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Fast Facts Friday

NPORT

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Point of Service Documentation

What does this mean for the therapist?

As therapists, when we hear the phrase "point of service" documentation we tend to think about the daily note that pertains to the treatment that we are providing between the time we clock in with the patient and the time we clock out. In reality, "point of service documentation" is all encompassing and includes all the documentation that we are responsible for regarding that patient.
Some of which include:

- G-Codes (when required)
- Progress Notes
- Updated Plans Of Care
- Documentation Regarding Assistant Supervision
- Patient Education
- Daily Notes

Thorough documentation completion requires the therapists to ensure that they allow enough time during supervisory visits to address all necessary documentation; frequently we under schedule ourselves for supervisory visits. Remember that during these visits we are evaluating progress and revising the plan of care. Through completion of a visit/treatment, g-code, and progress/note every time we are scheduled for a supervisory visit we can not only reduce errors but we can improve our overall documentation and patient involvement.

Benefits of Point Of Service Documentation:

- Reduced errors on the placement of g-codes
- Reduced treatments beyond 10 visits when appointments are scheduled for visits 8 or 9.
- Increased clarity and improved content in documentation
- Review of the goals and progress with the patient
- Facilitates patient/caregiver education regarding progress toward goals
- Facilitates patient involvement in goals

References: February 20, 2015 FFF "Point of Service Documentation"
Policy 02.15 Progress Note