allianceRx Walgreens + PRIME

# Patient Assessment Form - Pediatric (Birth through 12 years of age)

☐ Start of Care ☐ Recertification ☐ Homebound ☐ Visit Type: ☐ Home ☐ ATS ☐ PRN ☐ **Patient ID Verified**

| Patient Name: | MRN | Age | DOB | Sex ☐ M ☐ F | Date |
|---|---|---|---|---|---|
| | | | | | |

Source of Information: ☐ Patient ☐ Other:

Reason for Homecare – Primary Diagnosis & Current Home Infusion Medications:

Other Pertinent History and Surgeries: | Primary Language:

Family Religious/Cultural Practices: | Immunizations: ☐ Up-to-date ☐ Other:

## Social / Environmental History

Living Situation:
☐ House
☐ Mobile Home
☐ Apartment
☐ Nursing Home
☐ Hotel suite / Efficiency
☐ Other: _____

Lives With:
☐ Mother ☐ Father
☐ Stepmother ☐ Stepfather
☐ Foster Parents
☐ Other: _____

# of Siblings: _____

## Home Environment Safety

Suitable for Care: ☐ Yes ☐ No (See Skilled Intervention Note)
☐ Safety Locks ☐ Child proof Rx containers ☐ Infestation
☐ Cluttered Living Space/Stairs ☐ No Smoke Detectors
☐ No Fire Extinguisher ☐ Scattered Rugs ☐ Unsafe Bathroom
☐ Oxygen used ☐ Unsafe Entry or Exits ☐ No Telephone
☐ Improper Storage of Hazardous Material
Inadequate: ☐ Air ☐ Heat ☐ Plumbing ☐ Electrical ☐ Refrigeration
Comments: _____

## Vital Signs

| WT Actual: | WT Stated: | **Temp:** _____ ☐ PO ☐ Ax ☐ Other: _____ | **Resp:** | **Heart Rate:** | **B/P:** _____ ☐ RA ☐ LA ☐ Sitting ☐ Lying ☐ Standing |
|---|---|---|---|---|---|
| | | | | | |

***NPA = No Problem Assessed**

## Systems Review

### Endocrine

☐ NPA
☐ Diabetes – Type: _____
☐ Current FSBS: _____
☐ Thyroid Disorder: _____
☐ Adrenal Disorder: _____
☐ Other: _____

### Genitourinary

☐ NPA ☐ Urgency
☐ Frequency ☐ Retention
☐ Incontinence ☐ Dysuria
☐ Hematuria
☐ Other: _____
Toilet Trained: ☐ Yes ☐ No
# of wet diapers/day: _____
☐ Catheter: ☐ Indwelling ☐ Intermittent
☐ External Date Placed: _____
Comments: _____

### Cardiovascular

☐ NPA ☐ Cap Refill>3 secs ☐ Abnormal Heart Rhythm
☐ Palpitations ☐ Neck Vein Disten. ☐ Abnormal Hearts Sounds
☐ Tachycardia ☐ Hypotension ☐ Edema
☐ Bradycardia ☐ Hypertension ☐ Pitting: ☐ +1 ☐ +2 ☐ +3 ☐ +4
☐ Cyanosis ☐ Pacemaker Location: _____
☐ Other: _____

**Peripheral Pulses:**
**RUE:** ☐ Present ☐ Absent **RLE:** ☐ Present ☐ Absent: Location: _____
**LUE:** ☐ Present ☐ Absent **LLE:** ☐ Present ☐ Absent: Location: _____
Comments: _____

### Psychosocial

☐ NPA
☐ Alert
☐ Lethargic
☐ Unresponsive
☐ Flat Affect
☐ Agitated
☐ Anxious
☐ Confused

**Communication Issues:**
☐ NPA
☐ Vision: _____
☐ Hearing: _____
☐ Language/Literacy
☐ Aids Used/Needed: _____
Comments: _____

