485/POC INSTRUCTIONS

485/POC is the plan of care or service plan for the patient. Whoever does the SOC(Start of Care) for the patient completes the initial 485 filling in each of the following:

- 1. Diagnosis
- 2. Meds
- 3. Visit Frequency Orders (VFO)= this is the schedule of visits
- 4. Clinical Orders= this is what the clinician is doing for the patient, the interventions and goals. These should be a reflection of the patients diagnosis, Meds, problem areas. You want some short and long term goals. You can update your clinical orders whenever needed. Orders should be specific-i.e.= if you call the doctor for wound care you should write it like "Pt/Caregiver/Nurse to clean rt ankle stage 2 pressure ulcer with NS Daily, apply a thin layer of Bacitracin, cover with 2- 2x2 gauze pads and secure with silk tape." Your Bacitracin should also be listed in the patients Med list and you should have a Rt Heel Stage 2 diagnosis in the Diagnosis list.
- 5. 485 In Draft Orders= these are locator items- DME/supplies, nutrition, activity level, mental status, prognosis, etc. *** On the SOC this area is labeled "485 In Draft" after the SOC the computer automatically changes the name to "Interim Order In Draft". The inside of this area looks the same, only the title changes.

ALL OF THESE AREAS HAVE TO BE FILLED IN ON ADMISSION BY THE ADMITTING CLINICIAN THAT DAY!!!!

After the admitting clinician completes the SOC and completes their Visit Frequency Orders, Clinical Orders and 485 In Draft Orders, they sign their 485 and the signing process triggers medical records to send a paper copy of the 485 to the physician for their signature. If the admitting clinician orders an EVAL to be done by other clinicians, the it is the other clinicians to see the patient and evaluate their needs, then they will write their own Visit

Frequency Orders and Clinical Orders. So nursing is not going to tell therapy how frequently to visit the patient and what to do with the patient and vice versa. The only time you will schedule another skill a visit or write a clinical order for another skill is if you write a 1xw1wk Evaluation visit for another skill to come in on the case. (Ordering another skill has to be approved by a doctor. This means you call the doctor, ask for the order, document that call in a CALL LOG and then schedule a 1xw1wk visit in your VFO and write an eval clinical order intervention and goal. Leave the rest of the orders to that specific clinician to write after they do their eval.)

Any changes you make to the 485, (diagnosis changes, med changes, clinical order or visit frequency order changes, or IN DRAFT orders) have to be signed by you!!!!! To sign the 485 follow these steps. (FYI- you can sign 1 or 1000 changes to the 485 all with one signing)

- 1. Highlight the 485 Tab.
- 2. Tap on the SIGN box at the bottom of the screen
- 3. Scope tab- decide which orders you are willing to sign
- 4. Approval tab- ALWAYS put a V in the box "Verbally Approved Via Phone" When you put a checkmark in that box, that triggers medical records to send out a paper copy of this order(s) that you are signing so the physician can sign their approval.
- 5. Clinical Summary- ALWAYS include a clinical summary when you sign your orders. The clinical summary may be short or long. If you are making a medication change your summary would be short. It would spell out why the med change was made. If you are doing a recert and you have written fresh new orders for this new cert period, your clinical summary will be long. This will be a 60 day summary explaining progress and problems encountered in the previous 60 days and why you are needing another 60 day cert period.

The remaining tabs in the signing area are just their to show you changes you made (orders written) one more time before you say OK and lock down this order signing process.

On a Recertification, you MUST rewrite ALL of your Clinical Orders, Visit Frequency Orders and In Draft orders for your patient. You cannot copy orders into the new cert period. Make sure that you open up the new set of certification dates under the 485 Tab and rewrite NEW FRESH CLINICAL ORDERS, VISIT FREQUENCY ORDERS AND 485 IN DRAFT ORDERS. As the case manager, you must talk with other skills on the case and see if they want back in the new cert period. If they do, you will need to schedule them an Eval 1xw1w visit just like you did at the Start of Care.

Basically a recert is the same as a START OF CARE except, the patient isn't signing all the consents forms again. You still do a big Oasis (recert Oasis) you do a thorough complete head to toe assessment, you rewrite the clinical orders, visit frequency orders and 485 In Draft orders. You should also communicate with the physician that you need another cert period and discuss with them any changes.

*** If your patient has more than one episode opened with different payors (i.e. patient has Medicare for skilled and Medicaid for home health aide) then you need to go to your [MINE] tab and you should see that patients name listed more than once. You would then write the appropriate orders under the appropriate episode/payor's 485.