



PATIENT JOURNEY– COMPLEX CARE (NH)

HOSPITAL INFORMATION SYSTEM (HIS)

ACUTE REHABILITATION – OCCUPATIONAL THERAPY (OT),
PHYSIOTHERAPY (PT), SPEECH LANGUAGE PATHOLOGY (SLP),
RECREATION THERAPY, REHAB ASSISTANT (RA), COMMUNICATIVE
DISORDERS ASSISTANT (CDA), RECREATION THERAPY ASSISTANT

This tip sheet is designed to guide the rehab team through the patient’s journey from initial engagement in rehabilitation for Low-Intensity Rehab to patient discharge.

1. Prescriber may place Consult Orders to therapy:

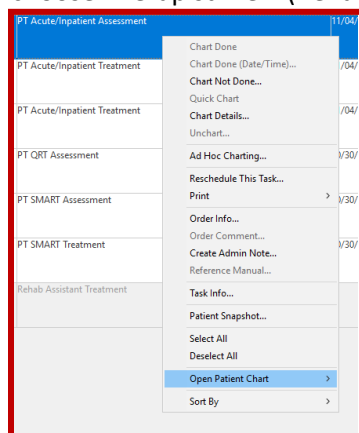
- Occupational Therapy Assessment & Treatment
- Physiotherapy Assessment & Treatment
- Speech Language Pathology Assessment & Treatment
- Recreation Therapy Assessment & Treatment

***Note:** Because the patient was transferred from a Niagara Health site, and has already been consulted by a therapist, that accepting therapist in Complex Care is not required to complete an initial assessment. If therapists receive initial assessment tasking based on a new Consult Order, they can choose to use the assessment tasked and qualify it as a Reassessment.

2. Therapists review the patient’s chart in PowerChart

a. To review the patient’s chart:

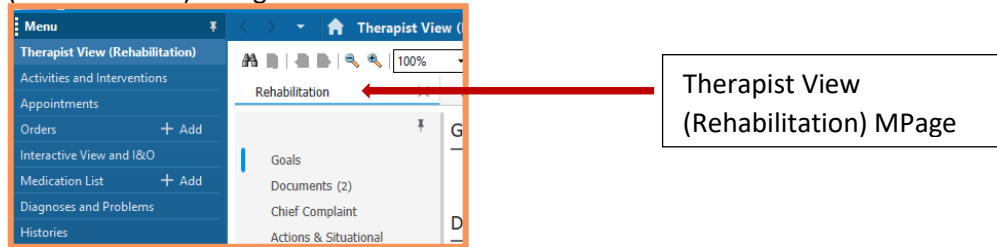
- From MPTL viewpoint, right-click the task, choose Open Patient Chart, and choose Therapist View (Rehabilitation) MPage



- From Rehab Organizer, click the patient’s name hyperlink; this will open the patient’s chart to the Therapist View (Rehabilitation) MPage by default.



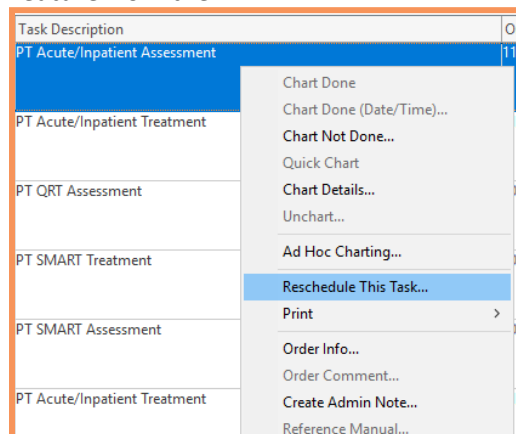
- b. Review all patient information first by navigating through the Therapist View (Rehabilitation) MPage.



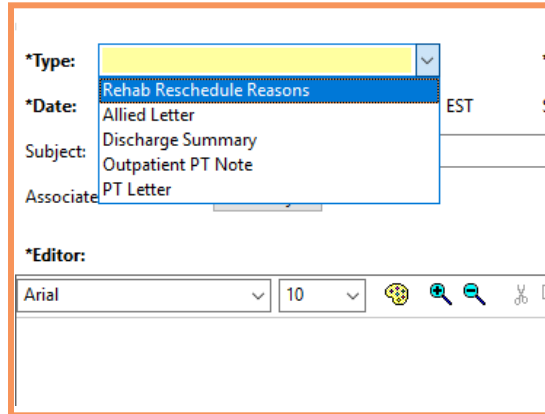
- c. Review any items along the blue [Table of Contents](#).
- d. Review Orders by clicking on the **Orders** tab.
- e. Review any treatment flowsheets, nursing notes, labs, diagnostics through **Results Review**.
- f. Review any published documentation through the **Documentation** tab.
- g. Click on **Clinical Connect** to review any out of Region medical documentation.

