Documentation Types

Evaluation

Comprehensive: Capture all relevant patient information, including medical history, current functional status, and specific goals.

Objective Measurements: Use objective and subjective assessments to quantify baseline function to track progress (or declines) over time.

Progress Note

Clear Documentation: Use clear and concise documentation of treatment sessions, including interventions performed, patient responses, and any change in status or goals.

Objective Reporting: Use objective language and measurable outcomes to describe progress and demonstrate treatment effectiveness.

Daily Note

Detail-Oriented: Attention to detail, including specific exercises performed, repetitions, sets, and any modifications made based on patient response.

Observational Skills: Develop strong observation skills to accurately assess patient responses to treatments.

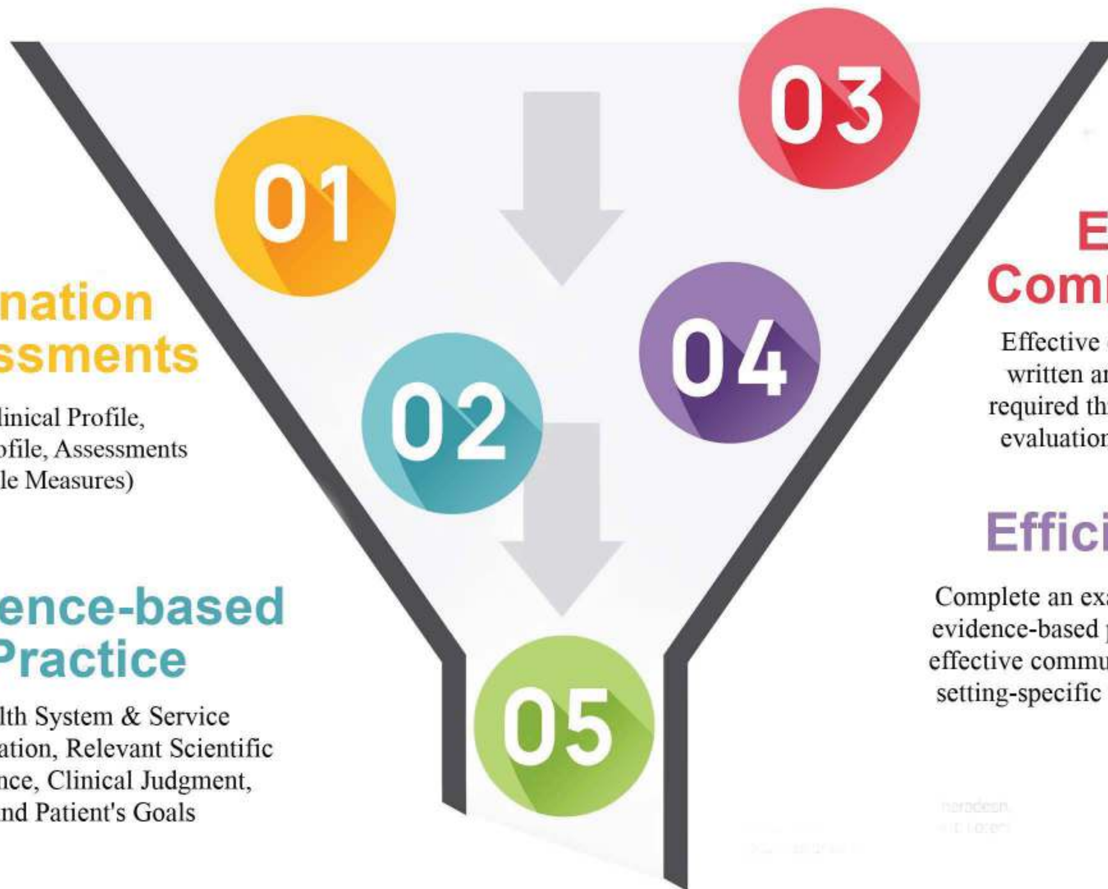
Communication with Team: Update healthcare team of any significant changes or response to treatment

Discharge Note

Goal Achievement: Summarize patient progress and goal achievement in the discharge note, including functional gains, improvements in quality of life, and any remaining deficits.

