

Case Note Sample Narratives

An assessor's case notes have the ability to "tell the story" of a consumer's medical and social situation in a manner which significantly augments information contained solely from completion of current assessment tools as well as the UAS-NY when implemented. Samples of case notes are provided to serve as examples for assessors to narratively illustrate an individual consumer's strengths and service needs.

Sample Narrative 1

Client has expressed a continuing need for PCA services to assist him with some personal care, household chores, laundry, and shopping. Client transfers and ambulates independently. He is able to walk short distances on his own and uses a walker for longer distances. Owns and drives his own vehicle but states he has not driven his car since last October 2009. Client says he drives when he has to for appointments and shopping. He is morbidly obese. He continues to suffer from poor circulation in both legs/ankles. He no longer receives VNA CHHA for nursing and wound care as open wounds to the front and back of left calf have healed. Client says he takes weekly sponge baths instead of baths or showers as he is unable to get into tub. He sleeps on a single bed in the area that once served as the dining room. Client has no surviving immediate family members. His mother passed away in 2006 and his one brother in 1996. The home is in his mother's name. Client says he spends much of his time at home. He did provide writer with names of nearby neighbors [see "contacts"] who check in on him from time to time and who will bring him food, and maybe do some odd jobs around the home for him [e.g.: mow his yard, rake leaves, shovel the walk]. Client says he is independent with some of his personal care, meal prep, some HH chores and with managing finances and personal business. Client says SSI payments are mailed directly to him monthly and he pays his bills with money orders. Client has PERS which was found to be in working order and he wears a PERS necklace. CW and Client are in agreement with continuing same PCA CP 6hpw/3dpw/2hpd.

Sample Narrative 2

Client is 72 Yr. old male lives alone. Hx: Bilateral lower extremity edema cellulitis of lower extremities, HTN, venous stasis, renal insufficiency, hypercholesterolemia and obesity. A&O X3, self directing. Ambulates and transfers independently with walker. Skin is intact. Incontinent of bladder & bowel at times. No issues are noted with regards to chewing or swallowing. Appetite is fair, states his appetite is not what it used to be. He is very intent on healthy eating and is eager to stop eating high sodium foods. He is 5'8" and is 352#. Senses WNL with glasses for reading. Sleeps on a hospital bed which is easier for him to transfer into. PERS checked this visit. Response time <2 min reminded client that he is to wear the "button". Client agrees. Client has his own car which he only drives in the summer. Client does his own grocery shopping, laundry, meds and MD appointments. However, due to his weakness and limited physical abilities, personal care is recommended 6hrs a week to help with household chores and washing his lower extremities. CP safe and adequate for this client.

Sample Narrative 3

Client is 27 year old single female, A/O x3 self directing Wt: 100-150 lbs. Ht: 5'4" vision, speech, and hearing ok. Due to a spinal cord injury/quad client requires total care in all ADL's and IADLs. Client resides in single family home with 50 year old mother, 52 year old father, 29 year old sister and a dog and 2 cats. Both parents are the primary caregivers and have joint guardianship. Client's aunt is the secondary guardian. Client's sister teaches and works during the summer months. Per client and mom, sister is not reliable but does assist in some of the client's care. Client's mom is a nurse works 3dpw (varies) 11a-11p shifts (leaves 10:15p and returns home anywhere between 12:30a-3:00a in addition to working a lot of overtime. Dad is an accountant and works mon-fri; up at 5:30a and out of the house by 6:30a-home around 5:00p. Dad is also gone a lot in the evenings with various social activities. Client transfers with stand pivot and one assist. Non ambulatory uses electric w/c (client operates herself) for mobility. Client needs to be wheeled in the manual wheelchair. Client is a professional and works full-time days and part-time evenings. Regular Mon-Fri hours are 8:30a-4:30p however actual hours vary so much due to overtime, work schedules and mandatory continuing education classes. Client has a private w/c lift van for medical appt., work and social transportation. Client very well aware that transportation is not a medical task and is not part of the care plan and that the attendant is not allowed to drive/transport. Client pays the people who drive the van privately. Client needs to have the attendant with her during all work hours since client requires total assistance with everything; taking off coat, feeding, toileting (st cath every 2-4 hrs), stands client during breaks taking notes etc... Client goes to hospital every 3 months to have her Baclofen pump changed. Parents pick up/oversees medication administration. Client needs to be fed. Client's bathroom is w/c accessible with roll in shower. Landline phone in client's bedroom is the only one client is able to use. Client can push buttons to dial out using speaker phone. Client needs help with her cell phone. Client left alone for short periods of time a couple hours at a time with no apparent problems. House is all on one level so it is easy for client to get around with power w/c going out the front door with a small ramp incline to get in/out. Client needs help with opening the door. Washer/dryer off kitchen; electric stove, microwave. Client handles own finances on the computer. Client able to push keyboard buttons. Parents both have POA and assist client as needed. Parents continue to be responsible for major grocery shopping, laundry, meals, cath care/bowel regime and all care during non-service hours. Parents provide all night care. Client has to be turned and positioned and toilet needs attended 2-3x per night. All family members have keys to the house. CDPAP assistants assist with all AM/PM personal care (bathing, shampoo, dressing and undressing), meds, meals (must be fed), catheterization/bowel regime ROM/exercises, minor groceries, personal laundry and household chores.