3. Therapists deem the patient inappropriate for the Initial Assessment/Reassessment

- a. If the patient is inappropriate for the Initial Assessment, use the **Reschedule This Task** feature from the MPTL.



- b. Create the **Rehab Reschedule Reason Note**, from the **Notes** tab on the patient's blue Table of Contents.



*Type: Rehab Reschedule Reasons

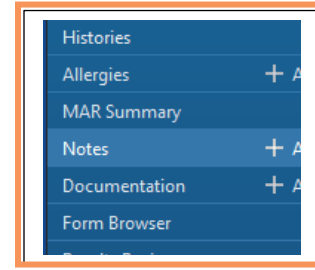
*Date: EST

Subject: Discharge Summary

Associate: Outpatient PT Note

*Editor:

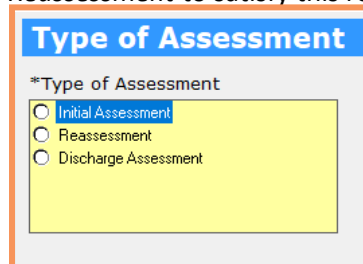
Arial 10



Access the Rehab Reschedule Reasons note in the Notes section on the blue Table of Contents menu

4. Therapists deem the patient appropriate for Initial Assessment/Reassessment and the patient provides consent

- a. Once the initial assessment/reassessment is complete, navigate back to the MPTL or Rehab Organizer to retrieve the documentation.
- b. **MPTL:**
 - i. Locate the task in the task list and double-click to open the Acute/Inpatient Assessment PowerForm.
- c. **Rehab Organizer:**
 - i. Locate the patient and click within the **Tasks** column. Click the Document tab next to the appropriate PowerForm.
- d. Complete the required field, titled ***Type of Assessment**. Choose *Initial Assessment* or *Reassessment* to satisfy this required field.



Type of Assessment

*Type of Assessment

Initial Assessment

Reassessment


Discharge Assessment

- e. Complete any areas within the PowerForm. The *Home Environment*, *Preadmission Status* sections have Last Charted Value (LCV) functionality.

***Note:** If another therapist, from another Niagara Health site completed and signed their PowerForms, some fields may be pre-populated with the last recorded values. Therapists can choose to add new data or modify any existing information to ensure it accurately reflects updated or corrected details.



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- f. **PTs and OTs** – complete any flowsheets within the Review/Treatments section of the PowerForm, as well as the *PT Instructions* and *OT Instructions* sections for Rehab Assistant information. Therapists may need to alter the existing flowsheets; they can write over data or clear existing flowsheets at their discretion.
 - g. **SLPs** – complete any Short-Term Goals in your PowerForm to help guide future treatment for CDAs. Since this area is last charted value from an SLP at a previous Niagara Health site, SLPs may write over data or clear existing STGs at their discretion.
 - h. Complete the required ***Plan** section of the Acute/Inpatient Assessment PowerForm, and select **Yes** for ongoing therapy treatment/services. This will place the therapy follow-up order and Treatment PowerForm tasking will occur in the MPTL and Rehab Organizer.
 - i. Once all areas are completed in the PowerForm, SIGN it. 
 - j. Ensure the Acute/Inpatient Assessment PowerForm is published by navigating to the blue Table of Contents on the patient’s chart, and clicking on Documentation.
***Note:** If the patient did not consent to the Initial Assessment, complete **Step 4**.
***Note:** If the therapist does not wish to use the Acute/Initial Assessment PowerForm tasked, they may eliminate the task by using the **Chart Not Done** (MPTL) and **Not Done** (Rehab Organizer) feature to clear the task and complete the Consult Order.
5. **If a Consult Order was not placed, therapists can utilize any treatment documentation tasked based on the previous therapists’ follow up orders. If no treatment documentation tasking is available and no Consult Order was placed by the prescriber, therapists may AdHoc an Assessment or Treatment PowerForm to document at this time.**

