Name of Employee	Date
Name of Agency	Test Score

Immune Globulin Post Quiz – Nursing Credentialing

This test evaluates your infusion nurse's knowledge of Immune Globulin therapy indications, use and administration. A score of 80% or better is required for all nurses providing home infusion services.

1. Autoimmune disease is a rare disease that affects a minimal amount of individuals throughout the world.

    A. True
    B. False

2. Autoimmune disease relates to the abnormal function of:

    A. The circulatory system
    B. The Nervous System
    C. The Immune System
    D. All of the above

3. The immune system is a complex system of biological structures and processes within an organism that protects against disease. Components of the immune system include:

    A. White blood cells
    B. B cells
    C. D cells
    D. Antigens and Antibodies
    E. Phalanges
    F. A, B and D are correct
    G. All of the above
    H. None of the above

4. The immune system is a network of cells, tissues and organs that work together to protect the body against "foreign" invaders such as bacteria, parasites, viruses and fungi.

    A. True
    B. False

Name of Employee	Date
Name of Agency	Test Score

5. While infusing SCIg, you notice leaking at one of the injection sites. What do you do?

    A. Stop the infusion and send patient to the ER
    B. Stop the infusion and discard the remaining SCIG product
    C. Place a gauze under the needle and continue the infusion
    D. Assess site for stable needle placement

6. Immune Globulin are produced in the
    A. D cells
    B. T cells
    C. B cells
    D. All of the above

7. Volume of SCIG that can be safely administered through a single site is:

    A. 75 mL/hr
    B. 50 mL/hr
    C. 100 mL/hr
    D. 25 mL/hr

8. Immune Globulin can be administered by which routes

    A. Epidural
    B. Intrathecal
    C. Intravenous
    D. Subcutaneous
    E. All of the above
    F. C and D are correct
    G. A and B are correct

9. All IVIG products should be administered based on the titration rates recommended by the manufacturer.

    A. True
    B. False

10. First Dosing of IG products can only be done in a controlled hospital setting?

    A. True
    B. False

Name of Employee	Date
Name of Agency	Test Score

11. When placing a vascular access device (IV catheter), the nurse shall only attempt needle placement no more than:

    A. 1 time
    B. 2 times
    C. 3 times
    D. 4 times

12. When administering IVIG to a patient with a peripheral line, the pH of the solution must be adhered to according to the recommendations of the Infusion Nursing Society . The pH should be between:

    A. pH of 2-5
    B. pH of 5-9
    C. ph of 10-12
    D. no pH is specified

13. When administering IVIG to a patient with a peripheral line, the osmolality of the solution must be adhered to according to the recommendations of the Infusion Nursing Society . The osmolality should be between:

    E. 100-300 mOsm/L
    F. Greater than 600 mOsm/L
    G. 700-900 mOsm/L
    H. Less than 600 mOsm/L
    I. no osmolality is specified

14. Side effects of SCIG are:

    A. Redness at needle insertion sites
    B. Insertion sites are cold to touch
    C. Headache
    D. Phlebitis
    E. All of the above
    F. None of the above
    G. Both A and C are correct
    H. Both D and E are correct

15. Side effects of IVIG include:

    A. Headache
    B. Nausea/Vomiting
    C. Fever and Chills
    D. Muscle Pain
    E. All of the above
    F. None of the above

Name of Employee	Date
Name of Agency	Test Score

16. Some patients may require acetaminophen and diphenhydramine prior to the administration of IG products:

    A. True
    B. False

17. Appropriate veins to use for the administration of IVIG to an adult patient are:

    A. Cephalic
    B. Basilic
    C. Metacarpal
    D. Saphenous
    E. Radial artery
    F. All of the above
    G. None of the above
    H. Only A, B, and C are correct

18. An appropriate dosage of a SCIG is:

    A. 0.1-0.15 gm/kg per week
    B. 20-25 gm/kg per month
    C. 0.1-0.15 gm/kg 3x per week
    D. 20-25 gm/kg every 2 weeks

19. The three types of immunity are:

    A. Mild, moderate, severe
    B. Innate, adaptive , passive
    C. Progressive, remitting, primary
    D. None of the above

20. If administering IVIG directly from a glass container, you must utilize a vented tubing system.

    A. True
    B. False

Score _____

Agency Name _____

Agency Phone Number _____

To: Nurse Manager / Documentation Specialist

From: Lynette Streator, RN
Director of Centralized Nursing
BioScrip, Inc.
Office Phone: 877-409-0714

Re: RN Documentation Requirements / Therapy administration qualifications

Hello,

Thank you for your service in providing the best care possible to patients referred by BioScrip – Columbus, OH. Your staff's dedication and commitment to quality is reflected within documentation and is a testament to the high standards you hold your staff to providing on a daily basis.