**Speech:**
☐ NPA ☐ Slurred
☐ Garbled ☐ Aphasic

**Memory:** ☐ N/A
☐ Good ☐ Fair ☐ Poor

**Oriented to:** ☐ N/A
☐ Person ☐ Place ☐ Time
Comments: _____

### Neuromuscular

☐ NPA ☐ Vertigo
☐ Headache ☐ Spasticity
☐ Paresis ☐ Flaccidity
☐ Tremors ☐ ROM Loss
☐ Ataxia ☐ Numbness
☐ Alt. Level of Consciousness (describe)
_____
☐ Paralysis – Level: _____
☐ Seizures (describe): _____
_____
☐ Head Circumference: _____
☐ Fontanel(s): ☐ Bulging ☐ Sunken
☐ CVA ☐ Shunt
☐ Other: _____
_____
☐ Sensory Alterations:
☐ Smell ☐ Touch ☐ Taste
Comments: _____

### Respiratory

☐ NPA ☐ Orthopnea:
☐ Diminished # pillows ____
☐ Wheezes ☐ Tachypnea
☐ Stridor ☐ Rhonchi
☐ Crackles: ☐ Course ☐ Fine
☐ Dyspnea:
☐ On Exertion ☐ At Rest
☐ Retractions Location: _____
☐ Cough:
☐ Productive ☐ Non-Productive
☐ Sputum (describe): _____
☐ Apnea monitoring: _____
☐ Other: _____
☐ $O_2$ at: ____ LPM: _____
☐ Continuous ☐ Intermittent
☐ N/C ☐ Mask
DME Co.: _____

### GI/Nutrition

☐ NPA ☐ Abdomen:
☐ Nausea ☐ Vomiting ☐ Taut
☐ Dysphagia ☐ Distended
☐ Constipation ☐ Masses
☐ Diarrhea ☐ Tenderness
☐ Bleeding ☐ ABD Girth:
☐ Ostomy: _____ _____
**Last BM:** _____ #Stools/Day: _____
**Bowel Sounds:** ☐ Present ☐ Absent
Diet: _____
☐ Breast Fed ☐ Bottle Fed
**Appetite:** ☐ Good ☐ Fair ☐ Poor
☐ Enteral Tube Type: _____
☐ Formula: _____
☐ Intermittent : _____
☐ Continuous: _____
☐ Wt Gain/Loss _____ lbs
Comments: _____

### Integumentary

☐ NPA ☐ Dry ☐ Diaphoretic ☐ Pale ☐ Turgor Poor ☐ Rash ☐ Pruritus ☐ Petechiae ☐ Jaundice ☐ Birthmark
☐ Bruises ☐ Abrasion ☐ Incision ☐ Staples ☐ Sutures ☐ Laceration ☐ Pressure Ulcer ☐ Burns
☐ Patient/Caregiver Independent with Wound Care ☐ Wound Managed by: ☐ Wound Clinic ☐ MD Office
☐ Other HHA: _____
☐ SN Performing Wound Care/Assessment (see Wound Addendum) ☐ SN treating active Bleed (see Bleeding Disorder Addendum)
Comments: _____


©2018 AllianceRx Walgreens Prime.
All rights reserved.

**Patient Name:** _____ **MRN:** _____

## Developmental / Behavioral

**Age-Appropriate / Milestones met:** ☐ Yes ☐ No*
*Explain: _____
**Appropriate bonding with Caregiver:** ☐ Yes ☐ No*
*Explain: _____

☐ Change/Regression In Development Since Last Visit
☐ Developmental Delay: _____
☐ Learning Disability: _____
Comments: _____

**Pain:** ☐ NPA Current Pain Level (0 - 10): _____ Location: _____ Acceptable Pain Level (0 - 10): _____
Pain Description: _____
Relief Measures: _____
Pain Controlled? ☐ Yes ☐ No* *Intervention: _____


**Access:** ☐ N/A
☐ Peripheral IV start - Attempts x _____ ☐ Peripheral line in place Gauge: _____ Length: _____ Date/Location: _____

