Not Documented? Not Done!
DOCUMENTING PROFESSIONAL REHABILITATION NURSING CARE
WORKBOOK

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WORKING SMARTER NOT HARDER
Not Documented? Not Done!

Documenting Professional Rehabilitation Nursing Care

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This workbook is for use with the course Documenting Professional Rehabilitation Nursing Care, which is part of the Rehab Nursing Series™ published by Rehab ClassWorks, LLC®.

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GETTING STARTED

This course is designed to facilitate the development of the professional nurse’s documentation skills. This workbook is intended to be used with the Rehab ClassWorks® computer course: Not Documented? Not Done! Documenting Professional Rehabilitation Nursing Care.

Launching the Course

**Single User License:** After installing the course, launch it on the computer by selecting it from your Windows menu or by using the desktop icon.

**Multiuser License:** Follow your organization’s instructions for accessing the course.

Logging In

Enter your login name as the name you want to see on the CE certificate. Select your own password and keep track of this information so you can use it in the future to enter the course. (Support cannot access this information.) Click the Start button on the login page to view the menu.
Functions of the Main Menu

The course is navigated from its **Main Menu**.

1. You can roll your mouse onto a chapter title to display information about a given chapter.
2. Click on the chapter title to enter the chapter.
3. Start with the Overview chapter for an introduction to the course and access to Course HELP tools.

Continuing Education Hours

All RCW courses offer continuing education contact hours.

- The course posttest must be completed with a score of 80% or better in order to receive a continuing education certificate.
- This course is worth **XX** contact hours.

The test is in the computer course that accompanies this workbook and your results are displayed on the computer when you complete the exam. **Complete the form that contains your score on the computer and print it. Be sure to verify that all the information has printed successfully before closing this screen because you will not be able to return to that page once you have left it.**

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- Send by **fax** (801) 253-7520
- Send by **mail** to RCW, PO Box 1306, Riverton, UT 84065
- Send by **email** to pam@rehabclassworks.com (This course does not require connection to the internet to run, so results can be sent via email by scanning in a printed copy or by pressing PRINT SCREEN (Prt Scr) on your computer keyboard while the results are displayed to create a copy or image of the test results and then pasting that image into an email).
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Using the Course

Listed below are features of the course and how to best use them.

Workbook and Computer Course: To get the most out of this course, you should use this workbook concurrently with the computer course. There is audio in the course, so be sure your speakers are on. There are exercises in the workbook and in the computer course to help you learn and remember the material. When you see the following, you should go to the designated section of the course on the computer.

On the Computer

Note that each chapter in the workbook matches the chapter of the same name in the computer course. Answers to questions in the workbook are in the back of the workbook for your reference.

This course is a lengthy course and should therefore be approached in small chunks of time for best retention. Each chapter in the computer course has a bookmarking feature so that you can return to the page you last viewed when you return to the chapter. Be sure to exit the course using the EXIT button on
the bottom right of the course navigation bar (not the X on the top right corner of the window) to initiate the bookmark.

**Quizzes:** There are quizzes at the end of each section of the computer course to help you assess your understanding of the information in that part of the course.

**Links:** There are links in the computer course that take you to more information when you click on them. They appear in blue underlined text. If your internet security system allows you to do so, you will be able to jump to external web pages as well as internal links while in this course. Otherwise, type the address in your web browser to view those resources.

**Functions of the Navigation Bar**

The **Navigation Bar** at the bottom of the screen allows access to information, return to the **Main Menu**, or the ability to go to a specific page in the course.

**Page Numbers:** Page numbers in the computer course are located on the left side of the **Navigation Bar**.

**Reference:** The **Reference** link displays definitions of terms and additional reference material.

**Main Menu:** Return to the **Main Menu** by clicking that item on the **Navigation Bar**.

**Index:** You can use the **Index** link to display the electronic pages of the chapter. Click on the page you want to go to when this tool is open.

**Help:** This item provides information on using and navigating the course. If you do not find your answer there, contact technical support at technicalsupport@rehabclassworks.com or call (888) 294-0412.

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**Progress Report:** The *Progress Report* summarizes your scores on quizzes in the course. The Posttest score also is recorded, but not the subset scores you will see at the end of the Posttest. Only Posttest scores are reported in a learning management system. Quizzes are for self-assessment of content learned in each chapter and are not reported in a learning management system.

**Other Features**

**Notes Books/Feedback:** Some screens contain a *Notes Book* icon in the top right corner. You can click on those for feedback or more information. The *Notes Book* icon is pictured here on the right.
Chapter 1

Overview

We are, in our documentation, creating a word picture of the care given. In that manner, we provide proof to those paying for services that the patient got what was paid for and benefited from it.

The documentation problem is really a communication problem. It has many issues, excuses, barriers, and potential failure points just like any other communication effort. Think of all the things you have heard about documentation. Does this sound familiar?

- Who are we documenting for? The auditors, the compliance or accreditation reviewers, the lawyers? What happened to documenting to improve continuity of care to the patient?
- I spend more time documenting than I do taking care of patients!
- It seems like there is something new I have to document every month!

Chapter Highlights

- When you are documenting care, recognize that you are writing for an audience that looks at the record in different ways. With each entry, you are addressing reimbursement, quality of care, outcomes, and liability.

- There is a hierarchy of requirements for care, and therefore also for the documentation of care, which impacts all healthcare delivery. Regulatory requirements are law. Standards define practice.
Course Objectives or What Is Your Job?

The purpose of this course is to explain the specific requirements for documentation of the work of the professional rehabilitation nurse and to provide opportunities to practice using rehabilitation-specific documentation principles. It will help you understand the reasons why you are in a situation that requires you to become proficient in rehabilitation nursing documentation.

When you finish this course, you should be able to pass the posttest with a score of 80% or better, demonstrating an understanding of:

- Elements of documentation that describe skilled professional rehabilitation nursing care.
- The use of documentation principles to tell the story of the patient, describing therapeutic care activities, efforts to support goal achievement, coordination of care, and effectiveness in reducing the burden of care.
- Key components of documentation that demonstrate the need, according to CMS law, for acute inpatient rehabilitation care vs. other levels of care.

Course Goal: The goal of this course is to facilitate the ability to document care in a manner that meets all documentation requirements and demonstrates the need for, and the care provided by, a professional rehabilitation nurse.

Documentation is communication, to each reader of the record, of the care provided and the responses of the patient to that care. It must be done in a way such that any and every reader gets the picture. We own the problem.

- Are we good at what we do? If so, then are we good at documenting what we do so others know that?
- Are we efficient in documenting what we do so patient care does not suffer under the burden of documentation requirements?
• Do we document in a manner that shows we are specialists in rehabilitation?

