STUDENT ORIENTATION CHECKLIST
Behavioral Health Hospital- Recreational Therapy

Student Name:_____ Date of affiliation: _____

CCCE ORIENTATION

Introduction

___ CCCE Role
__ CI Role
___ Nametag
___ Gait Belt
___ Student Orientation Manual
___ Organizational Structure
___ Midterm/Final Evaluations
___ In-service/Project
___ Permission for References
___ CI Assessment/Facility Assessment

Policy and Procedure

___ Location of Safety, Human Resources, & Admin Manuals
___ Attendance Policy
___ Fire
___ Disaster
___ Code Blue
___ Evacuation procedure
___ Substance Abuse
___ Crisis Intervention Policy
___ Hazardous Spills Policy
___ Student Program Guidelines
__ Social Media Policy

Medical Requirements

___ Health Insurance
___ MMR
___ Diphtheria/Tetanus Booster (10 years)
___ TB Test (3 months)
___ Chicken Pox
___ Hepatitis B or declination
___ Influenza
___ CPR Certification
__ 12 Panel Drug Screen
__ Criminal Background Check

Training Requirements

__ Student and Faculty Core Orientation (online test)

BHH Orientation

Facility:

___ C/A Unit
___ Adults Unit
___ TMS
___ OBS Unit
___Administrative Offices
___ Social Work Suite
___ Pharmacy
___Staff Lounges
___ Restrooms

C/A Unit:

___ Patient Charts
___ Medication Room
___ RN Station
___ Tx team room
___ LRT Office
___ Seclusion Room
___ Patient Library
___ Day Rooms

Adult Unit:

___ Patient Charts
___ Medication Rooms
___RN stations
___Day Rooms
___ Group Rooms
___ Seclusion Rooms

BHH Checklist- CI Orientation:

Introduction:

___ BH Intern Manual
___ Unit Whit Boards
___ Structure of Units
___ Reference Books/Group Resources
___ Location of supplies/Equipment
___ Phone List
___ Seclusion Chair

Documentation:

___Patient Education
___ Group Notes
___ 1:1 Notes
___ Care Plan
___ Tx Team
___ TR Plan
___ H&P (read and r

Student Signature: _____Date: _____

CI Signature: _____ Date: _____

CCCE Signature: _____Date: _____

STUDENT ORIENTATION CHECKLIST

Outpatient Rehabilitation Center

Student Name:_____ Date of affiliation: _____

Introduction

___ CCCE Role
___ CI Role
___ Organizational Structure
___ Services Provided @ OP Centers
___ Nametag
___ Student Orientation Manual
___ Midterm/Final evaluations
___ CI Assessment/Facility Assessment
___ In-service/Project
___ Permission for References

Policies and Procedures

___ Location of Policies/Manuals
___ Student Program Guidelines
___ Social Media Policy
___ Verbal Orders
___ Technician/Support Personnel Duties
___ Call Tree/Inclement Weather Policy
___ Ordering/Issuing DME
___ Fire
___ Natural Disaster
___ Code Blue
___ Hazardous Chemical Spill
___ Evacuation Procedures
___ Crisis Intervention (CIRT)
___ Violent Behavior (Code Gray)

Medical Requirements

___ Health Insurance
___ Immunizations
___ TB test
___ Chicken Pox
___ Hepatitis B or Declination
___ CPR certification
___ MMR
___Diphtheria/Tetanus
___Flu (Oct-March)
__12 Panel Urine Drug Screen
___Criminal Background Check

Training Requirements

___ Student and Faculty Core Orientation

Tour of facility

___ Ingoing/Outgoing Fax Machines
___ Incoming/Outgoing/Interoffice Mail
___ Phones/Phone Use
___ Check In Notification
___ Copy Machines/Fax/Scanner
___ Charting areas
___ Treatment Areas
___ Location of supplies/Equipment
___ First Aid/Emergency Equipment
___ Therapeutic exercise programs/handouts
___ Clean Linen/ Dirty Laundry
___ Microwave/Refrigerators/kitchens
___ Vending Machine/Lounge Area
___ Conference Room
___ Admin Personnel Office Locations
___ Restrooms

Documentation

___ Chart Sequence
___ Computer Documentation: Templates for Evaluations, Renewal and Discharge Summaries
___ Daily Notes
___ Charge Sheets/Charge Codes
___ G-Codes
___ Physician Progress Notes
___ Functional Outcome Tools

Student Signature: _____ Date: _____

CI Signature: _____ Date: _____

CCCE Signature: _____ Date: _____

STUDENT ORIENTATION CHECKLIST
Moses Cone ACUTE

Student Name:_____ Date of affiliation: _____

CCCE ORIENTATION

Introduction
___ CCCE Role
___ CI Role
___ Nametag
___ Gait Belt
___ Student Orientation Manual
___ Organizational Structure
___ Midterm/Final Evaluations
___ In-service/Project
___ Permission for References
___ CI Assessment/Facility Assessment

Facility
___ Elevators (East, Central, West)
___ 5N Ortho Gym
___ Inpatient Rehab
___ AHEC Library
___ Gift Shop
___ Cafeteria/Food Options
__ Exercise Rooms 1st floor/4th floor
__ Security Office (for name badge)

Policy and Procedure
___ Location of Safety, Human Resources, & Admin Manuals
___ Attendance Policy
___ Fire
___ Disaster
___ Code Blue
___ Evacuation procedure
___ Substance Abuse
___ Crisis Intervention Policy
___ Hazardous Spills Policy
___ Student Program Guidelines
__ Social Media Policy

Acute Rehab Services Department
___ Sign-in board
___ Slot for charges
___ Outgoing mail
___ Personal Copies
___ Breakroom/Microwave/Refrigerator
___ Can help/Need help
___ Supervisors' offices
___ Restrooms

Medical Requirements
___ Health Insurance
___ MMR
___ Diphtheria/Tetanus Booster (10 years)
___ TB Test (3 months)
___ Chicken Pox
___ Hepatitis B or declination
___ Influenza
___ CPR Certification
__ 12 Panel Drug Screen
__ Criminal Background Check

Training Requirements
__ Student and Faculty Core Orientation

ACUTE
CI ORIENTATION

Introduction:

___ Structure of chart room & floors
___ Venue recommendations
___ Reference books
___ Weekly student expectation schedule
___ Satellite storage closets
___ Tech Sign Up
___ Message board
___ Copy machine
___ Nursing/tech assignments
___ Patient snacks/supplemental nutrition
___ Ordering/issuing DME
___ Location of supplies/equipment
___ Use of phone/paging
___ Mandatory meetings
___ Phone/beeper list
___ Technician duties
___ Weekend scheduling/staffing
___ Patient labels
___ Admission/discharge lists
___ Crash cart
___ Co-tx philosophy/charging

Documentation:

___ Charges/charge codes/charge sheets
___ Levels of assistance
___ Evaluations
___ Discharges
___ Progress note utilization/goal updates
___ Cancel Notes
___ Patient Education/Care Plan Section
___ Chart sequence
___ Prioritization protocol (weekday/weekend)
___ Logs
___ Exercise/HEP/Exit Care
___ Co signature

Student Signature: _____ Date: _____

CI Signature: _____ Date: _____

CCCE Signature: _____ Date: _____

GAIT BELT RELEASE

I,_____, agree to pay the cost to replace the gait belt issued to me if it is lost, stolen or damaged.

Student Signature: _____ Date: _____

CCCE Signature: _____ Date: _____

STUDENT ORIENTATION CHECKLIST

Wesley Long Acute

Student Name:_____ Date of affiliation: _____

CCCE ORIENTATION

Introduction

___ CCCE Role
__ CI Role
___ Nametag
___ Gait Belt
___ Student Orientation Manual
___ Organizational Structure
___ Midterm/Final Evaluations
___ In-service/Project
___ Permission for References
___ CI Assessment/Facility Assessment

Acute Rehab Services Department

___ Slot for charges
___ Outgoing mail
___ Personal Copies
___ Breakroom/Microwave/Refrigerator
__ Supervisor office
___ Restrooms

Policy and Procedure

___ Location of Safety, Human Resources, & Admin Manuals
___ Attendance Policy
___ Fire
___ Disaster
___ Code Blue
___ Evacuation procedure
___ Substance Abuse
___ Crisis Intervention Policy
___ Hazardous Spills Policy
___ Student Program Guidelines
__ Social Media Policy

Medical Requirements

___ Health Insurance
___ MMR
___ Diphtheria/Tetanus Booster (10 years)
___ TB Test (3 months)
___ Chicken Pox
___ Hepatitis B or declination
___ Influenza
___ CPR Certification
__ 12 Panel Drug Screen
__ Criminal Background Check

Training Requirements

___ Student and Faculty Core Orientation

ACUTE
CI ORIENTATION

Introduction:

___ Structure of chart room & floors
___ Venue recommendations
___ Reference books
___ Weekly student expectation schedule
___ Satellite storage closets
___ Tech Sign Up
___ Message board
___ Copy machine
___ Nursing/tech assignments
___ Patient snacks/supplemental nutrition
___ Ordering/issuing DME
___ Location of supplies/equipment
___ Use of phone/paging
___ Mandatory meetings
___ Phone/beeper list
___ Technician duties
___ Weekend scheduling/staffing
___ Patient labels
___ Admission/discharge lists
___ Crash cart
___ Co-tx philosophy/charging

Documentation:

___ Charges/charge codes/charge sheets
___ Levels of assistance
___ Evaluations
___ Discharges
___ Progress note utilization/goal updates
___ Cancel Notes
___ Patient Education/Care Plan Section
___ Chart sequence
___ Prioritization protocol (weekday/weekend)
___ Logs
___ Exercise/HEP/Exit Care
___ Co signature

Student Signature: _____ Date: _____

CI Signature: _____ Date: _____

CCCE Signature: _____ Date: _____

GAIT BELT RELEASE

I,_____, agree to pay the cost to replace the gait belt issued to me if it is lost, stolen or damaged.

Student Signature: _____ Date: _____

CCCE Signature: _____ Date: _____

STUDENT ORIENTATION CHECKLIST
REHAB

Student Name:_____ Date of affiliation: _____

CCCE ORIENTATION

Introduction

___ CCCE Role
___ CI Role
___ Nametag
___ Student Orientation Manual
___ Organizational Structure
___ Midterm/Final Evaluations
___ In-service/Project
___ Permission for References
___ CI Assessment/Facility Assessment

Facility

___ Elevators (East, Central, West)
___ 5N Ortho Gym
___ Inpatient Rehab
___ AHEC Library
___ Gift Shop
___ Cafeteria/Food Options
___ Exercise Rooms 1st floor & 4th floor
___ Security Office (Name Badge)

Policy and Procedure

___ Location of Safety, Human Resources, & Admin Manuals
___ Attendance Policy
___ Fire
___ Disaster
___ Code Blue
___ Evacuation procedure
___ Substance Abuse
___ Crisis Intervention Policy
___ Hazardous Spills Policy
___ Student Program Guidelines
__ Social Media Policy

Medical Requirements

___ Health Insurance
___ MMR
___ Diphtheria/Tetanus Booster (10 years)
___ TB Test (3 months)
___ Chicken Pox
___ Hepatitis B or declination
___ Influenza
___ CPR Certification
__ 12 Panel Urine Drug Screen
__ Criminal Background Check

Training Requirements

___ Student and Faculty Core Orientation

REHAB CI ORIENTATION

Introduction

___ Location of supplies/equipment
___ Bioness, Biodex, Lite Gait, etc.
___ Venue Recommendations
___ Use of Phone/locators
___ Weekly student expectation schedule
__ Satellite Storage Closets
___ Technician Duties
___ Verbal Orders
___ Copy Machine/Charge Basket
___ Patient Snacks/Supplemental Nutrition
___ Ordering/Issuing DME
___ Co-Tx Philosophy/Charges
__ Staff Refrigerator
___ Oxygen Storage
___ Community Outings
___ Diligent Lift Equipment (PRN)
___ Patient/Caregiver Education Materials
__ Structure of Assigned Area
___ Exercise/Home Programs/Exit Care
___ Reference books
___ Mandatory meetings
___ Weekend Scheduling/Staffing
___ Patient stickers
___Team Conference/Conference Room
___ Crash Cart
___ Veil Bed
___ Schedule Board
__ Home Evaluations
___ Group Therapy
___ Clean Utilities/Linen Carts
___ Quick Release Belt & Alarms

Documentation:

___ Charges/Charge codes/Charge sheets
___ Levels of Assistance
___ Evaluations
___ Discharges
___ In Room Safety Plan
___ Team Conference
___ Progress Notes
___ Sticky Notes
___ Pt./Caregiver Education
___ Miscellaneous paperwork
___ Chart Sequence

Meet the Staff:

___ Therapy Teammates
___ Nurse & Nurse Tech duties/assignments
___ Team SW & CM
___ Rehab Technicians
___ Team Physician
___ Physician Assistants
__ Therapy Supervisor
___ Clinical Specialists

Student Signature: _____ Date: _____

CI Signature: _____ Date: _____

CCCE Signature: _____ Date: _____

GAIT BELT RELEASE

I,_____, agree to pay the cost to replace the gait belt issued to me if it is lost, stolen or damaged.

Student Signature: _____ Date: _____

CCCE Signature: _____ Date: _____

CONE HEALTH
The Network for Exceptional Care

Badge ID Request and Parking Registration Form

(Please Print Legibly)

First _____ M.I. _____ Last _____ EID #/SAN _____

Preferred Name (name you prefer to be called): _____

Department: _____ Job Title: _____

Credentials/Degrees (maximum of 3): _____ Phone # (work): _____

Campus at which you work: MC WL AP WH BHH ARMC Homecare Daycare

Other: _____

Reason(s) for new badge:

_____

_____

If badge has been lost or damaged due to neglect of the employee, a fee will be charged. A $10 fee should be paid at the Cashier's Office on your campus or at General Accounting (MC Campus Room #0640) and a copy of the receipt submitted with this form.

Vehicle Information

Color	Year	Make	Model	Tag #	State	Decal # (Office Use)

Old badge must be turned in to Security Services at time of accepting new badge.

This form is located on Cone Connects in the Human Resources Folder.

Completed form may be submitted to Security Services: 1) Delivered by hand to any security office, 2) emailed to secserv1@conehealth.com or fax to 336-832-2993.

