



# PATIENT JOURNEY– COMPLEX CARE (HDS)

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.

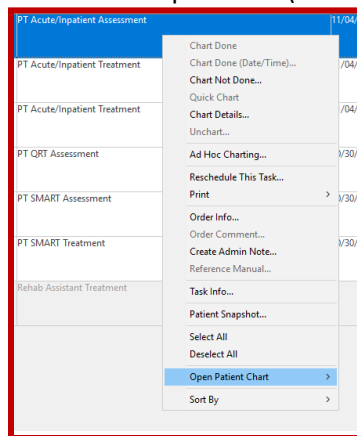
1. **Prescriber places the Admission PowerPlan, including the Level of Care. The following order are placed based on the PowerPlan:**

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

2. **Therapists review the patient’s chart in PowerChart**

a. To review the patient’s chart:

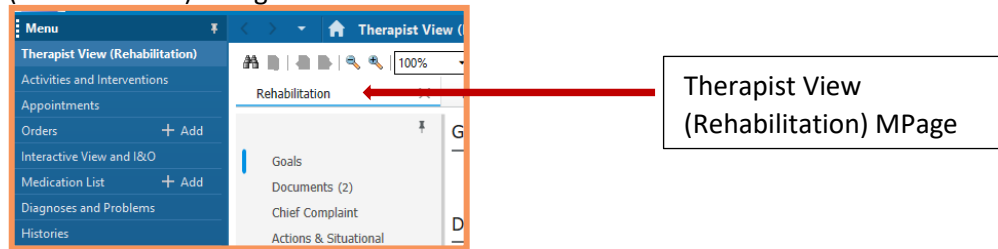
- i. From MPTL viewpoint, right-click the task, choose Open Patient Chart, and choose Therapist View (Rehabilitation) MPage



- 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.



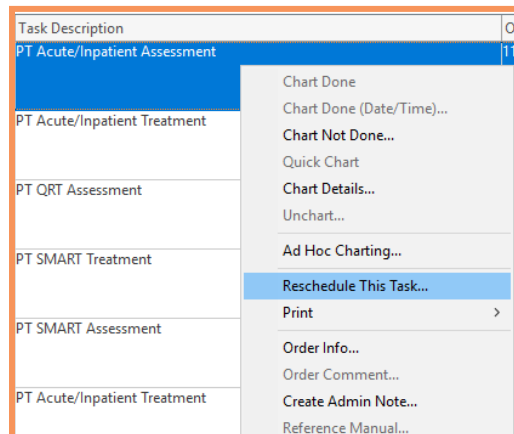
- b. Review all patient information first by navigating through the Therapist View (Rehabilitation) MPage.



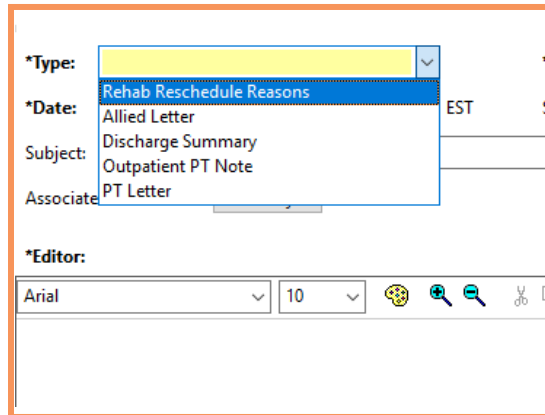
- c. You can review any items along the blue [Table of Contents](#).
- d. Review Orders by clicking on the **Orders** tab.
- e. Review any treatment flowsheets, nursing notes, labs, diagnostics through **Results Review**.
- f. Review any published documentation through the **Documentation** tab.
- g.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

### 3. Therapists deem the patient inappropriate for the Initial Assessment

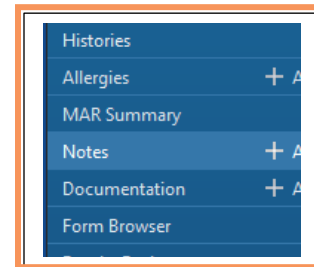
- a. If the patient is inappropriate for the Initial Assessment, use the **Reschedule This Task** feature from the MPTL.



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



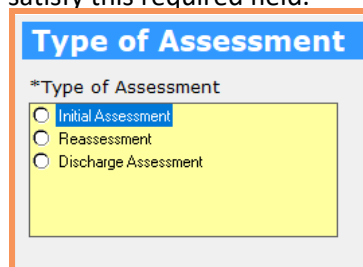
\*Type: Rehab Reschedule Reasons  
 \*Date: EST  
 Subject: Discharge Summary  
 Outpatient PT Note  
 Associate: PT Letter  
 \*Editor:  
 Arial 10



Histories  
 Allergies + A  
 MAR Summary  
 Notes + A  
 Documentation + A  
 Form Browser

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 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.