Sample Narrative 4

Client is 27 y.o. female dx: spinal cord injury with quadriplegia (MVA when client was 16), spasticity, neurogenic bowel and bladder. Client is alert oriented x3, self directing client is non-ambulatory is transferred via stand pivot; has power w/c client able to maneuver PWC independently; needs assist with manual w/c client purchased van with lift access. Client graduated from law school and is now employed full and part time evenings. CDPAP gets client ready for work, makes breakfast feeds, does all personal care and grooming, cleans up client's area, accompany client to work and assist with toileting (st cath every 2-4hrs) feeding and taking notes for client at work, bowel regime, (suppository), and assist with PM care and putting client to bed, ROM, incidental groceries, laundry, HHC's client area. Weight stable approx. 100-105 lbs. Client has Baclofen pump monitored by BGH 3mos. Skin intact, sleeps well appetite good, no problem chewing or swallowing. Client has received PT and OT in the past and follows a home program based on previous instruction of therapist. Client feels no further need for formal PT and OT at this time. Parents assist with medication pick up and setup, parent provide care at night for turning and positioning and all care during non-covered hours. Coworker gives client ride to work. Cont CDPAP care plan of 85 hrs. a week as safe and adequate at this time.

Sample Narrative 5

Client is 75 yo female alert and oriented x's3 with some mild memory loss. Client speaks only in Arabic. Son acted as interpreter and information source DX: hypertension and diabetes. Son is very involved. He brings some meals for client takes to MD, does the shopping, errands, Rx pickup and finances there are no CHHA services involved. Sensory: vision-client states vision is blurry due to retinal damage, hearing and speech are WNL, communication as above, skin is intact. Ambulates and transfers independently. Client uses no assistive devices for safety, no recent falls. Client has cell phone with her at all times and pull cord in bathroom and bedroom. Left foot turns out on ambulation--son states she has weak ankle and chronic burning pain in it. For this reason, she is unable to walk for any length of time and requests assistance. Client is continent of bowel and bladder. Diet: diabetic, low cholesterol. Client can heat some meals; family brings some meals on service days; there is enough that can be prepared and left for later use. Height 5'2" weight 140lbs. Client can sponge self but is requesting assist with shower and shampoo 2d/wk. She can also dress herself. Her son states it just takes her forever as she moves slowly. She can finish her own grooming tasks. Medications are self-administered. Son calls to remind client to take her medication. Client sleeps poorly and naps during the day due to her inability to stand and walk. Client requires assist with some personal care, household chores and laundry. CW and RN agree that CDPAP 4hours/week will be appropriate for this client.

