DOCUMENTATION

It is important that **EVERY area of EVERY note** be addressed and acknowledged. If you do not perform a certain assessment, treatment or test, or if an area is non-applicable, still address the area by noting, **"to be assessed later", "N/A", "NT", etc.** This shows that we still addressed the area and did not look over it.

Three of the most important aspects of documenting in homecare are:

1. Showing **SKILLED CARE** is needed
2. Showing **PROGRESS TOWARDS GOALS**
3. Showing why **CONTINUED SKILLED CARE** is needed

These components should be documented and repeated **IN EVERY NOTE.**

Now, more so now than ever, insurance companies are looking for these components in documentation to be sure services are necessary and they will pay for them.

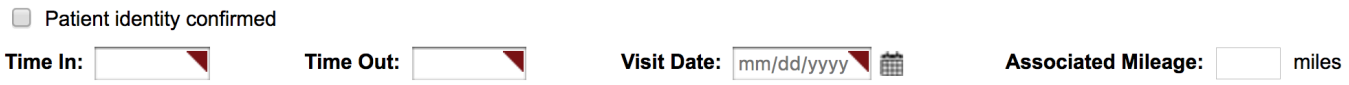
All documentation should be completed and signed **WITHIN 24 HOURS** of the visit.

Be sure on every note to check that patient identify was confirmed and to fill out the proper time in and time out.

Times are to be in military time e.g. 14:20 = 2:20pm. According to CMS, the minimum visit duration should be **30 minutes**. If it

is less you must explain why. It is OK if your time overlaps with another disciplines time. You will be warned of the overlap, however can accept it.

Do NOT worry about filling out "Associated Mileage:"

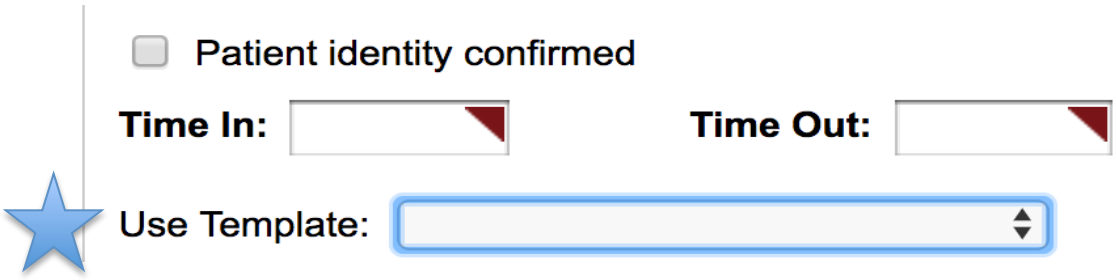


<u>Using Kinnser Templates</u>: Templates are an efficient way to save previous notes and upload them to be modified in a new note. Most of all the information you save as a template will be carried over into the new note you load it to. This **<u>DOES NOT</u>** mean you repetitively document the same information in every note. Information should be changed, added and removed according to how that patient presented during the visit and what skilled care was provided.

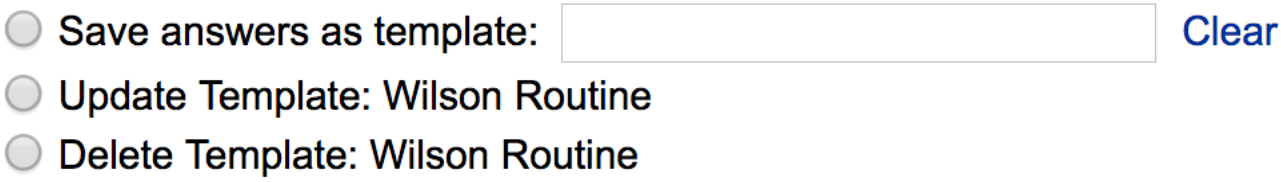
When you have entirely completed an Evaluation or Visit Note, you can save that note as a template. At the very bottom of the page you will see:

Simply click the circle and then name your template e.g. "Wilson Routine Visit"

If you had saved a template of the first visit (not evaluation) for patient "Wilson", then the next time you open a visit for "Wilson" you can simply find the first template and open it up. This is located at the top of each note.



When you are done completing the newest note you have options at the very bottom of the page:



You can save the newest template as something else e.g. "Wilson Visit 3".

You can update the template that will save only the information from the above note.

