Royal Quality Nursing Inc.
Patient Admission Record

Referred From: _____
DOB: _____

Name:_____
Address:_____
City:_____ **State**:_____ **Zip Code**:_____
Phone#: Home:(____) _____-_____**Work**:(____)_____-_____ **Cell**:(____)_____-_____
Primary Diagnosis:_____
Secondary Diagnosis:_____
Allergies:_____ **Code Status**: Resuscitate DNR
Advance Directives: None Medical Power of Attorney Living Will
Ethnicity/Race: White Black Hispanic Asian Native Indian Other: _____
Language Spoken: _____ **Religion**: _____
Marital Status: Single Married Divorced Separated Widowed Comments:_____
Emergency Contact:_____ **Relationship To Patient**:_____
Phone# Home:(____) _____-_____ **Work**:(____) _____-_____ **Cell**:(____) _____-_____
Physician:_____ **Phone#**:(_____)_____-_____ **Fax**:(____)_____-_____
Place of Therapy: Home Other:_____
Method of Infusion: Gravity Pump Other:_____

A/B TPN Chemo Pain HYD IV/Supp/Equip IVIG Steroid
Vascular Access Device:_____
Vital Signs: Ht:_____ Wt:_____ Temp:_____ HR:_____ R:_____ B/P:_____
Past Medical/Surgical History:_____
_____

Environmental Evaluation:

Home Condition: Unsafe Cluttered Tidy Unclean Clean
Living Arrangements:_____ **# In Family Household**_____

Home Safety	YES	NO
Safe Neighborhood	____	____
Smoke Detectors	____	____
Running Water(hot/cold)	____	____
Handrails on all Stairs	____	____
Electricity	____	____
Electrical Outlets/Switches	____	____
Working Phone	____	____
Heating	____	____
Refrigerator	____	____
Kitchen(check appliances etc.)	____	____
Bathroom(check shower etc.)	____	____
Presence of Rugs/Mats	____	____
Adequate Lighting	____	____
Sharps Container	____	____
Air Conditioning	____	____
Free of Infestation	____	____

Ability	YES	NO
Grooming	____	___
Toileting	____	___
Preparing Meals	____	___
Feeding	____	___
Home Maintenance	____	___
Adequate Caregiver	____	___

Ability	YES	NO
Ability to use phone	___	___
Medication Administration	___	___
Transferring	___	___
Walking	___	___
Stair Climbing	___	___

Nutritional Assessment

The patient has an illness that requires he/she has to change food intake?	Y/N
The patient eats fewer than two meals per day?	Y/N
The patient eats few fruits and vegetables or milk products?	Y/N
The patient consumes three or more alcoholic beverages daily?	Y/N
The patient has oral problems that make it difficult for he/she to eat?	Y/N
The patient does not always have enough money to buy food?	Y/N
The patient eats alone most of the time?	Y/N
The patient takes multiple prescribed or O-T-C drugs daily?	Y/N
Has the patient lost 10 lbs. in the last 6 months without wanting to?	Y/N
He/she can not always shop, cook or feed him/herself?	Y/N

*If the patient answers "yes" to "3" or more questions from above they are considered to have a nutritional risk.

___ Physician Notifies by RN
___ Physician aware of patient's nutritional status

PT./Caregiver or Responsible Party_____Date:____/____/_____

Royal Quality Nursing Inc.
Nursing Visit Record

Vital Signs: Ht:_____ Wt:_____ T:_____ HR:_____ R:_____ B/P:_____
Patient Name:_____ D.O.B _____
Date:____/____/_____ Day: M T W Th F Sat. Sun.
__ Initial Visit __ Re-visit **Referred From:_____**
Time in: ____:____ AM PM Time Out: ____:____ AM PM

NEUROLOGICAL
__ Aphasia
__ Confused
__ Disoriented
__ Forgetful
__ Headache
__ HOH
__ Lethargic
__ Neuropathy
__ Paralysis
__ Pupils Non-Reactive/Unequal
__ Restlessness
__ Seizures
__ Semi Comatose/__ Comatose
__ Tremors
__ Vertigo
__ Vision Impaired
__ NPN

RESPIRATORY
__ Non-prod. Cough
__ Prod. Cough/color _____
__ Wheezing
__ Cyanosis
__ O2 @ ____ liters
__ Crackles/Coarseness
__ Absent
__ Decreased
__ SOB
__ CTA
__ DOE
__ NPN
Comments _____
_____