As the Director of Bioscrip Centralized Nursing Unit, one of my responsibilities is to review all RN notes from patient visits made. I would like to provide a friendly reminder of the required elements for each RN note:

- Patient Name
- Date / Time In / Time Out
- Vital Signs – (pre-infusion / with every ramp level for infusions ramped / every 30-60 minutes for infusions ≥ 2 hours / post-infusion)
- Patient assessment (with emphasis on primary IV / SQ / IM related disease process
- Access Type & location(s) / Name / Gauge / Length of catheters used / # access attempts (if unsuccessful after 2 access attempts, approval required from agency DON or BioScrip National Nursing Management)
- Aseptic / Sterile Technique used
- Drug / Dose / Lot # / Expiration Date of all meds (includes saline / diluents)
- Transfer device type, if used
- Pump Name, if used
- Teaching / Education provided and to whom
- Progress toward independence, if Teach & Train
- Patient tolerance to therapy administered
- Plan for next visit
- Recent / Next MD appt
- Recent hospitalization(s) & reason
- RN signature

In addition, please make sure that **all** RNs who see referred patients review the therapy-related Power Point presentation(s) / Handouts, complete the therapy-related post-test prior to patient visit and then FAX completed post-test to BioScrip - Columbus, OH @ 877-312-3637 (ATTN: Lynette Streator)

Once again, your commitment to quality patient care makes us proud to be affiliated with you, your staff and your agency. Please don't hesitate to call with questions.

Kind Regards,

Lynette Streator, RN

RN Skills Checklist:

Subcontracted Agency Nurse

Registered Nurse's Name: _____ Date: _____

Agency Name: _____ Location: _____

In addition to the required therapy related competency / post-test completion and return, I / We acknowledge that the above listed Registered Nurse has completed training and is competent to provide care, as follows:

- Vascular Access:
  - ____ Short Peripheral IV Catheter (insertion, care & maintenance, removal)
  - ____ Midline Catheter (care & maintenance, removal)
  - ____ Peripherally Inserted Central Catheter (PICC) (care & maintenance, removal)
  - ____ Non-Tunneled Central Venous Catheter (care & maintenance)
  - ____ Tunneled (cuffed) Central Venous Catheter (care & maintenance)
  - ____ Implanted Central Venous Access Port (access, care & maintenance, de-access)
- Non-Vascular Access:
  - ____ Epidural / Intrathecal Access (care & maintenance)
  - ____ Subcutaneous Access (needle insertion, care & maintenance, removal)
- Blood Sample Collection: (vacutainer / syringe method, as applicable)
  - ____ Peripheral
  - ____ Central Venous Access
  - ____ Implanted Port
- Infusion Pump Competency:
  - ____ Gemstar ambulatory pump
  - ____ CADD Prizm ambulatory pump
  - ____ Bodyguard ambulatory pump
  - ____ Curlin (4000 / 6000) ambulatory pump
  - ____ Freedom 60 ambulatory syringe pump
  - ____ Other:_____
- ____ Pediatric Patient Care Competency (pediatric referrals only)

- *(NOTE: Proof of competency need only be documented on those therapy and access / pump types that are associated with the care of the patient the Registered Nurse is providing per the subcontracted services agreement / contract. BioScrip will also accept equivalent proof of the above from the Accredited Home Care Agency.)*

Manager's / Supervisor's Name: _____

Manager's / Supervisor's Signature: _____

Date: _____

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ADULT INITIAL PATIENT ASSESSMENT/ CARE PLAN

Form CLIN-GEN24-01

Date:_____ Time In:_____ Time Out:_____

PATIENT NAME: (Last, First)

HOME PHONE: WORK/CELL PHONE:

DOB: AGE: SEX: ☐ M ☐ F

ADMIT : ☐ HOME ☐ HOSPITAL ☐ CLINIC ☐ DRS. OFFICE ☐ OTHER _____

Person Providing Information: ☐ *SELF* ☐ *OTHER:*_____

GENERAL INFORMATION

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

OCCUPATION: _____

SIGNIFICANT OTHER:_____

RELATIONSHIP:_____

PHONE:_____

PHYSICIAN 1:_____

PHYSICIAN 2: _____

LANGUAGE SPOKEN: ☐ English ☐ Other:_____

EMERG.CONTACT:_____

RELATIONSHIP:_____

PHONE:_____

DIAGNOSIS 1: _____

DIAGNOSIS 2: _____

CODE STATUS: ☐ Resuscitate ☐ Do Not Resuscitate (If DNR, must have signed copy in home)

LIVING WILL/ADVANCE DIRECTIVES: ☐ No ☐ Yes If Yes, explain briefly: _____

PRESENT MEDICAL HISTORY

Diabetic? ☐ No ☐ Yes **Insulin Dependent?** ☐ No ☐ Yes

ETOH Use?: ☐ No ☐ Yes-Use:_____ **Drug Abuse?:** ☐ No ☐ Yes-Use:_____ **Smokes:** ☐ No ☐ Yes **PPD:**_____

Allergies? : ☐ No ☐ Yes If Yes, List: # of Pack Years:_____

TB Status: ☐ Active ☐ Unknown PPD Neg. Date: **Other Infectious Disease:** ☐ No ☐ Yes: ☐ Airborne ☐ Droplet ☐ Contact

Present Symptoms and Duration per patient/caregiver

Recent Treatments/Hospitalizations:

PAST MEDICAL HISTORY

☐ **No pertinent medical history**	☐ Musculoskeletal	☐ Metabolic
☐ Respiratory	☐ Communicable Disease	☐ Psychosocial
☐ Neurological	☐ GYN/GU	☐ Eye, Ear, Nose, Throat
☐ Gastrointestinal	☐ Cardiovascular	☐ Integumentary

If "Yes", Explain:

Past Surgery: ☐ None

VITAL SIGNS

T_____ P_____ R_____ B/P_____/_____ (☐ L Arm ☐ R Arm - ☐ Sitting ☐ Standing) HT._____ **WT.**_____

Comments: _____

RESPIRATORY

Assess: chest configuration, resp. rate, rhythm, depth, breath sounds, comfort

- ☐ NO PROBLEM
- ☐ asymmetric
- ☐ cyanotic
- ☐ tachypnea
- ☐ dyspnea
- ☐ shallow
- ☐ diminished
- ☐ wheezing
- ☐ crackles
- ☐ pain
- ☐ orthopnea
- ☐ cough
- ☐ oxygen therapy
- ☐ intubated
- ☐ trach

Explain:

CARDIOVASCULAR

Assess: heart sounds, rate, rhythm, comfort

- ☐ NO PROBLEM
- ☐ tachycardia
- ☐ bradycardia
- ☐ irregular
- ☐ pace maker
- ☐ diminished pulse
- ☐ absent pulse
- ☐ edema
- ☐ palpitations
- ☐ pain in chest
- ☐ syncope
- ☐ fatigue
- ☐ numbness
- ☐ tingling

Explain:

NEURO

Assess: motor function, sensation, LOC, strength, grip, gait, coordination, orientation, speech, vision,

- ☐ NO PROBLEM
- ☐ lethargic
- ☐ confused
- ☐ stuporous
- ☐ comatose
- ☐ weakness
- ☐ unsteady
- ☐ paralysis
- ☐ seizures
- ☐ pain
- ☐ numbness
- ☐ tremors
- ☐ vertigo
- ☐ headache
- ☐ pupils
- ☐ visual abnormality
- ☐ grip
- ☐ speech
- ☐ tingling

Explain:

GI

Assess: abdomen, bowel habits, bowel sounds, comfort

- ☐ NO PROBLEM
- ☐ nausea/vomiting
- ☐ diarrhea
- ☐ distention
- ☐ hyperactive BS
- ☐ hypoactive BS
- ☐ pain
- ☐ mass
- ☐ rigidity
- ☐ anorexia
- ☐ constipation
- ☐ obese
- ☐ ostomy

Explain:

NUTRITION

Assess: diet, weight, swallowing, nutrition support,

Diet: ☐ Regular ☐ Other: _____

Food Allergies: ☐ None _____

_____

Adheres to Special Diet? ☐ Yes ☐ No

- ☐ Recent unplanned weight loss or appears malnourished?
- ☐ Persistent nausea/vomiting/diarrhea for > 3 days?
- ☐ Taking liquid nutritional supplements?
- ☐ Difficulty chewing/swallowing. Dysphagia?
- ☐ Has open wound?
- ☐ Referral made to Dietitian
- ☐ Patient does not desire intervention
- ☐ Patient terminally ill – comfort measures
- ☐ Patient followed by another Dietitian
- ☐ Patient followed by Physician for diet

GU/GYN

Assess: urine, frequency, control, color, bleeding, discharge, pregnancy, comfort

OB PTS:
*Gravida*_____ *Para*_____

- ☐ NO PROBLEM
- ☐ pregnancy
- ☐ contractions
- ☐ cramps
- ☐ low backache
- ☐ pelvic pressure
- ☐ discharge
- ☐ vaginal bleeding
- ☐ pain
- ☐ incontinence
- ☐ hesitancy
- ☐ frequency
- ☐ dysuria
- ☐ hematuria
- ☐ nocturia
- ☐ oliguria
- ☐ urostomy
- ☐ catheter
- ☐ dialysis

Explain:

MUSCULOSKELETAL

Assess: mobility, motion, gait, joint function

- ☐ NO PROBLEM
- ☐ assist devices
- ☐ balance
- ☐ transfers
- ☐ swelling
- ☐ atrophy
- ☐ eating
- ☐ bathing
- ☐ prosthesis
- ☐ stiffness
- ☐ pain
- ☐ deformity
- ☐ wound
- ☐ dressing

Explain:

In the past 3 months, how many times have you fallen?

How many of these falls caused an injury?

EENT

Assess: eyes, ears, nose, throat for abnormality

- ☐ NO PROBLEM
- ☐ impaired vision
- ☐ glasses
- ☐ blind
- ☐ hard of hearing
- ☐ hearing aid
- ☐ deaf
- ☐ gums
- ☐ teeth ☐ dentures
- ☐ pain
- ☐ reddened
- ☐ edema
- ☐ burning
- ☐ lesion
- ☐ drainage

Explain:

INTEGUMENTARY

Assess: color, temperature, turgor, integrity

Color:
- ☐ pink
- ☐ cyanotic
- ☐ mottled
- ☐ flushed
- ☐ pale
- ☐ jaundiced

Skin:
- ☐ warm
- ☐ dry
- ☐ cold
- ☐ diaphoretic

Turgor:
- ☐ normal
- ☐ other _____

Skin Integrity:
- ☐ intact
- ☐ impaired
- ☐ wound
- ☐ surgical incision

Explain:

PAIN ASSESSMENT

A. Do you have any ongoing pain problems? ☐ No ☐ Yes

Explain: _____

B. Do you have any pain now? ☐ No ☐ Yes

If yes to either A or B, indicate location of pain by marking diagram below

Pain Intensity Rating Scale Used: 0 = no pain 10 = worst possible

☐ Numerical 0-10 : _____

☐ Wong-Baker FACES

Description of pain sensation(burn, stab, prick, ache, sharp, dull, etc):

☐ **PCA Pt.**– Pain Assessment Flow Sheet initiated, Form INF-GEN022-1

What causes pain to get worse:

What pain medications and interventions do you use:

Are the interventions effective?

Are you ever pain free?

Does the pain affect your sleep?

Patient is unable to self-report:

☐ Facial expressions ☐ Vocalizations

☐ Physical movements ☐ No indicators present

Explain:

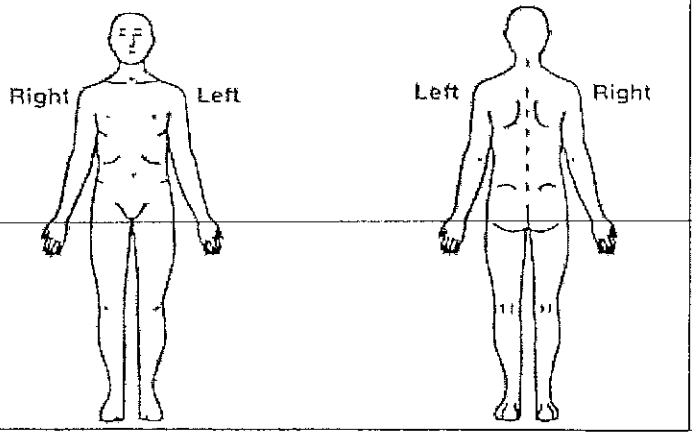
PSYCHOSOCIAL

Support Systems:	**Mental Status**	**Speech:**	**Spiritual/Cultural:**
☐ Spouse/Significant Other	☐ Alert/Oriented	☐ Clear	Is there anything from your culture or religion that we need to know in caring for you? ☐ No ☐ Yes
☐ Children: Number?:	☐ Participates in decision process	☐ Slurred	
☐ Friends	☐ Understands nature of condition	☐ Unresponsive	
☐ Neighbors	☐ Confused	☐ Non verbal	
☐ Meals on Wheels	☐ Unresponsive/comatose		If yes, explain:
☐	**Communication:**	**Emotional Status:**	
☐ **Agencies? Name/Services:**	☐ Not able to make needs known	☐ Effective coping skills	
	☐ Not able to answer simple questions	☐ Anxious/agitated	
	Any barriers to learning? ☐ No ☐ Yes	☐ Withdrawn/sad	
Caregiver:	Explain:	☐ Recent loss	
☐ Available, lives elsewhere		☐ Previous Psych. Hx.	
☐ Lives in residence			
☐ Available at all times	**Overall Status:** ☐ homebound ☐ bedbound	**Memory:**	
☐ Support systems adequate	☐ ambulatory ☐ non-ambulatory	☐ Memory intact	
☐ Lives alone	**ADL's:** ☐ Independent ☐ Dependent	☐ Loss of memory	
☐ Unsafe psychosocial climate	Able to continue to work? ☐ No ☐ Yes		

ENVIRONMENT/SAFETY

☐ Private home	☐ Adequate storage space	**Pets?** ☐ Yes ☐ No Type:
☐ Condo	☐ Adequate refrigeration	**Hygiene:** ☐ Good ☐ Fair ☐ Poor
☐ Apartment	☐ Adequate electrical outlets	Patient/caregiver able to comply with aseptic technique? ☐ No ☐ Yes
☐ Mobile home	☐ Working phone in home	
☐ Assisted living	☐ Phone available nearby	**Is there evidence of neglect by self or caregiver?** ☐ No ☐ Yes
☐ Safe neighborhood	☐ Running water available	If "Yes", explain:
☐ Unsafe neighborhood	☐ Safe/Adaptable for therapy	
Any interventions to make the environment safe?:		

DIAGRAM



B = Bruise

L = Laceration

D = Decubiti

R = Rash

S = Surgical Incision

W = Wound

P = Pain

C = Catheter Site

O = Ostomy Site

TEACHING/LEARNING

☐ Patient ☐ Caregiver:

- ☐ Are appropriate/able to learn and carry out procedures
- ☐ Demonstrates adequate motivation to comply with plan
- ☐ Verbalizes understanding of procedures taught
- ☐ Comprehends responsibilities in the care process
- ☐ Understands medical regime and possible complications
- ☐ Understands diagnosis / prognosis

Comments:

PATIENT EDUCATION LEVEL:

☐ SPECIAL EDUCATION NEEDS: *DESCRIBE BELOW*

Person to be taught Medication Administration:

☐ Patient
☐ Caregiver Relationship?:

Has experience in administering IV Therapy?: ☐ No ☐ Yes

SKILLED NURSING INTERVENTIONS

☐ CATHETER/NEEDLE PRESENT ON ADMISSION:

☐ Peripheral ☐ Central ☐ SubQ Needle
☐ Other:

Size/Type:

Location: Lumens:

External Length: cm

Inserted Where: Date:

Site Assessment:

Blood Return?