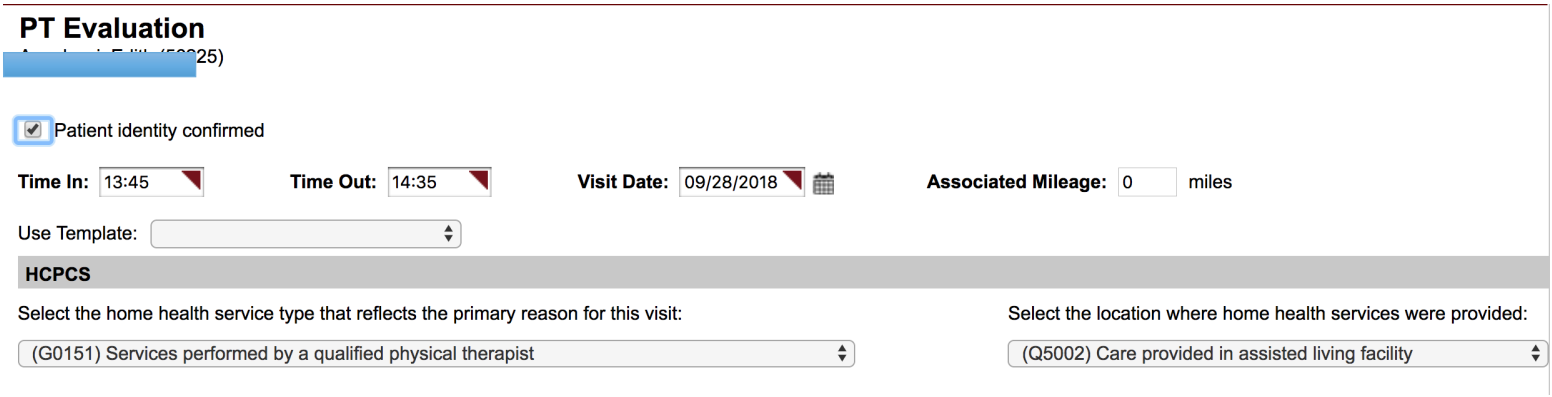
Or you can delete the template.

It is highly recommended that you **save every Evaluation Note as a template**. This is because every Medicare patient needs a 30 Day Reassessment Note. The 30 Day Reassessment Note happens to be **identical** to the initial Evaluation Note so non-changing information can easily be carried over via a template.

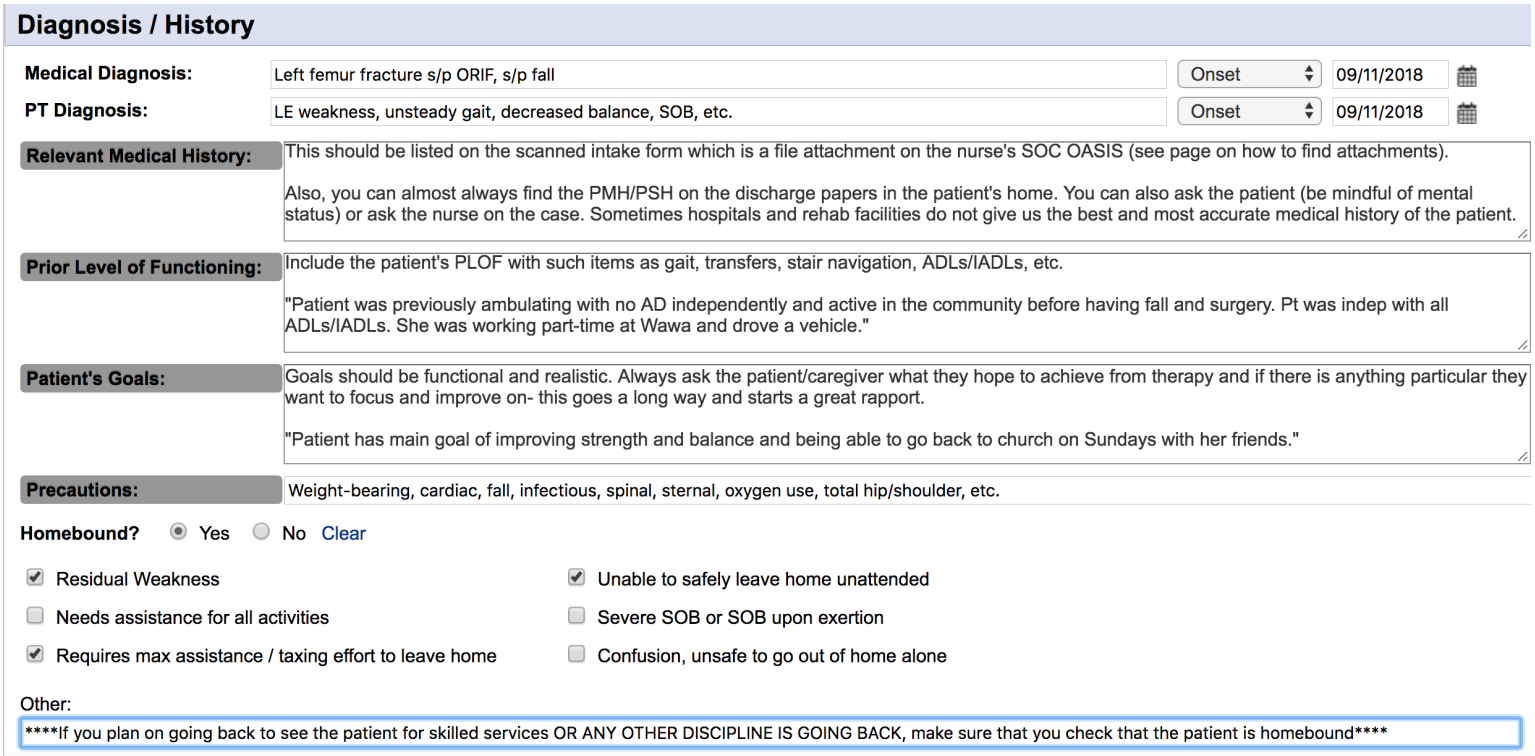
Templates can be a little confusing at first but do end up saving a lot of time and stress so **ASK** with any questions ☺

DOCUMENTING: EVALUATIONS

For the most part, documenting evaluations (and every other note) is very straightforward. Always keep in mind to never leave any areas empty. Use “N/A”, “NT”, “Not tested/assessed”, etc. The Kinnser templates for therapy evaluations are **EXACTLY** identical to the 30 Day Re-evaluation, so it is always a good idea to save your evaluation as a template so you can load it in the re-evaluation if need be. Here are areas to note and examples of what to include:



Always make sure **“Patient identity confirmed”** box is checked.
Do not worry about ever filling out **“Associated Mileage”**- this is filled out on our daily timesheets if applicable.
Do **not change** what is automatically always selected under **“HCPCS”**.



