DOCUMENTATION ASSIGNMENT:
ICU Co-Treatment (Stroke)

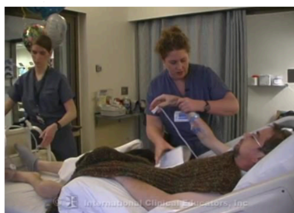
Learning objectives:

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

1. Document an OT/PT co-treatment for an individual s/p stroke who is currently in the ICU.
2. Reflect on the role of OT and PT in a co-treatment and what should be included in a co-treatment note.
3. Critically analyze documentation and provide constructive peer feedback.

Co-Treatment in the ICU

Use the following videos from the ICE Video Library to document your OT/PT co-treatment. Find the videos by typing the title in the search box. For example, type, "ICU, Co-treatment, Part 1" to find the first video.



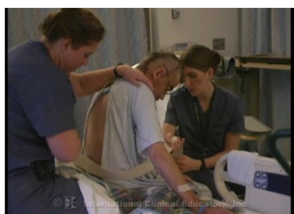
ICU, Co-treatment, Part 1
3:57
The PT and OT work together in the ICU, demonstrating how to prepare the environment, equipment and monitors prior to patient treatment.

ICU, Co-treatment, Part 2
1:27
The PT and OT work together in the ICU, demonstrating how to prepare the patient for his treatment session.

ICU, Co-treatment, Part 3
1:38
The PT and OT work together, demonstrating bed mobility techniques (rolling, sidelying to sitting) with a stroke survivor in the ICU.

ICU, Co-treatment, Part 4
4:51
While PT and OT demonstrate how to work together with a stroke survivor on sitting balance in the ICU, an alarm signals a problem with one of his monitors.

ICU, Co-treatment, Part 5
5:13
While PT and OT demonstrate how to work together with a stroke survivor on sitting balance in the ICU, an alarm signals a problem with one of his monitors.



ICU, Co-treatment, Part 6
4:45
The PT and OT work together in the ICU, adjusting lines and monitors while preparing a stroke survivor for a two-person transfer from the bed to the chair.

ICU, Co-treatment, Part 7
2:17
The PT and OT reposition the stroke survivor in the chair and demonstrate proper positioning of the upper extremity, all in the ICU.

ICU, Co-treatment, Part 8
1:52
The therapist demonstrates oral hygiene and use of the suction catheter with a stroke survivor in the ICU.

ICU, Co-treatment, Part 9
4:17
The PT and OT work together in the ICU and demonstrate how to prepare the patient and the environment for a two-person transfer from the chair to the bed.

ICU, Co-treatment, Part 10
7:39
The PT and OT work together in the ICU and complete their treatment session by returning the patient to bed and reconnecting all lines and monitors to their original …

Amanda K. Giles, OTD, OTR/L
Medical University of South Carolina

Initial Evaluation Documentation Checklist

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

HEADING:

	Includes a title such as "Occupational Therapy Treatment Note."
	Includes patient name, date of birth, medical record number.
	Includes information about the length, location, and purpose of the treatment session (either in the heading or as the first line of the Objective section).

Comments:

SUBJECTIVE:

	The note includes something significant that the client said about his treatment or condition.
	Pain is addressed.

Comments:

OBJECTIVE:

	Includes a summary of what was observed, either chronologically or using categories.
	Demonstrates professional, concise, and specific documentation.
	Focuses on the client's response to the treatment provided rather than on what the therapist did.
	Written from the client's point of view, leaving the therapist out.
	Includes objective, measurable information (specific about assist levels using FIM, cues, etc).
	Does NOT include judgmental statements.
	Uses only standard abbreviations.
	Includes information re: ADLs using appropriate FIM/GG scores.
	Includes information regarding mobility.
	Includes information about cognition (alert, responding appropriately, following commands, etc). Remember you don't have to do a formal test to OBSERVE cognition. Document exactly what you see but BE OBJECTIVE and without judgment.
	EXTRA: Includes that the "Patient was left in bed with call bell within reach at end of evaluation."

Comments:

ASSESSMENT:

	Includes update on progress towards goals (e.g., goals met, ongoing, good progress, goal #1 met)
	Includes a statement about client's strengths and a problem list regarding areas that need improvement. Problem list is not too vague nor too lengthy.
	Notes client's potential for rehabilitation.
	Ends with recommendations for OT (e.g., "Client would benefit from continued skilled OT to address…." "Anticipate inpatient rehab needs upon d/c from acute care…").
	Also includes recommendations for adaptive equipment (such as drop arm BSC, walker).
	The information in the A section is supported by information (evidence) in the O section.
	A section is organized, to the point, includes all important points, and is easy to read.

Comments:

PLAN:

	Specifies the frequency and duration of future OT sessions (e.g., "2x/wk for 4wks").
	EXTRA: Includes methods of treatment anticipated, such as therapeutic exercise, functional activities, education, ADL training in compensatory techniques and/or adaptive equipment.
	Note is signed and dated by the occupational therapy student, including credentials "OTS."

Comments:

Amanda K. Giles, OTD, OTR/L
Medical University of South Carolina