Policly #: CR-011

NEWBORN NURSES/NBN INFUSIONS
CLINICAL RECORDS POLICY

PHYSICIAN’S PLAN OF TREATMENT (POT)

POLICY: The Physician’s Plan of Treatment form is initiated for each client receiving clinical skilled services upon admission to service by the Nursing Supervisor, Case Manager or Registered Nurse designee. The physician’s orders are obtained verbally, electronically or from written prescription documentation and transferred to the Plan of Treatment form by that agency office nurse. Included on this form is the individualized care plan for private duty care. The client is consulted for input and the document sent to the physician. The Plan of Treatment is then reviewed and further developed by the physician providing medical supervision, and signed. Drugs and treatments are administered to patients only as ordered by the physician.

All orders on the POT are to be followed by the agency staff and omissions and changes in the plan are to be amended by verbal order. Deviations from the POT must be reported to the nursing supervisor verbally within 24 hours. During non-business hours the report may be directed to the on-call supervisor who will direct the information to the nursing supervisor. Standard Plan of Treatment forms may be used for acute care and infusion patients with select diagnoses as a baseline template. Then individualized data and orders added to the template POT to reflect each client’s special needs (see attachments).

REQUIREMENTS: The physician is expected to return the signed initial Plan of Treatment within thirty (30) days from the beginning of service or from the start date of the period of coverage. Signed renewals will also be returned and placed in the client’s office chart prior to the start date of the renewal period. Faxed copies of the signed orders will be placed in the clinical record but, an original signed copy of the faxed order will be solicited. (See Annex A, Guidelines for POT Development)

Revisions in the Plan of Treatment are made for the following reason:

- Change in service or level of care
- Change in physician providing medical supervision
- Readmission to a hospital for longer than seven (7) days
- Change in medical status

Every sixty (60) days the Plan of Treatment is renewed, potentially revised and signed by the physician for skilled private duty nursing, acute care and therapy services. The POT is renewed, and signed every six (6) months for HHA services. The POT is renewed every thirty (30) days for infusion patients on infused controlled substances and every sixty (60) days for all other infusion patients.

The Plan of Treatment includes diagnoses, service type/scope/frequency & duration, equipment, supplies, schedule of hours/visits, prognosis,
rehabilitation potential, functional limitations, mental status, safety measures, allergies, activities permitted, nutritional requirements, medications, parenteral fluids, treatments, lab tests, procedures to be performed, precautions, contraindications and reporting changes in patient condition and needs, as appropriate.

PROCEDURE: The original signed Plan of Treatment is placed on the client’s permanent clinical record office chart. A copy of the signed Plan of Treatment is placed on the private duty client’s home chart for use by the field staff.

All physician ordered treatments, assessments and procedures are to be followed by the agency staff. Verbal orders from the physician to change the POT must then be generated to alter the established plan of care. Deviations from the POT which include but are not limited to: withheld therapies/assessments, changes in alarm settings, changes in equipment settings, changes in the intensity of therapies/assessments, and changes in treatments must be reported to the family, physician and nursing supervisor. Alarms on equipment are set at physician ordered parameters. All alarms must be promptly responded to and interventions to correct the altered patient status must be implemented. Other types of settings on equipment such as flow rates, pressures, etc. are to be maintained at the physician ordered parameters.

ATTACHMENTS: Annex A. Guideline for Plan of Treatment development
Plan of Treatment form - Blank
Standard Plans of Treatment for:
Apnea Maternal Child Visits
Phototherapy Enteral Therapy