Social Supports / Safety Hazards

Patient Living Situation and Availability of Assistance

Patient lives: with other person(s) in the home

Assistance is available: around the clock

Current Types of Assistance Received (other than home health staff)

Include family and social support, if they have aides coming in from another agency, Meal-on-Wheels, etc.

"Patient lives with caring husband and daughter. Her husband is home at all times and her daughter works 9-5pm M-F."

Safety / Sanitation Hazards

- [ ] No hazards identified
- [x] Steps / Stairs: 14
- [x] Narrow or obstructed walkway
- [x] Cluttered / soiled living area
- [ ] No running water, plumbing
- [ ] Lack of fire safety devices
- [ ] Inadequate lighting, heating and/or cooling
- [ ] Insect / rodent infestation
- [ ] No gas / electric appliance
- [x] Pets
- [ ] Unsecured floor coverings

Other:

Always include that safety hazards were noted and changes were addressed.

"Patient has small dog and 2 cats. Environmental hazards brought to patient and husband's attention for modification. Family said they would remove all throw rugs this afternoon."

Evaluation of Living Situation, Supports, and Hazards

Include access to home and all living areas. Be sure to include number of stairs and if railings are present.

"Patient lives in two story home with 5 steps to enter with 1 railing. There are 14 steps with bilat railings to second floor where patient sleeps and uses the bathroom. Currently, patient is sleeping on the first floor couch with BSC nearby."

Vital Signs

Temperature:

97.6 taken Temporal

BP:			*Position*	*Side*	**Heart Rate:**	**Respirations:**	**O2 Sat:**	*Room Air / Rate*	*Route*
Prior	124	/ 78	Sitting	Left	Prior 70	Prior 15	Prior 98	Room Air	via
Post	128	/ 80	Sitting	Left	Post 80	Post 17	Post 98	Room Air	via

Comments: Be sure on every visit to check and recheck vitals. Also, this is a good area to report about blood sugar levels for patients with diabetes and to note if patient took meds

Subjective Information

Include not only what the patient reports, but if possible what their caregivers are saying. We all know this can be totally different!

"Patient reports since coming home from rehab he is significantly weaker but doing great. Daughter states he has had multiple episodes of loss of balance when trying to walk and is staying in his bed all day."

Physical Assessment

	Level	Functional Impact		Level	Functional Impact
Orientation:	WNL	Person, place, time	**Muscle Tone:**	WNL	WNL
Speech:	Impairment	"Min expressive aphasia"	**Coordination:**	WNL	"No errors with finger-to-nose test."
Vision:	Impairment	"Deceased bilat due to glaucoma. Has Rx glasses for reading."	**Sensation:**	Impairment	"Intermittent bilat foot "tingling" due to diabetic neuropathy."
Hearing:	WFL	"Has hearing aides."	**Endurance:**	Impairment	"Poor+. Complaints of mod LE fatigue after TUG test"
Skin:	WNL	"No s/s or risk of developing pressure ulcers." "No s/s of infection around incisional wound."	**Posture:**	Impairment	"Forward head and slumped seated posture."

Edema

- (○) **Absent** [ ] **Dependent**
- (●) **Present** [ ] **Pitting** +2

Location: Include location. "Bilateral feet".

Circumferential Measurements: "RN Pam assessing and monitoring patient's edema."

Pain Assessment

☐ No Pain Reported

	Location:		Intensity:		Location:		Intensity:
Primary Site:	Other	Left lateral hip	3	Secondary Site:	Other	Low back	2

Increased by: e.g. movement, positional, weather, insidious, prolonged standing, point tender, time of day, weight-bearing

Relieved by: e.g. rest, positional, medicines, positional, heat/ice, breathing techniques, splints/braces/wraps, non weight-bearing, relaxation techniques, nothing

Interferes with: e.g. gait, transfers, functional activities, sleep, therapy tolerance, mood, appetite

ROM / Strength

		ROM		Strength				ROM		Strength	
Part	***Action***	***Right***	***Left***	***Right***	***Left***	***Part***	***Action***	***Right***	***Left***	***Right***	***Left***
Shoulder	Flexion					Hip	Flexion				
	Extension						Extension				
	Abduction						Abduction				
	Adduction						Adduction				
	Int Rot						Int Rot				
	Ext Rot						Ext Rot				
Elbow	Flexion					Knee	Flexion	90			
	Extension						Extension	-5			
Forearm	Pronation					Ankle	Plantar Flexion				
	Supination						Dorsiflexion				
Finger	Flexion						Inversion				
	Extension						Eversion				
Wrist	Flexion					Neck	Flexion				
	Extension						Extension				
Trunk	Extension						Lat Flexion				
	Rotation						Rotation				
	Flexion										

Description of Functional Impact:

Gross left LE MMT strength WNL, gross right LE MMT strength 4-/5 with exception to 3/5 for right knee flexion. Right knee AROM flexion 90 deg, right knee AROM extension -5 deg.

