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Guidelines for Physical Therapy Practice in an Educational/School Setting: Documentation

Sara N. Masilko
University of North Dakota

GUIDELINES FOR PHYSICAL THERAPY PRACTICE

IN AN EDUCATIONAL/SCHOOL SETTING:

DOCUMENTATION

by

Sara N. Masilko
Bachelor of Arts
Thiel College, 1964
Certificate in Physical Therapy
D. T. Watson School of Physiatrics, 1964

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This Independent Study, submitted by Sara N. Masilko in partial fulfillment of the requirements for the Degree of Master of Physical Therapy from the University of North Dakota, has been read by the Chairperson of Physical Therapy under whom the work has been done and is hereby approved.

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(Chairperson, Physical Therapy)

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ABSTRACT

The purpose of this study was to thoroughly review the various documentation requirements and uses in both clinical and educational settings, with the final outcome being to establish the documentation portion of the Guidelines for Physical Therapy Practice in the Educational/School Setting for the State of North Dakota.

A thorough search was made of national and state level requirements, educational setting guidelines from other states, and the uses of the problem-oriented medical record.

A good understanding of the problem-oriented medical record format is invaluable as a communication tool which can be effectively applied in either setting. The use of monthly flow sheets with monthly revisions of short-term objectives will facilitate validation that appropriate programming is being provided.

Documentation requirements as outlined by a school district are often inadequate when applied to the practice of physical therapy.

CHAPTER I

INTRODUCTION

The Quality Assurance Committee of the North Dakota Physical Therapy Association (NDPTA), in recognition of the need for such a document, has requested that a current guideline be drafted for Physical Therapy Practice in an Educational/School Setting in the State of North Dakota. In late September of 1991, a group of pediatric physical therapists met to discuss topics felt to be essential for such a document. Of fourteen specific topics analyzed, this paper will review the area of documentation.

Documentation is a vitally important aspect of physical therapy. It is written communication which must be logical, clear, and concise.[1] Well-formulated documentation should state the problem (or problems) for which services are required. Such documentation should include subjective information received from the patient and relevant to the present condition for which he/she is being treated. It should also include objective data found in the evaluation and used in planning the treatment, along with a problem list, a list of long-term goals, a list of short-term objectives to meet the goals, a summary of the assessment, and, finally, the treatment plan.[2] This outline, stating present status, treatment goals, and programming needs, must satisfy third-party payers as to appropriateness of programming, essential treatment, and

adequate progress.[3] Documentation can be defined as the act of authenticating with documents.[4] Since physical therapy progress notes are a part of a patient's medical records, it is important that physical therapists include all essential information about the patient, according to the policies of the facility for which the therapist works.[3] It is also important that documentation occur in a timely manner, so as to satisfy third-party payers, thus ensuring reimbursement for the services rendered.[3]

Physical therapists working in the educational system may or may not be required to satisfy third-party payers.[5] They must not only satisfy the documentary requirements of the school district for which they work, but, in addition, they are also required by law to meet the requirements of the examining committee of the state in which they work.[6]

Due to the unique role of the public school physical therapist, cooperation and communication are essential elements in developing the documentation which assures optimal programming for each handicapped child.[7] Original copies of all documentation concerning a particular child are included in the child's "permanent educational record" rather than in a "medical record," and are kept on file at the office of the Board of Education.

CHAPTER II

METHODOLOGY

Documentation, to most physical therapists, is considered to be one of the least desirable aspects of the job. For this reason, it has become maligned perhaps unfairly. This is evidenced by the lack of information available on the subject, and the level of confusion among clinicians as to how best to satisfy the requirements of everyone concerned with the care of a specific patient (whether served in a clinical setting or in an educational setting). The initial literature search concerning documentation began with a review of the **GUIDELINES FOR DOCUMENTATION OF A PATIENT RECORD**[1] as outlined by the American Physical Therapy Association in their respective guidelines. Additional guidelines were also obtained from other states (Iowa[8] and Oregon[5]) with each guideline providing minimal information specifically dealing with documentation. A methodical manual search was conducted through the Physical Therapy Forum, Physical Therapy Bulletin, and APTA Progress Report accumulation from the last two years, resulting in only two small articles[9,10] dealing with the subject of documentation. Although a systematic computerized search was made (including Medline and Odin), there was very little current literature to be found. For the most part, only the most recent materials (those written after 1980) were selected. The most recent guidelines as outlined by

Blue Cross/Blue Shield of North Dakota[3] as well as criteria for assuring reimbursement by Medicaid were areas also reviewed. Despite the recognition of the differences between the medically-based and educationally-based treatment models, it soon became apparent that certain basic documentation concepts apply to both. With this thought in mind, the discussion section will focus on basic documentation concepts which will facilitate the development of consistently higher standards in documentation regardless of the treatment model.

CHAPTER III

RATIONALE FOR AND REQUIREMENTS OF DOCUMENTATION

Among the most basic roles of documentation is its ability to serve as a control of operation. It is the essential function of health care professionals which allows enhancement of communication for medical and legal purposes.[7]

The primary purpose for record-keeping is for betterment of patient care.[10] It serves as an educational tool for staff, students, health team members, the patient, physician, administration, other workers, and the public. Standardization allows for the most effective way of communicating among clinicians.[2,11]

Clinical records are those that relate to patient care. They include the referral, an evaluation, progress notes, discharge summaries, home programs, follow-up forms, and other specialized forms.[1] The Problem Oriented Medical Record (POMR) organizes each medical record into a standard format.[2,10,11] If all departments in a facility use the same method of record-keeping, it simplifies the communication process between departments. A POMR includes a data base, problem list, and initial, progress, and discharge notes. It includes audit for peer review and quality assurance.[2,11]

When working in an educational setting, accountability in services provided can be achieved only through appropriate documentation. This is greatly

enhanced by the establishment of a data base and efficient record-keeping. A physical therapist is obligated both legally and ethically to measure and document changes related to a child's educational plan. Types of documentation related to the student contacts include: assessment results, IEP goals and objectives, data sheets, progress reports, single case studies, end-of-year reports/discharge summaries, home and classroom programs, and observations of student functioning.[6] Other essential record-keeping should include consultations with physicians or other pertinent medical personnel, contacts with parents, and contacts with educational staff. Documents should be written to the reader with organized sequencing of information. It should be clear and concise. Each agency should define their documentation requirements for educational referrals, physician's orders, parental permission, assessment, reassessment, IEPs, and other pertinent factors. Standardization of documentation facilitates communication across districts and regions.

