Goal Writing with Electronic Documentation

Documentation Solutions Inc.

In reviewing documentation it has come to our attention that the recent transition to e-doc has created a few issues with goal writing and in turn has created a serious problem in supportive documentation:

First of all one is only forced to report the status of the short term goals (STGs) each week and not the long term goals (LTGs) - optional. This has led to a Lack of documented progress week to week to support the duration of therapy services.

E.g. 7 deficits may have been identified on the evaluation with only 3 STGs established

- If the three tasks with goals did not progress, it appears that no progress was made
- If two of the three goals were met and the only remaining STG is not a functional task, such as strength, it appears that the patient has reached their maximum functional level which does not support the need for further strengthening.

7 deficits identified in the eval with only 3 having STG or LTG established for them.
-If therapists work on the deficits that have no goal and associated plan, then they are working outside the plan of care approved by the MD.
There has been an increase in plan of care techniques chosen but without a coordinating goal.
E.g. w.c mobility training is listed as a planned technique but no goals are established for wc mobility or training.

Providing care outside the established plan approved by the MD.
E.g. If there is a functional task that needs work but not addressed at all in the original POC (no goal set for the skill), then if it is addressed you are outside the approved plan of care.

RECOMMENDATIONS

Minimum standards for STGs or measurements to be identified within the STG for the *typical* patient, if their PLF supports them (there must be a PLF status for each task addressed:

PT

-Bed Mobility

-Measurement for Rolling
-Measurement for Supine to sit

-**Transfers**

-measurement for Sit to stand
-Measurement for Pivot transfers

-**Ambulation**

-Measurement for assist, device, distance on levels
- unlevel surfaces as appropriate

-Balance (sit/stand – static/dyn as appropriate) to improve specific function
-LE strength as identified by eval to improve specific function
-LE ROM as identified by eval to improve specific function

If the patient is low functioning, a slow progressor, or is unilaterally affected, the goals or measurement standards within the goals might need to be expanded to include:

- Roll left
- Roll right
- More joint/muscle specific strength measures

OT
-**Eating**
-Grooming/hygiene
-Dressing
-UB Dress
-LB Dress
-Bathing
-UB Bathing
-LB Bathing
-Tolieting tasks
-clothing management
-toilet hygiene
-Toilet transfers
-sit to stand
-pivot
equipment
-Shower/tub transfers
-sit to stand
-pivot
equipment
-UE strength as identified by eval to improve specific function
-UE ROM as identified by eval to improve specific function
-Balance (sit/stand – static/dyn as appropriate) to improve specific function

Ideally"
UB dressing should be broken down into overhead shirt, button up, fasteners, bra
LB dressing should be broken down into pants, sock, shoes, underwear, fasteners

ST- Dysphagia
- Tolerating a specific diet, completing OM ex and comp strats *are not sufficient*.
- Unless the patient is able to progress only through the use of comp strategies, there should be a goal for each identified deficit:
    - Oral residue, mastication time, AP transit, swallow initiation, voice quality, bolus formation, lingual strength labial strength, etc.
    - E.g. Lingual strength will inc from mod imp to WFL to eliminate oral residue
    - If only comp strats are to be instructed they should be detailed and functional
    - E.g. chin tuck to protect airway. Liquid wash to eliminate oral residue. Etc.

ST- Communication/Cognition
- As with dysphagia, there should be a STG for every deficit identified that is impacting function such as: yes/ no accuracy, problem solving, sequencing, orientation, STM, LTM, etc.

ST and Long Term Goals

Because one is only forced to report on STGs on a weekly basis, it is critical that ST include their functional LTGS *also as STGs* so that progress toward them is measured weekly.
E.g. of Functional LTGs (only the functional component is noted- not the objective level):

- Manage MS diet
- Manage meds
- Communicate wants and needs
- Manage money
- Locate room
- Use call light
- Problem solve home emergency situations
- Use telephone
- Manage appointments
- Etc.

A patient may be progressing with all of the component deficits but without a functional STG, you and the reviewer are forced to wait until the day of discharge to learn if those gains had a positive impact on function.

As noted above, these are recommendations for the typical patients. Low-functioning, high-functioning, contracture, seating and positioning patients, etc. may call for different or more detailed goals.

While it takes time, up front, to create comprehensive goals the benefits far outweigh this including:

- Increased opportunity to capture progress to support duration
- Decreased risk of working out of your scope of practice
- Time saved by not having to add goals at a later date
- Time and money spent by having the claim paid vs. having to go through the denial process

One last note: remember that PLF must be supportive of the goals. If there are goals for stairs, community ambulation and IADLs, for example, there should be a prior level captured for each.