Penn Medicine | Penn Home Infusion Therapy

Date: _____

Team: _____

Patient Name: _____ Account #: _____ DOB: _____

Treatment Diagnosis: _____

Current Therapies: _____

Drug Name (generic), dose, freq., route: _____

Other Agency/Disciplines ☐ N/A

Contact #: _____

Allergies:

Immunization: ☐ N/A ☐ Up to Date

☐ Flu: _____

☐ Diphtheria/Tetanus: _____

☐ Pneumonia: _____

Vital Signs:

Temp		☐ Oral	☐ Axillary	☐ Tympanic
☐ Apical Pulse		☐ Reg	☐ Irreg.	
☐ Radial Pulse		☐ Reg	☐ Irreg.	
Resp		☐ Reg	☐ Irreg.	
BP R		☐ Lie	☐ Sit	☐ Stand
L		☐ Lie	☐ Sit	☐ Stand
Height		Current Weight		
Goal Weight		Usual Weight		

Pertinent Medical History

☐ Migraine
☐ Epilepsy/Seizures
☐ CVA ☐ TIA
☐ Hemorrhagic ☐ Ischemic
☐ Head Trauma
☐ Significant Memory Loss
☐ Multiple Sclerosis
☐ Asthma
☐ Emphysema/COPD
☐ Pneumonia
☐ Tuberculosis
☐ Sleep Apnea
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ M.I. ☐ CABG # _____
☐ Hypertension
☐ Arrhythmia ☐ Pacemaker
☐ Defibrillator ☐ Murmur
☐ DVT ☐ Embolism/Filter
☐ Anticoagulation Therapy monitored by: _____
☐ Anemia _____
☐ Hemophilia _____
☐ Diabetes: ☐ Type I ☐ Type II Glucometer Use
☐ Thyroid Problems
☐ Immun-Compromised: If Yes, explain: _____
☐ Arthritis _____
☐ Cancer Type: _____
Location: _____
☐ Metastasis location(s): _____
☐ Crohn's ☐ Anorexia _____
☐ GERD ☐ Ulcer
☐ Diverticulitis ☐ Diverticulosis ☐ Colitis
☐ GI Bleed ☐ Upper ☐ Lower
☐ Kidney Disease
☐ Dialysis Schedule: _____
☐ Liver Disease ☐ Gall Bladder Disease
☐ Pancreatis
☐ Bell's Palsey
☐ Other

Surgical History

☐ Appendectomy _____
☐ Cholecystectomy _____
☐ Hernia Repair _____
☐ Stents, location: _____
☐ Amputations _____
☐ Angioplasty _____
☐ Mastectomy _____
☐ Urostomy _____
☐ Craniotomy/Shunt _____
☐ Cholelithiasis _____
☐ Other _____
☐ Ostomy
☐ Nephrectomy ☐ R ☐ L
☐ Splenectomy
☐ Tracheostomy
☐ Spinal, specify _____
☐ Fractures
☐ Orthopedic ☐ Hip ☐ Knee____
☐ Bypasses, specify _____
☐ TURP
☐ Hysterectomy/BSO
☐ Partial ☐ Total

☐ Chemical Dependency

	Past	Present	Quantity
☐ Tobacco	☐	☐	
☐ Alcohol	☐	☐	
☐ Drug/Type	☐	☐	

Psychosocial

☐ No Problem Noted
Agitated
☐ Angry
☐ Anxious
☐ Depressed
☐ Difficulty Coping
☐ Flat Affect
☐ Hallucinating
☐ Mood Swings
☐ Paranoia
☐ Sleep Disturbances
☐ Withdrawn
☐ Possible victim of abuse or neglect ☐ No ☐ Yes, see narrative

Psycho-Social History: _____

Support System(s) Profile:

☐ Spouse/Significant Other ☐ Family ☐ Friends/Neighbors

☐ Patient/Caregiver willing to provide care: ☐ Yes ☐ No

Emergency Contact: _____

Relationship: _____

Phone Number: _____ Cell: _____

Environmental

Residence

☐ Apartment
☐ House
☐ Mobile Home
☐ Nursing Home
☐ Other
☐ Condominium

Conditions

☐ Pets
☐ No Heat
☐ No Phone
☐ No Electricity
☐ No Running Water
☐ No 3-Pronged Outlet
☐ No Refrig./Freezer Space
☐ Pests (i.e. Insects, rodents)
☐ Stairs
☐ Throw Rugs
☐ Unclean

Safe Environment ☐ Yes ☐ No Explain:

Education

Person Being Instructed: _____

Relationship to patient: _____

Comments: _____

Limitations to Learning: ☐ Knowledge Deficit ☐ Cognitive Deficit

☐ Physical or Time Restraints ☐ Language Barrier ☐ None

Ability to: ☐ Read ☐ Write

Explain: _____

Advanced Directives

Advanced Directives: ☐ Yes ☐ No

A Copy Obtained ☐ Yes ☐ No ☐ Requested

DNR ☐ Yes ☐ No ☐ Order Obtained

☐ Clinician has reviewed and discussed with patient out of the hospital DNR

☐ Bracelet in place ☐ Yes ☐ No

☐ Home Chart Updated

Neurological

☐ Alert ☐ Oriented ☐ Disoriented ☐ Confused ☐ Lethargic

☐ Headaches, location _____

☐ Numbness ☐ Tingling ☐ Dizziness ☐ Seizures ☐ Other

COMMUNICATION:

☐ Aphasia ☐ Expressive ☐ Receptive

☐ Unresponsive ☐ Slurred Speech ☐ Hoarseness

Head/Neck/EENT

☐ WNL ☐ Glasses ☐ Contacts ☐ Legally Blind ☐ Optic Neuritis

☐ Visual Changes/Impairments (describe): _____

☐ HOH: ☐ Loss of Hearing: Left > = < Right ☐ Hearing Aid(s)

☐ Hearing Changes/ Impairments (describe) _____

☐ Alteration in smell (describe): _____

☐ Dentures ☐ Throat complications _____

Musculoskeletal

☐ WNL ☐ Pain ☐ Weakness ☐ Location: _____

☐ ROM ☐ Impaired (explain) _____

☐ Fatigue ☐ Spasticity ☐ Steady Gait ☐ Poor Balance

Assist Device/Safety Device

☐ Hospital Bed
☐ Crutches
☐ Cane
☐ Commode
☐ Other
☐ Prosthesis
☐ Walker
☐ Wheelchair
☐ Shower-Chair

☐ Specify Activity Limitations: _____

☐ Physical/Occupational Therapy Referral to Physician

Penn Medicine Penn Home Infusion Therapy

Integument

Color: ☐ WNL ☐ Jaundice ☐ Cyanotic ☐ Pallor ☐ Flushed
Skin: ☐ Warm ☐ Dry ☐ Cool ☐ Moist
Turgor: ☐ Good ☐ Fair ☐ Poor ☐ Alopecia
Integrity: ☐ Intact ☐ Bruises ☐ Erythema ☐ Rashes ☐ Itching
☐ Abrasions ☐ Lacerations ☐ Wounds ☐ Surgical ☐ Non-Surgical
Location(s): _____

☐ Sterile Dressing Intact ☐ Open to air ☐ Sutures/Staples/Steristrips

Nutrition

☐ Diet ☐ Reg ☐ Other (weight loss during last 6 months) _____
☐ Supplements _____
Appetite: ☐ Good ☐ Fair ☐ Poor ☐ Improved ☐ Worsening
Fluid Intake: ☐ Good ☐ Fair ☐ Poor (explain) _____
☐ TPN ☐ Enteral

Genitourinary

☐ WNL ☐ Sediment
☐ Burning ☐ Urgency
☐ Frequency ☐ Anuric LMP
☐ Incontinence, type _____
☐ Hematuria
☐ Color _____ ☐ Odor
Foley Type: ☐ Indwelling ☐ External
☐ Urostomy ☐ Penile/Vaginal discharge

Are you pregnant?
☐ Yes ☐ No
LMP_____ ☐ N/A

Respiratory

Breath Sounds: ☐ WNL
☐ Decreased, location _____
☐ Rhonchi, location _____
☐ Rales, location _____
☐ Wheezes, location _____
☐ SOB: ☐ Rest ☐ Exertion ☐ Dyspnea ☐ Orthopnea
☐ Cough ☐ Nonproductive ☐ Productive (describe) _____
☐ O_2 Use, Liter(s) _____
☐ Continuous ☐ Intermittent ☐ Nebulizer Use
☐ Incentive Spirometer
☐ Tracheostomy Shiley ☐ cuffed ☐ non-cuffed

Cardiac

☐ Heart Sounds Assessed ☐ WNL ☐ Auscultated Abnormalities
Rhythm: ☐ Reg. ☐ Irreg. ☐ Palpitations ☐ Angina
☐ Edema, location and scale (+1 - +4) _____
Measurements, if applicable: _____
Calf (R) _____ cm (L) _____ cm
Abdominal Girth _____ cm
Ankle (R) _____ cm (L) _____ cm
☐ Diaphoresis ☐ Fluid Restriction
☐ Neck Vein Distention ☐ R ☐ L ☐ Lightheadedness
☐ Pacemaker settings, if known _____
☐ Internal Defibrillator Settings

Gastrointestinal

Bowel Sounds: ☐ WNL ☐ Absent ☐ Hypoactive ☐ Hyperactive
Abdominal: ☐ Soft ☐ Firm ☐ Nontender ☐ Tender, location _____
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Abdomen Distention ☐ GERD
Mouth: ☐ Mucositis ☐ Dysphagia ☐ Thrush ☐ Other _____
Last BM: _____ Bowel Regimen: _____
☐ Bloody/Tarry Stool ☐ Cramping ☐ Constipation ☐ Incontinence
☐ Fistula ☐ Eating Disorder ☐ Ostomy ☐ Laxative, Stool Softener