Assessment documentation is of vital importance. Completion of reports should be within a time frame established by the local agency.[8] Reports should be clear, concise, understandable by parents and teachers, and written in the format of the local agency.[9] They should be void of medical terminology or acronyms that are not readily understandable by lay people. Reports should include assessment tools and conclusions regarding the relevance of the results. Recommendations should be made to the staffing team in regard to the need for services, the type of service, and the duration of such.

According to the North Dakota Physical Therapy Association's (NDPTA's) Guidelines for Documentation of a Patient Record,[1] physical therapy records are and must remain a part of the patient's medical records. Included could be any or all of the following:

1. initial evaluations
2. progress notes
3. treatment plans
4. treatment goals
5. discharge status statements
6. attendance records
7. written flow sheets
8. exercise programs

The record should follow the policies and procedures of the facility, with the approval of medical records. It should be completed within an appropriate time frame (established by the facility) and done at a minimum of one time per week. Initial evaluations, progress notes, treatment plans, and discharge statements should be signed with full name and title by the appropriate person and dated (month, day, year) in ink. Documentation may be typed or handwritten with errors corrected and signed. Entries should be factual, based on observation, patient's subjective reports, and crucial behavioral incidents. The initial evaluation is performed, documented, dated, and signed by the registered physical therapist who performed it or, if performed by a student, is cosigned by

the responsible registered physical therapist.[1] The initial note should contain the following:[1] mode of transportation to the department, diagnosis and onset, problems, precautions, physical status, functional status, statement of behavioral status, and goals. Treatment plans are based on the order or on the evaluation and must include the method, frequency, duration, modality, written exercise programs, and long-term goals. Progress notes include goal changes, treatment changes, and changes in patient's status. Included in the discharge status statement is the patient's physical, functional, and mental status as compared to the initial evaluation note, and the discharge program (home program) showing the recipient and its disposition.[2]

There are significant differences between the medical-based versus the educational-based treatment model. When working under a medical model, the therapy goals are primary, intensive direct goals. When working under an educational-based model, the therapy goals are secondary to the educational process as a "related service," and the educational goals are primary. In either case, basic concepts of documentation facilitate communication between disciplines and validate the appropriateness of the program.[6,9,11]

The school record is comprised of: assessments, progress notes, Individual Educational Plans, Individualized Family Service Plans, flow sheets, attendance logs, and reports. The basic concepts of documentation, whether in a medical or educational setting, are similar with the important single factor being an ability of the record to meet the requirements of the facility or district

as well as the requirements of third-party payers. Once this is done in a clear and concise manner, professional accountability will be achieved.[9,11]

CHAPTER IV

DISCUSSION

Documentation, whether in a clinical or educational setting, is far too important a topic to pass over lightly.[6] Physical therapists need documentation in order to establish a baseline during the initial evaluation/assessment. This documentation serves to substantiate a need for future care/services by identifying specific goals which will reflect the outcome of physical therapy intervention. Such documentation must be clear and legible in order to allow other physical therapists, payers, and clinicians from other disciplines to easily obtain necessary information. Compliance with the APTA Standards of Practice and knowledgeability about documentation regulations of third party payers is of utmost importance.[9]

As outlined in rule number V. "Guidelines for Documentation of a Patient Record" by the Quality Assurance Committee of the North Dakota Physical Therapy Association, physical therapy records are a part of the patient's medical records and should be retained with them.[5] They may contain any or all of the following:

Initial Evaluations

Progress Notes

Treatment Plans and Goals

Discharge Status Statements

Attendance Records

Flow Sheets

Exercise Programs[5]

All documentation should follow the policies and procedures of the facility where the evaluation/assessment takes place, with all forms and reports being approved by the medical record approving body of the facility.[1] Documentation must be completed within an appropriate time frame, reflect the patient's condition or conditions, and specify the type of treatment facility and/or setting. Unless otherwise stated by department policies, documentation should be accomplished at a minimum of once per week. Initial evaluations, progress notes, treatment plans, and discharge status statements should be signed in ink, with the full name and title, by the responsible person. When students are involved in documentation, the title Student Physical Therapist (SPT) is used, and the note is co-signed by the registered physical therapist (PT). Documentation may be handwritten or typed. In all cases, the physical therapist is responsible for content. Errors must be corrected and signed. All entries in the medical record should be factual, based on observation, based on subjective reports, and significant behavioral incidents.[1]

The primary focus of the physical therapy curriculum is clinically based. It is from this point of view that this discussion begins.

In the clinical setting, betterment of patient care is the primary purpose of documentation, with all other considerations being secondary.[8] A large number of professionals may be involved in the care of any given patient. In order to coordinate the various aspects of patient care, a high level of communication must exist among the professionals concerned. Thus, documentation becomes an essential function of health care professionals[2], allowing the highest level of patient care to be given at all times. When this has been done, those caring for the patient and providing family support will know: (1) what has been determined about the patient's condition; (2) identified medical problems, (3) goals of treatment; (4) treatment strategies; (5) patient response to treatment; and (6) rationale for stated goals and treatment. Without this information, initial patient status and patient progress is difficult to monitor, coordination of patient care is lost, quality assurance cannot be adequately performed, and, importantly, reimbursement by third party payers may be lost.[2]

Weed introduced a Problem Oriented Medical Record (POMR) System to facilitate patient care by standardizing a medical record format.[2,11] If all departments in a facility adopt the same method of recordkeeping, communication among professionals is greatly simplified.