**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 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



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
## HOSPITAL INFORMATION SYSTEM (HIS)

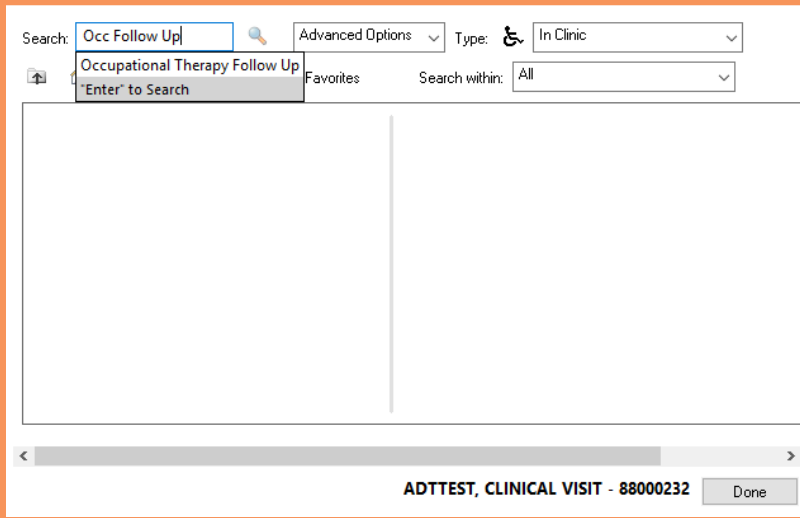
or modify any existing information to ensure it accurately reflects updated or corrected details.

- f. **PTs and OTs** – complete any flowsheets within the Review/Treatments section of your 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. Once you've completed all areas in the PowerForm, SIGN it. 
- i. Ensure your initial 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**.

### 5. Place Follow Up Orders for ongoing treatment

- a. If you wish to provide ongoing treatment for a patient after your initial assessment, navigate to the Orders tab on the blue Table of Contents in the patient's chart.
- b. Click the +Add icon. 
- c. Search the Follow Up Order for your discipline, in the search window. Click Done. For example, for Occupational Therapy, search Occ Follow Up.



The screenshot shows a search interface with a search bar containing 'Occ Follow Up'. Below the search bar, a dropdown menu is open, displaying 'Occupational Therapy Follow Up' with a sub-option '\*Enter\* to Search'. To the right of the search bar, there are several filters: 'Advanced Options' (dropdown), 'Type: & In Clinic' (dropdown), 'Favorites' (dropdown), and 'Search within: All' (dropdown). At the bottom of the interface, there is a status bar with the text 'ADTTEST, CLINICAL VISIT - 88000232' and a 'Done' button.

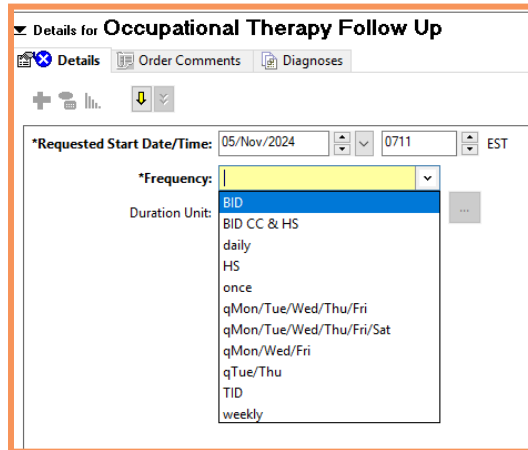
- d. Complete order details, including the required fields of \*Frequency and \*Treatment. The frequency should be chosen based on documentation frequency, and not how often