Venous Access Assessment

☐ None ☐ Peripheral ☐ Midline ☐ PICC
Insertion Date: _____ Facility Placed: _____
☐ Tunneled ☐ Non-Tunneled ☐ Implanted
Lumens: ☐ One ☐ Two ☐ Three Size/Gauge: _____
☐ Open-Ended (Hickman Type) ☐ Closed-Ended (Groshong)
☐ No Blood Return, explain _____
Location: _____ ☐ Flushes Well
Site Assessment: ☐ Unremarkable ☐ Sutured
☐ Securement Device _____ ☐ Other
☐ Migration Noted: _____
Length of PICC Catheter: _____ cm

Pump Verification ☐ N/A

Serial #: _____
Pump Type/Mode: _____ Settings ☐ Cont ☐ Intermittent
Res Vol _____ mls Dose _____ Period/Rate _____
☐ Freq _____ ☐ KVO Rate Lock Level _____
☐ Bolus Amt. _____ freq. _____ ☐ Taper _____ up _____ down
☐ Back-up pump for inotropic use Serial #: _____
☐ Settings Verified

PICC Line Measurements

Arm Circumference (10cm above ante cubital) _____
External Length _____ cm ☐ N/A
☐ Sutured ☐ STAT Lock

Other Lines or Accesses:
☐ Implanted Pump
☐ Intrathecal
☐ Jejunostomy Tube
Gastrostomy Tube
☐ Nasogastric Tube
Shunt/Fistula ☐ Bruit/Thrill
☐ Other _____
Treatments Performed: ☐ No ☐ Yes (Describe) _____

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NUTRITIONAL RISK SCREENING

Circle the number if a "YES" answer

Patient has illness or condition that makes him/her change the kind and/or amount of food eaten	2
Eats fewer than 2 meals per day	3
Eats few fruits and vegetables or milk products	2
Has 3 or more drinks of beer, liquor or wine almost everyday	2
Has tooth or mouth problems that make it hard for him/her to eat	2
Does not always have enough money to buy the food needed	4
Eat alone most of the time	1
Takes 3 or more prescribed or over-the-counter drugs/day	1
Without wanting to, has lost or gained 10 lbs. in the last 6 months	2
Not always physically able to shop, cook, and/or feed themselves	2

☐ 0-2 Low Nutritional Risk Total _____

☐ 3-5 Moderate Nutritional Risk — Refer to RN Coordinator

☐ 6 or More High Nutritional Risk — Diet / Nutrition Teaching and possible MSW / Dietician Referral

FALL RISK SCREENING

Check "YES" or "NO" as applicable:

	NO	YES		NO	YES
History of Falls (High Risk)			Expresses Fear of Falling		
Poor Conditioning / Endurance			Weakness		
Poor Judgment			Neuromuscular Disorders		
Impulsivity			Neuropathies		
Shuffling Gait			Amputation		
Wandering Behavior			Alcohol / Drug Abuse		
Confusion / Agitation			Incontinence		
Balance Deficit			New or changed dose of medications such as antihypertensives, diuretics, CNS depressants		
Visual Deficit					
Perceptual Deficit			Environmental Hazards		

If "YES" to History of Falls and/or "YES" to 2 or more other indicators, instruct patient/caregiver on fall precaution.

PAIN SCREENING

Check "YES" or "NO" as applicable: Any "YES" response, complete Initial Pain Assessment.

	NO	YES		NO	YES
Are you experiencing pain?			Are you presently taking pain medication or other treatment modalities to relieve the pain?		
Are you having trouble sleeping because of pain?			Has your pain interfered or prevented you from any ADL?		

Comments / Treatments Performed (Describe): _____

Care Plan: ☐ Reviewed with patient / caregiver and initialed

Additional problems and goals: _____

_____ _____ Time In: _____ Time Out: _____

RN Signature Patient Signature

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Penn Medicine

RN PAIN ASSESSMENT

Wissahickon Hospice • Penn Care at Home • Penn Home Infusion Therapy

Date: _____
Team: _____
Account#: _____

Patient's Name _____ Diagnosis _____

Etiology if known: _____ Physician _____

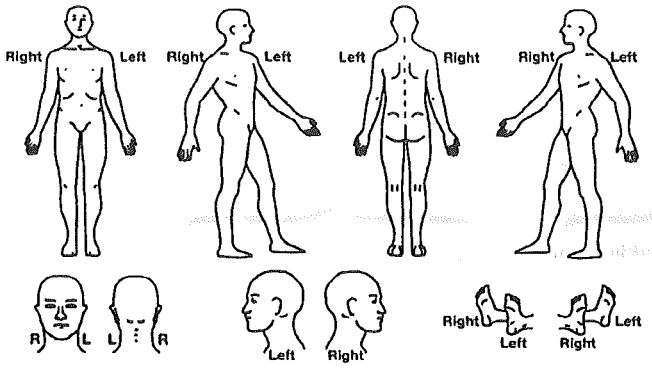
If patient is cognitively impaired, name of person giving information _____

Do you have (do you feel the patient is having) pain/discomfort now? _____

Presence of common or cultural beliefs that would inhibit reporting pain/discomfort? _____

1. LOCATION:

Patient or nurse mark drawing. If more than one site, label A, B, C, D.



