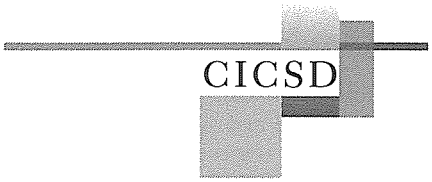

Documentation for Speech-Language Pathologists in Pediatric Hospital-Based Programs

Lemmietta G. McNeilly
University of Florida Health Science Center, Gainesville

Medical record documentation in pediatric hospital-based programs encompasses numerous areas. Documentation requirements in medical settings have incurred numerous changes during the past 5–10 years. Evaluations, treatment plans, progress notes, and discharge summaries for children receiving services through the health care system have been impacted by legislative changes and changes in authorization procedures for third-party reimbursements. It is the goal of this article to provide the reader with specific information concerning the content of the medical record and some sample documentation to facilitate effective communication regarding pediatric patients' services in medical settings.

ABSTRACT: Medical record documentation in pediatric hospital-based programs encompasses numerous areas. Documentation of services rendered to children in the health care system has been impacted by reimbursement and legislative changes. This article provides an overview of the unique facets of pediatric service delivery in medical settings and their documentation requirements. Documentation of interdisciplinary service delivery that addresses speech, language, and feeding issues is discussed. The reader is provided information concerning the medical record to facilitate the documentation of services. Several documentation samples are provided for illustrative purposes. As services are delivered to the complex pediatric population, it is important for clinicians to communicate clearly and effectively. Timeliness and cultural sensitivity are critical factors that must be addressed consistently in medical record documentation and in communication with others.

Pediatric rehabilitation medical facilities provide multidisciplinary services to children with multiple diagnoses and their families. This article will provide an overview of the unique facets of pediatric service delivery in medical settings and their documentation requirements, specifically in assessments, treatment plans, and patient progress. Details regarding the speech, language, and feeding services provided by speech-language pathologists while interfacing with other disciplines will also be addressed.

INTERDISCIPLINARY DOCUMENTATION SYSTEMS

Children with medically complex conditions generally require the expertise of professionals from several disciplines. To maximize a child's performance, it is important for the disciplines to coordinate their assessment results and ensuing treatment plans. If co-treatments are indicated, the report should specify the skills to be addressed by each participating discipline. Frequency of treatment sessions should be included in the report, and the format for progress reports should be discussed among clinicians as well.

Some major rehabilitation hospitals have adopted an interdisciplinary documentation system for a patient's records, which includes team assessment reports, interdisciplinary progress notes, and discharge summaries. The benefits to such a system include the elimination of duplicative information available in the patient's chart. These areas may include identifying information, medical case history, and diagnostic codes. In order for the team to

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generate a single report, communication among the partners is necessary, thereby increasing knowledge of how each discipline's work collectively impacts the patient's overall improved function. These strategies result in a reduction in documentation time, thereby permitting more time for patient contact.

Within an interdisciplinary documentation system, each discipline is acutely aware that his or her decisions directly impact the other members of the team and the patient's function. Several clinicians expressed some growing pains as the paradigm shift from independent reports to interdisciplinary reports evolved. However, most persons reported that after the first 6 months of implementation, the benefits far outweighed the challenges of systemic change.

MEDICAL RECORDS

Some factors that challenge administrators and clinicians include diverse multicultural clientele and varied diagnostic categories, severity level, and ages of patients. The interests of patients and families, as well as the expertise of clinical staff, help determine how services should be delivered and documented effectively. Family education is an important aspect of intervention, including advocacy and facilitation of continued growth and development of the child's communication skills. A phrase often heard in medical settings is "If it isn't documented appropriately in the patient's chart, it didn't happen." Accurate medical record documentation is an area in which clinicians need to quickly become competent.

The patient record serves as the central repository for clinical information pertaining to a patient's care (Cornett & Chabon, 1988). Many professionals rely on the information contained in this record of clinical activities. According to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the purposes of the patient's medical record are as follows (Fromberg, 1990):

- to serve as a basis for planning patient care and for continuity between evaluation and treatment;
- to document the course of a patient's evaluation, treatment, and change in condition;
- to document communication among health professionals who contribute to the patient's care;
- to assist in protecting the legal interests of the patient, facility, and practitioner responsible for patient care; and
- to provide data for research, education, utilization review, and quality assurance purposes.

JCAHO delineated the requirements for the content of patient records for individuals who receive rehabilitation services in JCAHO-accredited facilities in the *Comprehensive Accreditation Manual for Hospitals: The Official Handbook* (JCAHO, 1999), which is updated annually. The *2000 Hospital Accreditation Standards* is another publication by JCAHO that serves as a resource for clinicians employed in medical settings (JCAHO, 2000).

The American Speech-Language Hearing Association's (ASHA's) Professional Services Board (PSB) (1995) requires that accurate and complete records shall be prepared and maintained for each client. Records shall be accessible to appropriate personnel and systematically organized to facilitate storage and retrieval. These are guidelines for all PSB-accredited clinical programs. According to PSB, adequate and current records are essential to the provision of quality speech-language-hearing services. PSB does not specify a particular format for clients' records, but does require each accredited program to establish policies and procedures for content as well as organization of client's records that address the following items:

- systematic and consistent organization of individual client files;
- client identification data;
- referral source, date, and reason for referral;
- correspondence pertinent to the individual client;
- records of information released to other parties, including authorization for the release by a legally responsible party;
- reports from other professionals;
- clinician responsible for client's care;
- pertinent information concerning the client's history and prior service;
- chronological log of all services provided;
- signed and dated reports of evaluation;
- signed and dated treatment plans;
- signed and dated progress reports;
- signed and dated discharge summaries; and
- documentation of follow-up activities.

