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Occupational Therapy

Practical guide to assessment and documentation

SEPT 2017

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GUIDANCE FOR OT INTERVENTION.

These are some general guidelines to ensure OT treatments are delivered in a consistent manner across inpatients. If you are unsure about any intervention you should contact your Senior for advice.
Please read and use in conjunction with the credentialisation sheets for each specific piece of equipment.

- Ensure infection control policies are followed.
- Ensure consent is gained from the patient for the activity to be carried out.
- Ensure a clear description of the activity is given to the patient.
- Ensure appropriate moving and handling policies are applied.
- Ensure you are using the appropriate walking aid as determined by physio.
- It is your responsibility to ensure the safety of the patient at all times during the treatment.
- Always give the patient opportunity to complete a task independently. Only give assistance where, a. carers/family would normally assist, or if b. the patient is unable to achieve the task either with verbal prompting or by advising on an alternative method.

Treatments carried out by OTA's must be under the direction of TI or qualified OT.

Before approaching a patient to carry out a treatment, you should;

- Clear with nursing staff that the patient is well enough to participate with OT – you should also check medical notes, kardex and observations chart to be aware of any changes
- Be aware of weight bearing status if applicable
- Be aware of any precautions/contra-indications
- Be aware of any changes to patients diet
- Be aware of need for O2 – refer to OT guidance for O2

Before you start a treatment you should ensure;

- The environment replicates the home situation as closely as possible – this may mean carrying out the treatment in the OT dept.
- Any equipment the patient usually uses at home is used in the treatment (unless this is no longer indicated)
- Ensure you explain clearly the purpose of the equipment and demonstrate how to use the equipment before letting the patient try. Always clean equipment between patients.

Before you start treatment with the patient, you should ensure the patient has;

- The appropriate walking aid (for KA the patient needs to be using the walking they will use on discharge, as determined by Physio).
- Glasses (if appropriate)
- Hearing aid (if appropriate)
- Suitable footwear (use foam slippers provided by ward if patient has no appropriate footwear of their own) – never mobilise a patient barefoot
- Leg bag fitted if catheterised

- Dressing gown/blanket if bringing the patient's off the ward (preferably patients should be dressed if clothes available)
- O2 if indicated – refer to OT Guidance for O2

Wherever you are assessing a patient for equipment, ensure you explain clearly the purpose of the equipment and demonstrate how to use the equipment before letting the patient try. Always clean equipment between patients.

Bed transfer

- Ensure bed set up replicates home situation e.g. same number of pillows, patient assessed getting in/out of same side, any equipment normally used at home is set up/available i.e. bed lever, leg lifter

- Ensure the patient can manage all of the following;
    1. lying to sitting on edge of bed
    2. sit to stand from bed
    3. standing to sitting on edge of bed, lifting legs onto bed and laying on bed
    4. able to turn on bed and achieve their normal sleep position
    5. able to move self up the bed
    6. manage bed clothes i.e. cover self up and remove covers

Toilet transfer

- Ensure any equipment used at home previously is available e.g. RTS, Mowbray, rail
- Ensure the patient can manage all of the following;
    1. standing to sitting on toilet
    2. clothing management i.e. taking down and replacing clothing
    3. able to clean themselves
    4. sitting to standing

Bathing

- Establish which end of the bath the patients taps (and shower if applicable) are to ensure transfer replicates home
- Establish any environmental factors at home which may impact transfer, i.e. shower screen, shower rail, grab rails, previous equipment

Chair

- Establish the height of patients chair/seating at home if the transfer in the hospital is effortful

Personal ADL

- Ensure gloves and apron are worn
- Establish where the patient washes and dresses at home to replicate their usual practice
- Wherever possible, carry out washing at a sink not with a bowl by the bed (unless this is what they would normally do)
- Ask the patient to complete their wash as they would usually do at home
- Note if the patient initiates the activity and completes without prompting
- Ensure patient is able to put on and take off all items of clothing, including footwear
- Give the patient opportunity to do teeth, hair and shave where applicable
- Patients who have a weaker/less mobile side may find it easier to dress the affected side first

Kitchen

- Ensure patient washes hands before embarking on the activity
- Show the patient the layout of the kitchen and the location of appliances and smaller items.
- Establish what type of kettle/cooker the patient normally uses at home
- Describe clearly what you want the patient to do.
- Allow the patient opportunity to initiate and complete the task independently, giving assistance only for those activities they usually receive assistance with at home.
- Establish where the patient would normally consume their drinks and meals at home, and assess their ability to transport meals/drinks if this is what they would normally do.

