



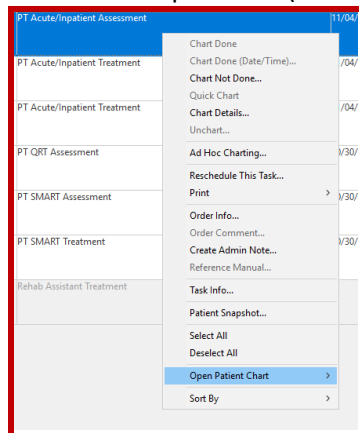
# PATIENT JOURNEY – ACUTE STROKE

## HOSPITAL INFORMATION SYSTEM (HIS)

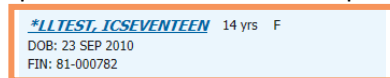
ACUTE REHABILITATION – OCCUPATIONAL THERAPY (OT),  
PHYSIOTHERAPY (PT), SPEECH LANGUAGE PATHOLOGY (SLP), REHAB  
ASSISTANT (RA), COMMUNICATIVE DISORDERS ASSISTANT (CDA)

This tip sheet is designed to guide the rehab team through the patient’s journey, from initial engagement in rehabilitation to the recommendation for inpatient rehab. The focus is on a patient who has experienced an ischemic stroke.

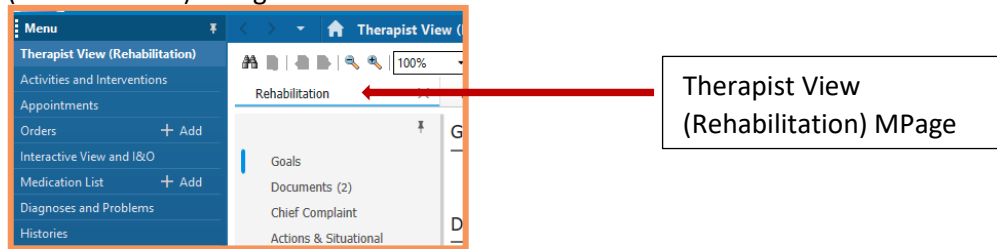
1. **Prescriber places the following consult orders:**
  - Occupational Therapy Assessment & Treatment
  - Physiotherapy Assessment & Treatment
  - Speech Language Pathology Assessment & Treatment
2. **Therapists receive tasking on the Multi-Patient Task List and Rehab Organizer**
  - a. Occupational Therapy – tasking OT Acute/Inpatient Assessment
  - b. Physiotherapy – tasking PT Acute/Inpatient Assessment
  - c. Speech Language Pathology – SLP Acute/Inpatient 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.



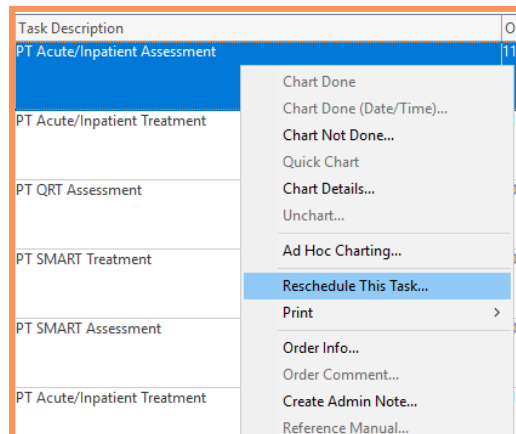
- b. Review all patient information first by navigating through the Therapist View (Rehabilitation) MPage.



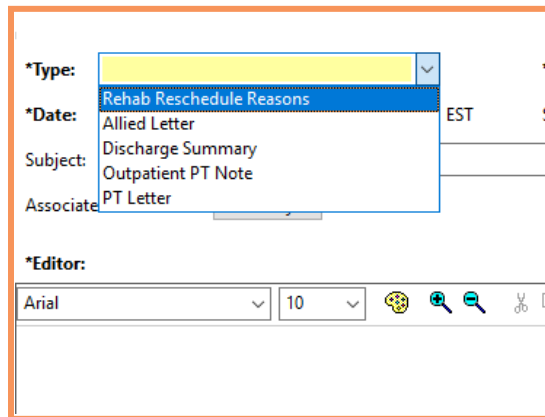
- c. You can review any items along the blue [Table of Contents](#).
- d. Review Orders by clicking on the **Orders** tab.
- e. Review any treatment flowsheets, nursing notes, labs, diagnostics through **Results Review**.
- f. Review any published documentation through the **Documentation** tab.
- g.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