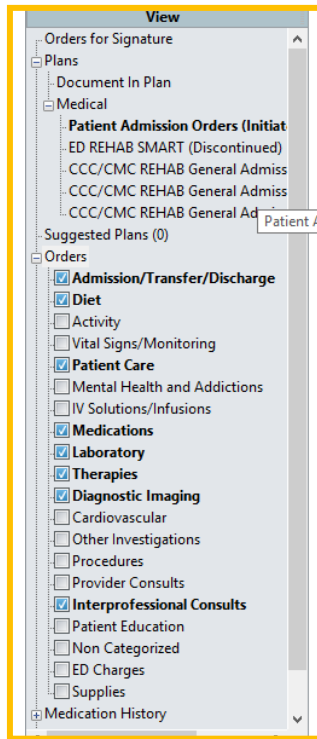


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6. Placing or Modifying Follow Up Orders for ongoing treatment

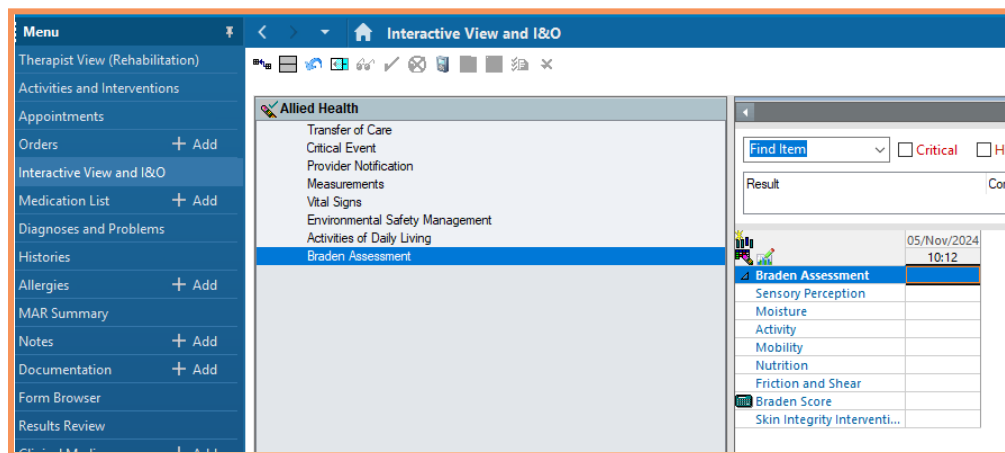
- If therapists decide to provide ongoing treatment for a patient while completing the initial assessment/reassessment, therapists will need to place the follow-up order from the ***Plan** section of the Acute/Inpatient Assessment PowerForm.
- Complete the required ***Plan** section of the Acute/Inpatient Assessment PowerForm, and select **Yes** for ongoing therapy treatment/services. This will place the therapy follow-up order and Treatment PowerForm tasking will occur in the MPTL and Rehab Organizer.
- If a follow-up order and Treatment PowerForm tasking exist, therapists can review the follow-up order in the **Orders** section of the patient’s chart, under the **Therapies** tab.




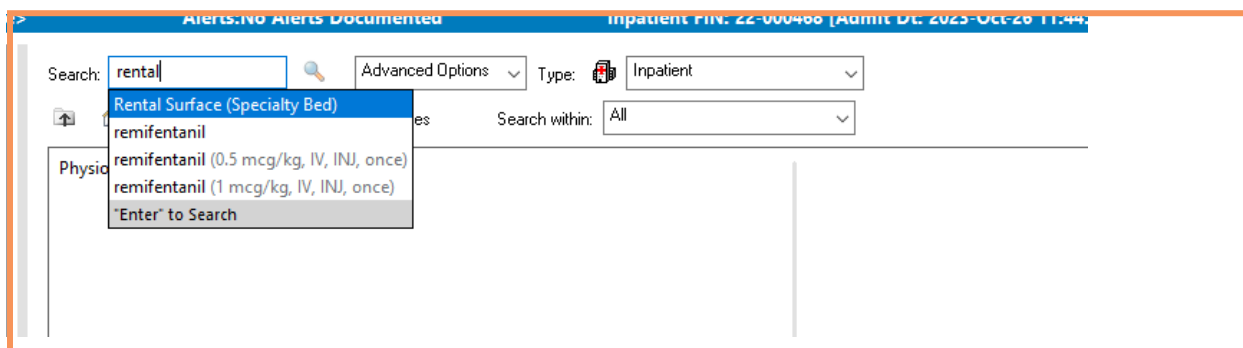
- Therapists may right-click on the order, and choose **Modify**. The order detail window opens. If the therapist determines an end-date is needed for Treatment PowerForm tasking, they can create an end-date in the follow-up order details. If an end-date is established, Treatment PowerForm tasking will cease at the end-date.
- If the patient does not have any active follow-up orders, therapists will have to AdHoc their Acute/Inpatient Assessment PowerForm, and complete the **Plan** section.