Education and Home Programs: Provide clear instructions for HEPs, adaptive strategies, and tips for follow-up care to support continuity of care.

Evaluation Process



Examination & Assessments

Interview, Clinical Profile, Occupational Profile, Assessments (Quantifiable Measures)

Evidence-based Practice

Health System & Service Organization, Relevant Scientific Evidence, Clinical Judgment, and Patient's Goals

Effective Communication

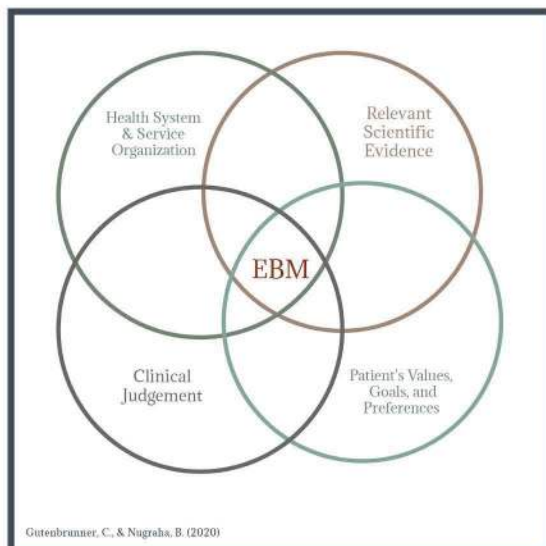
Effective communication using written and verbal mediums is required throughout examination, evaluation, and documentation.

Efficiency

Complete an examination using evidence-based practice through effective communication under a setting-specific time constraint.

Integrative Explanation

Combine 1-4 to produce an integrative explaination and plan



Clinical Profile & Occupational Profile

Occupational Therapy Practitioners combine both profiles to maintain a holistic vantage point in the rehabilitation process.

Clinical Profile

Demographic Information

Medical History

Social History

Functional Limitations

Rehabilitation History

Imaging and Diagnostic Reports

Clinical Treatment Plan

Physican Notes

Discharge Planning

Occupational Profile

Occupational History

Occupational Roles and Responsibilities

Occupational Performance Patterns

Performance Skills

Values and Beliefs

Environmental Factors

Personal Factors

Support Systems

Perspectives

Collaborative Goal Setting

What is a Clinical Profile?

1. Demographic Information: Patient's name, age, gender, contact information, and other relevant personal details.

2. Medical History: Past and current medical conditions, diagnoses, surgeries, allergies, and medications.

3. Occupational History: Patient's work history, including job demands, exposure to occupational hazards, and any previous occupational therapy involvement.

4. Social History: Patient's living situation, family dynamics, support systems, cultural background, and social activities.

5. Functional Limitations: Assessments and reports of physical, cognitive, and psychosocial limitations affecting daily activities and participation.

6. Rehabilitation History: Previous therapy interventions, treatments, and outcomes.

7. Imaging and Diagnostic Reports: Radiology reports, laboratory results, and other diagnostic findings.

8. Treatment Plan: Current treatment goals, interventions, and progress notes.

9. Physician Notes: Relevant physician assessments recommendations and medical management plans.

10. Discharge Planning: Plans for other healthcare professionals, and recommendations for ongoing therapy or support.

What is a Occupational Profile?

1. Client's Occupational History: Detailed information about the client's past and present occupations, roles, and routines.

2. Occupational Roles and Responsibilities: Description of the client's roles within the family, workplace, and community, and the expectations associated with those roles.

3. Occupational Performance Patterns: Evaluation of the client's habits, routines, and rituals that influence their daily occupations.

4. Performance Skills: Assessment of the client's abilities in various performance areas, such as motor skills, sensory processing, cognitive skills, and emotional regulation.

5. Client's Values and Beliefs: Understanding the client's personal values, beliefs, interests, and goals related to their occupations.

6. Environmental Factors: Identification of the physical, social, and cultural aspects of the client's environment that impact their occupational performance.

