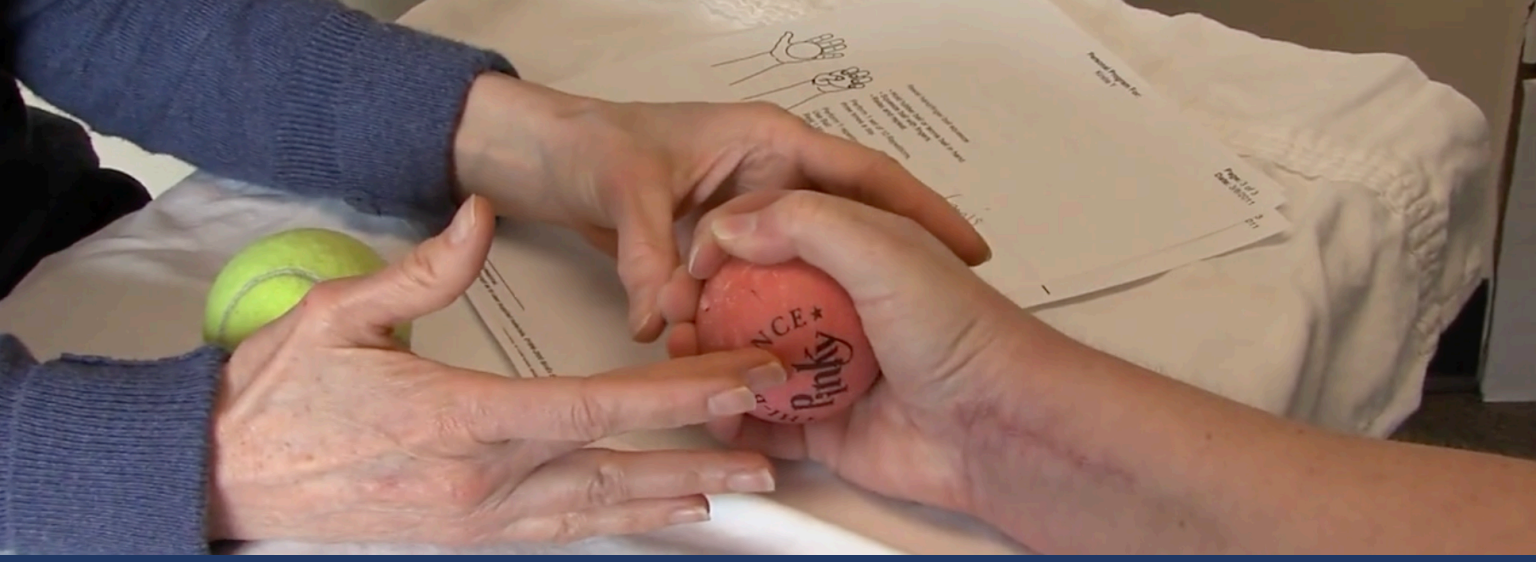


DOCUMENTATION ASSIGNMENT:
Initial Evaluation and Patient Education (Radial Fracture)

Learning objectives:

By the end of this assignment, the successful student will be able to:

1. Document an initial evaluation note for a client s/p radial fracture.
2. Prepare a typed patient education packet for a client s/p radial fracture.
3. Reflect on what should be included in an evaluation.
4. Critically analyze documentation and provide constructive peer feedback.

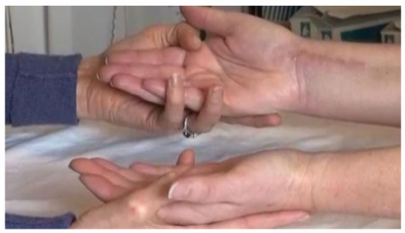
PART 1: Initial Evaluation Note

Review the patient's medical chart on the next page before watching the evaluation videos.
Use the following videos from the ICE Video Library to document your Initial Evaluation Note.
Find the videos by typing the title in the search box. For example, type, "radial fracture part 1" to find the first video.