A POMR is comprised of the following:

1. Data base
2. Problem list
3. Initial, progress, and discharge notes

Each medical record outlines:

1. Patient's medical history
2. Medical findings of signs, symptoms, and tests
3. Patient's problems based on evaluation of signs, symptoms, and test results
4. Treatment goals
5. Methods of treatment
6. Patient's response to treatment

Implementation of the POMR System allows audit for peer review, including quality assurance.

A SOAP note format is the usual format used for medical chart notes written by health care professionals using the POMR System. S.O.A.P. stands for: Subjective, Objective, Assessment, and Plan.[2,12]

According to Kettenbach,[2] the purpose of documentation is to:

1. Record patient care (SOAP notes are legal documents)
2. Communicate valuable information with physician and other health care professionals, clearly stating goals and current level of function
3. Influence third party payers
4. Provide information for chart review
5. Provide structured problem solving for patient care
6. Provide quality assurance
7. Provide scientific base for research

A Problem Oriented Medical Record begins with a stated problem or diagnosis. This is follows by "S" or subjective information about the patient obtained by patient interview or interview of a family member. This can include information related to the patient's history, complaints, home situations, and goals. Next comes the "O" portion which includes objective data which can be classified as signs. "A" represents assessment which identifies factors that are not within normal limits. Thus begins the formation of a problem list which leads to the establishment of goals. Long-term goals indicate the final result of therapy and short-term goals are the intermediate steps to reaching the long-term goals. The final "P" portion is the plan which outlines the treatment plan to achieve the goals.[1,2]

The problem or diagnosis must be stated prior to beginning a SOAP note. This statement can include, among other things, the patient's chief complaint, a diagnosis, or record of loss of function. It may be medical, psychological, or functional in nature. It can include past surgeries affecting the present condition, past conditions or diseases affecting the present condition or treatment, present conditions or diseases affecting the present condition or treatment, test results affecting the present condition, or reports of recent surgery.

Following a statement outlining the problem or diagnosis, the SOAP note proceeds with the relevant Subjective (S) information.[1] When writing the (S) portion of the note, information received by the patient or patient's family

members which is relevant to the present condition is stated. This helps to justify the goals.

Items belong under the subjective heading if: (1) the patient or family member relates the patient's history; (2) the patient or family member tells the therapist something about the lifestyle or home situation; (3) the patient relates his/her emotions or attitudes; (4) the patient states goals; (5) the patient voices a complaint; (6) the patient reports response to treatment; and (7) the patient relates to the therapist anything pertinent to the present condition. A key consideration to remember is that information in "S" is assumed to be from the patient or family member.

In a progress note, the "S" portion of the note is optional, used to update previous information or to state new information. In discharge notes, "S" is part of a complete summary of the patient's status upon discharge. Subjective information assists with goal setting, treatment planning, and deciding when to discontinue treatment.

Following the Subjective notes is the Objective "O" portion of the note which is the part where the measurement results are recorded and objective observations are made. This measurable observable information is used for purposes of treatment planning. The testing procedures are repeatable.[2]

An item belongs under "O" if it: (1) is part of the history taken from the medical record which is relevant to the current problem; (2) is the result of objective measurement (repeatable) used for data base, flow sheets, or charts;

(3) is part of the treatment given with exercises, level of independence, number of repetitions tolerated, positions, and modifications.[2]

To better organize objective data, this information can be divided into categories depending on the patient's diagnosis or deficits.[2] Some examples are as follows:[2]

ROM	UEs	R extremities
strength	LEs	L extremities
sensation	trunk	trunk
transfers	gait	ADL
gait	ADL	gait

Common mistakes made when recording objective data are: (1) failing to state the affected part; (2) failing to put the data into measurable terms; and (3) failing to state the type of measurement.[2]

For interim or progress notes, use only new information obtained during reassessment made during treatment. If important areas remain unchanged, make mention in the note. Include data used for comparison purposes and be sure to include areas mentioned in the short-term goals. When writing discharge notes, patient status may be updated or a complete summary of the patient's condition may be made. It is preferable to have a complete summary.[2]

"O" is a very important section of the record which should be included in every type of note. It should be organized under headings, written in a clear

and concise manner, and should list the results of measurements done by the therapist.

Following the "S" and "O" portions of the note, the next step is the Assessment "A" portion of the record.[1,2] A "problem list" is the initial part of the assessment portion of the note. It summarizes the major problems as listed in "S" and "O" and is a reference point for other health care professionals, third party payers, or other agencies needing an overview of the patient's significant problems.

The problem list includes areas found not to be within normal limits during the subjective interview and objective testing. It is usually recorded in list format. When formulating the problem list: (1) Write "S" and "O"; (2) review "S" and "O," highlighting areas not within normal limits which can be influenced by therapy intervention; (3) prioritize the problems; (4) list the problems in order of significance.

Each problem should be covered by a long-term goal. When writing interim notes only list new problems, a resolved problem, or make reference to a present problem. When writing the discharge summary, it should always be noted if a problem has been resolved or still exists. The problem list is an important part of the patient care plan which involves judgment and forms the basis for goal setting.[2]

Long-term goals is the next phase of the assessment process. Setting long-term goals is that part of assessment which states the expected final

outcome. Goals are written for a variety of reasons. They allow for treatment planning to meet specific needs; they prioritize treatment and measure its effectiveness; they serve as a monitor for cost effectiveness for third party payment; and they communicate patient goals to other health care professionals.[2]

There are four elements of writing a good goal:[2]

1. **Audience** (who)
2. **Behavior** (what)
3. **Condition** (position, equipment)
4. **Degree** (distance, repetitions, ROM, strength, expected improvement)

The **audience** is the patient, family member, or patient and family member and the goals are patient oriented.