PSB also requires each program to have policies regarding the timely preparation, filing, and dissemination of clients' reports and other information, with evidence that they are followed. Additionally, accredited programs need to follow policies and procedures for the maintenance of records that are designed to ensure:

- protection from theft, vandalism, and other hazards;
- accessibility only to appropriate personnel;
- organized storage and retrieval of individual files;
- retention of records for a specified period of time as determined by state law, or, where no law exists, for a time period that reflects client and program needs; and
- disposal of obsolete records in a manner that protects the confidentiality of client information.

Confidentiality of health information has become increasingly important as data have become computerized and used by a variety of personnel from various locations. Most states have enacted laws that pertain to the confidentiality of information contained in patient records. Exchange of medical record information requires a written authorization consent form signed by the patient or the

legal guardian to receive/release information. Additional authorization is not required for the review of records by health professionals currently involved in the patient's care who are employed in the same medical setting and are a member of the interdisciplinary team. Hospital personnel who are conducting utilization review/quality assurance activities, or certain educational purposes, may also be exempt from needing additional signed consents.

The patient record is a legal document and may be used as evidence in legal proceedings. Clinicians should consult individual state laws and facilities for policies pertaining to the confidentiality of patient records, procedures for release of information, and patient access to health records and reports (Cornett & Chabon, 1988). Medical settings may use unique grouping patterns to maximize skill levels of clinical staff.

Format

The medical record format for recording health information in hospitals and clinics is the most popular in the world. It is a compilation of all of the services provided to a single patient within a health care facility. Medical records may be sectioned according to health specialty, or progress/ patient care notes may be integrated among all health care providers. Information is presented in chronological order, and all illnesses, disorders, or problems are discussed concurrently. Flower (1984) described the sections of the medical record as follows: application data (patient identification and payment information), initial examination (chief complaint, history, examination, and diagnosis), progress notes, special examinations, treatment record, laboratory reports, specialists' examinations and treatments, and authorizations and correspondence (pp. 139–143).

Correction of Errors in Medical Records

Mistakes sometimes occur in the keeping of medical records. Corrections need to follow the legal requirements for the facility. The following are general procedures that are typically acceptable in hospitals across the country.

If an error is noticed at the time of the entry, the error may be corrected by drawing a single line through the error, entering the date and initials of the person making the correction, and entering the correct information as neatly as possible. The correction should be made above, below, or beside the error and should be legible. Corrections should be obvious regarding which entries or information the correction is intended to modify.

In the event an error cannot be corrected, either because the correction would make the entire entry illegible or confusing, or because the correction changes the substance of the entry, then the correction should be made by a new entry in the appropriate section of the chart. The new entry should explicitly identify the earlier entry for which it is intended to correct.

Each correction in the medical record should be dated and initialed by the person making the correction. Corrections in the physician's orders section need to also include the time of the correction. The method of correction should indicate that the mistake was made as the record was being prepared and there was no intent to defraud.

A person should not make an alteration in the record that would indicate change from the original information provided. Errors should not be erased, written over, obliterated by marking over, or painted out with liquid paper.

PEDIATRIC MEDICAL SETTINGS

Medical settings and the types of services rendered by speech-language pathologists vary across the globe. This article will focus on documentation for services provided to pediatric populations in the following settings: acute care hospitals including neonatal intensive care units (NICUs), rehabilitation hospitals, and outpatient clinics affiliated with hospitals.

The rehabilitation services offered across pediatric health care settings are vast. Some of the professional services available include speech, language and feeding therapy, audiology, occupational and physical therapy, nutrition, developmental pediatrics, pediatric physiatry and neurology, recreation and child life, and neuropsychology. Specific services provided by the speech-language pathologist include a variety of specialized assessments, including modified barium swallow studies, clinical feeding assessments, comprehensive speech and language evaluations, voice and fluency assessments, alternative/ augmentative communication assessments, and hearing screenings. Each child's needs are assessed and the patient/ family members are integral participants in the development of treatment plans.

The majority of the services provided are therapeutic in nature. Intervention services include feeding/swallowing, voice, phonological, fluency, language therapy, and the design of alternative/augmentative communication systems. Skills from a variety of disciplines are combined to maximize patient outcomes. Many speech-language pathologists are involved in co-treatments with occupational therapy to address sensory integration difficulties and oral motor and augmentative communication needs. Some patients also need signing and bilingual services.

The populations served include children with the following diagnoses: pervasive developmental disorder (PDD), autism, traumatic brain injury, different genetic syndromes, neurological impairments, language-learning disabilities, feeding and swallowing disorders, hearing impairments, voice disorders, phonological disorders, and language disorders, to name a few. Therefore, it is clear that documentation requirements must meet needs across diagnostic categories, health care settings, accreditation standards, referral sources, and multicultural populations in various geographical locations. Novice clinicians often feel overwhelmed by practice within medical settings, particularly because much of the jargon and documentation procedures are unfamiliar and quite different from documentation within university clinics or educational settings.

Acute Care Hospitals

Pediatric inpatients at acute care hospitals may be referred to the speech-language pathologists by otolaryngologists, neurologists, and/or pediatricians. The reasons for referral may be concerns in the areas of swallowing, phonation for a patient with a tracheostomy, language abilities following a brain injury or shaken baby syndrome, as well as numerous congenital/genetic disorders including cleft palate, Pierre Robin, and Treacher Collins. All referrals need to be addressed within 24–48 hours of receipt.