Form will not be accepted if not completed and signed by Department Director, Manager or Supervisor .

_____ _____

Department Director, Manager or Supervisor - *Signature* Date

_____

Department Director, Manager or Supervisor - *Printed Name*

CONE HEALTH LiveLifeWell *Employee Wellness: Caring for ourselves.*

Cone Health Fitness Centers

Waiver and Release of Liability Form

In consideration of being allowed to participate in the activities and utilization of provided equipment in the Cone Health Fitness Centers, I do hereby waive, release and forever discharge Cone Health, its officers, agents, directors, employees, and representatives from any and all responsibility or liability arising out of or related to injury or damage resulting from my participation in any activities or my use of equipment in the above mentioned Cone Health Fitness Centers. I understand that my participation in activities and use of any and all equipment in the Cone Health Fitness Centers (a) is completely voluntary and is not a condition of employment, (b) is not within the scope of my employment and not part of my job duties, and (c) will be conducted on my own time. Therefore, I understand that Cone Health will not be liable for any worker's compensation claims resulting from any injury or damage as mentioned above.
Please initial (_____)

I understand and am aware that strength, flexibility and aerobic exercises, including the use of equipment, are potentially hazardous activities. I also understand that fitness exercises involve a risk of injury or even death, and that I am voluntarily participating in these activities and using equipment with knowledge of the dangers involved. I understand that it is highly recommended to consult with my physician prior to undertaking participation in any exercise program or use of equipment. I hereby expressly assume and accept any and all risks of injury or death.
Please initial (_____)

I agree to follow any and all policies and procedures regarding the utilization of the Cone Health Fitness Centers. I also agree that prior to utilization of any equipment; I will read the equipment instruction manuals or attend an Equipment Orientation to understand how to use the equipment safely.
Please initial (_____)

I agree to refrain from sharing access with any individual regardless of the circumstance or situation.
Please initial (_____)

The undersigned further states that he/she has carefully read the foregoing release and knows the contents thereof and that he/she signs the same as his/her own free act.

Print Name: _____ Lawson ID #: _____ Date_____

Signature_____ Dept/Location_____

**Before receiving access, we also request that you complete your LiveLifeWell online Wellness Profile to assess risk level for exercise. Please login to your LiveLifeWell account at https://livelifewell.conehealth.com (first time logging on? ID: Lawson Number; Password: 8-digit date of birth), and click on the Wellness Profile button under the Self Awareness section.*

Addendum for Alamance Regional (Burlington) Location only
(Complete the above section as well as this section)

I hereby authorize a payroll deduction of $5 per pay period (covering the 2 weeks immediately prior to pay day) to cover the fee for the Fitness Program. I understand that the deduction process will begin following the completion of this form, assessment, and equipment orientation and the minimum enrollment period is three (3) months, no refunds or temporary suspension for travel, vacation, short term illnesses, etc. will be provided, and membership and payroll deduction will automatically be extended after 3 months unless a completed cancellation form is returned to the LifeStyle Center staff.

Print Name: _____ Lawson ID #: _____ Badge #_____

Signature_____ Dept/Location_____ Date_____

Fax completed document to (336) 832-8527 or drop off at your nearest Human Resources office. Burlington employees, fax completed document to (336) 538-7529 or drop off at the ARMC Fitness Center.

Search

Password Self Service - Reset KB0012000

Authored by Lauren Williams • 28 Views • 3y ago

CONE HEALTH
The Network for Exceptional Care

Overview - Password Reset – complete this step whenever you forget or need to reset your password

This document details how to use Cone's new Password Reset system, specifically the Reset Portal. This system uses Security Questions and Answers to verify a user's identity before allowing them to reset their password.

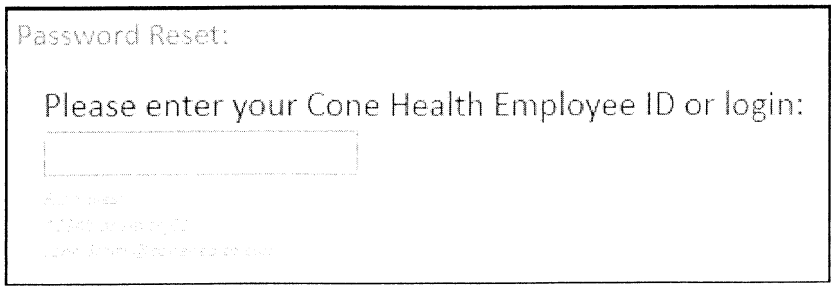
Users must have registered through the Password Registration portal before they can use this Reset Portal to change their password.

Procedure

1. Open the Password Reset Portal by going to https://passwordreset.conehealth.com

2. Enter your Cone Health username in one of the following formats and click Next

- 12345 or smithj01
- John.Smith@conehealth.com



Also in Security

Password Self Service - Registration
6 Views

Identifying Suspicious Emails
3 Views

KB Top Rated

Mobile Application Management (MAM) Troubleshooting Instructions for Android
★★★★★

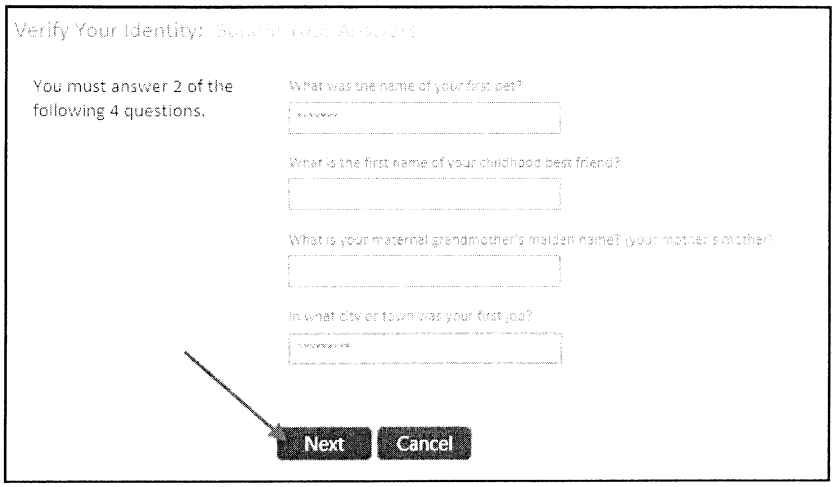
Outlook Groups – Self-service team sharing
★★★★★

iOS Removal of Native Mail and Contacts
★★★★★

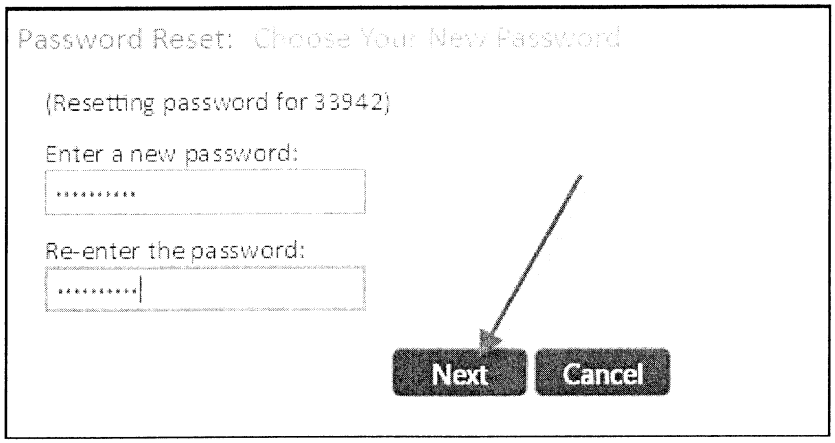
Email Best Practices FAQ
★★★★★

Android OS E-mail Setup Instructions
★★★★★

3. Answer 2 of the 4 questions that are presented. Click Next.



4. Enter what you would like your new password to be and click Next. Remember that the new password must be:
- Minimum 8 characters
- Must contain one uppercase letter, one lowercase letter, one number/special character
- Cannot contain your last name
- Cannot be the same as any of your last 3 passwords



5. Congratulations! You have successfully reset your password! You can now log in using this new password.

Additional Comments/Notes

KB Top Viewed

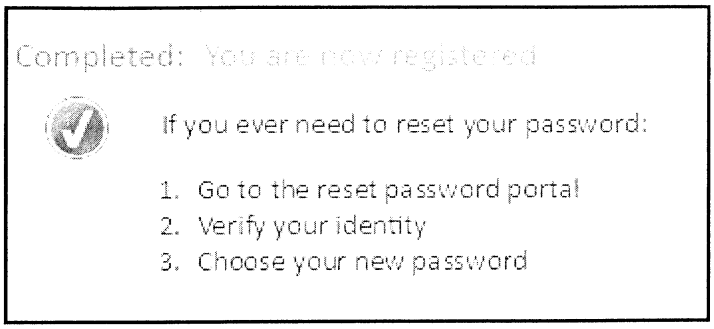
Signing Up for Multi-Factor Authentication (MFA)
1003 Views

MFA Enrollment Instructions for Smartphone App
573 Views

Requesting Remote Access
380 Views

Citrix Remote Access Minimum System Requirements
352 Views

Cone Health Worx MFA
186 Views



Additional Comments/Notes

- This portal is currently **not** available for ARMC logins (ARMCNT accounts using 4 & 4 convention).
- You can change your Security Questions & Answers at any time by logging back into the Password Registration portal (https://passwordregistration.conehealth.com) with your current password and answering the questions again or answered new questions.
- If you have any problems using this system or have any questions, please contact the IT Help Desk at 336-832-7242.

Helpful? Yes No 75% found this helpful

Rate this article ☆ ☆ ☆ ☆ ☆

Search

Password Self Service - Registration KB0011999

Authored by Lauren Foster • 6 Views • 3y ago

CONE HEALTH
The Network for Exceptional Care

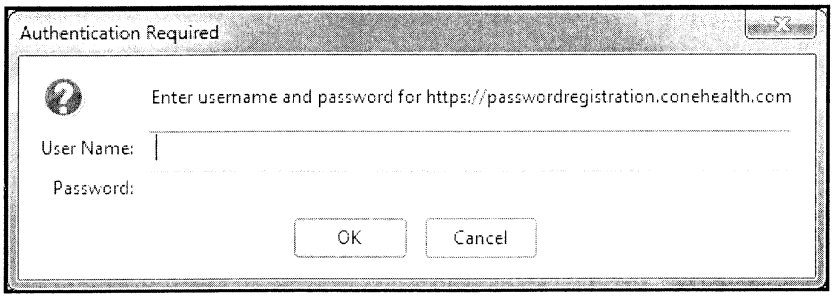
Overview - Initial Registration - complete this step at any time

This document details how to use Cone's new Password Reset system, specifically the Registration Portal. This system uses Security Questions and Answers to verify a user's identity before allowing them to reset their password.

Users **must register** through the Password Registration portal with their current password before they can use the Password Reset portal to reset their password.

Procedure

1. Open the Initial Registration Portal by going to https://passwordregistration.conehealth.com.You may have to log in using your current login and password if you are accessing this from a generic/shared PC. The login box will look like this from a generic/shared PC and some Internet Browsers. ARMC users will need to enter mchsnt\EID in order to log in here. Cone users can just enter their EID or named login.



2. Click Next to open the portal.

Also in Security

Password Self Service - Reset
29 Views

Identifying Suspicious Emails
3 Views

KB Top Rated

Mobile Application Management (MAM) Troubleshooting Instructions for Android
★★★★★

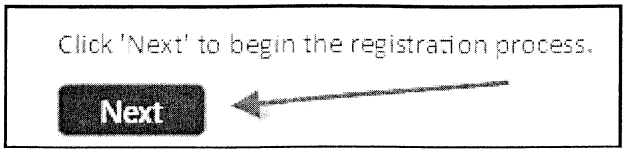
Outlook Groups – Self-service team sharing
★★★★★

iOS Removal of Native Mail and Contacts
★★★★★

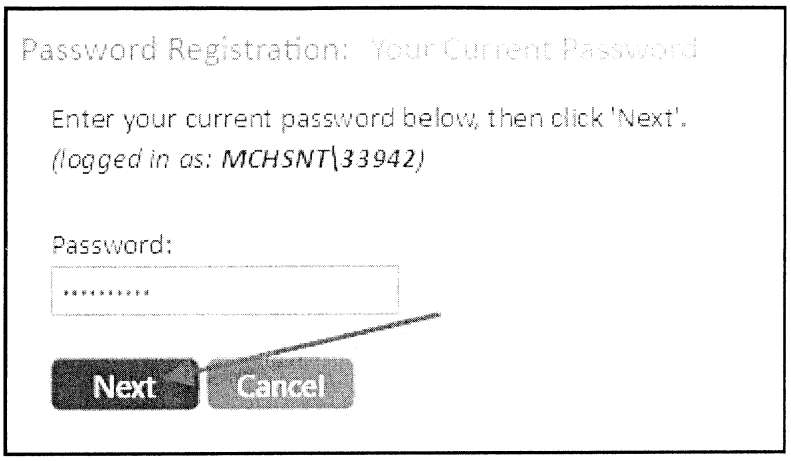
Email Best Practices FAQ
★★★★★

Android OS E-mail Setup Instructions
★★★★★

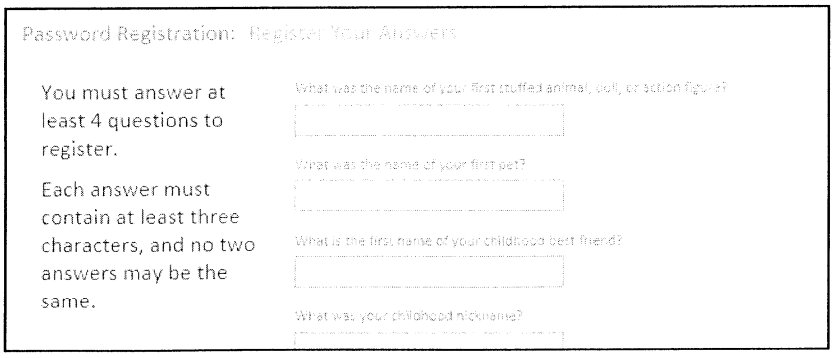
KB Top Viewed



3. Confirm your identity by entering the current password that you use to log into Lawson and Email.



4. Choose your Security Questions. You must answer at least 4 questions from the options shown on the page. Each of your answers must be at least 3 characters long and no 2 questions can have the same answer. Click Next once you have chosen and answered your questions.