#### 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.



\*Type: **Rehab Reschedule Reasons**

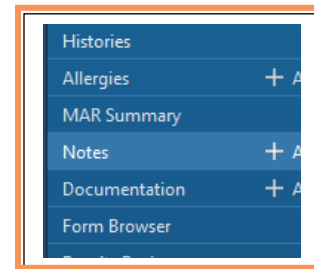
\*Date: EST

Subject: Discharge Summary

Associate: Outpatient PT Note

\*Editor:

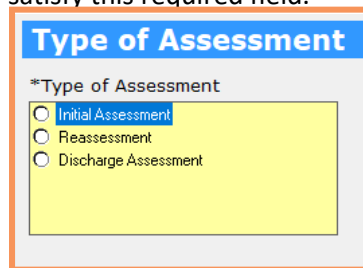
Arial 10



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

### 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.



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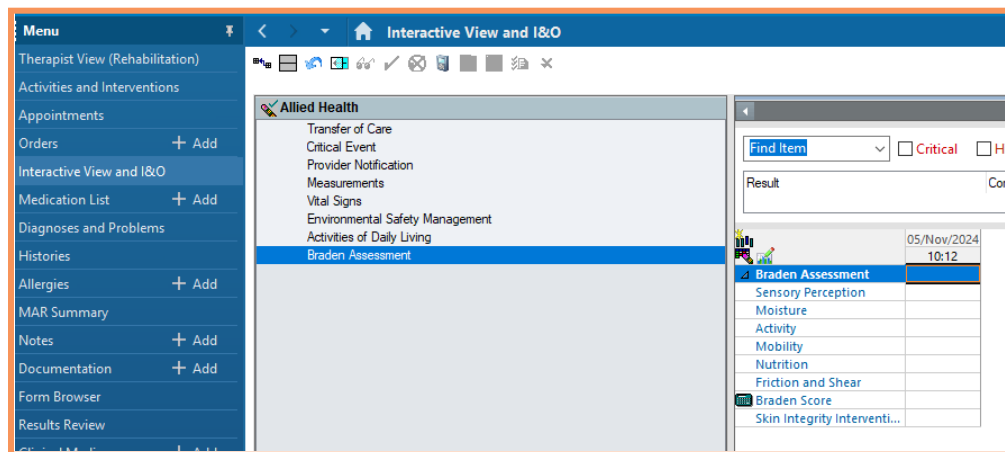
or modify any existing information to ensure it accurately reflects updated or corrected details.


- 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.

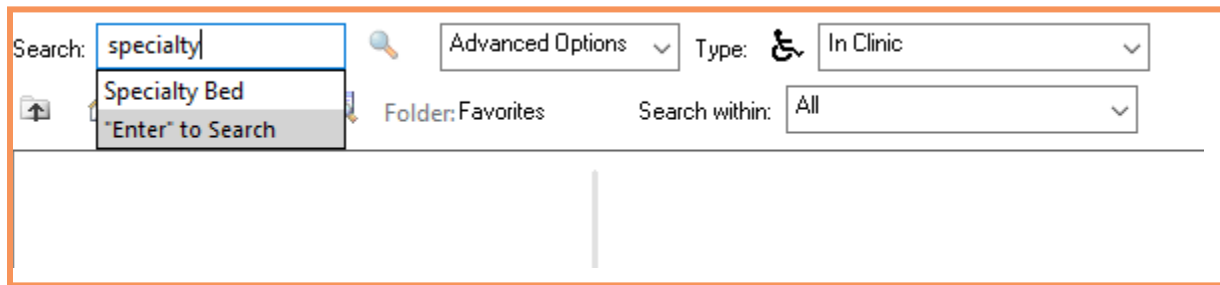
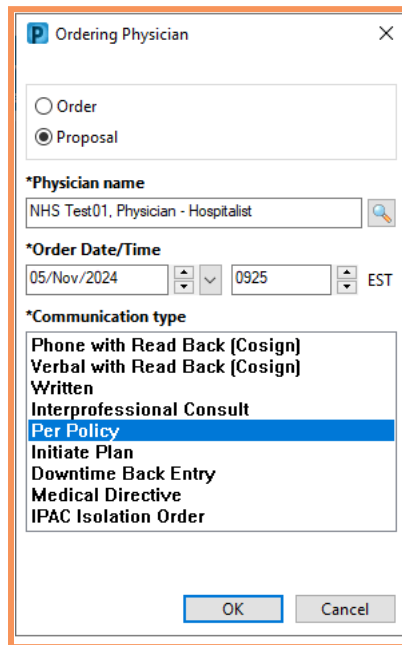
**\*Note:** If the patient did not consent to the Initial Assessment, complete **Step 4**.

