A Practical Solution to the Challenges of Rehabilitation Nursing Documentation

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Recommended Citation  
Summar, Ann; Belanger, Joyce; and Vee, Melissa, "A Practical Solution to the Challenges of Rehabilitation Nursing Documentation" (2013). *Nursing Posters*. 8.  
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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

Findings in the Literature

• Disease / Comorbidity Management & Prevention of Complications:
  - Bowel & Bladder Management:
  - Hydration & Nutrition Management:
  - Swallowing Precautions & Compensatory Techniques:
• ADLs & Self-Care:
• Mobility Skills & Energy Conservation:
• Medication Management:
• Communication, Memory & Cognition:
• Psychosocial, Relationships, Intimacy & Sexuality:
• Pain Management:
• Sleep:
• Skin Care Management:
• Safety Precaution Education & Carryover:
• Family Involvement & Education:
• Patient Goals, Interventions & Discharge Planning:

References