GENITOURINARY
Ostomy Tube: _____
Vaginal Problems: _____
Urinary Problems: _____
Nephrostomy Tube: _____
Prostate Problems: _____
Catheter Problems:
____ NPN
Comments: _____

NPN: No Problem Noted

CARDIOVASCULAR
__ Irregular Heart Rate
__ JVD
__ Orthostatic Changes
__ Perph Pulses:
Diminished Absent

Edema:
_____
Lymphedema:
_____
Comments: _____
_____
__ NPN

MUSCULOSKELETAL
__ Bed bound
__ Balance Problems
__ Coordination Problems
__ Fatigue
__ Decreases Endurance
__ Cane
__ Walker
__ Sleep Disturbance
__ W/C
__ Safety Risk
__ Requires Assistance
__ Safety Precautions reviewed
__ NPN
Comments: _____

GASTROINTESTINAL
Bowel Sounds:
__ Hyperactive __ Hypoactive
__ Absent
Abdomen:
__ Tender __ Firm
Oral Mucosa:
__ Lesions __ Ulcers
__ Plaque __ NPN
Last BM: __/__/__
__ Anorexia __ Nausea
__ Vomiting __ Diarrhea
__ Constipation
__Ostomy __ Incontinent
__ Taste Alteration
__ Indigestion __ Hiccoughs

PAIN
Intensity: 1 2 3 4 5 6 7 8 9 10
1= Least 5=Moderate 10=Worst
Location: _____
Quality: _____

Interrupts Sleep:
__ Never
__ Daily
__ On Occasion

How often does it interfere with activity?
__ Never
__ Sometimes
__ Daily
__ Always
__ NPN

PSYCHOSOCIAL
__ Tearful
__ Flat affect
__ Anxious
__ Difficulty Coping
__ Angry
__ Depressed
__ NPN
Caregiver:
__ None
__ Unable to manage responsibilities
__ NPN
Comments: _____
_____

INTEGUMENT
__ Lesions
__ Rash
__ Itching
__ Bruises
__Poor Turgor
__ Redness/ Erythema
__ Dry/Scaly
__ Diaphoretic
__ NPN

Color:
__ Flushed
__ Cyanotic
__ Ashen
__ Pale
__ Mottled
__ Jaundiced

Comments: _____
_____

Patient Name:____________________________________ **Referred From:**__________________________

Access & Device Site Assessment page 2

__ Subcutaneous __ Hickman/Groshong __ Midline __ Peripheral __ Midclavicular
Implanted Pump: (Arterial/Epidural/Intrathecal) __ PICC __ Implanted Port

MEDICATION REVIEW AND/OR ADMINISTRATION:
__ Instruction on client's medication __ Client/Caregiver verb. Understanding. Comments:

Medication Adm. During Visit: Dose Route Conc. Time Frame: __ Pump Refill __ Cassette Change __ RN Stay for infusion __ Cit to D/C Med __ Med Hook up (time) __ Med D/C RN (time)

Medication Adm. During Visit: Dose Route Conc. Time Frame: __ Pump Refill __ Cassette Change __ RN Stay for infusion __ Cit to D/C Med __ Med Hook up (time) __ Med D/C RN (time)

Medication Adm. During Visit: Dose Route Conc. Time Frame: __ Pump Refill __ Cassette Change __ RN Stay for infusion __ Cit to D/C Med __ Med Hook up (time) __ Med D/C RN (time)

SEARS Noted:______________________ Flushes __ NSS__ml __ IVP __ Heparin___ml_____ units/ml IVP

Medication Changes (since last visit): ______ None ______ Yes (Please attach revised Medication Profile)

INSERTION SITE STATUS:

1	2	3	
__	__	__	Pain
__	__	__	Edema
__	__	__	Heat
__	__	__	NPN
__	__	__	Sutures
__	__	__	Cord
__	__	__	Streak
__	__	__	Drainage
__	__	__	Erythema
__	__	__	Other

Insertion Site:
1-_______________
2-_______________
3-_______________
Blood Return: + - (circle one)

PICC: SL __ DL __ TL __
Securing Device: __ Stat Lock __ Sutured
Upper arm circ. ____ cm
Ext. length ____ cm
Port Access: Gauge ____ Length ____

Precautions:
__ Aspiration
__ Bleeding
__ Fall
__ Home Environment/Safety
__ Neutropenic
__ Seizure