### 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. 
  - ii. Search Specialty Bed 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 Specialty Bed is considered Ordered.




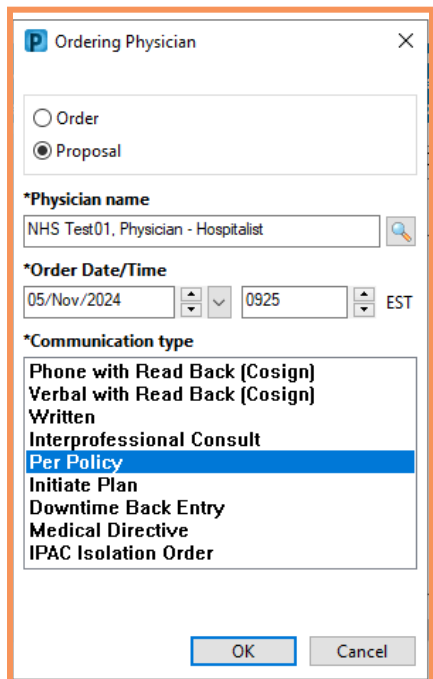
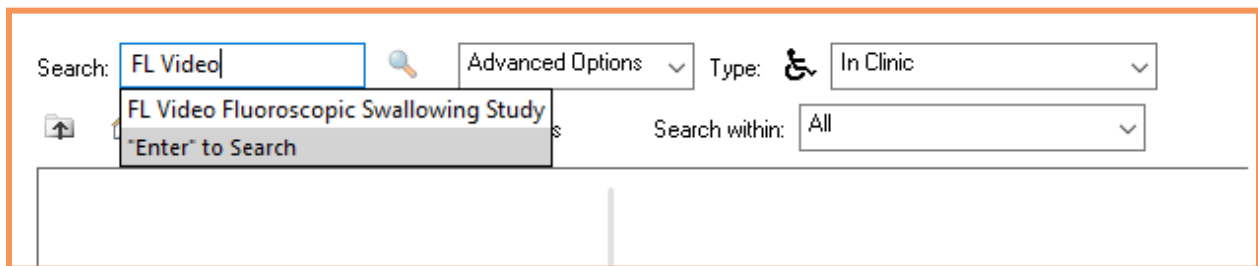
# PATIENT JOURNEY – ACUTE STROKE

## HOSPITAL INFORMATION SYSTEM (HIS)

### 7. Patient requires a Video Fluoroscopic Swallowing Assessment (VFSA) – Speech Language Pathologist

a. To propose a VFSA, navigate to the Orders tab on the blue Table of Contents in the patient's chart.

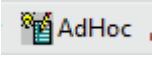
- i. Click the +Add icon. 
- ii. Search FL Video Fluoroscopic Swallowing Study

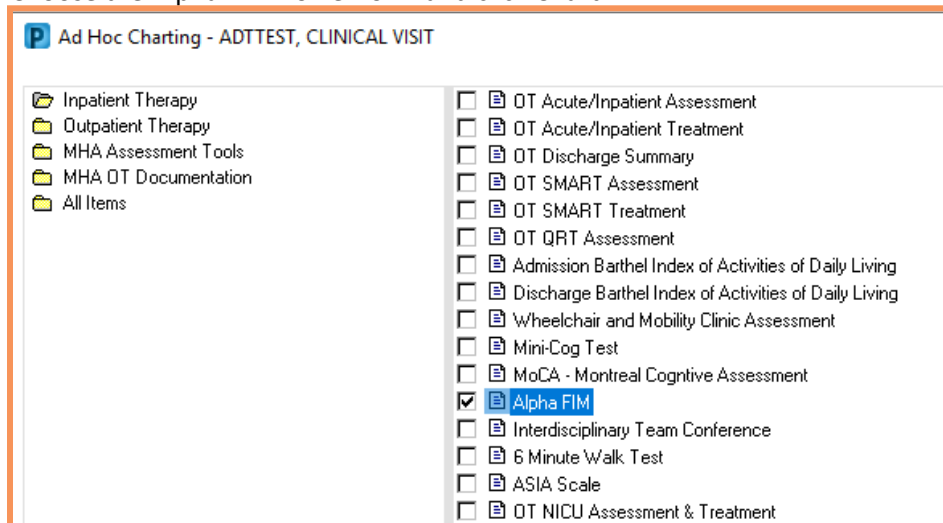


Complete the Proposal details, including clicking Proposal; fill in the Physician Name, Order Date/Time, and Communication Type. Click OK when done.