7. Personal Factors: Consideration of the client's personality traits, coping strategies, resilience, motivation, and other personal attributes.

8. Client's Support Systems: Assessment of the client's social support networks, relationships, and resources available to facilitate their occupational engagement.

9. Client's Perspectives: Exploration of the client's subjective experience, challenges, barriers, and motivations related to their occupations.

10. Collaborative Goal Setting: Establishing client-centered goals and priorities for intervention based on the client's preferences, values, and identified areas of concern.

ADRD Examination Considerations

Medical Chart Review (This resource is not inclusive)

Tip: Use keywords and phrases (K/P) to launch your research and search inquiries when preparing for treatments / managing the plan of care.

Diagnosis and Progression:

K/P: Alzheimer's disease, dementia, cognitive impairment, memory loss, cognitive decline, neurodegenerative disorder; "Diagnosis of dementia," "Progression of cognitive decline," "Baseline cognitive assessment."
Why? It is important to identify the patient's primary diagnosis, track the progression of cognitive decline over time, and establish a baseline for functional status and cognitive abilities.

Medication History:

K/P: Cholinesterase inhibitors (e.g., Donepezil, Rivastigmine), NMDA receptor antagonists (e.g., Memantine), psychotropic medications; "Medications for dementia management," "Side effects of dementia medications."
Why? Crucial for assessing the effectiveness of pharmacological interventions for managing cognitive symptoms, as well as potential side effects or interactions that may impact therapy outcomes.

Functional Status:

K/P: Activities of daily living (ADLs), instrumental activities of daily living (IADLs), mobility, independence, "Functional assessment," "Assistance required for ADLs," "Mobility limitations."
Why? Provides insight into their level of independence, assistance needs, and potential barriers to participation in therapy activities.

Behavioral and Psychological Symptoms:

Keywords: Agitation, aggression, wandering, hallucinations, delusions, depression, anxiety.
Phrases: "Behavioral symptoms of dementia," "Management of behavioral disturbances."
Why? Helps anticipate potential challenges during therapy sessions and develop strategies for managing or addressing these symptoms to optimize engagement and participation.

Caregiver Support:

K/P: Caregiver burden, caregiver stress, caregiver support services, caregiver education,"Involvement of caregiver," "Support systems for caregivers."
Why? Essential for developing collaborative care plans, providing education and resources, and promoting caregiver well-being,

Safety Concerns:

K/P: Fall risk, wandering risk, medication management, home safety, "Safety assessment," "Fall prevention strategies," "Wandering prevention."
Why? Essential to mitigate risks associated with mobility limitations, fall hazards, medication management, and wandering behavior, thus promoting a safe therapeutic environment and reducing the risk of adverse events.

Risk Factors and Comorbidities:

K/P: Hypertension, diabetes, cardiovascular disease, stroke history, "Medical comorbidities," "Risk factors for cognitive decline."
Why? Allows for a comprehensive assessment of their health status and consideration of potential contributors to cognitive impairment.

ADRD Examination Considerations

Initial Interaction, Medical Chart Review Data Collection

3 Important Elements:

Initial Interaction and Interview - Soft Clinical Skills

Medical Chart Review - General Observations and Keywords or Phrases

Data Collection - Assessments

Initial Interaction and Interview - Soft Clinical Skills

We use soft clinical skills to build rapport with our clients (patient and caregiver). These soft clinical skills are specifically important for those who are traveling through a journey of dementia or cognitive impairment because of the complexities and multi-system impact of these diagnoses.

Communication: Simplify language and use clear, concise sentences. Speak slowly and allow extra time for comprehension. Use visual aids or gestures to support verbal communication.

Empathy: Be patient and understanding, the patient and caregiver may experience frustration or confusion. Validate their emotions and provide reassurance.

Non-verbal communication: Maintain gentle eye contact and use facial expressions that convey warmth and understanding. Be aware of the patient's body language for cues about how they are feeling.

Professionalism: Maintain a calm and reassuring demeanor, even in challenging situations. Respect the dignity and privacy of the patient and caregiver at all times.