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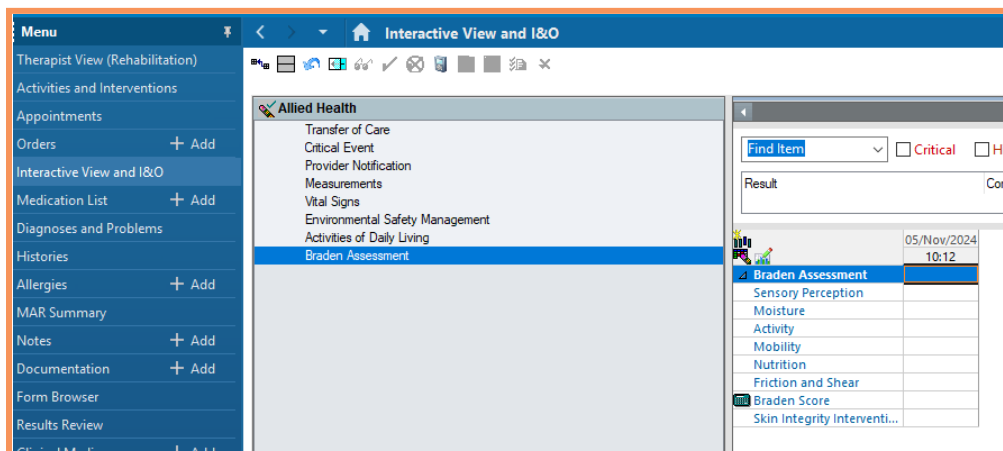
## HOSPITAL INFORMATION SYSTEM (HIS)


a patient should receive treatment. The treatment is a free text box. You can set a Duration and Duration Unit as desired.



### 6. 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. 



# PATIENT JOURNEY– COMPLEX CARE (HDS)

## HOSPITAL INFORMATION SYSTEM (HIS)

ii. Search Specialty Bed in the Orders Search window and click Done.

Search: specialty  
Specialty Bed  
Enter to Search  
Advanced Options  
Type: In Clinic  
Folder: Favorites  
Search within: All

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.

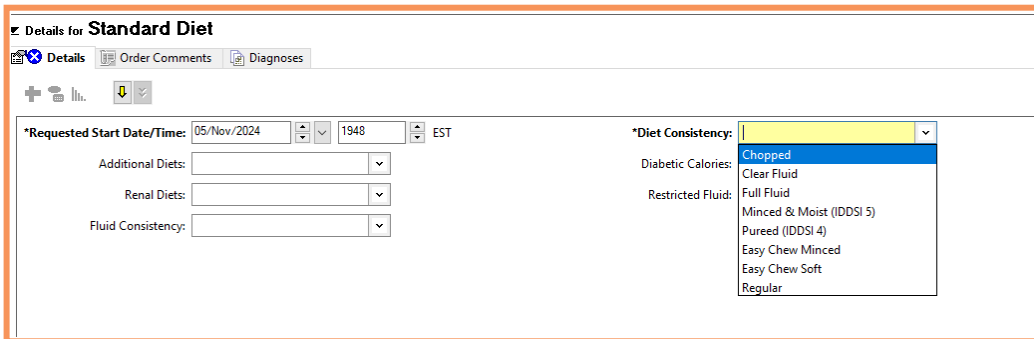
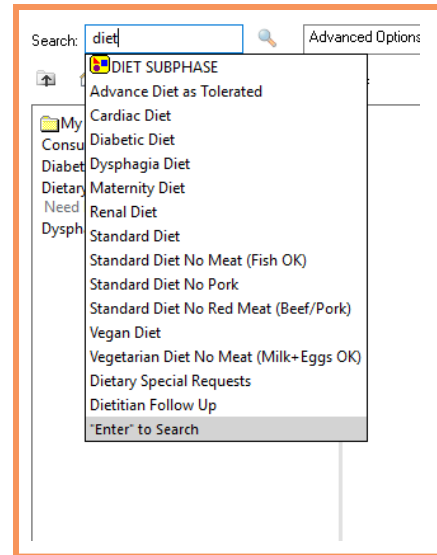
Complete the order details to include the type of Specialty Bed surface recommendation.

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

### 7. 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.



# PATIENT JOURNEY– COMPLEX CARE (HDS)

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## 8. 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.

## 9. 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.

## 10. 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





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HOSPITAL INFORMATION SYSTEM (HIS)

- 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.

Instructions
Team Members
* Interdisciplinary Discharge Planning
Nursing Patient Safety
Nursing Summary
Nursing ADL
Patient/Caregiver Goals
OT Cognition
OT Long Term Goals
OT Discharge Planning
PT Mobility
PT Long Term Goals
PT Discharge Planning
SLP Long Term Goals
SLP Discharge Planning
SW Long Term Goals
SW Summary
RecT Goals and Treatment Plan

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

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

## 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.



# PATIENT JOURNEY– COMPLEX CARE (HDS)

HOSPITAL INFORMATION SYSTEM (HIS)

**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.

### 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



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HOSPITAL INFORMATION SYSTEM (HIS)

- 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.
- e. All therapy Follow Up Orders will cancel/discontinue automatically upon patient discharge.

### 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.