2. TYPE OF PAIN:

- ☐ Aching ☐ Throbbing ☐ Shooting ☐ Deep Pressure
- ☐ Dull ☐ Burning ☐ Cramping ☐ Diffuse
- ☐ Sharp ☐ Electrical ☐ Neuralgia ☐ Other _____
- ☐ Stabbing ☐ Pulling ☐ Spasms _____

3. PHYSIOLOGIC TYPE OF PAIN ASSESSED:

☐ Somatic
Well localized
In bone, blood vessels, subcutaneous tissues, muscle, and connective tissues
Described as gnawing, aching, constant throbbing

☐ Visceral
Poorly localized, diffuse
In organs and lining of the body cavities
Described as cramping, dull, constant, deep pressure

☐ Neuropathic
Nerve injury pain due to the destruction of the nerve endings
Described as a burning and shock-like sensation

4. DOCUMENT INTENSITY USING THE SCALES ON THE BACK OF THIS FORM AS REFERENCE

Intensity at present: (As rated by patient/caregiver): intensity scale:

Scale Used: ☐ Faces Scale ☐ 0-10 Scale

0-10 Numerical Rating: _____ Acceptable Level of Pain _____

Worst Pain Gets: _____ (Within 24 hours)

Best Pain Gets: _____ (Within 24 hours)

☐ Patient unable to rate the pain. Who reports the pain? _____

5. ONSET: DURATION: PATTERN:

ONSET	DURATION	PATTERN
☐ Sudden	☐ Continuous	☐ Daily
☐ Gradual	☐ Intermittent	☐ All The Time
☐ Chronic	☐ Breakthrough	☐ Sporadic
	☐ Other _____	☐ At Night
		☐ Occasionally

6. WHAT CAUSES OR INCREASES THE PAIN?

- ☐ Physical Activity ☐ Touch
- ☐ Inactivity ☐ Body Positioning
- ☐ Sleeping ☐ Other _____

7. WHAT ALLEVIATES THE PAIN?

☐ Medication

Current Medication Management:

_____

_____

- ☐ Short Acting Medication ☐ Long Acting Medication
- ☐ Heat/Cold ☐ Relaxation/Breathing
- ☐ Body Repositioning/Exercise ☐ Massage
- ☐ TENS Unit ☐ Reduced Noise
- ☐ Physical Therapy ☐ Music Therapy
- ☐ Dimming of Light ☐ Rest
- ☐ Nothing ☐ Counseling
- ☐ Other _____

_____

8. WHAT EFFECT DOES THE PAIN HAVE ON A PERSON'S QUALITY OF LIFE?

PHYSICAL:	PSYCHOLOGICAL:
☐ Decreased functional ability	☐ Diminished leisure, enjoyment
☐ Diminished strength, endurance	☐ Increased anxiety, fear
☐ Nausea, poor appetite	☐ Depression, personal distress
☐ Poor or interrupted sleep, no restorative sleep	☐ Difficulty concentrating
	☐ Difficulty coping
☐ Excessive Sleeping	☐ Anger
☐ Constipation	☐ Crying
	☐ Withdrawal

SOCIAL:	SPIRITUAL:
☐ Diminished social relationships	☐ Increased suffering
☐ Decreased sexual functions, affection	☐ Altered meaning
☐ Altered appearance	☐ Reevaluation of spiritual beliefs
☐ Increased caregiver burden	
☐ Irritability	

9. PAIN PLAN:

- ☐ Call PHIT – RN/Pharmacist Coordinator
- ☐ Call Physician/Nurse Practitioner/Clinical RN Specialist
- ☐ Made referral to Penn Home Care & Hospice Service for ☐ PT ☐ OT ☐ MSW ☐ Pastoral Care
- ☐ Discuss with patient other modalities of management
  - ☐ Counseling ☐ Energy Conservation
  - ☐ Stress Management ☐ Education
  - ☐ Exercise/Rehabilitation ☐ Bowel Regime

