Appendix B

Home Visitation Program Model Guide

1. Home Visit Preparation with HDM Initial Malnutrition Assessment
2. PowerPoint Presentation: "Guide to a Successful Nutrition Home Visit"

Home Visit Preparation

1. Review past patient records (medical, AAA, HH)
2. Discuss, when appropriate, with other providers
3. Call to remind patient you are coming
4. Review "Home Visitation" power point presentation

Name:_____Assessment Date:_____DOB:_____ Age: Sex: M/F

Address:_____apt#_____City:_____Zip:_____County:_____

Phone: (___)_____-_____Email: _____

Referred by: _____

HDM Initial Malnutrition Assessment

Demographic/Social

Marital status: Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other ☐_____

Caregiver/ Contact Person:_____Relation:_____Phone: (___)_____-_____

Household Composition:

Alone ☐ Spouse/partner ☐ Spouse and children ☐ Child/children ☐ Relative ☐ Non-relative ☐

Other ☐_____

Medical benefits:

Medicare ☐ Medicaid ☐ None ☐ Other ☐_____

Finances: Below national poverty level? Yes ☐ No ☐

☐ Independently manages all finances and money

☐ Independently manages daily purchases but needs assistance with paying bills/ banking/ large transactions

☐ Unable to manage finances

Currently receiving the following services:

Food stamps ☐ Weatherization ☐ Lifeline ☐ Food Bank/Pantry ☐ Medicaid Waiver ☐

Subsidized Housing ☐ Homemaker program ☐ Veteran ☐ Spouse of Veteran ☐ Home Health Aide ☐

Nursing Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Senior Companion ☐

Other ☐ _____

Race or ethnic background:

Caucasian ☐ Asian, Pacific Islander ☐ African American ☐ Hispanic ☐ American Indian/native Alaskan ☐

Other ☐_____

Legal Guardian? Yes ☐ No ☐ Name:_____Phone: (___)_____-_____

Pets? Yes ☐ No ☐ If yes describe: _____

Pets provided with: Pet food ☐ Table scraps ☐ Both ☐

Perceived Wellbeing

Would you say your physical health over the past year has: Improved ☐ Stayed same ☐ Become worse ☐

Explain why:_____

_____

_____

_____

Would you say your mental health or emotional state over the past year has: Improved ☐ Stayed same ☐ Become worse ☐

Explain why:_____

_____

_____

_____

Would you say your ability to get around and take care of yourself, and to do things for yourself and other people over the past year has: Improved ☐ Stayed same ☐ Become worse ☐

Explain why:_____

_____

_____

_____

Medical/Physical

Primary Doctor: Name:_____Phone: (___)_____-_____

Recent hospital discharge date: _____ Admission Diagnosis: _____

History of hospitalization (past 3 years):

Admission date:_____Admission Diagnosis: _____

Admission date:_____Admission Diagnosis: _____

Admission date:_____Admission Diagnosis: _____

Current medical diagnosis:_____

Self-assessed pain scale: Are you dealing with any pain? Yes ☐ No ☐ Location:_____

If yes rate your pain on a scale 1-10 (1 no pain, 10 worst pain)

1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Medications	
Analgesics	Diuretics
Antacids	Insulin/hypoglycemic Agents
Antibiotics	H_2 Blockers
Anticoagulants	Laxatives
Anticonvulsants	Lipid Lowering
Antihypertensive	Non-Steroidal
Anti-Parkinsonian	Psychotherapeutic Drugs
Cardiac Glycosides	Steroids

Dietary Supplements/Herbals	Dose
Vitamin/Mineral	
Nutrition/Herbal Supplement	
OTC	

Additional details / notes

(Check most appropriate box)

☐ Independently takes medications as prescribed (correct dose and times)

☐ Ability to take medications independently from prefilled daily pill dispenser

☐ Unable to take medications independently

Risk factors for fall and injury, i.e., identify any conditions about this patient that increase his/her risk of falling or injury *(check all that apply)*

Orthostatic hypotension ☐ osteoporosis ☐ gait problem ☐ impaired balance ☐ confusion ☐ Parkinsonism ☐ pain ☐ inadequate assistive device(s) ☐ other ☐