5. Congratulations! You are now registered! You can now use the Password Reset portal at https://passwordreset.conehealth.com any time you need to reset your password.

Signing Up for Multi-Factor Authentication (MFA)
1003 Views

MFA Enrollment Instructions for Smartphone App
573 Views

Requesting Remote Access
380 Views

Citrix Remote Access Minimum System Requirements
352 Views

Cone Health Worx MFA
186 Views

- This portal is currently **not** available for ARMC logins (ARMCNT accounts using 4 & 4 convention).
- You can change your Security Questions & Answers at any time by logging back into the Password Registration portal (https://passwordregistration.conehealth.com) with your current password and answering the questions again or answered new questions.
- If you have any problems using this system or have any questions, please contact the IT Help Desk at 336-832-7242.

Helpful? Yes No 100% found this helpful

Rate this article ☆ ☆ ☆ ☆ ☆

Student Survey of
CI Clinical Performance and Clinical Education Program

Adapted from: Kelly, SP. "The Exemplary Clinical Instructor: A Qualitative Case Study." Journal of Physical Therapy Education; April, 2007.

PLEASE COMPLETE AT MIDTERM AND FINAL. USE A DIFFERENT COLOR OF INK FOR EACH PERIOD.

Please rate your Clinical Instructor on the following behaviors on a scale of 0-5:

5 = always/excellent
4 = frequently/very well
3 = often/well
2 = sometimes/not very well
1 = rarely/poorly
0 = did not demonstrate

How well did your CI create and maintain an open and collegial relationship by:						
1. Encouraging open communication	5	4	3	2	1	0
• Is honest, straightforward and open	5	4	3	2	1	0
• Gets to know me as a person	5	4	3	2	1	0
• Help me feel like a colleague or team member	5	4	3	2	1	0
• Helps me feel comfortable giving as well as receiving feedback	5	4	3	2	1	0
• Seeks input into desired CI behaviors by using phrases like "How can I help you better?" "Is this working for you?" "Am I talking too much/little?" "Do you want more feedback?"	5	4	3	2	1	0
2. Providing clear expectations	5	4	3	2	1	0
• Work hours	5	4	3	2	1	0
• Dress code	5	4	3	2	1	0
• Student's role in learning	5	4	3	2	1	0
• Commitment to addressing professional behaviors immediately	5	4	3	2	1	0
3. Providing direct feedback	5	4	3	2	1	0
• Positive and constructive (addressing the elephant in the room)	5	4	3	2	1	0
• Gives feedback at appropriate times/places and based on my preference (when able)	5	4	3	2	1	0
• Find neutral ground, quiet and uninterrupted time/space to review formal evaluations	5	4	3	2	1	0

Comments:

How well did your CI adapt the learning experience to you and your needs by:						
1. Determining your learning goals and needs	5	4	3	2	1	0
• Utilization of pre-affiliation forms	5	4	3	2	1	0
• Utilization of program-provided forms	5	4	3	2	1	0
• Assessment of learning style	5	4	3	2	1	0
• Assessment of feedback preference	5	4	3	2	1	0
2. Meeting you 'where you are'	5	4	3	2	1	0
Understanding and incorporating:						
• Learning needs	5	4	3	2	1	0
• Unique learning style and/or individual personality	5	4	3	2	1	0
• Putting you in charge of setting your learning goals (with guidance)	5	4	3	2	1	0
3. Establishing student-led weekly goals	5	4	3	2	1	0
• Directing you to complete and discuss with CI	5	4	3	2	1	0
• Development of learning experiences based on these goals	5	4	3	2	1	0
• Facilitating opportunities to observe with other clinicians, etc	5	4	3	2	1	0
• Teaching clinical skills that are specific to your needs and/or interests	5	4	3	2	1	0
3. Encouraging self-assessment of performance	5	4	3	2	1	0
• Requiring completion of formal self-assessment (mid-term/final)	5	4	3	2	1	0
• Allowing you to speak first and listening actively and with intent	5	4	3	2	1	0
• Integrating the results of discussion into new goals/plan	5	4	3	2	1	0
• Remaining open, honest and direct	5	4	3	2	1	0

Comments:

How will did your CI facilitate your clinical reasoning by:						
1. Encouraging active learning	5	4	3	2	1	0
• Asking what you are doing, why you are doing it	5	4	3	2	1	0
• Placing problem-solving responsibility on you	5	4	3	2	1	0
• Encouraging you to jump in and practice without being perfect; creating a judgment free (though not feedback free) zone	5	4	3	2	1	0
• Knowing when to "nudge you out of the nest"	5	4	3	2	1	0
2. Developing your clinical/assessment skills	5	4	3	2	1	0
• Facilitating synthesis of subjective and objective information	5	4	3	2	1	0
• Challenging documentation using 'formless' practice notes	5	4	3	2	1	0
• Making learning timely	5	4	3	2	1	0
3. Thinking out loud	5	4	3	2	1	0
• Sharing thought process with you when applying clinical reasoning	5	4	3	2	1	0
• Talking through how the CI approaches familiar and unfamiliar situations	5	4	3	2	1	0
• Discussing with you the CI's decision-making strategy	5	4	3	2	1	0
• Being transparent with problem-solving through an interaction/assessment	5	4	3	2	1	0
How well did your CI make time for you during this clinical by						
1. Creatively finding time in the day	5	4	3	2	1	0
2. Giving extra time to complete tasks when necessary	5	4	3	2	1	0
How well did you perceive that the department adequately supported your CI?						
1. Clinical teaching is a part of the job here	5	4	3	2	1	0
2. Clinical teaching/students appear to be valued	5	4	3	2	1	0
3. Clinical teaching/students appear to benefit the department/facility	5	4	3	2	1	0

YOUR FEEDBACK MATTERS! PLEASE COMMENT ON THE QUALITY AND IMPACT OF YOUR AFFILIATION:

1. Please comment on the content and timing of your orientation. In what ways could this process be altered or improved?

2. In what ways could this have been a better affiliation?

3. What did you observe or experience that makes Moses Cone an appealing place to work as a new graduate? What was unappealing?

4. What do you perceive as our areas of expertise? In what ways could we improve our therapy services?

5. Please mention any clinicians (including your CI) who had a positive impact or influence on you during your affiliation, and what that impact was on your professional growth.

Thank you for your thoughtful feedback! Your comments help develop our clinical program and learning environment for future students.

Student: _____ CI: _____

Date _____ Date _____

STUDENT INSERVICE FEEDBACK AND EVALUATION

Date_____

Student _____ Venue _____

Topic _____

KEY: SA: Strongly Agree A: Agree D: Disagree SD: Strongly Disagree U: Unsure

	SA	A	D	SD	U	COMMENTS
The topic was pertinent to the audience.						
The presenter was prepared and knowledgeable about this topic.						
The method (demo, lab, lecture) of the presentation was appropriate.						
The use of A/V or other materials was helpful.						
The presenter showed good communication skills.						
Overall, this inservice was helpful to me.						

How will you incorporate the information presented in this inservice into your practice?

_____

_____

How can the presenter improve this presentation topic? For future presentations in general?

_____

_____

SURGERY OBSERVATION REPORT

Name: _____ Date: _____

School and program: _____

Surgery(s) Observed: _____

_____

Surgeon(s) Performing: _____

_____

_____

Other People Present (e.g., scrub nurse, anesthesiologist, other students, etc.): _____

_____

_____

Questions

1. What anatomical structures were incised? Were displaced? Were removed?

2. In what position was the patient placed, and what structures might be affected because of positioning? How/Why?

3. Where were sutures, staples or drains placed?

4. What impairments do you anticipate this patient will present with?

5. What functional deficits do you expect will be present because of this surgery?

6. What post-operative "normal" symptoms do you anticipate following this surgery? What are some potential complications (i.e., need to inform the nurse or MD)?

7. Where/to what degree do you anticipate this patient will experience pain? Why?

8. What (if any) precautions should you take when determining how/when to mobilize this patient?

9. How will you need to modify bed mobility for this patient?

10. What type of education might you need to provide for the patient/caregiver/nurse?

11. Who provided you with education during this observation (nurse, MD, vendor, etc., and names if you remember) **and** would you recommend this specific experience to another student?

END OF AFFILIATION CHECKLIST

Before the student leaves Cone Health, please review, return and complete the following:

- ❑ CONE HEALTH NAME BADGE
- ❑ GAITBELT (if issued one)
- ❑ FORMAL EVALUATION FORMS (please have student and CI sign all forms leaving originals for schools and copy for center coordinator)
  - ❑ Mid-Term and Final evaluation (Make copy if PAPER or print if WEB-BASED) with both CI and student comments.
  - ❑ Cone Health's or School's Student Survey of CI Clinical Performance and Clinical Education Program.
  - ❑ Any other school-issued evaluation tools you may have completed.
- ❑ ANY OTHER FEEDBACK FORMS, NOTES, TREATMENT PLANS, ETC, THAT WERE COMPLETED
- ❑ BE CERTAIN THE STUDENT DOES NOT LEAVE WITH ANY FORMS/DOCUMENTATION CONTAINING PATIENT INDENTIFICATION

Please provide your mailing and email addresses in case we need to contact you after you affiliation:

Student Name: _____Dates of Affiliation: _____

Email address: _____

Mailing address (and dates you expect to be in this location)

_____

_____

_____

PERMISSION FOR REFERENCES

I, _____, give my permission for the Moses Cone Health System, Rehabilitation Services to give verbal or written references for me.

I _ **do**/_ **do not** give permission to refer to evaluation forms from my student affiliation at Moses Cone Health System when making references.

The following individuals have my permission to give a reference:

___ Any staff member

___ Only these individuals:

1.

2.

3.

4.

Signed: _____ Date: _____

Dates of Affiliation: _____

Clinical Instructor(s): _____

Site or venue(s): _____

2019 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly

NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
NPSG.01.03.01	Make sure that the correct patient gets the correct blood when they get a blood transfusion.

Improve staff communication

NPSG.02.03.01	Get important test results to the right staff person on time.

Use medicines safely

NPSG.03.04.01	Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
NPSG.03.05.01	Take extra care with patients who take medicines to thin their blood.
NPSG.03.06.01	Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Use alarms safely

NPSG.06.01.01	Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

Prevent infection

NPSG.07.01.01	Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
NPSG.07.03.01	Use proven guidelines to prevent infections that are difficult to treat.
NPSG.07.04.01	Use proven guidelines to prevent infection of the blood from central lines.
NPSG.07.05.01	Use proven guidelines to prevent infection after surgery.
NPSG.07.06.01	Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

Identify patient safety risks

NPSG.15.01.01	Find out which patients are at risk for suicide.

Prevent mistakes in surgery

UP.01.01.01	Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
UP.01.02.01	Mark the correct place on the patient's body where the surgery is to be done.
UP.01.03.01	Pause before the surgery to make sure that a mistake is not being made.

The Joint Commission
Accreditation
Hospital

This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

Quick Reference Guide for Rehab Services Staff
Moses Cone/Wesley Long Campus
Safety and Emergency Response

ALERT	If the Emergency is in your area:	If you hear the Code Announced:
Fire Alarm Activation	• RACE ➢ R = Rescue anyone in immediate danger. ➢ A = Activate the alarm - pull the fire alarm and call the emergency number. ➢ C = Close doors and windows, clear hallways, check that all automatic doors close and latched. ➢ E = Extinguish the fire if possible. • Facilities Mgt and Nursing will shut off O2 and gas outlets if necessary. • Ask visitors to remain in rooms or exit by stairs only (do not use elevators). • Prepare to Evacuate if necessary.	• Listen to announcement for the location of the fire. • If in your area, see previous column. • Close doors and windows. • Check that automatic doors closed and latched. • Clear hallways, prepare for possible evacuation. • Ask visitors to remain in rooms or to exit by stairs only. • Do not use elevators during a Fire Alarm Activation.
Emergency Lockdown	• Call the emergency response phone number as soon as the situation is identified. • Remain with or near any patients or visitors. • Close all nearby patient rooms, offices, and procedure room doors. • Attempt to maintain a visual of the situation until assistance arrives. • In some instances, a situation may develop prior to any patient or visitor arrival and the Emergency Lockdown alert maybe activated proactively.	• The announcement will be: Attention: Security Alert: Emergency Lockdown, location (and repeated 3 times). • This announcement serves as notification for ancillary staff and support staff to suspend activity in the identified location or department. Staff should avoid the area until the "all clear" has been announced.
Bomb Threat	• If you receive the bomb threat, ask the caller, "Where is the bomb?" and "When will it go off?" • If possible, ask a co-worker to call the Emergency number while you keep the caller on the phone. • DO NOT pull the fire alarm. • Complete the Bomb Threat Checklist located under Policy and Procedures on the Cone Connects page.	• Prepare for possible evacuation. • Listen for additional announcements. • Report anything out of place or suspicious to Security.
Missing Infant/Child	• Call the Emergency number **and** notify the Charge Nurse or Department Manager. • Send staff to monitor all exits from the unit. • If possible, maintain visual contact of suspect (follow at a safe distance). • Charge Nurse or Department Manager will confirm missing infant/child. • Verify patient census to account for all other patients. • Transfers infants to mothers' rooms, ask pediatric patients to stay in their rooms.	• Rehab Services does not have any specific responsibilities during a missing infant/child situation. • All available employees should watch for suspicious person(s) and/or activities, especially in hallways, stairwells, and near exits. • If the child is over the age of 1, a description of the gender and age will follow the announcement, along with the last know location. For example, "Security Alert: Missing child, Female, 8, radiology" means an 8 year old female last seen in radiology. • Call security to report anything relevant to the Missing Infant/Child.
Mass Casualty/ Disaster	• Call the emergency number to report the disaster. • Response details depend on the specifics of the emergency. • Department Leadership will receive directions from the Incident Commander or his/her designee.	• Overhead alert will be: Attention: Code Triage – External – standby, or Attention: Code Triage – Internal – location • Call down to the department and check in and/or for further instructions. • Response details depend on the specifics of the emergency. • Department Leadership will receive directions from the Incident Commander or his/her designee and will inform their staff. • Continue working. Be prepared to perform other duties as assigned.
Hazardous Material Spill (Internal)	• Isolate the area and contain spill (if safe to do so). Call Security and/or Facilities Mgt if assistance is needed. • Notify your supervisor. • Identify the chemical, if possible, and obtain the MSDS on the Cone Connects page, under Resources or use the phone number on any system telephone. • Determine if safe for available staff to clean up or if the spill meets the criteria for a "major spill" – see Policy "Hazardous Materials Spill Incident".	Adjacent departments should clear hallways and prepare for possible evacuation or reception of re-routed traffic.