The focus of the assessment should be to address the concern expressed by the referring physician. The documentation in the medical record should include acknowledgment and appreciation for the physician's order. Additionally, a statement regarding specific findings and the location of the actual report (with detailed findings) in the patient's medical record should be included. The preceding documentation should occur in the physician's progress notes section of the medical record. The speech-language pathologist's evaluation report, however, may be filed in either the rehabilitation or consultations section of the chart, depending on procedures for practice at the acute care facility.

NICUs. NICUs are prevalent in many urban acute care hospitals. Today, speech-language pathologists have a more active role in NICUs than they did in the past. The role of the speech-language pathologist in the NICU involves assessment of oral-motor skills, sensation, symmetry and tone, pre-linguistic skills, and respiration as it relates to feeding. Familiarity with characteristics of premature infants' respiration issues and typical feeding concerns is required. Familiarity with normal newborn feeding facilitates an understanding of abnormal characteristics.

Assessment reports should indicate specific feeding positions, strategies, and tools (i.e., nipples, bottles, and pacifiers), as well as recommended physical assistance techniques. Documentation regarding the coordination and timing of suck-swallow-breath patterns should also be provided. Documentation regarding participation in feeding training and specific procedures to be used for individual patients should also be noted. Collaboration with neonatologists, respiratory therapists, nursing, and other clinicians should also be documented in the patient's chart. NICU documentation should be filed in the physician's progress notes section of the medical record. (See Appendix A for an example of an NICU swallowing evaluation.)

Rehabilitation Hospitals

Documentation requirements for speech-language services performed in rehabilitation hospitals are specific and will need to comply with reimbursement policies from the Commission on Accreditation of Rehabilitation Facilities (CARF), JCAHO, and/or another third party. Patients typically have lengths of stay that range from a few weeks to months. The need for reassessments, measurement of targeted outcomes, and preparation for reentry to the community with maximized functioning necessitates interdisciplinary collaboration among all professional team members as well as patients and their families.

Outpatient Hospital-Based Clinics

Documentation requirements for speech-language services delivered at outpatient facilities vary based on reason for referral and need for intervention. Sometimes, patients are seeking second opinions or specific findings in order to qualify children for services in the schools. Documentation of evaluation recommendations that will be sent to another agency need to state specific findings and generalized suggestions for intervention that are flexible enough for another clinician working in a different setting to implement and meet identified areas of weakness.

JCAHO/CARF outpatient medical records require that certain information be documented, including the items listed in Table 1.

Pediatric records include the assessment of infants, children, and adolescents as are age appropriate. They include developmental age, length/height, head circumference, weight, and immunization status. As appropriate, assessments include consideration of the patient's educational needs and daily activities. Family guardian's expectations for and involvement in the assessment, initial treatment, and continuing care of the patient are also documented.

Table 1. Outpatient medical records required documentation.

General
• Advance directive on face sheet
• Evidence of informed consent for assessment and treatment
• All entries dated and authenticated
• Treatment plans documented
Education
• Patient's learning needs, abilities, preferences, and readiness to learn are assessed.
• Assessment includes consideration of cultural values, religious beliefs, and barriers to learning.
• When appropriate, the patient is educated about the safe and effective use of medical equipment, diet and nutrition, rehab techniques, available community resources, personal hygiene and grooming.
• The educational process is interdisciplinary as appropriate to the care plan.
Assessment
• Physical, psychological, and social status are assessed for each patient.
• When warranted by the patient's need, functional status is assessed.
• Functional assessment is performed for each patient referred for rehabilitation services.
Reassessment of each patient
• To determine the patient's response to treatment
• When there is significant change in the patient's condition
• Integration of information from various assessments of the patient to identify and assign priorities to care needs
• Care decisions based on the identified patient needs and care priorities

COMMUNICATION FEEDING ASSESSMENTS

Assessment

Assessments are probably the most prevalent type of services rendered in medical settings. The types of assessments include clinical observations, instrumentation, and administration of standardized tests. The patient's skills in one or more of the following areas are assessed: feeding, swallowing, speech production, vocal quality, fluency, linguistic expression, and comprehension and functional use of language.

The report should be written to answer the questions presented by the referral source. If written to the physician, the report should be succinct, including a statement of the problem and specific recommendations for intervention. If no problem was identified, then a statement should be included indicating appropriate skills and no intervention necessary. If a copy of the report is going to the parent, all medical jargon should be defined and clearly stated for the reader's interpretation.

The medical advisory board of a large pediatric health care system surveyed referring primary care physicians to obtain feedback concerning documentation practices. Pediatricians were the largest percentage of the respondents. The results revealed that the physicians felt that reports were too long, contained too much jargon, and were too technical. Additionally, the patient problem or diagnosis was not clearly identified and therapy goals were not clearly stated. The physicians reported that they were not interested in the process and tools used to glean the results. They did, however, indicate that they really wanted and needed a rapid method of communicating findings (i.e., checklist, summary report) rather than a lengthy narrative report whenever possible.

Payer's requests for information have also increased in frequency and specificity. Many payers now request that an assessment summary be sent to them within 24 hours of treatment. The summaries need to include diagnosis, any abnormal findings, significant strengths, long- and short-term treatment goals, and the number of visits expected for the client to achieve targeted goals. Requests for extensions also need to be accompanied by progress notes. The notes need to clearly state progress to date and targeted goals for extended visits. Therefore, many hospital-based programs have instituted procedures to expedite this process.

Purpose of assessments and reports. Referrals for the evaluation of communication disorders may come from parents, pediatricians, otolaryngologists, family practitioners, psychologists, and neurologists. The referring body usually has a concern about a particular component of communication and wants to know if the problem warrants intervention. Therefore, the primary element of evaluations should yield a response regarding the initial concern. The report should also address a screening of other areas to indicate whether the child's development in these areas is appropriate or if intervention is indicated. A copy of the report should be sent to the referring person and should be written clearly with professional terms clearly defined.