Additional details / notes

History of falls, trip, and/or stumble? Yes ☐ No ☐_____# in the past 6 months_____# GLF (explain)

Bone fractures in the past 6 month? Yes ☐ No ☐_____# in the past 6 months (explain/location)

Sensory impairments affecting functioning *(check all that apply)*

Hearing: Conversation difficulties ☐ deaf ☐ uses corrective aid ☐

Vision: Uses corrective lenses ☐ Blind ☐

Additional details / notes

Cognitive/Behavioral

Mini-Cognitive Test

a. Ask patient to repeat three unrelated nouns. Then tell them you will be asking them to repeat the words later.

b. Instruct patient to draw a clock. Have patient perform task after each instruction item.

   i. Draw clock face
   ii. Place numbers on face
   iii. Place hands on clock to read 11:10
   iv. Repeat the three nouns.

c. Interpretation:

   i. Give one point for each recalled word after the clock draw distracter
   ii. A score of zero indicates positive screen for dementia
   iii. A score of one or two with an abnormal CDT* indicates positive screen for dementia
   iv. A score of one or two with a normal CDT* indicates negative screen for dementia
   v. A score of three indicates negative screen for dementia

   *(*CDT – clock drawing test)*

   Date:_____Score: _____

d. Past Scores

   Date:_____ Score:_____

   Date:_____ Score: _____

Anxiety ☐ Yes ☐ No How long?__(Days/Weeks/ Months/Years)

Depression: ☐ Yes ☐ No How long?___(Days/Weeks/Months/Years)

Mood changes: ☐ Yes ☐ No How long?___(Days/Weeks/Months/Years)

Patient Health Questionnaire (PHQ-2):

Over the past two weeks, how often has the patient been bothered by any of the following problems?

e. Little interest or pleasure in doing things
   0 = not at all
   1 = several days
   2 = more than half the days
   3 = nearly every day

f. Feeling down, depressed, or hopeless
   0 = not at all
   1 = several days
   2 = more than half the days
   3 = nearly every day

Date:_____ Score: _____

Functional

Shopping:

Grocery shopping provided by: Spouse/Family ☐ Friend ☐ Other ☐_____

Frequency:_____per (Week/Month)

Food Preparation:

(Check most appropriate box)

☐ Able to plan, prepare, and serve balanced meals if supplied with ingredients

☐ Able to heat and serve pre-made meals

☐ Unable to prepare, heat or serve meals

Cooking Facilities (check all that apply): Stove ☐ Microwave ☐ Refrigeration ☐ Plumbing/water ☐

Kitchen stocked with adequate food preparation equipment/tools? Yes ☐ No ☐ _____

Able to independently use all food preparation equipment/tools? Yes ☐ No ☐ _____

Kitchen is clean and tidy? Yes ☐ No ☐ _____

Fridge is well stocked? Yes ☐ No ☐ _____

Pantry is well stocked? Yes ☐ No ☐ _____

Foods in kitchen are within expiration dates? Yes ☐ No ☐ _____

Safely reaches items on low and high shelves? Yes ☐ No ☐ _____

Meal preparation: Self (times/week____) ☐ Other person (times/week____) ☐ Nutrition services (times/week____) ☐

Additional details / notes

Home environment

Living room:

☐ Cluttered _____

☐ Couch/chair- patient able to stand from: _____

☐ Rugs_____

☐ Adequate Lighting _____

Bedroom:

Patient able to get on and off of bed? Yes ☐ No ☐

Bathroom: (check all that apply)

☐ Shower handles ☐ Hand held shower ☐ Shower chair ☐ Commode ☐ Raised toilet seat

☐ Floor condition good ☐ Rugs ☐ Shower/ Tub ☐ Walk-in

Additional details / notes

Safety considerations:_____

_____

_____

Physical Self-Maintenance Scale (PSMS)

Activities of Daily Living

Descending numbered items represent worsening states of function. Choose the item that best describes the resident's functional status. Scores in all categories should then be totaled. The higher the final score, the greater the degree of impairment.