Financial resources to fill prescription(s): ☐ Yes ☐ No

☐ Referral made: _____

Patient satisfied with current plan of care of pain management? ☐ Yes ☐ No

_____ _____
RN Signature Print Name

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TEACHING RECORD

Name:_____ Team:_____

Account No._____ Therapy:_____

I = INDEPENDENT N = NON-INDEPENDENT

	Date	Additional Return Demonstrations Comments	I	N
THERAPY				
Principles of Therapy	1			
Treatment Requirements				
Patients Rights & Responsibilities	2			
Plan of Care				
Medication Information				
Side Effects	3			
SAFETY/INFECTION CONTROL				
Handwashing				
Clean Work Area				
Asepsis	1			
Standard Precautions				
Contact Precautions (if applicable)				
Respiratory Hygiene Precautions				
Waste Disposal				
Environmental Safety	2			
Spill/Chemo Precautions				
Fall Precautions				
Supplies/Equipment/Inventory				
Oxygen Precautions (if applicable)	3			
MEDICATIONS				
Name of Patient/Drug Verified	1			
Storage/Inspection				
Additives				
Preparation	2			
Dosage/Concentration				
Expiration Date				
Room Temperature Stability	3			
ADMINISTRATION				
Pump:_____				
Alarms				
Back-up pump/battery/powerpack	1			
PCA by Proxy				
Catheter/Tube Placement				
Connection Procedures				
Disconnection Procedures	2			
Rate of Administration				
Flushing (Heparin, Saline)				
SASH Protocol				
Blood Back-up	3			
SELF-MONITORING				
Weight				
Temperature	1			
Intake/Output				
Urine Testing (Concept)				
Glucose Monitor (Concept)	2			
Catheter Site Signs & Symptoms of Infection				
DME Alarms				
1-800-666-6002 - 24 hours Emergency	3			
COMPLICATIONS				
Infiltration/Extravasation				
Phlebitis (Chemical, Bacterial, Mechanical)				
Infection (Local, Bloodstream)				
Cellulitis				
Hematoma	1			
Venous Spasm				
Embolism (air, pulmonary, catheter)				
Venous Thrombosis				
Speed Shock				
Pulmonary Edema				
Nerve Damage				
Device Allergic Reaction	2			
Catheter Migration/Malposition				
Catheter Occlusion/Fracture				
Cardiac Tamponade/Arrythmias				
Absence of Blood Return				
Twiddler's Syndrome				
Pinch off Syndrome	3			

1. RN Signature:

2. RN Signature:

3. RN Signature:

I/We _____ (patient and/or caregiver) have received educational material (see page 2), and agree to undergo instruction in order to feel competent to safely and effectively perform the functions associated with the prescribed therapy. I/We understand that I/We will routinely perform these functions in a facility other than a hospital or medical institution.

Patient/Caregiver Date

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Penn Home Infusion Therapy

Infection Prevention: Teaching Review & Technique Observation

Patient/Caregiver Name: _____ **Team:** _____
Assessment by _____ **Date** _____

Indicator	Yes/No/ N/A	Notes
Proper Storage of Medication & Supplies		Indicate observation (O) or interview (I) or both (B)
Utilization of a Clean Work Area		Indicate observation (O) or interview (I) or both (B)
Hand Hygiene • Per CDC hand washing guidelines - Discuss the use of soap and water versus waterless alcohol-based cleaner - Discuss scenarios as applicable		Indicate observation (O) or interview (I) or both (B)
Aseptic Technique • Cap Change • Flush • Dressing Change *Port Access (if applicable) *Port De-Access (if applicable)		Indicate observation (O) or interview (I) or both (B)
Presence of a Thermometer in the Home		Indicate observation (O)
Utilization of a Temperature Readings Tracking Method		Indicate observation (O) or interview (I) or both (B)
Signs & Symptoms to report immediately to PHIT at 1-800-666-6002: • Fever of 100.4F or Higher • Sweating • Chills (during flushing of the IV line) • Whole-Body Chills & Aches & Pains • Wet Biopatch/Wet IV Site Dressing • Dirty Biopatch/Dirty IV Site Dressing • Reddened IV Site • Swollen IV Site • Painful IV Site • Oozing/Bruising at IV Site		Indicate observation (O) or interview (I) or both (B)
Comments:		

Penn Home IT Chemotherapy Administration Checklist

Patient Name: _____ **DOB:**_____

The following should be completed with each chemotherapy administration dose or "hook up" of chemotherapy continuous infusions. This checklist is in addition to standard nursing visit summary report per policy and procedure.

- Review the Prescription File/Rx Form, the Physician Orders/Plan of Treatment Files' Free Form/Prescriber Order, and the prescription label.
- Check chemotherapy bag or cassette prescription label: verify patient name and DOB, medication, dose, route of administration, rate, expiration date and duration against the Prescription File/Rx Form.
- Verify pump settings with the Prescription File/Rx Form and the prescription label.
- Check for any prescribed prn and/or pre-medication (oral or IV) antiemetic and hydration; via the Prescription File/Rx Form, and the Physician Orders Files' Free Form/Prescriber Order.
- Labs will be monitored by the prescribing physician.
- Review medication purpose, side effects, and chemotherapy precautions with patient and /or caregiver.
- Assess the catheter and check for blood return. The physician must be contacted if there is no blood return.

