A Practical Solution to the Challenges of Rehabilitation Nursing Documentation

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A Practical Solution to the Challenges of Rehabilitation Nursing Documentation

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Our Progress Notes Needed to Change

- Organizational and regulatory documentation requirements are changing
- Higher patient acuity, increased time restraints, and new technology created new challenges for nursing documentation
- Medicare and private insurers required we prove the "worth" of our nursing services
- Medical record audits highlighted the importance of nursing documentation to help support medical necessity
- Rehab documentation requirements were not easily understood by nurses in other settings
- Our own documentation policies worked best for acute units, rather than the unique environment of the rehab unit

Findings in the Literature

- The U.S. Department of Health & Human Services estimated in 2004, Medicare paid $3.1 billion in rehab stays that had "inadequate documentation" (Hentschke, 2009)
- Nursing documentation must support the need for a higher level of care than what is provided in a skilled nursing facility, or subacute setting
- A Rehabilitation Nursing article (Hentschke, 2009) highlights the charting difference between settings:
  - SNF: "Patient slept well."
  - Rehab Unit: "Patient closely monitored for signs of grimacing or other noticeable signs of discomfort. Routine positioning was performed; pain meds or other comfort measures did not seem to be indicated at this time."
- Rehabilitation documentation differs from acute care documentation and should minimally include:
  - Patient and family education
  - Nursing interventions and patient responses
  - Techniques learned in therapy sessions
  - Burden of care AND patient progress towards goals

Our Nursing Template

We created, revised, and put into practice a daily progress note template that:
- Was easily adaptable for each patient
- Allowed nurses document only on what was relevant that shift
- Met Centers for Medicare and Medicaid Services (CMS) requirements to support medical necessity
- Included the areas supported by the literature
- Was compliant with the hospital's documentation policy
- Prevented duplication with the electronic medical record
- Added value for nurses, physicians, and our colleagues
- Could be implemented easily and in a timely manner
- Was intuitive for new staff, float staff, and students

References