Clinicians have expressed concerns regarding the amount of time it takes to write evaluation reports and the length of reports, as well as hardships with turnaround of final typed reports. Completion of reports in a timely manner often occurred because many clinicians stayed late at the clinic to complete reports.

Benefits of a streamlined process include:

- reports that summarize and present information to the receiver in a clear, logical format that is easy to read;
- continued clinical reasoning by the speech-language pathologist, without a narration of the process in the written evaluation report;
- summary reports of abnormal findings, including a statement of diagnosis, plan of treatment, and expected number of visits to achieve targeted goals; and
- significant decrease in the amount of time needed to complete reports, thereby decreasing the receipt of final reports from 10 to 3 days.

A major paradigm shift is necessary to implement the documentation changes. Traditionally, clinicians have been trained to write thorough, lengthy reports. Now, the evaluation process doesn't change, but the length, specificity, and reporting elements of the evaluation process change. The outcome should be succinct and clear to pediatricians, parents, and educators who receive the reports. Appendix B provides an example of a speech-language initial/reevaluation report.

Assessment summary report. After an extensive continuous quality improvement process, the rehabilitation therapies at The Hospital for Sick Children in Washington, DC developed a process and procedure for documenting assessments that would streamline the amount of time clinicians spent writing assessment reports. The specific procedures are listed below and comply with JCAHO and CARF accreditation standards.

The rehabilitation therapy assessment summary form is completed and accompanies all departmental assessment tools. It allows all interdisciplinary team members to access evaluation findings.

- Identifying information at the top of the form is completed (date of assessment, assessment type, and assessment tools used).
- Evaluation findings are listed in the assessment summary section. The patient's test scores (if applicable) and strengths and weaknesses (areas of concern) are included. The patient's adjusted age (if applicable) is documented.
- Patient/family goals are listed as discussed.
- Recommendations for treatment including treatment frequency, next reevaluation date, and immediate needs are included.
- Long-term goals are stated clearly and concisely. Short-term goals are written on the rehabilitation progress notes form.
- A checkmark is placed beside the appropriate discipline.

- The signature and date/time are entered.
- All summaries and all pages of the assessment tool(s) are entered with the patient's addressograph stamped in the lower right-hand corner.
- The completed form serves as a cover sheet to the assessment tool.
- All clinicians using the assessment summary form attach the form to the original standardized assessment tool and submit it to the patient's medical record to be filed within the designated discipline's section.

Appendix C provides an example of an assessment summary form.

Feeding

Speech-language pathologists conduct bedside or clinical dysphagia assessments as well as fluoroscopic swallowing evaluations. Some clinicians participate in fiberoptic endoscopic evaluation of swallowing safety (FEESS) and ultrasound. The FEESS is an endoscopic examination of oropharyngeal functions during swallowing and it may be videotaped (Golper, 1998). This procedure is not used with many pediatric patients; instead, it is usually used by otolaryngologists to view structures (i.e., pharynx and vocal cords) during endoscopic assessments in children older than 8 years. Ultrasound for the assessment of swallowing presently is not routinely used in most hospitals to assess problems associated with feeding (Sonies, 1997).

The contents of a feeding evaluation report for a pediatric patient should include the following information:

- procedures used;
- positioning of patient;
- description of the behaviors observed;
- specific textures used;
- amounts and conditions under which food/drinks were presented to the patient;
- utensils used;
- feeding strategies employed and subsequent success; and
- impressions and recommendations with respect to each of the above. Include who will be trained in feeding strategies, frequency of feeding sessions per day, and who will be the primary feeder.

Appendix D provides an example of a pediatric feeding evaluation report.

Speech/Language

Speech and language reports should address the following speech areas: oral motor skills, voice, fluency, and phonemic production. Linguistic information should include expressive language, auditory comprehension of language, and the child's ability to use morphological, semantic, and pragmatic elements of language. Communication partners, conditions observed, parental reports, and the results of standardized tests should also be included. The report should indicate if language skills are functional or below expectations for the child's age. Intervention strategies should be addressed or recommendations for follow-up should be provided if skills are borderline. A statement indicating that the results and recommendations were discussed with the family should also be included.

Culturally Appropriate Assessments

The multicultural population is increasing in the United States and speech-language pathologists in most urban communities are assessing the needs of children and families from cultures that differ from their own. It is the speech-language pathologist's responsibility to become knowledgeable of any cultural differences that may impact the assessment process prior to seeing the patient. Information regarding feeding and child rearing practices are of significant importance. Assessment procedures and materials should include methods and activities that are appropriate for the child and family's culture. Specific information can be gathered from books, journal articles, and information accessible via the Internet.

Parents and persons who are members of the culture can also be instrumental in providing the speech-language pathologist with helpful, accurate information. The family can address whether the cultural practices are practiced in the home or if the family has decided to assimilate the values and practices of the mainstream culture. Discussions with family members regarding assimilation and acculturation of the family can provide the service provider with useful information. The amount of time a family has lived in a country and/or the level of English proficiency are not direct indicators of acculturation level. Clinicians should avoid making assumptions about families based on these variables. Open and honest discussions concerning specific areas will help the service provider make reasonable conclusions regarding the family's level of acculturation (McNeilly & Coleman, 2000).

TREATMENT PLANS

Treatment plans in pediatric facilities vary. Formats range from interdisciplinary plans to recommendations stated in the progress notes section.

Interdisciplinary Treatment Plans

The interdisciplinary style used at the Hospital for Sick Children in Washington, DC includes documentation of all therapeutic interventions on the rehabilitation therapy progress note (Appendix E). Its intent is to facilitate written communication among disciplines regarding the services provided to patients.