CONE HEALTH
The Network for Exceptional Care

Therapeutic Guidelines for PT/OT/SLP: Based on Best Available Evidence

Contraindications to Exercise

Absolute : Hold exercise until therapeutic

- **Unstable angina**
- **Uncontrolled cardiac dysrhythmias with hemodynamic compromise**
- **Symptomatic severe aortic stenosis**
- **Uncontrolled symptomatic heart failure**
- **New onset PE or DVT**
- **Acute myocarditis or pericarditis**
- **CPK-MB or Troponin-I elevation—Don't treat pt if 0.8-2.0 with symptoms as well as values need to be trending down prior to resuming activity if patient with cardiac issues. If > 2.0 and asymptomatic, treat and monitor for symptoms**
- **Suspected or known dissecting aneurysm**

Relative: Discuss care with nurse or physician

- **Tachycardia or bradycardia (>120bpm or < 60 bpm)**
- **Neuromuscular and musculoskeletal disorders exacerbated by exercise**
- **High degree heart block**
- **Severe arterial hypertension (i.e., systolic BP of >200 mmHg and diastolic BP of > 110 mmHg) at rest (Unless CVA protocol –allows permissive HTN per orders/PN). Also if BP elevated 180 & >, check with nurse to ensure pt medicated & monitor pressures if you proceed**
- **Symptomatic hypoglycemia/hyperglycemia**
- **SaO2 <90% or 5% below resting value if patient has COPD**
- **RR > 45**

Indications for Terminating Exercise

Absolute

- **Any new onset angina**
- **Symptomatic orthostatic hypotension**
- **Signs of poor perfusion (confusion, light-headed, ataxia, pallor, cyanosis, nausea, cold/clammy skin)**
- **Technical difficulties monitoring the ECG or systolic BP**
- **Sustained V-tach**
- **ST elevation (+1.0 mm) in leads without diagnostic Q-waves**
- **Subject's desire to stop**

Relative

- **ST or QRS changes such as excessive ST depression (>2 mm horizontal or downsloping ST-segment depression)**
- **Arrhythmias including triplets of PVCs, supraventricular tachycardia, heart block, or bradyarrythmias**
- **Fatigue, shortness of breath, wheezing, leg cramps, or claudication (>8/10 pain)**
- **Hypertensive response (systolic BP >250 mmHg and/or a diastolic BP of >115 mmHg)**
- **Failure of HR to increase with increased activity**
- **SaO2 <90% or 5% below resting value if patient has COPD**

Limitations for Exercise Based on Lab Values

WBC (x1000) Adult male= 5-10/ccm Adult female= 5-10/ccm	>11—use caution with accompanying fever when exercising/mobilizing pt. <4—symptom based approach to determine activity <2—vigilant with hand washing, pt wear mask in hallway; avoid skin tears as this incr risk of infection
Hemoglobin Adult male= 14-18 g/dL Adult female= 12-16 g/dL	<7 consider no therapy if patient is symptomatic Monitor VS with SpO2 to predict tissue perfusion. May present with tachycardia/orthostatic hypotension.
Hematocrit Adult male= 42-52% Adult female= 37-47%	<25% consider no therapy; light ROM exercises permitted >60% -spontaneous blood clotting can occur
Platelets (x1000) Adult normal range= 150-400 micro liter	<50 no resistance exercises, ADL/ambulation as able <20 light ADL/ambulation only <10 consider no therapy
Sodium (Na) 134-142 mEq/L	>145 impaired cognition, hypotension, tachycardia <130 impaired cognition, orthostatic hypotension,lethargy
Potassium (K) Nml: 3.5-5.1 mEq/L MC limits: 2.8-5.5 mEq/L	>5 at risk for cardiac arrythmias <3 causes decreased contractility of the heart. If K < 3, K meds usually ordered. If pt asymptomatic, DO NOT wait for meds to be initiated to treat pt.
Blood Urea Nitrogen (BUN) 6-25 mg/dL	If high, decreased tolerance to activity
Creatinine Male = 0.7-1.3 mg/dL Female = 0.4-1.1 mg/dL	If high, decreased tolerance to activity
Glucose 70-100 mg/dL	<60 pt. may have low activity tolerance >300 use caution

Hypokalemia symptoms: Fatigue, paresthesias, muscle weakness, shallow respirations, arrhythmias, hypotension, marked ECG changes, polyuria, and nocturia.
Hyperkalemia symptoms: flaccid paralysis of legs and progressing paresthesias of the face, tongue, hands and feet; nausea, diarrhea, oliguria, arrhythmias to include V-fib.

DVT:
Patients with a diagnosed DVT are safe to mobilize (preferably with compression stockings) **after anticoagulants are initiated** without increasing risk of PE **as long as** lab values remain in therapeutic range (within specific parameters above) . Research also indicates that early mobility improves acute symptoms in the affected limb acutely and over time. If a patient develops a DVT despite prophylaxis, consult with the physician.

If on heparin for 24 hours, level should be within 0.3-0.7 units/ml.	Therapeutic dose of IV heparin must be given 24 hours prior to initiating evaluation. Consider bed level evaluation/transfers until level falls into therapeutic range up to 48 hours. If MD is discharging pt prior to pt in therapeutic range, get order from MD for OOB.
If on LMWH (Lovenox), Arixtra, Pradaxa, Xarelto, or Eliquis, verify time of initial dosage.	Do not ambulate patient until 3 hours after initial dose is given.
If on Coumadin/warfarin, check INR Normal range: 0.8-1.2 without meds Therapeutic range: 2-4 (or as set by pharmacist)	<2 = no mobility 2-5 = mobilize >5= Increased risk of hemarthrosis so bed to chair transfer only if not grossly unsteady. Use your clinical judgment to determine if it's safe or not and write cancellation in chart and check patient in 24 hours.

**Refer to Algorithm for mobilizing patients with known DVT for more information. .

Contraindications for Use of a Passy-Muir Speaking Valve (PMSV)

- Inflated tracheostomy tube cuff
- Severe medical instability
- Foam-filled cuffed tracheostomy tube
- Airway obstructions impeding use of upper airway
- Unmanageable secretions
- Pt necessity of fully inflated cuff
- Severely reduced lung elasticity secondary to poor pulmonary function
- Not intended for use with endotracheal tubes or other artificial airways
- Not intended for use during sleep

Possible Indication for Terminating Use of PMSV

- During sleep
- Poor upper airway patency
- Copious unmanageable secretions
- Discomfort/Difficulty breathing
- Increase in respiratory rate above 30 or heart rate above 120
- Inability to maintain oxygen saturation levels consistently above 90%
- Retention of CO2 with valve placement

Contraindications for Swallowing Evaluations

- Excessive secretions
- Decreased level of alertness
- Poor respiratory status/inability to maintain oxygen saturation levels above 90%
- Open hub tracheostomy tube without speaking valve placement
- Inability to raise head of bed past 45 degrees
- Presence of a large bore nasogastric feeding tube

Contraindications for performing Fiberoptic Endoscopic Evaluations of Swallowing (FEES)

- Not sufficiently alert enough to be fed orally
- Severe nasal and/or pharyngeal stenosis
- Agitation and/or combative
- Severe movement disorders
- History of epistaxis
- Bleeding disorder or critically low platelets
- Acute cardiac conditions with significant cardiac irregularities

Reasons for patients to be on bedrest but it not be clear in orders:
(Please use this list as a starting point for discussion with nurse or MD to clarify a patient's activity status)

Cardiopulmonary

- Removal of EPW (epicardial pacing wires) - **One hour**
- Femoral access heart catheterization—**4-6 hours**
- Femoral sheath removal—**4-6 hours**
- Last chest tube removed for cardiac pt (no other CTs remain on same side) - **until chest xray**
- Pulmonary Artery Catheter (Swan-Ganz) - **BR if in wedge position**
- TEE with loop recorder placed—**Up to 24 hours**

Neuro

- Dural tear/CSF leak post-lumbar surgery—**2-3 days**
- Lumbar puncture—**varies (1-4 hours)**
- Lumbar drain—**Really varies (BR or up ad lib even unclamped)**
- Intraventricular (IVC) Drain or bolt (unclamped) - **Until clamped**
- CT angiogram—**3 hours**

Other

- PICC line (placing or removing) - **Until chest xray**
- After thoracentesis—chest X-ray prior to mobilizing
- Inferior Vena Cava (IVC) filter (for LE DVT) - **Varies**

Line precautions

If a patient has a **femoral artery catheter**, you will need an order by the MD that the patient can mobilize OOB. Make sure that the patient does not bend their hip greater than 90 degrees when mobilizing to EOB and sit to stand.

If a patient has a **temporary non-tunneled hemodialysis catheter (NTHDC)** in the groin, the patient should be on bedrest with HOB<45 degrees (no hip flexion >30 degrees). If tunneled hemodialysis catheter, pt can mobilize. If the catheter is in the neck, the patient's bed can be placed in the chair position and with MD approval, the patient can get OOB. If femoral catheter, the patient cannot be placed in the chair position.
Patients with HD catheters (even CVVHD) can exercise all extremities except the extremity that has the HD site. Consult with the nephrologist to ask any other mobility progression questions as some patients with CVVHD catheters in the neck can mobilize to EOB/OOB with nursing present and if BP stable.

If a patient has a **PA (pulmonary artery/Swan Ganz) catheter**, do not treat them if the catheter is in the wedged position as movement can risk tearing the arterial wall. Check with the nurse to determine the position. These patients should pivot to a chair or perform sit to stand only. Avoid excessive movement of the line when mobilizing.

IVC/CSF drains should be clamped prior to mobility.

Dyspnea Scale:
0= No dyspnea
1= Mild, noticeable to patient, not observer
2= Some difficulty, noticeable to observer
3= Moderate difficulty, but can continue
4= Severe difficulty, patient cannot continue

Orthostatic Blood Pressure Monitoring

Postural orthostatic hypotension is defined as systolic blood pressure decrease of at least 20mm Hg or a diastolic blood pressure decrease of at least 10mm Hg within three minutes of standing.

Monitor Blood Pressure:
1. **Pt. supine for 10 minutes prior to recording BP and HR**
2. **Record BP and HR immediately after next postural change.**
3. **Record BP and HR immediately after standing**
4. **Record BP and HR 3 minutes after standing**

***Drop in blood pressure with symptoms per above protocol will result in termination of current therapy session until blood pressure improves. Document blood pressure measurements in progress notes for nursing and MD.**

Possible indications of orthostatic hypotension and termination of therapy

- **Light-headedness**
- **Dizziness or fainting**
- **Blurred or narrowed vision**
- **Temporary darkening or blackening of the visual field**
- **Weakness or fatigue**

Recommendations for inpatient exercise programming include: RPE < 13 (6-20); Post-MI: HR <120 beats/min or HR at rest + 20 beats/min; Post surgery: HR at rest + 30 beats/min; To tolerance if asymptomatic.

RPE scale: Healthy subjects reach fatigue at 18-19. Subjects with disabilities/disease processes reach fatigue at 11-14.

- **Normal PEEP (Positive End-Expiratory Pressure) - 5 cm H2O**
  If PEEP is > 10 cm H2O, consider no therapy/consult with MD.
- **Normal Minute volume (rr x Vt) - 5-10 L/min**
  ICU patients with respiratory failure may be at 10-13 L/min
  If minute volume is 15-18 L/min, work with RT to ? change Vent settings or stop activity. (Vt=tidal volume)
- **Normal PaO2: 80-95 mmHg**
  Normal PaCO2: 37-43 mmHg
  Normal HCO3: 20-30 mmol/L
- **Adequate oxygenation:**
  PaO2 > 60-70 mmHg; FiO2 of .4 to .5; PEEP 5-8 cm H2O
- **Adequate ventilation:**
  PaCO2 35-45 mmHg; pH 7.35-7.45
- **MAP (Mean Arterial Pressure) = 1/3 (SBP-DBP) + DBP**
  Normal MAP - 80-100 mmHg
  If MAP is < 70 mmHg , circulation to vital organs compromised.
  We do initiate therapy if MAP 60-70 and monitor patient.
- **CVP (Central Venous Pressure) = 2-8 mmHg**

LVAD: Only see if LVAD certified.

Effects of Medications with Exercise

Medications	Heart Rate	Blood Pressure	Exercise Capacity
B-Blockers	↓	↓	↑ in pts. with angina
Nitrates	↑ or ↔	↓ or ↔	↑ in pts. with angina / CHF
Calcium channel blockers -pine = Diltiazem Verapamil	↑ or ↔ ↓	↓	↑ in pts. with angina
Digitalis	↓ in pts. with a-fib	↔	Improved only in pts. with a-fib
Diuretics	↔	↓ or ↔	↔, except possibly CHF pts.
Vasodilators ACE inhibitors/ Angiotensin Antiadrenergic agents	↑ or ↔ ↔ ↓ or ↔	All ↓	All ↔
Antiarrhythmic agents	↑ or ↔	↓ or ↔	↔
Bronchodilators	↑ or ↔	↑ or ↔	↔

↑:increases ↔:no change ↓:decreases

Pressors

When a patient is initially started on pressors (neosynephrine, Levophed, dopamine), treatment is not indicated.
However, when patients are weaning to a low dose of pressors (5-10 mcg), speak with the MD/nurse as OOB to chair may be allowed. Always check with the nurse as they can give valuable information about the patient's present status on pressors. Watch MAP and BP when mobilizing.

