PATIENT JOURNEY– COMPLEX CARE (NH)

HOSPITAL INFORMATION SYSTEM (HIS)

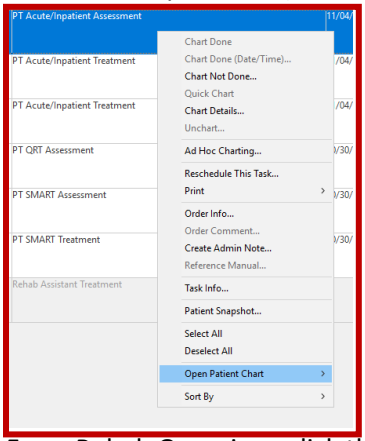
ACUTE REHABILITATION – OCCUPATIONAL THERAPY (OT), PHYSIOTHERAPY (PT), SPEECH LANGUAGE PATHOLOGY (SLP), RECREATION THERAPY, REHAB ASSISTANT (RA), COMMUNICATIVE DISORDERS ASSISTANT (CDA), RECREATION THERAPY ASSISTANT

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

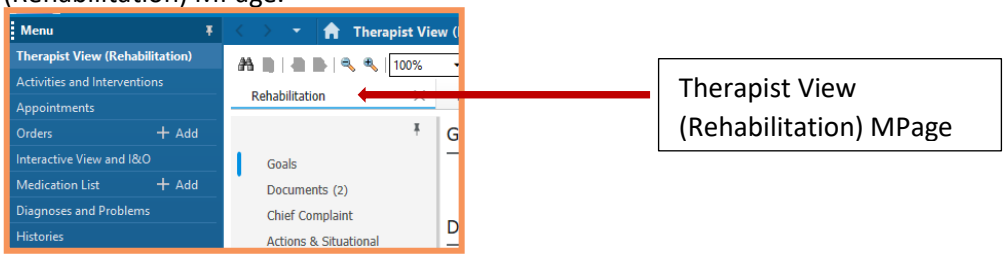
***Note:** Because the patient was transferred from a Niagara Health site, and has already been consulted by a therapist, that accepting therapist in Complex Care is not required to complete an initial assessment. If therapists receive initial assessment tasking based on a new Consult Order, they can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

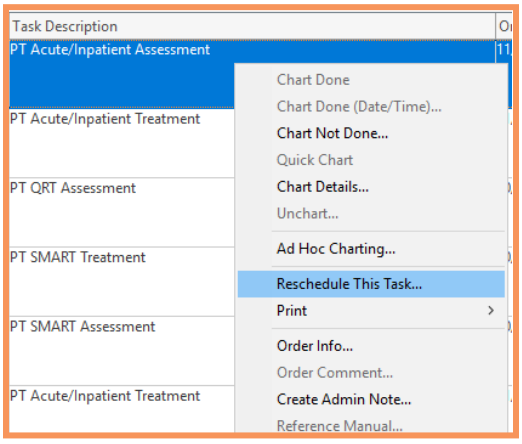
b. Review all patient information first by navigating through the Therapist View (Rehabilitation) MPage.



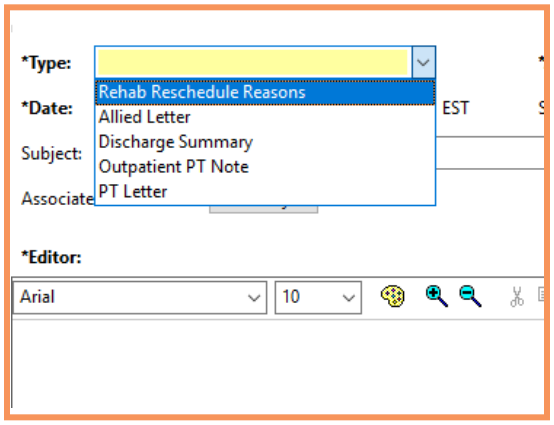
c. You can review any items along the blue Table of Contents.
d. Review Orders by clicking on the ***Orders*** tab.
e. Review any treatment flowsheets, nursing notes, labs, diagnostics through ***Results Review***.
f. Review any published documentation through the ***Documentation*** tab.
g. Click on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

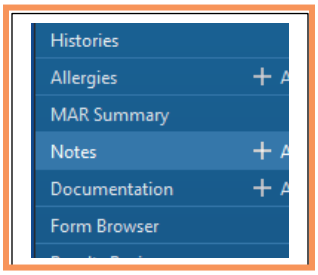
3. Therapists deem the patient inappropriate for the Initial Assessment/Reassessment

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



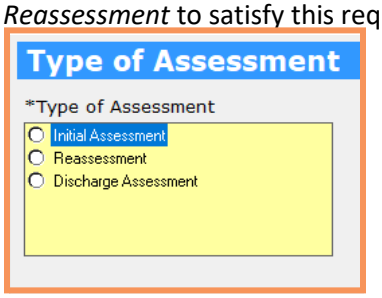
b. Create the Rehab Reschedule Reason Note, from the Notes tab on the patient's blue Table of Contents.