SEARS-side effects and related symptoms

WOUND ASSESSMENT: Wound Treatment ____ Per POC ____ Changes: ____
Wound Type: ____ Pressure/Stasis _____ Surgical ____ Tumor ____
Appearance: ____ Pink/Red ____ slough _____ Eschar ____ Inflammation ____ Undermining
Odor: ____ None ____ Mild ____ Foul
Drainage: ____ None ____ Serous ____ Serosanguinous ____ Sanguinous ____ Purulent
Amount: ____ Small ____ Moderate ___ Large
Stage: __ I – Red/Discolored __ II – Skin Break/Blister __ III – SQ tissue __ IV – Muscle/Bone
Healing: __ Early/Partial Granulation __ Fully Granulated __ Not Healing
Size: (cm LxWxD) ____ Comments: ____________________________________

Plan of Care

__ Call Physician, other (specify) re: ________________________________
Next Contact Date: _______________ by: __ RN __ LPN __
Next MD visit: _______________
__ Home Visit __ Facility __ Other
__ Assessment
__ Dressing/Cap change
__ Drug Administration
__ Drug Adjustment (specify) ________________________________
__ Nutritional Assessment
__ IV Restart/SQ site change/Port Needle change
IV insertion: Site _______ Gauge _______
__ IV Removal
__ Implanted Pump refill
__ Venous Port: __ access __ deaccess
__ Equipment Procedure(battery change, tubing/cassette change)
__ Blood Draw (specify)
____
Site: PICC Port Peripheral Lab Used: __ HHLA __ Pepper Lab __ Other: __________________
Tracking/Pick-up #: ____________________________
__ Wound care/treatment
__ Pt/Caregiver Teaching (circle one) Initiate Continue Complete
__ Supply Inventory

Comments: ____
____

Patient/Caregiver Signature ____ **Date** ___/___/___

Nurse's Signature ____ **Date** ___/___/___

ROYAL QUALITY NURSING SERVICES, INC.
223 Riveredge Drive
New Castle Delaware 19720
Phone (302) 325-3110 Fax (302) 325-3114

Arrived:_____
Departed:_____
Total Hours:_____
Day #:_____

IV Medication Titration Record

Patient Name:	**I.D. #**

Lot # _____ **Expiration Date**_____**Company**_____

Medication Name:_____ **Allergies**:_____

Delivery System:_____ **Orders**: _____

Time Started	Rate Decreased To	Rate Increased To	Blood Pressure	Pulse	Respiration	Side Effects
	Initial Rate:					

Pre Medication: Tylenol 650mg po __ Benadryl 25mg po __ Loratadine 10mg po __ Other _____
Pre Hydration:_____ **Post Hydration:**_____
IV Flush NSS_____**cc(s) Heparin**_____ **Units/ cc**_____ **cc(s) D5W** _____ **cc(s)**
IV Insertion_____ **IV Removal**_____
Pt/ caregiver teaching for IV maintenance _____
Comments: _____
_____

RN Signature: _____ Date: _____

RAY 6/11

Royal Quality Nursing Services, Inc

Name:_____
Date:_____
Therapy:_____

TEACHING/EDUCATION RECORD

I = INDEPENDENT N = NON-INDEPENDENT (Please Check Off)

Education	Additional Comments	I	N
THERAPY			
Royal Quality Nursing Services, Inc. Folder			
Principles of Therapy			
Treatment Requirements			
Patients Rights & Responsibilities			
Plan of Care			
Medication Information			
Side Effects			
Lab Work			
Nurse Visit Schedule			
MEDICATIONS			
Name of Patient/Drug Verified			
Administering Dose/Infusion			
Dosage/Concentration			
No Missed Doses/Infusions			
Use Oldest Supplies First			
OTC Drugs (ie: Tylenol, Vitamins, etc)			
Storage/Inspection			
Additives			
Preparation			
Expiration Date			
Room Temperature Stability			
SAFETY/INFECTION CONTROL			
Handwashing			
Clean Work Area			
Asepsis			
Standard Precautions			
Contact Precatutions (if applicable)			
Respiratory Hygiene Precautions			
Waste Dsiposal			
Environmental Safety			
Assembling Supplies			
Biohazardous/Sharps Container			
Label and Solution Bag Inspection			
Proper Storage & Handling			
Supplies/Equipment/Inventory			
Spill/Chemo Precuaitions			
Oxygen Precautions			
Fall Precatuions			
Avoiding Trauma			
Showering & Bathing			
Emergency Removal of Device			
Record Keeping			
ADMINISTRATION			
Pump:_____			
Alarms			
Back-up pump/Battery/Powerpack			
PCA By Proxy			
IM or Subcutaneous Injection			
Preparing Solution Bag & Tubing			
Catheter/Tube Placement			
Connection Procedures & Clamps			
Disconnection Procedures			
Rate of Administration			
Flushing (Heparin, Saline)			
NEVER Force Flush			
Air Bubbles & Air In Line			
SASH Protocol			
Blood Back-up			