Document pump settings, type of IV site, blood return and patient/caregiver education below.

Chemotherapy Administration Verification Note:

IV Medication:_____

PUMP VERIFICATION (*Write settings from pump):*

Reservoir Volume:_____

Rate:_____

Infusion time (for each cassette or bag):_____

Pump settings verified with the Rx Form and the prescription label (initial) _____

Dose Change/Pump taken out of LL2? (circle) Yes No
*If YES, who was the 2nd person verification:

_____

SITE ASSESSMENT:

IV site (circle): Port/Hickman /PICC /other _____

Blood return (circle): Yes No Non-Applicable
*If NO blood return contact physician

Date and Time of hook up: _____

Signature of Chemo Certified Nurse:

_____

Patient /Caregiver education: (initial each line)

____Explained purpose, side effects, and chemotherapy precautions with patient and /or caregiver

Chemotherapy Precautions:

- Chemo Spill Kit
- Mouth care- oral rinses (no alcohol based mouth wash), preventing mouth sores
- Nausea-hydration and antiemetics
- Diet- No fresh, uncooked foods
- Temperature checks
- Sunscreen
- Neutropenic Precautions
- Infection Precautions
- Sexuality Precautions
- Other:_____

Infusion Pump and Further Education:

____Review of pump audible alarm system

____Explained and demonstrated battery change (if applicable) and checking pump for battery life

____Explained/reviewed checking chemotherapy tubing connections

____Explained/reviewed what to do in case of chemotherapy emergency/disconnect and how to contact PHIT

____Patient/caregiver acknowledged understanding of education and infusion pump.

Penn Home Infusion Therapy
Falls Prevention Education

Patient's Name: _____ **DOB:** _____

RN signature: _____ **Date**_____

Instructions: Initial or check the box to indicate the falls prevention education and intervention provided to the patient and or caregiver(s), based on the Falls Risk Screening tool (if admission visit) or your on-going Falls Risk Assessment if this is a revisit.

Risk Factor on PHIT's Falls Risk Screening Tool	Falls Prevention Education and Intervention Provided	Intervention
History of Falls (High Risk)		Instruct regarding applicable patient specific falls prevention education and home safety awareness.
Poor Conditioning/Endurance		Encourage patient to engage in physical activities as tolerated. Refer to PT/OT for home exercise program instruction, if appropriate.
Poor Judgment		Provide education to the patient/caregiver on safety awareness; may need to recommend 24 hour supervision.
Impulsivity		Provide education to the patient/caregiver on safety awareness; may need to recommend 24 hour supervision.
Shuffling Gait		The patient will demonstrate the correct use of his/her DME (name the DME). The patient will wear footwear with anti-skid, gripping soles. ***DME:** _____
Wandering Behavior		Recommend 24 hour supervision to the patient and caregiver(s).
Confusion/Agitation		Recommend 24 hour supervision to the patient and caregiver(s). Assess any potential contributory medications and work with the care team on medication changes, if appropriate.
Balance Deficit		The patient will demonstrate the correct use of DME (name the DME). Refer to PT/OT if appropriate. ***DME:** _____
Visual Deficit		Recommend that the patient will plan annual vision checks, that the patient will keep glasses within reach at all times, and that the patient will always utilize adequate lighting.
Perceptual Deficit		Recommend a vision evaluation appointment. Refer to PT/OT for assessment, if appropriate.
Express fear of falling		Review environmental hazards education with patient (below); assess need for possible DME and a possible PT/OT home evaluation, if appropriate.

Penn Home Infusion Therapy

Falls Prevention Education

Patient's Name: _____ **DOB:** _____

Risk Factor on PHIT's Falls Risk Screening Tool	Falls Prevention Education and Intervention Provided	Intervention
Neuromuscular Disorders		Discuss potential needs for DME and a home PT/OT evaluation, if appropriate.
Neuropathies		Discuss potential needs for DME and a home PT/OT evaluation, if appropriate.
Amputation		Discuss and recommend an in-home PT/OT assessment, if appropriate.
Alcohol/Drug Abuse		Provide teaching that alcohol and drug abuse causes cognitive impairment and increases risk for falling. Review environmental hazards education (below).
Incontinence		Recommend that the path to the bathroom is well-lit, clear and unobstructed. If needed, place grab bars near the toilet and/or recommend a three-in-one commode.
New or changed dose of medications such as antihypertensives, diuretics, CNS depressants		Provide medication reconciliation and medication education. Educate the patient to rise up slowly from a supine position and to stand up slowly from a seated position.
Environmental Hazards		Provide instruction regarding home environmental safety: use rugs with non-skid backs; use a light within easy reach at night, use non-slip mats in the bathroom, install grab bars in the bath/shower.
PT/OT is appropriate for Patient		Referral made for PT/OT. ***Name of Agency:** _____
Additional Comments (if applicable):		