☐ PICC or ☐ Midline Site: _____ Type: _____ Lumens: _____
Ext. catheter length: _____cm ☐ Arm Circumference: _____ cm Measurement: 4cm or _____cm above insertion site.
☐ CVAD Site: _____ Type: _____ Lumens: _____ ☐ Tunneled ☐ Non-tunneled
☐ Accessed Port this SNV ☐ Port access in place: Non-coring needle size: _____ gauge _____ inch ☐ Port de-accessed
☐ Subcutaneous ☐ NGT/GT/JT Location: _____ Type: _____ ☐ Other: _____
Access site clean/dry & free of s/sx infection ☐ Yes ☐ No – Describe: _____
☐ Access discontinued – Reason: ☐ Site rotation ☐ Infiltration ☐ Erythema ☐ Leak ☐ Occlusion ☐ Thrombosis ☐ Infusion complete
☐ Therapy concluded ☐ Prescriber order Comments: _____
**Dressing / Flush:** Access Dressing Change: ☐ N/A ☐ Access flush pre/post med: _____ ml of ☐ NS ☐ D5W
Access flush pre/post lab: ☐ _____ ml NS ☐ Access flush for maintenance: ☐ NS _____ ml ☐ Heparin: _____ ml
Antiseptic Agent: ☐ 3 Alcohol ☐ 3 Betadine ☐ChloraPrep ☐ Other: _____
Dressing: ☐ Transparent ☐ Gauze & tape ☐ Other: _____ ☐ Antibacterial dressing changed
☐ Securement device changed ☐ Needleless connector changed x _____ Lumens ☐ Extension tubing changed x _____ Lumens
**Lab Work:** ☐ N/A ☐ BMP ☐ CMP ☐ Pro-time ☐ ESR ☐ Trough ☐ Peak ☐ CBC ☐ Other: _____
Specimen obtained from: ☐ Peripheral Venipuncture ☐ Venous Access Device _____ ml blood discarded
Specimen delivered to: _____

## INFUSION RECORD ☐ N/A

☐ **Rx Properly Stored** ☐ **Anaphylaxis Kit Expiration:** _____ ☐ **N/A**
**Medication:** _____ **Dose:** _____ **Volume:** _____
**Medication:** _____ **Dose:** _____ **Volume:** _____
**Method of administration:** ☐ **IVP** ☐ **INJ** ☐ **Gravity-Flow Controlled** ☐ **Pump** ☐ **Disp. Pump** ☐ **Other:** _____
**Pump Program #1:** _____ **Pump Program #2:** _____
**Factor: Lot #:** _____ **Exp. Date:** _____ **Labeling checked with orders: SN initial** _____
☐ **Pre-medication (dose & time):** _____

| TIME | TEMP | PULSE | RESP. | B/P | RATE | (Patient status / condition / comments) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

☐ **Inventory completed:** ☐ **Adequate supplies** ☐ **Ordering** ☐ **Medication Profile Reviewed: No Changes**
☐ **Discharge Plan discussed with patient/caregiver.** **Plan for next visit:** _____

Communication with: ☐ MD ☐ RPh ☐ Other: _____

Skilled Intervention Note: _____

**Patient Visit Time:** *Start:* _____ *End:* _____ **Lab Time:** *Start:* _____ *End:* _____ **Total Time:** _____

**Nurse's Signature** **Patient Representative Signature** **Date**


©2018 AllianceRx Walgreens Prime.
All rights reserved.