7. Patient requires a specialty bed surface – Occupational Therapist

- a. Complete the Braden Assessment as needed – navigate to the Interactive View and I&O from the blue Table of Contents of the patient’s chart. Complete the Braden Assessment.



- b. To propose a specialty bed surface, navigate to the **Orders** tab on the blue Table of Contents in the patient’s chart.
 - i. Click the +Add icon. 
 - ii. Search **Rental Surface** in the Orders Search window and click **Done**.





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Ordering Physician

Order
 Proposal

***Physician name**
NHS Test01, Physician - Hospitalist

***Order Date/Time**
05/Nov/2024 0925 EST

***Communication type**
Phone with Read Back (Cosign)
Verbal with Read Back (Cosign)
Written
Interprofessional Consult
Per Policy
Initiate Plan
Downtime Back Entry
Medical Directive
IPAC Isolation Order

OK Cancel

Complete the Proposal details, including clicking **Proposal**; fill in the *Physician Name, Order Date/Time, and Communication Type*. Click **OK** when done.

Complete the order details to include the type of Specialty Bed surface recommendation.


***Note:** The Prescriber will receive notification in their Message Center to review the Proposed Order. Once signed, the Rental Surface (Specialty Bed) is considered Ordered.

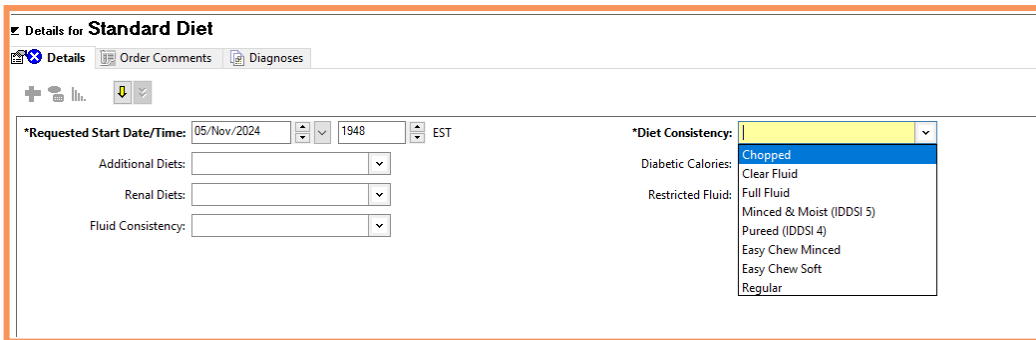
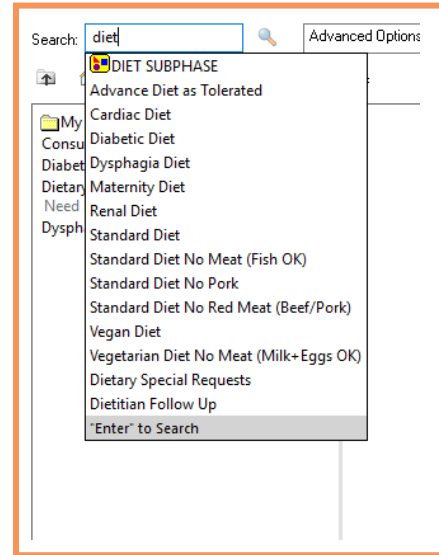


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8. Patient requires a change in Diet Orders – Speech Language Pathologis

- a. To order a diet, navigate to the **Orders** tab on the blue Table of Contents in the patient’s chart.
 - i. Click the +Add icon. 
 - ii. Search Diet



***Note:** If a diet order already exists, that diet order needs to be canceled prior to a new diet order being placed.

9. Communicate with Rehab Assistant and CDA for ongoing treatment plan

- a. Ongoing communication between PT and Rehab Assistant, OT and Rehab Assistant, and SLP and Communicative Disorders Assistant is essential for coordinating the patient’s care.
- b. The OT and the PT should create treatment flowsheets in their respective PowerForms and provide clear instructions for which treatment flowsheets the Rehab Assistant should access, and any safety parameters or special considerations in the PT Instructions.