You do not need to fill out every assessment box for every body part/movement for strength and ROM. Instead, you can use the text box ("Description of Functional Impact:") at the bottom to clearly state your objective findings.

***Note that you can find the definitions of each level of assistance by scrolling over them. Also, please use

Functional Assessment

Independence Scale Key: *hover over term for definition*

Dep	Max Assist	Mod Assist	Min Assist	CGA	SBA	Supervision	Ind with Equip	Indep

Independence; Patient is able to complete all tasks including preparation without any help, and performs task safely.

Bed Mobility

	Assist Level	
Rolling	SBA	☑ L ☑ R
		Assistive Device
Supine - Sit	Min Ax1	Bed rail
Sit - Supine	Min Ax1	Bed rail

Factors Contributing to Functional Impairment:

"Decreased right LE strength and pain in right LE with movement."

Make a note if patient experiences vertigo/dizziness if applicable.

Gait

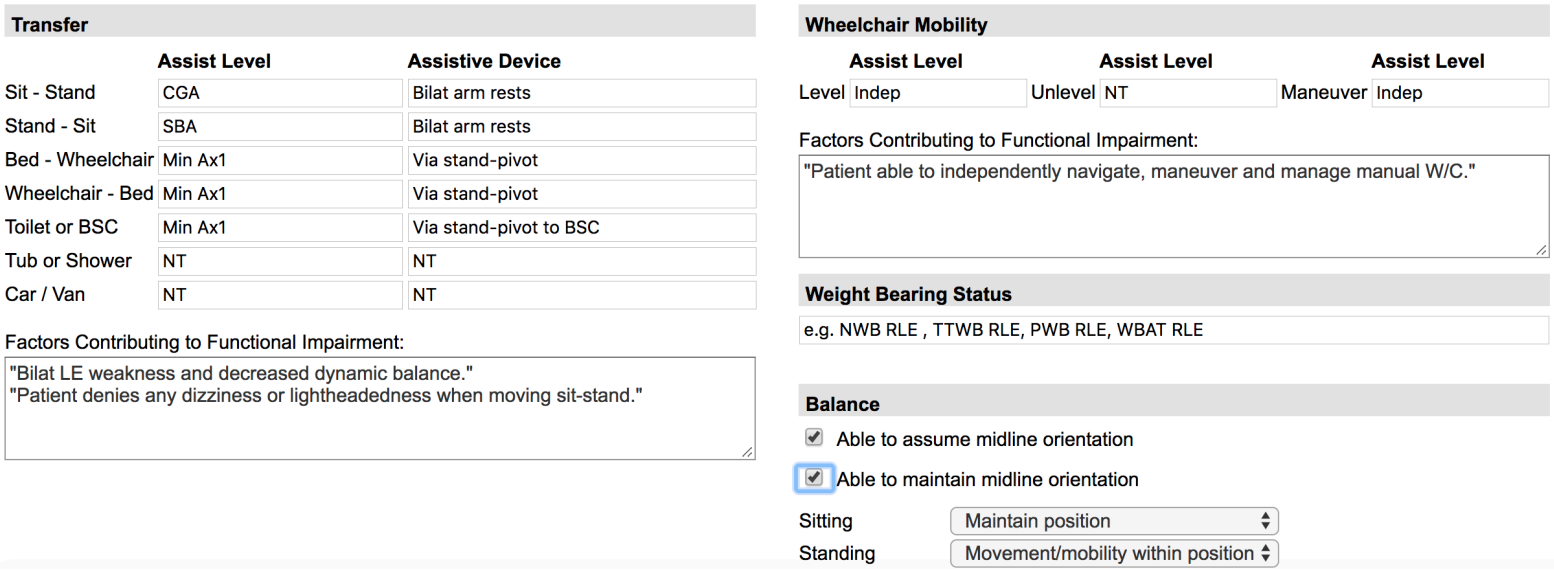
	Assist Level		Distance/Amount (Ft)	Assistive Device
Level	Min Ax1	X	20	RW
Unlevel	NT	X		
Steps/Stairs	Mod Ax1	X	14	Railing/SPC

Factors Contributing to Functional Impairment:

This is a good area to describe gait pattern and abnormalities.
e.g. Pt with two episodes of loss of balance requiring manual assistance to correct.
e.g. Patient shows decreased weight shift to right LE and antalgic gait.
e.g. Patient demonstrates non-reciprocal pattern on stairs for ascend/descend.