Sutures/Clips Present: ☐ None

Number and Location:

Midarm Circumference 10 cm ↑ site cm

☐ CATHETER/NEEDLE REMOVED:

☐ Per procedure
☐ Phlebitis 0 to +3
☐ Infiltrated 0 to +3

☐ CATHETER/NEEDLE INSERTED BY RN AT VISIT:

Size/Type:

Location:

Length: No. of Attempts:

Midarm Circumference 10 cm ↑ site, if applies cm

☐ MEDICATION ADMINISTERED/CONNECTED AT VISIT:

DRUG / FLUID:

INFUSION METHOD:

DOSING SCHEDULE:

☐ NS IV: ML's ☐ Heparin IV: Units/ML ML's

☐ EXT. Set Change ☐ Connector/Cap Change

☐ Dressing Change DSG. Type: ☐ Gauze ☐ Transparent

☐ OTHER:

☐ BLOOD DRAW:

Specify lab tests:

Drawn From: ☐ Catheter ☐ Venipuncture

Venipuncture Site:

Taken To: Lab

Evaluation of peripheral venous access: ☐ Good ☐ Fair ☐ Poor

****Arm not to be used for venous access:** ☐ Left ☐ Right

Reason:

Previous History of IV Therapy?:

SUMMARY

Conclusions on patient's ability to reach goals and patient's expectations of therapy:

Next scheduled appointment with ordering physician: **Next RN visit:**

Patient Signature: **Nurse Signature:** **Date:**

Personal Representative Signature: **Relationship:**

Name of Dispensing Pharmacy:

bioscrip

Form CLIN-GEN019-1

Medication Profile

Patient: _____ Patient ID: _____

Date: _____ Allergies: _____

Height: _____ Weight: _____ Age: _____

Other Pharmacy: _____ Other Pharmacy Phone Number: _____

Start Date	Stop Date	Medication Name	Dosage	RT. CD.	Freq. Code	New/ Chg.	Physician	Init.	Comments
		Heparin							
		0.9% NaCl							

Route Code			
EN	Ear/Nose	TO	Topical
IM	Intramuscular	NG	Nasogastric
OP	Ophthalmic	IC	Intravenous Central
PO	Oral	IP	Intravenous Peripheral
IN	Inhale	PR	Per Rectum
VG	Vaginal	ET	Enterostomal Tube
SubQ	Subcutaneous	IVP	IV Push

Frequency Code			
Q2H	Every Two Hours	BID	Twice A Day
Q3H	Every Three Hours	QAM	Every AM
Q4H	Every Four Hours	QPM	Every PM
QID	Four Times A Day	Must write out	Every Other Day
TID	Three Times A Day		

Unit	Amount of Measurement
GM	Gram
GR	Grain
ML	Milliliter
OZ	Ounce
CM	Centimeter

Initials:____ Signature:_____ Initials:____ Signature:_____

Initials:____ Signature:_____ Initials:____ Signature:_____

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INFUSION PATIENT TEACHING CHECKLIST

Form INF-GEN023-1

PATIENT NAME: (last, first) | Date of Birth:

THERAPY: ☐ Anti-infective ☐ Antiemetic ☐ Biological ☐ Chemo ☐ Diuretic ☐ TPN ☐ Hydration ☐ Immunotherapy ☐ Line Maintenance ☐ Pain ☐ Steroid

Other:_____ Drug:_____

Infusion Method:

☐ Pump (NAME): _____

☐ Elastomeric Device ☐ Gravity ☐ IV Push ☐ Other:_____

Access Device:

❑ Subcutaneous ❑ PICC
❑ Peripheral ❑ Central Catheter
❑ Midline ❑ Implanted Port
❑ Other: _____

Date/Initial Demonstrated By	Date/Initial Independent With	***Introduction:***
		❑ Customer Orientation Booklet
		❑ Disease Process/reporting changes
		❑ Physician's Orders
		❑ Therapy risks and benefits
		❑ Patient/Caregiver Participation
		❑ Identifying treatment goals
		❑ Plan of Care
		❑ Written Patient Education Materials
		❑ Importance of compliance
		❑ Drug Monograph/Medication Guide
		❑ Coping Strategies (Resources)
		❑ RN Visit Schedule
		Safety/Infection Control
		❑ Hand Washing
		❑ Work Area Preparation
		❑ Clean & Sterile Procedures
		❑ Standard Precautions
		❑ Waste Disposal
		❑ Sharps Disposal Instructions
		❑ Chemo Precautions/Using Spill Kit
		Meds and Supplies
		❑ Reporting medication changes
		❑ Store/Order/Delivery Schedule
		❑ Checking the drug and label
		❑ Preparing and adding drugs
		❑ Dosing Schedule
		Self-monitoring
		❑ Drug toxicities reporting
		❑ Temperature
		❑ Weight
		❑ Measuring Intake & Output
		❑ Monitoring Blood Sugar
		❑ Recordkeeping
		Other Procedures
		❑
		❑