# Patient Education Checklist

Patient Name: _____

*Check all applicable content*

MRN: _____ SOC Date: _____

*Enter service date(s) into columns as appropriate*

Therapy: _____

| CONTENT | CONTENT DISCUSSED / REVIEWED | ASSISTED RETURN DEMONSTRATION | INDEPENDENT RETURN DEMONSTRATION |
|---|---|---|---|
| ☐ **Patient Admission Documents Given/Reviewed:**<br>☐ Consents ☐ "Getting started with infusion therapy" Booklet<br>☐ Admission Agreement/Acknowledgement of Receipt of Information<br>☐ Accreditation information<br>☐ Home Health Agency state required information (☐ N/A)<br>☐ Agency 24 Hour Contact #: _____<br>☐ Other: _____ | | | |
| ☐ **Review of Disease Process** ☐ **Compliance Needs**<br>☐ **Patient Education Handouts Given & Reviewed:**<br>☐ Drug Monograph ☐ Medication Guide ☐ Access Device: _____<br>☐ Pump Manual: _____<br>☐ IV Access (as needed for IV insertion training)<br>☐ Other: _____ | | | |
| **Drug / Solution:**<br>☐ Dose: _____ ☐ Schedule: _____<br>☐ Label Accuracy ☐ Container Integrity<br>☐ Inspection of Drug/Solution<br>Storage: ☐ Refrigeration ☐ Room Temp ☐ Protect from light | | | |
| **Infection Prevention:**<br>☐ Hand Washing ☐ Aseptic Technique<br>☐ Work Surface Preparation ☐ Device Access / De-access<br>☐ Blood & Body Fluid Precautions<br>Prepping: ☐ Injection Site(s) ☐ Connectors ☐ Tubing ☐ Needles | | | |
| **Infusion Access Device Management:**<br>☐ Type / Access: _____ ☐ Clamping<br>☐ Site Inspection ☐ Patency Check ☐ Flushing<br>☐ Site Care/Dressing Change ☐ Connector/ Extension Change<br>☐ PIV Insertion / Removal ☐ Other: _____ | | | |
| **Drug / Solution Preparation:**<br>☐ Premixed ☐ Reconstitution/Transfer ☐ Additives: _____<br>☐ Medication-Solution Set-Up<br>☐ Other: _____ | | | |
| **Administration Method:**<br>☐ IV Push<br>☐ Gravity ☐ Rate-Flow Controlled Tubing<br>☐ Disposable Elastomeric<br>☐ Pump: _____<br>☐ Continuous ☐ Intermittent ☐ Cycle/Taper<br>Injection: ☐ Intramuscular ☐ Subcutaneous | | | |
| **Administration Technique:**<br>☐ Tubing Calibration ☐ Pump Programming ☐ Loading Pump<br>☐ Filter ☐ Priming Tubing ☐ Batteries ☐ Alarms<br>☐ Troubleshooting<br>Access Device: ☐ Connect ☐ Disconnect<br>☐ Other: _____ | | | |


©2018 AllianceRx Walgreens Prime. All rights reserved.

White - Medical Records Yellow - Patient Pink - Medical Records

Patient Name: _____ MRN: _____

| | | | |
|---|---|---|---|
| **Potential Complications - Prevention & Intervention:**<br>☐ Infection: ☐ Exit/Injection Site ☐ Systemic ☐ Blood Reflux<br>☐ Occlusion ☐ Phlebitis ☐ Infiltration ☐ Migration ☐ Break<br>☐ Thrombus/Embolus ☐ F/E Imbalance ☐ Hyper-Hypoglycemia<br>☐ Metabolic ☐ Aspiration (oral/enteral) ☐ Nausea/Vomiting<br>☐ Diarrhea ☐ Adverse Reactions ☐ Anaphylaxis<br>☐ Hypersensitivity Reaction ☐ Using Epinephrine Autoinjector | | | |
| **Supplies - Handling / Disposal / Inventory:**<br>☐ Sharps Container ☐ Regular Waste ☐ Narcotics<br>☐ Hazardous Material ☐ Chemo Precautions<br>☐ Supply Inventory ☐ Deliveries ☐ Pump Return☐ Other<br>Resources: _____ | | | |
| **Safety:**<br>☐ 911 / EMS ☐ Electrical / Fire ☐ Falls ☐ Travel & Supplies<br>☐ Other: _____ | | | |
| **Ongoing Monitoring:**<br>☐ Weight: _____ ☐ I&O: _____<br>☐ Temp: _____ ☐ Blood Glucose: _____<br>☐ Lab Draws: _____ ☐ Appointments: _____<br><br>☐ Other: _____ | | | |

**Additional Instructions / Comments:** _____

| Date | Nurse Signature | Date | Nurse Signature |
|---|---|---|---|
| | | | |
| | | | |

I have received the above information and understand that I will be learning about my disease process, therapy and treatment using the information in the materials that were given to me.

_____
Patient Signature Date

_____ _____
Caregiver Signature (if applicable) Date Caregiver Relationship to Patient

**Release of Direct Supervision:** I understand that I am now able to perform all of the above listed activities and no longer need the direct supervision of a nurse or pharmacist. I also understand that these skills will be checked by the nurse or pharmacist when needed.