ACCURATE and CONSISTENT abbreviations when depicting level of assistance

Dep = Dependent
Max Assist = Max A, Max Ax1, Max Ax2, etc.
Mod Assist = Mod A, Mod Ax1, Mod Ax2, etc.
Min Assist = Min A, Min Ax1, Min Ax2, etc.
CGA = Contact Guard Assistance
SBA = Standby Assistance
Sup = Supervision (can denote Far Supervision vs. Close Supervision)
Ind with Equip = Mod Indep = Modified Independent
Indep = Independent
Any verbal cues are instant qualification for at least Supervision



Transfer

	Assist Level	Assistive Device
Sit - Stand	CGA	Bilat arm rests
Stand - Sit	SBA	Bilat arm rests
Bed - Wheelchair	Min Ax1	Via stand-pivot
Wheelchair - Bed	Min Ax1	Via stand-pivot
Toilet or BSC	Min Ax1	Via stand-pivot to BSC
Tub or Shower	NT	NT
Car / Van	NT	NT

Factors Contributing to Functional Impairment:

"Bilat LE weakness and decreased dynamic balance."
"Patient denies any dizziness or lightheadedness when moving sit-stand."

Wheelchair Mobility

Assist Level		Assist Level		Assist Level	
Level	Indep	Unlevel	NT	Maneuver	Indep

Factors Contributing to Functional Impairment:

"Patient able to independently navigate, maneuver and manage manual W/C."

Weight Bearing Status

e.g. NWB RLE , TTWB RLE, PWB RLE, WBAT RLE

Balance

- [x] Able to assume midline orientation
- [x] Able to maintain midline orientation

Sitting: Maintain position
Standing: Movement/mobility within position

The definitions used to grade balance in Kinnser are very vague and somewhat confusing. Loose definitions for each classification of balance can be best defined as:

Attain position: Patient is able to get **INTO** the desired seated or standing position.
Maintain position: Patient is able to **HOLD** and **STAY** in desired seated or standing position for a period of time.
Movement/mobility within position: Patient is able to move (head turns, reaching, trunk rotations, receiving perturbations) within their confines.
Movement into/out of position: Patient is able to move dynamically out of their confines in the seated or standing position e.g. reaching away from base of support.

You can also give a grade to seated and standing static and dynamic balance
Poor-, Poor, Poor+, Fair-, Fair, Fair+, Good-, Good, Good+, Normal

When testing balance, it is always best to note episodes of loss of balance and correction strategies patient does or does not use.

> "Patient with two episodes of loss of balance while standing in tandem and reaching bilat across midline with eyes open. Patient unable to self-correct loss of balance requiring therapist assistance."

Fall Risk and Other Testing

	Test Used	Other	Test Results	
Cognition				
Sensation				
Endurance				
Balance				
Gait	TUG	with SPC	32	**sec**
Bal Confidence				

DME

Available

☑ Wheelchair ☑ Walker ☐ Hospital Bed ☑ Bedside Commode ☐ Raised Toilet Seat ☐ Tub / Shower Bench

Other:

SPC, axillary crutches, recliner lift chair, grab bars, rollator, stair glide, handheld shower, etc.

Needs

"Recommended grab bars for upstairs bathroom."

Clinical Statement of Assessment Findings and Recommendations

This is the area of your evaluation where you bring everything together. It is best to copy all of this information and put it into a Communication Note, so all involved disciplines and the office are on the same page. You can even include your visit pattern and what days you'd like your next few visits to be scheduled on.

"PT Evaluation completed on 9/21/18. Patient will be seen 1w1, 2w8. Please put in next visits for 9/24 and 9/26 when able to. Thanks. CJM" **Include in Communication Note only**

Example:

"70 year old Caucasian female referred to homecare services s/p fall, UTI, COPD and fungal rash. Patient states she was at her shore home and suddenly became weak resulting in a fall. Pt denies any dizziness or lightheadedness and states she was not using any AD at time of fall. Pt reports ambulance came and took her to Stanko Hospital from 8/11-8/15 and then she was transferred to PBCC from 8/28-9/15/18. In hospital it was found she had a UTI which is still being treated with antibiotics. Around time of fall, patient was seeing oncologist and pulmonary surgeon regarding mass noted in right lung. Pt states no metastasis was found, however there is significant scar tissue on her left lung resulting in her need for supplemental O2 continuously at 2L/min via NC. Oxygen safety reinstructed with patient and husband. Patient has c/o intermittent low back pain, decreased bilat LE strength and endurance, decreased balance with hx of falls, SOB, decreased vision bilat and difficulty sleeping. Pt denies any numbness/paresthesia, dizziness/lightheadedness, decreased appetite, difficulty using bathroom, s/s DVT or edema. Pt has f/u with PCP on 9/25/18. Patient would benefit from continued skilled PT to achieve all goals and maximize function and safety. Patient has good rehab potential to achieve all goals and be discharged to HEP and self-care program and potentially pulmonary rehab at Methodist."

Again, this should be the area to paint a picture of your patient's current status.

Next, fill out Goals and Interventions as described in “Progress to Goals” section.

Treatment Goals and Plan

Go To Goals and Interventions

Comments:

"Session well tolerated. Patient and caregiver agreeable with PT POC and seem highly motivated."

