Diagnoses, Functional Outcomes, Goals, & Rx Effectiveness

**ASSESSMENT**

- Provides the rationale for the necessity of the physical therapy medical treatment
- “so what” what does the subjective and objective data mean in relation to treatment effectiveness, functional outcomes, goals?
- Interpretation of meaning of the objective & subjective data

Assessment

Elements that support necessity of PT Rx

- PT Diagnosis
- PT Rx plan & PT Goals
- Rx Outcomes & Rx effectiveness
Assessment Physical Therapist

- Includes goals in this section in the eval (the goals GIVE THE PTA DIRECTION FOR PLANNING TREATMENT SESSIONS)

- Goals may be LTG's (functional outcomes, broad statements, action, measureable criteria, time period) or STG's (functional abilities, steps needed to reach LTG)

Assessment PTA

- PTA describes treatment RESULTS/pt response and pt's progress toward goals in assessment component of progress note

APTA Guidelines for Assessment PT Initial Eval

- PT Diagnosis
- PT Problem
- Goals

- "PT interprets signs & symptoms, test results, & observations to make a judgment or conclusion about the meaning & relevance of the data

- Answers question “What does it mean?”
**Goals**

- Goals: address impairments and functional abilities
- Functional Abilities: ability to perform activities or tasks that support the individual's physical, social, and psychological well-being, creating a personal sense of meaningful living.

**Goals**

- Goals must include:
  - Action or performance
    - will ambulate
  - Measurable Criteria
    - 50 feet or from bed to bathroom
  - Time period
    - When expected to reach goal
      - 3 days? 3 Rx's

**Goals**

- A description of the change in “function” is the best measurement to ensure third-party reimbursement.
  - ROM for left shoulder flexion will improve from 0 to 60 degrees to 0 to 110 degrees so patient can reach top of head for grooming in 2 weeks.
  - Strength of right gluteus medius will increase from 2/5 to 4/5 so patient will no longer demonstrate a significant trunk shift to the right during stance phase of ambulation in 4 weeks.
Goals

- PTA does NOT design treatment goals but the PTA can work with PT in offering suggestions
- PTA does notify the PT when goals are met and recognizing when the PT may need to modify or change goals
- PTA does make statements in assessment component of progress note about progress toward goals

Goals PTA

- PTA must be aware of goals and treatment plan to progress treatment to meet goals
- PTA demonstrates awareness and understanding of goals by documenting in assessment component of note relating treatment plan and progress to goals

Assessment

- MOST important part of progress note
- Tells reader if PT Rx is helping pt
- All comments made in assessment component of progress note by PTA MUST be supported by information in the subjective & objective info
Assessment

- Assessment in progress note should
- Summarize data
- Demonstrate effectiveness of treatment plan

Content of PTA Progress note in Assessment may include:

- Change in the impairment (compare to initial eval measurements etc.)
- Progress toward goals or functional abilities/outcomes
- Lack of progress toward goals (give possible reason)
- Inconsistency in the data (pain scale pt. rates 10 but is observed to move without grimacing etc.)
  Be cautious here!
- Avoid comments that are not relevant
- Must be supported by subjective/objective data
- Comment on whether or not the goals are being accomplished

Common Mistakes when Documenting Assessment

- Statements such as “Tolerated well” or “pt was cooperative & motivated” should be avoided - don’t tell us anything
- Statement in assessment doesn’t have supportive data in S or O part of note
- No mention of goals
What is wrong with this assessment?

1.57 PT De: Dressed with dignity due to 80 year old age.

Q: 1. Regret for, physical and social deficits and how they affect the client.
A: Performed his usual of TPT and ADL independently with minimal assistance.

Q: 2. Intact ADL and IADL abilities and what the patient is doing to maintain these skills.
A: TPT and ADL independently with minimal assistance.

Q: 3. hare and gait on level surface, with or without assistive device.
A: TPT and ADL independently with minimal assistance.

Q: 4. Does the client need to be reminded of daily activities.
A: TPT and ADL independently with minimal assistance.

What is wrong with this assessment?

AAP 10/14/2023 -

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What is wrong with this assessment?

