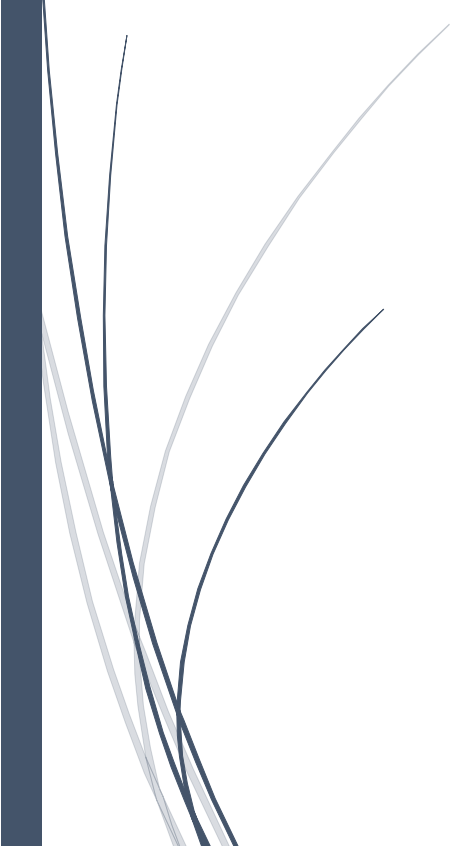


A dark blue vertical bar on the left side of the page. A blue arrow points to the right from the bar, containing the year 2023.

2023

OT Subsequent Visit

Homecare Homebase

A series of thin, curved lines in dark blue and light grey that originate from the bottom left and curve upwards and to the right.

HEMOCARE HOMEBASE, LLC

OT SUBSEQUENT VISIT

OBJECTIVES OF LEARNING

Your Company and Homecare Homebase are invested in your learning experience. Therefore, it is necessary we follow a set of strategies & tactics to achieve our objectives, which ultimately lead us to our overall goal through Empowering Exceptional Care.



1. **Mission / Goal:** Successfully facilitate the development and implementation of HCHB through the learning and growth of all end users
 - 1.1. **Objective:** User to understand HOW, WHEN, & WHY in using the system
 - 1.1.1. The HCHB new user should understand the basic functionality of the PointCare application upon completion of the Online Learning Hub curriculum.

OT SUBSEQUENT VISIT

- 1.1.2. The HCHB new user will be able to document against the desired Therapy Goals and Status and identify progress toward each goal by the end of this course.
- 1.1.3. The HCHB new user should understand where to identify the key components that determine discharge and how to write the discharge order for their discipline by the end of this course.

OT SUBSEQUENT VISIT

AGENDA ITEMS

Introduction

- Who is my patient?
- How do I start my day?

15 min

Visit Actions

- Unexpected Events / Therapy Reassessment Warning
- Mileage / Drive Time
- Vital Signs
- Physical Assessment
- New Order
- Interventions / Goals
- Therapy Assess / Plan
- Therapy Goals / Status

45 min

PRN

- Client Complaint

5 min

Notes

Agency Specific Note(s)?

5 min

COMPLETE YOUR VISIT

OT SUBSEQUENT VISIT

PATIENT CASE STUDY

ASSESSMENT AND PLAN OF CURRENT VISIT

General: *Patient is awake, alert, and oriented to person, place, and time (AAOx3) with periods of confusion. Overall, patient is exhibiting signs of improvement in all areas.*

Vitals:

HISTORY OF PRESENT ILLNESS

Patient is a woman being admitted for home care due to St. II Pressure Ulcer to left heel and need for wound management. Patient has past medical history significant for type 2 diabetes, hypertension, and nicotine dependence. According to patient's husband, John Smith (contact), she has exhibited no cognitive issues or functional deficits prior to this episode of care. The patient has been noted to have a good appetite and denies problems with sleeping or weight changes. She also denies any suicidal ideations and visual/auditory issues.

OT SUBSEQUENT VISIT

Temperature	98.8
Respirations	20
Pulse	75
BP	160 / 95

Cardiopulmonary: *Patient’s lungs are diminished, but clear, and patient does not have a cough.*

Gastrointestinal: *Patient has no nausea, vomiting, or constipation.*

Functional: *Patient is homebound due to generalized weakness and a decline in function related to disease process. Patient also uses walker for ambulation and is at risk of falls. Patient uses walker boot to lower left extremity. Patient experienced a fall yesterday while husband, John, was at home. Patient will continue with designed plan of care in addition to sitting in wheelchair and attempting to practice sit to stand. Patient is pleasant and cooperative during treatment session. Patient performed with both upper extremities during the home exercise program with a yellow theraband in order to increase independence in activities of daily living. Patient performs static sitting balance activity with moderate assistance at the edge of her chair. We will address impairments in upper extremity strength by providing interventions in strengthening and caregiver education. Patient has a good rehabilitation potential to improve bed mobility and it seems all goals will be met by next week.*

Complaint: *Patient complains that the Home Health Aide who has been providing care is not giving them enough heads-up time prior to arriving at their home. They would like to have at least 30 minutes heads-up.*

RECOMMENDATIONS FROM CASE CONFERENCE

Patient is improving and meeting her goals, so we should adjust the Plan of Care accordingly. We need to discharge from OT services next week.

THERAPY GOALS/STATUS

Functional (OT)		
Bed Mobility (OT)	Status	Carryover
Roll to Side	Independent	N
Transfers (OT)	Status	Carryover
Toilet	Modified Independent	Y
Balance (OT)	Status	Carryover

OT SUBSEQUENT VISIT

<i>Static Standing</i>	<i>Fair – Requires Minimal Support</i>	Y
<i>Dynamic Standing</i>	<i>Poor – Requires Support to Maintain Balance</i>	Y
<i>Timed Up and Go (in seconds)</i>	35	Y
Wheelchair (OT)		
<i>Manual – Propel Level Surface Distance (in feet)</i>	15	N
Self Care (OT)		
<i>Bathing/Showering Ability</i>	<i>Standby Assist</i>	Y
<i>Dress Lower Body Ability</i>	<i>Modified Independent</i>	Y
<i>Toileting</i>	<i>Minimal Assist</i>	Y

COORDINATION NOTES

REQUEST TO ADD NEW PHYSICIAN

DEMOGRAPHIC CHANGE REQUEST