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February 2018

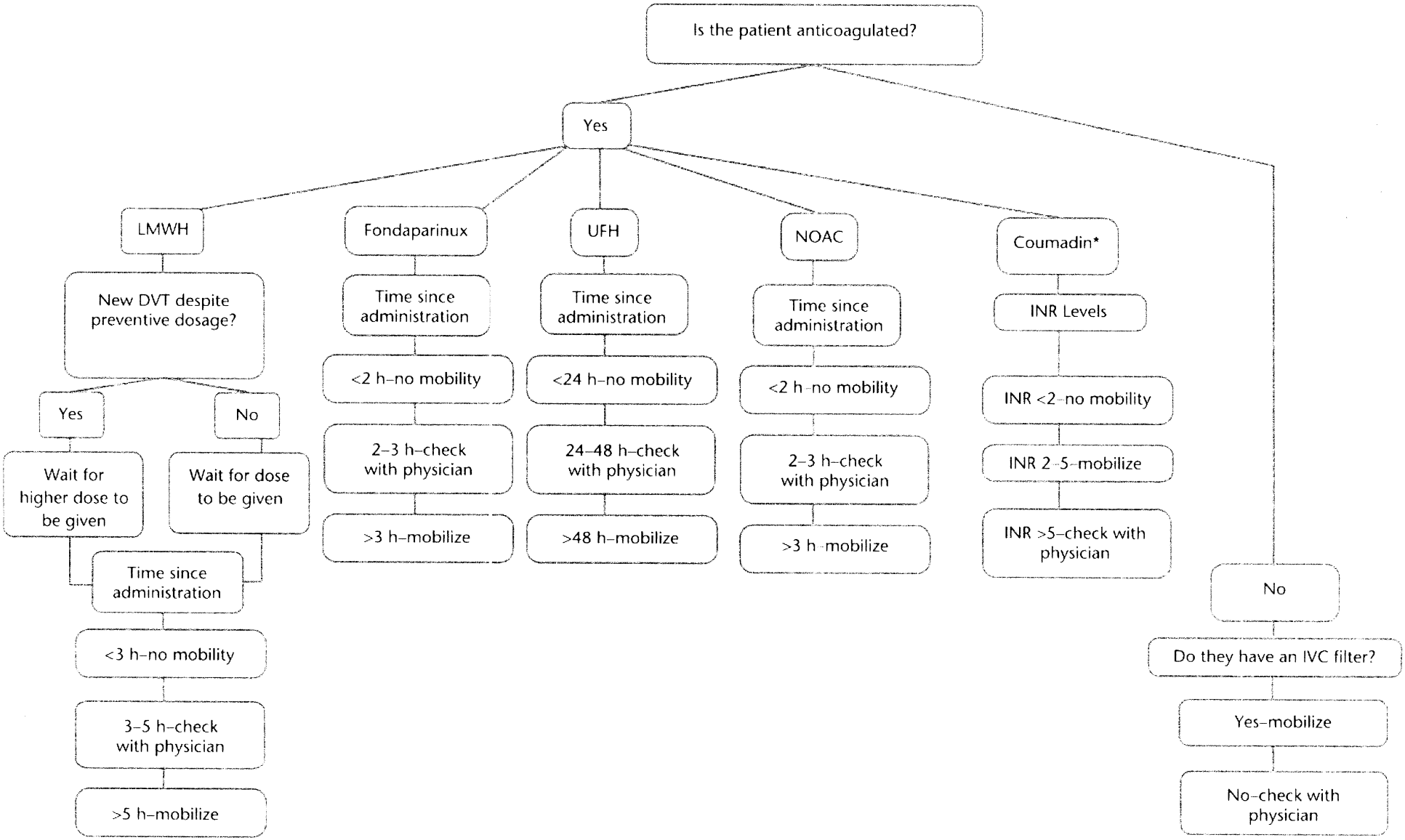

Fig. 3. Algorithm for mobilizing patients with known lower extremity deep-vein thrombosis. DVT, deep-vein thrombosis; LMWH, low-molecular-weight heparin; UFH, unfractionated heparin; NOAC, novel oral anticoagulants; INR, international normalized ratio; IVC, inferior vena cava. *If started on Coumadin, LMWH usually also started. Use LMWH guidelines for mobilization decision in these situations. Reprinted from Phys Ther. 2016;96(2):143–166, with permission of the American Physical Therapy Association. Copyright © 2016 American Physical Therapy Association.

The following list of procedures typically requires the patient be on bedrest for various amounts of time (see below). Unfortunately, the orders do not always clearly indicate bedrest. Please use this list as a starting point for a discussion with the nurse or physician to clarify the patient's activity status before proceeding with your evaluation or treatment (including elevating the head of bed).

Cardiopulmonary	Bedrest timeframe
• Removal of EPW (epicardial pacing wires)	One hour
• Femoral access heart catheterization	4-6 hrs
• Femoral sheath removal	4-6 hrs
• Last chest tube removed (no other CTs remain on same side)	until chest xray
• Pulmonary Artery Catheter (Swan-Ganz)	BR if in wedged position
*Transfer only if not wedged and do NOT pull on the line	
• TEE with loop recorder placed	up to 24 hrs
Neuro	
• Dural tear/CSF leak post-lumbar surgery	2-3 days
• Lumbar puncture	varies (1-4 hrs)
• Lumbar drain	*really varies (bedrest or up ad lib even unclamped)
• Intraventricular (IVC) Drain or bolt (unclamped)	until can be clamped
• CT angiogram	3 hrs
Renal	
• Temporary femoral hemodialysis catheter (non-tunneled)	no hip flexion >30
• CVVHD femoral access	no hip flexion >30
*May exercise other 3 extremities	
*If jugular access, bed to chair with RN for CVVHD lines (if BP OK)	
Other	
• PICC line (placing or removing)	until chest xray
• Inferior Vena Cava (IVC) filter (for LE DVT)	?varies

Defensible Documentation elements

American Physical Therapy Association

TOP 10 TIPS

1. **Limit use of abbreviations.**
2. **Date and sign all entries.**
3. **Document legibly.**
4. **Report functional progress towards goals regularly.**
5. **Document at the time of the visit when possible.**
6. **Clearly identify note types, eg, progress reports, daily notes.**
7. **Include all related communications.**
8. **Include missed/cancelled visits.**
9. **Demonstrate skilled care and medical necessity.**
10. **Demonstrate discharge planning throughout the episode of care.**

Documenting Skilled Care

- Document clinical decision making/ problem-solving process.
- Indicate why you chose the interventions/ why they are necessary.
- Document interventions connected to the impairment and functional limitation.
- Document interventions connected to goals stated in plan of care.
- Identify who is providing care (PT, PTA, or both).
- Document complications of comorbidities, safety issues, etc.

Documenting Medical Necessity

- Services are consistent with nature and severity of illness, injury, medical needs.
- Services are specific, safe, and effective according to accepted medical practice.
- There should be a reasonable expectation that observable and measurable improvement in functional ability will occur.
- Services do not just promote the general welfare of the patient/client.

Tips for Documenting Evidence-Based Care

- Keep up-to-date with current research through journal articles and reviews, Open Door, Hooked on Evidence at www.apta.org.
- Include valid and reliable tests and measures as appropriate.
- Include standardized tests and measures in clinical documentation.

Documentation Format

INITIAL EXAMINATION

History – May include:

○ Pertinent medical/surgical history	○ Cultural preferences
○ Social history	○ General health status
○ Growth and development	○ Previous and current functional status/activity level
○ Living environment	○ Medication and other clinical tests
○ Work status	○ Current condition(s)/chief complaint(s)

Systems Review – Brief, limited exam to rule out problems in the musculoskeletal, neuromuscular, cardiovascular/pulmonary, and integumentary systems that may/ may not be related to the chief complaint and may require consultation with others. Also may include:

○ Communication skills	○ Factors that might influence care
○ Cognitive abilities	○ Learning preferences

Tests and Measures – Used to prove/ disprove the hypothesized diagnosis or diagnoses. Includes:

- ○ Specific tests and measures: increased emphasis placed on standardized tests/measures, eg, OPTIMAL
- ○ Associated findings/outcomes

Evaluation – A thought process leading to documentation of impairments, functional limitations, disabilities, and needs for prevention. May include:

- ○ Synthesis of all data/findings gathered from the examination highlighting pertinent factors
- ○ Should guide the diagnosis and prognosis
- ○ Can use various formats: problem list, statement of assessment with key factors influencing status

Diagnosis – Should be made at the impairment and functional limitation levels. May include:

- ○ Impact of condition on function
- ○ Common terminology, eg ICD-9 CM coding or Preferred Physical Therapist Practice Patterns

Prognosis – Conveys the physical therapist's professional judgment. May include:

- ○ Predicted functional outcome
- ○ Estimated duration of services to obtain functional outcome

Plan of Care – May include:

- ○ Overall goals stated in measurable terms for the entire episode of care
- ○ Expectations of patient/client and others
- ○ Interventions/treatments to be provided during the episode of care
- ○ Proposed duration and frequency of service to reach goals
- ○ Predicted level of improvement in function
- ○ Anticipated discharge plans

Tips for Documenting Progress

- Update patient/client goals regularly.
- Highlight progress toward goals.
- Clearly indicate if this is a progress report by demonstrating patient/client improvement.
- Show comparisons from previous date to current date.
- Show a focus on function.
- Re-evaluate when clinically indicated.

Avoid

- "Patient/client tolerated treatment well"
- "Continue per plan"
- "As above"
- Unknown/confusing abbreviations – use abbreviations sparingly

Confidentiality

- Keep patient/client documentation in a secure area.
- Keep charts face down so the name is not displayed.
- Patient/client charts should never be left unattended.
- Do not discuss patient/client cases in open/public areas.
- Follow HIPAA requirements: http://www.cms.hhs.gov/HIPAAGenInfo/

Coding Tips

- Have a current CPT, ICD-9, and HCPCS book.
- Review code narrative language.
- Select codes that accurately describe the impairment or functional limitations that you are treating.
- Use the most specific code that accurately describes the service.
- Know when a modifier is necessary and accepted by a payer.

Additional Resources:

- State Licensing Boards: http://www.fsbpt.org/licensing/index.asp
- Joint Commission: http://www.jointcommission.org/
- CARF: http://www.carf.org/
- CMS: http://www.cms.hhs.gov/
- Physical Fitness: http://www.apta.org/pfsp

APTA
American Physical Therapy Association
The Science of Healing. The Art of Caring.

For additional information on Defensible Documentation, please visit **www.apta.org/documentation**

RE-EXAMINATION

Is provided to evaluate progress and to modify or redirect intervention. Should occur whenever there is:

- An unanticipated change in the patient's/client's status
- A failure to respond to physical therapy intervention as expected
- The need for a new plan of care and/or time factors based on state practice act, or other requirements

○ Includes findings from repeated or new examination elements

VISIT/ENCOUNTER NOTES

Document implementation of the plan of care established by the physical therapist.

Includes:

○ Changes in patient/client status	○ Variations and progressions of specific interventions used
○ Patient/client/caregiver report	
○ Interventions/equipment provided	○ Frequency, intensity, and duration as appropriate
○ Patient/client response to interventions	

○ Communication/collaboration with other providers/patient/client/family/ significant other

○ Factors that modify frequency/intensity of intervention and progression of goals

○ Plan for next visit(s): including interventions with objectives, progression parameters, precautions, if indicated

DISCHARGE SUMMARY

Required following conclusion of physical therapy services, whether due to discharge or discontinuation.

May include:

○ Highlights of a patient/client's progress/lack of progress towards goals/discharge plans

○ Conveyance of the outcome(s) of physical therapy services

○ Justification of the medical necessity for the episode of care

Top 10 Payer Complaints about Documentation (Reasons for Denials)

1. **Poor legibility.**
2. **Incomplete documentation.**
3. **No documentation for date of service.**
4. **Abbreviations – too many, cannot understand.**
5. **Documentation does not support the billing (coding).**
6. **Does not demonstrate skilled care.**
7. **Does not support medical necessity.**
8. **Does not demonstrate progress.**
9. **Repetitious daily notes showing no change in patient status.**
10. **Interventions with no clarification of time, frequency, duration.**

Defensible Documentation Quick Reference

Following the Patient/Client Management module, patient care should be documented through the episode of care:

Initial Examination

History- The history of the examination is a collection of information which can be gathered through a patient/client or caregiver interview and includes a review of past and current medical and social information. The medical history may include pertinent medical diagnosis, surgical history, a list of current medications, information about previous clinical tests (X-rays, CT scan, etc) and a general review of current health status. The social history may include information on the patient / client's living environment, work status, and cultural preferences. In addition, it is recommended to include information on a patient / client's previous level of function.

Systems Review - A systems review is a necessary component of any initial examination. Information gathered from a systems review is imperative as it assists the physical therapist in determining conditions related and perhaps unrelated to the current chief complaint. In addition to a review of the various systems, this is a where information regarding a patient's/ client's communication skills, cognitive abilities, and other important factors that might influence care or that is pertinent to function should be documented.

Tests and Measures - From the information gathered in the history and systems review, the physical therapist determines a hypothesis for a diagnosis. The physical therapist then determines which tests and measures are required to further prove (or disprove) the hypothesized diagnosis or diagnoses. In the documentation of tests and measures, a physical therapist should clearly identify the specific tests and measures, and any associated finding or outcome. In addition to traditional tests and measures (ROM, strength, balance, etc), more and more emphasis is placed on the importance of standardized tests and measures.

Evaluation – An evaluation is a thought process which leads to documentation of such items as impairments, functional limitations, and disabilities. This evaluation process is a synthesis of all of the data and findings gathered from the examination and should guide the physical therapist to a diagnosis and prognosis for each patient / client. The documentation of an evaluation can use formats such as a problem list or a statement of assessment with key factors (e.g., cognitive factors, co- morbidities, social support) influencing the patient/client status.

Diagnosis – The diagnosis determined by the physical therapist after the evaluation process should be made at the impairment and functional limitation levels. It should identify the impact of a condition on function at the level of the system and the level of the whole person. The diagnosis by a physical therapist should be clearly documented and can take many formats. Some therapists choose to use common terminology to describe a diagnosis such as ICD coding or similar medical terminology. Another option is the Practice Patterns in the Guide to Physical Therapist Practice.

Prognosis - Documentation of the prognosis conveys the physical therapist's professional judgment for the patient / client's predicted functional outcome and the required duration of services to obtain this functional outcome.