Date/Initial Demonstrated By	Date/Initial Independent With	***Access Device Care***
		❑ Device Name/Type
		❑ Site Inspection & Care
		❑ Dressing Change
		❑ Flushing All Lumens
		❑ Flushing Frequency/ Amount
		❑ Changing Connector or Cap
		❑ Clamp usage
		❑ Device Removal
		❑ Activity Restrictions/Bathing
		Possible Complications
		❑ Signs of an Allergic Reaction
		❑ Drug Adverse Reactions
		❑ Catheter Blockage
		❑ Catheter Damage/No scissors
		❑ Catheter Leakage
		❑ Catheter related Infection
		❑ Septicemia
		❑ Phlebitis
		❑ Infiltration/extravasation
		❑ Blood Backup
		❑ Air Embolism
		❑ Speed Shock
		Administration Procedures
		❑ Gravity Infusion
		❑ Electronic Pump
		• operation/maintenance
		• alarm system
		• change or charge battery
		• troubleshooting
		❑ Connection Procedures
		❑ Disconnection Procedures
		❑ Setting the Rate
		❑ Changing/Priming IV Tubing
		❑ Changing the Cassette/Bag
		❑ IV Push
		❑ Sub Q Injection or Infusion

I fully understand that I am responsible for complying with the regimen prescribed by my physician, and hereby release the physician and COMPANY from any liability connected therewith, or any complication of treatment failure that may result from my non-compliance.

Patient Signature :_____ **Nurse Signature :**_____ **Date :**_____

Personal Represntaive Signature :_____ Relationship :_____

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Routine Nursing Visit Assessment Note/Care Plan **Form CLIN-GEN025-1**

Patient Name: _____ **DOB:** _____ **Time In:** _____ **Time Out:**_____ **Date:** _____

Reason for Visit (check all that apply): □ Assessment □ Teach □ Line Insertion □ Dressing Change □ Blood Draw
□ Medication Administration □ Other: _____
□ Scheduled Visit □ Unscheduled Visit □ Discharge
Patient/Caregiver Status: □ Cooperative □ Difficulty Coping □ Able □ Willing □ Available □ No Change
WT: _____ BP: _____/_____ TEMP: _____ PULSE: AP_____ PULSE: RP_____ RESP: _____

Neuromuscular □ Alert □ Confused □ Lethargic □ Forgetful □ Oriented □ Disoriented PERLA: □ Yes □ No
□ Other: _____ Mobility: _____
Have you fallen since our last visit? □ Yes □ No
Comments: _____

Cardiac Chest Pain: □ None □ Yes, describe_____
Heart Sounds: □ WNL □ Abnormal Edema: □ None □ Yes, where _____
Pulses: □ Regular □ Irregular □ Quality_____
Comments:_____

Respiratory □ Normal □ Dyspnea □ At Rest □ With Exertion
Lung Sounds: _____
Cough: _____ Sputum: _____
Oxygen Use: Liters for hrs/day Comments:

GI Bowels _____ LBM _____ □ Normal-no issues noted
Bowel Regime _____
□ Nausea □ Vomiting □ Diarrhea Color _____ Frequency _____
Abdomen _____
Bowel Sounds: □ None □ Hypo □ Normal □ Hyper Stoma _____
Comments: _____

Genitourinary Voiding pattern _____ Frequency/day:_____
□ Normal □ Incontinent □ Retention □ Nocturia □ Burning □ Pain □ Frequency
Urine: □ Clear □ Cloudy □ Sediment □ Hematuria
Catheter: Size _____ Balloon _____ Change Date _____
Comments: _____

Nutrition Change in Nutritional Status: □ Yes □ No Diet Type: _____
Oral supplements consumed: Name_____ Amt/Day_____
Loss/gain weight _____lbs in_____day/week
Enteral Tube Feeding: □ N/A □ Present Rate_____ Pump_____
Change in formula, regimen, administration: □ No □ Yes, Explain_____
Tolerating: □ Yes □ No, Explain_____
Parenteral: Total Vol/day_____ml _____days/week _____hrs/day
Signs /symptoms of hyper/hypoglycemia □ No □ Yes, explain_____
Signs/symptoms of fluid intolerance: □ No □ Yes, explain_____
Other: _____