After the treatment you should

- Feedback to nursing staff
- Record the outcome of the intervention onto therapy manager and place sticker in medical notes.
- OTA's need to feedback to OT/TI who will determine the next stage of treatment

* Please read in conjunction with OT note writing guidance.

Jo Hartley
Lead Senior OT

May 11

PROCEDURE FOR NOTE KEEPING

1. General rules for record keeping

2. OT record keeping

   a. Data Base

   b. Problems

   c. Progress – SOAP notes

   d. Discharge summary

   e. Examples of problem list

   f. Example of SOAP/progress entries

4. Medical note entries

Inpatient Initial Assessment should include:

1. Details of patient's abilities and circumstances prior to admission. This is a subjective view as given by patient or where appropriate carer/relatives.

2. Summary on the third tab should be used to highlight possible areas needing assessments.

NB Ensure explanation of OT role and consent to treatment are recorded in full in the journal (use template).

General Assessment

This is a practical, objective assessment of patient abilities. This should be used as a baseline for the problem list and treatment plan.

Sub sections of general assessment form must not be left blank. Reasons for assessments not observed should be recorded.

Problem Continuation List.

This is exactly what it says – a list of patient problems, identified from initial interview or general assessments. Each problem is numbered and any future reference to the problem in SOAP notes should be prefixed by this number.

Problems should be actual not potential or anticipated.

C. Journal – (SOAP Notes)

These should be related to problems with appropriate number recorded

1. OT records should include an update at least twice weekly recording pt. status, medical plans or d/c plans to explain why active OT intervention is not appropriate/taking place.

The journal entries are written under 4 headings in SOAP format:

Subjective	information from the patient and others – how patient feels about a problem.
Objective	the Occupational Therapist's clinical observations, measurements and/or findings.
Analysis	the Occupational Therapist's professional opinion based on the above findings.
Plan	future plans of action, short term and long term goals/aims, details of planned treatment.

DISCHARGE SUMMARY

Complete tick box summary related to treatment given and condition on discharge.

Remember to complete all treatments entries and stats before completing summary as you will not be able to complete once you have completed discharge summary.

AUDIT

OT notes will be audited every 12 months in accordance with OT/PT department standards.

4. PROCEDURE FOR WRITING IN MEDICAL NOTES – IN-PATIENTS

1) Complete Initial Interview and record in medical notes by placing a sticker in the medical notes. Tick any interventions completed as appropriate. A brief summary of the intervention should be recorded next to the sticker. Ensure date and time recorded and signature, (with name printed underneath), designation and contact number recorded.

2) Place sticker in notes after each intervention and tick relevant interventions. Again, a brief summary of the intervention should be recorded next to the sticker. Ensure date and time recorded and signature, (with name printed underneath), designation and contact number recorded.

3) OTA's to use OTA intervention stickers.

When OT treatment completed, on last entry, state no further OT indicated.

SPLINTS

Record when splint has been fitted and splint form/contact no. issued.

OT Checklists
&
Functional Measurement Rating

OT CHECKLIST
PADLS
Use with functional measurement ratings

1.Did patient remember OT was coming?	
2. Did patient collect own belongings or did you need to assist or prompt ?	
3. Where was it done? Sink/bedside/shower	
4. If walked to location, or around bed space how did patient do?	
5. What level of assistance and/or verbal prompts did patient need to undress self Upper body – Lower body –	
6.What level of assistance and/or verbal prompts did patient need to wash and dry self ? Upper body – Lower body	
7. What level of assistance and/or verbal prompts did patient need to dress self Upper body Lower body Fine motor tasks	
8. What level of assistance did patient need with any grooming tasks/teeth	
9. Did patient sit to stand to complete task. If a stool was required does it need to be of a specific height/type	
10. Did patient comment on their performance ?	

