PT Start of Care Visit

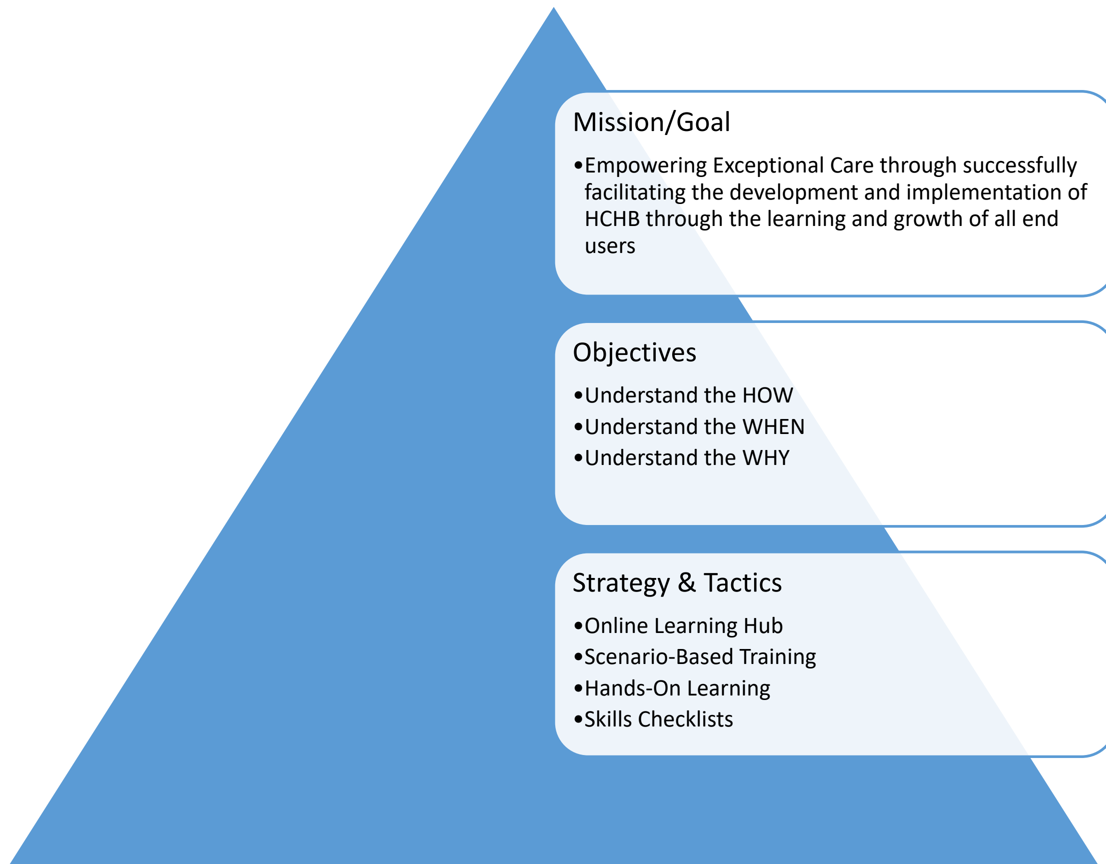
Homecare Homebase

HOMECARE HOMEBASE, LLC

PT START OF CARE 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.

These materials are the confidential and proprietary information of Homecare Homebase and subject to your organization's confidentiality obligations to Homecare Homebase. You are not permitted to share, distribute or grant access to these materials to any individuals outside of your organization.

1.1.2. The HCHB new user will understand how to properly begin their day and prepare before visits provided by the instructor by the end of this course.

1.1.3. The HCHB new user should understand how to properly develop a 485 order that drives future visits for the patient by the end of this course.

1.1.4. The HCHB new user will be able to identify the different components of a visit that will contribute to that patient's SOAP note by the end of this course.

These materials are the confidential and proprietary information of Homecare Homebase and subject to your organization's confidentiality obligations to Homecare Homebase. You are not permitted to share, distribute or grant access to these materials to any individuals outside of your organization.