Royal Quality Nursing Services, Inc

Name:_____
Date:_____
Therapy:_____

TEACHING/EDUCATION RECORD

I = INDEPENDENT N = NON-INDEPENDENT (Please Check Off)

Education	Additional Comments	I	N
SELF-MONITORING			
Weight	_____	___	___
Temperature	_____	___	___
Intake/Output	_____	___	___
Urine Testing (Concept)	_____	___	___
Glucose Monitor (Concept)	_____	___	___
Infusion Signs & Symptoms of Infection	_____	___	___
Alarms	_____	___	___
1-302-325-3110 – 24 HR Emergency	_____	___	___
COMPLICATIONS			
Problems To Report And To Whom	_____	___	___
Emergencies	_____	___	___
Consultation With The Pharmacist	_____	___	___
Phlebitis (Chemical, Bacterial, Mechanical)	_____	___	___
Infection (Local, Bloodstream)	_____	___	___
Cellulitis	_____	___	___
Hematoma	_____	___	___
Venous Spasm	_____	___	___
Embolism (Air, Pulmonary, Catheter)	_____	___	___
Venous Thrombosis	_____	___	___
Speed Shock	_____	___	___
Pulmonary Edema	_____	___	___
Nerve Damage	_____	___	___
Device Allergic Reaction	_____	___	___
Allergy Treratment Kit	_____	___	___
Interaction With Caffeine	_____	___	___
Interaction With Sedatives	_____	___	___
Avoiding Alcohol	_____	___	___
Catheter Migration/Malposition	_____	___	___
Catheter Occlusion/Fracture	_____	___	___
Cardiac Tamponade/Arrythmias	_____	___	___
Absence of Blood Return	_____	___	___
Twiddler's Syndrome	_____	___	___
Pinch Off Syndrome	_____	___	___

I, _____, have received the above instructions and written materials. I understand these functions will be performed in the home or other setting without a medical doctor on site. I have discussed my questions fully with the Nurse and returned a satisfactory demonstration of the skills noted. I agree to provide infusion therapy according to my Doctor's orders and as instructed by my Nurse and Pharmacist. I know how to contact Royal Quality Nursing Services, Inc. and I agree to do so if any concerns, problems, and/or questions arise. I understand it is my responsibility to report medical signs or symptoms to the Nurse who visits me and to my attending Physicain. I agree to report any malfunction of home infusion equipment or supplies to my Nurse or supply company.

Patient/Caregiver Signature_____ Date_____

RQNSI Representative Signature_____ Date_____

ACH 06/2014

Royal Quality Nursing Services, Inc. **Plan of Treatment**

Patient: _____ **DOB:** _____ **SOC Date:** _____

Address:_____ **City:** _____ **State:** _____ **Zip:** _____

Provider_____

Diagnosis: Primary _____ ICD9 Code: _____

Secondary _____ ICD9 Code: _____

Code Status: Resuscitate DNR DNI Durable Power of Attorney

_____

Allergies: (List allergen and describe reaction.): _____

_____

Medication: _____

_____

_____

Flush Access Device: NSS ____ mL(s) □ before and after med administration □prn □____ mL(s) post lab draws

Heparin _____ units/mL _____mL(s) □ after med administration □ prn □ post lab draws

Other flush solution: _____

□See current medication profile attached. Physician to review and contact Royal Quality with any inconsistencies.

□See attached Acute Infusion Reaction Orders.