Skin Color_____ Integrity_____
Wound/Decub: Location_____ Size/Depth_____
Stage □ I □ II □ III □ IV Drainage (Color, Odor, Amount)_____
Comments: _____

Rest Comfort Comfort Assessed: □ No problems □ Pain Location_____
Rest Assessed: □ No problems □ Concern:_____
Level Scale 0-10 _____ □ Quality □ Dull □ Sharp □ Gnawing □ Stabbing □ Throbbing
Frequency: □ Sporadic □ Constant □ With Activity
Pain Medication (dose and freq.)_____ Effective: □ Yes □ No

Routine Nursing Visit Assessment Note/Care Plan Form CLIN-GEN025-1

Patient Name: _____ DOB: _____ Date: _____

Access Access Type_____ Brand _____
Size _____ # of Lumens _____ Location: _____
Site Assessment: ▫ Unremarkable ▫ Red ▫ Drainage ▫ Pain ▫ Edema ▫ Ecchymosis ▫ Sutures Intact
Existing Dressing as found: ▫ Change ▫ Intact ▫ Dry Other_____
▫ Transparent ▫ Gauze ▫ Antimicrobial disc ▫ Locking Device_____
Date dressing last changed _____ External Length _____cm Arm circumference 10 cm from site: _____ cm
Comments:_____

Skilled Care Plan Interventions: (Check all that apply and describe)
▫ Teach _____
▫ Reviewed side effects of Medications Supplied by the Company ▫ Yes ▫ No
▫ Dressing Change: ▫ Injection Cap ▫ Extension ▫ Securement device ▫ Antimicrobial disc ▫ Transparent ▫ Gauze
▫ Labs Drawn: _____
Drawn from _____ Delivered to _____
▫Catheter Insertion: Access Type_____ Brand _____
Size _____ # of Lumens _____ Length: _____
Insertion Site _____ # of Attempts _____
▫ Medication Administration: Name of Medication:_____ Diluent/Vol: _____
_____ml (Total Volume) _____mg/ml (Concentration) ▫_____rate/hr or ▫IV push Given over _____
Bolus given _____
Begin time: _____ Pump/Method of Administration: _____
Flush ▫ _____ml NS ▫ _____ml D5W ▫Pre ▫Post _____units/ml_____ml heparin ▫Post
▫Patient independent with Infusion
▫Other Skilled Assessments and Interventions: _____
_____
Comments: _____
_____

Diagnosis: _____
Ongoing Therapy Progress Towards Goals:
_____
_____
_____
_____
_____
_____

Medication Profile Change: ▫No ▫Yes, list _____
_____
Reviewed POT and Orders Current ▫ Yes ▫ No, Physician to be contacted
Next Physician Visit: _____ **Last Physician Visit:** _____
Next RN Visit:_____

Patient Signature: _____ Date: _____
(If required by ins.)

Nurse Signature: _____ Date_____

Name of Dispensing Pharmacy: _____

IV Flow Sheet

bioscrip

Form CLIN-NUR207-1

Patient Name: _____ Date: _____

Height _____ Weight: _____lb _____ kg Allergies: _____

_____

_____

Premeds given: ☐ N/A

TIME PRE-MEDS Given: _____

□ 25 mg Diphenhydramine □ PO □ IV
□ 50 mg Diphenhydramine □ PO □ IV
□ 650 mg AcetaminophenTylenol PO

□ Other: _____

Medication: _____

Dose: _____ grams in _____ ml of _____ to infuse for _____ hours via _____.

Lot Number: _____ Expiration Date: _____
Lot Number: _____ Expiration Date: _____
Lot Number: _____ Expiration Date: _____

Administration and patient monitoring
For IVIG (pre-infusion, every 15 minutes for the first hour, hourly during infusion, and post infusion)

Time	Temp	Pulse	Resp	BP	Rate, as □ ml/hr □ gtts/min	IV Patent	S/S adverse reaction	Comments
						□Y □N	□Y □N	**Pre-Infusion**
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	

Clinical Notes: _____

_____

_____

_____

Clinician Signature: _____ Date: _____