Therapist Treatment Cards

Purpose

The purpose of the Treatment Card is to provide the department with an accurate report of services administered to the patient for proper charging on the RCS charge slip.

Audience

All Licensed Respiratory Care Practitioners employed by Respiratory Care Services providing patient care and patient care items.

Scope

Treatment cards are prepared with the following information:

- Patient' name
- Unit History number (complete 11 digits)
- Location (general care/critical care unit)
- Pulmonary diagnosis
- Current RT orders
- Date of service
- Therapist signature

Guidelines

The treatment card is initiated by either:

- The Respiratory Care Assistant or supervisor when preparing treatment cards for the next day.
- The therapist - administering the initial therapy or oxygen set-up.

A record of the patient's history of therapy, including current orders, remains in the master file until therapy is discontinued, at which time it is pulled from the file by the dispatcher. The file is set up on the dispatcher's computer.

Orders on the patient's treatment card must be accurate and current.

Changes in therapy must be documented on the treatment cards by the therapist.

To insure proper operation of the charge system, the therapist must complete information on the treatment card accurately. The treatment card is the primary audit tool for all patient billing.

All entries on the treatment cards will be made in black ball point ink and must accurately reflect equipment, personnel, and time involved in patient care. All information must be neatly inscribed for clerical personnel to accurately process your account of services provided.

The treatment cards are to be turned in by 0200. All changes must be called in before 1500/0300 to ensure correct procedure count for oncoming shift.

Guidelines

In the event a therapist fails to place the treatment cards in the "OFF-

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GOING" file at 0630:

- The Supervisor may contact the therapist at home and obtain the appropriate information (i.e., order changes, time(s) therapy/ oxygen rounds performed, equipment change-out) over the phone. The appropriate information will then be given for processing. The therapist will then be required to turn in the treatment cards when he/she returns to work.
- If treatment cards are lost or misplaced, the Supervisor may require the therapist to immediately return to the hospital and recreate his/her assigned treatment cards with the appropriate information obtained from the patient's medical record. After the treatment cards are completed, they will be turned in to the Supervisor.

No exception may be made to this policy without the explicit approval of the Program Manager of Respiratory Care Service.

Essential information:

- Patient's Name - enter patient's first and last name.
- Unit History Number - enter complete unit history number (11 digits).

Location/Date of service - enter general care/critical care unit location of patient (including bed number) on correct side of treatment card.

Diagnosis – enter the patient’s pulmonary and/or primary diagnosis.

Therapist (1-4) - Signature/Date - All therapists administering therapy must sign. Enter legible signature.

Therapy/Delivery Systems - Orders - enter complete and most recent order(s); Enter any order changes and time in comments/order changes box.

General Care Area:

Oxygen/L/M or FIO_2 - enter ordered liter flow or FIO_2. Indicate nasal cannula, simple facemask, partial rebreather mask, non-rebreather mask or venti-mask. Note frequency ordered. Indicate the time Oxygen is assessed. Indicate hours in use per day.

Aerosol - enter FIO_2. Indicate aerosol facemask, aerosol trach collar, face tent, oxy hood, or blow by. Note frequency ordered.

Guidelines Continued

General Care Area Continued:

Bronchodilator therapy - circle appropriate device and note drug/dosage and frequency ordered. Peak Flow measurement If ordered by a physician, to be

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done before and after bronchodilator therapy. Remember to document in EPIC.

Incentive Spirometry - note order as written: Instruction or frequency ordered.

Chest Percussion/Postural Drainage - enter appropriate order and note positions/lobes and frequency ordered.

Suction/airway care - enter appropriate order and note nasal, oral, endotracheal or tracheal suction and frequency ordered.

Critical Care:

Ventilator - enter appropriate device: adult, pediatric, or neonatal.

Suction/airway care - enter appropriate order and note nasal, oral, endotracheal or tracheal suction and frequency ordered.

Bedside Pulmonary Mechanics - note with ventilator check and when ordered to monitor patient's spontaneous efforts. Note frequency ordered.

Bronchodilator therapy - enter appropriate device and note drug/dosage and frequency ordered.

Chest Percussion/Postural Drainage - enter appropriate order and note positions/lobes and frequency ordered.

Transports - note adult, pediatric, or neonatal. Charge twice for round trip. Indicate the times of the oxygen transports.

Ambu Bag - Charge for adult, pediatric or neonatal resuscitator bag when set up or changed out.

Undesignated items for documentation.

Any arterial blood gases performed or arterial line samples obtained are to be noted and an accurate account kept for procedure documentation.

- Any EKG's performed are to be noted and an accurate account kept for procedure documentation.
- Neonatal Resuscitation Stand: each patient assisted is to have a stamped card with time of procedure and duration of therapy noted.

Note when patients are intubated, extubated, endotracheal tubes are re-taped or tracheostomy care is done for procedure documentation. If patient requires extra care, indicate the amount of time spent with patient on the treatment card and document in EPIC.

Other procedures not specifically pre-printed on card are to be documented in blank lines provided.

Guidelines

Critical Care Continued:

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Equipment - Circle an ISU (initial set-up) or C/O (change out) at side of the specific piece of equipment set up or changed-out if the item is not taken from the Omni-cell. If you change out a single item, (example: aerosol trach collar) note this in a blank space and indicate number. If extra aerosol tubing or oxygen connecting tubing is used, document number of extra items used.

Time

- Enter exact time(s) treatments attempted, oxygen assessed, and/or setups done. Make a diagonal slash in the box under the appropriate hour. Indicate minutes in top half and your initials in the bottom half. Circle time(s) of missed treatments. Indicate appropriate reasons for missed therapy in comments/order changes section.
- Use Hours - Enter total number of hours the oxygen or continuous aerosol equipment and/or ventilator has been in use during the shift. If the equipment was not in use during the shift, place an NIU in this section.

Specific Procedures:

One-time Orders:

- A procedure or treatment performed one time only must be indicated in the ORDERS section of the treatment card.
- Example: 0.3cc metaproterenol and 3cc NS via neb X 1 only.
- The time the therapy was performed must be indicated.
- Ventilator Discontinuance and Change to Continuous Oxygen Therapy:
- If a ventilator is discontinued and oxygen therapy is initiated, the new set-up must be indicated.

Both the number of hours the ventilator <u>and</u> oxygen equipment were in use during the shift must be indicated.

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Guidelines Continued

Other Information:

Unusual occurrences:

- Unusual occurrences affecting a patient's treatment schedule should be documented on the back of the patient's treatment card.