A. Toileting
   1 ☐ Cares for self at toilet completely, no incontinence.
   2 ☐ Needs to be reminded or needs help in cleaning self, or has rare (weekly at most) accidents.
   3 ☐ Soiling or wetting while asleep more than once a week.
   4 ☐ Soiling or wetting while awake more than once a week.
   5 ☐ No control of bowels or bladder.

Score:

B. Feeding
   1 ☐ Eats without assistance.
   2 ☐ Eats with minor assistance at mealtimes and/or with special preparation of food, or help in cleaning up after meals.
   3 ☐ Feeds self with moderate assistance and is untidy.
   4 ☐ Requires extensive assistance for all meals.
   5 ☐ Does not feed self at all and resists efforts of others to feed him/her.

Score:

C. Dressing
   1 ☐ Dresses, undresses, and selects close from own wardrobe.

2 ☐ Dresses and undresses self with minor assistance.
3 ☐ Needs moderate assistance in dressing or selection of clothes.
4 ☐ Needs major assistance in dressing, but cooperates with efforts of others to help.
5 ☐ Completely unable to dress self and resists efforts of others to help.

Score:

D. Grooming
1 ☐ Always neatly dressed, well groomed, without assistance.
2 ☐ Grooms self adequately with occasional minor assistance, e.g., shaving.
3 ☐ Needs moderate and regular assistance or supervision in grooming.
4. ☐ Needs total grooming care, but remain well-groomed after help from others.
5. ☐ Actively negates all efforts of others to maintain grooming.

Score:

E. Physical Ambulation
1 ☐ Goes about grounds and surrounding area (e.g., town or city) on their own.
2 ☐ Ambulates within residence or about one block distances.
3 ☐ Ambulates with assistance of (check one)
☐ Another person ☐ railing ☐ cane ☐ walker
☐ Wheelchair – gets in and out without help
☐ Wheelchair – needs help getting in and out
4 ☐ Sits unsupported in chair or wheelchair, but cannot propel self without help.
5 ☐ Bedridden more than half the time.

Score:

F. Bathing
1 ☐ Bathes self (tub, shower, sponge bath) without help.
2 ☐ Bathes self with help in getting in and out of tub.
3 ☐ Washes face and hands only, but cannot bathe rest of body.
4 ☐ Does not wash self but is cooperative with those who bathe him/her.
5 ☐ Does not try to wash self, and resists efforts to keep him/her clean.

Score:

Total of all scores:

The higher the final score, the greater the degree of impairment with a total score of seven representing the lowest level of impairment, and a total score of 30 representing the highest level of impairment.

Additional details / notes

Nutrition

Weight:_____Height: _____

(a) Any unintentional weight change in the past six months? Yes ☐ No ☐ Loss ☐ Gain ☐

(b) How much weight change?_____lbs/kg in the past_____weeks/ months

(c) Appetite: Good ☐ Fair ☐ Poor ☐ _____

Estimated Requirements:

Calories:_____-_____kcal/day	Protein:_____-_____g/day
Based on:_____-_____kcal/kg	Based on:_____-_____g/kg

24hr Dietary Recall

Meal	Food Item	Quantity	Calories	Protein
Breakfast				
AM Snack				
Lunch				
PM snack				
Dinner				