Penn Home Infusion Therapy

EBOLA SCREENING

Patient Name: _____ DOB: _____

Date and Time of Screening: _____

Name of the Person You Spoke to Regarding this Screening:_____

Assessment by: _____

Ebola Screening Question(s)	
In the past 3 weeks, have you or anyone in your home traveled to Mali, Guinea, Liberia or Sierra Leone OR been in the presence of anyone who has traveled to Mali, Guinea, Liberia or Sierra Leone?	☐ YES ☐ NO
If Yes to the above question, then ask: Have you or anyone in your home had fever, headache, muscle pain, diarrhea, vomiting, weakness, abdominal pain or unusual bleeding in the last 3 days.	☐ YES ☐ NO

If YES to BOTH Screening Questions, Follow the Guidelines Below:

Which Symptoms are present?	☐ Fever ☐ Headache ☐ Muscle Pain ☐ Diarrhea ☐ Vomiting ☐ Weakness ☐ Abdominal Pain ☐ Unusual Bleeding
Document how long each symptom has been present:	
Inform the patient that someone will call them back with scheduling information.	☐ YES ☐ NO
Contact Dr. Anne Norris at 610-331-6020. If not available call 215-614-0524.	☐ YES ☐ NO

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

Royal Quality Nursing Services, Inc.

Plan of Treatment

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 _____

Penn Medicine
Home Infusion Therapy

Date: _____

Patient Full Name: _____ **Date of Birth:** _____ **UPHS MRN:** _____

Allergies: _____ **Provider Name:** _____

Medications to Include:
Prescription
Over the Counter
Home Remedies

ALERT! Do Not Use Abbreviations			
Trailing Zeros	U	IU	Naked Decimal Points
q.d or QD	MgSO4	MS or MSO4	q.o.d. or QOD

INITIALS	START DATE	STOP DATE	MEDICATION NAME	DOSE	ROUTE	FREQUENCY	PRN INDICATION	INITIALS
			Normal Saline Flush	10ml	IV	Prior to and after infusion and as needed	Infusion administration, troubleshooting and/or educational needs	

White Copy: Return to PHIT Canary Copy: Stay in Patient's Home

Penn Medicine | Penn Home Infusion Therapy

GENERAL CONSENT FORM

Patient Name:_____ **Patient DOB:** _____ **Penn MRN:** _____

Thank you for choosing Penn Home Infusion Therapy (PHIT). Penn Home Infusion Therapy is a licensed retail pharmacy that is part of the Hospital of the University of Pennsylvania and the University of Pennsylvania Health System. The Health System is part of Penn Medicine and the University of Pennsylvania. PHIT provides home infusion pharmacy services and related nursing care.

I have read and understood each paragraph below, and by signing give consent voluntarily. This consent further certifies that I have received information related to: the services offered by PHIT; PHIT's on-call system; the procedure to voice a grievance; and the mechanism to access information regarding my plan of treatment.

If signing electronically: I accept and I intend the signature(s) below to be legally binding and the equivalent of my handwritten signature.

Patient Signing:

Patient Printed Name	Patient Signature	Date	Time

Legally Authorized Representative Signing:

Print Name	Signature	Date	Time

Relationship to Patient

Penn Medicine Representative Signing:

Print Name	Signature	Date	Time

CONSENT TO CARE: I present myself for care by PHIT. I voluntarily consent to care including routine tests and treatment. I know that no guarantees have been made to me about the results of the care provided. I understand that Penn Medicine is part of the University of Pennsylvania, which is a teaching institution. I agree that those in training programs may take part in my care. I understand that for the purpose of my care, certain of my tissue(s), bodily substances and/or fluids may be removed and used, modified, disposed of, or transferred by Penn Medicine. I agree that any remaining tissues(s), bodily substances, and/or fluids may be used for education and research not specifically related to my care. If such material identifies me, research use will occur only with my permission. I understand that video, audio, and/or digital recordings/images of my treatment by Penn Medicine may be taken, and may be used for:

- Quality improvement and education, in which case the recordings/images will not become part of my medical record and will be erased after review. I have the right to decline the recording or image collection or its use for purpose of quality improvement and education; and
- Consultative services and treatment by healthcare providers at a distant site, such as another hospital, authorized by Penn Medicine, which may include interactive video, audio, and telecommunications technology (also known as "telemedicine"). Details of my health history, examinations, x-rays, tests and medical records may be reviewed by and discussed with these other healthcare providers at these distant sites and other hospitals.

CONSENT TO USE AND DISCLOSE PERSONAL HEALTH INFORMATION: I understand and consent that Penn Medicine is permitted to use and disclose health information about me in any form for **treatment, payment, and healthcare operations** and as otherwise allowed by law. This includes sharing my health information with:

- Penn Medicine or outside providers involved in my care, and family members or friends involved in my care.
- Individual or parties responsible for payment for the care I receive, such as insurance companies, managed care companies, government programs and agencies such as Medicare, and each of their agents or auditors.
- I further consent and authorize PHIT to release to the Centers for Medicare and Medicaid Services (CMS) or its agents, any information contained or included in the Outcomes and Assessment Information Set (OASIS).