Maintain Catheter Access Type:

□N/A □ PICC □Intrathecal □Implanted port

□Peripherial □ Central tunneled □ Implanted pump □Subcutaneous infusion

□Midline □ Epidural □ Central non-tunneled □Other: _____

□If catheter is removed, may replace with: _____

□ May remove PIV at end of therapy □ Remove PIV after each infusion

□ Replace PIV: □ every 72-96 hours □ prn complications □ maximum of 7 days dwell time

Central Catheter/PICC repair by: □ Hospital □ Royal Quality Nurse □ N/A

□ May apply heat to treat and/or prevent access device complications

□ May apply antibiotic ointment after CVC removal

□ Reaccess port every ____ days or every ____ week(s) when not in use

□ May administer Alteplase 2mg IV prn occluded CVC, and repeat once if needed

Patient Name:_____

Dressing Change: □ Transparent every ____ days and prn □ Gauze every _____ days and prn

□ Other: _____

Teach patient/caregiver the following procedures: □ Catheter dressing change □ Medication administration

□ Access port □ Deaccess port □ Remove PIV Other: _____

Lab Orders: _____

□ Labs may be drawn from access device

□ Patient/caregiver may be taught how to draw labs from access device

Nursing Visit Frequency: □ Weekly and prn □ Other: _____

□ RN to administer prescribed therapy □ Home □ Hospital □ Nursing Home □ Other _____

Diet:
□ Regular □ Diabetic □ Renal □ Other diet restrictions: _____

Enteral Feedings: _____

Wound Care: _____

Other: _____

Goals:

□ Patient will complete therapy as prescribed, without complications.

Patient specific and measurable goals for this certification period include:

□ _____

□ _____

Discharge Plan: □ Unknown date □ Discharge from services on: _____

Certification Period: _____ to _____ □ Initial Certification □ Recertification

Clinician Signature: _____ **Date**: _____

I hereby certify that the above infusion and services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed. An infusion pump and all supplies may be provided as required for the administration of the above prescribed therapies.

Physician Name (Print) _____ **Physician's Address** _____

_____

Physician's Phone _____ **Physician's Fax** _____

Physician's Signature X_____ **NPI#** _____ **Date** _____

(Please complete and return within **24** hours of SOC.)

REV ACH 6/2014

ROYAL QUALITY NURSING SERVICES, INC.

PATIENT: _____ DIAGNOSIS: _____

NURSING CARE PLAN

Patient Problem (Check all that apply)	Nursing Intervention (Check all that apply)	Desired Outcomes/End Goals (Check all that apply)
1. Identified by _____ RN Date: _____ ___ Knowledge deficit as related to the purpose, indications, management of home therapy: (Circle one) ABT ST IVIG HYD LAB CC Other: _____	_Nurse will provide patient/caregiver education by explanation, discussion, demonstration and handouts.	Patient/Caregiver will be able to: _ Verbalize understanding of purpose and goals of prescribed therapy/treatment _Verbalize understanding of complications/problems and their interventions Independent Administration of prescribed regimen: _ SASH _ Saline Only _ Heparin Only _Safely operate device: (Specify) _____ _____
2. Identified by _____ RN Date: _____ _ Potential for complications related to non-compliance	_ Nurse will review with patient/caregiver the prescribed regimen.	Patient/Caregiver will be compliant with prescribed therapy evidenced by: _ Desired outcomes. _ Progression to goals.
3. Identified by _____ RN Date: _____ _ Potential for Adverse Drug Reactions	_ Nurse will review with patient/caregiver possible signs/symptoms of adverse reactions related to the prescribed drug regimen.	Patient/Caregiver will be able to: _ Verbalize understanding of possible signs/symptoms of adverse reactions
4. Identified by _____ RN Date: _____ _ Alteration in comfort (pain) related to (Specify) _____	_ Nurse will assess patient's pain each visit. _ Nurse will review patient's prescribed pain control regimen	Patient will obtain optimal level of comfort evidence by: _ Verbalizing pain free. _Verbalizing improvement of pain (pain at a manageable level)
5. Identified by _____ RN Date: _____ _ Fluid Volume Excess/Deficit	Nurse will monitor: _ Vital Signs (Orthostatic BP necessary for all patients receiving hydration.) _ Weight _ Intake & Output _ Electrolytes	Patient will maintain fluid volume balance evidenced by: _ Normal Vital Signs _ Adequate urinary output _ Normal Electrolyte levels

ROYAL QUALITY NURSING SERVICES, INC.