The **behavior** is a functional behavior that can be measured or described accurately and is stated with an action verb.

The **condition** describes the circumstances under which the behavior must be accomplished.

Degree includes a minimal number, degree of, proportion, limitation, or distinguishing features for achieving success.

The goal must be realistic, measurable, or observable within a specific time span which is expressed in functional terms. Long-term goals can be revised if the patient's condition deteriorates, improves, or if the time span is

not appropriate. In interim notes, the long-term goals are not mentioned unless goals are achieved or need revision.[2] When writing discharge summaries, long-term goals are listed with current short-term goals. Short-term goals are, simply stated, the interim steps toward achieving long-term goals. The treatment is designed to achieve the short-term goals and the short-term goals help guide the immediate treatment plan. They should be reviewed periodically and reset to help measure progress.[2] Short-term goals are objectives requiring the same four elements (audience, behavior, condition, and degree) mentioned for long-term goals. To state them in functional terms requires the addition of a final phrase.[2] For example:

A. Greg will

B. crawl in four point

C. with assist of one for reciprocal LE movement

D. 15' per trial in 2:3 trials

* to prepare him for eventual gait training.

Short-term goals are seldom written in functional terms. Additionally, this process is a good means of notifying third party payers of the reason for the goal. When stated clearly, it communicates the purpose of the treatment. The time span varies with the diagnosis and condition. Short-term goals must be revised periodically when the time period has passed or the goal has been met. They are also listed in order of priority.[2] Interim notes refer to the short-term

goals, setting new ones if not achieved. Discharge notes comment on the most recent short-term goals and their status with emphasis on the long-term goals.[2]

The summary portion of "A" pinpoints inconsistencies between "S" and "O." This summary provides justification for the goals set, the treatment plan, and/or the clarification of the problem. It includes a discussion of the patient's progress in therapy, his/her rehabilitation potential, any difficulty in obtaining information, suggestions for further testing or treatment needed, or, finally, any other unusual or significant factor.[2,12]

The "A" portion of a note is extremely important, justifying what is written in the rest of the note and requiring much professional judgment. This is the most challenging portion of the note for the new practitioner.[2]

Section "P" or Plan refers to plan for treatment. The essential information included under "P" is:[2,12]

1. the frequency of treatment per day or per week
2. treatment to be given
3. for discharge note, where patient is going and the number of times treated.

Other information which may be included under plan is:

4. location of treatment
5. treatment progression
6. plans for assessment or reassessment
7. discharge plans

8. a copy of the home program
9. equipment needs
10. referrals or recommended further treatment.

"P" describes what the patient will receive rather than the reaction to treatment as stated in "O." The treatment plan is set to achieve short-term goals and the aim is towards efficient programming.[2,12]

When recording treatment, some or all of the following factors need to be considered:[2]

Modalities:

- which
- where
- how long
- intensity
- position

Ambulation:

- distance
- level of assistance
- devices
- time
- weight-bearing status
- gait pattern

Exercise:[2]

- extremity or trunk
- type
- repetitions
- position
- equipment used
- modifications
- amount of resistance or weight used
- home programs with:
  - goal statement
  - illustrations
  - position
  - directions
  - repetitions and time of day
  - progression
  - equipment
  - precautions[2]

When writing interim notes, revise the treatment plan as the condition is reassessed and new goals are set, and then mention the revision in the note. When there is no change, "continue with previously described program" can be used.[2]

When writing the discharge note, briefly state the type of treatment completed; e.g., was a home program done? Was any other type of instruction given? Was equipment sold to the patient? Was a referral made? When instruction is performed, record who was instructed, the type of instruction given, and the level of independence. Always included should be the number of times the patient was seen in therapy; if not seen or put on hold, mention why; mention skipped or canceled sessions; to where the patient is discharged; the reason for discharge; and recommendations for follow-up treatment or care.[2]

Under the SOAP approach to documentation, the Plan "P" is the final step in planning for patient care. Initial and interim notes outline the treatment used with the patient while the discharge note gives a summary of treatment, the number of treatments, home programs given, equipment sold, and recommendations for future treatment.[2]

As previously stated, medical records are legal documents and the SOAP note format enhances communication for medical and legal purposes.[12] Furthermore, it facilitates communication with doctors and other health care workers by clearly stating goals and current level of function.[2]

As the role of physical therapy increases in health care so does the cost associated with its services. Physical therapists, as care providers, must be

cognizant of the concerns of the third party payers when it comes to containing costs.[9]

When writing notes for third party payers, the therapist must show an appropriate diagnosis which justifies assessment of the patient's functional level.[2,3] The subjective information must demonstrate a need for therapy, must briefly list the problems associated with it, and must rate the complaints on a scale. Objective measurements must show deficits that require a therapist's care. Baseline measurements are required for goal setting or treatment planning. The patient's orientation to person, place, and task must be described, as well as the ability to participate in therapy. The patient must be reevaluated regularly to reset goals and assess effectiveness of treatment. Third party payers require a reasonable estimate of time for achieving goals.[3] Goals should be focused on the patient and state a specific behavior, special conditions, or equipment required. Deficits should be related to function and a concise problem list should be formulated. Treatment must continue to be justified and progress toward goals must be reported.[3] Under plan "P," the frequency of treatment should be stated, treatment that requires a therapist must be described, and the time spent must be justified.[2,3] All forms must be completed fully, notes should not be written more frequently than required, and preapproval must be acquired prior to continuing beyond the prescribed number of authorized treatments. When the stated therapeutic goals of treatment have been achieved, a home maintenance program must be implemented to

preserve the patient's present level of function and prevent regression of that function.[3]