Sample Narrative 6

Client is 61 y/o female. Client was unable to answer most questions and her spouse answered for her as her self-directing other. DX: early dementia and, per her MD, it is progressing fast. Obesity, HTN, DJD and depression. Client was able to state name and address but asked spouse for all other info. Allergic to PCN. Client's husband is doing everything for her 24/7 and only leaves the house for his own MD appointments. A neighbor comes to sit with her at those times. Client attends Mental Health counseling once a week. Sensory is WNL, skin is intact, ambulates with a cane and contact guard. She also has a walker. Client transfers with some assist. Continent of bowel and incontinent of bladder, refuses to wear disposable briefs so husband toilets her regularly through the day and night. Sleep is disturbed. Client is active at night and wants to sleep during the day. Diet: low salt, spouse prepares and serves all meals. Height 5'2" weight 176lbs. appetite good. No problems chewing or swallowing. Client requires assist with showers and incontinent care. Spouse states she falls a lot and always has contact guard. Client's spouse is at his wits end caring for client and is looking for maximum assist. We explained we don't provide for client supervision. Discussed Medical Day Program and both client and spouse were agreeable. CW made referral, discussed case with CW client need assist with personal care only. Recommend PCA 1hr/3dy/wk to assist with identified need.

Sample Narrative 7

Client is a 26 y/o white female living alone. A & O self directing, DX: Cerebral Palsy, Asthma. Client stated she was born premature and at 2 weeks old had a stroke which caused the cerebral palsy. PMH: eye surgery at age 13 months to align eyes. Transfers via weight bearing Sara lift 2000 with 1 assist, non ambulatory; power w/c for mobility, no falls. UE: L hand functions pretty well; R hand immobile. Receives PT weekly with improvement noted in flexibility and strength to right leg. Left leg remains weak. Moderate core muscle strength. Client stretches in bed to keep self limber. Is able to use computer and dictation software; able to use phone. Vision; astigmatism near and far sighted. Wears glasses. Hearing and speech WNL. Occ bladder incontinence. Wears incont. briefs when out for long periods of time. Cont. of bowel. Toileted via sara lift 4-5 x/day. Skin intact; appetite good no difficulty chewing/swallowing, own dentition. HT5'0" 130# med scripts filled at Rite Aide and delivered by pharmacy. Client manages own medications. Uses Medicaid w/c van for medical apt. PAL through NFTA for social transport. Independent with feeding self simple breakfast (cereal).

Client awakens between 8- 9 AM and bedtime is between 11 – 11:30 PM. Client serviced 4x/day for toileting. D/T poor UE & LE mobility, requires asst. 7 day a week with bathing (shower) and PM care, grooming dressing, transfers, toileting, meal prep (B, L, D) help with microwave, household chores and laundry. Client has rehab aide who handles shopping and errands. Requires an increase in 1hr/wk as aides do not have enough time to complete personal care and other tasks; recommend increase PCA/SAS to 44 hr/wk to be provided 7 days/wk 4 times per day.

Sample Narrative 8

Client is 95 year old female alert oriented and self directing with some input from daughter. DX: CVA 9/09 DM, HTN, early stage dementia, hyperlipidemia, heart murmur, R bundle branch block, UTI (resolved) lives with daughter and son-in-law. Daughter provides 24 hour supervision and is primary caregiver. Sensory vision WNL with glasses, somewhat hard of hearing, speech is clear with mild dysphasia, ambulates with cane or rolling walker independently, sometimes needs supervision or contact guard on stairs, transfers independently, client is continent of bowel, incontinent of bladder, wears disposable undergarments. Client is on an 1800 diabetic low cholesterol, low salt, cardiac diet – daughter prepares most meals. She may need PCA to prepare meal on request. Client requires cut and pour prior to feeding herself. Daughter states appetite is good. No problems chewing or swallowing. Has her own teeth with partial upper. Height 5' 2", weight 118lbs. Daughter assists with meds. Meds from Walgreen's pharmacy, daughter picks them up. Client needs assist with personal care some meal prep, HHC in client's area or after use and laundry, continue same care plan of CDPA 6 hrs/wk to meet needs.