PATIENT: _____ DIAGNOSIS: _____

NURSING CARE PLAN

6. Identified by _____ RN Date: _____ _ Alteration in nutrition less than body requirements related to inadequate nutrient intake/disease process.	_ Nurse will provide patient education by explanation, discussion, demonstration and handouts. Nurse will monitor: _ Vital Signs _ Weight _ Intake & Output _ Electrolytes	Patient will achieve and maintain acceptable level of nutrition as evidenced by: _ Weight gain/loss _ Maintenance of acceptable nutritional parameters including ordered laboratory test/values.
7. Identified by _____ RN Date: _____ _ Potential for infection Access site: PICC Periph. Port Hickman/Groshong	_ Nurse will assess access site as prescribed by MD _ Nurse will review with patient/caregiver: signs and symptoms of infection	Patient will remain infection free as evidenced by: _Normal temperature: < 100 F _ No redness, pain or drainage at access site
8. Identified by _____ RN Date: _____		
9. Identified by _____ RN Date: _____		

Reviewed Date: _____ by _____ RN
Reviewed Date: _____ by _____ RN

I have had an opportunity to discuss my care and treatment in the development of this plan of care and approve of the care prescribed.
Patient/Caregiver _____
Initiated by _____

Royal Quality Nursing Services

Patient Name: _____ ID# _____

Pharmacy: _____ Phone# (____) ____ - _____

Medication Profile

Date Start	Date Stop	Prescription Medications, Over the Counter, & Home Remedies	Dose	Route	Frequency	Duration/ Comments

Allergies:_____

_____

Medication Profile reviewed & updated as needed

Date										
Initials										

Royal Quality Nursing Services, Inc.

DISCHARGE SUMMARY

Patient Name: _____ **SOC:** _____ **D/C Date:** _____
Company:
Diagnosis (list all): _____

Therapies Provided: ___ Anti-infectives ___ TPN ___ IVIG ___ Chemotherapy
___ Pain Management ___ Other _____

Access Device remaining at time of D/C: ___ None 1. _____ 2. _____
Reason for discharge: ___ Therapy complete ___ Disease Progression
___ Non-compliance ___ Non-response to therapy
___ Other _____

Summary of Care Provided:

___ Nutrition Assessment/Consultation
___ Education to provide self-care
___ Equipment/supply management
___ Lab collection and/or result monitoring
___ Therapy review
___ Access device care & maintenance
___ Pharmaceutical Monitoring
___ Wound Care
___ Medication Administration
___ Other: _____

Response to Therapy:
Symptoms since initiation of therapy: ___ Resolved ___ Improved ___ Unchanged
___ Other: _____
Describe any unmet goals: _____

The following discharge instructions were provided to the patient and/or caregiver:

___ Notify physician of fever greater that 100 degrees F within 24 hours of discharge
___ Notify physician if complications develop at access device site within 48 hours after device is removed
___ Notify physician if symptoms return after medication has been discontinued
___ Leave occlusive dressing in place for 24 hours
___ Other: _____

Clinician: _____ **Date:** _____

ROYAL QUALITY NURSING SERVICES, INC.

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights:

- You have the right to safe, high quality, medical care, without discrimination, that is compassionate and respects personal dignity, values and beliefs.
- You have the right to participate and make decisions about your care and pain management, including refusing care to the extent permitted by law. Your care provider (doctor, nurse, etc.) will explain the medical consequences of refusing recommended treatment.
- You have the right to have your illness, treatment, pain, alternatives and outcomes be explained in a manner you can understand. You have the right to interpretation services if needed.
- You have the right to know the name and role of your care providers (doctor, nurse, etc.). At your request, you have a right to a second opinion.
- You have the right to request that a family member, friend and/or physician be notified that you are under the care of this facility.
- You have the right to be informed about transfers to another facility or organization and be provided complete explanation including alternatives to a transfer.
- You will receive information about continuing your health care at the end of your visit.
- You have the right to know the policies that affect your care and treatment.
- You have the right to participate in or decline to participate in research. You may decline at any time without compromising your access to care, treatment and services.
- You have the right to private and confidential treatments, communications and medical records to the extent permitted by law.
- You have the right to receive information concerning your advance directives, (living will, health care power of attorney, or mental health advance directives), and to have your advance directives respected to the extent permitted by law.
- You have the right to access your medical records in a reasonable timeframe, to the extent permitted by law.
- You have the right to be informed of charges and receive counseling on the availability of known financial resources for health care.
- You have the right to be free from restraints that are not medically required or are used inappropriately.
- You have the right to access advocacy or protective service agencies and a right to be free from abuse.
- You and your family have the right to have your compliments, concerns and complaints addressed. Sharing your concerns and complaints will not compromise your access to care, treatment and services.