After the consideration of third party payers, another function of documentation is to provide information for chart review. Department documentation should not only serve as a reinforcement tool for staff but also as a motivational tool. Documentation feedback can be a powerful tool when used to reinforce a desired behavior and coupled with the proper reward.[8]

Effective communication in the form of accurate standardized documentation contributes to the area of quality assurance.[11,12] A critical review of department administrative records displays strengths and weaknesses within the department. Review of quality assurance can be regarded as peer review. When reviewing records for the purpose of quality assurance, the standards used must be the standards of care. A valid audit must include a measurement of the outcome of the patient's treatment as well as the patient's satisfaction.[11]

While the discussion to this point has attempted to relate to documentation in a clinical setting, of equal importance (if applicable) are the requirements for documentation for therapy performed in an educational setting.[9]

Since the passage of the "Bill of Rights" for handicapped children by President Gerald Ford on November 25, 1975 (Public Law 94-142), the focus of physical therapy services in this area has been required to shift from a medical

orientation to an educational orientation. Since 1975, physical therapists (working in an educational setting) are called upon to assess physical dysfunction of children and, additionally, to assist in interdisciplinary planning and implementation of appropriate services to augment the education of handicapped children.[12]

A handicapped child must receive a full individual evaluation prior to placement in special programming.[13] Such an assessment includes all areas related to the disability. Interpretation of the evaluation data, including information from a variety of sources, along with a description of the child's physical condition and adaptive behavior, are documented and considered by a multidisciplinary team. Although the implementation of the Rehabilitation Act requires some changes in the traditional role of the physical therapist, it also requires the formation of new lines of communication and willingness to share on the part of the teachers.[13]

The primary purpose for assessment in the educational setting is to determine a need for services. "Standardized tests" are not always used by physical therapists. Included in the assessment should be: (1) the determination of a developmental motor level; (2) a neuromuscular/musculoskeletal component; and (3) the identification of those functional motor skills affecting the educational program.[11]

Assessment results and recommendations must be documented according to procedures contained in the Individuals with Disabilities Education

Act. Results must be presented in language that is easily understood by parents and the school team, and should be specific to the discipline involved. A staffing is held by the multidisciplinary team to document: (1) the need for support services; (2) the extent of the services; and (3) the frequency of student contacts.[11]

After the completion of the assessment and the identification of the handicapped child, in order to provide an appropriate education for that student, an Individualized Education Plan (IEP) must be developed.[12] Such a plan is developed by a staffing team led by a case manager, and including the pupil's teacher, members of the diagnostic team, one or both parents, the pupil, if appropriate, and other individuals designated by the parents, school district, or director.[11]

Included in the IEP is: (1) a statement of the child's present level of performance; (2) a statement of annual goals including short-term instructional objectives; (3) a statement of the special education and related services to be provided to the child; (4) projected dates for initiation of services and anticipated duration of services; and (5) objective criteria and evaluation procedures and schedules to determine whether short-term objectives are being achieved.[2,14,15]

The primary purpose for documentation of an IEP is for recordkeeping and to facilitate present and future decision-making on behalf of the student.[16]

The IEP is handwritten during the meeting. After completion, copies are made and provided to the team members.[16]

The IEP, unlike the medical record, is not a legally binding document. It is made in "good faith" on the part of those involved in its development for the purpose of achieving its goals and objectives.[13] In order for this to be accomplished, the unique needs of the student must be identified and the process must focus on the student.[15]

For many handicapped students, physical therapy services are a necessary part of their IEP. Therapists are responsible for providing appropriate assessment and intervention strategies, and for developing annual therapy goals and measurable short-term objectives as part of the child's IEP.[15] Although educational programs are quite different from therapy programs, progress can be measured through observation of behavioral change as a means of evaluating effectiveness of treatment in a pediatric setting.[10]

When included in the IEP meeting, the physical therapist must communicate with the parents, teachers, and team members to explain the following: the model of service; goals; objectives; identified personnel to provide the services; and frequency and duration of services.[8] For the aforementioned reason, application of SOAP note format to IEP planning can be very effective. Annual goals are the equivalent of long-term goals with an educational component, and the short-term objectives are the equivalent of the short-term goals.[2]

The local educational agency is responsible for monitoring the development and implementation of the IEP. The chid in the classroom must be monitored for proper positioning, adequate bracing, and specified medication.[14] Documentation in the school setting is essential for good communication and accountability of the therapist's actions. It should always be specific. In the evaluation process, the current physical status and level of motor functioning must be documented so that changes in condition or performance can be measured.

A plan similar to the IEP is implemented for infants and toddlers. This involves an assessment and program development for an Individualized Family Service Plan (IFSP).[6] Similar to an IEP, the IFSP begins with a thorough assessment. When the need for service is identified, the IFSP is written and developed by a multidisciplinary team. It is written yearly and evaluated at six-month intervals.

The IFSP contains:[6] (1) a statement of the present level of physical development; (2) a statement of families' strengths and needs; (3) a listing of long-term goals, short-term objectives, and possible recommended revisions; (4) the type of intervention required with a statement of the frequency, intensity, and service delivery; (5) a proposal for initiation of services and the anticipated duration of such; and (6) the selection of the most relevant team member as case manager.