Radial Fracture, Part 1: Initial Assessment Begins

2:51

It's been eight weeks since she had her surgery for her distal radial fracture. The certified hand therapist (CHT) begins the outpatient treatment session by gathering …



Radial Fracture, Part 2: Initial Observations

4:02

As the therapist begins her exam to determine impairments that will affect hand function, she compares both hands and notes edema, points of pain and limitati…

Radial Fracture, Part 3: Measuring ROM

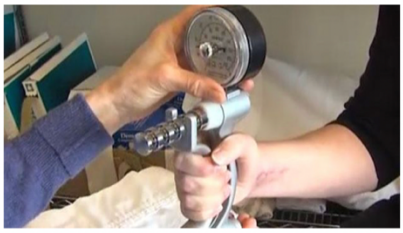
3:49

During the initial assessment, the therapist measures range of motion (ROM) of the wrist, thumb and forearm in order to determine a baseline for treatment. The patient …

Radial Fracture, Part 4: Measuring Edema of the Hand

1:25

Edema of the hand can impact overall hand function following surgery. The therapist measures the swelling of the hand and compares it to the non-involved hand in …



Radial Fracture, Part 5: Measuring Hand Strength

2:10

Eight weeks post surgery, the initial assessment continues with the measurement of hand strength following surgery for fracture of the distal radius. The therapist uses a …

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Chart Review:

Before any evaluation, you should always review the medical chart. Assume you were able to get copies of the following excerpts from the patient's medical chart from her inpatient hospitalization. Only include what you think is pertinent for your evaluation note.

PATIENT IDENTIFICATION SECTION OF MEDICAL CHART

Patient Name: M.U. Essee
Medical Record Number: 987654321
Primary Physician: I.M. Adoctor, MD
Insurance: BCBS
Patient Address: 513 Ralston Court
City: Mount Pleasant State: SC Zip: 29464
Marital Status: Married
DOB: 3-7-1965
Gender: Female
Race: Caucasian

HISTORY SECTION OF MEDICAL CHART

Date: 12/30/2019 **Time**: 22:00

Summary of medical condition: 54yo WF who underwent ORIF to R wrist s/p fall.

Prior medical history: appendectomy, arthritis

Social history: Married and living with husband. Working as an office manager full-time prior to injury. Reports she enjoys cooking and making necklaces for her family and two grandaughters. Reports that she is the primary housekeeper in her home (i.e., laundry, dishes, cooking, cleaning).

Physician's assessment: Clinical evaluation in the ER revealed comminuted fx of the R dominant distal radius with wrist ligament damage, displaced fracture of the ulna. Admitted to the hospital on 12/30 for stabilization of injuries. R radial fracture required pinning for stability.

OPERATION SECTION OF MEDICAL CHART

Date: 1/2/2020 **Time**: 7:30

Procedures: Surgical repair was made to R (dominant) radial fracture using ORIF procedure with placement of internal fixator using screws.

PHYSICIAN'S ORDER SECTION OF MEDICAL CHART

Date: 1/2/2020 **Time**: 18:00
Apply soft splint to R wrist for support. *X I.M.Adoctor, MD*

Date: 1/3/2020 **Time**: 7:00am
Consult OT for evaluation and treatment at 8 weeks post-op. *X I.M.Adoctor, MD*

Tips for Writing Your Evaluation Note:

1. Type your note as if you are about to place it in your patient's chart, including all important general patient information at the top and a signature at the bottom. Occupational profile is required.
2. SOAP format is required. You may use the evaluation formats in your required SOAP textbook as an example, but please note that these are just examples. You may need to add or delete subsections as necessary. You may also refer to your musculoskeletal notes/templates on writing SOAP notes from last semester.
3. Your note must include a **problem list, 4 short term goals (1 week) and 4 long term goals (4 week).**
4. Because the videos do not show the entire evaluation, you will need to **add the information** in the box below to your Evaluation Note.
5. When finished, check yourself: Does your evaluation note meet all criteria listed in the *Guidelines for Documentation of Occupational Therapy* (AOTA, 2018)? Did you meet all of the criteria on the Initial Evaluation Documentation Checklist (last page of this handout)?