Identifying information. Identifying information at the top of the note should be completed (discipline, treatment period, treatment frequency per week, therapy treatment week number). The treatment frequency must be specific (3 times a week, not 3–5 times a week). The frequency for

treatment for a patient should be based on the professional's judgement according to the needs of the patient in order to ensure achievement of goals.

Goals. Individual short-term goals should be numbered consecutively and entered on the grid. Goals should be written objectively and in measurable terms (i.e., established specific criterion levels). Patient's performance for each goal addressed should be entered below the corresponding day. Only measurable data should be documented (e.g., 3/4, 75%, 10 min.). Measurement methods for stated goals and actual performance need to match (i.e., if goal criterion is stated in percentages, then actual performance should also be stated in percentages).

If a patient is seen twice in one day, a diagonal line is drawn through the box for that day. The top half of the box represents the first treatment for the day and the second half represents the second treatment for that day.

If a patient is seen three or more times in one day, the first two treatments will be documented according to the procedures outlined above. The remaining treatments for the day should be recorded in the intervention section according to the following concise format:

Goal # ___ performance;

Goal # ___ performance;

For example: #1-50%; #2-min. assist.

(Narratives should be avoided.)

The baseline measure for a particular goal should be proceeded by a "B" (e.g., B-50%). This allows easy identification of the day on which the goal was first addressed. The status of each goal (and date as necessary) are entered at the end of each weekly treatment period as follows:

M = Met/Date

R = Revision/Date

O = Ongoing

DC/Date = Discharge/Date

X = Goal Not Addressed

If a patient is not seen on a particular day of the week, an X should be placed in the box and a line should be drawn vertically through the remaining spaces. There should be no blank spaces. Additionally, all goals are averaged at the end of each weekly treatment period, and the values are entered in the "Avg." column. If a treatment session is missed, "CX" is written at the top of the appropriate day's column to indicate cancellation. The reason for the cancellation should be documented in the comment's section.

Goal numbering. Each goal retains its original number throughout the course of treatment. For example, Goals 1, 2, and 3 may be established at the initiation of treatment; Goal 2 may be discontinued at the end of the first week. That goal number is retired at that point, and any new goals established are numbered 4, 5, and so forth.

Only changes in the nature of a goal necessitate the introduction of a newly numbered goal (e.g., from imitating nonspeech sounds to imitating speech sounds). If the criterion level or type/amount of cueing is changed, the appropriate changes may be made on the grid and a brief reference to the reason for the changes should be made in the intervention; however, the number of the goal remains unchanged.

Intervention section. The date of treatment, treatment start/stop times, interventions given, number of goals addressed, clinician's signature, and date/time of entry should be entered in the comments section. Significant changes/responses, new techniques, and plan of care should be included in the "intervention" area as needed. If there is a significant event (e.g., patient has a medically acute episode), this should be documented in the pink progress notes section of the chart for all disciplines to read.

The date, treatment start/stop time, short-term goal number (STG#), clinician's signature, and entry date/time should be provided for each intervention line completed. There should be no blank spaces. Clinicians who co-sign progress notes should sign each page ONLY ONCE according to the following format: "Reviewed: S. Clinician, PT/Date."

Co-signatures are entered at the end of the reporting period with a line drawn through any unused portion of the intervention section. After a prescription for therapy has been received from the physician, the clinician acknowledges receipt by stating so in the intervention section of the progress notes (i.e., MD orders received to evaluate and treat patient, initiated evaluation). This entry should be dated, timed, and signed as stated above.

When an evaluation is in process, each contact with the patient is documented in the intervention section and a line is drawn through the days(s) in the goals section, as goals have not yet been established (i.e., evaluation in process). All entries in the intervention column should only address interventions performed with the patient that relate back to the goals established for the patient.

Weekly documentation. A brief narrative regarding patient/family agreement with goals and family teaching/contact must be documented weekly by the primary clinician or designee. Discussions concerning the family made with the case manager, social worker, or nurse may be documented in this section. The clinician should make every effort to have contact with the family and, when appropriate, include the goals of the family in the treatment plan. The total number of sessions completed for the week should be entered at the bottom of the page.

The primary clinician or designee acknowledges the information addressed weekly with signature, date, and time of the progress note when this section is completed.

All progress notes should have the patient's addressograph stamped in the bottom right-hand corner of the progress note.

General information. All disciplines in rehabilitation services document on the progress note (OT, PT, REC/CL, Speech and Education). The progress is filed in the discipline-specific section of the medical chart. The primary clinician enters a new progress note with goals for filing in the patient's medical record at the beginning of the week.

Speech Progress Notes

Documentation of speech and language services in the medical chart for inpatients is performed either in the

physicians' progress notes section or the rehab or speech section of the medical record. The location is specified in the departmental policies and procedures manual of each facility.

Outpatients. The format for outpatients' progress notes is usually narrative or on a form developed by the hospital-based department. The following components should be included: patient's name, date of birth, medical record number (MR#), date of report, period of progress included in the report, dates of sessions, summary of patient's behavior, and quantitative performance on targeted goals. Plans for the next period to include frequency, continuing of present goals, or new goals to be addressed should also be included and the report should be signed and dated by a certified speech-language pathologist.

Style and frequency of progress notes. Several styles are acceptable and the frequency of notation is per contact with patient or about patient. The progress notes section of a patient's medical record serves as a chronology of events and services that occurred during the patient's length of stay. The progress note may be very brief, containing short comments or descriptions of events. For example, a telephone call from a client to cancel a session would require only a short entry. However, the progress note written after a treatment session would be lengthier.