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- c. and OT Instructions areas in the flowsheet section. This information will appear in the Rehab Assistant’s Treatment PowerForm.
- d. SLP should outline Short-Term Goals in the Short-Term Goals section of their PowerForm to help guide ongoing treatments for the CDA.
- e. Recreation Therapists can create use the flowsheet in the Daily Treatment section.

10. Rehab Assistant (RA), Communicative Disorders Assistant (CDA), and Recreation Therapy Assistant Treatment and Documentation

- a. Rehab Assistants will AdHoc their Rehab Assistant Treatment PowerForms.
 - i. The Rehab Assistant Review/Treatments section will have all treatment flowsheets and OT and PT Instructions. The RA will complete all flowsheet documentation within this section.
 - ii. The Rehab Assistant will write any notes in the Rehab Assistant Notes section of the PowerForm.
 - iii. If the RA provides equipment to the patient at the request of the therapist, the RA can write this information in the Rehab Assistant Notes section of their PowerForm.
- b. Communicative Disorders Assistant will AdHoc their Treatment PowerForms.
 - i. The CDA should review the STGs section of their PowerForm to help guide treatment.

11. Continue to treat patient and provide treatment updates within the treatment documentation and with other team members.



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12. Patient Destination Scenarios

Scenario 1 – Patient Appropriate to Return Home, to Retirement Home, etc., but would benefit from the HDS Rehab Program

- a. Therapists can AdHoc their respective Discharge Summary or AdHoc their respective Assessment PowerForm and qualify it as a Discharge Assessment.

Type of Assessment

*Type of Assessment

Initial Assessment

Reassessment

Discharge Assessment

- b. Therapists to complete all necessary documentation within their respective Discharge Summary or Discharge Assessment PowerForms. It is recommended that therapists complete the Discharge SMART Goals section to assist Outpatient Therapy Staff.

Discharge SMART Goals

Occupational Therapy – OT Discharge SMART Goals section
Physiotherapy – PT Discharge SMART Goals section
Speech Language Pathology – SLP Discharge SMART Goals

- c. If the patient no longer requires therapy in hospital, therapists may **Cancel/Discontinue** their Follow Up orders to eliminate any unnecessary documentation tasking.
- d. Therapists to communicate with Case Managers of their recommendation for the HDS Outpatient Stroke Rehab Program.
- e. Case Managers will complete the HDS Outpatient Referral PowerForm.
- f. All therapy Follow Up Orders will cancel/discontinue automatically upon patient discharge.



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Scenario 2 – Patient Appropriate to Return Home, to Retirement Home, with Home Care Supports

- a. Therapists can AdHoc their respective Discharge Summary or AdHoc their respective Assessment PowerForm and qualify it as a Discharge Assessment.

Type of Assessment

*Type of Assessment

Initial Assessment

Reassessment

Discharge Assessment

- b. Therapists to complete all necessary documentation within their respective Discharge Summary or Discharge Assessment PowerForms. It is recommended that therapists complete the Discharge SMART Goals section to assist Home Care Coordinators with prioritizing home care services in the Community.

Discharge SMART Goals

Occupational Therapy – OT Discharge SMART Goals section
Physiotherapy – PT Discharge SMART Goals section
Speech Language Pathology – SLP Discharge SMART Goals

- c. If the patient no longer requires therapy in hospital, therapists may **Cancel/Discontinue** their Follow Up orders to eliminate any unnecessary documentation tasking.
- d. Therapists may place a Referral Order to Ontario Health at Home (Home and Community Care Support Services), and complete relevant order details – alternatively, therapists can communicate with the Case Manager to place this order.
- e. All therapy Follow Up Orders will cancel/discontinue automatically upon patient discharge.



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Scenario 3 – Patient Requires Alternate Level of Care

- a. Therapists should AdHoc their respective Discharge Summary or AdHoc their respective Assessment PowerForm and qualify it as a Reassessment or Discharge Assessment.

Type of Assessment

*Type of Assessment

- Initial Assessment
- Reassessment
- Discharge Assessment

- b. Therapists should communicate with the interdisciplinary team regarding any recommendations for alternate living destinations.
- c. Therapists should modify or cancel/discontinue Follow Up Orders as needed to address treatment documentation tasking.