ADD THIS ADDITIONAL INFORMATION TO YOUR INITIAL EVALUATION NOTE:

- Evaluation took 45 minutes and took place in an outpatient clinic on Feb 3.
- Patient education took 25 minutes (in addition to the 45 min eval).
- All ROM measurements were AROM (PROM NT).
- All ROM measurements had normal range at the beginning of range (in other words, the client was able to reach 0 degrees).
- LUE was WNL for strength, sensation, and AROM. Include exact measurements for wrist and hand because it will be good to have these for comparison as patient progresses. Assume:
    - AROM L wrist flexion 0-70 degrees (over the top of wrist – only document ONE method)
    - AROM L wrist extension 0-80 degrees (over the top of wrist)
    - AROM L radial deviation 0-20 degrees
    - AROM L ulnar deviation 0- 35 degrees
- BUE AROM and strength were WFL for elbow and shoulder joints.
- RUE sensation – patient was able to identify light touch and pin prick accurately but reports that the sensation is "not normal" and feels "hypersensitive."
- Patient **reported** the following regarding ADL:
    - *"I can bathe and use the toilet by myself, but I use my left hand to reach behind me because my right arm is so hypersensitive. I don't' want it to rub against anything."*
- Therapist **observed** the following ADL:
    - Needed to use two hands to move a pot of water to the stove.
    - Independent in dressing, including buttoning shirt and fastening bra but needing increased time and has to fasten bra in the front instead of back.
    - Patient works at a desk and her right hand is slower to type. Fatigues and needs rest break when using the mouse and typing after about 10 minutes.
    - Independent with walking around in the clinic and sit ⇔ stand, no balance issues noted.
- **Remember that only the things that the therapist OBSERVED should go in the O section. If the patient verbalizes function only, it must be put in the S section.**
- Patient Education: Patient education was provided x 25min for scar mobilization, heat therapy, AROM exercise program, strengthening and edema management, and compression glove use. Patient attended appropriately to instructions and verbalized understanding.

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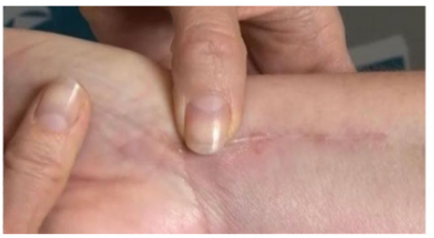
PART 2: Patient Education

Prepare a patient education packet based on the following patient education videos.

Your patient education packet should be compiled in an easy-to-read, a user-friendly format, as if you are about to give it to the patient to take home with her for reference. Pictures are encouraged. Your packet should include all patient education areas addressed by the therapist in the six ICE patient education videos.



Radial Fracture, Patient Education 1: Scar Mobilization

2:14

As she examines the scar at the surgical site, the therapist describes the importance of scar mobilization to reduce adhesions and improve joint mobility. The patien…

Radial Fracture, Patient Education 2: Improving Soft Tissue Elasticity with Heat

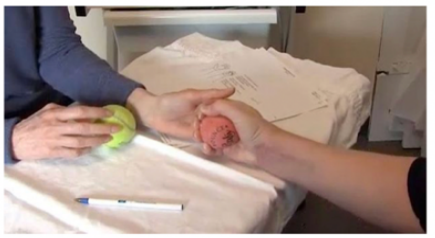
2:07

Eight weeks post surgical repair of a distal radial fracture, the therapist begins her treatment instructing the patient how to use heat to prepare soft tissue for a passive ran…

Radial Fracture, Patient Education 3: AROM Program

7:09

Eight weeks post surgical repair for a distal radial fracture, the therapist instructs the patient on a home program to increase active range of motion of the fingers, hand and…



Radial Fracture, Patient Education 4: Strengthening & Edema

1:08

Weakness and edema are two key problem areas for this patient (eight weeks post radial fracture repair). The therapist introduces a strengthening program for grasp …

Radial Fracture, Patient Education 5: Compression Glove for Edema Control

2:06

A compression glove helps reduce edema of the hand after a surgical repair of a distal radial fracture. The therapist determines whether the glove is the correct si…

Radial Fracture, Patient Education 6: Answering Patient Questions

2:09

As the initial treatment session ends, the patient asks a common question: "How long will this take?" The therapist explains how end range of motion feels and the …

PART 3: Reflection

- What did you like best about this therapist's evaluation, treatment, interaction?
- What would you recommend doing differently?
- List at least 3 other questions you would like to have asked during the subjective interview.