Care Coordination

Conference with:

☐ PT ☐ PTA ☑ OT ☐ COTA ☐ ST ☑ SN ☐ Aide ☑ Supervisor Other: Office (if you send a Communication note you can add Office/Supervisor)

Name(s): Full name and discipline

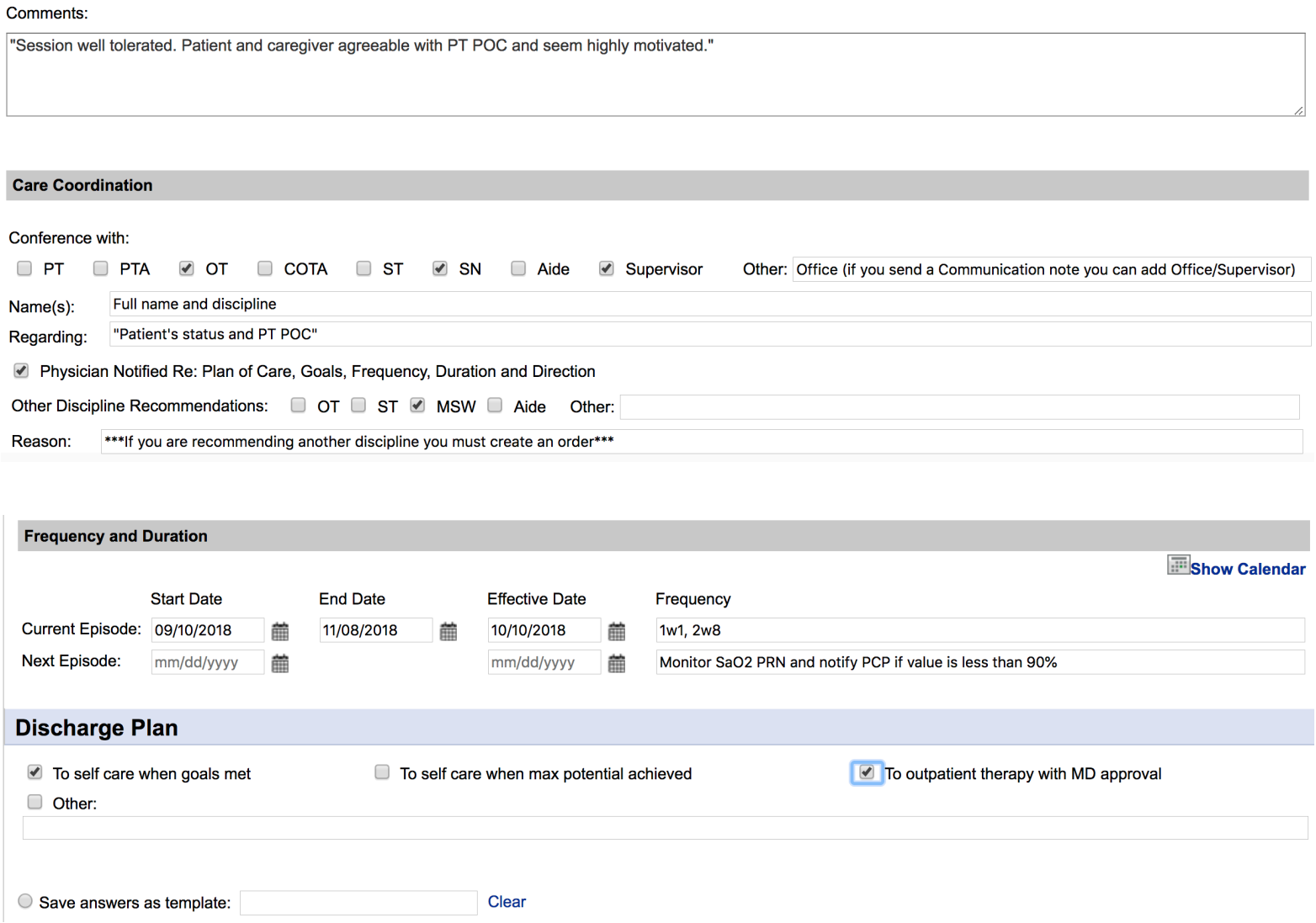
Regarding: "Patient's status and PT POC"

ALWAYS CHECK!

☑ Physician Notified Re: Plan of Care, Goals, Frequency, Duration and Direction

Other Discipline Recommendations: ☐ OT ☐ ST ☑ MSW ☐ Aide Other:

Reason: ***If you are recommending another discipline you must create an order***



<u>Writing visit frequencies and patterns:</u>

You should always write your frequency for the remaining duration of the certification period even if you think you will be discharging prior (usually 8 or 9 weeks).

- "1w1, 2w8" would mean you will see the patient one time in the first week and two times for 8 weeks after.
- "2w9" would mean you will see the patient two times a week for 9 weeks.
- "2w1, 1w1, 2w7" would mean you are seeing the patient two times in the first week, one time in the second week and two times the next seven weeks.

***The text box below your visit pattern is where you always include your order for taking a pulse ox (See "Pulse Ox Orders" page).