**In this chapter,** your job is to review basic principles of documentation and to begin to understand the reasons **why** you are in a situation that **requires** you to become proficient in rehabilitation nursing documentation.

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**On the Computer: Overview, pages 3-12**

(From the top bar of the frame.)

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**The Fuss Is About…**

Documentation requirements are ever-changing. Many changes are in response to concerns that the care we have been delivering costs too much and that quality is not what it should be. Every year there are new laws addressing these issues and impacting practice as well as reimbursement in specific settings of care.

1. Reimbursement is shifting to value-based care. What does that mean?

---

**Method to the Madness**

We do indeed document for many different reasons. Communication needs, reimbursement, regulations, accreditation, legal, and business requirements all direct documentation efforts. But the bottom line is that there are definitive standards directing documentation requirements.

Standards used to be relatively local, but they are now widespread, easily dispersed, and promoted by professional practice. All professional caregivers are expected to stay current regarding standards applicable to patients in their care.
2. What is at the base of the pyramid, driving documentation requirements?

3. What is the purpose of organizational policy and procedures?

4. What are the two most common legal areas of risk for healthcare providers?

Documentation FACTs

- **Factual**: Documentation should be objective, first-hand knowledge—what you see, hear, feel, or smell firsthand. It should also include professional judgment and actions taken in response to that judgment. The nursing process should be obvious.

- **Accurate**: Document sufficient detail to provide an accurate picture of the care provided. Include quotes, individuals present for discussions/teaching, communications, planning, etc.

- **Concise**: Represent activities without lengthy narrative.

- **Timely**: Date and time all entries, recording data as close to the time of the event as possible.

  Cartwright-Vanzant, 2013

Drivers of Care

Documentation tools and processes should make it easy to demonstrate compliance to regulations and standards of care, while at the same time making it easy to tell and see the story of the patient.

5. What is the relationship between standards, policies, and procedures and documentation?
The Electronic Health Record (EHR)

Many of the EHRs of today tend to be fragmented and do not make it easy to tell the story of the patient rather than the story of individual disciplines. Meaningful use (a CMS requirement) is one strategy encouraging the designers of EHRs to address how the patient is presented to the various members of the team.

6. What is the goal of a good EHR system?

Working Smarter!

When it comes to documentation, knowing the basics of documentation that are applicable to all healthcare providers is a necessary key to working smarter. Remember to review these in the References in the computer course if you need a refresher (see Basic Documentation Principles).

This course cannot address the particulars of every documentation system in use at IRFs. Therefore, there is a worksheet at the end of this chapter that can be used to generate a personal job aid to help you keep track of the many requirements for documenting rehab nursing care and how you might apply them in your organization’s documentation system.

On the Computer: complete the Quiz in the Overview chapter, page 13. Then, return to the Main Menu and start the next chapter: CMS Regulations. Watch for the instruction that tells you to return to the workbook.

 למעלה! 

- Regulations, accreditation, and standards of care direct practice; documentation provides a written record to prove that care was provided to meet these requirements.
- Documentation should be unique to each patient, demonstrating actions to address unique needs and problems and responses to care.
CHAPTER 2

CMS Regulations

Nurses should be familiar with the regulatory requirements applicable to their clinical area and entries in the medical record should reflect adherence to regulatory agency requirements.

Cartwright-Vanzant, 2013

What Is Your Job in This Chapter?

In this chapter, you will review terminology and documentation requirements according to the Centers for Medicare & Medicaid Services (CMS). Your job is to learn or review them and consider if you and your team are able to prove you have met these regulatory requirements through your documentation.

It is a fact that CMS is refining Medicare’s Prospective Payment System (PPS) to reduce the costs to taxpayers and to improve the quality of care.

Chapter Highlights

- Rules of documentation are determined by governmental regulations and guidelines. The Centers for Medicare & Medicaid Services (CMS) defines many of these regulations. CMS regulations are laws.

- CMS defines the expected behavior of the rehabilitation team and looks in the record for evidence that the team met the requirements.
Therefore, it is addressing discrepancies it finds in all settings. As noted in the last chapter, an example of one action CMS has taken to address these issues is eliminating payment for preventable hospital-acquired conditions in acute care settings. (CMS refers to these as Never Events.)

**What Does This Mean to Me?**

Every reduction in revenue directly impacts the ability of the organization to pay salaries and other overhead expenses. In the example of no longer paying for preventable problems, we find that the acute care setting no longer receives payment of extra funds for a urinary tract infection complication in a female patient with a stroke who had a catheter placed for acute urinary retention due to neurological dysfunction. The organization is now required to prevent this problem or to pay for it themselves. **As a result, your practice has changed and, therefore, so has your documentation.**

**The Fuss Is About...**

Post-acute care settings are not immune from efforts to contain costs and improve quality of care. A major ongoing effort by CMS to contain costs is the auditing for appropriate placement and utilization of the continuum of care.

This directly impacts acute inpatient rehabilitation care.

1. What does Medicare rely on to determine whether a claim will be paid or denied?

2. Who determines the types of patients most appropriate for IRF admission in sites caring for Medicare beneficiaries?

**FAQ!**

What if the patient is covered by private insurance or Workers Compensation? Do the CMS requirements apply to them as well?

- With the exception of the 60% Rule, CMS requirements only apply to Medicare Beneficiaries.
- Each insurance company has its own requirements and contracts individually with the IRF for coverage. The IRF must meet their contractual requirements.
- It is common to find that private insurance has many of the same expectations as CMS. Many IRFs find it easier to apply CMS regulations to all patients to avoid problems.
3. How does this entity determine if the IRF is compliant with CMS law?

4. What is the risk if the IRF fails to comply with CMS regulations?

Reality Check

CMS regulations regarding IRFs are NOT new!!!! They were initially put in place in the mid-1980s.

Newer are the laws addressing cost containment and the RAC Program. The risk is real—you may work at a site that has experienced RAC audits. These audits have resulted in the return of millions of dollars from rehabilitation settings across the country due to documentation failures.

We can’t keep doing the same thing when it is obvious that it has resulted in denials. We have to learn from experience and avoid contributing to the problem. That means being well-informed regarding documentation requirements.

- In our documentation, we provide the evidence that supports the denials. Therefore, we can equally well provide the evidence to avoid denials.

FAQ!

What are the most common reasons for denials?