Intervention PLAN

- PT EVALUATION PLAN: what is planned for the future
  - Treatment plan should be related to accomplishing the LTG and STGs
  - Directed toward the problems 2 parts
    - PT activities or modalities that treat the impairment and/or functional limitations
    - Training in the functional tasks
PT Eval; plan component

- Interventions/activities to treat impairments & functional limitations
- Training
- Use action words (verbs)
- Measurable
- Time frame
- Document rationale for each intervention/activity

PT Eval plan examples

```
Due to hip replacement surgery, [patient’s name] is unable to perform activities of daily living.

Expected Functional Outcomes: [patient will be able to perform ADLs such as dressing, transfers, and ambulation.]

Interventions:
1. [Specific activity, e.g., range of motion exercises]
2. [Another specific activity, e.g., gait training]

Rationale: To improve [specific functional outcome, e.g., decrease pain, increase range of motion.]
```

PT Eval plan examples

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Due to knee replacement surgery, [patient’s name] is unable to perform activities of daily living.

Expected Functional Outcomes: [patient will be able to perform ADLs such as dressing, transfers, and ambulation.]

Interventions:
1. [Specific activity, e.g., range of motion exercises]
2. [Another specific activity, e.g., gait training]

Rationale: To improve [specific functional outcome, e.g., decrease pain, increase range of motion.]
```
PT Eval plan example

**INTERVENTION PLAN**

1. A single point measure of TKE measurements can be used to optimize sessions.
2. PT data. Local ROM and synergy is utilized. Allow walking training patient to the desired ADLs with her static and dynamic needs.
3. Progress & Evaluation Opportunities: Including goals in span. Request to request the patient to continue to use ADLs with her static and dynamic needs.

**Plan**

- What will be done in the next session to enable pt. to meet goals?
- When the next session is scheduled?
- What PT consultation is planned?
- Any equipment or inform that need to be ordered or prepared before next session?
- Number of treatment sessions remaining before D/C?
- *use future tense verbs*

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**Interim Note/Progress Note Plan**

- What will be done in the next session to enable pt. to meet goals?
- When the next session is scheduled?
- What PT consultation is planned?
- Any equipment or inform that need to be ordered or prepared before next session?
- Number of treatment sessions remaining before D/C?
- *use future tense verbs*

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**Interim Note/Progress Note Plan**

- Any comment on what plan to do at next session as a reminder.
- Statement on intent to talk to PT if appropriate.
- Frequency of treatment per day per week.
- Treatment planned for pt. to receive.
- Treatment progression ex. 3x week 2 weeks then 1x week for 2 weeks.
Interim Note/Progress Note Plan

- Reassessment date
- Referral to other services
- Pt. family education plan
- Equipment needs/ordered
- USE verbs in future tense “will”

Examples of PTA Plan documentation

- Will increase weights in PRE strengthening exercises next session
- Will discuss with PT patient’s noncompliance with exercise program
- Will notify PT patient is ready for discharge evaluation
- PT will see pt next Rx session for reassessment
- Will provide gait training on stairs this pm
- Will order standard walker to be available for treatment session on 8-30-05

Example of Plan Interim/Progress Note

- P: Cont. with quad sets and SLR 3x week as O.P. Will progress to 20 reps as tolerated
- P: continue with previously described program or continue with same program
Examples cont’d

- Continue PT POC bid, 3 more days
- Continue gt training bid, 3 more days
- Will consult PT prior to next Rx session due to pts change in orientation

Documenting Home Program Instruction

- WHO was instructed (pt., family member, caregiver)
- TYPE of instruction (verbal, written, demonstration)
- Level of Pt./family competence performing home program (independently demonstrate, able to state the precautions, correctly describe the activity)

Other Documentation Responsibilities

- Rule of Confidentiality
  - Medical records and pt info of condition, treatment are confidential
  - Medical record only provided to those providing direct patient care
  - Medical record can only be released if patient authorizes release
**Confidentiality**

- Release of information form
  - Signed by pt for each person information can be released to
  - Follow policies & procedures at facility for releasing info once release of information form is completed

- Never discuss patient in area that is not private
- Never discuss patient with anyone not authorized
- Return chart to secure location