_____
Patient Signature Date

_____ _____
Caregiver Signature (if applicable) Date Caregiver Relationship to Patient


©2018 AllianceRx Walgreens Prime. All rights reserved.
White - Medical Records Yellow - Patient Pink - Medical Records

allianceRx Walgreens + PRIME

# PRESCRIBER PLAN OF TREATMENT

**PATIENT NAME:** _____ **MR#:** _____

| | | | |
|---|---|---|---|
| SOC Date: | DOB: | Certification Period | From: __/__/____ To: __/__/___ |
| Address: _____<br>_____<br>Phone: _____ Cell: _____ | | Gender: ☐ Male ☐ Female<br>Height: _____ Weight:_____<br>Allergies: | |
| Primary Diagnosis: | | | ICD-10 Code: |
| Secondary Diagnosis: | | | ICD-10 Code: |
| Surgical Procedure: | | | ICD-10 Code: |

**ACCESS TYPE**

☐Tunneled CVC ☐Non-valved ☐PICC ☐Peripheral
☐Non-tunneled CVC ☐Valved ☐Midline ☐Intrathecal
☐Implanted Port ☐Subcutaneous ☐IM ☐Epidural
Number of Lumens: ☐Single ☐Double ☐Triple
Other:

**SKILLED NURSING FREQUENCY ORDERS**

☐RN to visit ____ times ☐per week ☐per month for _weeks
☐RN to visit weekly for _____ weeks
☐Number of PRN visits: _____ Reason: _____

**ADVANCED DIRECTIVES**

DNR Status: ☐Do not resuscitate ☐Patient has advanced directives

**VASCULAR ACCESS DEVICE MAINTANENCE ORDERS**

Peripheral IV change: ☐Every ____ days ☐PRN ☐With each dose
Non-coring needle change frequency: ☐Weekly and PRN
Injection cap change: ☐ Weekly ☐ ____ times per week and PRN
Extension set change: ☐ Weekly ☐ ____ times per week and PRN
Dressing type: ☐Sterile ☐Occlusive ☐Gauze☐ChloroPrep ☐ETOH/PVI
Change Dressing: ☐Weekly and PRN ☐Every ___ days and PRN ☐Daily
Apply _____ ☐Weekly and PRN ☐PRN ☐With occlusive drsg
Other:

**FUNCTIONAL LIMITATIONS**

☐Performs daily activities without difficulty ☐Amputation
☐Needs assistance with _____ ☐Paralysis
☐Bowel ☐Bladder incontinence ☐ Contracture
☐Hearing loss ☐ Speech ☐Vision ☐Ambulation
☐Dyspnea with minimal exertion
Unmet spiritual needs: follow up with: _____

**TREATMENT ORDERS ☐ See attached medication profile**

☐Complete skilled assessment with each visit including instruction regarding disease processes, purpose of therapy, signs and symptoms of potential side effects and response to therapy
☐Instruct patient/caregiver on 24 hour availability of clinical staff, emergency procedures and EMS activation
☐Skilled nurse to administer and/or instruct patient/caregiver in administration of infusion therapy, pump operation, troubleshooting, catheter management, and signs and symptoms related to therapy
☐First Dose: RN to administer, and monitor for adverse reactions
☐Use attached treatment orders PRN for drug reaction. Anaphylaxis – Call 911
☐Remove ☐PICC ☐Non-tunneled CVC when therapy is complete
Apply ☐Pressure dressing ☐Antimicrobial ointment following CVC removal
☐May use Lidocaine 1% 0.1mL to start IV sites for pain management
☐Other:

Plan of Care reviewed with ☐patient ☐caregiver

**MENTAL STATUS**

☐Oriented ☐Comatose ☐ Disoriented ☐Forgetful
☐Depressed ☐Lethargic ☐Agitated ☐ Other: _____

**ACTIVITY ORDERS / SAFETY MEASURES**

☐As tolerated ☐No restrictions ☐Bedrest
☐Bedrest / Bathroom only ☐Pt not to lift > 5-10 pounds
Assistive devices: ☐Walker ☐Wheelchair ☐Cane

**TEACH PATIENT SAFETY MEASURES**

☒Standard precautions ☒Sharps safety ☒Home safety
☒Emergency disaster measures ☒ Medication storage
☒Hazardous waste disposal ☒Electrical safety
Other: _____

