Case Note Examples

Initial Assessment Examples

- Attended F2F visit for an initial assessment. Pt, pt's son and niece were present and participated in the assessment and care plan development. DOB verified. Pt lives in home with son and friend. No structural or pest issues reported or observed. Pt was alert and oriented and able to answer questions appropriately. Pt demonstrated no concerns with ability to self-direct. Pt diagnoses are arthritis and left side numbness from 2 strokes. Pt walks with a limp and is unable to stand long or walk far. Pt tires out easily. Pt reported hands shake often causing difficulty with fine motor tasks such as shaving and meds. Discussed pt Medicaid Spenddown not being active and HCB Medicaid requirements. Pt in agreement for referral to be sent to FSD for HCB ME if LOC met. Completed assessment & discussed care plan. Pt already receives HDM 5days/week, so will be added to care plan to meet HCB Medicaid requirements. Pt requests CDS 7days/week with Advantage and niece as attendant. Bathing (in/out, setup, wash/dry backside & lower body). Dressing/grooming (setup/ dress upper & lower body/shave). Pt informed of shared household tasks. Pt has private bedroom & laundry. HC tasks provided for these needs. RN visit-Meds (setup planner). Essential transportation needed weekly. Pt seldom drives and unable to walk far or carry/load items. Pt eats meals with family. Copies of forms left with pt.

- Completed initial assessment with participant in her home where she lives alone. Home had no safety risks or pest concerns. Her friend was present, with permission, during assessment but did not assist her with the questions. Pt is seeking In-home services and was referred by Always First. Primary diagnosis is Chronic Pain Syndrome of back and knees due to a car accident in 2008. This pain limits her mobility at times. She is ambulatory without an assistive device, and I witnessed her walking without difficulty. She has poor vision in her left eye. She has COPD and uses 3 inhalers and nebulizer treatments 2x a day. She sees her PCP and pain doctor monthly to monitor pain. Participant is able to prepare and cook small meals. Due to her pain, pt reports she can only stand for short periods of time and has trouble lifting heavy items and bending over making cleaning and laundry tasks difficult. Pt also becomes SOB when trying to clean. She needs occasional med reminders but manages independently. She manages her finances with her friend's help. She can still drive without difficulty. She has difficulty walking through a grocery store, buying and carrying grocery bags into the house and putting them away due to pain. She needs assistance with getting in/out of the tub safely. She manages washing self once in. She prefers to bathe with someone in the home for safety reasons. Care Plan discussed and she is seeking in-home assistance 5 days a week with Always First.

Case Note Examples

MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES
Division of Senior & Disability Services

Reassessment Examples

- Met with Pt in his home to conduct reassessment. Pt continues to live alone in the same apartment. Pt's apartment is clean with safe pathways. Pt expressed satisfaction with provider and services. Pt states he didn't have an aide for several months but a new aide started last month.
  Pt states he continues to have all the same medical and mental health issues as before including heart disease, disc degeneration in back, osteoarthritis, depression, and anxiety. Pt states he has had one fall in the last month, saying he lost his balance in the shower. Pt states he would need assistance with balance/support if he had to use the stairs. Pt states he has a shower chair and grab bars, saying he needs no other assistance with bathing at this time. Pt states he continues to use walls and furniture for balance in his home, this was observed. Pt states he continues to use a CPAP at night. Pt continues to need assistance with household cleaning tasks, dishes, meals, etc. due to mobility issues, chronic pain, and fatigue as a result of Pt's conditions. Pt states he also now needs assistance with laundry for the same reasons. Pt states the laundry is in a different area of apartment complex, laundry task will be added for 90 minutes 1x per week. Pt states his informal helper would be his cousin saying she assists with necessary tasks when needed and available. Pt expressed agreement and understanding of all care plan changes.

- Met with Pt. in her home for annual reassessment. Pt. recently moved in with her adult daughter who does not have HCBS and is participant's CDS attendant. Pt. has her own bedroom and bathroom, but all other areas of the home are shared. The home was cluttered but no safety concerns. Pt. was able to answer all questions independently. Daughter was also present for the reassessment at Pt's. request and provided additional information, at times. Though Pt. does have some memory issues, she was oriented to time, place, person and answered all questions appropriately. Self-direction and SLUMS were completed. No concerns with her ability to self-direct at this time. Pt's diagnoses include: COPD, Diabetes (neuropathy), stroke (hemiplegia) and depression. Pt. reports continued need for services due to left sided weakness and shortness of breath which causes her to become dizzy and weak when she attempts to complete tasks herself. Pt. continues to need assistance with setting up for shower, getting in/out, and washing hair/body. She needs hands on assistance with socks, shoes, zippers, and buttons. Pt needs assistance cleaning up after incontinent episodes. Pt ambulates around the home with a walker and frequently needs assistance getting up from a seated position. (continued next page)

Daughter is setting her meds up informally and will continue to do so. Pt. has continuous oxygen and a nebulizer for daily use. She requires assistance to clean/maintain this equipment. She needs help setting up her breathing treatments. Pt. has Class 1 compression stockings. Daughter assists her with putting them on but Pt. is able to take them off independently. Pt. has a physician-ordered diabetic diet and finances are kept separate. Due to this, Pt's. meals are prepared only for her. Pt. receives informal support from a friend who picks her up and takes her shopping. Therefore, no time is authorized for essential transportation. Pt. sees her psychiatrist monthly for depression and sees a counselor weekly through Compass Health and has an ITP. Pt's mental health case manager is Jane Doe (Phone Number: 573-XXX-XXXX). Pt. called Ms. Doe while I was present and Ms. Doe confirmed ITP to maintain current functioning.
Pt. understood and agreed to reduction of clean floors and removal of clean kitchen as these areas are shared by others. Pt. is satisfied with her provider and requested no other changes to the care plan as she feels it is sufficient in meeting her needs. Trash and laundry continue to exceed suggested frequency due to daily incontinence.