- Failure to submit IRF-PAI by established deadlines.
- Required CMS documentation elements missing or not recorded at expected time.
- Lack of documentation that provides evidence of medical necessity (care is reasonable and necessary at the IRF level).
- Lack of documentation that supports provision of 24-hour rehabilitation nursing care including burden of care, functional skill development, and evidence of carryover of techniques from therapy.
- Lack of documentation supporting a coordinated program of care involving an interdisciplinary approach.
- Lack of documentation to support FIM® scores placed on the IRF-PAI.

Uniform Data System for Medical Rehabilitation (UDSMR), 2013

(For a summary of the IRF Prospective Payment System, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/InpatRehabPaymtfctsht09-508.pdf.)
What Do You Need to Know?

It is clear that CMS has specific requirements regarding how an IRF proves reasonable and necessary care.

5. Identify at least 3 ways you can document evidence of a 24-hour, intensive, and coordinated interdisciplinary approach to care.

Tip!

Look at prescreening information before doing the admission assessment. It will provide information regarding chronic diseases, prior functional ability, risks for complications, and plans for IRF care.

The CMS Calendar

CMS requires specific documents at specific times during the patient's care. These documents are intended to prove that care in the IRF is reasonable and necessary, and to direct the team in the plan of care.

6. Why should the team know what is in the Post-Admission Physician Evaluation (PAPE)?

7. When does the nurse need to be ready to document and participate in the initial team conference for the patient?
Get Your Dates Straight

Rehab nursing care requires attention to functional skills. This care is an additional skill set, with documentation requirements just like those associated with other nursing skills (e.g., IV administration). The IRF-PAI uses the FIM® to capture snapshots of the patient’s functional skills and to determine level of disability.

8. When does the team need to document FIM® scores (for all items except bowel and bladder accidents) to determine the final FIM® scores to record on the IRF-PAI form for admission?

9. When does the team need to document FIM® scores (for all items except bowel and bladder accidents and management) to determine the final FIM® scores to record on the IRF-PAI form for discharge?

10. What is the nurse required to document in the record in order to support the FIM® scores?

FAQ!

What if the patient is ill for a few days and misses therapy or has excessive needs?

- The Brief Exceptions policy allows for a brief period—maximum of 3 consecutive days—during which a patient may have a limited ability to participate in therapy due to an unexpected clinical event. The specific reasons for the break in therapy must be documented by the physician.

Get to Therapy!

Clearly there are minimum requirements for participation in therapy to provide evidence of the need for IRF admission.

11. Why does nursing need to make sure patients are ready for therapy on time?
Get Involved!

CMS indicates that a patient is not appropriate for an IRF admission unless he has need of rehabilitation nursing, medical management by a rehabilitation physician, an intensive therapy program, and interdisciplinary care. Documentation in the record must provide evidence of an intensive and coordinated interdisciplinary approach to care. It must also prove efforts to support progress toward goals, as noted in Section 110.3 Definition of Measurable Improvement of the Medicare Benefit Policy Manual.

Further, the IRF medical record must also demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment. Since in most instances the goal of an IRF stay is to enable a patient’s safe return to the home or community-based environment upon discharge, the patient’s treatment goals and achievements during an IRF admission are expected to reflect significant and timely progress toward this end result.

12. According to CMS, what document provides evidence of the work of the interdisciplinary team?

About That FIM®

It is clear that if the patient’s functional skills are going to be evaluated and scored, the patient must have an opportunity to practice skill development. It is not acceptable to simply wait for therapy to get started. Every day counts.

What Does This Mean to Me?

If the therapist is not available during a FIM® assessment period, nursing caregivers must still evaluate the patient and facilitate practice.

- While the therapist is the expert and will refine and direct care, the patient is in an IRF for 24/7 therapeutic intervention. Nursing staff must address functional care needs if therapy care providers are not present (e.g., the patient is admitted on a weekend).

Tip!

It may surprise some to learn that staff time is an important resource for functional skill documentation.

- Leadership and staff must recognize that the effort applied to improving functional skills and the preciseness of the documentation is important to care planning, discharge planning, quality measures, and reimbursement.

- Adequate time for this task must be carved out of their shifts so staff can thoughtfully consider what they are documenting.
Details Matter!

FIM® scores are important to determining reimbursement for each Medicare beneficiary. Use the IRF-PAI training materials and practice so that you can score accurately. If you have not yet had to pass a test regarding scoring accuracy, you likely will in the future.

What Does This Mean to Me?

There are many details that must be considered when scoring the FIM®. Here are a few more reminders.

- There is no such thing as Not Applicable regarding the functional skills listed on the FIM®. That means that all of the activities listed on the FIM® are expected to be completed within the realm of good basic IRF-level care.

- Yes, the patient needs to wear street clothes and shoes, needs to shower/bathe, needs to comb hair, brush teeth, shave and put on makeup, and needs to actively pursue mobility, increasing strength, endurance, and skills.

- The need for safety is implicit in any functional skill activity. With respect to scoring an item in the FIM® a 6, you must ask yourself whether the patient is at risk of injury while performing the task. As always, your judgment should take into account a balance between risk and the corresponding risk of what occurs if the patient does not complete a task—are you providing adequate opportunity to practice safety for a skill that will be required in the community?

13. What score should the nurse record and what should be documented if a task on the FIM® was performed by the patient’s mother during the discharge assessment period?

Lower Scores with Nursing?

There is often concern that nursing scores do not reflect the patient’s actual ability. Have you heard comments like these?

- There is not enough time with the patient to allow the patient to be successful.
- The nurse does not score accurately.
- The nursing staff allows the patient to be more dependent than he really is.

Nursing sees the patient for 21 hours of the day. Their documentation may be used to evaluate accuracy of FIM® scores whether the nurse scores are included in the IRF-PAI or the scoring is assigned to another discipline. Therefore:

- Nursing must provide the patient with opportunities to demonstrate abilities.
- Nurses must know how to accurately score a patient.
14. What activity is most likely at the lowest level of performance during the first few minutes of admitting the patient, and often the least likely to be considered in documenting and evaluating function?

**REALLY, Details Matter!**

When scoring the FIM®, a change of even 1 point in scoring may lead to thousands of dollars of difference in reimbursement and can impact calculations related to the average length of stay. It is important that ALL clinicians working with the patient consistently document that lowest burden of care on admission.

15. Which functional behaviors should be documented in reference to the percent of time assistance is needed **during a 24-hour day** in order to support scores on the FIM®?