OT CHECKLIST

KITCHEN ASSESSMENT

Use with functional measurement ratings

1. Did patient remember OT was coming?	
2. Was patient able to recall purpose of assessment on arrival at kitchen?	
3. Was patient able to recall where items were after initial instruction?	
4. How did patient mobilise around kitchen	
5. Was patient complete all stages of the task and in the right order	
6. Was patient able to stand for sufficient periods to complete parts of tasks?. If a stool is required does it need to be of a specific height or type	
7. Was patient able to reach all items? (cupboards/fridge)	
8. Was patient able to use appliances appropriately?	
9. Was patient able to grip and handle items?	
10. Was patient able to carry items as required at home?	
11. If patient needed a trolley what height?	
12. Did patient demonstrate an awareness of risk ?	
13. Did patient say anything significant? How did patient feel about their performance? How do they feel that they would manage at home?	

OT CHECKLIST
BED TRANSFER
Use with functional measurement ratings

1. Was patient able to align self with bed in preparation to sitting on bed and stand – sit on bed?	
2. Was patient able to lift legs on bed?	
3. Was patient able to adjust position on bed and get into usual sleep position?	
4. Was patient able to adjust covers whilst on bed?	
5. Was patient able to get from supine/side lying to sitting on edge of bed?	
6. Was patient able to sit – stand from bed?	
7. Did bed need to be of a specific height in order for patient to manage? If so what?	

OT CHECKLIST
BATH BOARD TRANSFER
Use with functional measurement ratings

1. Did patient follow your directions without prompts?	
2. Did patient need any help: Sitting onto board? Getting legs over side of bath? Positioning self on board? Standing up from board	
3. Was patient unsteady at any point?	
4. Was patient short of breath?	
5. Could patient explain in their own words how they would do this safely at home	

IF INCLUDES BATH SEAT:

1. Did patient follow your instructions or need prompts?	
2. Could patient lower self safely onto seat?	
3. Could patient raise self back onto bath board?	
4. Could patient resume bath board transfer?	

OT CHECKLIST
CHAIR TRANSFER
Use with functional measurement ratings

1. Was patient able to prepare to sit-stand from chair? -Move position in seat? - Place feet appropriately?	
2. Was patient able to sit-stand from chair	
3. Did patient use safe technique?	
4. Is patient able to maintain standing balance on standing?	
5. Is patient able to lower self back onto seat safely?	
6. Did chair need to be of a specific height to enable transfer if so what ?	

OT CHECKLIST
TOILET TRANSFER
Use with functional measurement ratings

1. Was patient able to manoeuvre around the toilet successfully to align self with toilet	
2. Was patient able to adjust clothing prior to sitting on toilet	
3. Was patient able to lower self onto toilet	
4. Was patient able to reach for toilet paper and attend to personal hygiene	
5. Was patient able to stand from the toilet, did they use any rails or equipment, and what position and height did equipment need to be	
6. Could patient adjust clothing again, and wash hands	

FUNCTIONAL MEASUREMENT RATINGS

PURPOSE: TO PROMOTE CLEAR AND CONSISTENT DOCUMENTATION OF OT INTERVENTION SO IT IS MEASURABLE AND REPEATABLE BY YOU OR YOUR COLLEAGUES

SAFE TO DISCHARGE:

INDEPENDENT (with 1 assessor)	• Safe and no assistance needed • With or without aids • Can include set-up / environmental assistance and self prompts as appropriate

UNSAFE TO DISCHARGE WITHOUT NECESSARY SUPPORT IN PLACE:

SUPERVISION (WITH 1 ASSESSOR)	• Verbal prompts **<25%** • **NO HANDS ON** • e.g: 'Has the kettle switched off yet?' close at hand for balance or mobility
MINIMAL (WITH1 OR 2 ASSESSORS)	• verbal/physical prompts and/or physical assistance **<25%** of activity • e.g: Assisted with socks and shoes or one limb PADLS transfers with one hand on back to guide to stand instruction for hand placement for transfers prompts needed for initiating up to ½ components of task
MODERATE (WITH 1 OR 2 ASSESSORS)	• verbal/physical prompts and/or physical assistance **≤26 - 50%** of activity • e.g: assisted with top ½ or bottom ½ during PADLS transfers with physical effort by OT(s) assist to stand with hands(s) on back or bottom for support and application of effort. Prompts needed to initiate up to ½ components of task
MAXIMUM (WITH 1 OR 2 ASSESSORS)	• verbal/physical prompts and/or physical assistance **≤51 - 75%** of activity • e.g: assisted with 3 of 4 limbs during PADLS patient would be unable to stand, transfer, or step around without physical assistance prompts needed to initiate up to 75% of components of task
DEPENDENT (WITH 1 OR 2 ASSESSORS)	• verbal/physical prompts and/or physical assistance **>75%** of activity • e.g: patient can only wash hands and face patient is unable to weight bear on legs so needs to be hoisted prompts are needed to initiate every component if task

