HACKETTSTOWN MEDICAL CENTER
PHYSICAL/OCCUPATIONAL THERAPY PROCEDURE MANUAL
PROGRESS NOTES

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Effective Date: June, 1995	**Policy No: 5200-2.004/5300-2.004**
Cross Referenced:	**Origin: Physical/Occupational Therapy**
Reviewed Date: 09/12, 03/16	**Authority: Therapy Services Manager**
Revised Date:	**Page: 1 of 1**

POLICY

All patient outpatient visits will be documented in writing in the patient's record. Each outpatient will have a chart that will include the initial and subsequent referrals, initial evaluation, progress notes. Inpatient progress notes are documented in the patients' charts in the HIS system. The patient will be assessed prior to each treatment session for any changes in condition or diagnosis.

Treatment goals will be reassessed and modified for inpatients after 4 visits or at least weekly and for outpatients at least monthly or with any significant change. Any inpatient who is moved to a different nursing unit (i.e.: Med/Surg>Step>Down>ICU) must be re-evaluated for therapy only after obtaining a new order by the referring physician.

PROCEDURE

The following information should be used as a guide for documentation.

For each session, documentation will include:

- Date of treatment
- Time treatment rendered (including start and stop time)
- Treatment rendered and area administered to
- Information that is important to treatment (patient comments, objective findings, response to treatment)
- Signature of caregiver with professional designation and NJ license number.

Progress Notes

The following is the format for progress note documentation (SOAP guidelines):

Subjective Report any information given by the patient. Use quotes; address pain reports here.

Objective Report any changes that pertain to objective information. Maintain accurate records with specific description, e.g., skin/wound color, edema, distance patient ambulated, length of treatment, use of assistive device, strength, ROM, vital signs, therapeutic activities/level performed. Record any discussions with physician.

Assessment Use professional judgment to note improvement or lack thereof. Notations of patient's cognitive, perceptual and emotional/social functioning. Report any limitations to goals, any changes in goals and probable outcome.

Plan Report on plan of care, plans for family teaching, plans to contact physician. Changes in frequency of treatment and recommendations for discharge to be noted.