A particular style of writing progress that is used across most hospitals is referred to as the *SOAP* format, an acronym for subjective-objective-assessment-plan.

The components of SOAP are further described below.

- *Subjective:* A description of the subjective comments concerning the patient's feelings/statements of the patient's performance, which is relevant to the patient's progress or lack of progress.
- *Objective:* A report of the observable data or comments, which are measurable and indicate the patient's performance or lack of performance on target areas. Test results may be included.
- *Assessment:* An assessment of the patient's reactions (either positive or negative) to the intervention activities. Interpretation of results as well as probes of new areas for future testing may be indicated in this section.
- *Plan:* The plans for the next session and how they continue or differ from the current session with respect to additional data, specific treatment strategies, and plans to disseminate information to others.

Narrative progress notes. Progress notes that are written for patients with multiple sessions per week or month should include the following information:

- dates of service from ___ to ___;
- communication diagnosis;
- etiology;
- date of birth;
- long-term goals (written in functional terms);
- short-term goals
  - patient/family education
  - home program
  - Goals should be short-term objectives for the next 4 weeks of treatment.
  - Goals should be functional, objective, measurable, and specific.
- weekly notes: State dates seen and patient's tolerance. State the goals addressed and the performance level using quantitative and qualitative information;
- problems/impressions/suggestions;
- goals for next period;
- prognosis;
- type/frequency/length of stay;
- date of entry; and
- speech-language pathologist signature, degree, CCC-SLP.

Appendix F provides an example of a weekly progress note.

DISCHARGE SUMMARIES

Discharge summaries provide written documentation of the criteria for the patient discharge from therapy. A discharge note is either typed or handwritten in the progress notes section of a patient's medical record. The note should include date of discharge, reason for discharge, destination, current services (frequency and type), and plans to resume services. A discharge summary is written when a client is no longer receiving therapy for one or more of the following reasons:

- Patient was discharged from the hospital.
- Therapy goals have been achieved.
- Patient has achieved maximum benefit from the therapeutic intervention.

The discharge summary is often written in a narrative style and typed. The discharge summary should include the following information:

- patient identification (name, date of birth, chronological age, medical record number, date of admission, date of report);
- diagnosis;
- frequency, duration, and type of services;
- statement of the patent's condition at the time of discharge as related to the condition at the time of initial evaluations (i.e., goals, progress, etc.);
- family involvement and instruction; and
- recommendations for further services or follow-up.

A reevaluation report may also serve as a discharge summary if the outcome of the reevaluation is to discontinue therapy services. Appendix G is an example of an outpatient discharge summary.

SUMMARY

The purpose of this article was to provide the reader with a reference for documentation requirements and procedures used in several pediatric programs across the country. Each hospital-based program will have its own policies and procedures for documentation. Students and clinicians should refer to the facility's policies and procedures manual for specific requirements. Several documentation samples were provided here for the purpose of illustration and instruction of some medical record documents used across medical settings that service pediatric populations. This article is introductory in nature. It was not the intent of this article to illustrate all possible types of assessments, treatment plans, and/or progress note formats.

It is also important for clinicians to familiarize themselves with medical record terminology that was not addressed in detail here. Several resources may be used to obtain this information, ranging from texts to hospital policy manuals. Additionally, clinicians should describe in lay terms any medical terminology written in reports that are written for parents and/or families of patients.

As we provide services to the complex pediatric population, it is important for clinicians to be mindful of effective clear communication. Timeliness and cultural sensitivity are also factors that we must address consistently in medical record documentation and communication with others.

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Contact author: Lemmietta G. McNeilly, PhD, Department of Communicative Disorders, P.O. Box 100174, UFHSC, Gainesville, FL 32610. Email: lemmie1@aol.com

APPENDIX A: NICU SWALLOWING EVALUATION

12/3/99 Patient is a 19-day-old white female with history significant for numerous dysmorphic features (low set ears, absent obicularis oris muscle, cleft palate mild pectus; small, retracted mandible. Patient presents with respiratory distress, probable Pierre Robin sequence, genetics assessment scheduled. Mild airway obstruction secondary to soft tissues. Positioning helps facilitate breathing. Does better prone or 3/4 prone/sidelying. OTR working with patient on PO feeds. Patient doing slightly better, took 7-8 ccs today with OT using Nuk nipple. Patient presents with increased oral secretions. Per chart review and discussion with OT, the following plan was developed:

1. OT to continue with PO trials, manipulating positioning as needed. (OT also reported increased oxygen during feeds). OT will see patient over weekend to continue treatment.
2. Patient to use pacifier for non-nutritive sucking.
3. Watch monitor pulmonary status carefully. If lungs remain clear, fluro study may not be needed. If lungs begin to decrease in status, discontinue PO trials and schedule rehab pharyngogram Monday.
4. Will return Monday @ 9:00 am to work with OT on PO trials.
5. Continue craniofacial clinic input.

12/6/99 Co-session with OT during PO feeding this morning. Good non-nutritive suck. When transitioned to bottle (squeeze bottle with cleft palate nipple), patient initially seemed to do ok – in side lying position, but then began to desat significantly (down to the 40s). Cervical auscultation during initial suck/swallow revealed what appeared to be a protected airway (from aspiration) with oxygen desats noted, it appears that this is an airway obstruction issue, rather than a swallow pharyngeal issue patient with very short lingual frenum, which, if anything, may be helping to keep the tongue more anteriorly positioned (although it probably is moving too far posteriorly during suck/swallow).

