



01 Narrative (Note)

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Purpose:

To guide therapists on what to document in the narrative coordination note during an assessment visit.

Question Intent:

Narrative notes are required on all therapy assessment visits at Evaluation or Start of Care. This provides a concise summary of the patient's history and assessment presentation and is a beneficial Note for all disciplines to review.

Looking at Medicare Benefit Policy Manual Chapter 7 - Home Health Services, the narrative helps to paint the picture of why the patient requires skilled therapy and relays that "for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method which objectively measures activities of daily living such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. The measurement results must be documented in the clinical record."

This is essential in Restorative Therapy documentation.

NOTE - see the Maintenance Therapy article to see how Interventions/Goals should be utilized for Maintenance Therapy patients.

Response-Specific Instructions:

At SOC (00) and Evaluation (01) visits, the therapist will add a narrative after the completion of their visit note. Here are the key elements of a narrative note:

1. Reason for Referral-Why was the patient referred by a physician or representative to home health? If they were a previous patient, what has changed or exacerbated?
2. Diagnosis and or relevant medical history/conditions to show complexity - Supports skilled need.
3. Prior Level of Function - must know what this patient looked like just before decline in function. This is a critical element to make the case.
4. Patient Goal - Must be reasonable!
5. Abnormal objective data to support argument - Come from specific functional tests and or objective measures - know the out of parameter norms / age related norms.
6. Current level of Function - Specific examples unique to this patient - do not underestimate the importance of this in making a specific case.
7. Plan - What will the Therapist do to address the impairments identified?

Below are examples of what to document in the HCHB narrative section for an initial assessment visit. Each discipline is listed.

Physical Therapy

Type

NARRATIVE

Note

PT EVALUATION PERFORMED TODAY ON 4/6/24. PATIENT IS A 62 YEAR OLD FEMALE WHO WAS HOSPITALIZED ON 4/2/24 DUE TO NEW ONSET OF ATRIAL FIBRILLATION. PRIOR TO THE EVENT, SHE WAS INDEPENDENT WITH DRESSING HER UPPER AND LOWER BODY, ABLE TO AMBULATE WITH HER ROLLATOR AROUND HOME WITHOUT RESTING, AND TRANSFER INTO AND OUT OF CHAIRLIFT TO GET TO SECOND FLOOR TO ACCESS THE MAIN BATHROOM AND BEDROOM. CURRENTLY, SHE HAS LOST STAMINA AND CANNOT AMBULATE MORE THAN 20 FEET WITHOUT RESTING, CANNOT TRANSFER ONTO THE LIFT, THUS CANNOT USE HER NORMAL SLEEPING AND BATHROOM FACILITIES. HER FUNCTIONAL TESTS SHOW HIGH FALL RISK WITH TUG OF 35 (13 OR LESS IS NORMAL) AND 30 SECOND SIT TO STAND IS 4, WHICH IS WELL BELOW AGE RELATED NORM OF 14 REPETITIONS, INDICATING HIGH FALL RISK AND NON FUNCTIONAL MMT OF 3+/5 FOR LE. THERAPY IS NECESSARY TO ADDRESS IMBALANCE THROUGH DYNAMIC AND STATIC EXERCISES, PROGRESSIVE RESISTED EXERCISES TO INCREASE STRENGTH, AND TRANSFER/GAIT TRAINING TO ADDRESS MOBILITY AND ENDURANCE SO SHE CAN RETURN TO ACCESSING THE BEDROOM AND USE OF STAIRLIFT. PATIENT'S PROGNOSIS IS EXCELLENT AS SHE IS MOTIVATED, HAS GOOD CAREGIVER SUPPORT, AND CURRENT IMPAIRMENTS ARE SHORT IN DURATION RELATED TO ONSET OF CONDITION.

Occupational Therapy

OT01 - BUZZRRNS, MISTY H

Type

NARRATIVE

Note

OT EVALUATION COMPLETED TODAY ON 5/15/24. PATIENT IS AN 84 YEAR OLD MALE WHO WAS REFERRED TO HOME HEALTH S/P HOSPITALIZATION FOR UTI ON 5/12/24. PATIENT RESIDES IN A SINGLE LEVEL HOME WITH PAID CAREGIVER 3 DAYS A WEEK. PMH INCLUDES OA BILATERAL KNEES, HTN, AND ANXIETY. PRIOR TO HOSPITAL STAY, PATIENT WAS AMBULATING WITH A ROLLATOR SBA, REQUIRED CGA WITH TOILET AND TUB TRANSFERS, AND CGA WITH BATHING. PATIENT SCORED A 50/100 ON BARTHEL INDEX, WHICH INDICATES A MODERATE IMPAIRMENT WITH TUB AND TOILET TRANSFERS, BATHING, AND PLACES PATIENT AT RISK OF FALLING. PATIENT EXPRESSED NEW FEAR OF BATHING AND PREFERS SPONGE BATH BY CAREGIVER. PATIENT ALSO EXPRESSED HE HAS MODERATE FATIGUE WITH TRANSFERS AND BATHING TASKS. HE SCORED A 4/10 ON MODIFIED BORG, INDICATING SOB AND FATIGUE WHEN PERFORMING ADL TASKS. PATIENT GOAL IS TO IMPROVE ENDURANCE FOR HIS DAILY SELF CARE ROUTINE. OT IS WARRANTED TO IMPROVE PATIENT ENERGY CONSERVATION AND SAFE PERFORMANCE OF TUB AND TOILET TRANSFERS, AS WELL AS BATHING TASKS. PATIENT'S REHAB POTENTIAL IS GOOD DUE TO MOTIVATION LEVEL AND CAREGIVER SUPPORT IN HOME.

Speech Therapy



ST01 - ANDZZZREWS, CORY M



Type

NARRATIVE

Note

PATIENT EVALUATED BY HOME HEALTH SLP ON 5/25/24 S/P SUSTAINING A MILD LEFT MCA CVA ON 5/23/24. PMH INCLUDES HTN AND OBESITY. PRIOR TO CVA, PATIENT WAS WORKING AT HOME IN IT SALES AND WAS ABLE TO COMMUNICATE ALL WANTS AND NEEDS EFFECTIVELY AT THE CONVERSATIONAL LEVEL. GIVEN ORAL MOTOR EXAM, PATIENT PRESENTED WITH MILD RIGHT SIDED FACIAL DROOP WITH MILDLY IMPAIRED LABIAL AND LINGUAL STRENGTH AND ROM. SPEECH SAMPLE INDICATED SPEECH WAS SLURRED WITH APPROXIMATELY 70% OVERALL INTELLIGIBILITY. PATIENT ALSO SCORED 16/30 ON SLUMS, WHICH REVEALED MODERATE WORD FINDING DEFICITS. PATIENT GOAL IS TO COMMUNICATE WANTS AND NEEDS EFFECTIVELY IN ORDER TO RETURN TO WORK. SPEECH THERAPY IS REQUIRED TO IMPROVE SPEECH INTELLIGIBILITY AND FUNCTIONAL COMMUNICATION VIA INSTRUCTION OF ORAL MOTOR EXERCISES, PACING STRATEGIES, AND WORD FINDING ACTIVITIES UP TO THE SENTENCE AND CONVERSATIONAL LEVEL.

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