**\*Note:** The Prescriber will receive notification in their Message Center to review the Proposed Order. Once signed, the VFSA is considered Ordered. The VFSA is booked in DI, with the SLP schedule. SLP can review all scheduled appointments in the Rehab Organizer, Rehab Schedule View MPage. SLPs have access to and can place **diet orders and specialty diet requests**, as well as **propose NPO** if the patient requires it.

### 8. Alpha FIM Documentation

- Designate one therapist from the care team to complete the Alpha FIM PowerForm.
- Complete all calculations from the UDSMR Website prior to starting the Alpha FIM PowerForm.
- From the patient's chart, click on the AdHoc tab on the Action Toolbar. 
- Choose the Alpha FIM PowerForm and click Chart.




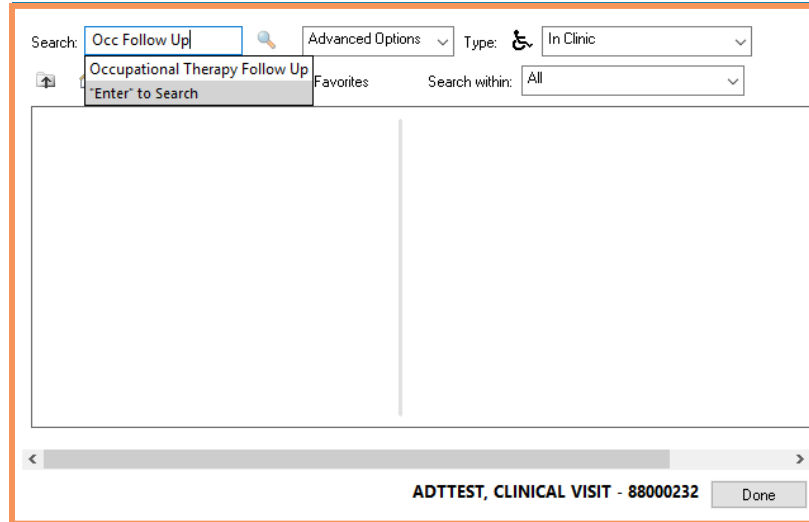
**P** Ad Hoc Charting - ADTTEST, CLINICAL VISIT

<input type="checkbox"/> Inpatient Therapy	<input type="checkbox"/> OT Acute/Inpatient Assessment
<input type="checkbox"/> Outpatient Therapy	<input type="checkbox"/> OT Acute/Inpatient Treatment
<input type="checkbox"/> MHA Assessment Tools	<input type="checkbox"/> OT Discharge Summary
<input type="checkbox"/> MHA OT Documentation	<input type="checkbox"/> OT SMART Assessment
<input type="checkbox"/> All Items	<input type="checkbox"/> OT SMART Treatment
	<input type="checkbox"/> OT QRT Assessment
	<input type="checkbox"/> Admission Barthel Index of Activities of Daily Living
	<input type="checkbox"/> Discharge Barthel Index of Activities of Daily Living
	<input type="checkbox"/> Wheelchair and Mobility Clinic Assessment
	<input type="checkbox"/> Mini-Cog Test
	<input type="checkbox"/> MoCA - Montreal Cognitive Assessment
	<input checked="" type="checkbox"/> Alpha FIM
	<input type="checkbox"/> Interdisciplinary Team Conference
	<input type="checkbox"/> 6 Minute Walk Test
	<input type="checkbox"/> ASIA Scale
	<input type="checkbox"/> OT NICU Assessment & Treatment

- Complete the Alpha FIM PowerForm by choosing the appropriate responses and inserting the calculations generated from the UDSMR Website.
- SIGN the PowerForm.
- Ensure the Alpha FIM is published on the patient's chart by navigating to the Documentation tab on the blue Table of Contents.

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

- 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.
- Click the +Add icon. 
- Search the Follow Up Order for your discipline, in the search window. Click Done. For example, for Occupational Therapy, search Occ Follow Up.

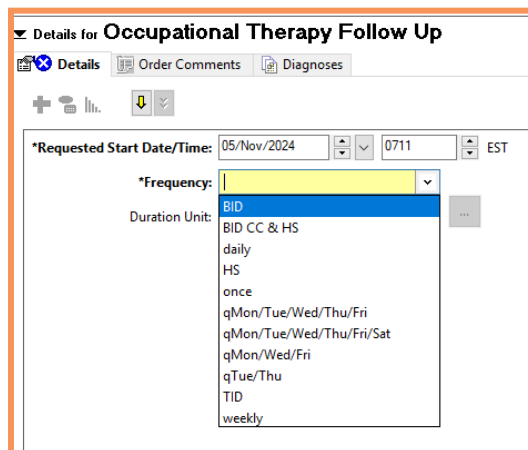


Search: Occ Follow Up  Advanced Options Type:

Occupational Therapy Follow Up Favorites Search within: All

ADTTEST, CLINICAL VISIT - 88000232

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



Details for **Occupational Therapy Follow Up**

Details Order Comments Diagnoses

\*Requested Start Date/Time: 05/Nov/2024 0711 EST

\*Frequency:

Duration Unit:

daily  
HS  
once  
qMon/Tue/Wed/Thu/Fri  
qMon/Tue/Wed/Thu/Fri/Sat  
qMon/Wed/Fri  
qTue/Thu  
TID  
weekly





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## HOSPITAL INFORMATION SYSTEM (HIS)

### 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.

### 11. Rehab Assistant (RA) and Communicative Disorders Assistant (CDA) 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. Continue to treat patient and provide treatment updates within the treatment documentation

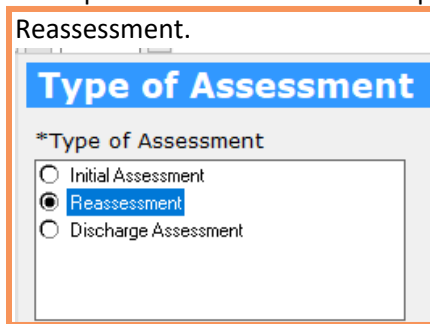
### 13. Patient becomes medically stable

- a. Therapists reassess the patient to determine the patient's discharge plan and discharge destination.

### 14. Patient Destination Scenarios

#### Scenario 1 – Patient Requires Ongoing Inpatient Rehab for Stroke (Rehab High at Hotel Dieu Shaver)

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



**Type of Assessment**

\*Type of Assessment

Initial Assessment

Reassessment

Discharge Assessment

- b. Therapists to complete all necessary documentation within their respective Reassessment PowerForms, but MUST complete the Discharge SMART Goals section to justify ongoing inpatient rehab.

### Discharge SMART Goals

Occupational Therapy – OT Discharge SMART Goals section

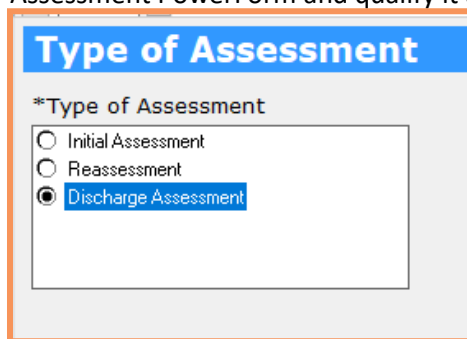
Physiotherapy – PT Discharge SMART Goals section

Speech Language Pathology – SLP Discharge SMART Goals

- c. Therapists will communicate their recommendation to the prescriber and interdisciplinary team.
- d. Prescriber will place the Consult to Inpatient Rehab High (HDS) Order.
- e. Therapists, Rehab Assistants and Communicative Disorders Assistants will continue with patient care until an inpatient bed becomes available at Hotel Dieu Shaver, or if the patient becomes appropriate for discharge home (whichever occurs first).
- f. Once a bed offer is made, the Prescriber will write a Discharge Order for patient to transfer to HDS.
- g. All therapy Follow Up Orders will cancel/discontinue automatically upon patient discharge.

### Scenario 2 – 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

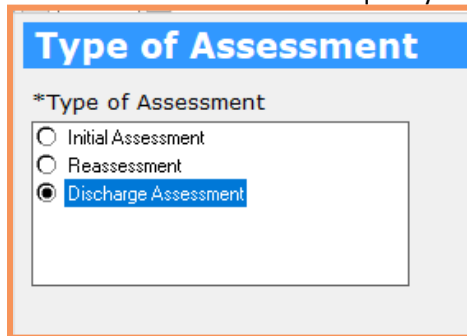
Physiotherapy – PT Discharge SMART Goals section

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

### Scenario 3 – 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

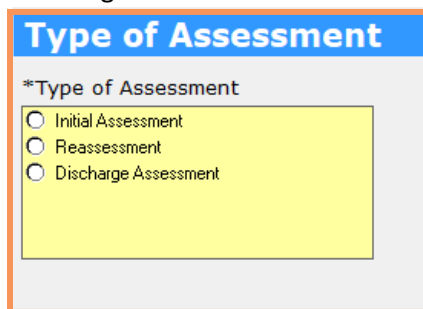
Physiotherapy – PT Discharge SMART Goals section

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

## Scenario 4 – 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.