Recommendations

1. Consider feeding PO with OG in place, as it may help to hold tongue down and forward and decreased obstruction. This was discussed with OT and she will try this strategy.
2. May have to consider alternative long-term means of nutrition (i.e., G-tube) especially while mandible grows. Also, neurological status may improve somewhat.
3. Rehab pharyngogram does not seem indicated at this time as it will likely not change the management plan, OT in agreement.
4. OT to continue with therapeutic PO trials altering positions and nipples increasing oxygen as indicated.
5. Please reconsult Communicative Disorders if needed.

_____

Signature, CCC-SLP

APPENDIX B. SPEECH-LANGUAGE INITIAL/REEVALUATION REPORT

Center for Communication Disorders

Date:
Initial Evaluation:
Re-Evaluation:
Referred by:
Communication Diagnosis:

Evaluator:
Diagnostic Summary Note:
DOB.:
Reason for Referral:
Etiology:

Speech-language	Unable to assess	WNL	WFL	Mild	Mild/Mod	Mod	Mod/Sev	Severe
Receptive								
Expressive								
Articulation								
Oral Motor								
Fluency								
Voice								
Other								

Summary of Patient's Functional Status:

Long-Term Goals for Length of Stay:

Short-Term Objectives:
1. Patient/Family Education: Weekly discussion to focus on patient's strengths/weaknesses, treatment techniques and progress.
2. Home Program: To facilitate generalization of targeted goals to a variety of contexts.

Recommendations: Therapy was _____ recommended _____ not recommended due to:

Type of Treatment: Speech/Language Therapy
_____ Individual _____ Group _____ Co-Treatment (PT or OT) _____ Supplemental

Frequency/Duration: _____ times per week for _____ hour(s) per session

Estimated Length of Treatment: _____ months with reevaluation _____, based on good/fair rehabilitation potential, with progress attainable within a _____ month period given intensive therapeutic intervention.

Patient/Family was involved in setting goals and was _____ was not _____ in agreement with treatment plan.

Date: _____ Signature: _____

Pertinent Background Information:

Birth:

Medical:

Developmental:

Educational:

Other:

Continued on next page

Continued from previous page

Behavioral Observations/Pragramatics
Patient's attention, cooperation, and motivation were/were not consistent with age expectations. The following results are judged to be a valid and reliable indication of the patient's present communicative functioning as presented during today's session _____ yes _____ no

Comments:

Hearing Screening: Passed: Failed: N/A:

Date/Site of most recent auditory evaluation:

Results:

Peripheral Speech Mechanism: WNL: Impaired:

Structure/Function: Rate/Precision

Articulation: WNL: Impaired:
Intelligibility: _____ good _____ fair _____ poor
Stimulability: _____ good _____ fair _____ poor _____ not assessed _____ N/A

Receptive Language: WNL: Impaired:
Strengths:

Areas of Concern:

Expressive Language: WNL: Impaired:
Strengths:

Areas of Concern:

Written Language/Reading: N/A: WNL: Impaired:
Abilities:

Areas of Need:

Voice: N/A: WNL: Impaired:

Fluency: N/A: WNL: Impaired:

Speech and Language Assessment Results:
Please refer to the attached evaluation checklist form for specific tests administered and results.

If you have any questions regarding any aspect of this report, or if I may be of further assistance, please do not hesitate to contact me at

_____

Date: _____ Signature: _____

APPENDIX C. REHABILITATION ASSESSMENT SUMMARY

Date of Referral: _____

Date(s) of Assessment: _____ Assessment Type: _____ Initial

Physician: _____ _____ Reassessment

Assessment Tool(s) Used: _____

_____

Assessment Summary (Strengths, weaknesses)

Adjusted Age:

Patient/Family Goals:

Recommendations (Treatment frequency, next re-eval date, immediate needs, d/c planning)

Long-Term Goals:

_____ OT _____ SP&H _____ ED
_____ PT _____ REC/CL

Signature

Date & Time

The Hospital for Sick Children
Rehabilitation Therapy Assessment Summary

Note. From the Hospital for Sick Children, 1999. Reprinted with permission.

APPENDIX D: PEDIATRIC FEEDING EVALUATION REPORT

Name: Stephen Jones Date of Birth: 7/20/97
Age: 16 months Date of Evaluation: 11-21-98

Referral
Referred by Jennifer Ears, M.D. of Pediatric Gastroenterology Clinic to assess feeding aversion.

History and Complaint
Stephen drinks from a bottle, eats small amounts of pureed foods from spoon but has not successfully progressed to solids per mother. He presents with a chromosomal abnormality and reportedly had a poor suck after birth but was discharged from the hospital at 2 weeks of age feeding by mouth.

Behavioral Observations
Stephen's mother accompanied him to the evaluation. He sat in his stroller seat and was responsive to tactile and auditory stimuli. He was mentally alert and awake during the assessment.

Stephen watched the faces of his mother and then the examiner as they each performed the role of feeder during today's session. He repeatedly closed his mouth upon smelling and seeing the spoon approach his face. He would also hide his mouth. He put his fingers in his mouth during breaks and smiled and engaged in vocal play by producing "raspberries" and vowel sounds. The behaviors displayed today were characterized by his mother as typical for Stephen.

Evaluation
Oral Motor Examination: Oral structures were assessed informally as Stephen was not able to perform movements upon request. Observations indicated oral structures of normal size and symmetry and movement for feeding purposes. The tongue did not move independently of the jaw; however, tongue lateralization and protrusion was noted. The lips and mandible were mobile.

Oral food presentation: The mother brought some foods that Stephen has eaten at home. They included apple juice (thickened), pediasure, and baby food bananas.

Utensils/Equipment: A Teflon-coated spoon, maroon spoon, baby bottle, and spouted tippy cup were items used during the evaluation.

