**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.