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 Rehab High – Stroke Rehab to discharge. The focus is on a patient who has experienced an ischemic stroke, was admitted to Acute Care, and has now entered Hotel Dieu Shaver for inpatient Rehab High.

1. **Prescriber places the Admission PowerPlan, including the Level of Care. The following order are placed based on the PowerPlan**:
   - Occupational Therapy Assessment & Treatment
   - Physiotherapy Assessment & Treatment
   - Speech Language Pathology Assessment & Treatment
   - Recreation Therapy Assessment & Treatment

2. **Therapists receive tasking on the Multi-Patient Task List and Rehab Organizer**
   a. Occupational Therapy
      i. OT Acute/Inpatient Assessment
      ii. NRS/FIM Admission
   b. Physiotherapy
      i. PT Acute/Inpatient Assessment
      ii. NRS/FIM Admission
   c. Speech Language Pathology
      i. SLP Acute/Inpatient Assessment
   d. Recreation Therapy
      i. Recreation Therapy Assessment
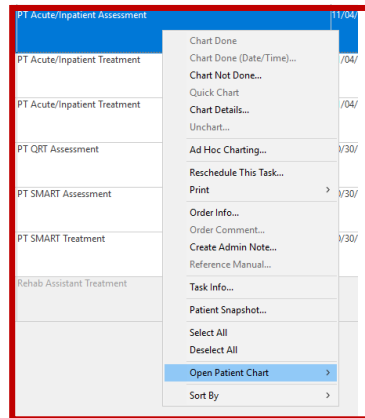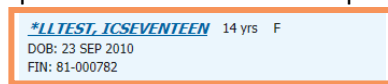
3. **Therapists review the patient's chart in PowerChart**
   a. To review the patient's chart:
      i. From MPTL viewpoint, right-click the task, choose Open Patient Chart, and choose Therapist View (Rehabilitation) MPage

      ii. 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.
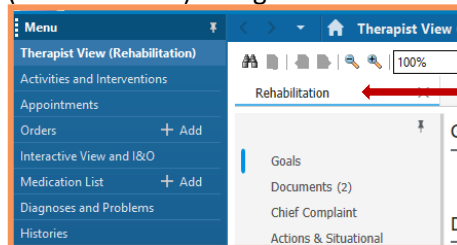
Therapist View (Rehabilitation) MPage

   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.

4. **Therapists deem the patient inappropriate for the Initial Assessment**
   a. If the patient is inappropriate for the Initial Assessment, use the ***Reschedule This Task*** feature from the MPTL.
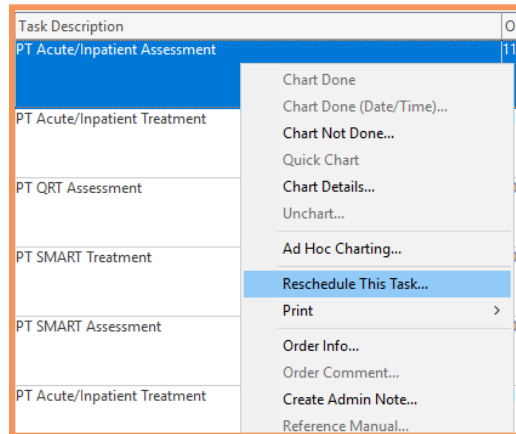
   b. Create the Rehab Reschedule Reason Note, from the Notes tab on the patient's blue Table of Contents.
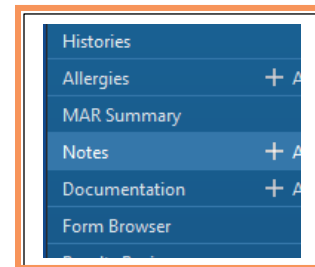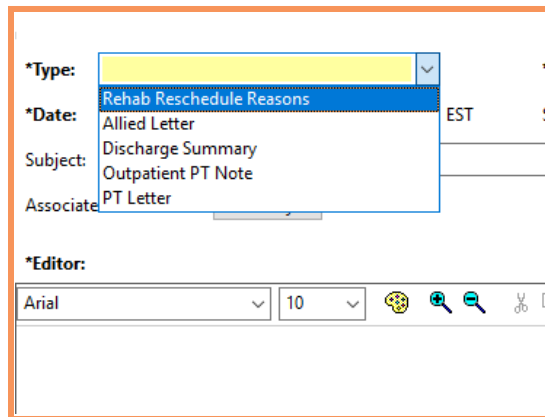
   Access the Rehab Reschedule Reasons note in the Notes section on the blue Table of Contents menu

5. **Therapists deem the patient appropriate for Initial Assessment and the patient provides consent**
   a. Once the initial assessment is complete, navigate back to the MPTL or Rehab Organizer to retrieve your 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* to satisfy this required field.

 e. Complete any areas within the PowerForm. The *Home Environment*, *Preadmission Status* sections have Last Charted Value (LCV) functionality.
  *Note: If another therapist, from a different discipline completed and signed their assessment PowerForm before you begin your PowerForm, you may notice that some fields are pre-populated with the last recorded values. You can choose to add new data or modify any existing information to ensure it accurately reflects updated or corrected details.
 f. **PTs and OTs** – complete any flowsheets within the Review/Treatments section of the Acute/Inpatient Assessment PowerForm, as well as the *PT Instructions* and *OT Instructions* sections for Rehab Assistant information.
 g. **SLPs** – complete any Short-Term Goals in your PowerForm to help guide future treatment for CDAs.
 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 your 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**.