The writing of progress notes and the keeping of attendance logs is included in the documentation procedures in the educational setting.[6] The frequency of the writing of progress notes as well as documentation of program review is established by each educational agency. Therapists must be accountable for their intervention time as defined in the IEP and for information regarding the pupil's progress.[15]

CHAPTER V

SUMMARY AND CONCLUSIONS

Documentation, whether in a medical or educational setting, is essential for good communication between disciplines and for validation of programming.[2,8,12] In either setting, it establishes a baseline during the assessment phase which substantiates the need for services. Providing the highest level of patient care is of primary importance when it comes to recordkeeping.[11,12] Without proper documentation, initial functional status of the patient, and subsequent progress, is difficult to monitor. This results in poor coordination of patient care and compromise of reimbursement by third party payers.[12]

Physical therapists working either in the clinic or educational settings can benefit from the understanding and implementation of a problem oriented system with use of the SOAP note format. This system simplifies the communication process between departments and disciplines, and facilitates communication between physical therapist and physician.[12]

Adequate documentation enhances communication for medical and legal purposes.[11] It must be precise, concise, legible, and timely. Precise means that measurements and test results must be recorded accurately. Concise

documentation is well organized and clear. Legible notes can be read easily by all team members and timely entries are entered immediately.[12]

Documentation in a school setting is essential for good communication and accountability of the therapist's actions.[2,8] It is of utmost importance to document the current physical status of the student and the level of motor functioning in measurable terms.[8] This is greatly facilitated by the SOAP note format. This format can be applied to IEP planning from the assessment phase through the formulation of long-term goals and short-term objectives.[2]

On March 27, 1993, the pediatric physical therapy group will meet to begin to draw up the recommended GUIDELINES FOR PHYSICAL THERAPY PRACTICE IN AN EDUCATION/SCHOOL SETTING. At that meeting, the following factors will be considered when writing the DOCUMENTATION guidelines:

1) Perform a thorough assessment with a problem oriented format. Keep in mind the necessity of showing a direct relationship between the deficits of the student and his/her ability to perform in the educational setting.
2) Draw up a prioritized listing of need areas and treatment recommendations.
3) Develop annual goals and short-term objectives to help meet the goals. Review and revise these objectives as indicated.

4) Flow sheets are valuable tools to assist in accounting for the therapist's pupil contacts. These should be reviewed on a monthly basis to summarize progress made and allow for revision of short-term objectives.

5) Provide written instructions for the teacher or aide concerning positioning of the student, use of adaptive equipment, a walking or standing program, or any other special instructions which must be carried out by anyone other than the physical therapist.

6) Provide a home program to parents when indicated.

7) When writing goals, always include a functional statement to validate the goal.[18]

8) When communicating with physicians, include the following information: 1) diagnosis; 2) family dynamics, including understanding of diagnosis; 3) movement abnormalities; 4) functional goals; 5) precautions; 6) intensity of programming.[18]

9) When writing on flow sheet or in progress note, always mention: 1) treatment given; 2) student's reaction to treatment; 3) student's tolerance or cooperation; 4) ability to perform the short-term objectives; 5) whether progress is being made.

10) Include attendance log in the student's folder to keep a record of student contacts and reason for missed sessions.

11) Include copies of evaluations from physicians or medical based facilities in the student's educational record.

12) A comprehensive evaluation must be performed every three years and a copy of the report placed in the student's educational record.

13) At the annual review, changes in performance must be accounted for, the plan must be reviewed, and the current level of function must be documented.

14) At termination of services, the current level of performance is documented with recommended follow-up care.

Given the above considerations, it is the intent of the pediatric group to elevate documentation to its rightful place as an essential factor in the delivery of quality care.

APPENDIX A

APPROVED ABBREVIATIONS AND SYMBOLS FOR HOSPITAL USE[2,19]

A:	assessment
AAROM	active assistive range of motion
AC joints	acromioclavicular joints
ac	before meals
ACTH	adrenocorticotrophic hormone
ad lib	as desired
ADL	activities of daily living
adm	admission
AE	above elbow
AFO	ankle foot orthosis
AJ	ankle jerk
AG	antigravity
AIIS	anterior inferior iliac spine
AK	above knee
ALS	amyotrophic lateral sclerosis
am	morning
AMA	against medical advice
AP	anterior-posterior
AROM	active range of motion
ASA	aspirin

ASAP	as soon as possible
ASHD	arteriosclerotic heart disease
ASIS	anterior superior iliac spine
assist	assistance
BE	below elbow
BKF	biofeedback
bid	twice a day
BK	below knee
BM	bowel movement
BP	blood pressure
bpm	beats per minute
BRP	bathroom privileges
B/S	bedside
BUN	bloodurea nitrogen (blood test)
C	centigrade
C_1-C_7	cervical vertebrae
C&S	culture and sensitivity
CA	carcinoma, cancer
CABG	coronary artery bypass graft
CAD	coronary artery disease
cal	calories

CBC	complete blood count
CBS	chronic brain syndrome
CC, C/C	chief complaint
cc	cubic centimeter
CHF	congestive heart failure
cm	centimeter
CNS	central nervous system
c/o	complains of
CO_2	carbon dioxide
COLD	chronic obstructive lung disease
cont	continue
COPD	chronic obstructive pulmonary disease
COTA	certified occupational therapy assistant
CP	cerebral palsy
CPR	cardiopulmonary resuscitation
CSF	cerebrospinal fluid
CV	cardiovascular
CVA	cardiovascular accident
CWI	crutch walking instructions
Cysto	cystoscopic examination
D/C	discontinued or discharged
dept	department

DIP	distal interphalangeal joint
DJD	degenerative joint disease
DM	diabetes mellitus
DO	doctor of osteopathy
DTR	deep tendon reflex
Dx	diagnosis
ECF	extended care facility
EKG	electrocardiogram
EEG	electroencephalogram
EENT	ear, eyes, nose, throat
EMG	electromyogram
E.R.	emergency room
F	fair (muscle strength)
FBS	fasting blood sugar
FH	family history
FLK	funny looking kid
ft	foot, feet
FUO	fever, unknown origin
FWB	full weight bearing
Fx	fracture
G	good (muscle strength)