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 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* or *Reassessment* 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 another Niagara Health site completed and signed their PowerForms, 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 your PowerForm, as well as the PT Instructions and OT Instructions sections for Rehab Assistant information. You may need to alter the existing flowsheets. Write over data or clear existing flowsheets at your 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, you may write over data or clear existing STGs at your discretion.

h. Once you've completed all areas in the PowerForm, SIGN it. ☑

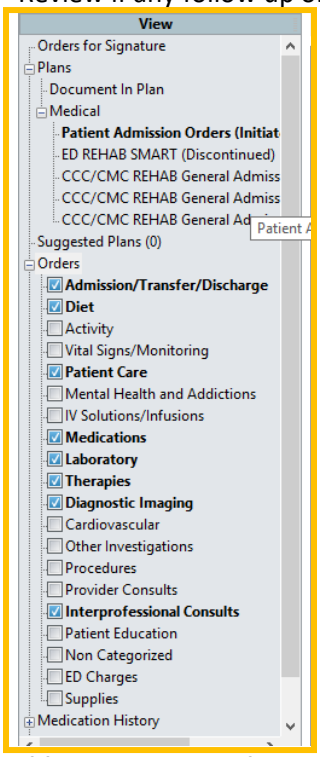
i. Ensure your initial assessment PowerForm is published by navigating to the blue Table of Contents on the patient's chart, and clicking on Documentation.
*Note: If the patient did not consent to the Initial Assessment, complete **Step 4**.
*Note: If the therapist does not wish to use the Acute/Initial Assessment PowerForm tasked, you 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.**

6. Placing or Modifying Follow Up Orders for ongoing treatment

a. If you wish to provide ongoing treatment for a patient after your initial assessment/reassessment, navigate to the Orders tab on the blue Table of Contents in the patient's chart.

b. Review if any follow up orders were placed and are still active under the Therapies tab.

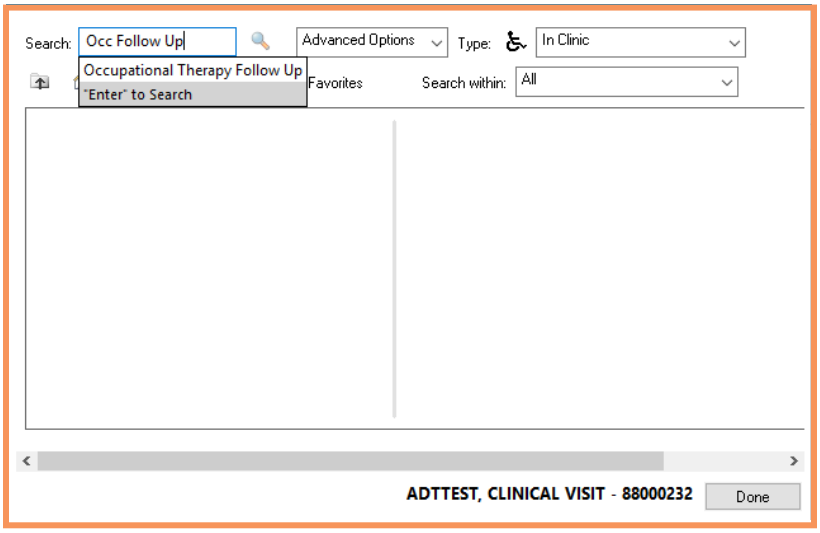


c. If follow up orders for your discipline are present, you may right-click on the order, and choose modify. The order detail window prompting you to change the Frequency. Set a new Frequency at your discretion. This frequency is based on how often you wish to document on the patient.

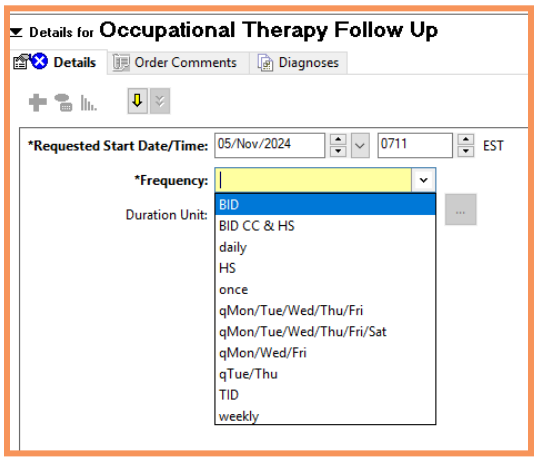
d. If the patient does not have any active follow up orders in your discipline, click the +Add icon. 

from the top of the Orders section.

