



PATIENT JOURNEY– STROKE REHAB HIGH

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

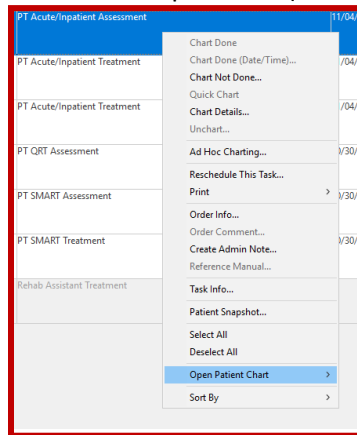
This tip sheet is designed to guide the rehab team through the patient’s journey, from initial engagement in rehabilitation for Rehab High – Stroke Rehab to discharge. The focus is on a patient who has experienced an ischemic stroke, was admitted to Acute Care, and has now entered Hotel Dieu Shaver for inpatient rehab.

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

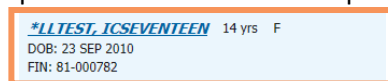
2. **Therapists receive tasking on the Multi-Patient Task List and Rehab Organizer**
 - a. Occupational Therapy
 - i. OT Acute/Inpatient Assessment
 - ii. NRS/FIM Admission
 - b. Physiotherapy
 - i. PT Acute/Inpatient Assessment
 - ii. NRS/FIM Admission
 - c. Speech Language Pathology
 - i. SLP Acute/Inpatient Assessment
 - d. Recreation Therapy
 - i. Recreation Therapy Assessment

3. Therapists review the patient’s chart in PowerChart

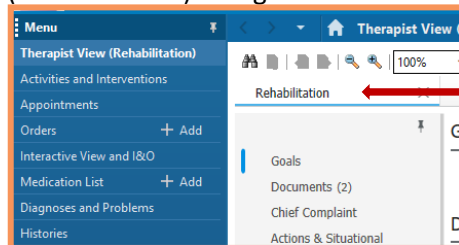
- a. To review the patient’s chart:
 - i. From MPTL viewpoint, right-click the task, choose Open Patient Chart, and choose Therapist View (Rehabilitation) MPage



- 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.

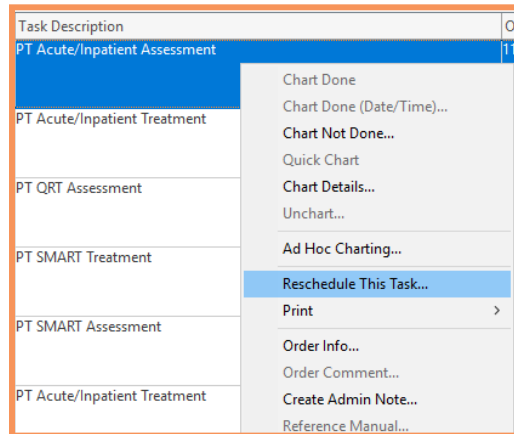


Therapist View
(Rehabilitation) MPage

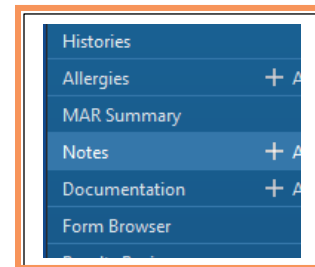
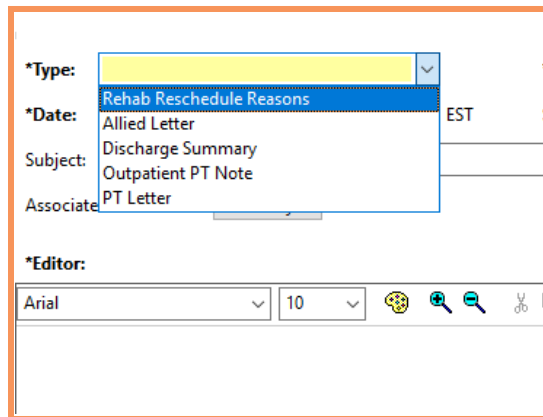
- c. You can review any items along the blue [Table of Contents](#).
- d. Review Orders by clicking on the **Orders** tab.
- e. Review any treatment flowsheets, nursing notes, labs, diagnostics through **Results Review**.
- f. Review any published documentation through the **Documentation** tab.
- g.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



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

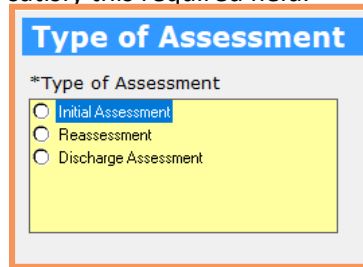
5. Therapists deem the patient appropriate for Initial Assessment and the patient provides consent

- 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 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. 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.