Remember that daily documentation for all patients must **describe** functional abilities. This is part of the nursing assessment, even if it is within normal functional limits (e.g., *demonstrated good problem solving in daily care, attending therapy, and planning for discharge*). Scoring the FIM® for the IRF-PAI, or even because it is required as part of team conference or daily documentation, does not **describe** functional abilities. You must have evidence that proves the score recorded in order to comply with CMS regulations.
Documenting Evidence of Medical Necessity

The rehabilitation nurse has accountability to prove that IRF care is reasonable and necessary by addressing medical, health, and functional care needs. The record should tell the story of management of any medical, functional, or psychosocial issue, tracking the changing needs of the patient. It should prove why a patient needs 24-hour care in an IRF. Your job is to reduce the burden of care as much as is safely possible while supporting and maintaining health.

- Burden of care is not a subjective experience (e.g., *it took about 50% of my effort to complete this task*). Rather, it is an objective and quantifiable experience much like a blood pressure.

16. What should a professional rehabilitation nurse do—monitor or manage?

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*On the Computer: complete the CMS Regulations chapter, pages 18-19.*

*Then, return to the Main Menu and start the next chapter: Rehab Nursing Standards. Watch for the page that tells you to return to the workbook.*

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*One More Time!*

- The Centers for Medicare and Medicaid (CMS) have specific documentation requirements that impact every member of the team.

- CMS regulatory expectations are law and require that documentation by every member of the team proves that regulatory requirements have been met.

- Failure to meet these requirements may result in forfeiture of payment for services.
Chapter 3

Rehab Nursing Standards

Consumers face a variety of options when deciding what services to use and who should provide them. Accreditation is a sign of quality and is an important consideration in their decision making.

Commission on Accreditation of Rehabilitation Facilities (CARF), n.d.

What Is Your Job in This Chapter?

In this chapter, you will review standards of care from CARF and ARN that impact rehabilitation nursing documentation expectations. Your job is to determine whether your documentation habits provide evidence that accreditation and professional practice standards are met.

Chapter Highlights

- CARF defines accreditation standards for medical rehabilitation. Documentation proves compliance to CARF standards for patient care.
- The Association of Rehabilitation Nurses defines the professional standards and scope of rehabilitation nursing, and provides guidance on the documentation expected of professional rehabilitation nurses.
CARF

CARF standards address training and competency of staff and reinforce the expectation that nursing staff will be competent in the specialty of rehabilitation nursing.

They emphasize the involvement of the patient/caregiver and the importance of continuity of care. Standards specifically require that all shifts see and use the plan of care and document measurable progress toward goals. They also require that documentation strategies avoid unnecessary duplication.

1. CARF defines secondary prevention activities that are expected in rehabilitation care. List at least three items from this category that should be evident, when applicable, in your documentation.

Medication Education Standard

Were you surprised that there was such a specific list for the elements to be included in Medication Education? Was anything on the list new or surprising to you?

2. List at least three things that should be documented to prove the standard for medication education has been met.
Accreditation-Driven Documentation

Some standards are very specific. The box below lists some of the expectations for care of a patient with limb loss. What would you expect to see in the record to prove the standards were met? Do you notice that the term management, not monitoring, is used here as well? There is some consistency in expectations across the levels in the pyramid.

<table>
<thead>
<tr>
<th>Limb loss education regarding self-management</th>
<th>Strategies that address health and medical conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Management of secondary complications</td>
<td>• Diabetes management</td>
</tr>
<tr>
<td>• Skin care</td>
<td>• Pain management</td>
</tr>
<tr>
<td>• Prosthetic options</td>
<td>• Regular preventive foot and limb care</td>
</tr>
<tr>
<td>• Fit of the prosthesis</td>
<td>• Cardiovascular management</td>
</tr>
<tr>
<td>• Accuracy of information received regarding prosthetic issues</td>
<td>• Risk reduction</td>
</tr>
<tr>
<td></td>
<td>• Wound care</td>
</tr>
<tr>
<td></td>
<td>• Skin care/integrity</td>
</tr>
<tr>
<td></td>
<td>• Fitness and exercise promotion</td>
</tr>
<tr>
<td></td>
<td>• Nutrition</td>
</tr>
</tbody>
</table>

Are You a Rehab Nurse?

You should have noted by now that rehabilitation nursing is a specialty practice. The job you have to do as a rehabilitation nursing specialist is very important to the health and outcomes of the patients in your care. You have special skills and a special job, and your patients need you to be at the top of your game.

Your documentation is an opportunity for you to express your skills and knowledge in the care of your patients, to prove you are making a difference.

3. Who defines the behaviors of the professional rehabilitation nurse?
Defining the Specialty of Rehab Nursing

The Association of Rehabilitation Nurses (ARN) defines professional rehabilitation nursing.

What Does This Mean to Me?

These standards are authoritative statements by which the profession describes its accountabilities and responsibilities. They describe a competent level of professional nursing care and practice common to all rehabilitation nurses active in clinical practice.

4. What document provides a reference for this specialty?

5. Why do you care about what is in this document?

Proof is in the Documentation

Regardless of where care is delivered, the documentation of the professional rehabilitation nurse must reflect that care was delivered by a nurse with specialized training or experience in rehabilitation care within the context of the rehabilitation team. You can review the summary of expected documentation in Appendix A at the end of this chapter. Do you see the similarities to the content in regulatory and accreditation standards?

6. The specialty practice of rehabilitation nursing is proven in daily documentation by attentiveness to the rehabilitation diagnosis and participation in a patient-centric interdisciplinary plan of care. According to the information in Appendix A, what are the principles that direct the focus of this care?
7. What specific criteria are to be applied to goals according to the information in Appendix A?

8. Are cognitive functions such as memory, judgment, and problem solving included in the list?

"Your documentation should tell a concise, understandable story about your patient’s functional limitation and a logical, acceptable plan for achieving a realistic functional goal in a reasonable amount of time."
—Jerry Henderson, PT

On the Computer: complete the Rehab Nursing Standards Quiz on page 14.

Then, return to the Main Menu. Start the next chapter: Documenting Professional Rehabilitation Nursing Care. Watch for the page that tells you to return to the workbook.

One More Time!

- CARF accredits rehabilitation care, and many of its standards speak directly to nursing care expectations that should be reflected in documentation.

- Rehabilitation nursing meets all the criteria for a specialty practice. The Association of Rehabilitation Nurses (ARN) defines the standards and scope of rehabilitation nursing practice.
Appendix A: ARN Documentation Guidelines

The specialty practice of rehabilitation nursing is proven in daily documentation by attentiveness to the rehabilitation diagnosis and participation in a patient-centric interdisciplinary plan of care. The focus of this care is:

- Holistic, addressing functional, physical, and psychosocial self-care
- Proactive, addressing prevention and management of problems
- Practical, addressing reductions in the burden of care through the development of meaningful functional skills
- Community-focused, preparing for optimal quality of life, safety, and self-care management on return to the community

ARN, in a position statement and letter to CMS entitled Rehabilitation Nursing Criteria for Determination and Documentation of Medical Necessity in an Inpatient Rehabilitation Facility (http://www.rehabnurse.org/advocacy/content/pcriteria.html), provides the following list of expected topics to be addressed in rehabilitation nursing documentation.