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

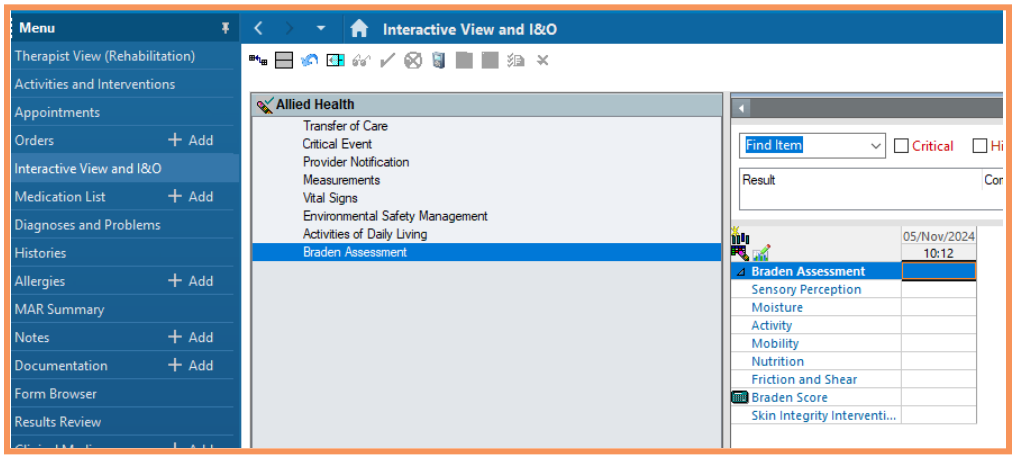


f. Complete order details, including the required fields of *Frequency and *Treatment. The frequency should be chosen based on documentation frequency, and not how often a patient should receive treatment. The treatment is a free text box. You can set a Duration and Duration Unit as desired.



7. Patient requires a specialty bed surface – Occupational Therapist

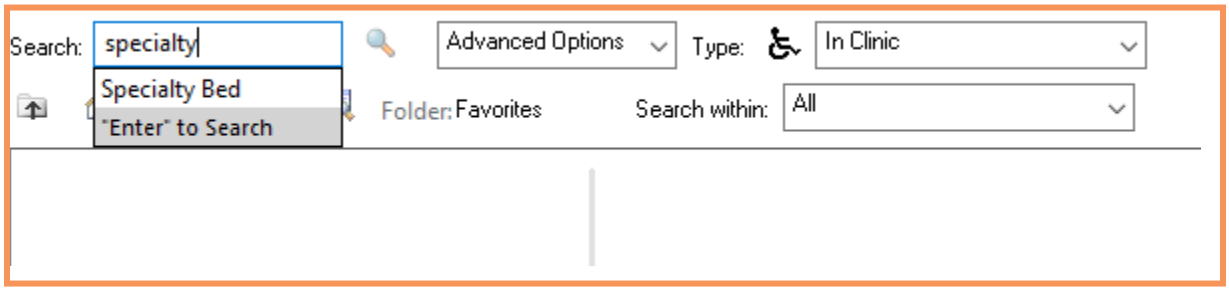
a. Complete the Braden Assessment as needed – navigate to the Interactive View and I&O from the blue Table of Contents of the patient's chart. Complete the Braden Assessment.

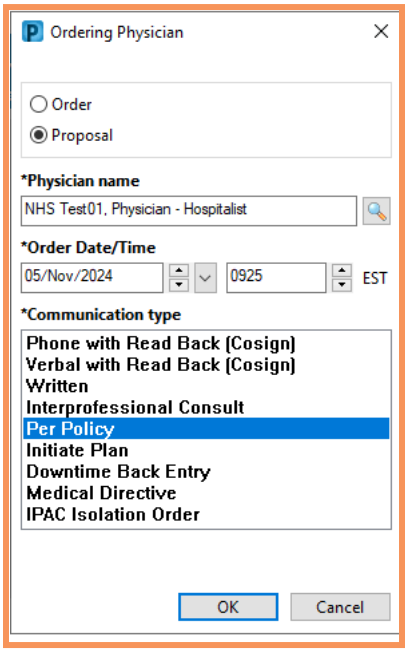


b. To propose a specialty bed surface, navigate to the Orders tab on the blue Table of Contents in the patient's chart.