EXAMPLES OF WRITTEN OUTCOMES:

INCORRECT	CORRECT
Independent with supervision for bed mobility	Supervision of 1 for bed mobility lying to sitting
Patient needed some help with lower ½ PADLS	Minimal assist for lower ½ PADLS

NOTES:

- TRANSFERS: each part of the transfer can be measured
  e.g.: supervision of 1 for transfers lying to sitting and mod assist of 2 to stand
- **ALWAYS INDICATE: 1 OR 2 (OR MORE) ASSESSORS INVOLVED IN ASSISTED ACTIVITY**
- The above ratings are subject to clinical reasoning skills. If there are 2 of you present for supervision of balance and there is no hands on then you must document @supervision of 2'
- If one of you puts a hand on the patients back to steady them and the other is needed for balance then document 'minimal assistance of 1 and supervision of 1'
- If there are 2 of you but clearly the patient would not have needed the second person then document it as its best outcome e.g.: ' supervision of

APPENDICES

Chesterfield Royal Hospital

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OCCUPATIONAL THERAPY ABBREVIATIONS LIST

Chesterfield & Royal Hospital NHS Trust
Occupational Therapy Service

ABBREVIATIONS LIST

AAT	Admission Avoidance Team
Abd	Abduction
ACT	Adult Care Team
Add	Adduction
ADL	Activities of daily living
AF	Atrial fibrillation
AKA	Above knee amputation
Appt	Appointment
AS	Ankylosing spondylitis
ASAP	As soon as possible
AROM	Active range of movement
Ax	Assessment
BA	Bath assessment / bath practise
BB	Bath board
BD	2 x daily
BKA	Below knee amputation
BIM	Best Interest Meeting
BP	Blood pressure
↑BP	Increased blood pressure
BS	Bath seat
C/O	Complains of
Ca	Cancer
CABG	Coronary artery bypass graft
CBD	Continual bladder drainage
CCF	Congestive cardiac failure
CCU	Coronary Care Unit
CDU	Clinical Decisions Unit
CMCJ	Carpometacarpophalangeal joint
CNS	Central nervous system
CNT	Clinical navigation team
COPD	Chronic obstructive pulmonary disease
Cont	Continue/d
CPN	Community psychiatric nurse
CRPS	Chronic Regional Pain Syndrome
CRT	Community Rehab Team
CT(S)	Carpal Tunnel (Syndrome)
CVA	Cerebral vascular disease / accident
D/W	Discussed with
DADL	Domestic activities of daily living
DART	Dales Assessment & Rehab Team
DC	Discharge
DCS	Dynamic condylar screw
DES	Disability employment service
DH	Drug history
DHS	Dynamic hip screw
DIPj	Distal Interphalangeal Joint
DPM	Discharge planning meeting
DN	District Nurse
DNA	Did not attend
DOB	Date of Birth
DP	Dressing practise
DSC	Disablement services Centre
D2A	Discharge To Assess
ED	Emergency Department
EDC	Extensor digitorum communis
EDD	Estimated Discharge date
EMU	Emergency Medical Unit
EPL (B)	Extensor pollicis longus (brevis)
ER	Easy reach
EUA	Examination under anaesthetic
Ex Fix	External fixation
Exs	Exercises
Ext	Extension
FDP	Flexor digitorum profundus
FDS	Flexor digitorum superficialis
FDSp	Foot drop splint
FFD	Fixed flexion deformity
FH	Family history
Fib	Fibula
FPL	Flexor pollicis longus
FWB	Full weight bearing
FSTF	Free standing toilet frame
GA	General anaesthetic
GCH	Gas Central Heating
GP	General practitioner
HA	Home assessment
HAP	Hospital Acquired Pnuemonia
HCA	Home Care Aide
HDU	High Dependency Unit
HFH	Home from hospital
HH	Home Help
HO	History of
HPC	History of present condition
HTG	Hand therapy group