6. **FIM Retrieval and Completion**
 a. Occupational Therapist and Physiotherapist retrieve the tasked NRS/FIM Admission PowerForm.
 i. MPTL: Location the NRS/FIM Admission task and double-click to open the PowerForm.

    ii.   Rehab Organizer: Locate the patient and click within the Tasks column. Click the Document tab next to the appropriate PowerForm.

    iii.   OT and PT complete their respective sections of the NRS/FIM Admission PowerForm and SIGN.

    iv.   OT and PT will log in to Clarity, and submit the FIM scores for submission to CIHI

*Note: SLP may AdHoc the NRS/FIM Admission PowerForm if needed. SLP will complete their respective sections of the NRS/FIM PowerForm and SIGN. SLP will log in to Clarity, and submit the FIM scores for submission to CIHI.

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.
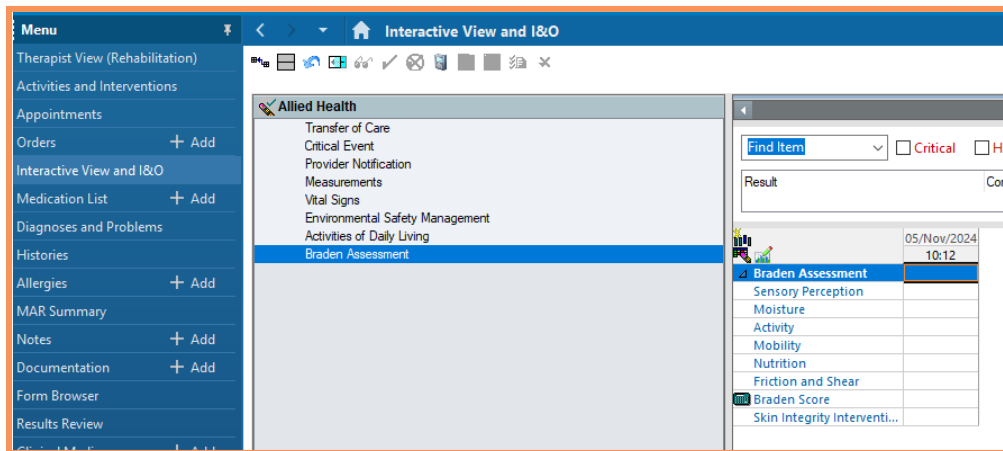
b. To propose a specialty bed surface, navigate to the **Orders** tab on the blue Table of Contents in the patient's chart.

    i. Click the +Add icon. **➕ Add**

    ii. Search **Rental Surface** in the Orders Search window and click **Done.**
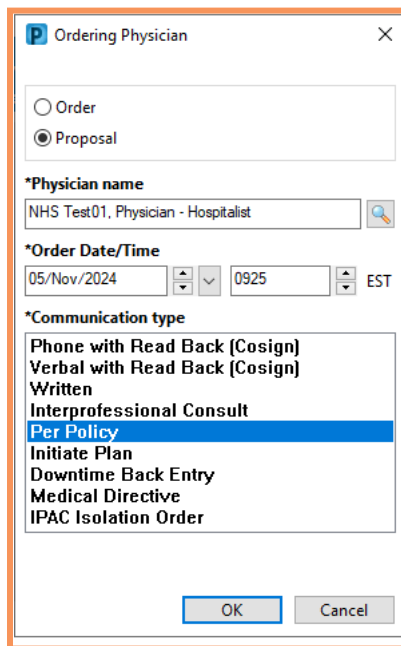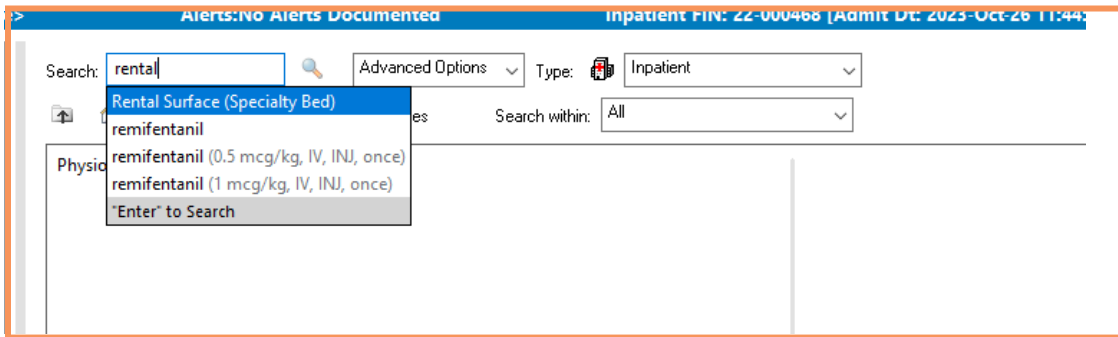
Complete the Proposal details, including clicking **Proposal**; fill in the *Physician Name*, *Order Date/Time*, and *Communication Type*. Click **OK** when done.

