart disease** |  |  |  |  |  |  |  |  |  |  |  |
| **Hypertension** |  |  |  |  |  |  |  |  |  |  |  |
| **Peripheral arterial disease** |  |  |  |  |  |  |  |  |  |  |  |
| **Stroke and transient ischaemic attack** |  |  |  |  |  |  |  |  |  |  |  |
| **Diabetes mellitus** |  |  |  |  |  |  |  |  |  |  |  |
| **Asthma** |  |  |  |  |  |  |  |  |  |  |  |
| **COPD** |  |  |  |  |  |  |  |  |  |  |  |
| **Mental health** |  |  |  |  |  |  |  |  |  |  |  |
| **Dementia** |  |  |  |  |  |  |  |  |  |  |  |
| **Epilepsy** |  |  |  |  |  |  |  |  |  |  |  |

[