Documentation should include, as appropriate, yet not be limited to:

- Rehabilitation diagnosis, course of treatment, plan of care, and expected outcomes
- Disease and comorbidity management
- Primary prevention and adoption of health and wellness
- Prevention of secondary complications
- Bowel and bladder management goals; progress in bowel and bladder continence or regulation following an injury that impacts such functions
- Skin care management, including body positioning and pressure redistribution, wound care, and the prevention of skin insults
- Medication and pain management
- Reinforcement of self-care and mobility skills
- Functional aspects of daily living skills
- Cardiovascular, pulmonary, and autonomic management
- Nutrition and lifestyle adaptations
- Safety (precautions, education, and carryover); ongoing assessment of safety, including not only physical limitations, but also such cognitive functions as memory, judgment, and problem-solving abilities
- Swallowing precautions and compensatory techniques
- Energy conservation
- Intimacy and sexuality
- Role changes and psychosocial manifestations
- Family involvement
- Aftercare, including community resources, equipment, emergency services, and external support systems
- Patient goals that are practical, realistic, and individualized

Goals and interventions that integrate and demonstrate carryover of techniques from therapy to increase the functional status and lessen the burden of care should also be evident in the medical record.

CMS requires that the IRF Patient Assessment Instrument (IRF-PAI) is included in the IRF medical record. Because the information in the IRF-PAI must correspond with information provided in the medical record, nursing documentation is vital to supporting the burden of care for medical and functional complexity of the patient.

Frequent conflicting documentation between disciplines, widely fluctuating patient abilities throughout a 24-hour period based upon changes in medical stability, pain, endurance or cognition, or failure to progress as planned should be explained and a realistic plan to address the problem(s) identified. Documentation of discharge plans should be indicated early in the plan of care.
## Appendix B: Your Personal Meaningful Use Guide

<table>
<thead>
<tr>
<th><strong>Tips to Remember</strong></th>
<th><strong>Where in My Documentation System</strong></th>
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CHAPTER 4

DOCUMEnTING PROFESSIONAL REHABILITATION NURSING CARE

Professional rehabilitation nursing documentation should clearly demonstrate the medical complexity of the patient and the skilled and specialized rehab nursing care provided. It is probable that someone will review your documentation to see if this is present.

What Is Your Job in This Chapter?

Your job in this chapter is to practice building documentation that demonstrates the care of a professional rehabilitation nurse so that you know the principles required and can then apply those principles in your documentation system.

While this course is focused on documenting professional rehabilitation nursing care in the medical record, it is important to note that

 réuss Chapter Highlights
- Start by thinking about what you are doing, why you are doing it, and how you can facilitate the patient or caregiver in doing it.
- Describe what the patient and caregiver are doing, analysis of the situation, and what was done about it (communication or teaching that occurred, coordination of efforts, changes in plan of care, etc.).
evidence of exceptional rehabilitation nursing care also shows up in other forms of documentation such as outcomes reports, quality reports, and satisfaction surveys.

It Is a Must-Do Activity

While there is to you, the writer of the moment, obvious understanding of content (i.e., *handouts given, sister present, demonstrate understanding*, etc.) when documenting, the person reading your documentation was not likely present during your care. You need to paint a picture for them with your words, using terms easily understood by anyone reading the notes years later (i.e., *which handouts, which sister, and demonstrated understanding by doing what?*).

1. What does it mean when a nurse documents that the patient was able to perform 50% of the task of bathing?
   a. Able to wash chest, back, arms, and face
   b. Able to shampoo; wash face, chest and arms
   c. Able to wash legs, chest, back, and perineum
   d. Able to wash left side of body, torso, and face
   e. Any of the above

2. What is wrong with simply documenting a percent or the statement *Mod Assist*?

Close the Loop!

If you have identified an issue and communicated it to another team member, remember to close the loop by documenting the action expected and whether there was successful resolution of the issue.

- 2/14/15 0815 Pt indicated concern regarding insurance coverage for wheelchair. Nurse notified case manager of concern and advised pt to review coverage with case manager to solidify understanding of coverage.
- 2/14/15 1230 Questioned pt re discussion with case manager regarding insurance coverage. Pt indicates comfortable with options and better understanding of process of getting wheelchair.

Identify a strategy for following up when the follow-up activity needs to occur on another shift or with another caregiver!
One Task—Many Opportunities

There is a lengthy list of issues that can be addressed with any given patient on any given day when the emphasis is on promoting health and function. Care is so integrated in rehabilitation settings that it is possible that almost the entire list of safety, functional, and health items rehabilitation nurses address can be addressed in one trip to the bathroom.

3. Again, what are the elements of care that should be evident in the word picture you create?

4. How many different topics could be addressed if a patient with a change in diuretic medication, who is on a timed voiding program, was taken to the bathroom and a family caregiver was present? Can you list potential topics?

Did Rehab Nursing Occur?

Remember that there has to be evidence that your expertise is needed to coach and facilitate carryover from therapies and to evaluate the effectiveness of the interventions in the care plan. Look at the differences in documentation when you emphasize your expertise.

- **General Nursing Documentation:** Transfers with 1+ moderate assist.
• **Emphasis on Supporting FIM® Scores:** Transfers bed to w/c with moderate lifting assist to come to sit & then stand when bed flat. Once standing, steadying assist to pivot to chair. Minimal seating assist with verbal cues to lean forward to ease safely down to chair.

• **Emphasis on Rehab Nursing Expertise:** PT indicates Gabe’s able to stand to pivot to w/c. Transfers bed-wheelchair with moderate lifting assist to come to sit & then stand when bed flat. Once standing, steadying assist to pivot to chair. Minimal seating assist with verbal cues to lean forward to ease safely down to chair. No s/s of orthostatic hypotension during transfer. Demonstrated safety awareness; responded well to coaching to push harder to a standing position. Improving daily. Wife watched; instructed in safe transfer technique with emphasis on completing task slowly to increase Gabe’s participation and maximize safety. Wife able to verbally teach back this instruction during next transfer. Plans to practice hands-on tomorrow with physical therapy.

5. What does the night shift nurse need to document to demonstrate rehab nursing expertise is needed for overnight care?

What Proves That Rehab Nursing Occurred?