Before Bed				
Total				

Are you following any specific diet at home? Yes ☐ No ☐ (if yes explain)_____

_____

NFPE Checklist

Region	Location	Task	Mild	Moderate	Severe
Skin	**Globally**	• Dermatitis, rashes, petechiae, ecchymosis, scaliness, dryness.			
Head	**Hair**	• Touch and observe for the following: thinness, dullness, dryness, brittleness, patchy growth and easily pluck able.			
	Temporalis	• Palpate temporal muscles. Check for fullness and firmness. Observe for depression, hollowing.			
	Eyes	• Orbital pads: Gently palpate area below eyes. Observe for darkness, hollowness, and/or loose skin.			
		• Observe for cracked or reddened corners of eyes, foamy (Bitot's Spots) areas on sclera; dull, dry or rough sclera; dull, milky, opaque cornea.			
	Mouth	Have patient open mouth and shine penlight into oral cavity. Next, have patient stick out tongue. Observe: • Mucosa: pallor, dryness, decreased salivary flow, ulcerations (mucositis)			
		• Tongue: magenta or beefy red color; smooth, slick appearance (glossitis) (Swallowing Impaired? Yes ☐ No ☐) (Chewing Impaired? Yes ☐ No ☐)			
	Teeth	• Observe for tooth decay, missing teeth. (Dentition: Teeth ☐ Edentulous ☐) (Dentures: Upper ☐ Lower ☐)			
	Gums	• Observe for sponginess, bleeding; swollen, red, receding gums.			
	Lips	• Observe for bilateral cracks at corners of mouth, redness (angular stomatitis/cheilosis).			
Upper Body	**Deltoid**	• Palpate muscles around the shoulders (deltoid muscles) for fullness and firmness. Observe for squaring of shoulders.			

	Clavicle	• Gently palpate above and below the clavicle for fullness and firmness. Observe for prominence of clavicle.			
	Ribs	• Have patient sit forward and palpate ribs.			
	Triceps Skinfold	• Have patient bend arm at 90 degree angle with upper arm perpendicular to body; if patient unable to cooperate, bend elbow at 90 degrees and place forearm horizontally across body if possible; grasp upper arm midway between shoulder and elbow with palm and fingers and gradually pull skin away from arm with fingers while wiggling slightly to separate fat from muscle.			
	Interosseous	• Have patient make okay sign with thumb and first finger and while palpating interosseous muscle between thumb and first finger and the interosseous muscles between remaining fingers. Check for fullness and firmness. Observe for depression.			
		• Observe fingernails for missing, misshapen (spoon shaped), splintered, transverse ridging, discoloration, dullness, lackluster appearance, mottling.			

Grip Strength

Dominant Hand: Right ☐ Left ☐	
Right Hand:	Left Hand:
_____ _____ _____	_____ _____ _____
Avg.	Avg.

Nutrition Diagnosis:

_____

Functional Deficits:

_____

_____

Care Plan:

_____

Goals:

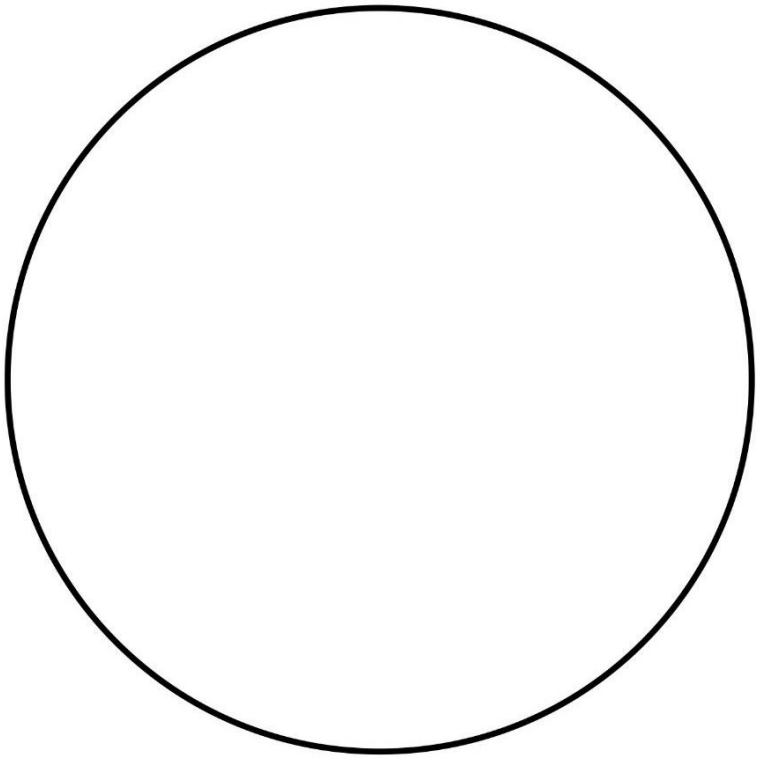
1) _____

2) _____

3) _____

Clock Drawing

ID:_____Date:_____



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