GB	gallbladder
GI	gastrointestinal
gm	gram
GYN	gynecology
hr	hour
H & H	hematocrit and hemoglobin
H & P	history and physical
HA, H/A	headache
Hb	hemoglobin
HCVD	hypertensive cardiovascular disease
HEENT	head, ear, eyes, nose, throat
Hemi	hemiplegia
HNP	herniated nucleus pulposus
HOB	head of bed
HR	heart rate
hr	hour
hs	at bedtime
ht	height
Ht	hematocrit
Htn	hypertension
hx	history

I & O	intake and output
ICU	intensive care unit
IM	intramuscular
imp	impression
in	inches
IP	inpatient
IPPB	intermittent positive pressure breathing
IR	infrared
IV	intravenous
kcal	kilocalories
kg	kilogram
KJ	knee jerk
KUB	kidney, ureter, bladder
L_1-L_5	lumbar vertebrae
L	left
L	lumbar
lb	pound
LB	low back
LBP	low back pain
L/E	lower extremity
LE	lupus erythematosus

LLL	left lower lobe
LOC	loss of consciousness
LP	lumbar puncture
LS	lumbosacral
LUL	left upper lobe
m	meter
MA	moistaire
MCP	metacarpal phalangeal
MD	muscular dystrophy
MD	medical doctor
MED	minimal erythemal dose
Meds	medications
mg	milligram
MI	myocardial infarction
min	minutes
ml	milliliter
mm	millimeter
MMT	manual muscle test
mo	month
MP	metacarpal phalangeal
MR	mentally retarded
MS	multiple sclerosis

N	normal (muscle strength)
N/A	not applicable
N.H.	nursing home
NDT	neurodevelopmental treatment
neg	negative
noc	at night
NPO	nothing by mouth
NR	normal range
NSR	normal sinus rhythm
NT	not tested
NWB	non weight bearing
O:	objective
OA	osteoarthritis
OB	obstetrics
OBS	organic brain syndrome
od	once daily
OP	outpatient
O.R.	operating room
ORIF	open reduction, internal fixation
OT	occupational therapist, occupational therapy
oz	ounce

P	poor (muscle strength)
P:	plan (treatment plan)
P.A.	physicians assistant
PA	posterior/anterior
para	paraplegia
pc	after meals
PE	pulmonary embolus
per	by/through
per os, p.o.	by mouth
PIP	proximal interphalangeal
PNF	proprioceptive neuromuscular facilitation
PNI	peripheral nerve injury
POG	power of grip
POMR	problem oriented medical record
pos	positive
poss	possible
post-op	after surgery
pre-op	before surgery
PRE	progressive resistive exercise
PROM	passive range of motion
prn	whenever necessary
PSIS	posterior superior iliac spine

PT	physical therapy, physical therapist
Pt	patient
PTA	physical therapist assistant
PTA	prior to admission
PTB	patellar tendon bearing
PVD	peripheral vascular disease
PWB	partial weight bearing
q	every
qd	every day
qh	every hour
qid	four times a day
qn	every night
Quad	quadriplegic
qt	quart
QS	quad sets
R	right
RA	rheumatoid arthritis
RBC	red blood cell count
R.D.	registered dietician
re:	regarding
resp	respiratory

RLL	right lower lobe
RN	registered nurse
R/O	rule out
ROM	range of motion
ROS	review of systems
RROM	resistive range of motion
R.T.	respiratory therapist
RUL	right upper lobe
Rx	treatment, prescription
SACH	solid ankle cushion heel
SAQ	short arc quad
SC joint	sternoclavicular joint
sec	seconds
SED	suberythemal dose
SHLD	shoulder
sig	give as follows
SI	sacroiliac
SLB	short leg brace
SL cast	short leg cast
SLE	systemic lupus erythematosus
SNF	skilled nursing facility
SOAP	subjective, objective, assessment, plan

SOB	shortness of breath
S.P.	status post
SPT	student physical therapist
spec	specimen
stat	immediately
STNR	symmetrical tonic neck reflex
Sx	symptoms
T	trace (muscle strength)
T_1-T_{12}	thoracic vertebrae
tab	tablet
TB	tuberculosis
tbsp	tablespoon
TENS	transcutaneous electrical nerve stimulation
THA	total hip arthroplasty
TIA	transient ischemic attack
tid	three time daily
TIR	treat in room
TKA	total knee arthroplasty
TMJ	temporomandibular joint
TNR	tonic neck reflex
t.o.	telephone order
TPR	temperature, pulse, respiration

tsp	teaspoon
TT	tilt table
TUR	transurethral resection
UA	urine analysis
UE	upper extremity
UMN	upper motor neuron
URI	upper respiratory infection
US	ultrasound
UTI	urinary tract infection
UV	ultraviolet
VC	vital capacity
VD	venereal disease
v.o.	verbal orders
vol	volume
v.s.	vital signs
WB	weight bearing
WBC	white blood cell count
w/c	wheelchair
W/cm^2	watts per square centimeter
wk	week
WNL	within normal limits

w/o	without
WP	whirlpool
wt	weight
x	number of times performed
y/o	years old
yd	yard
yr	year
+1, +2	assistance (1 person, 2 people)
♂	male
♀	female
↓	down, downward, decrease
↑	up, upward, increase
//	parallel, parallel bars
c	with
s	without
p	after
a	before
~	approximately
@	at
∆	change
>	greater than

<	less than
=	equals
+	plus, positive (pos.)
-	minus, negative (neg.)
#	number (#1 = number 1), pounds (5# wt = 5 pound weight)
/	per
%	percent
+, &, etc.	and
<-->	to and from
-->	to, progressing forward, approaching
1	primary
2	secondary, secondary to