You should be able to start creating your own pattern of documentation to demonstrate that rehab nursing has occurred. If you focus on the transition to self-care, self-management, and community living, the issues that need to be addressed, practiced, and planned for so that the patient and caregiver are successful on discharge become more apparent.
6. What should you document to provide evidence of professional rehabilitation nursing, integrated care, and carryover from therapy to provide evidence that you are taking special efforts to protect the patient from injury?

What, Why, & How?
To answer these questions, you must know your patients. Get involved with your patients, so that you know them and can recognize early any deviations from baseline. Perform care with intention; know the patient’s risks and look for evidence of complications. **It is important to be particularly attentive to documenting any healthcare issues that impact participation in therapy.**

7. Why is it significant to document that you had to use a device or provide special assistance due to medical restrictions?

Response, Analysis, & Actions
Analysis is focused on the evaluation part of the nursing process. Document your conclusion and the rationale for any changes in the plan. Provide the evidence of progress toward goals.

8. Why do you think it is important to address self-management of chronic health conditions during the patient’s IRF stay?
Document This!

There are specific items that should be consistently documented to support IRF-level care. If you are working with aides or LPN/LVN staff, there must be evidence of the need for a professional nurse’s management in coordination with the staff she is supervising.

9. What does the nurse need to document regarding the care provided by an aide?

10. Identify three actions that can be taken, when a float nurse is providing care, to ensure the patient is continuing to learn and practice/carryover techniques from therapy.

Find It!

The details are important! They prove the care you provided, and they protect you in the event of litigation. Focus on the expected elements of documentation that reflect the expertise of the professional rehabilitation nurse.

11. List the eight documentation elements expected to be found in the documentation of the rehab nurse.
Continuity Promotes Efficiency

Consistency across team members is critical to demonstrating collaboration, continuity, and interdisciplinary care. Variations of response and/or ineffective interventions should be addressed immediately. What are you going to do about it? Don’t just document you are going to do it; document that you did it!

Chizek, 2013

12. What should you expect to see documented in the next shift when the last shift documented the following?

_Request to OT re consideration of additional adaptive equipment for bathing: back scrubber and soap in a mitt._

Tip!

If a patient is refusing to go to therapy, do NOT simply document _refused therapy_. Instead, use quotes from the patient and document efforts to remove barriers and get the patient to therapy (e.g., _changed the time, allowed for a nap, managed pain_, etc.). It should be evident that the team worked hard to address this issue.

What’s Missing?

Omissions of information are common and the reasons are plentiful. Consideration of how your documentation will look to another, days or even years later, might justify a bit of extra effort in creating the story you want to tell. Consider this documentation.

_Psychosocial Support Comment:_ Interpreter provided for patient. Spoke with patient and family regarding noncompliance with falls prevention policy. Patient has fallen three times since admission and refuses to use call light or to wait for assistance. Family supports patient refusal of bed or chair alarm due to dignity issues. Obviously well-informed regarding the risks of the patient’s choices. Reinforced information previously shared by team. Will continue to monitor.

13. What do you think was happening in this situation? What is missing from the documentation?
Self-Assessment: The Future

It is hoped that you have increased your confidence in knowing what needs to be documented and that you have started to solve the problem of how to do this in the documentation system you are required to use at work.

14. What do you need to continue to work on? Do you have a plan?

Practice, Practice, Practice!

Practice, self-evaluation, and feedback lead to expertise and efficiency. Compare Your Personal Meaningful Use Guide with the information in Appendix C. Then, use your resources to continue to improve your documentation skills.

On the Computer: complete Documenting Professional Rehabilitation Nursing Care, page 17.

Then, review Appendix C at the end of this chapter.

Return to the Main Menu and complete the Posttest. A score of 80% or better on the Posttest is required to obtain continuing education credit.

Print the score sheet at the end of the test. It contains the details required for contact hours, and you will not be able to retrieve it later.

One More Time!

- Remember! Document the care provided to reduce the impact of disability or illness on function, utilization of the plan, collaboration with and carryover from the team, equipment and assistance for functional activities, progress toward goals, education provided, communication with the physician and team, and activities to support a successful transition to the community.
Appendix C: Rehabilitation Nursing Documentation Requirements

Specialized rehabilitation nursing care must be proved in the documentation. It must be demonstrated in the documentation 24 hours a day, 7 days a week. Therapists provide care for a minimum of 3 hours per day; nursing provides care for a minimum of 21 hours. Nursing spends more time with the patient than any other team member, and therefore has the biggest burden of care resulting in the biggest burden of documentation to:

- Capture the story of the patient
- Justify the medical necessity of the admission
- Support the FIM® scores
- Provide evidence that the patient needs to continue this level of care

Nursing is responsible for implementation of the patient-centric rehabilitation plan during those 21 hours. The goal of this effort is to provide practice opportunities and to better prepare a patient for community living. This behavior is not assumed because of the setting. It must be proved in documentation.

**What MUST be documented?**

- Implementation of the individualized patient-centric plan of care
- Management of medical and functional problems
- Carryover of recommended therapeutic techniques from therapists
- Functional abilities and responses to interventions in the plan of care
- Communication with fellow team members (not only physicians, but also therapists, care management, psychology, pharmacy, respiratory therapy, recreational therapy, etc.)
- Goals that are objective, measurable, and functional with specified periods for attainment (with the functional part of each goal supporting the medical necessity of services)
- Evidence of the burden of care
NOTE: Monitoring is a passive behavior that can be provided at a lower level of care (e.g., skilled nursing, home health, or outpatient settings). Management is active, and:

- Embraces prevention of complications and reduction of risk
- Involves changes in the plan of care in light of patient responses
- Includes implementation of skilled interventions, dynamic interactions with the patient/caregiver, evaluation of responses
- Requires patient/caregiver engagement, education, and feedback to support self-care knowledge and behaviors

Documentation should show the patient's status on a daily basis so there is a logical progression from admission to current status and through to discharge.

Remember!
Remember that you must document efforts to manage health and medical needs.

- Emphasize preventive healthcare efforts. Are they effective?
- Include education and patient/caregiver competence in managing chronic diseases and self-health care
- Address patient/caregiver education, understanding, and application of ongoing preventive healthcare practices (e.g., preventing pressure ulcers, contractions, bladder infections, constipation, another stroke)

Document the use of any equipment.

- Include AFO, eating tools, positioning aids, mobility aids, hearing aids, glasses, etc. (Also, do you help the patient to don/doff them or keep from losing them?)
- Give the reason for needing this equipment (e.g., weakness, balance, lack of function/paralysis). However, don’t duplicate documentation if this is already in your physical assessment.
Document ANY type of assistance.