**REHABILITATION POTENTIAL**

☐Poor ☐ Guarded ☐Fair ☐Good ☐Excellent

**PROGNOSIS**

☐Poor ☐ Guarded ☐Fair ☐Good ☐Excellent

**LAB ORDERS**

May draw labs from: ☐CVC ☐Peripherally
Labs: _____
Frequency: _____

**DME AND SUPPLIES**

☐Disposable infusion supplies ☐ Pump
☐IV pole Other: _____

**NUTRITION ORDERS**

☐Regular ☐Diabetic Other: _____
☐Low Na ☐ Bland _____
☐NPO ☐As tolerated

**GOALS/DISCHARGE ORDERS – PATIENT WILL BE DISCHARGED:**

☐When independent with self-care
☐When therapy completed ☐When goals are achieved
☐With prescriber follow-up ☐ To assisted living
☐To long term care ☐Other: _____

**PRESCRIBER INFORMATION**

Name:
Address:
Phone: Fax:

☒I have reviewed this document in full (2 pages) See next page for continued orders)
I hereby ☒certify ☐recertify that the above home infusion and home health services are medically necessary and are authorized by me with a written plan of treatment which will be periodically reviewed by me. This patient is under my care and is in need of the services as indicated.

Prescriber Signature: Date:

RPh Initials: _____

allianceRx Walgreens + PRIME

# PRESCRIBER PLAN OF TREATMENT

**PATIENT NAME:** _____ **MR#:** _____

| SKILLED NURSE TO ADMINISTER / INSTRUCT ADMINISTRATION OF: | | | | | | |
|---|---|---|---|---|---|---|
| **START DATE** | **STOP DATE** | **NEW OR CHANGED** | **DRUG/CONCENTRATION** | **DOSE** | **FREQUENCY** | **ROUTE** |
| | | ☐N ☐C | HEPARIN FLUSH _____UNITS / mL | | | |
| | | ☐N ☐C | 0.9% SODIUM CHLORIDE FLUSH | | | |
| | | ☐N ☐C | ANAPHYLXIS KIT | | SEE ATTACHED TREATMENT ORDERS | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |

| MEDICATION PROFILE<br>(List all prescriptions, OTC, herbals and home remedies) ☐ NONE ☐NO OTC/HERBALS OR HOME REMEDIES | | | | | | |
|---|---|---|---|---|---|---|
| **START DATE** | **STOP DATE** | **NEW OR CHANGED** | **DRUG/CONCENTRATION** | **DOSE** | **FREQUENCY** | **ROUTE** |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |
| | | ☐N ☐C | | | | |

| | |
|---|---|
| **GOALS OF THERAPY** | ☐ PT/CG INDEPENDENT WITH ALL ASPECTS OF IV / MEDICATION THERAPY<br>☐PT/CG ABLE TO VERBALIZE SIGNS AND SYMPTOMS TO REPORT<br>☐PT/CG ABLE TO VERBALIZE SIDE EFFECTS OF MEDICATION (CHECKED BOX INDICATES ACHIEVED)<br>☐VASCULAR ACCESS WILL REMIN PATENT AND FREE OF COMPLICATIONS<br>☐PATIENT WILL TOLERATE THERAPY WITHOUT ADVERSE EFFECTS |
| **60 DAY SUMMARY** | ☐**NA** |

| **NURSE'S SIGNATURE:** | **DATE:** | **VERBAL SOC DATE:** |
|---|---|---|
| | | |

RPh Initials: _____

# ROYAL QUALITY NURSING SERVICES, INC.

PATIENT: _____ DIAGNOSIS: _____

## NURSING CARE PLAN

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

ROYAL QUALITY NURSING SERVICES, INC.

PATIENT: _____ DIAGNOSIS: _____

NURSING CARE PLAN

| | | |
|---|---|---|
| 6. Identified by _____ RN Date: _____<br>_ 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.<br>Nurse will monitor:<br>_ Vital Signs<br>_ Weight<br>_ Intake & Output<br>_ Electrolytes | Patient will achieve and maintain acceptable level of nutrition as evidenced by:<br>_ Weight gain/loss<br>_ Maintenance of acceptable nutritional parameters including ordered laboratory test/values. |
| 7. Identified by _____ RN Date: _____<br>_ Potential for infection<br>Access site: PICC Periph. Port Hickman/Groshong | _ Nurse will assess access site as prescribed by MD<br>_ Nurse will review with patient/caregiver: signs and symptoms of infection | Patient will remain infection free as evidenced by:<br>_Normal temperature: < 100 F<br>_ 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 _____