SPECIFIC CONSENT TO USE AND DISCLOSE SPECIAL RECORDS: I understand that Federal and state law specially protect health information and records relating to treatment for mental illness, HIV or AIDS, and/or drug or alcohol abuse ("Special Records"). Such laws allow Penn Medicine to use and share Special Records for my care and treatment and for other specified purposes and, in certain circumstances, require a special patient consent to release records.

Patient Name: _____ Date of Birth: _____

NOTICE OF PRIVACY PRACTICES: I have been given a copy of Penn Medicine's Notice of Privacy Practices, which explains in more detail how my health information may be used and/or disclosed.

PATIENT RIGHTS AND RESPONSIBILITIES: I have been informed of the Patient Bill of Rights and Responsibilities that explains my rights and responsibilities as a patient in a language and manner that I understand and a copy has been made available to me. Penn Medicine provides translated Patient Bill of Rights and Responsibilities to assist patients and families on its website, http://www.pennmedicine.org/for-patients-and-visitors/patient-information/patient-rights-and-safety/patient-rights and language interpretation services are available, as needed.

ASSIGNMENT OF BENEFITS: In exchange for the care and services I am receiving from Penn Medicine, I hereby give and assign to Penn Medicine, including its Hospitals and providers and PHIT, the right to receive payment directly for all insurance and other health benefits to which I am entitled, and/or which may be payable on my behalf. I understand that this is called an "assignment of benefits" and that Penn Medicine, its Hospitals, PHIT and/or providers may be called my "assignees." I agree that they can sue anyone in their own names as my assignee and obtain payment for charges relating to my care and payment for lawyers' fees resulting from collection efforts. I understand that I may be required to pay for charges for my care that others do not pay on my behalf.

MEDICARE BENEFITS: I request that payment of Medicare benefits be made on my behalf to PHIT, Penn Medicine, the Hospitals or their providers for any care or services provided to me. I authorize them to give the Centers for Medicare & Medicaid Services and its agents any information about me (or the person I signed for) needed to determine Medicare benefits. I have provided accurate information about Medicare secondary payors.

FINANCIAL RESPONSIBILITY: Even if I have insurance, I may be responsible for charges for my care that others do not pay on my behalf. I agree that within forty-five (45) days after Penn Medicine provides care to me (or the person I signed for), or the bill for such care is given to me or whomever is responsible for payment, I will pay Penn Medicine any unpaid charges. If the matter is sent to a collection agency or lawyer for collection, I will pay the outstanding charges and all lawyers' fees and collection expenses.

RIGHT OF SUBROGATION AND LIEN: I understand and agree that PHIT, Penn Medicine or its providers are "subrogated" to (substituted for me) and have the right to recover from any person or company legally responsible (whether by contract, tort, or some other way) for paying the charges for care provided to me. Also, if I make a legal claim against any person or company for compensation for the injuries or illness for which I am being treated, I agree that, to the extent permitted by law, Penn Medicine shall have a "lien" against (right to) any money I recover and I direct that any lawyers representing me pay this lien from the funds recovered before they distribute any funds to me. This right of subrogation and this lien will not include any money already paid to Penn Medicine. I agree to take, and to assist Penn Medicine in taking, whatever action is necessary to protect their subrogation rights (rights of substitution) and liens.

SEVERABILITY: If any part of this consent form is declared to be invalid, illegal or unenforceable, the rest of this consent form will not be invalid. This does not take away any rights I, my employer, or my insurance company may have under any existing contracts with Penn Medicine, or any statutory rights I may have.

PHARMACY COUNSELING: I have been given a printed copy of information related to the medication I am receiving. I understand that I may request to speak with a pharmacist to answer any questions I may have by calling PHIT at 1-800-666-6002.

ADVANCED DIRECTIVES: I have received and reviewed information regarding my right to accept or refuse medical treatment and of my rights to formulate Advance Directives. I understand that I am not required to have an Advance Directive in order to receive medical treatment and that the terms of any Advance Directive that I have executed will be followed by PHIT and my caregivers to the extent permitted by law.

- ☐ I have executed an Advance Directive and provided a copy.
- ☐ I have executed an Advance Directive and have not provided a copy.
  I understand that PHIT may not be able to implement this directive unless a copy is provided.
- ☐ I have not executed an Advance Directive

RESUSCITATION: I have received information about resuscitation (making my heart start to beat again and/or making me breathe again) and at this time, I have decided that **I DO**_____ or **I DO NOT** _____want resuscitation.

I have designated a Durable Power of Attorney for Healthcare. That person is:

_____

Name/Relationship **Phone #**

_____

Email Address