Patient Responsibilities:

- Accurate and complete medical history and any changes in your condition.
- Change in advance directive or Do Not Resuscitate orders
- Provide copy of advance directive
- Inform us if you are hospitalized
- Participate in development and updating of plan of care for therapy provided
- Communicate whether he or she clearly understands the course of treatment and plan of care
- Communicate any problems, concerns, or complaints
- Fulfilling financial obligations for care and services
- Respecting the rights of health care providers

By signing below you acknowledge that you have received and understand your Patient Rights and Responsibilities.

Patient/Caregiver Signature _____ Date _____

REV ACH 6/2014

Royal Quality Nursing Services, Inc.
Notice of Privacy Practices.
Effective June 9, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Royal Quality Nursing Services, Inc. has always been committed to respecting and protecting the privacy of our clients. This Notice of Privacy Practices tells you about the ways we use and share your medical information.

To provide you with quality medical care, members of our clinical staff need to share your medical information with each other. We also share it with people who participate in your care, including any doctor who refers you to us and your family physician. Sharing this medical information is one way that we carry out our mission of helping clients realize their health goals through appropriate home health care and related services. In order for us to be paid for your care, and to run our business, we need to share your medical information. Details about this and other examples are listed below.

We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. This Notice of Privacy Practices ("Notice") describes how we may use and disclose PHI to carry out treatment, payment, or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to PHI about you.

We are required to follow the terms of this Notice. We will not use or disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

Your Health Information Right

You have the following rights with respect to PHI about you:

Obtain a paper copy of the Notice upon request. You nay request a copy of the Notice at any time. To obtain a copy, contact our Compliance Office and request that a Notice be mailed to you.

Inspect and obtain a copy of PHI. You have the right to access and copy PHI about you contained in a designated record set for as long as we maintain the PHI. The designated record set will include prescription, medical, and billing records. To inspect or obtain a copy of PHI about you, you must send in a written request to our Compliance Officer. We may charge you a fee for the costs of copying, mailing, and supplies that are necessary to fulfill your request. We may deny your request to inspect and copy in certain limited circumstance. If you are denied access to PHI about you, you may request that the denial be reviewed.

Request and amendment of PHI. If you feel that the PHI we maintain about you is incomplete or incorrect, you may request that we amend it. You may request an amendment for as long as we maintain the PHI. To request an amendment, you must send a written request to our Compliance Officer. You must include a reason that supports your request. In certain cases, we may deny you request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with the decision and we may give a rebuttal to your statement.

Receive an accounting of disclosures of PHI. You have the right to receive an accounting of the disclosures we have made of PHI about you on or after June 9, 2013, for most purposes other than treatment, payment, or health care operations. The accounting will exclude certain disclosures, such as disclosures made directly to you, disclosures you authorize, and disclosures to friends or family members involved in your care. The right to receive an accounting is subject to certain other exceptions, restrictions, and limitations. To request an accounting, you must submit a request in writing to our Compliance Office. Your request must specify the time period for which you wish to obtain an accounting, which may not exceed six years. The first accounting you request within a twelve month period will be provided free of charge, but you may be charged for the cost of providing additional accountings. We will notify you of the cost involved, if any, and you may choose to withdraw or modify your request at that time.

Request communications of PHI by alternative means or alternative locations. You have the right to request to receive communications of PHI from the Pharmacy by alternative means or at an alternative location. For example, you may request that we contact you on a mobile phone number instead of your home number. To request confidential communication of PHI about you, you must submit a request in writing to Royal Quality Nursing Services, Inc. Your request must state how or where you would like to be contacted. We will accommodate all reasonable requests. In the event of an emergency regarding your treatment, if we cannot reach you promptly using the alternative means or alternative location you requested, we may try to reach you by other means or at another location.

Request a restriction on certain uses and disclosure of PHI. You have the right to request additional restrictions on out use or disclosure of PHI about you by sending a written request to our Compliance Officer. We are not required to agree to those restrictions.

Examples of How We May Use and Disclose PHI

The following are description and examples of ways we use and disclose PHI:

We will use PHI for treatment. For example, information obtained by clinical staff will be used to monitor the effectiveness, safety, and compliance of your drug therapy. In addition, we may contact you to provide refill reminders; check on your supplies; schedule nursing visits and coordinate deliveries.