APPENDIX B

APPENDIX C

DATE/ UNITS	COMMENTS	GOAL I	GOAL II	GOAL III	GOAL IV
		Greg will maintain his pelvis in neutral in quadruped, during U.E. play, for 30-60" per treat.	Greg will roll in a straight line c̄ tactile and verbal cues for 5-15'	Greg will assume an upright kneeling posture with Mod/Min A and maintain this posture for 30-60" per treat.	Greg will kick reciprocally in supine and prone in the therapeutic pool for 5-10x's. per treat.
11/17/92	Greg returned from Minneapolis following Rhizotomy surgery on 11/4/92. O.P. programming resumes (daily basis - 60' sessions), c̄ two 30' sessions of ther. pool per week. Tx goals will be directed toward: 1) ↑ trunk strength; 2) ↑ prox. stability; 3) facilitation of L.E. dissociation. Approximation & distraction of the spinal column are contraindicated for 3 months post-op. ↓ trunk tone noted during side-sitting activities. Greg tolerated active scooter board activities, a variety of sitting and reaching activities & propelling of hand powered trike. Programming outlined in goals begins on 11/18. Sally Masikko, PT				
11/18/92	From bench sit, kicked ball x5 each foot.	Up to 4 pt, hold ~ 15-20" x3.	rolled ↑ wedge mat c̄ arms overhead.	N/A. Sally Masikko, PT	Reciprocal kicking easier on (R).
11/19/92	↓ Tolerance for lateral reach	4 pt. tolerated and hold for 15-20"	Rolled in barrel, 10' x2.	4 pt. to heel sit in beans.	Sally Masikko, PT
11/20/92	Tolerated variety of sitting postures	↑ tol. for 4 pt. Crawled 3' to scooter board.	Rolled in barrel c̄ cuing for straight line.	N/A Sally Masikko, PT	active assistive kicking tolerated Recip. kick, sup. & prone
11/23/92		Played in 4 pt c̄ 30-40" hold.	Rolled 25' in barrel.	4 pt. to tall kneel @ bean box.	Sally Masikko, PT
11/24/92	Scooter board prone relays tol. well.	Played in 4 pt. c̄ 20-48" holds ↑ treat	N/A. Instead, WB walked to bean box.	Held erect kneeling @ bench. Reached for bean bags c̄ sup @ pelvis.	N/A. Sally Masikko, PT

MR#

over

MEDICAL CENTER REHABILITATION HOSPITAL
University of North Dakota
Grand Forks, North Dakota

NAME: Gregory
NUMBER: 0123496-001-02

CETP PHYSICAL THERAPY PROGRESS NOTE

Side 2 of 2

DATE/ UNITS	COMMENTS	GOAL I Greg will maintain kyphosis in neutral in quadriped, during U.E. play, for 30-60" period. Progress/revised	GOAL II Greg will roll in a straight line c tactile & verbal cues for 5-15' met/dropped	GOAL III Greg will assume an upright kneeling posture c MOA/MIA & maintain for 30-60" period. progress/revised	GOAL IV. Greg will perform reciprocally in supine & prone in the therapeutic pool for 0-10" trial Progress/, cont.
11/25/92		Neutral quadriped maintained, 30" trial.	Rolled 6' x 3 c tactile cues, little bowing	Heel sit → tall kneel c MIA & tactile cues @ bench.	A-A & A. recip. knee flexion/ext & abduct./adduct.
	Sally Masilko, PT				Sally Masilko, PT
11/26/92	Thanksgiving	Holiday - no P.T.			
11/27/92	Scooterboard recreational. well	Held 4 pt. on mat & in beam for 30-60".	Rolled in barrel c cuing for straight line	Heel sit to tall kneel c tactile cues	Kickball. Gal. AA & A recip kick Sally Masilko, PT
11/30/92	Stood @ sandbox c pelvis and legs stabilized.	Quadriped activities tolerated well.	Rolled on mat with less.	Tall kneeling @ bench, 15-30" trial c MIA.	Sally Masilko, PT
11/30/92	Summary: Greg was present for all 9 scheduled sessions of direct P.T. services for now. Due to excellent family support & motivation, he is progressing well in all areas. Goal I is being revised to include reciprocal crawling. Goal II was met & dropped as a specific goal. A new goal is written in its place for independent steering of the hand powered tube). Goal III is being revised to further tolerance for tall kneeling. Goal IV will continue to remain on Greg's program. Progress will be slow in this area. Greg will continue to received daily (5x/wk) programming for 60 min. sessions. Frequency will be downgraded following Rhizotomy clinic in Jan. 93. Sally Masilko, PT				

APPENDIX D

GOAL WRITING COMPARISON

CLINICAL AND EDUCATIONAL

CLINICAL: 3-year-old patient post Selective Posterior Rhizotomy surgery

Long-term Goals:

1) Greg will transition independently into and out of his wheelchair 75% of the time.
2) Greg will crawl independently in quadriped with a reciprocal pattern and open fingers, 50% of the time.

Short-term Goals:

1) Greg will roll in a straight line with tactile and verbal cues for 5-15 feet.
2) Greg will assume an upright kneeling posture with moderate to minimal assist and maintain this posture for 30-60 seconds per trial.
3) Greg will kick reciprocally in supine and prone in the therapeutic pool for 0-10 seconds.
4) Greg will maintain his pelvis in neutral in quadriped, during upper extremity play, for 30-60 seconds per trial.

EDUCATIONAL: 3-year-old student entering placement in a handicapped pre-school program.

Annual Goals:

1) Greg's independent means of mobility within the classroom setting will be to crawl in 4-point with a reciprocal pattern with verbal cues only.
2) Greg will transition from tailor-sit to side-sit to either side independently in the classroom setting and maintain an erect sitting posture throughout circle time.

Short-term Objectives:

1) Greg will bench sit in the classroom with lower extremity stability with tactile cues given at pelvis, while participating in an upper extremity activity.
2) Greg will transition independently from 4 point to tall kneeling while transferring from the floor to a small classroom chair.
3) Greg will stand erect at the table with support given at the pelvis for 5 minutes while participating in a classroom activity.

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