Cultural competence: Understand the cultural background of the patient and caregiver, as cultural factors can influence their beliefs and behaviors related to dementia care.

Respect and dignity: Treat the patient and caregiver with utmost respect and dignity, recognizing their autonomy and individuality despite cognitive impairment.

Empowerment: Involve the caregiver in discussions and decision-making, acknowledging their role as a valuable partner in the care process. Offer support and resources to help them navigate the challenges of caregiving.

Adaptability: Be flexible in your approach, adjusting communication strategies and care techniques based on the unique needs and abilities of the patient with Alzheimer's or dementia.

Patience: Strive for patience and understanding, especially when repetitive behaviors or memory lapses occur. Avoid rushing interactions and allow ample time for the patient to express themselves.

Conflict resolution: Approach conflicts or misunderstandings with patience and empathy. Focus on de-escalating tensions and finding solutions that prioritize the well-being of the patient and caregiver.

ADRD Documentation Considerations

Be Aware of Cognitive Impairments

- Understand the cognitive deficits commonly associated with Alzheimer's disease and dementia, such as memory loss, executive dysfunction, and language impairments

- Adapt documentation to ensure it's straightforward, clear, and repetitive, making it easier for patients and caregivers to understand.

Adapt Communication Strategies

- Utilize communication techniques tailored to the needs of patients, such as using simple language, visual aids, and allowing more time for understanding.

- Ensure documentation reflects these adjusted strategies to make it accessible and clear for everyone involved.

Be Sensitive to Behavioral and Psychological Symptoms:

- Be mindful of the behavioral and psychological symptoms of dementia (BPSD), like agitation, aggression, and hallucinations.

- Document observations of these symptoms, details about interventions tried, and how patients responded to them.

Collaborate with the Healthcare Team:

- Work closely with doctors, nurses, social workers, and other healthcare professionals to provide comprehensive care.

- Ensure documentation supports effective communication and coordination among team members, sharing updates on patient status, treatment plans, and referrals.

Involve Family and Caregivers:

- Recognize the vital role of family and caregivers by including information about caregiver support needs, education provided, and recommendations for managing caregiving challenges in documentation.

- Be aware that family and caregivers will often read the reports you write looking for information and education.

Approach Discharge Planning with Sensitivity

- Consider the unique needs and challenges of both patients and caregivers when preparing discharge plans.

- Offer detailed instructions for post-discharge care, available support services, and resources to help with the transition to home or long-term care settings in documentation.

ADRD Examination Considerations

Data Collection - Assessments

Tip: Choosing the right assessment can be challenging, so it is good to have an understanding of assessments available for specific impairments and how those assessments may help shape your plan of care and future interventions.

Observation →	Apply Clinical Understanding →	Select Assessment
You read that your patient has been diagnosed with Early Onset Alzheimer's Disease	This individual requires a comprehensive cognitive evaluation that addresses executive dysfunction, and impairments of language and communication, visuospatial, and occupational performance.	Dementia Rating Severity Scale Montreal Cognitive Assessment Boston Naming Test Motor Free Visual Perception Test Functional Activities Questionnaire
Your patient reports having difficulty switching their attention between multiple things happening.	This individual may have attention and information processing speed deficits resulting in difficulty shifting focus between tasks or stimuli, maintaining attention in the face of distractions, and switching attention rapidly.	Trail Making Test (A & B) Stroop Test Digit Span Test
Your patient who has been diagnosed with Lewy Body Dementia scored WNL on the cognitive screen, but you visually observed slow movement and shuffling steps when they walked in.	Based on the pathogenesis and symptom profile of LBD, though cognitive screen is WNL, the individual is experiencing possible bradykinesia and gait ditrubances.	Timed Up and Go (TUG) test Berg Balance Scale Lewy Body Composite Risk Score
Your patient reports that they have always been able to remember things like grocery lists, but now they get to the store and completely forget the items on their list.	This individual expresses deficits in episodic and semantic memory impacting instrumental activities of daily living.	Category Fluency Test: Wechsler Memory Scale (WMS) Trail Making Test (A & B) Lawton Brody IADL Scale