Documentation

Chapters 4, 5, 6

Writing the Content
Guidelines

- Progress Notes
  - Report of pt.’s PT treatment sessions
  - Proof Rx plan in I.E. is being cared out & effective
  - Documents Rx progression focused on reaching goals
  - Provides evidence for reimbursement & quality assurance
  - Legal Record

Guidelines

- Frequency of Documentation
  - Insurance co.
  - Facility standards & policies
  - Progress note each Rx session
  - PT or PTA documents progress note – whoever provided pt. Rx
Guidelines APTA
  - Rx provided
  - Equipment used and/or provided
  - Pt status
  - Progress or regression
  - Functional outcome
  - Progress note may utilize any format i.e. SOAP, DEP, PSP, PSPG

Principles for Documenting in a LEGAL Record
  - Accuracy
  - Brevity
  - Clarity
  - Date & Signature
  - Black Ink
  - Timeliness

Principles/Guidelines for Documentation
  - Accuracy
    - NEVER falsify, exaggerate, or make up data
    - Info pertinent to pt's care should always be included
Principles/Guidelines for Documentation

- **Brevity**
  - Short, concise sentences
  - Info relevant to Rx effectiveness
  - Info changes & improvement in pt.’s functional abilities
  - Avoid abbreviations b/c they don’t always have the same meaning resulting in misunderstanding of info

Principles/Guidelines for Documentation

- **Clarity**
  - Be clear
  - Paint a picture of pt.’s functional ability
  - Ex: “In sitting position, client grasps pant leg to lift and place on L lower leg on R knee to reach L shoe.”
  - Correct punctuation, grammar, & spelling

Principles/Guidelines for Documentation

- **Date & Signature**
  - Legal signature
  - License #
  - Title
    - SPTA
    - PTA
    - PT
**Principles/Guidelines for Documentation**

- **Use of Black Ink**
  - No opportunity to change or falsify info
  - Do NOT use erasable pens
  - Do NOT erase errors
  - Mistakes – draw one line through it date it and initial it
  - Do NOT leave any empty lines or spaces

- **Timeliness**
  - Document ASAP after Rx
  - BID Rx’s document am or pm by date and time
  - Addendum if you remember something after you have written a note and need to add it, add it as an addendum
    - “addendum to PT note 8/30/05”

- **Legal Guidelines followed?**
Writing the Content
Subjective Data

Definition: information the patient, significant other or caregiver tells the PT or PTA that is relevant to the patient's condition, and treatment, AND

- Relates to treatment effectiveness and accomplishment of goals.
- Relevant: should pertain to problem, goals, treatment effectiveness

Subjective Data

- Recorded in S section of SOAP note
- Important information in initial evaluation (describes functional needs, problems)
- Necessary in progress note only if it provides evidence of treatment effectiveness or Progress toward functional goals.
- More important to health care provider than lawyer or third party payer

Subjective Data
Listening for Relevant Info

- Analytic – listening for specific kinds of info (pain, lifestyle, fears)
- Directed – listening to a patient's answers to specific questions
- Attentive – listening for general info to get total picture of patient
- Exploratory – listening due to interest in subject
- Appreciative – for pleasure
- Courteous - it is polite
- Passive - overhear
Subjective Data
PTA’s role during treatment
- PTA should read initial evaluation
- Be aware of treatment plan and goals
- Be aware of functional activities identified in the evaluation.
- LISTEN for any information not reported earlier that is relevant to the patient discharge plans, goals, treatment effectiveness.

Examples of Relevant Information Categories
- Environment:
  - lifestyle, home situation, work tasks, school needs, leisure
- Emotions or attitudes:
  - pt's attitudes can change during treatment
- Goals or functional outcomes:
  - goals may need to be modified as PTA learns more about the patient's needs

Examples of Relevant Information Categories
- Unusual events or chief complaints
  - pt's symptoms may indicate progress toward goals
- Treatment effectiveness or ineffectiveness,
- Response to treatment
  - document effectiveness of treatment; Influences future treatment
- Level of functioning
  - any changes or progress toward meeting functional goals
Organizing & Writing Subjective Data

- Organize subjective info into categories
- Document subjective data only if there is an update on previous info or relevant new info

Guidelines for writing Subjective Data

- Use verbs such as states, reports, complains of, expresses, describes, denies to make it clear information is being supplied by the patient
- Quoting the patient (needed at times to make intent or relevance of comment clear)
  - illustrate confusion or loss of memory
  - illustrate denial
  - attitude toward therapy
  - use of abusive language

Guidelines for writing Subjective Data

- Document when information is taken from someone other than caregiver, include who provided
- Information and reason patient couldn’t provide
- Document pain using a consistent scale, place this info in Subjective data
  - Pain scale (0-10)
  - Checklist
  - Body drawing
5 General Topics

- Results of measurements or test
- Description of pt’s function
- Description of treatment provided
- Objective observations of pt. made by PTA
- Record of treatment session

Guidelines

- Same scale as in I.E.
- Side of body, UE or LE
- Motion – active or passive
- Patient position
- Start & End points

Results of Measurements or Tests

- Re-administer tests & measurements performed in I.E. to show progress
- Valid tests: must use same procedure & technique as in I.E.
- Compare results to I.E.
### Objective Data

#### Description of Pt.'s Function

- **Function:** gait, transfer, stairs, lifting, sweeping, sitting, standing, transitions, bed mobility
- **Quality:** coordinated, smooth,
- **Level of Assistance:**
  - Independent
  - Verbal Cues
  - Supervision
  - Contact Guard
  - Stand by Asst
  - Min asst of 1
  - Mod asst of 1-2
  - Max Asst of 1-2
- **Purpose of Assistance:** v/c for gait pattern, weight bearing, etc

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#### Description of Function

- **Equipment needed**
- **Distance, height, length, times, weights, repetitions,**
- **Environment:** level, linoleum, carpet, ramp, chair without armrests, with armrests,
- **Cognitive Status:** understand, able to follow directions, 1 step instruction, 2 step instruction, memory

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#### Description of Treatment

- **Modality, exercise, activity**
- **Dosage, repetitions, distance**
- **Equipment**
- **Settings i.e. Tens, US**
- **Tissue or area treated**
- **Purpose of treatment**
- **Patient position**
- **Duration, frequency, breaks**
Objective Data
Observations of patient

- What PTA sees or feels
  - i.e. red skin over bony prominence of spine of scapula following application of hot packs
  - pt. ambulated with decreased step length on right LE and forward flexed trunk

Objective Data
Observations

Objective Data
Record of Treatment Sessions

- # Treatments provided
- # Missed treatments
- Why treatment missed
- Did patient phone & cancel
Objective Data

Common Mistakes

- PTA reports what they did instead of patient's response or performance
- Objective is about what patient does and how they respond to Rx
- Failure to show "skilled" need
- What is a "skilled" need?
  - Could someone not trained in PT do what I have just described?

Skilled need?

- Pt amb'd 50 feet with walker & min asst
- During gait training, Pt amb'd 50 feet with walker with verbal instruction for correct gait sequence and min asst for occasional loss of balance. Pt performed gait sequence correctly 50% of time

Skilled Need

- Carefully select words
  - Gait training not walking pt
  - Pt education in body mechanics
  - Give patients response to educational training; the patient should ALWAYS demonstrate the activity after instruction/training - then document patient's ability to perform
  - Do they need further instruction? Prove it through your documentation!
Skilled Need?

Figure 1a. Example of the new method used to identify critical needs.

Figure 2a. The table below summarizes the results of the analysis.