2023

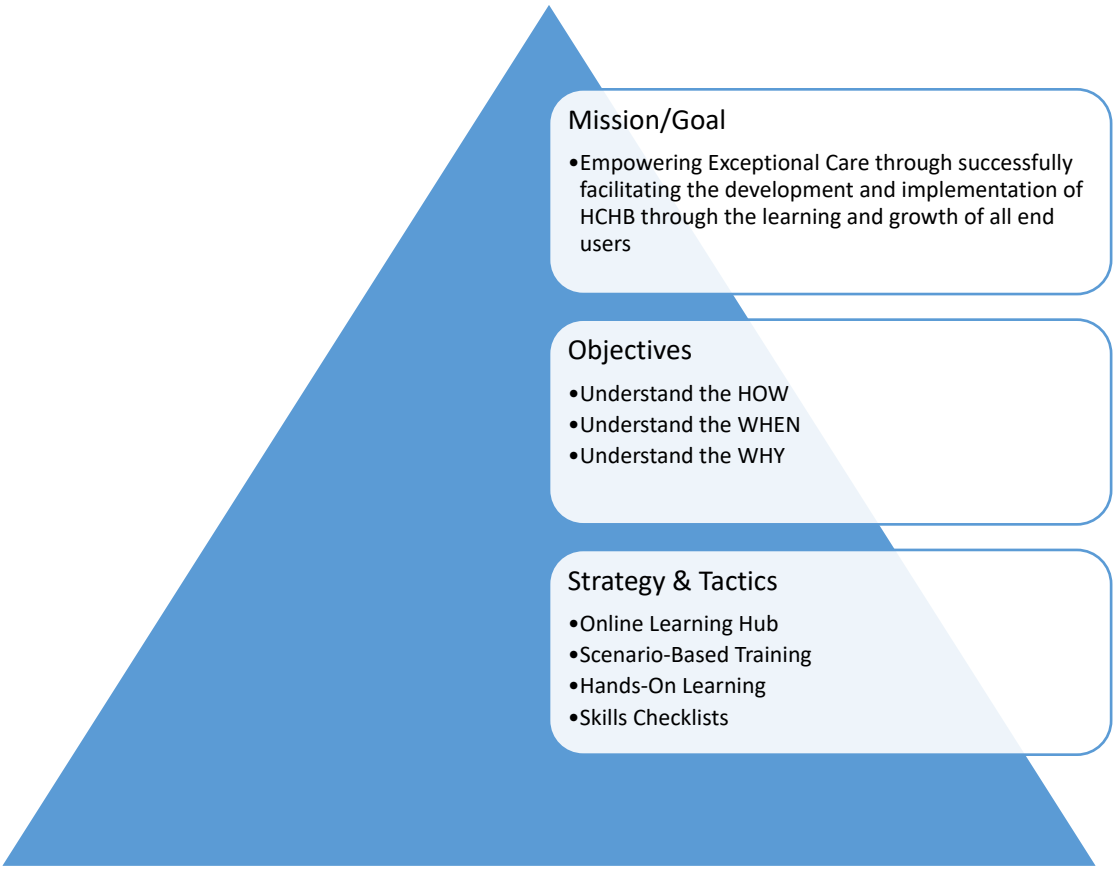
PT Evaluation Visit

Homecare Homebase

PT EVALUATION 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.

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 discipline-specific plan of care that drive 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.

PT EVALUATION VISIT

AGENDA ITEMS

Introduction

15 min

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

Visit Actions

- Vital Signs
- Diagnoses
- Physical Assessment
- Pathways
- New Order
- Intervention / Goals
- Therapy Assess / Plan
- Therapy Goals / Status

INCOMPLETE YOUR VISIT

Visit Actions

3 min

- Mileage / Drive Time

Notes

- Agency Specific Note(s)?

COMPLETE YOUR VISIT

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PATIENT CASE STUDY

ASSESSMENT AND PLAN OF CURRENT VISIT

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.

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Temperature	98.8
Respirations	20
Pulse	75
BP	160 / 95

Pain: *Patient 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.*

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. 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.*

Frequency: *3 visit per week for the first 3 weeks, 2 visits for the next 2 weeks, 1 visit for the rest of the episode. Plan to discharge from discipline by end of episode.*

- *Plot PT33 (Reassessment) around day 25*
- *Patient states she would prefer not to be seen on Wednesdays due to wound clinic visits*

DIAGNOSES

R26.89 OTHER ABNORMALITIES OF GAIT AND MOBILITY
? HISTORY OF FALLING

THERAPY GOALS/STATUS

Functional (PT)			
Transfers (PT)	***Status***	***STG***	***LTG***
Bed to Chair	*Standby Assist*	*Minimally Independent*	*Independent*
Toilet	*Standby Assist*	*Minimally Independent*	*Independent*

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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

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

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