PT START OF CARE VISIT

AGENDA ITEMS

Agenda Item	Time
Introduction • Who is my patient? • How do I start my day?	15 min

Visit Actions
• Signature Forms
• Entitlement
• Demographics
• Vital Signs
• Diagnoses
• Client Medications
    ○ Allergies
    ○ Vaccination History
    ○ Medication Understanding
• Physical Assessment
• Pathways
• Patient Goals
• Integumentary Command Center
• Client Calendar
• Interventions / Goals
• Therapy Assess / Plan
• Therapy Goals / Status
	180 min

INCOMPLETE YOUR VISIT	
Visit Actions • Mileage / Drive Time • Supplies / DME • Aide Care Plan • Claim Codes • Physical Assessment (continued)	30 min
Notes Agency Specific Note(s)?	15 min
COMPLETE YOUR VISIT	

These materials are the confidential and proprietary information of Homecare Homebase and subject to your organization's confidentiality obligations to Homecare Homebase. You are not permitted to share, distribute or grant access to these materials to any individuals outside of your organization.

PT START OF CARE VISIT

These materials are the confidential and proprietary information of Homecare Homebase and subject to your organization's confidentiality obligations to Homecare Homebase. You are not permitted to share, distribute or grant access to these materials to any individuals outside of your organization.

PT START OF CARE 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. Patient states her goals are to understand how to get better and heal her wound. She also wishes she could improve her gait and walking skills.*

Vitals, Allergies, and Vaccinations:

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.

These materials are the confidential and proprietary information of Homecare Homebase and subject to your organization's confidentiality obligations to Homecare Homebase. You are not permitted to share, distribute or grant access to these materials to any individuals outside of your organization.

PT START OF CARE VISIT

Temperature	99.1	*Weight*	150 lbs.
Respirations	20	*Height*	68 in.
Pulse	85	*Pain*	7
BP	160 / 100		

Patient states she is allergic to Penicillin and Vitamin K. Patient reports she is up-to-date with her Flu and Pneumonia vaccines as of last week.

Pain: *She complains of pain in LLE and foot with a subjective score of 7 out of 10 on a numeric scale. She states her pain is constant. We discuss pain control measures and how to take pain medications before pain gets intolerable. We also discuss importance of offloading and elevating foot when sitting in order to decrease pain and promote healing.*

Endocrine: *Diabetes Management is discussed, including diet and nutrition related to diabetes and wound healing.*

Nutritional: *We discuss the importance of eating protein in patient's diet. Patient states fair appetite and good hydration.*

Functional: *Patient needs to increase strength, primarily in the core and proximal extremities. Patient has a lack of coordination with movements requiring training, decreased endurance, decreased balance and standing static and dynamic, decreased transfer and gait status. Patient agrees with the plan of care and discharge planning. Patient will benefit from physical therapy to allow maximum functional return to modified independence to independent functional mobility in and around the home. We discuss safety ambulating and preventing falls, which can be reinforced with OT evaluation (ordered by physician). Patient states she uses a cane for short distances and a walker for long distances. Patient is being seen due to a decline in safety and functional mobility. Patient needs to continue to improve strength, balance, endurance, transfer, and gait status. Patient has a good rehabilitation potential with continued physician therapy to continue to progress toward all of the established goals within the plan of care.*

SERVICES NEEDED

These materials are the confidential and proprietary information of Homecare Homebase and subject to your organization's confidentiality obligations to Homecare Homebase. You are not permitted to share, distribute or grant access to these materials to any individuals outside of your organization.

PT START OF CARE VISIT

Patient states she would prefer not to be seen on Wednesdays due to wound clinic visits.