Positioning: Stephen was fed while seated in his soft stroller. He was positioned at approximately 120-degree angle.

Manner of presentation: After some tactile stimulation to the arms, then face and lips, pureed foods were presented from spoon. Thickened apple juice was presented followed by bananas and ending with a bottle with pediasure.

Amounts: Only small amounts of food were accepted by mouth from the spoon but he consumed more volume from the bottle.

Summary and Recommendations
Stephen presents with feeding skills, which are developmentally delayed. He does accept foods although he does exhibit behaviors to avoid accepting food when presented. He is receiving speech and occupational therapy in his community. Based upon the reported history and the results of today's evaluation, the following recommendations and plans are presented:

1. Feeding therapy goals should continue to include opportunities for oral feeding of a variety of tastes and smells.
2. Stephen should be provided opportunities to play with food by placing his fingers and toys in pureed foods.
3. Positive reinforcement should be provided for acceptance of small amounts of food offered as many times per day as is feasible for the family.
4. Limit the length of each feeding session to discourage boredom and fatigue.
5. Play soft music during feeding sessions.
6. Reevaluation recommended in 3-6 months.

It was a pleasure to work with Stephen and his parents. Please feel free to contact me regarding this evaluation. Thank you for the referral to the Speech and Hearing Center.

_____
Signature Ph.D., CCC-SLP
Speech-Language Pathologist

xc: Referring physician
Pediatric Gastroenterology

APPENDIX E: REHABILITATION PROGRESS NOTES

Prescribed Treatment Frequency/Week Treatment Week # Discipline: _____ OT _____ SP&H

Treatment Period From _____ to _____ _____ PT _____ REC/CL

Goal #	Short-Term Goals (STG)	S/S	M	T	W	Th	F	Goals Status	Goals Date	AVG (Mode)

Comments

1. Please document significant changes and responses, new techniques, changes in Plan of Care with regard to treatment.
2. Signature required for all treatment and documentation.

Key

CX - Cancelled
X - Goal not addressed
O - Ongoing
DG - Discharge/Date
M -Met/Date
R - Revision/Date

Date	TX Time Start/Stop	Intervention	STG #	Therapist Signature & Credentials	Entry Date/Time

Please address weekly:

1. Patient/family agreement with goals: _____
2. Family teaching/contact: _____
3. Total number of treatment sessions completed this week: _____

Signature _____ Date/Time _____

The Hospital for Sick Children
Rehabilitation Therapy Progress Note

Note. From the Hospital for Sick Children, 1999. Reprinted with permission.

APPENDIX F: WEEKLY PROGRESS NOTES

Speech/Language Pathology
Page 1 of 2

Weekly Notes and Progress Note:

Period of _____ to _____

Communication Diagnosis:

Speech-language	Unable to assess	WNL	WFL	Mild	Mild/Mod	Mod	Mod/Sev	Severe
Receptive								
Expressive								
Articulation								
Oral Motor								
Fluency								
Voice								
Other								

Etiology: _____

Patient DOB: _____

Long-Term Goals:

Short-Term Goals:
1. Patient/family education: Weekly discussion to focus on patient's strengths/weaknesses, treatment techniques, and progress.
2. Home program: To facilitate generalization of targeted goals to a variety of contexts.

(Week #1): Dates seen:

Pt. attended treatment session(s) with _____ tolerance.

Goal # _____ addressed with performance level of

_____

_____

Date: _____ Signature _____

(Week #2): Dates seen:

Pt. attended treatment session(s) with _____ tolerance.

Goal # _____ addressed with performance level of

_____

_____

Date: _____ Signature _____

Speech/Language Pathology
Page 2 of 2

Weekly Notes and Progress Note:

(Week #3): Dates seen:

Pt. attended treatment session(s) with _____ tolerance.

Goal # _____ addressed with performance level of

_____

_____

Date: _____ Signature _____

(Week #4): Dates seen:

Pt. attended treatment session(s) with _____ tolerance.

Progress Note Period of _____ to _____

Problems/Impressions/Suggestions:

Progress Toward Goals:
1. Patient/family education: Weekly discussion focused on patient's strengths/weaknesses, treatment techniques, and progress. Treatment plans/goals have not _____/have _____ been reviewed with patient/family. Patient/family has not _____/has _____ agreed.
2. Home program:

_____

_____

_____

_____

_____

_____

Goals for Next Period:
1. Continue with long-term objectives, family education/home program as stated above.
2. Increase accuracy level of above goals. Refer to subsequent documentation for specific modifications in criterion level of therapy goals.

Rehabilitation/Habilitation potential: _____ Good _____ Fair _____ Guarded _____ Poor

Factors: _____ Parental support _____ Motivation _____ Attendance _____ Behavior

_____ Other _____

Type of Treatment: Speech/language therapy

_____ Individual _____ Group _____Co-Treatment (PT or OT) _____ Supplemental therapy

Frequency/duration: _____ times per week for _____ hour(s) per session.

Estimated length of treatment: _____ months with reevaluation _____

Date: _____ Signature _____

APPENDIX G: OUTPATIENT DISCHARGE SUMMARY

Center for Communication Disorders

Date of discharge: _____

Reason for discharge:

_____ Patient achieved long-term goals

_____ Services will be transferred to

_____ Patient/family are relocating

_____ Other:

Communication Diagnosis: Etiology:

Summary of Patient Status:

Discharge Recommendations:

_____ Continued therapy is recommended.

_____ Continued therapy is not recommended due to:

_____ A reevaluation in _____ months is recommended to reassess:

Discharge Recommendations/Follow-up N/A:

Patient/family was involved in setting goals and was _____ was not _____ in agreement with patient's discharge plan.

Date: _____ Signature _____