Nurse Monitoring Visit Checklist

CLIENT NAME: _____

NURSE MONITOR NAME: _____

DATE OF HOME VISIT: _____

ITEM	YES	NO	N/A
Copy of Client's Plan of Care in Home? Dated:			
Agency Nurse Visiting per regulations (every 45 day, if medication admin./Delegation; every 3 months with Med reminders; or every 4 months, if no medication assistance needed)? Date of Last copy of assessment at client's Home:_____ Date of Last Nursing visit:_____			
If Medication Administration – Is MAR in the home &being completed by CMT?			
Are there any holes on MAR? Y/N; If yes, was documentation completed by CMT?			
If MAR being used, is it signed by RN at least every 45 days?			
Any New Medication? Y/N OR Discontinued Medication?			
Is ADL completed daily?			
Is Daily shift Log completed daily to reflect client condition?			
Is Client satisfied with Agency and Care provider being sent?			
Is OTP device in the home and seen by you? (if applicable)			

Vital Signs:

Temp:_____BP:_____Pulse:_____Respiration:_____

Assessment Summary/Concerns

RN Signature:_____Date:_____

_____ _____

Client (or Representative) Signature **Date:**