i. Click the +Add icon. + Add

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



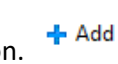


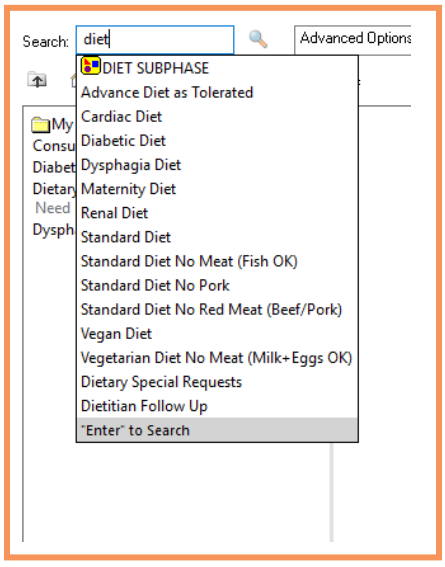
Complete the Proposal details, including clicking Proposal; fill in the Physician Name, Order Date/Time, and Communication Type.
Click OK when done.

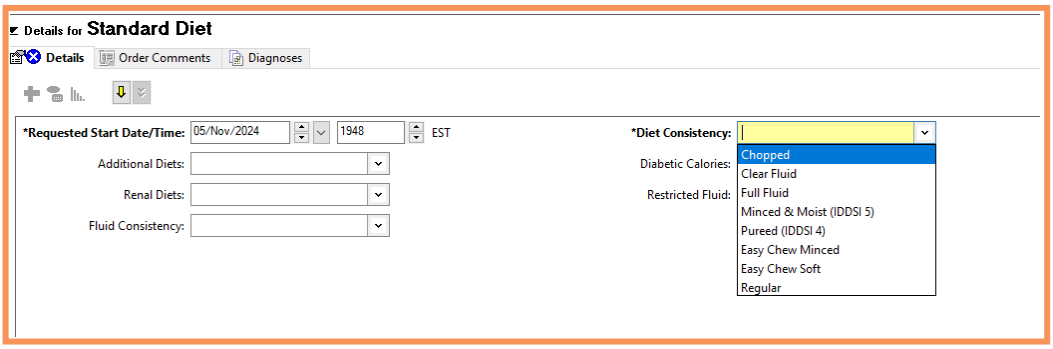
Complete the order details to include the type of Specialty Bed surface recommendation.

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

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

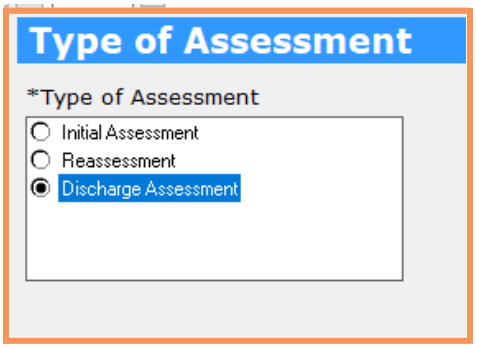
b. Communicative Disorders Assistant will AdHoc their Treatment PowerForms.
    i. The CDA should review the STGs section of their PowerForm to help guide treatment.

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

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.



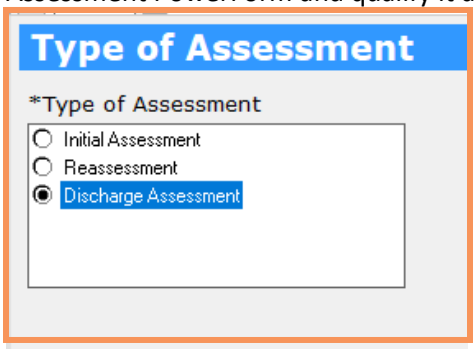
b. Therapists to complete all necessary documentation within their respective Discharge Summary or Discharge Assessment PowerForms. It is recommended that therapists complete the Discharge SMART Goals section to assist Outpatient Therapy Staff.

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.



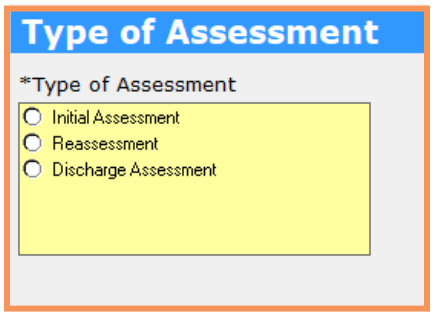
b. Therapists to complete all necessary documentation within their respective Discharge Summary or Discharge Assessment PowerForms. It is recommended that therapists complete the Discharge SMART Goals section to assist Home Care Coordinators with prioritizing home care services in the Community.

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.



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.