SAFEMED 1st HOME VISIT CHECKLIST

Patient Name:_____ FIN:_____ MRN:_____
Date of Visit:_____ Start Time: _____am:pm End Time: _____am:pm
Was home visit completed? ☐ Yes ☐ No **If no, why?**_____

Assessment of condition-related signs and symptoms

1. The patient shows signs/symptoms of a life threatening condition during today's visit. ☐ Yes ☐ No
   If yes, contact 911, APN. (If no, continue to question #2)
2. The patient shows evidence of signs/symptoms in the red zone during today's visit. ☐ Yes ☐ No
   If yes, contact APN for 'RED' on-site consult. (If no, continue to question #3)
   If yes, did the APN provide on-site consult? ☐ Yes ☐ No ☐ Not available
3. The patient shows evidence of signs/symptoms in the yellow zone during today's visit. ☐ Yes ☐ No
   If yes, assist patient with urgent PCP appointment. (If no, continue to question #3)
   If yes, did patient get appt with PCP in the next 24 to 48 hours? ☐ Yes ☐ No
   If no, contact APN for 'YELLOW' on-site consult.
4. The patient shows no signs that indicate condition deterioration (green zone) during today's visit.
   ☐ Yes ☐ No
5. Does the patient have any questions about signs or symptoms that require APN follow up at a later time? ☐ Yes ☐ No
   If yes, alert APN via text/email.

Home-based Medication Reconciliation

1. Do the medications the patient reports taking exactly match the discharge medication list?
☐ Yes ☐ No
[*If yes, skip sequence for 2,3, &4*]

2. Do the medications the patient reports taking include all essential acute and chronic disease medications (not including prn medications)?

3. Is the patient taking any prescription medications that are not on the medication list? ☐ Yes ☐ No
   If yes, how many?_____
   *List:*_____
   *Notify CHP of discrepancies
4. Are there medications on the discharge medication list that the patient is not taking? ☐ Yes ☐ No
   *If yes, how many?*_____
   *List:*_____
   *Notify CHP
5. Has the patient experienced a change in any of the following symptoms since starting any new medications?

☐ Headache/pain	☐ Problems with sleep	☐ Change in mood
☐ Muscle aches	☐ Fatigue	☐ Dizziness/balance problems
☐ Hives/rash	☐ Stomach or gastrointestinal	☐ Incontinence/urinating problems
☐ Nausea	☐ Irregular heartbeat	☐ Sexual problems
☐ Other, what? _____		☐ No symptoms reported

*If yes, notify CHP

6. Is the patient taking any over-the-counter medications or herbal supplements? ☐ Yes ☐ No

*If yes, list:*_____

*Notify CHP if OTC/herbal supplement was started after discharge or if patient reports symptoms.

7. Was the CHP available during the home visit for on-site consultation if needed? ☐ Yes ☐ No

8. If the medications the patient reports taking does not match the discharge medication list, document the reasons why using the following answer choices. Please select all answer choices that apply"

☐ Could not afford co-pays at this time

☐ Lack of transportation/no one available to pick up yet

☐ Visit is less than 72 hours, prescription being filled/is filled and has plans to pick/up

☐ Prior authorization required and authorization not obtained

☐ Patient was not given all of the necessary prescriptions before discharge from hospital

☐ Patient wants to see PCP before filing new prescriptions

☐ PCP changed the medications

☐ Patient does not want to take the medication

☐ Other

If other, please describe reasons:

Drug Disposal

1. Has the patient identified any unused or expired medications that are not on the current discharge medication list? ☐ Yes ☐ No

2. Has the patient been warned of dangers associated with keeping unused or expired medications on hand?

☐ Yes ☐ No

3. The patient has given permission for in home drug disposal. ☐ Yes ☐ No

If yes, the patient was assisted with in-home drug disposal today. ☐ Yes ☐ No

If no, all old or expired medications have been properly separated and marked. ☐ Yes ☐ No

4. The patient has been given a flyer on appropriate drug disposal. ☐ Yes ☐ No

Teach back of discharge material

1. The patient has (poor, fair, good) comprehension of their medication regimen.

If poor, does the patient's carer comprehend the medication regimen? ☐ Yes ☐ No ☐ Not available

2. The patient has (poor, fair, good) comprehension of the appropriate person/place to call when symptoms occur.

If poor, does the patient's carer comprehend the symptom triage? ☐ Yes ☐ No ☐ Not available

3. The patient has (poor, fair, good) comprehension of self-care management guidelines.

If poor, does the patient's carer comprehend self-care management guidelines? ☐ Yes ☐ No ☐ Not available

4. Does the patient/caregiver have any questions requiring CHP/APN consult? ☐ Yes ☐ No

If yes, did the APN/CHP provide on-site consult? ☐ Yes ☐ No ☐ Not available

5. Does the patient have any questions about self-care management that require CHP/APN follow up at a later time? ☐ Yes ☐ No

If yes, document question at end of SOAP note in Cerner system and alert APN via text/email.

6. Does the patient/caregiver require referral for additional patient education or assistance? ☐ Yes ☐ No

If yes, document assessment in the SOAP note in Cerner system and alert APN/CHP via text/email.

Implement simple medication adherence and symptom monitoring aids.

1. The patient has successfully demonstrated the ability to fill the pillbox. ☐ Yes ☐ No

If yes, skip questions 2 through 4

2. The patient's caregiver has successfully demonstrated the ability to fill the pillbox. ☐ Yes ☐ No ☐ Not present

3. The patient's pillbox was filled for the upcoming week by the pharmacy technician. ☐ Yes ☐ No

* Follow up with caregiver via phone.

4. The patient will likely need additional assistance filling the patient's pillbox. ☐ Yes ☐ No

* Inform CHP by text or email.

5. The patient has successfully demonstrated the ability to self-monitor and record information into the log and symptom diary. ☐ Yes ☐ No

If yes, skip questions 5 through 9

6. The patient's care giver has successfully demonstrated the ability to self-monitor and record information into the log/diary. ☐ Yes ☐ No ☐ Not present

* Follow up with caregiver via phone.

7. The patient will likely need additional assistance with self-monitoring and recording information into the log/diary. ☐ Yes ☐ No

* Inform APN to identify additional sources of self-monitoring assistance by text or email.

Patient goal setting

1. The patient has chosen a goal area related to self-management of driving diagnosis. ☐ Yes ☐ No

If yes, identify category of goal: [ADD OTHER CATEGORIES FROM ALL CONDITIONS]

☐ Doctor follow up	☐ Diet	☐ Alcohol	☐ Fluid intake
☐ Smoking	☐ Activity	☐ Medicines	☐ Self monitoring
☐ Prevention (primary/secondary)		☐ Environmental Irritants (COPD/asthma)	
☐ Treatments (COPD/asthma)		☐ Other, specify:_____	

2. The patient has identified barriers to recommended self-management behaviors. ☐ Yes ☐ No

If yes, identify barrier type and one primary example: (check all that apply)

☐ Environmental (i.e., access, home conditions), specify:_____

- ☐ Social (i.e., what other people do or say), specify:_____
- ☐ Psychological (i.e., feelings, thoughts), specify:_____
- ☐ Other, specify:_____

3. The patient/caregiver/staff have brainstormed possible solutions to barriers. ☐ Yes ☐ No

   *If no, why*_____

4. The patient has developed an action plan based on chosen solution. ☐ Yes ☐ No

   *If no, why*_____

   If yes, staff should use Ipad camera function to capture action plan for future monitoring.

5. Staff will follow up by (home visit, phone) to assess progress in (one, two) weeks.