- Include set-up, supervision, cuing, hand-over-hand, contact guard, total, etc.

- Remember that gathering articles for a task is part of the task. If the patient cannot do that, then assistance is required. On the other hand, note if the environment is set up for the patient’s success. For example: 
  Attempted to gather clothing, but unable to reach rack in closet. 
  Discussed possible use of reacher with pt and OT. Will access and evaluate use this afternoon.

Consider the whole task!

- Take into account planning, organizing, and accessing (e.g., adjusting temp of water in shower or at sink, accessing toiletry items in bathroom).

- Keep in mind the use of supports (e.g., grab bar, elevated toilet seat). Where does the patient complete dressing (bed, chair, standing)? Does the patient use the position of the bed to improve function? Is the patient able to adjust the bed for this purpose independently? Is the patient going to need to do this at home as well? What plans are being made for functioning in the home environment?

- Think about whether every type of assistance will be present after discharge. Is the patient wheeled into shower by another? Is it possible for the patient to wheel self in the type of chair used? If not, can the patient transfer in shower to safely reduce burden of care? Wean off of devices prior to discharge, if possible.

- Evaluate the many things that are occurring during a single task (e.g., cognitive and communication skills along with toileting, bathroom transfers, and bladder management).

Know the parts of care as defined by FIM®!

- Be consistent with FIM® definitions (e.g., toileting consists of pants down, perineal hygiene, pants up) when you are documenting. Do not mix tasks (e.g., toileting, bowel and bladder management, toilet transfers); rather distinctly document each component.
• Documentation should, at minimum, provide evidence of the patient’s abilities and/or burden of care for any areas of the FIM® addressed during care activities.

• Remember that functional care is not limited to the functional items of the FIM®. Address all patient needs (e.g., self-management of healthcare, medication and pain management, intimacy and sexuality, and other community-level skills).

You can summarize your shift, but focus on the details!

You do not need to give a full explanation in each instance of an activity. (E.g., in the flow sheet, you can chart voids/continence. In your summary, you can chart performance indicating that the patient was max assist on waking in morning—stiff and hard for her to move, to moderate assist midday, and increasing assist needed with fatigue in the afternoon.) However, in this process you must address all the elements of the tasks. (Thus, sometimes it is easier to document each episode of care individually.)

Showing the changes of the burden of care across the day or week is important. It is also important to document the implementation of strategies for addressing limiting factors and the evaluation of the effectiveness of those strategies.

Document in team conference notes.

Documentation of the team conference must reflect the patient’s progress toward goals (measured in practical value to the patient), barriers to discharge, resolution of problems and/or barriers addressed, reassessment of appropriateness of current goals and plan, and any updates/changes made to the plan. Remember to address return-to-work/school issues, caregiver support, self-health management, etc.

ARN, 2014a; UDSMR, 2008; UDSMR, 2013
**Chapter 1 Overview**

1. It means that reimbursement is based on patient outcomes.
2. CMS
3. To refine CMS, accreditation, and professional standards of care in order to address the unique needs of the individual environment of care.
4. Failure to comply with organizational policies and procedures, particularly those targeting patient safety and supported by accrediting organizations such as TJC and CARF; failure to prudently practice according to widely-recognized patterns of practice that are supported as best practice according to standards, scope of practice, and scholarly information (professional organizations, trade journals, textbooks, clinical guidelines, expert consensus on best care, etc.)
5. Documentation is the record of care and the evidence proving that standards, policies, and procedures have been followed. So, those involved in the design of documentation tools must understand all standards, policies, and procedures requirements to ensure that it is easy to demonstrate compliance to standards and requirements for care.
6. The best EHRs make it easy to read the story of the care of the patient, support interdisciplinary communication and planning, and are efficient and easy to use.

**Chapter 2 CMS Regulations**

1. Documentation (Thus, physicians, nurses, and therapists must be diligent about documentation.)
2. CMS
3. Audits
4. Loss of reimbursement, loss of the ability to participate in the IRF PPS, and, in a fraud-type situation, potential jail time.
5. Document communication with team members, care planning, education, burden of care/functional abilities, and evaluation of progress toward goals.
6. The PAPE contains the history and physical and the physician’s expected course of treatment. The team should take this information into consideration during initial evaluations and while providing input into the Individualized Overall Plan of Care.
7. The initial team conference should occur by Day 7 of the patient’s stay. (The day of admission is Day 1.)
8. During the first 3 days of the patient’s stay. (The day of admission is Day 1.)
9. During a select 24-hour period within the last 3 days of the patient’s stay.
10. The patient’s medical chart must substantiate each FIM® rating. This documentation cannot be a FIM® score or simply the text for that score. You cannot support a score of a FIM® with a score of a FIM®. (E.g., a FIM® score of 5 on the IRF-PAI is not supported by documentation in the record of Supervision, patient = 100% or FIM® 5; rather, documentation should provide evidence of why that score was selected.)
11. The therapist must document the number of minutes in therapy and the minutes must total or exceed the minimum number of required minutes per CMS regulations.
12. The team conference notes provide evidence of this work.
13. The nurse must gather information from patient or the person who observed and/or assisted the patient with the task to document what occurred and to then score that item.
14. The first transfer on unit when the transferring unit is bringing the patient to you is likely the lowest level of performance (biggest burden of care), and it is usually not captured in documentation or for FIM® scoring.
15. Communication (comprehension and expression) and cognition (social
interaction, problem solving, and memory) are both scored in terms of percent of time during the 24-hour period that assistance is needed. It is recommended that you document how long you were with the patient and how often, during that period of time, assistance or support was needed. This way total percent for the 24-hour period can be objectively calculated.

16. Manage

**Chapter 3 Rehab Nursing Standards**

1. CARF standards indicate that the following should be actively prevented:
   - Adverse drug reactions
   - Aspiration pneumonia
   - Contractures
   - Deep vein thrombosis
   - Depression
   - Falls
   - Nutrition
   - Skin breakdown
   - Urinary tract infections
   - Other high probability risks associated with specific diagnostic categories

2. Medication education, as appropriate includes:
   - Actions in case of emergency
   - Administration
   - Dispensing
   - Errors
   - Identification of why each medication is prescribed
   - Drug interactions (with other medications, foods, herbal products, etc.)
   - Implications for managing multiple medications
   - Implications of abrupt discontinuation
   - Indications and contraindications
   - Obtaining medication

   - Side effects
   - Storage
   - Evidence of understanding of the education provided

3. The Association of Rehabilitation Nurses (ARN)

4. **Standards & Scope of Rehabilitation Nursing Practice**

5. These are the standards that we are held accountable to. They describe the responsibilities of professional rehabilitation nurses and are what the auditors and judges refer to for clarification of expected behaviors for this specialty practice.