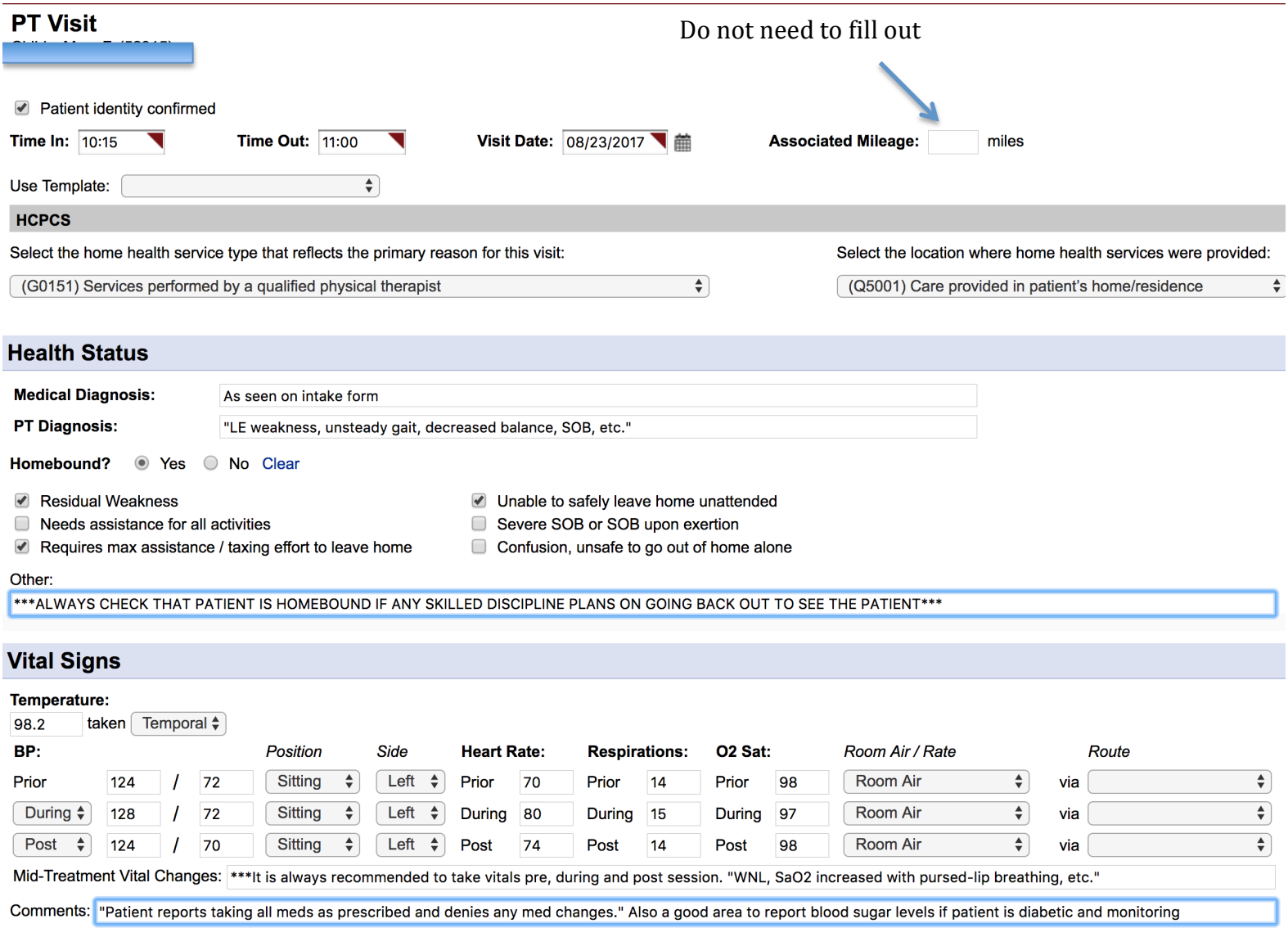
At the bottom is where you can name and save your evaluation as a template.

Sign, select date and submit

<u>Remember to save your work frequently because Kinnser does not automatically do it!</u>

DOCUMENTING: ROUTINE VISITS

It is strongly suggested to use templates when documenting routine visits. This saves a lot of time and is a great way to keep track of your patient's most recent functional status, therapy interventions performed and progress (or lack of) towards goals. Below is an example of a PT Visit and examples of what to include in certain areas:



PT Visit

Do not need to fill out

Patient identity confirmed

Time In: 10:15 **Time Out:** 11:00 **Visit Date:** 08/23/2017 **Associated Mileage:** miles

Use Template:

HCPCS

Select the home health service type that reflects the primary reason for this visit:

(G0151) Services performed by a qualified physical therapist

Select the location where home health services were provided:

(Q5001) Care provided in patient's home/residence

Health Status

Medical Diagnosis: As seen on intake form

PT Diagnosis: "LE weakness, unsteady gait, decreased balance, SOB, etc."

Homebound? Yes No Clear

- Residual Weakness
- Needs assistance for all activities
- Requires max assistance / taxing effort to leave home
- Unable to safely leave home unattended
- Severe SOB or SOB upon exertion
- Confusion, unsafe to go out of home alone

Other:

ALWAYS CHECK THAT PATIENT IS HOMEBOUND IF ANY SKILLED DISCIPLINE PLANS ON GOING BACK OUT TO SEE THE PATIENT

Vital Signs

Temperature: 98.2 taken Temporal

BP:			*Position*	*Side*	**Heart Rate:**		**Respirations:**		**O2 Sat:**		*Room Air / Rate*	*Route*
Prior	124	/ 72	Sitting	Left	Prior	70	Prior	14	Prior	98	Room Air	via
During	128	/ 72	Sitting	Left	During	80	During	15	During	97	Room Air	via
Post	124	/ 70	Sitting	Left	Post	74	Post	14	Post	98	Room Air	via

Mid-Treatment Vital Changes: ***It is always recommended to take vitals pre, during and post session. "WNL, SaO2 increased with pursed-lip breathing, etc."