PART 4: Peer Feedback

- **BRING A PAPER COPY OF YOUR EVALUATION NOTE AND EDUCATION PACKET TO LAB ON THE DUE DATE.**
- *In lab,* read a peer's Initial Evaluation Note and Patient Education Packet.
- Give constructive peer feedback regarding strengths and areas for improvement using the Initial Evaluation Documentation Checklist on the following page.

Initial Evaluation Documentation Checklist

Please provide peer feedback by checking areas that need further attention below.
When finished, please **STAPLE THIS TO THE DOCUMENTATION NOTE AND SUBMIT TO INSTRUCTOR IN LAB**.

HEADING:

	Includes a title such as "Initial Occupational Therapy Evaluation."
	Includes patient name, date of birth, medical record number.
	Includes information about the length, location, and purpose of the treatment session (either in the heading or as the first line of the Objective section).
	Includes referring physician and reason for being referred.
	Includes a summary of current medical condition (including precautions and special conditions, such as medical equipment to which patient is connected), PMH, and social history.
	Organized logically and easy to read.

Comments:

OCCUPATIONAL PROFILE:

	Describes the client's occupational history and experiences, patterns of daily living, interests, values and needs. The profile includes information gathered about what is currently important and meaningful to the client and identifies past experiences and interests that may assist the therapist in understanding current issues and problems. (Some of this information may be placed in the heading of the document instead of occupational profile – it only has to be in one location).
	Includes the client's priorities and desired outcomes/goals (client-centered).
	Easy to read and understand.

Comments:

SUBJECTIVE:

	The note includes something significant that the client said about his/her treatment or condition.
	Pain is addressed using pain scale. Pain scale is documented as "#/10." Best to note pain at rest compared to during activity.

Comments:

OBJECTIVE:

	Includes a summary of what was observed, either chronologically or using categories.
	Demonstrates professional, concise, and specific documentation.
	Focuses on the client's response to the treatment provided, rather than on what the therapist did.
	Written from the client's point of view, leaving the therapist out.
	Includes objective, measurable information (specific about assist levels using FIM, cues, etc).
	Does NOT include judgmental statements.
	Uses only standard abbreviations.
	Includes a clear and accurate ROM chart without any blank spaces. (use NT for not tested areas)
	Includes information re: ADLs using appropriate FIM scores. This should include grooming, feeding, dressing, bathing, and toileting.

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	Includes information regarding mobility ("Rolling with min A; OOB not tested due to bedrest.")
	Includes edema and sensory information.
	EXTRA: Includes information about cognition (alert, responding appropriately, following commands, etc). Remember you don't have to do a formal test to OBSERVE cognition. Document exactly what you see but BE OBJECTIVE and without judgment.
	EXTRA: Includes that the "Patient was left in bed with call bell within reach at end of evaluation."

Comments:

ASSESSMENT:

	Includes a statement about client's strengths and a problem list regarding areas that need improvement. Problem list is not too vague nor too lengthy.
	Notes client's potential for rehabilitation.
	Ends with recommendations for OT (e.g., "Client would benefit from continued skilled OT to address…." "Anticipate inpatient rehab needs upon d/c from acute care…").
	Also includes recommendations for adaptive equipment (such as drop arm BSC, walker).
	The information in the A section is supported by information (evidence) in the O section.
	A section is organized, to the point, includes all important points, and is easy to read.

Comments:

PLAN:

	Specifies the frequency and duration of future OT sessions (e.g., "2x/wk for 4 wks").
	EXTRA: Includes methods of treatment anticipated, such as cryotherapy, heat modalities, TENS, compression wraps, therapeutic exercise, functional activities, and education, relaxation techniques for pain, edema management, ADL training in compensatory techniques and/or adaptive equipment.
	Lists 4 short term goals (1 week) and 4 long term goals (4 week).
	Goals have a **time frame** that is written in the same location for all goals (beginning or end).
	Goals are **measurable** (you can easily tell what is needed for a goal to be considered "met"). This includes using a FIM score for all action oriented goals.
	Goals are **realistic** (as best you can tell).
	Goals are **functional** (either written about a functional activity or specifically says it is "in prep for" functional activity)
	Goals make sense, seem client-centered based on the client's comments, and are easy to read.
	Note is signed and dated by the occupational therapy student, including credentials "OTS."

Comments:

The note being evaluated was written by (student name) _____

and reviewed by (peer name) _____.