HV	Home Visit
ICS	Integrated Care Services
ICT	Intermediate Care Team
IDDM	Insulin Dependent Diabetes Mellitis
II	Initial Interview
In Tx	Initial Transfers
IM	Intramuscular
Indep	Independent
IPjt	Interphalangeal joint
ISQ	In status quo
ITO	Intratheacal opioid
ITU	Intensive Therapy Unit
IV	Intravenous
IVAB	Intravenous antibiotics
IVI	Intravenous infusion
jt	Joint
KA	Kitchen assessment
L	Left
LA	Local anaesthetic
LHSH	Long handled shoe horn
LL	Lower limb
LLA	Lower limb amputation
Ltd	Limited
LTOT	Long term oxygen therapy
LVF	Left ventricular failure
LWS	Light Workshop
MC	Metacarpal
MCPJ	Metacarpal phalangeal joint
MDT	Multi-disciplinary team
Mets	Metastasis
MFFD	Medically fit for discharge
MSFT	Medically stable for transfer
MI	Myocardial infarction
Mins	Minutes
Mobs	Mobilisations
Movt	Movement
MOW	Meals on wheels
MS	Multiple sclerosis
MSU	Midstream specimen or urine
MUA	Manipulation under anaesthetic
N/A	Not applicable
NAD	Nothing abnormal detected
NBI	No bony injury
NCS	Nerve conduction studies
Neuro	Neurological/neurology
NG	Nasogastric
NIDDM	Non-insulin dependent diabetes mellitis
NOF	Neck of femur
NP	New patient
NRS	Night resting splint
NWB	Non weight bearin
O/E	On examination
OA	Osteo-arthritis
O/A	On admission
OAB	Oral antibiotics
Obj	Objective
Op	Operation
OPA	Out-patient appointment
OPD	Out-patient department
ORIF	Open reduction and internal fixation
OT	Occupational Therapist
OTA	Occupational Therapy Assistant
OT TI	Occupational Therapy Technical Instructor
PADL	Personal activities of daily living
PCAS	Patient controlled analgesia system.
PIPJ	Proximal interphalangeal joint
PMH	Past medical history
POP	Plaster of Paris
Post op	Post operatively
Pre op	Pre operatively
PROM	Passive range of movement
Prox	Proximal
Pt	Patient
PT	Physiotherapist
PTA	Physiotherapy assistant
PTTI	Physiotherapy Technical Instructor
PVD	Peripheral vascular disease
PWB	Partial weight bearing
Quads	Quadriceps
QDS	4 x daily
R	Right
RA	Rheumatoid arthritis
Re:	Regarding
Resp Rate	Respiratory rate (RR)
ROM	Range of movement
ROS	Removal of sutures
RSD	Reflex sympathetic dystrophy
RTS	Raised toilet seat
RWSB W/ch	Rear wheel set back
Rx	Treatment
SH	Social history
SLR	Straight leg raise
SOB	Shortness of breath
SOBOE	Shortness of breath on exertion
SOBAR	Shortness of breath at rest
SOF	Shaft of Femur
SOH	Shaft of Humerus

SLT	Speech and Language Therapist
S/N	Staff nurse
SS	Social Services
SW	Social Worker

T/C	Telephone call
TA	Tendoachilles
TCI	To come in
TDS	3 x daily
THR	Total hip replacement
Tib	Tibia
TKR	Total knee replacement
TTO	Drugs to take home
Tx	Transfer
UL	Upper limb
UTA	Unable to attend
W/ch	Wheelchair
W/E	Weekend
WB	Weight-bearing
Wk	Week
Wt	Weight
XOA	X-ray on arrival
ZF	Zimmer frame

SLT	Speech and Language Therapist
S/N	Staff nurse
SS	Social Services
SW	Social Worker

1°	Primary
2°	Secondary
∴	Therefore
+++	A lot
Δ	Diagnosis
+ve	Positive
-ve	Negative
#	Fracture
1/7	One day
1/12	One month
1/52	One week
→	To or leading to
	With
↑	Upstairs or increase
↓	Downstairs or decrease
?	Query
S	Subjective
O	Objective
A	Analysis
P	Plan