We will use PHI for payment. For example, if you are covered under a health insurance plan, we will contact your insurer to determine whether it will pay for your therapy and the amount of your co-payment. We will bill you or a third-party payor for the cost of therapy medications and nursing services provided to you. The information on or accompanying the bill may include information that identifies you, as well as your prescribed therapy.

We will use PHI for health care operations. For example, we may use information in your health record to monitor drug usage and inventory levels. This information will be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We are also permitted or required to use or disclose PHI for the following purposes:

Business associates: We contract with business associates to perform certain services or functions on our behalf. For example, we may contract with a business associate to perform billing services for us or to appeal insurance payments. We may disclose PHI about you to our business associates so that they can perform the job we have asked them to do. To protect PHI about you, we require our business associates to appropriately safeguard the PHI.

Communication with individuals involved in your care or payment for your care: Health professionals such as pharmacists, nurses or patient care representative, using this professional judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care.

Food and Drug Administration (FDA): We may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
Workers' compensation: We may disclose PHI about you as authorized by and as necessary to comply with laws relating to workers'' compensation or similar [programs established by law.

Public Health: As required by law, we may disclose PHI about you to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose PHI about you for law enforcement purposes as required by law or in response to a valid subpoena or other legal process.

As required by law: We must disclose PHI about you when required to do so by law.

Health oversight activities: We may disclose PHI about you to an oversight agency for activities authorized by law. These oversight activities audits, investigations, and inspections, as necessary for our licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and administrative proceedings: If you are involved in a lawsuit or dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested PHI.

Research: We may disclose PHI about you to researchers when an institutional review board that has reviewed the research proposal and establish protocols to ensure the privacy of your information has approved their research. We may contact you to inform you of research opportunities in which you may wish to participate.

Coroners and medical examiners: We may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.

Organ or tissue procurement organizations: Consistent with applicable law, we may disclose PHI about you to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Notification: We may use or disclose PHI about you to notify or assist in notifying a family member, personal representative, or another person responsible for your care of your location and your general condition.

Correctional institution: If you are or become an inmate of a correctional institution, we may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.

To avert a serious threat to health or safety: We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and veterans: If you are a member of the armed forces, we may release PHI about you as required by military command authorities.

Victims of abuse, neglect, or domestic violence: We may disclose PHI about you to a government authority, such as social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary

to prevent serious harm to you or someone else or the law enforcement or public official that is to receive the report represents that it is necessary and will not be used against you.

Other Uses and Disclosures of PHI

The Pharmacy will obtain your written authorization before using or disclosing PHI about you for purposes other than those provided for above or as otherwise permitted or required by law. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing PHI about you, except to the extent that we have already taken action in reliance on the authorization.

Minors

If you are minor who has lawfully provided consent for treatment and you would like Royal Quality Nursing Services, Inc., to the extent permitted by your state's laws, to treat you as an adult for purposes of access to and disclosure of records related to such treatment, please notify the pharmacist.

For More Information or to Report a Problem

If you have questions or would like additional information about PHI practices, you may contact our **Compliance Officer** by writing to **Royal Quality Nursing Services, Inc., Compliance Officer, 223 Riveredge Drive, New Castle, DE 19720**, or you may call the **Compliance Officer** at **302-325-3110**. If you believe your privacy rights have been violated, you can file a complaint with our Compliance Office or with Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

ROYAL QUALITY NURSING SERVICES, INC.
223 Riveredge Drive
New Castle Delaware 19720
Phone (302) 325-3110 Fax (302) 325-3114

PATIENT CARE SURVEY

1. Who referred you to Royal Quality Nursing Services, Inc?

   _____

   _____

2. Did you feel you were treated with respect at all times? If not, why?

   _____

   _____

3. Were treatments explained to you before they were performed?

   _____

   _____

4. Were we effective with the teaching of medications, safety issues, treatments, etc?

   _____

   _____

5. Did you feel you could reach us when you needed?

   _____

6. What did you most value about your visit?

   _____

7. What would you suggest we change to improve our services?

   _____

8. Are there any other comments that you would like to make?

   _____

YOU HAVE THE RIGHT TO NOTIFY YOUR PHYSICIAN, PHARMACY AND THE ACCREDITATION COMMISION FOR HEALTH CARE (919-785-1214) OF ANY COMMENTS OR COMPLAINTS ABOUT YOUR SERVICES.

Thank you for your feedback!

Signature: _____ Date: _____