6. Care should be holistic, proactive, practical, and community-focused.

7. Goals should be practical, realistic, and individualized.

8. Yes

**Chapter 4 Documenting Professional Rehabilitation Nursing Care**

1. The answer is (e). If you are counting body parts for the FIM® to determine a percentage, any combination that includes 5 body parts will count as 50%. This leaves much to the discretion of the reader if that is all that is documented.

2. There is potential for too much self-interpretation if only a percent is indicated. When documenting Moderate Assistance, it is difficult to tell which components of an activity the patient can do well in comparison to other components.

3. This picture should describe why the patient needed 24-hour care in the IRF and what you were doing to ensure safety, promote recovery, and support the transition to the community, including a clear picture of functional status and the burden of care.

4. Referencing the ARN documentation list, the following items can likely be addressed in this situation. Can you think of others?
• Rehabilitation diagnosis, course of treatment, plan of care, and expected outcomes: *Diuretic adjusted, plan change, reason, and expected outcomes*

• Disease and comorbidity management: *Review why he is on a diuretic*

• Primary prevention and adoption of health and wellness: *Evaluate urine color for hydration level; discuss weight monitoring*

• Prevention of secondary complications: *Prevention of fluid imbalance and its associated risks (falls, fatigue, constipation, respiratory compromise, etc.)*

• Bowel and bladder management goals; progress in bowel and bladder continence or regulation following an injury that impacts such functions: *Continence with timed voiding program; low post-void residual*

• Skin care management including body positioning and pressure redistribution, wound care, and the prevention of skin insults: *No incontinence, no need to wear disposable briefs*

• Medication and pain management: *Effectiveness of new dose of diuretic related to reason for change*

• Reinforcement of self-care and mobility skills: *Walk/Wheelchair, Transfers—Toilet*

• Functional aspects of daily living skills: *Toileting, Grooming/Hand Hygiene*

• Cardiovascular, pulmonary, and autonomic management: *Assessment of systems for signs/symptoms of fluid imbalance*

• Nutrition and lifestyle adaptations: *Working toileting schedule into daily routine*

• Safety (precaution, education, and carryover); ongoing assessment of safety, including not only physical limitations, but also such cognitive functions as memory, judgment, and problem-solving abilities: *Comprehension (followed instructions), Expression (requested toileting), Social Interaction (appropriate request, actively involved in activity), Problem Solving (figured out how to keep track of time), Memory (remembered to use call light and to put brakes on chair), and Safety (attentiveness to safety by patient and family caregiver during practice session)*

• Energy conservation/activity tolerance: *No signs/symptoms of fatigue*

• Role changes and psychosocial manifestations: *Daughter uncomfortable acting like parent to father but knows it is necessary in order for him to be safe at home.*

• Family involvement: *Daughter present and practicing*

• Aftercare including community resources, equipment, emergency services, and external support systems: *Rehearsed how to manage toilet transfers at home post-discharge*

5. There should be a plan to address any quality of sleep issues. Night shift care addresses effectiveness of sleep agents, quality of sleep, whether the patient feels refreshed on awakening or hung over from sleep agents, ability to fall back asleep if awakened, efforts to organize nighttime care to reduce nighttime awakening, response to turning activities, ability to function safely when waking from sleep to toilet, etc. There should be clear evidence of a focus on nighttime safety, and reduction in the burden of nighttime care to promote quality sleep for both the patient and any associated caregiver. Rehearsal of community nighttime sleep patterns help to identify risks that need to be addressed prior to discharge. This requires assessment of nighttime resources or caregivers, toileting and positioning needs, and sleep surfaces. The night shift nurse can then evaluate effectiveness of the home self-care/self-management plan for preventing complications (skin, cardiopulmonary, etc.), promoting quality sleep, and maintaining safety.

6. Assessment of safety needs, the implementation of a patient-specific individualized plan, the effectiveness of the plan, education and practice in
self-management of own risks with the patient and the caregiver, and their ability to apply self-management.
(Self-management may be under supervision in the inpatient environment, but care should be actively focused on moving responsibility to the patient and caregiver in rehearsal for the home environment.)

7. It is important, in this situation, to note the impact on patient safety, functional abilities, and ability to self-manage the imposed restriction.

8. It is important to identify the impact of any chronic conditions on recovery (e.g., heart failure creates endurance problems) or to identify any increases in the risk of readmission (and especially, what you are doing to help prevent that from occurring).

9. The nurse documents analysis of the data recorded by the aide (e.g., progressing toward goal) and any necessary actions taken. Remember, monitoring is passive nursing care; management, assessing, and evaluating are active professional rehab nursing behaviors. Choose your actions and words carefully.

10. Provide necessary training, if the person floats frequently to the IRF; provide job aids; provide a rehab-experienced partner to coach the float person, with whom activities that are beyond the float person’s skill set can be traded.

11. Document these required elements to provide evidence of rehabilitation nursing care, analysis, and actions.
   - Care provided to reduce the impact of the disability or illness on function, safety, and health
   - Utilization of the care plan
   - Collaboration/carryover from the team
   - Any equipment used during functional activities, or assistance used during functional activities and self-health management
   - Progress toward goals identified in the patient’s plan

   • Education of patient/family caregivers
   • Communication with team and physician
   • Activities to support transition to the community (discharge planning)

12. Follow-up or answer from OT and how the team resolved the problem of self-bathing.

13. This example leaves too much to interpretation and is not specific enough. Why has the patient fallen? Why, specifically, does the family support the patient’s choices? What information did the team previously provide? (This may be documented elsewhere in the record.) What is going to be monitored?

Here is the actual story of the events: The patient is an elderly gentleman who has little trust in the medical system, is Greek, and speaks little English. He is frightened by the restrictions put on him and anxious to leave. All three falls occurred when he tried to wrest himself free of aides who were trying to put him back in the wheelchair because he was not cleared for ambulation. He has a mild weakness of the right leg and is walking in therapy. He demonstrates safety awareness when moving on his own. He has mild expressive aphasia with word-finding problems which, when combined with language limitations makes it difficult for him to express himself. He simply does not understand, and therefore does not comply with policy. He believes that the policy is a way to prevent his escape. His family feels strongly that if he is respected for his own self-care efforts and judgment, he will take care of himself, have reduced anxiety, and actively participate in therapy. They request that he not be treated like a child and be supported in proving he is an adult capable of taking care of himself.

14. This answer will reflect your experiences.