☐ SKILLED NURSING

☑ PHYSICAL THERAPY — 2 visits per week needed

☑ OCCUPATIONAL THERAPY — 1 evaluation visit needed

☐ SPEECH THERAPY

☐ MEDICAL SOCIAL WORKER

☐ HOME HEALTH AIDE

DIAGNOSES

Z91.81 HISTORY OF FALLING
M81.0 AGE-RELATED OSTEOPOROSIS W/O CURRENT PATHOLOGICAL FRACTURE
? ESSENTIAL (PRIMARY) HYPERTENSION
E11.0 TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS
Z79.01 LONG TERM (CURRENT) USE OF ANTICOAGULANTS

These materials are the confidential and proprietary information of Homecare Homebase and subject to your organization's confidentiality obligations to Homecare Homebase. You are not permitted to share, distribute or grant access to these materials to any individuals outside of your organization.

PT START OF CARE VISIT

MEDICATIONS

Medications are reviewed and reconciled if the PT follows this procedure. Otherwise, the Case Manager will review in the office.

MEDICATION	DOSAGE	AMOUNT	FREQUENCY	REASON
CALCIUM 500 + D ORAL	500 mg(1,250 mg) – 400 units	1 tablet	Daily	Calcium
DILTIAZEM ORAL	240 mg	1 tablet	Daily	Hypertension
MAGNESIUM ORAL	250 mg	1 tablet	Daily	Magnesium
SALINE WOUND WASH	0.9%	As Needed	As Needed	Wound
PRAVASTATIN ORAL	20 mg	1 tablet	Daily	Cholesterol
VALSARTAN ORAL	160 mg	1 tablet	Daily	Hypertension
WARFARIN ORAL	5 mg	1 tablet	Tuesday, Thursday, Saturday	Blood thinner
HYDROCODONE-ACETAMINOPHEN ORAL	10 – 325 mg	1 tablet	Every 6 hours PRN	Pain

SUPPLIES

These materials are the confidential and proprietary information of Homecare Homebase and subject to your organization's confidentiality obligations to Homecare Homebase. You are not permitted to share, distribute or grant access to these materials to any individuals outside of your organization.

DME – CANE

DME – WHEELCHAIR

DME – GLUCOMETER

PT START OF CARE VISIT

THERAPY GOALS/STATUS

Functional (PT)			
Transfers (PT)	***Status***	***STG***	***LTG***
Bed to Chair	*Standby Assist*	*Minimally Independent*	*Independent*
Toilet	*Standby Assist*	*Minimally Independent*	*Independent*
Gait (Deviations)	***Status***	***STG***	***LTG***
Narrow Base of Support	*Moderate Dysfunction*	*Minimal Dysfunction*	*WNL*
Decreased Knee Extension	*Maximum Dysfunction*	*Moderate Dysfunction*	*WNL*
No Heel Strike	*Minimal Dysfunction*	*WNL*	*WNL*
Unsteady / Unsafe	*Moderate Dysfunction*	*Minimal Dysfunction*	*WNL*
Poor / Inconsistent Placement of Assistive Device	*Moderate Dysfunction*	*Minimal Dysfunction*	*WNL*
Gait (Distance/Assistance)	***Status***	***STG***	***LTG***
Level Surface Distance (in feet)	*5*	*10*	*15*
Musculoskeletal (PT)			
Strength (PT)	***Status***	***STG***	***LTG***
Right Hip External Rotation	*3/Fair*	*4-/Good-*	*4+/Good+*
Left Hip External Rotation	*3/Fair*	*4-/Good-*	*4+/Good+*
Right Knee Flexion	*1/Trace*	*3/Fair*	*4+/Good+*
Left Knee Flexion	*1/Trace*	*3/Fair*	*4+/Good+*
Right Knee Extension	*1/Trace*	*3/Fair*	*4+/Good+*
Left Knee Extension	*1/Trace*	*3/Fair*	*4+/Good+*

COORDINATION NOTES

SCHEDULER NOTIFICATION

CLINICAL

PT START OF CARE VISIT

NOTES & QUESTIONS

Helpful Hint – Our Quick Reference Guides are available from any computer or tablet via the Online Learning Hub website using your internet browser at:

https://www.hchb-olh.com/page/resources

PT START OF CARE VISIT