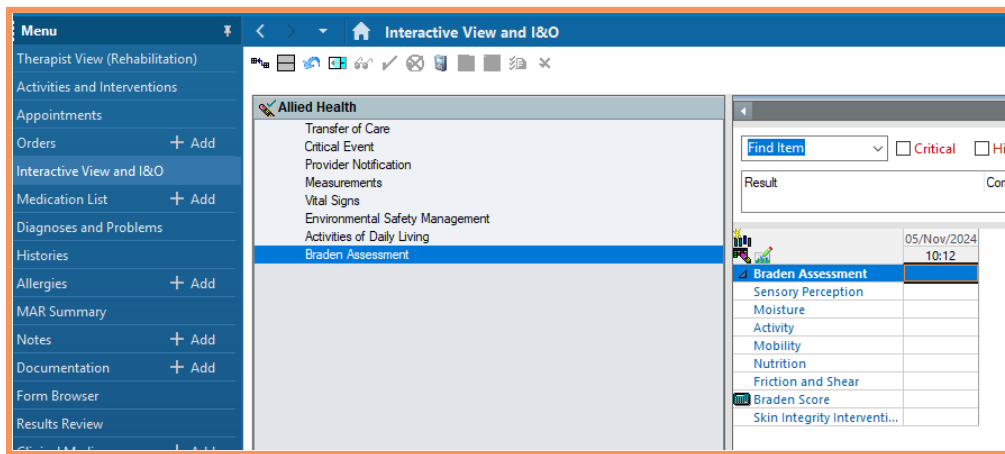
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
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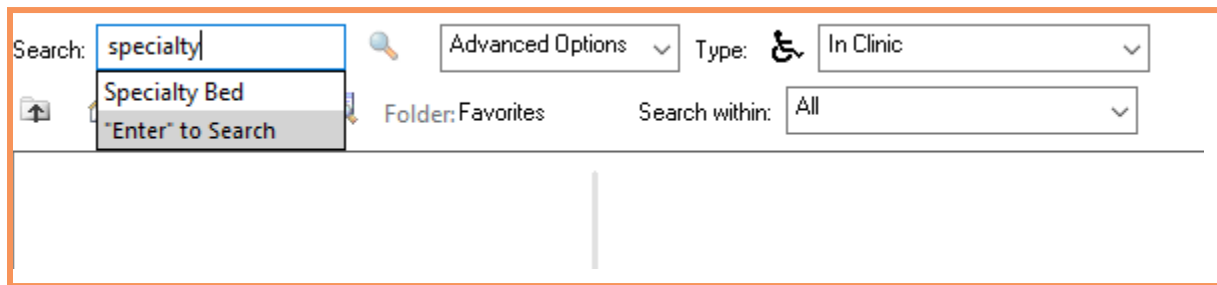
iv. OT and PT will log in to Clarity, and submit the FIM scores for submission to CIHI
***Note:** SLP may AdHoc the NRS/FIM Admission PowerForm if needed. SLP will complete their respective sections of the NRS/FIM PowerForm and SIGN. SLP will log in to Clarity, and submit the FIM scores for submission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

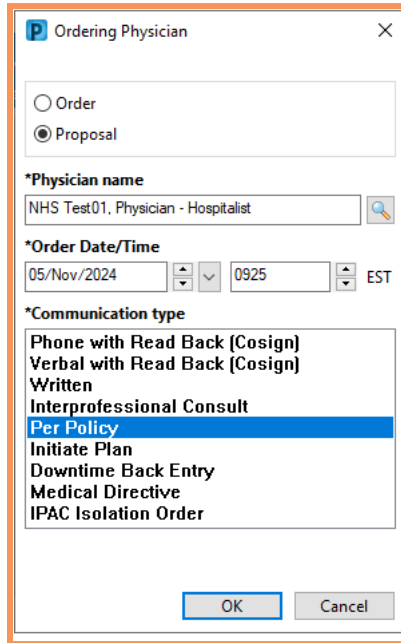
7. Patient requires a specialty bed surface – Occupational Therapist

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





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

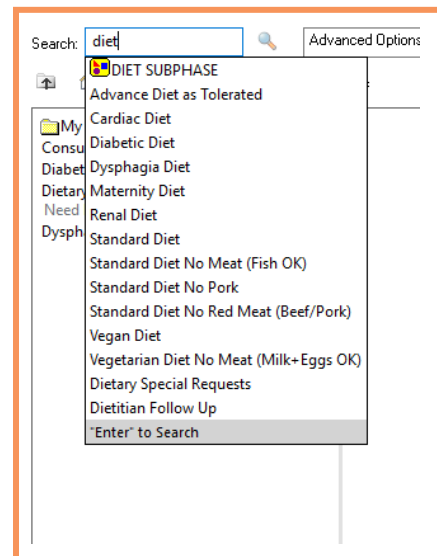
Complete the Proposal details, including clicking Proposal; fill in the Physician Name, Order Date/Time, and Communication Type. Click OK when done.

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.

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



Search: diet Advanced Options

- DIET SUBPHASE
- Advance Diet as Tolerated
- Cardiac Diet
- Diabetic Diet
- Dysphagia Diet
- Maternity Diet
- Renal Diet
- Standard Diet
- Standard Diet No Meat (Fish OK)
- Standard Diet No Pork
- Standard Diet No Red Meat (Beef/Pork)
- Vegan Diet
- Vegetarian Diet No Meat (Milk+Eggs OK)
- Dietary Special Requests
- Dietitian Follow Up
- *Enter* to Search



PATIENT JOURNEY– STROKE REHAB HIGH

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Details for Standard Diet

Details | Order Comments | Diagnoses

*Requested Start Date/Time: 05/Nov/2024 1948 EST

Additional Diets:

Renal Diets:

Fluid Consistency:

*Diet Consistency:

Diabetic Calories:

Restricted Fluid:

- Chopped
- Clear Fluid
- Full Fluid
- Minced & Moist (IDDSI 5)
- Pureed (IDDSI 4)
- Easy Chew Minced
- Easy Chew Soft
- Regular

***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.

Patient	Appointment Duration	Appointment Location	Appointment Time	Appointment Type	Appointment Status
ZZREHAB, CURTIS 38 yrs M DOB: 17 SEP 1986	60 mins	HD [REDACTED]	09:30 [REDACTED]	Assessment Face to Face	Confirmed



PATIENT JOURNEY– STROKE REHAB HIGH

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.
- 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.

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

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



PATIENT JOURNEY– STROKE REHAB HIGH

HOSPITAL INFORMATION SYSTEM (HIS)

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.



PATIENT JOURNEY– STROKE REHAB HIGH

HOSPITAL INFORMATION SYSTEM (HIS)

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.