Plan of Care - Documentation of the plan of care includes: 1) Overall goals stated in measurable terms that indicate the predicted level of improvement in function. Consider the expectation of the patient/client and others as appropriate; 2) A statement of interventions / treatments to be provided during the episode of care; 3) Proposed duration and frequency of service required to reach the goals; 4) Anticipated discharge plans

Re-examination- Includes data from repeated or new examination elements and is provided to evaluate progress and to modify or redirect intervention. In general, a re-examination of a patient/client should occur whenever there is an unanticipated change in the patient's/client's status, a failure to respond to physical therapy intervention as expected, the need for a new plan of care and / or time factors based on state practice act, or other requirements.

Visit / Encounter Notes – Can be referred to as daily notes. Document sequential implementation of the plan of care established by the physical therapist, including changes in patient/client status and variations and progressions of specific interventions used and may include specific plans for the next visit or visits. Components include: Patient / client or caregiver report; Interventions provided including frequency, intensity, and duration as appropriate; Patient/client response to treatments / interventions; Communication / collaboration with other providers/patient/client/family/ significant other; Factors that modify frequency or intensity of intervention and progression of goals; Plan for next visit(s) including interventions with objectives, progression parameters and precautions, if indicated.

Discharge Summary – Documentation is required following conclusion, whether due to discharge or discontinuation of physical therapy services. The purpose of the discharge summary is to highlight a patient / client's progression towards goals and discharge plans. Essentially, this is the last time a therapist has to convey the outcome of physical therapy services. It is also the last opportunity to justify the medical necessity for the episode of care.

Tips for Documenting Evidence-Based Care

1) Keep up to date with current research through journal articles and reviews, Open Door, Hooked on Evidence at www.apta.org.
2) Continue to incorporate valid and reliable tests and measures as appropriate.
3) Include standardized tests and measures in your clinical documentation.
4) Review literature for evidence based interventions with APTA's Hooked on Evidence.

Tips for Documenting Evidence-Based Care
5) Keep up to date with current research through journal articles and reviews, Open Door, Hooked on Evidence at www.apta.org.
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11) Include standardized tests and measures in your clinical documentation.
12) Review literature for evidence based interventions with APTA's Hooked on Evidence.

State Laws and Other Regulations
Physical therapists and physical therapist assistants must consider all requirements imposed by regulations when practicing and documenting.
State Law - Some state practice acts regulating physical therapy services may contain specific documentation requirements within their regulations. It is important that you review your state's licensure regulations with respect to documentation requirements. If state law is stricter than third party requirements, state law supersedes. The following link will direct you to information about your state practice act: http://www.apta.org/AM/Template.cfm?Section=Practice_Management1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=201&ContentID=21791
Insurance Regulations – Different insurance companies can require unique requirements for payment. Examples may include authorization, certification, progress reports, etc.
Other – Additional requirements may be imposed based on practice setting, accreditation status, etc.
JCAHO – www.jcaho.org (accredits Hospitals, Home Care, Long Term Care, Ambulatory Care, Behavioral Health)
CARF – www.carf.org

Terms/ Phrases to Avoid
• "Patient/client tolerated treatment well"
• "Continue per plan"
• "As above"

How to Use Abbreviations
Abbreviations can be a quick and efficient way of documenting information. However, use of unknown or confusing abbreviations can be the source of communication breakdown. APTA does not endorse any particular set of abbreviations and recommends that physical therapists use abbreviations sparingly and that facilities clearly define what abbreviations are allowed in clinical documentation. A facility accepted abbreviations list should be in the Policy and Procedure Manual.
Improper use of abbreviations can also cause frequent denials in payment. A clinic may wish to develop a key of frequently used abbreviations on most documentation forms or request therapists to completely spell any word the first time it is written with the shortened form in parentheses (e.g. American Physical Therapy Association (APTA)).
There are some abbreviations considered as Do Not Use (DNU) according to JCAHO National Patient Safety Goals (www.jcaho.org). These abbreviations should be avoided (i.e., QD, TID, etc).

Top 10 Tips for Defensible Documentation
1. Limit use of abbreviations.
2. Date & sign all entries.
3. Document legibly.
4. Report progress towards goals regularly.
5. Document at the time of the visit when possible.
6. Clearly identify note types, e.g. progress reports, daily notes, etc.
7. Include all related communications.
8. Include missed/cancelled visits.
9. Demonstrate skilled care.
10. Demonstrate discharge palnning throughout the episode of care.

Useful Links
www.cms.org – Centers for Medicare and Medicaid Services
http://www.cms.hhs.gov/transmittals/downloads/R140PI.pdf - Therapy Cap Transmittal
http://www.cms.hhs.gov/TherapyServices/ - CMS Therapy Service link
http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf - CMS manual - includes therapy requirements
http://www.apta.org – APTA's Home Page – links to Reimbursement, Practice, and Medicare information

Top 10 Payer Complaints about Documentation (Reasons for Denials)
1) Poor legibility.
2) Incomplete documentation.
3) No documentation for date of service.
4) Abbreviations – too many, cannot understand.
5) Documentation does not support the billing (coding).
6) Does not demonstrate skilled care.
7) Does not support medical necessity.
8) Does not demonstrate progress.
9) Repetitious daily notes showing no change in patient status.
10) Interventions with no clarification of time, frequency, duration.

Ways to Improve Documentation
• Establish a Peer Review program
• Take advantage of CEU courses related to documentation

How to Handle Denials
• Review the Explanation of Benefits (EOB) voucher. That voucher should have a code with a descriptor that states why a denial was made.
• Review your claim form & documentation to see if you have grounds for an appeal.
• Appeals should be submitted in writing and not initiated over the phone. It is recommended that you mail the appeal with a "return receipt requested". Submit in a timely fashion as specified on the EOB.
• Forward your documentation along with the letter of appeal but make sure that the documentation supports your case.
• You may also need a copy of your state practice act, APTA's *Guide to Physical Therapist Practice*, APTA's Standards of Practice, a copy of the patient/client's benefit language, and the records of any conversations that the office staff has had with the payer's professional services personnel.

Confidentiality
• Keep patient/client documentation in a secure area
• Keep charts face down so the name is not displayed
• Patient/client charts should never be left unattended
• Do not discuss patient/client cases in open/public areas
• HIPAA web site: http://www.cms.hhs.gov/HIPAAGenInfo/

Coding Tips
1. Have a current CPT, ICD9, and HCPCS Book.
2. Review code narrative language.
3. Select codes that accurately describe the impairment or functional limitations that you are treating.
4. Utilize the most specific code that accurately describes the service.
5. Know when a modifier is necessary and accepted by a payer.

Key Phrases for Documentation

Requiring Skilled Services

- Patient lives alone or will be alone __ hrs/day and must be modified I prior to D/C home
- Family/caregiver can only provide ___ assist/supervision
- Qualifying comments in addition to "min A"
  - Instructional cues for proper sequencing/hand placement with RW
  - Rolls with min A with rail with questioning cue to attend to L UE
  - Movement demonstrates disassociation of upper body and lower body movements
  - Patient demonstrates decreased problem solving when ambulating in controlled/uncontrolled environment thus decreasing safety

Not Meeting Goals

- Declining medical status
- Goals set for 2 weeks and patient discharged after only 3 days or 2 treatments
- Slower progress than anticipated
- Decreased participation and/or refusals
- Family not available for education

Overall, a lot of what we do to make it "skilled" services is education, but we need to document the details of what we are teaching (i.e. proper use of DME, WB status – why they can't maintain – weakness etc., "normal" movement patterns, safety awareness). We also need better documentation of cognitive training that we incorporate to increase safety/I.

Types of Cueing

- Document frequency as min <25%, mod 25-50%, max 50-75%, total >75%
- Non-verbal/subtle
  - Pregnant pause
  - Expectant look
  - Hand gestures
- Verbal
  - Instructional
  - Questioning or Prompting
  - Confirmational
- Visual
  - Demonstrational
  - Gesturing
  - Mirroring
- Tactile
  - Light touch
  - Heavy manual (e.g. steering RW)
- Manual Facilitation
  - Describe location and goal (scapula, pelvis)
  - Hand over hand
- Multi modal cues
  - Incorporating several different cue types

Considerations for Communication and Cognition

- Aphasia—receptive, expressive, global
- Dysarthria
- Arousal—stuporous, lethargic, awake, alert/mentally engaged, agitated, flooded
- Attention—focused, sustained, selective, alternating, divided
- Awareness
- Hearing acuity
- Visual acuity
- Language

Attention and Awareness:

Attention:

- Focused: brief
- Sustained: longer periods of time; can complete task without switching off
- Selective: enables you to avoid distractions; talk with the TV on
- Alternating: can go back and forth between tasks
- Divided: respond to multiple tasks at the same time, document while someone is talking to you and you can actually answer their questions.

Awareness:

- Intellectual: capacity to understand that a particular function is diminished from pre-morbid level and acknowledge the possible implications deficits may have on functional performance
    - Examples:
        - Hemi patient able to tell you they can't move their arm/leg, but have difficulty understanding why it is so hard to get up out of bed
        - Neglect patients
        - Sit to stand unaware of L leg not supporting weight
        - Hemiplegic patients who think they can get back to bed safely
        - Brushing teeth- toothpaste all over the place; trying to use affected hand to open container; unable to shift to compensate; leave water running.
- Emergent: The ability to recognize a problem when it is occurring in an activity
    - Examples:
        - Patient trying to get out of bed and reaching to move hemi side without cues
        - Trying to recover lost balance when sitting EOB with doing a functional task
        - Aware that leg is buckling when standing
        - Using the affected hand as a gross assist when brushing teeth, wiping toothpaste off hand/mouth.
        - Using the call bell when wanting to get back to bed.
- Anticipatory: the ability to anticipate that a problem may occur in a particular task or setting.
    - Examples:
        - I need to sleep on the side of the bed that is easier for me to get out of in the morning/night.
        - Pt sitting close to the foot board so that they can catch their balance if needed
        - Using a walker to prevent falling
        - Pt making sure their call bell is close so that they can call for help
        - I need to buy flip top containers so that I can open them with one hand.

Describing Mobility and Functional Deficits

- Considerations for **Bed Mobility**
  - **Do they even sleep in a bed at home**
  - Rolling
    - Predominately a flexion activity
    - Neck flexes and rotates to side
    - Arms out from under body but NOT overhead (creates spinal extension)
    - Trunk active in flexion/rotation toward roll-to side
    - Rib cage tucks
    - Pelvis is forward
    - Outwardly rotate leg on roll-to side, pull opposite leg forward (do not push into bed with heel)
    - Can use pad or sheet to assist trunk/hips to side
  - Side <> Sit
    - Legs flexed to chest, top arm in front of body
    - Swing legs off edge of bed, pelvis drops
    - Bottom arm flexes at shoulder to prop elbow; top arm assists to push trunk up
    - Trunk laterally flexed and rotated away from dropped hip, moves into neutral
    - Dropped hip—pelvis lowers to contact surface, patient assumes midline
  - Supine <> Sit
    - Lift head/shoulders forward, rotate to side
    - Rotate and flex trunk
    - Legs swing to side of bed
    - Hand can be flat on bed
    - Practice in reverse for increased ECCENTRIC control
  - Scooting
    - Forward/Backward
      - ✓ Laterally shift weight
      - ✓ Laterally flex pelvis to unload hip
      - ✓ Rotate hip forward
      - ✓ Can use upper extremities to assist
    - Sideways
      - ✓ Head-hips relationship
      - ✓ Center of gravity (COG) shifts over feet
      - ✓ Pelvis shift away from trunk
      - ✓ Can use upper extremities to assist

- Considerations for **Sitting Balance**
  - Base of Support vs. Center of Gravity (BOS/COG)
  - Pelvic positioning
    - Resting position
    - Ability to move in all planes
    - Anterior/posterior/lateral tilt
  - Trunk alignment

    - Resting position
    - Ability to move in all planes
    - Frontal plane: flexion/extension
    - Sagittal plane: lateral flexion
    - Transverse plane: rotation
  - Feet supported/unsupported
  - Firmness of support surface
  - Upper extremity support
  - Static versus dynamic (reaching, leaning, resistive)

- Considerations for **Sit-to-Stand Transitions**
  - Feet behind knees with open base of support
  - Begins with hip flexion/anterior pelvic tilting
  - Keep head/eyes lifted, avoid spinal flexion
  - COG moves diagonally forward and up over balls of feet
  - Active trunk, then stable/active trunk moving UP and FORWARD
  - Knees move forward (flex) then extend, followed by hip extension
  - Ankles dorsiflex then plantarflex
  - Hip and knee extensors contract concentrically to produce power to rise
  - Stand-to-sit: reverse and focus on ECCENTRIC control of knee/hip flexion

- Considerations for **Standing Balance**
  - Base of Support vs. Center of Gravity (BOS/COG)
  - Feet are shoulder width apart
  - Ankles neutral, weight even distributed through foot
  - Hips and knees extended, not locked
  - Pelvis neutral
  - Upper trunk is actively extended with normal curvature of spine
  - Head and neck over BOS
  - Upper extremities relaxed
  - Static versus dynamic (weight shifts laterally, ant/post on diagonal, reaching)

- Considerations for **Surface-to-Surface Transfers**
  - Use of upper extremities (UEs) to support
  - Stand pivot
  - Squat pivot
  - Head-hips relationship

- Considerations for **Gait**
  - Device or no device (What did they use prior to admission (PTA)?)
  - Sequencing (nose over toes, use hands or not use hands, forward translation of tibia over ankles)
  - Direction
  - Caregiver assistance
  - Weight bearing limitations
  - Braces

- Lift chair at home? (this can be good and bad)

- Considerations for **Stair Climbing**
  - Rail or no rail
  - Device or no device
  - Sequencing
  - Direction
  - Caregiver assistance
  - Weight bearing limitations
  - Affected limbs
  - Step height/depth

- Considerations for **Assistive Devices**
  - LRAD: Least Restrictive Assistive Device
  - Single point cane
  - Quad cane
  - Hemiwalker
  - Crutches
  - Standard walker
  - Rolling walker
  - Rollator (4 wheeled RW)
  - Roll-About
  - Platform walker

- Considerations for **Wheelchair Training**
  - Chairs
  - Cushions
  - Transfers
  - Maneuvering and Propulsion
  - Height of seat
  - Clearance at home/home setup

- Considerations for **Environment**
  - Hospital
  - Household
  - Community
  - Surface type
  - Obstacles
  - Distractions

- Considerations for **Communication and Cognition**
  - Aphasia
  - Dysarthria
  - Hearing
  - Arousal
  - Attention

- Language

- Considerations for **Assessing Learning**
  - Carry-over during session
  - Translating to novel task
  - Carry-over from previous session
  - Teach back (if able)
  - Interpreter

Documentation of Gait
Helpful Tips and Terminology

Observational Gait Analysis

Most clinical settings lack measurement tools like force plates or videography. Therapists must therefore rely on keen observational skills and knowledge of 'normal' gait.