Comments: "Patient reports taking all meds as prescribed and denies any med changes." Also a good area to report blood sugar levels if patient is diabetic and monitoring

Current Treatment Plan

Subjective Information

Subjective Information Collected During Visit

Include the patient's subjective response to last therapy session. It is also a good area to include upcoming medical appointments and/or results from recent medical appointments, tests, etc.
"Patient/daughter report no new complaints or adverse reactions to last PT session. Pt denies any breathing difficulty or chest pain/tightness. Pt states she is trying HEP in bed daily with the assistance of her daughter. Daughter states patient has f/u with PCP next week."

Psychiatric Worksheet

Pain Assessment

☐ No Pain Reported at Visit

	Location:	Other	Left lateral hip			*Location:*	Other	Low back	
Primary Site:	*Pre-Therapy Intensity:*	3	*Post-Therapy Intensity:*	2	Secondary Site:	*Pre-Therapy Intensity:*	0 None	*Post-Therapy Intensity*	0 None

Increased by: "Movement, prolonged standing/walking, weight bearing, worse in AM, cold weather, positional, etc."

Relieved by: "Rest, meds, positional, heat, ice, brace/splint/orthotic, etc."

Interferes with: "Sleep, gait, transfers, mobility, ADLs/IADLs, etc."

Wound Care Worksheet

ROM / Strength

☑ No ROM/Strength Reported at Visit

		ROM		Strength				ROM		Strength	
Part	***Action***	***Right***	***Left***	***Right***	***Left***	***Part***	***Action***	***Right***	***Left***	***Right***	***Left***
Shoulder	Flexion					Hip	Flexion				

***You do not need to reassess strength/ROM at every visit, however you should periodically, especially ROM with TKA patients

***Note that you can find the definitions of each level of assistance by scrolling over them. Also, please use **ACCURATE and CONSISTENT** abbreviations when depicting level of assistance

Dep = Dependent
Max Assist = Max A, Max Ax1, Max Ax2, etc.
Mod Assist = Mod A, Mod Ax1, Mod Ax2, etc.
Min Assist = Min A, Min Ax1, Min Ax2, etc.
CGA = Contact Guard Assistance
SBA = Standby Assistance
Supervision = Sup (can denote Far Supervision vs. Close Supervision)
Ind with Equip = Mod Indep = Modified Independent
Indep = Independent
__Any verbal cues are instant qualification for at least Supervision__

Objective Information

Independence Scale Key: *hover over term for definition*

Dep	Max Assist	Mod Assist	Min Assist	CGA	SBA	Supervision	Ind with Equip	Indep

Independence; Patient is able to complete all tasks including preparatio without any help, and performs task safely.

Bed Mobility Training

	Assist Level		Training / Intervention
Rolling	Mod Ax1	☑ L ☑ R	With bed rails 5x bilat
		Assistive Device	
Supine - Sit	Mod-Max Ax1	Bed rails	
Sit - Supine	Mod-Max Ax1	Bed rails	

Impact of Intervention(s) on Functional Performance / Patient Response to Treatment:

Pt required constant verbal and manual cues for correct usage of bed rails for bed mobility. Daughter instructed on proper bed mobility technique to provide adequate pressure relief throughout the day. Daughter will require further training.

Impact of Exercise(s) on Functional Performance / Patient Response to Treatment

See Goals and Interventions for ther ex specifics. Pt easy to fatigue with LE ther ex and requires constant manual and verbal cueing for proper performance due to cognitive impairment.

Assessment

Go To Goals and Interventions

See separate "Goals and Interventions" page for instructions

Summary of Patient Overall Performance on this Visit

Session well tolerated. Pt did not want to perform transfer training into wheelchair today from bed due to fatigue. She states she will try next visit. Pt would benefit from continued skilled PT to achieve all goals, especially improving bed mobility and transfers for pressure relief.

Plan

- [x] Plan for next visit:

transfer training, ther ex, balance training 9/6/18

- [ ] Supervising Therapist contacted to review / update the plan of care
- [ ] Physician contacted to review / update orders
- [x] Discharge Planning

To self care when goals met, To self care when max potential achieved

- [ ] Written notice of discharge provided to patient

Care Coordination

Conference with:

- [ ] PT
- [ ] PTA
- [x] OT
- [ ] COTA
- [ ] ST
- [x] SN
- [ ] Aide
- [ ] Supervisor

Other:

Name(s): Annette H. OT, Pam W., RN

Regarding: patient's status and patient's status update

"Discharge Planning" box is to be checked off **EVERY VISIT**. Discharge planning starts from day one.

Care Coordination should be done **AT LEAST every two weeks** and documented. It is expected that for **EVERY** patient **EVERY TWO WEEKS** a **Communication Note** is sent out updating all involved disciplines and the office on your patient's status, progress towards goals and reason for continued therapy. There are **NO** exceptions to this. Regardless if you have texted with or spoke on the phone with another colleague, it must be documented in **KINNSER**.

Save Submit

Electronic Signature: ••••••••• Signature Valid. Forgot My Electronic Signature.

Signature Date: 09/05/2018

*****SAVE your work continuously. Kinnser DOES NOT AUTOMATICALLY SAVE NOTES*****

Your **"Electronic Signature"** is the same password you use to login Kinnser.