How Can I Speed Up Case Noting?

It's important to remember, case notes are a tool that should be used to elaborate on areas of the assessment and care plan that need further clarification to paint the full picture. Duplicative information that is clear in the assessment, is not required in the case note.

In the case note below, the highlighted areas demonstrate items that could be removed to help shorten case noting timeframes.

- Initial F2F assessment conducted **12/5/2022**. Pt verified DOB. Pt. reports lives with disabled adult son in a 2 bedroom/1 bath home (laundry in basement). Pt. observed ambulating around home independently.; **no devices used at this time. Pt independently ambulates flight of stairs using banister; pt is able to ambulate from home to vehicle independently.** Pt. home environment is maintained, pt. has a pathway to safety; no environmental concerns. No one else present. The pt. was alert and oriented during assessment and answered questions accordingly. No concerns with pt. ability to self-direct own care. **Pt. has no legal guardian/POA.** Pt. reports no formal/no informal care at this time. Pt. reports son is unable to complete major household task due to son's health limits. Pt. reports pt's primary diagnoses are COPD, lung cancer, and heart failure. (continued next page)

Case Note Examples

Pt. uses oxygen and nebulizer daily. Pt. reports hx of chemo/radiation treatments. **Pt. wears reading glasses; no vision difficulties reported at this time.** Pt. reports 1 fall in last 30 days due to missing a step while walking to church. Pt. reports having good and bad days. Pt. reports diagnoses cause **problems sleeping**, sob, limited ambulation/standing and occasional chest pain/headache. Pt. reports able to make small meal using microwave/stove. Pt. reports assistance with meal prep/cooking is needed due to sob/weakness. **Pt. reports no physician ordered diet at this time;** pt. reports due to non-intact teeth, pt. has to modify foods and eats only soft foods. Pt. reports currently completing household task and laundry independently but needs assistance due to physical limits/sob. Pt. reports difficulty bending/lifting or moving heavy items. **Pt. reports managing finances and medications independently. Pt. reports 10 prescribed medications; 1 over the counter supplement taken.** Pt. reports shopping for the household with assistance (pt. reports use of the wheelchair cart when shopping); carrying bags/selecting various items/putting away items. Pt. has grocery stores/other convenience stores in proximity of home. **Pt. reports use of medical transportation for doctor's appointments. Pt. reports independently bathing/shower**; pt. reports primarily taking showers due to fear of inability getting out of bath. Pt. reports assistance is needed when dressing/grooming; pt. has difficulty bending/reaching. **Pt. reports independent with personal hygiene, toileting, toilet transfer and bed mobility.** Pt reports frequent bladder incontinence and use of bed pads. **Pt reports itchy/dry skin; no foot problems. Reports no procedures or restorative services. Reports primary Dr./ specialist seen every 2 months or as needed. We reviewed/discussed Authorization for Disclosure, Attestation, HIPAA, Rights & Responsibilities for CDS and HCBS-3. Pt stated understanding and signed all forms accordingly. Upon HCBS approval,** provider chosen, Angel Care. Proposed care plan 6 days of service**.** **LOC met.**

LOC Not Met Example: Initials or Reassessment

When documenting cases in which LOC was not met, it may be helpful to document additional information even though this is not required per policy. While this additional information may seem duplicative as discussed above, it may be helpful for cases likely to go to an administrative hearing as it further supports decisions about InterRAI coding and LOC determination.

- Attended F2F visit with pt. Pt, pt mother-in-law (MIL) and spouse were present and participated in the assessment. DOB verified. Pt lives in trailer with spouse, MIL, spouse's uncle and 11 dogs. Pt reported all adults work. Pt MIL works for Always First and spouse has own cab company. No pest issues were reported or observed. Pt reported trailer is in need of repairs for floors, but this is not a safety hazard at this time. Pt was alert and oriented and able to answer questions appropriately. Pt can self-direct. Pt diagnoses are Bipolar, PTSD, IBS, spinal stenosis and GERD. Pt reported lots of stomach issues/nausea. Pt reported stopping a lot of meds due to aggravating stomach issues. Pt reported back pain causes issues with cleaning at times.
  LOC process explained. Pt informed even if LOC is met, no cleaning or shopping tasks besides laundry could be provided due to shared household. Pt requested CDS with MIL as attendant for cleaning and shopping. Pt sees pain management monthly for stable condition. Pt sees PCP and Psychiatric NP every 2 months. Pt takes 9 prescribed meds from the bottles with no reminders. Pt reports no Treatments, Restorative, or Rehab services. Pt reports showering 3 days/week with no assist. Pt denied assist needed with dressing, grooming, hygiene or toileting. Pt denied bladder incontinence and reported bowel incontinence comes and goes with IBS, but had an accident in past 2 days. Pt follows no special diet and reported using all appliances. Pt reported MIL had cooked for her in past 3 days. Pt denied needing assistance with cooking. Pt reported eating soup/yogurt on days stomach is hurting. Pt does not use an assistive device for mobility and reported rail use only for steps/stairs. Pt walks dogs daily and reported no assist in/out of bed, car, etc. Pt was alert and oriented and reported handling own finances and making own daily decisions. Pt reported stopping meds for mental illness with no major changes. Pt reported depression goes up/down but doing fine for past 2-3 days. Standard LOC=18 Transformed LOC=6 with Safety-6.
  Informed pt LOC was not met. Reviewed interRAI responses with pt to ensure coding accuracy. Pt confirmed all original information obtained during assessment. Adverse Action mailed to pt.