- Observations should be made **in multiple planes**.
- The therapist should watch a person walking from the front, back and side for the best picture of what is happening. If you can't see exactly what the gait pattern is because you are guarding them closely, you may have to trade with the rehab tech or ask about gait pattern observed from further away.
- The therapist should **observe**
  - **the head and trunk position**
  - **hip, knee, ankle and toe joints**
  - **the role of the arms**
- The therapist needs to identify **at what time** or during **what phase of gait** positions and motions are occurring.
- More advanced observational skills can incorporate palpation to get a 'feel' for muscle activity, timing of activation, coordination and joint positioning, etc.

Remember that gait **is speed dependent** and observations may change based on cadence. Also, don't forget to have patients walk forward as well as backwards and sideways (if able).

Phase terminology for gait analysis
Stance Phase

Traditional	Rancho
heel strike	initial contact
foot flat/stance	loading response
midstance	midstance

heel off	terminal stance
toe off	pre-swing

Swing Phase

Toe off – acceleration	initial swing
mid-swing	mid-swing
deceleration	terminal swing

Documentation of Observational Gait Analysis

Quantitative descriptions of gait analysis describe what is seen and/or felt during the gait cycle. This type of data can be limited by personal subjectivity or bias and is not easily generalizable to other patients or populations, and lacks validity and reliability when attempting to make comparisons or predictions. Having said that, qualitative data can provide a rich picture of and individual's function and requires a confident understanding of 'normal' mechanics of dynamic posture during gait, as well as an appreciation of each patients idiosyncratic 'normal'.

Qualitative Examples:

- Increased trunk flexion
- Decreased forward translation of body weight over stance limb
- Decreased dorsiflexion in swing or toe drag
- Arms held in high guard position
- Head looking down, unable to turn head or look up
- Increased lateral weight shift in single limb stance
- Knee hyperextension with loading in midstance
- Lack of hip extension in late stance
- Step-to versus step-through pattern
- Decreased hip or knee flexion in swing
- Trendelenburg, steppage, antalgic, vaulting.

Observation of gait can be **quantitative,** wherein the therapist utilizes measurable data to provides reliable and measurable information to identify objective progress. For some measures, valid and reliable tests already exist. When choosing a test or measure, the therapist must consider the **population** and **what information** they are seeking for that specific patient or population (i.e. time required to walk a certain distance: Timed Up and Go test; distance walked in a certain amount of time: 6 Minute Walk Test), gait speed. Quantitative measures can also be documented without using a standardized test.

Quantitative Examples:

- Time how long it takes a patient to walk 150 feet with a stop watch
- Count and time the number of rest breaks or freezing episodes in a certain distance
- Count the number of losses of balance and assist required to regain balance in a specified distance
- Count the number and type of cues required to correct certain deviations
- Measure width of support base, step or stride length, length of stance phases etc. to demonstrate progress towards 'normal'
- Document blood pressure, heart rate and O2 saturation level responses to gait
- Document dyspnea level
- Document rating of perceived exertion
- Count the number of times a patient's toe drags and on what surface type
- Count number of cues required for patient to adhere to weight bearing status in a given distance
- Number of steps in a certain distance (speaks to step length)

LEVELS OF ASSISTANCE

The level of assistance a patient requires to perform an activity is dependent upon the percentage of the task the patient performs AND the number of people required to assist the patient in performing the task.

➢ **Patient requires only 1-person assistance:**

- **Independent (I)** – The patient performs the activity without physical assistance, verbal cuing, demonstration, set-up, etc. The patient can be left alone to perform the activity safely and within a reasonable length of time. Patient does not use any assistive devices (adaptive equipment, walkers, prostheses, etc.)
- **Modified Independent (Mod I)** – The patient performs the activity without physical assistance, verbal cuing, demonstration, set-up, etc. The patient may use and assistive device (this includes bed rail), take more than reasonable time, or there are safety considerations.
- **Supervision/Set-up (S)** – The patient can perform the activity without physical assistance. May need standby assistance, cuing, coaxing, demonstration, or set-up. The patient cannot be left alone to perform the activity safely.
- **Minimal Assistance (Min A)** – The patient performs 75% or more of the task and may require contact guarding. The therapist/assistant(s) perform 25% or less of task.
- **Moderate Assistance (Mod A)** – The patient performs 50-74% of the task.
- **Maximal Assistance (Max A)** – The patient performs 25-49% of the task.
- **Total Assistance (Tot A)** – The patient performs < 25% of the task.

➢ **Patient requires 2-person assistance:**

- **Total Assistance (+2 Tot A)** – Use this documentation ANY time the patient requires the physical assistance of 2 (or more, i.e. +3, +4, etc.) persons to safely perform the task.

- When using +2 physical assist you must also comment on the level of assistance (levels listed above) so that there is a clear picture of how much the patient is doing. For example: +2 physical assist/mod.
- When using +2 safety/equipment, it is implied that the second person is there for line management or chair to follow, but not actually providing physical help. You would still also comment the levels listed above. For example: +2 safety/equipment mod assist (chair to follow for safety).

➢ **Considerations for Levels of Assistance**

- What is the maximum burden of care for the caregiver of this patient?
- Document the most conservative estimate of performance and use comments to qualify. So, if someone is min-mod assistance during gait rate them as mod assist and comment to the fluctuation. For example: Mod assist for gait with RW. The patient is mod assist for LOB while turning RW, however, for controlled environment gait without turns, he is min assist for balance.
- What role does cognition play when performing a task with assistance?
- How much cuing or repetition of instruction does the patient need versus how much physical assistance? Consider both, however, rate the amount of physical assistance and comment to the cognitive factors. For example: The pt is mod assist for balance during gait, but require max multimodal cues to stay on task and for RW safety during gait.
- Make sure if someone did not use an assistive device PTA, and it is safe to do so, try mobilizing without the assistive device and document levels both with and without AD.
- How skilled is the assistance a second person provides?
  - Could a family member with no medical experience perform the same task safely?
  - Is the second person a convenience or a necessity?

Discharge Planning for the Acute Therapist
An Introductory Guide

- Home:
  - Has adequate family assistance, is safe and mobile at that level of assistance, has all DME needs identified and met
  - Home Health: "homebound" but with continuing Tx needs; eval for safety in home environment
  - Outpatient : continuing Tx needs; can safely and physically get to clinic

- SNF (for rehab)
  - No home d/c plan: no family assistance and/or not safe for d/c alone
  - Continues to have Tx needs, but cannot tolerate 3 hours of therapy daily
  - Will likely require greater than 2-3 weeks to get to home

- SNF (resident)
  - Cannot/will not participate in therapy
  - No assistance for home d/c

- ALF
  - Continues to require 24 hour supervision or assistance, and no family available to provide
  - Otherwise at supervision or minimal assistance level
  - Can receive Home Health services at ALF
  - We usually cannot recommend this as a new d/c destination as it is too timely and difficult for our social workers to set up. Usually, people go to SNF for rehab first and then transition into ALF level of care afterwards.
  - We can recommend this for someone who is from ALF, returning to ALF level of care.

- Inpatient Rehab (see next page)

Inpatient Rehabilitation at Moses H. Cone Hospital

Admission Coordinator Contacts

Melissa Bowie	**336-430-4505**
Barbara Boyette	**336-317-8318**
Genie Logue	**336-317-8538**

- Patient is 18 years of age or older. There is no maximum age.
- Patient requires active and ongoing intervention of multiple therapy disciples of which one must be either physical therapy or occupational therapy.
- Patient requires an intensive rehabilitation therapy program generally consisting of three hours of therapy per day for at least five days a week.
- Patient requires physician supervision by a rehabilitation physician.
- Patient is reasonably expected to actively participate in and benefit significantly from, the intensive rehab program.
  - Further Explanation: Patient's condition and functional status are such that the patient can be expected to make improvements within CIR average length of stay (10-14 days).
- Patient requires an intensive and coordinated interdisciplinary team approach to the delivery of care
  - Could include: 24/7 nursing care, wound care, bowel/bladder management, trach care, cortrak, patient/family education, etc.
- We accept uninsured, Medicare, Medicaid, private insurance, and others.
- Depending on payor source varying degrees of discharge planning are required prior to determination of admission.
- Each admission is examined on a case-by-case basis. If you have any questions, please contact the admission coordinators and let them screen the patient.
- It is always a good idea to make the referrals as early as possible so the patient can be transferred to rehab at the appropriate time.

ACUTE CHARGING GUIDELINES

❖ Choosing the Appropriate Charge

➢ Evaluation

- Eval charge must precede any treatment charge
- Eval charge is an untimed charge (as is re-eval, and canalith repositioning maneuver) and can only be charged once per day.
- Charge for eval when
  - You've reviewed the chart, begun some hands-on assessment, and determine the patient is (or is not) appropriate for acute therapy. Your skill is required to determine that therapy is not appropriate
- DO NOT charge for eval if
  - You review the chart but then cannot see the patient for assessment.
  - Your time in the room is less than 8 minutes
- Evals are classified as Low/Moderate/High Complexity
  - Here are some guidelines for when each should/would be used:

CPT Code	Low	Moderate	High
Required Components (all are required in selecting evaluation level)			
History: personal factors and/or co morbidities	No personal factors/comorbidities	1-2 personal factors and/or comorbidities	3 or more personal factors and/or comorbidities
Examination of body system (s)- elements include body structures and functions, activity limitations, and/or participation restrictions	Addressing 1-2 elements	Addressing a total of 3 or more elements	Addressing a total of 4 or more elements
Clinical Presentation	Stable/uncomplicated	Evolving/changing characteristics	Unstable/unpredictable
Clinical Decision making (complexity)	Low complexity decision making	Moderate complexity decision making	High complexity decision making

➢ Co-Evaluation

- Co-eval with **another discipline:** The total units billed are split between the two disciplines. For example, if there are 23 mins, each discipline takes one unit. 1 mod eval PT and one mod eval OT. If there are three units billed, then one takes two and one takes one. I mod eval PT and one mod eval and one therapeutic activity OT.
- If the time is under two units, for example, 21 minutes, then you can still with justification of why two skilled therapists were needed, charge 1 eval each because they are technically untimed charges.

- If co-eval with **same** discipline
  - For educational purposes, the person educating take the charge and the person learning takes clinical education (CE) time on their time worksheet.
  - For clinical observation, one person takes the charge and one person takes non-productive time, also put on their time worksheet.

➢ **Treatment**
- Charges should include all skilled activities involved in caring for the patient
- DO NOT charge for the time it takes the tech to set-up the room and wrap-up the treatment
- DO NOT charge for time the patient is toileting if there is not a skilled intervention happening at the same time
- DO NOT charge for time that RN, MD, lab, etc are in the room during your session and interrupting your treatment.
- See also, attached PT/OT/SLP charges

➢ **Co-Treatment**
- Co-tx with **another** discipline, then the treatment charge is split (PT/OT, SLP has charges billed differently/separately from PT/OT and can charge concurrently).
- See guidelines for co-evaluation.

➢ **Family Education**
- Time spent with families/caregivers should be added to your charges
- Charges are based on the functional task being taught
- Use the "Self care/Home management" charge if no other charge fits the situation.

➢ **Equipment**
- Charge for time arranging or ordering equipment
  - Specific to the needs of the patient
  - RN Case Manager typically responsible for **ordering**
- DO NOT charge for time FINDING equipment

❖ **Accounting for Time**

➢ **CPT Coding system—Minutes to Units**
- Units represent 15 minute time frames
- Treatments must extend at least 8 minutes into the next unit to be charged for a time code
- Minutes/Units Guide
  - 1-7 minutes 0 units
  - 8-22 minutes 1 unit
  - 23-37 minutes 2 units
  - 38-52 minutes 3 units
  - 53-67 minutes 4 units

PT

charge	description	Unit/visit
PT eval	Initial evaluation; re-evaluation if patient was discharged from therapy services or had major change in status (i.e. new amputation)	visit
PT re-eval	Re-evaluation in which formal reassessment is not necessary (i.e. remeasure wound, change in medical status in which reassessment is required)	visit
Physical Performance Test	Any assessment occurring after the initial evaluation is complete (i.e. BERG or other balance test, vestibular assessment, repeat detailed MMT for SCI, lymphedema eval). Must have separate documentation of assessment.	15 min unit
Electrical stim	Includes TENS, NMES, biofeedback; used for analgesia, strengthening, edema control, muscle re-education	15 min unit
Massage	Systemic manipulation to the soft tissue of the body for therapeutic purpose; must be used in conjunction with another therapeutic procedure designed to restore muscle function, decrease edema, increase joint motion, or relieve muscle spasm	15 min unit
Ultrasound	Used for deep heat to reduce pain, spasm, and joint stiffness or to increase muscle, ligament, and tendon flexibility	15 min unit
Therapeutic Exercise	Includes active, active assisted, or passive; used to develop strength and endurance, ROM and flexibility	15 min unit
Gait training	includes instruction in assistive device, stair training, fitting with a brace and/or standing transfer (pregait)	15 min unit
Sensory Integration	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands.	15 min unit
Neuromuscular Re-education	A therapeutic procedure provided to improve balance, coordination, kinesthetic sense, posture, and/or proprioception	15 min unit
Self-care/home management	Used for home eval (time in the home), family conference (1 charge/discipline regardless of time spent), pt/family education for adaptive equipment, home safety, stump care, and home instruction	15 min unit
Therapeutic Activities	Used for dynamic activities (i.e. bending, lifting, carrying, reaching, catching, and overhead activities) to improve functional performance; Usually directed at a loss or restriction of mobility, strength, balance or coordination; can be used for transfers and bed mobility if gait/pregait not involved)	15 min unit
Wheelchair management	used to train the patient in wheelchair safety, mobility and transfers; used for skilled input on positioning to avoid pressure points, contractures or other medical complications	15 min unit
Canalith Repositioning Maneuver	Performance of Epley Maneuver or Semont Maneuver, etc. Can only be charged once/day	Visit
Orthotic fit/training	Used for fabrication or education for application of orthotics and the functional use of orthotics; Used for splint fabrication. Use this charge to include gait training or self-care/home management component of treatment as well	15 min unit
Prosthetic training	used for education in the application of the prosthetic and the functional use of the prosthetic; Use this charge to include gait training or self-care/home management component of treatment as well	15 min unit