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.**
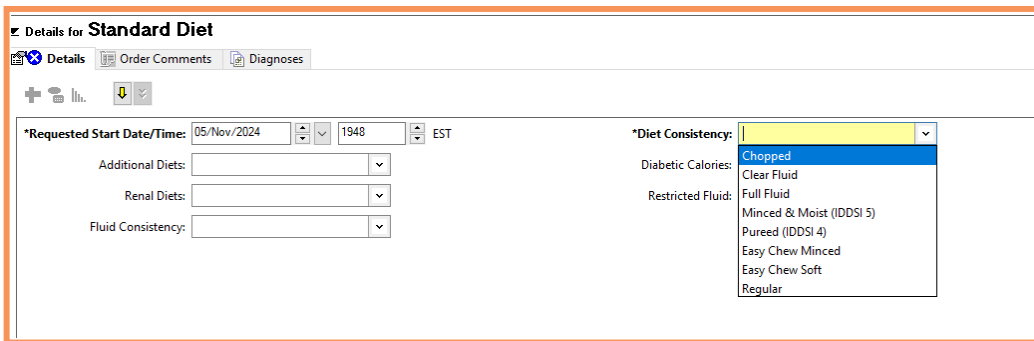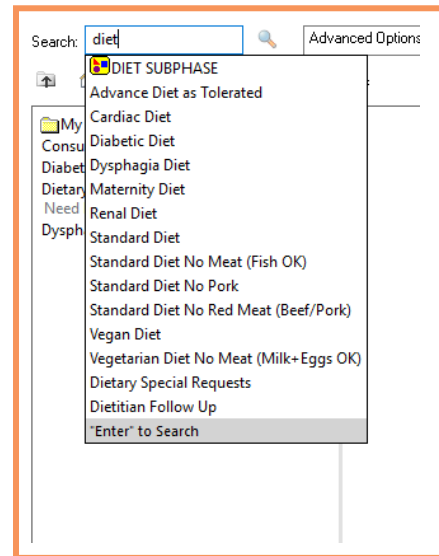
8. **Patient requires a change in Diet Orders**
   a. To order a diet, navigate to the Orders tab on the blue Table of Contents in the patient's chart.

      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. **Patient is scheduled for ongoing treatment**
   a. Schedulers will schedule patients on 1 East and 1 West for rehab, based on therapists' treatment frequency recommendation.
   b. OT, PT, SLP, and Rec Therapy will be able to see their schedule via the Rehab Organizer, Rehab Schedule View MPage.

c. Therapists, Rehab Assistants, and Communicative Disorders Assistants will utilize the Rehab Schedule View to prompt them to see, treat, and document patient interactions effectively.
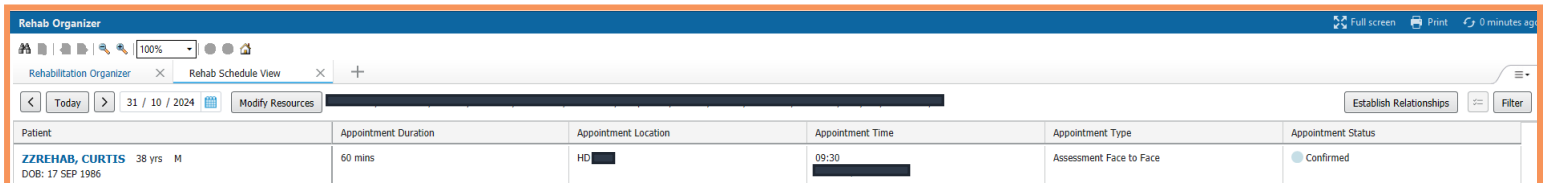
10. **Communicate with Rehab Assistant and CDA for ongoing treatment plan**
    a. Ongoing communication between PT and Rehab Assistant, OT and Rehab Assistant, and SLP and Communicative Disorders Assistant is essential for coordinating the patient's care.
    b. The OT and the PT should create treatment 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.
    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.

11. **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.

12. **Case Manager Orders Team Conference PowerPlan**
    a. Therapists and other members of the care team receive tasking of the Interdisciplinary Team Conference PowerForm in the MPTL and Rehab Organizer. Team members include:
        i. Rehab Nursing
        ii. Case Manager
        iii. Occupational Therapist
        iv. Physiotherapist
        v. Speech Language Pathologist
        vi. Social Worker
        vii. Recreation Therapist
    b. The Case Manager will place the PowerPlan at least 24 hours before the Team Conference.
    c. During or after the Team Conference, each team member will fill out their designated sections of the Interdisciplinary Team Conference PowerForm and include their name in the corresponding areas of the Team Members section.

Each team member will place their name into this section

Discipline specific areas of the PowerForm, divided into sections

    d. Each team member will SIGN their tasked PowerForm once

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

14. Patient Destination Scenarios

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

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 an 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.

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.