- Researchers wanting to use medical record must also obtain patient consent and researcher can not use pt name

**Medical Record**

**Patient Rights**

- Medical Record legally belongs to health care facility
- Patient can acquire copy of medical record; follow procedure at facility
Telephone Communications

- PTA can
  - Take verbal referral for PT from HCP (health care provider)
  - Receive info about pt from pt or representative of pt
  - Receive inquiries about pt’s medical condition or PT Rx
    - Follow rule of confidentiality here!

Physical Therapy
Phone Referrals

- Date of call
- Name of person phoning in referral
- Name of health care provider
- Name of PTA answering phone & receiving verbal referral
- Details of referral & pt info
- Comment on plans to send written verification of referral
- Comments indicating referral will be brought to PT

Info about the Patient received via phone

- Pt or family may call to:
  - Report change in pt’s condition
  - Report inability to keep appointment
  - If emergency have them call 911
  - Change in pt’s condition refer to PT, may need to refer back to physician before continuing PT Rx
Info about the Patient received via phone

- Date and time of call
- Name of person calling
- Name of PTA taking call
- Summary of conversation
  - Include any response from PTA
- Comment regarding apparent emotional state of caller (tone of voice, disposition, orientation)

Requests for Info about a Patient

- Requests may come from:
  - Attorney
  - Insurance representative
  - Parents
  - Other relatives
  - Friends, neighbors
  - Employer
  - In all of these instances, PTA MUST follow rule of confidentiality!

Informed Consent

- Obtained by PT in initial evaluation once Rx plan, risks & goals have been determined and reviewed with pt
- Included in informed consent:
  - PT diagnosis, POC
  - Name & qualifications of PT
  - Risks/Precautions of Rx procedures
  - Explanation of any alternative Rx's that would be appropriate; include their risks etc
  - Expected benefits of POC; expected outcomes if PT problem is not treated
  - Responsibilities of pt
  - Answers to pt questions
Patient refusal of treatment

- Pt has right to refuse Rx at any time even if initially signed consent form
- What PTA should do if pt refuses Rx:
  - Use active listening skills, interview, talk to pt to determine reason for refusal
  - Make sure pt understands purpose of Rx and expected outcomes if problem is not Rx’d
  - Document pt’s refusal and notify PT

Documenting Treatment Refusal

- Pt’s refusal & reason for refusal
- PTA’s response and action taken
- Statement about notifying PT

- Pt refused Rx this PM. After being encouraged to attend at a later time, pt stated her sister was visiting from out of state and the only time she would be able to visit with her was this afternoon. PTA agreed to cancel Rx this pm and scheduled pt for tomorrow am; will inform PT
  - Name, SPTA

Incident Report

- Incident:
  - Anything happening to a patient, employee, or visitor that is
    - Out of the ordinary
    - Inconsistent with facility’s usual routine or Rx procedure
    - Accident or situation that could cause an accident
Follow facility’s policies and procedures for documenting an incident report

Purposes of Incident report:
- Risk management & legal protection
- Method for providing prompt response to medical needs, identifying and eliminating problems, and gathering and preserving information that may be critical in litigation
- Identify dangerous situations that either caused or could cause an injury

Incident Report

Legal Responsibility
- Only eyewitness fills out & signs incident report, if more than 1 person witnessed, 1 completes form and lists other witness names
- Use facility’s incident form

Incident Report

Included in most forms:
- Name & address of person involved in incident
- If patient include DOB, gender, admission date, pt status before incident, dx, brief summary of Rx’s received
- Objective, factual description of incident
  - Don’t express opinion, blame, or make suggestions on how incident might have been prevented
- Identification of all witnesses to the event
  - Include name & addresses
  - Equipment: model # and manufacturer
Incident Report
Summary of DO’s

- Notify PT
- Know facility policy & procedure for reporting an incident
- Write legibly and use professional terms
- Include names & addresses of employees or visitors who know anything about incident
- Give completed report to supervising PT to route for appropriate signatures

Incident Report
Summary of DON’T

- Don’t
  - Mention you filed incident report in pt chart
  - Photocopy incident report
  - Write anything that implicates or blames anyone for the incident
  - Use report for complaining about co-workers or other employees
  - Talk about the incident with noninvolved personnel - confidentiality!
  - Acknowledge any incident or give info until you check with PT or supervisor