Orthotic/ Prosthetic check	check for orthotic/prosthetic use, established patient	15 min unit
Whirlpool		visit (1)
Debridement up to 20 cm	Charge for debriding wound that has eschar present for up to 20 cm of total surface area; includes time for PLS (also charge supply for kit)	visit (2)
Debridement add't 20 cm	Charge for debriding wound for each additional 20 cm (or part thereof) of surface area with eschar present.	1 unit for each add't 20 cm
Dressing	Zero dollar charge to patient, but does account for your time	15 min unit
Supply charge	Associated with a dollar amount for supplies	

OT

charge	description	unit/ visit
OT eval	Initial evaluation; re-evaluation if patient was discharged from therapy services or had major change in status (i.e. new amputation)	visit
OT re-eval	Re-evaluation in which formal reassessment is not necessary (i.e. remeasure wound, change in medical status in which reassessment is required)	visit
Physical Performance Test	Any assessment occurring after the initial evaluation is complete (i.e. BERG or other balance test, vestibular assessment, repeat detailed MMT for SCI, lymphedema eval). Must have separate documentation of assessment	15 min unit
Massage	Systemic manipulation to the soft tissue of the body for therapeutic purpose; must be used in conjunction with another therapeutic procedure designed to restore muscle function, decrease edema, increase joint motion, or relieve muscle spasm	15 min unit
Cognitive Skills Dev	development of cognitive skills to improve attention, memory, problem solving; includes compensatory training	15 min unit
Sensory Integration	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands.	15 min unit
Therapeutic Exercise	Includes active, active assisted, or passive; used to develop strength and endurance, ROM and flexibility	15 min unit
Neuromuscular Re-education	A therapeutic procedure provided to improve balance, coordination, kinesthetic sense, posture, and/or proprioception	15 min unit
Self-care/home management	Activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment; use for home eval (time in the home), family conference (1 charge/discipline regardless of time spent), home instruction for patient/family	15 min unit
Therapeutic Activities	Used for dynamic activities (i.e. bending, lifting, carrying, reaching, catching, and overhead activities) to improve functional performance; Usually directed at a loss or restriction of mobility, strength, balance or coordination; can be used for transfers and bed mobility if gait/pregait not involved)	15 min unit
Canalith Repositioning Maneuver	Performance of Epley Maneuver or Semont Maneuver, etc. Can only be charged once/day	visit
Wheelchair management	used to train the patient in wheelchair safety, mobility and transfers; used for skilled input on positioning to avoid pressure points, contractures or other medical complications	15 min unit
Orthotic fit/training	Used for fabrication or education for application of orthotics and the functional use of orthotics; Used for splint fabrication. Use this charge to include gait training or self-care/home management component of treatment as well	15 min unit
Prosthetic training	used for education in the application of the prosthetic and the functional use of the prosthetic; Use this charge to include gait training or self-care/home management component of treatment as well	15 min unit
Orthotic/ Prosthetic check	check for orthotic/prosthetic use, established patient	15 min unit
Supply charge	Associated with a dollar amount for supplies (splints)	

SLP

charge	description	code	unit/ visit
SLP eval	Initial evaluation; re-evaluation if patient was discharged from therapy services or had major change in status	EV1	visit
Swallowing Eval, BSS		BSS	visit
Swallowing Eval, MBS		MBS	visit
Swallowing Eval, FEES		FEES	Visit
Assessment of Aphasia	Includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by BDAE	AP	visit
Speech treatment, group	see above, group of 2 or more patients (i.e. diner's club)	TG	visit
Swallowing treatment	treatment of swallowing dysfunction and/or oral function for feeding	SWT	visit
Speech Treatment, Individual	Treatment of speech, language, voice, communication, and/or auditory processing disorder	TI	visit
Cognitive Skills dev	development of cognitive skills to improve attention, memory, problem solving; includes compensatory training)	CSD	15 min unit
Sensory Integration	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands.	SI	15 min unit
Self-care/home management	Activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment; use for home eval (time in the home), family conference (1 charge/discipline regardless of time spent), home instruction for patient/family	SC	15 min unit
Supply charge	Associated with a dollar amount for supplies		

SAMPLE BALANCE GOALS

Berg – Moderate assist or less
(Remember for clinically significant change require at least 5 point increase)

1. Patient will demonstrate with improved balance reactions in quasi-static and dynamic standing as evidenced by x point change in BERG thereby decreasing fall risk.
2. Patient will demonstrate decreased fall risk from significant to moderate as evidenced by increased BERG balance score to at least 46.
3. Patient will sit <> stand independently with controlled descent to surface without arm rests.
4. Patient will stand unsupported x 2 minutes to enable patient to participate in UE activities.
5. Patient will demonstrate ability to maintain balance independently at edge of bed/chair without support in preparation for sit<>stand.
6. Patient will transfer bed<>chair independently +/- arm use.
7. Patient will stand unsupported with eyes closed independently to simulate getting OOB to stand at night.
8. Patient will stand unsupported with feet together independently and safely x 1 minute to simulate negotiating tight spaces in home.
9. Patient will demonstrate ability to reach 10" out of base of support in standing to be able to safely reach household items.
10. Patient will demonstrate ability to safely and independently retrieve item from floor.
11. Patient will demonstrate ability to turn and look directly behind self without loss of balance.
12. Patient will demonstrate ability to turn 360 degrees in 4 seconds or less indicating decreased fall risk.
13. Patient will demonstrate ability to raise lower extremities to height of average step without loss of balance.
14. Patient will demonstrate ability to stand in step stance without loss of balance and maintain safely for 30 seconds for gait preparation.
15. Patient will maintain single limb stance> 6 seconds bilaterally to be able to step over community obstacles

Timed Up and Go – Supervision or less

1. Patient will demonstrate decreased fall risk in community by improving Timed Up and Go score to less than 13.5 seconds.
2. Patient will improve household fall risk by scoring less than 14.5 seconds on manual Timed Up and Go.
3. Pt will demonstrate improved cognitive Timed Up and Go by x seconds to show patients ability to maintain balance with cognitive task to decrease fall risk.
4. Patient will demonstrate with decreased fall risk in dual task conditions as demonstrated by decreased manual/cognitive Timed Up and Go score by x seconds.

Dynamic gait index – Supervision or less

1. Patient will demonstrate with improved dynamic balance as evidenced by x point change in DGI thereby decreasing fall risk
2. Patient will demonstrate with no evidence of imbalance with change in gait speeds thereby decreasing fall risk.
3. Patient will demonstrate ability to negotiate obstacles without evidence of imbalance thereby decreasing fall risk
4. The patient will perform vertical/horizontal head turns during gait x 100 ft without loss of balance to be able to scan the environment safely.
5. The patient will be independent with community obstacle negotiation including curbs, inclines, and compliant surfaces.

Gait velocity – Minimal guard assist or less

(Remember for clinically significant change require at least 0.15ft/second for small and 0.30ft/second for significant change)

1. Patient will demonstrate ability to ambulate speeds deemed sufficient for neighborhood ambulation (1.31-2.62 feet/second).
2. Patient will demonstrate ability to ambulate greater than 2.62 feet/second to enable increased community access.
3. Patient will demonstrate ability to ambulate 4.4feet/second to be able to cross road
4. Patient will demonstrate significant increase in gait speed to x feet/second to improve functional efficiency.
5. Patient will demonstrate ability to ambulate greater than 1.8 feet/second to decrease recurrent fall risk.

COMMUNITY RESOURCES

- **Matter of balance** - contact Kim Johnson at (336) 294-4950 or kjohnson@ptcog.org

Participants learn to view falls and fear of falling as controllable, set realistic goals to increase activity, change their environment to reduce fall risk factors, and learn simple low-impact exercises to increase strength and balance. Includes eight two-hour sessions for a small group led by a trained facilitator.

- **UNCG – HOPE** (Helping others participate in exercise) Mon- Wed – Fri 6.30-8.30 or 12–12.55pm

Provides a comprehensive fitness program to adults over 50 years old. Water and Tai chi classes. Phone: (336) 334-3274.

- **Greensboro Parks and Rec** – 55 and older: Smith $60 for 6 months Cardio /weights; $30 for 6 months senior swimming (336) 3752234/3752237. AHOY program (free) varying levels of impact. (336) 3732914
- **Moses cone outpatient fall screens** –free (15 minutes) – Adams Farm, Guilford College, Kernersville, HP & Cone

Dynamic Gait Index (DGI)	
Purpose	Assess ability to modify balance while walking with external demands
Populations	MS, PD, CVA, vestibular
Assistive device?	Can be performed with or without AD
Cut-off scores	**≤ 19/24 = increased fall risk** > 22/24 = safe community ambulator
MCID	1.8 for patients who score < 21/24 0.6 for patients who score > 21/24

Timed Up and Go (TUG)	
Purpose	Assess mobility, balance, walking ability, and fall risk in older adults
Populations	Joint conditions, cerebral palsy, MS, PD, SCI, CVA, vestibular
Assistive device?	Can be performed with or without AD
Older adults	**≥ 13.5 sec = predictive of falls** < 10 sec = "normal" < 20 sec = independent for basic transfers > 30 sec = dependent on transfers, help to enter/exit shower
Cut-off scores (by population) ***No MCID**	Older stroke patients > 14 sec Frail elderly > 32.6 sec LE amputees > 19 sec PD > 11.5 sec Hip OA > 10 sec Vestibular disorders > 11.1 sec
Cut-off scores (TUG variations)	TUG Cognitive *(counting backwards)* ≥ 15 sec TUG Manual *(carrying cup of water)* ≥ 14.5 sec

Berg Balance Scale (BBS)	
Purpose	Assess static balance and fall risk in adult populations
Populations	Joint conditions, brain injury, MS, PD, SCI, CVA
Assistive device?	No AD
Interpretation	41-56 = low fall risk 21-40 = medium fall risk 0-20 = high fall risk
Cut-off scores (for older adults)	= 56/56 indicates functional balance **< 45/56 indicates increased fall risk** < 40/56 associated with almost 100% fall risk
MCID	Change in 8 points to reveal genuine change in function
MDC (for acute stroke)	Patients who amb with assistance = 8.1 points Patients who amb with stand-by-assist = 6.0 points Patients who amb indep = 6.3 points Chronic stroke = 4.13 points

Gait/Walking Speed	
Purpose	Assess and monitor functional status and overall health in a wide range of populations
Populations	All
Cut-off score	**< 1.8 ft/sec = risk for recurrent falls**
Ambulatory status	Household walker = 0-0.2 m/s Limited community ambulator = 0.4-0.8 m/s Community ambulator = > 0.8 m/s Cross street safely = 1.4 m/s

Five Times Sit to Stand Test (5x STS)	
Purpose	Measure functional lower limb strength
Populations	Cerebral palsy, PD, CVA, vestibular
Assistive device?	No AD (arms folded across chest)
Cut-off scores	≥ 13.6 sec associated with increased disability and morbidity **> 15 sec indicates risk for recurrent falls**
Average scores	60-69 y.o. = 11.4 sec 70-79 y.o. = 12.6 sec 80-89 y.o. = 14.8 sec
MDC (for stroke)	3.6 sec

Postural Assessment Scale for Stroke (PASS)	
Purpose	Assess and monitor postural control following stroke (most sensitive in the first 3 months)
Populations	CVA
Normative data	Healthy older adults mean PASS score = 35.7/36
Response to change	≥ 0.8 at 14-30 days ≥ 0.63 at 60-90 days

STUDENT WEEKLY EVALUATION FORM

Student _____ Clinical Instructor _____

Week # _____

I was great this week when I . . .

I could have done better this week when I. . .

It was very helpful this week when my CI. . .

My CI could have helped me more this week when. . .

Were goals from prior week met?

My goals (at least 3 concrete, measurable goals) for next week are. . .

CI's comments on student's progress and achievement of goals. . .

Student Signature _____ CI Signature _____ Date _____

Gumby Award

Criteria for Consideration:

Demonstrates flexibility in communication, teaching/learning style, teamwork and/or scheduling requirements through any of the following:

- Adapts the type, frequency and style of feedback to facilitate the learning experience.
- Adapts or enhances the mode, method or message to meet a student's unique learning requirement.
- Successfully balances the needs of the student, the therapy team, the clinical education program and/or the department as it directly relates to accommodating a student or programming need.

Outstanding Clinical Instructor

Criteria for Consideration:

- Successfully precepts an exceptional and/or challenging student or in a complex situation (2:1 or back-to-back, etc) with an overall positive outcome based on student progress, observation, and feedback.
- Demonstrates enthusiasm and commitment to clinical education.
- Pursues opportunities to improve his or her clinical instruction skills.
- Creates a positive learning environment by being supportive of the student in all facets of the clinical internship experience.
- Creatively utilizes available resources (people, things, experiences) to enhance the learning experience.
- Consistently, effectively and appropriately communicates with all the stakeholders in a student's clinical experience, including the student, teammate, supervisors, CCCE, ACCE, ancillary and multidisciplinary staff.
- Is an excellent professional role model.
- Succeeds in motivating students to perform to their potential.

Rookie of the Year

Criteria for Consideration

- Demonstrates enthusiasm and commitment to clinical education.
- Pursues opportunities to improve his or her clinical instruction skills.
- Creates a positive learning environment by being supportive of the student in all facets of the clinical internship experience.
- Creatively utilizes available resources (people, things, experiences) to enhance the learning experience.
- Consistently, effectively and appropriately communicates with all the stakeholders in a student's clinical experience, including the student, teammate, supervisors, CCCE, ACCE, ancillary and multidisciplinary staff.
- Is an excellent professional role model.
- Succeeds in motivating students to perform to their potential.

Cone Health Rehabilitation
Clinical Education Awards
Nomination Form

Name: _____ Date _____

Role (circle): Staff Supervisor Student

Clinical Instructor you are nominating: _____

Briefly explain why you feel this CI deserves a Clinical Education Award: