ACHCA ANNUAL CONVOCATION: 2017

Patient Advocacy Through Documentation

Collaboration Between Nursing and Rehab

Barb Christensen, Clinical Director-Aegis Therapies and Lynn Freeman, Clinical Director-Aegis Therapies

AGENDA

- Review Various Audit Types
- Components of Good Rehab Documentation
- Collaborative Documentation
- Examples/tools
- QAPI Case Reviews

Patient Advocacy??

- How is documentation, advocacy?

Patient Advocacy??

- **How is documentation, advocacy?**
- **It's ALL we have to validate that our services were skilled.**
- **Audit entities don't see our patients.**
- **They only see what we write.**
- **What we write secures payment for our services today….**
- **And services for patients of the future!**

Volume To Value

- Medicare has been moving from volume to value for some time now.
- Historically only had billing information and diagnoses.
- Now:
  - Functional Limitation codes for Part B
  - Section GG for Part A
  - New evaluation codes which have greater specificity

5

Medicare Claims Review Entities

- **Medicare Administrative Contractor (MAC)**
- **Recovery Audit Program (RAs-formerly the RAC)**
- **Comprehensive Error Rate Testing Contractors (CERT)**
- **Zone Program Integrity Contractor (ZPIC)**

MAC (WPS for Missouri)

Goal: PREVENTION

How? Through Progressive Corrective Action (PCA)

- **Pre and post-payment review**
- **Probe Review**
- **Targeted Medical Review**
- **Education**

Recovery Audit Program (RA)

RA for Missouri: Health Data Insights (HDI)

Goal: DETECT AND CORRECT

How?

- **Post-payment claims review**
- **Pre-payment in some states**
- **Widespread or Targeted review**

$3700 Threshold

- No longer being conducted by RAs.
- CMS has contracted with StrategicHealthSolutions to perform targeted post-payment medical review of Part B therapy services over the $3,700 threshold.
- StrategicHealthSolutions has begun sending out Additional Development Requests (ADRs) to providers that have been selected for a targeted review.

9

Threshold Reviews Cont.

- According to CMS, they have tasked Strategic Health Solutions, a medical review contractor, to target the following:
- Providers with a high percentage of patients receiving therapy beyond the threshold as compared to their peers during the first year of MACRA (Peers means that SNFs will be compared to other SNFs; outpatient clinics to other outpatient clinics, etc)
- Therapy provided in skilled nursing facilities (SNFs), therapists in private practice, and outpatient physical therapy or speech-language pathology providers (OPTs) or other rehabilitation providers
- Of particular interest in this medical review process will be the evaluation of the number of units/hours of therapy provided in a day

Comprehensive Error Rate Testing (CERT) Program

Goal: MEASURE

How?

- **Randomly select statistically valid sample of claims**
- **Post-payment review**
- **Publish results annually**
  - **Used to guide provider education**

Top CERT Denial Reasons for SNF

- **Insufficient documentation to support medical necessity of the service.**

Zone program Integrity Contractors (ZPIC)

Goal: IDENTIFY POTENTIAL FRAUD

- **Perform data analysis and conduct medical review**
- **Conduct interviews**
- **Conduct onsite visits**
- **Investigate fraud and abuse**
- **Refer cases to law enforcement and OIG**
- **ZPIC in MO = AdvanceMed Corporation**

Increased Data Transparency

CMS is evolving its infrastructure and data systems to enhance transparency of quality and cost information and to allow for payment and management of accountable, value-based care

- CMS Quality Strategy 2016

5 Star

PUF Reports: Public Use Files - Utilization

Value

Quality Efficacy Safety

$$\text{Value} = \frac{\text{Outcome}}{\text{Cost}}$$

Resource tallies Dollars

Person-Centered Value

Value for the patient is created by providers' combined efforts over the full cycle of care. The benefits of any one intervention for ultimate outcomes will depend on the effectiveness of other interventions throughout the care cycle.

Porter. NEJM 2010

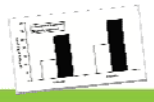
Person-centered….patient perspectives

Recent reform reduced cost (better value) of orthopedic care, but with unintended negative effects on patient experience such as post-acute support for mental outlook and care continuity

- "There was no rehab in the hospital this time, you were just shunted out the door after four days, and so obviously that was cost-cutting" – *Webster et al, 2014*

Where's the continuity?

Where's the CHANGE?



New Discharge Planning Requirement or SNF's

PHASE 1: NOV 28, 2016

For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, **data on quality measures**, and **data on resource use** to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

Quality and Resource use measures

- Quality Measures: defined in the IMPACT Act as measures relating to at least the following domains: Standardized patient assessments, including functional status, cognitive function, skin integrity, and medication reconciliation
- Resource Use Measures: defined as including total estimated Medicare spending per individual, discharge to community, and measures to reflect all-condition risk-adjusted preventable hospital readmission rates

SNF QAPI

Each LTC facility, including a facility that is part of a multiunit chain, must **develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life**.

Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at § 483.70(e) and including how such information will be used to develop and monitor performance indicators.

Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis

SNF QAPI

We believe that our focus on outcomes is appropriate. We agree that QAPI should focus on improving processes and practices, and believe that data is a necessary element in doing so. **Data is used to identify problems in processes and practices and to set goals related to improving those processes and practices.** It is then used to validate that a change is successful in improving that process or practice and subsequently to monitor that the change is sustained. **Using data involves critical reasoning and analytical thinking**; these are not mutually exclusive.

SNF Competencies

PHASE 2: NOV 28, 2017

As proposed and now finalized in this rule, § 483.70(e) requires that facilities must, among other things, conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies and this assessment must address or include the care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity; and other pertinent facts that are present within that population.

Home Health QAPI

The HHA must **develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program**. The HHA's governing body must ensure that the program reflects the complexity of its organization and services.

The HHA must **measure, analyze, and track quality indicators**, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations

The HHA must use the data collected to--
(i) **Monitor the effectiveness** and safety of services and quality of care; and
(ii) **Identify opportunities for improvement**.

Back To Advocacy

- **Regardless of who is looking or why…..**
- **It is the documentation they will look at.**
- **Each patient comes to us with a history and a story.**
- **Our job is to tell that story.**
- **That's the ONLY way to advocate for the services they deserve!**
- **As well as advocating for patients of the future.**

What To Expect From Good Rehab Documentation (Applies To Nursing As Well)

- **Each patient is an individual.**
- **Their medical record is their story.**
- **This story has 2 characters: The patient and the therapist/nurse.**
- **COVERAGE REQUIREMENTS**
  - MEDICAL NECESSITY = the patient
  - SKILLED SERVICES = you
    - Denials occur when either Medical Necessity or Skilled Services is not convincingly described.
    - Or….when there are obvious conflicts in the story (such as discrepancies between what therapy says vs. what nursing says or between what MDS says and the rest of the medical record says)

Medical Necessity

The <u>Patient's Story</u> explaining the need for skilled intervention at this time-whether it's the SOC or at intervals throughout the episode.

- The change in function related to the recent medical history.
- The Medical Diagnosis
- The co-morbidities and complexities
- The Functional Deficits impacting daily life
- The Underlying Impairments that are causing these Functional Deficits

Medical Necessity

- **What changed and why?**
- **Why now?**

- **Medical Necessity defines the need for Skilled Services**
  - Medical Necessity must be defined at SOC and at regular points throughout the episode of care to justify the need for skilled intervention.
- **What makes this patient so complex that they will only improve (or maintain) through your skilled treatment?**
  - This must be clear throughout the episode of care.

Skilled Service

Your Story explaining what you are doing during treatment sessions or nursing interventions.

- Describes **why you?**

The services that only therapists or nurses are qualified to provide because of our specialized training and knowledge.

Analysis and Adjustments

Therapy MUST provide this in notes:

- Analysis

- The thought process that goes on as the patient progresses through a task. What is observed, assessed, perceived and judged.

- Adjustments

- The adaptations, changes, variations and progressions that are made during treatment. Changing the task, the environment, the cues etc according to the analysis.

Skilled Analysis-Must Be Described

SO WHAT?? TELL ME WHY??

- WHY did the patient progress? WHAT underlying impairment improved to cause the functional progress?
- WHAT are the current challenges?
- WHAT is so complex about this patient's condition that they cannot continue on their own or with a caregiver?
- WHY is there a variation in the patient's abilities throughout the day or over the past week?

Skilled Adjustments

- The skilled adjustments are the decisions made based upon skilled analysis.
- If we don't describe the treatment decisions and adjustments, the intervention will appear repetitive.
- REPETITIVE SERVICES = DENIAL

Your Thoughts

MEDICAL NECESSITY and SKILLS NEEDED: Skilled nursing perspective?

CMS Example

MEDICAL NECESSITY and SKILLED SERVICES : Nursing perspective

Example:

- Patient with pneumonia, chest congestion, confined to bed, confusion.
- Immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of relapse. Skilled overseeing of the non-skilled services (position changes and deep breathing) would be reasonable and necessary
  - "Documentation must illustrate the complexity.."

Your Thoughts

MEDICAL NECESSITY and SKILLED SERVICE: Rehab?

CMS Example

MEDICAL NECESSITY and SKILLED SERVICE: Rehab

CHF, diabetes, prior amputee both LE's.

Training in bed mobility, transfer skills, functional activities at wheelchair level.

CMS Words-Benefit Policy Manual

- **" …coverage of skilled nursing and skilled therapy services…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care."**
- **"…While the presence of appropriate documentation is not, in and of itself, an element of the definition of a "skilled" service, such documentation serves as the *means* by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case…"**

Documentation Examples

Would this be a problem?

Therapy says: Gait training and strengthening exercises

Nursing note says: Patient walks ad lib.

Both statements are technically true.

Medically necessary?

Skilled need?

The REAL Story

Therapy: Patient has a low score on the Berg balance test, has difficulty with foot clearance during gait. In addition, O2 sats drop to 88 after 4 minutes of moderate activity. Hip flexors at 3/5 strength which impairs the ability to obtain good foot clearance.

On unit: Patient walks ad lib, but appears out of breath after a few minutes. Often reaches for rails or furniture to steady self. Gait is not fluid.

Is This Better?

Therapy says: High risk for falls due to results of Berg. Increasing balance challenges and leaving base of support. Focusing on hip flexor strength to improve foot clearance. Training in diaphragmatic breathing to improve O2 sats.

Nursing note: Patient able to walk independently but gait is impaired. Note breathlessness after short intervals.

Is medical necessity more obvious? How about skill?

Opportunity for QAPI? Collaborative?

Key Terms
Research vs. Quality Improvement

Quality of care research: Systematic examination of how people get access to health care, how much care costs, and what happens to patients as a result of this care, which is intended to identify the most effective ways to organize, manage, finance, and deliver high quality care; reduce medical errors; and improve patient safety.

Collaborative inter-organizational quality improvement: Initiatives in which multiple separate health care entities participate and work together to analyze performance and make systematic efforts to improve it.

https://www.qualitymeasures.ahrq.gov/

Collaborative Documentation

- **If discrepancy exists, nursing documentation will win.**
- **Medicare views nursing documentation to be representative of what is actually happening functionally on a day to day basis.**
- **Communication is fundamental – more on this later…**
- **Barriers to this:**
  - MDS
  - 24/7 vs. 1 hour a day
  - Patient time for nurses vs. nurse aides vs. therapy staff
  - Time to talk/collaborate

A Word About ADLs

- **Are you confident in ADL coding?**
- **Does it align with what rehab is saying?**
- **Patient may be more independent in rehab then on the MDS.**
- **What if MDS says they are MORE independent than rehab?**
- **Likely denial**

ADL examples

- Patient rolls side to side in bed by using half rails. They do this independently. Coded as such on MDS
- Rehab has goals for bed mobility and rates them "mod assist"
- Both statements may be accurate.
- ADL may have been coded based upon only part of the description.
- Rehab may be focusing on supine to sit, not rolling.
- Bed Mobility MDS: "how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture."

ADL Example

- OT working on clothing adjustment while toileting. Focusing on balance and use of adaptive equipment to facilitate this action.
- On unit, patient transfers on and off toilet independently. Coded as such on MDS.
- MDS: Toilet Use: "how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet, cleanses self after elimination, changes pad, manages ostomy or catheter; and adjusts clothes.
- Discrepancy = denial

ADL Example

- Patient eats and drinks by himself. Coded as independent.
- OT working on fine motor skills and grip strength to facilitate independence with eating as he wishes to live alone. Currently unable to open milk, cut food or open condiments.
- Discrepancy = denial
- MDS: Eating: " how resident eats and drinks, regardless of skill."
- Would this patient actually be "1" or supervision?

MDS

- Does not make collaboration easy!
- It is possible to make great gains in rehab (i.e. from max assist to min assist) but the MDS will remain the same at "extensive"
- "Extensive" on MDS equates to min/mod OR Max assist in rehab documentation. It implies nursing staff needs to actively guide and touch with more than "palms up" approach.
- "Limited" assist on MDS implies "palms up" only approach. It equates to CGA assist in rehab documentation.
- Good first step is to understand each others' lingo

Rehab Lingo

- Independent: No assistance
- Modified I: No assistance but needs equipment or more time
- Supervision: Observe from a distance, may need cues or set up, no physical assist
- SBA: Close supervision, no physical assist
- CGA: Minor contact may be necessary. May be unsteady
- Min: Patient routinely needs 25% assist (can be physical or cognitive assist)
- Mod: Patient routinely needs 50% assist
- Max: Patient routinely needs 75% assist
- Dependent: Needs 100% assist

24 and 7 vs. 1 hour

- Patients belong to nursing. They are yours 24 and 7!
- Rehab sees them about 1 hour a day.
- Rehab needs to communicate what the patient is capable of and how.
- Nursing needs to communicate when/why it's not possible.
- If the barriers to capability are related to underlying impairments rehab treats, (and this is documented), it all helps to tell that story. The story of skilled need.

TIME

- Nurse aides often spend the most time with patients.
- They record information such as ADL statistics
- But who writes the notes??? Nurses.
- How confident are you that aides are passing on information that is detailed and accurate?
- Do they understand the full definitions in the ADL section of the MDS?

Example

Aide sees: Patient required assist with lowering legs out of bed for transfer. Needed limited assist for transfer from bed to w/c. Needed help to put shoes on. Loses balance when making the turn in to the bathroom. Cues to use walker correctly and safely. Drinks thin liquids but coughs when using a straw.

Medical record charting is accurate but says only: "Alert and verbal. Patient ambulates ad lib. Takes thin liquids."

TIME – Rehab Perspective

- Often use assistants, but therapists see what they do, read/co-sign notes. Our barrier is not as great as the aide/nurse divide.
- But…..therapists dislike documenting as much as nurses.
- Rehab departments have productivity standards just like most industries. It's reality.
- Documentation time is NOT considered a billable service.
- Point of service is often an option.

Section GG
(slides 40 – taken from SNF QRP training on 6/21/16 per CMS)

- •The Improving Medicare Post-Acute CareTransformation Act of 2014 (IMPACT Act) requires that CMS implement cross-setting quality measures, and the items in Section GG are used to calculate this measure.
- •These items assess the need for assistance with self-care and mobility activities.
- •Items focus on resident's self-care and mobility:
- –Admission performance
- –Discharge goals
- –Discharge performance

aegis therapies 52

Section GG: Which Staff Members Should Complete This Section?

- •Refer to facility, Federal, and State policies and procedures to determine which staff member may complete an assessment, as resident assessments are to be done in compliance with facility, Federal, and State requirements.
- •Physical therapists, occupational therapists, speech language pathologists, and nurses are the typical staff involved in the assessment of self-care and mobility items.

aegis therapies 53

GG0130: Self-Care – Admission (Start of SNF PPS Stay)

GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper [illegible]

If activity was not attempted, code reason:
07. **Resident refused.**
09. **Not applicable.**
[illegible]

	1. Admission Performance ↓ Enter Codes in Boxes ↓	2. Discharge Goal ↓
A.	☐☐	☐☐
B.	☐☐	☐☐
C.	☐☐	☐☐

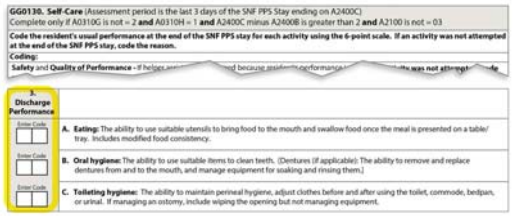
A. **Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.

B. **Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]

C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

aegis therapies 54

GG0130: Self-Care – Discharge (End of SNF PPS Stay)



GG0130. Self-Care (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

Coding:

Safety and **Quality of Performance** - If helper

3. Discharge Performance	
Enter Code	**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/ tray. Includes modified food consistency.
Enter Code	**B. Oral hygiene:** The ability to use suitable items to clean teeth. (Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.)
Enter Code	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

aegis therapies

55

GG0170: Mobility (3-Day Assessment Period) Admission (Start of SNF PPS Stay)

Code the resident's usual performance at the start of the SNF PPS stay for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale.

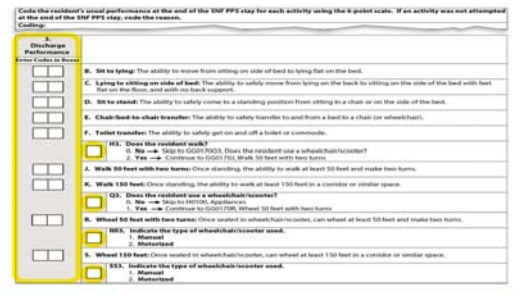
Coding:

1. Admission Performance Enter Codes in Boxes	2. Discharge Goal Enter Codes in Boxes	
		B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
		C. Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
		D. Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
		E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).
		F. Toilet transfer: The ability to safely get on and off a toilet or commode.
		H1. Does the resident walk? 0. **No,** and walking goal is not clinically indicated → Skip to GG0170Q1. Does the resident use a wheelchair/scooter? 1. **No,** and walking goal is clinically indicated → Code the resident's discharge goal(s) for items GG0170J and GG0170K 2. **Yes** → Continue to GG0170J, Walk 50 feet with two turns
		J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
		K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
		Q1. Does the resident use a wheelchair/scooter? 0. **No** → Skip to GG0130, Self-Care 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
		R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.
		RR1. Indicate the type of wheelchair/scooter used. 1. **Manual** 2. **Motorized**
		S. Wheel 150 feet: Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
		SS1. Indicate the type of wheelchair/scooter used. 1. **Manual** 2. **Motorized**

aegis therapies

56

GG0170: Mobility (3-Day Assessment Period) Discharge (End of SNF PPS Stay)



Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

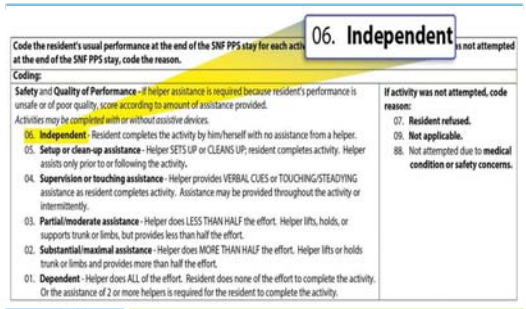
Coding:

3. Discharge Performance Enter Codes in Boxes	
	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
	C. Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
	D. Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
	E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).
	F. Toilet transfer: The ability to safely get on and off a toilet or commode.
	H3. Does the resident walk? 0. **No** → Skip to GG0170Q3. Does the resident use a wheelchair/scooter? 1. **Yes** → Continue to GG0170J, Walk 50 feet with two turns
	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
	Q3. Does the resident use a wheelchair/scooter? 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.
	RR3. Indicate the type of wheelchair/scooter used. 1. **Manual** 2. **Motorized**
	S. Wheel 150 feet: Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
	SS3. Indicate the type of wheelchair/scooter used. 1. **Manual** 2. **Motorized**

aegis therapies

57

Scoring Example



aegis therapies

58

Verbiage

- Residents should be allowed to perform activities as independently as possible, as long as they are safe.
- If the resident's mobility performance varies during the assessment period, **report the resident's usual status**, not the resident's most independent performance and not the resident's most dependent episode.

aegis therapies

59

Collaboration Strategies

- **The Medicare Meeting:**
  - All have one
  - Make it count
  - Ask: "What's the need?" "What's the skill?"
  - Write the note during the meeting
  - Function or problem oriented
  - Consider nurse aide in attendance
  - Tools to facilitate this conversation to follow

aegis therapies

Collaboration Strategies

- **Join a therapy session**
  - Perfect opportunity to talk to patient and therapist about status and progress and continued needs
  - Perfect opportunity for point of service documentation

Tools

- **Can be used in Medicare meeting**
- **Or other face to face times (in a therapy session)**
- **Used by aides as they work with patients**
- **Left at nurse's station as documentation guides**

FUNCTIONAL ABILITY

Date: _____ Resident:

_____

Medical Diagnosis:

_____

Therapy/Treatment Diagnosis:

_____

This checklist is designed to assist the charting nurse in describing the patient's functional ability on the unit. The intent is to help facilitate nursing documentation that is functional in nature and reflects the patient's performance as it relates to their rehab program. The rehab activity or program is checked and corresponds to suggested patient activities, or functional performances which might be noted in the nursing narrative.

Occupational Therapy

Rehab Activity	**Suggested Nursing Observation/Documentation**
____Feeding	Describe patient's ability to feed self. This comment should include any set up needed, as well as any assistive devices the patient is using. Is there any cueing required? (example: The patient feeds self 50% of meal using a built up spoon and plate guard.)

Tools

- **Can be checked by rehab and left on unit.**
- **Each discipline has a page.**
- **Each discipline has functional areas.**
- **Functional areas have suggested focus areas for documentation.**
- **Lends itself to individualized documentation, less "cookie cutter" than sample phrases.**
- **How might this be useful to you?**

Physical Therapy
Documentation to support the need for PT

Resident requiring additional assistance to walk due to _____ (loss of balance, falls, unsteadiness, weakness in legs, etc.)
Resident has had episode(s) of near falls
Resident demonstrates decreased walking distance with unsteady gait. (i.e. was walking to the dining room but now only walking in room)
Resident appears fatigued or SOB with ambulation

Documentation to support progress made with SLP

SLP provide training on use of external memory aid. Patient able to use to remember ….
SLP provide training to on appropriate positioning to reduce patient specific swallowing issues. Less coughing noted during meals.
SLP provided training on how to elicit yes/no responses from patient. Patient now able to select clothing for the day.

Tools

- Useful guide for both establishing the need for rehab as well as support for continued need.
- Can be used during Medicare meeting.
- Can be used at nurse's station.
- Discipline specific.
- Not accompanied by functional areas and can be "cookie cutter".
- How might you use this??

CHECKLIST FOR COLLABORATIVE DOCUMENTATION FOR THERAPY SERVICES

_____Transfer ability
_____Ambulation
_____Assertive device needed—if so what
_____Number of feet ambulated

Tools

- Easy to read
- Focus areas can be pre-checked by rehab.
- Can be left at nurse's station.
- Useful reminder, but not very specific to each week's status.
- How might you use this??

Nursing Documentation suggestions to support…..PT…..OT…..ST
PT
Nursing Documentation Examples

Bed mobility	Resident holds onto bed rail to pull self onto R or L side. Pillow is placed between knees.
Transfers	Resident sits with assistance but cannot stand up without assistance of 2 nursing staff. OR Resident needs assistance of 2 nursing staff to stand. Unable to bear weight on legs. Needs support at knees to keep from buckling.
Walk in room Walk in corridor	Working with therapist on ambulation training. Unsafe with nursing staff.

Tools

- Discipline specific.
- Identified functional areas.
- One page.
- Can be left at nurse's station.
- Could become repetitive.
- How might you use this???

Nursing Supportive Documentation Tool

Problem	What to document

Tools

- May be useful to support the medical necessity for rehab.
- Specific to positioning.
- Some opportunity for individualization.
- How might you use this???

Additional Tips/Thoughts

- Does rehab audit their documentation?
  - Timeliness
  - Completeness
  - Quality audits
- Is there an opportunity to view nursing doc and rehab doc side by side?

Education

- Newer therapists (and older) often do not understand the importance of doc.
- Is this true for nurses as well?
- What education is provided to nursing staff?
- Education or "tip sheets" for aides on ADL definitions.
- Does your rehab provider mandate documentation training?

TRANSLATING RESEARCH INTO PRACTICE

The PAC-QAPI Files

CASE REVIEW

K.I.S.S.

"Organizations must invest in the tools and skills needed to create a culture of evidence-based practices where questions are encouraged and systems are created to make it <u>easy</u> to do the right thing."

- Titler, 2010: Translation Science and Context

Measure & Improve…

Old Habits

New Habits

Documentation Dream

Electronic Medical Records Decision Support

Imagine....

1. Field Consolidation
2. Problem-Oriented Documentation
3. Nursing-Rehab Relationships

Data Analysis – Methods

- To evaluate the effect of Documentation Redesign (field consolidation and PODs) on documentation quality
- To evaluate standardized rehab measures and its relationship to function among SNF in-patients with multiple chronic conditions
- Training. Follow up audits. Statistical Analysis

http://www.ihi.org/

Results

Competent § 483.70(e)?

Most frequent primary **medical diagnosis**. Excludes episodes with missing values *n*=1064 (4.4%). Partitioned row represents least frequent.

Utilization
Joint/FX?
Cardiopulmonary?

Primary Medical Diagnosis (ICD-9 code)	Frequency (%) [Cum %] *N*=13,161
Muscle weakness, generalized (728.87)	1197 (5.0)[5.2]
Other cerebrovascular disease (436.0)	1008 (4.2)[9.6]
Fracture, neck of femur closed (820.8)	969 (4.0)[13.8]
Urinary tract infection, site not specified (599.0)	764 (3.2)[17.1]
Pneumonia, unspecified organism (486.0)	760 (3.2)[20.4]
Congestive heart failure, unspecified (428.0)	597 (2.5)[23.0]
Primary generalized OA (715.0)	584 (2.4)[25.5]
Altered mental status, unspecified (780.97)	432 (1.8)[27.4]
Acute respiratory failure, unspecified (518.81)	406 (1.7)[29.1]
Pain in unspecified knee (719.46)	378 (1.6)[30.8]
...	...
Complications of surgical and medical care (999.9)	1 (0.0)[100.0]

Results

Addressing NEED (Competent § 483.70(e)?)		Count	Frequency % *N*=24,111
ROM Description	Gait - Level Surfaces	3831	15.9%
	Dressing	3767	15.6%
	Bed Mobility	3138	13.0%
	Transfers	2714	11.3%
	Cognitive Linguistics	1567	6.5%
	Stair Climbing	1524	6.3%
	Bathing / Showering	983	4.1%
	Toilet Hygiene	948	3.9%
	Swallowing	854	3.5%
	Home Management	691	2.9%
	Meal Preparation / Cleanup	470	1.9%
	Standing Balance	376	1.6%
	Grooming / Hygiene	355	1.5%
	Feeding	261	1.1%
	Gait - Uneven Terrain	227	0.9%
	Exercise / Ambulate	218	0.9%

Measures
%Mobility?
%ADLs?

Pain?

ROM deficit areas. Excludes episodes with missing values *n*= 1075 (4.5%)

Outcomes

FIELD CONSOLIDATION AND PODS

- Most fields maintained quality after the consolidation. One field did not, resulting in re-activating that field
- Rehab documentation quality significantly improved after POD Among the doc quality grades that changed within each POD condition, the majority improved (69.7%).

NURSING-REHAB ASSOCIATIONS

- Standardized rehab measure is related to functional gain captured in the MDS and discharge destination.
- MDS D/C disposition significantly related to the > variance rehab measure d/c scores, thus **validation of nursing care burden**

Questions

Thank You

CHECKLIST FOR COLLABORATIVE DOCUMENTATION FOR THERAPY SERVICES

_____Transfer ability

_____Ambulation

_____Assertive device needed—if so what

_____Number of feet ambulated

_____Weight bearing status

_____Balance problems

_____Safety factors

_____Complaints of fatigue/rest requirements

_____Complaints of pain

_____Assistive requirements to perform ADL's (feeding, bathing, dressing, grooming)

_____Ability to communicate

_____Ability to follow directions

_____Ability to swallow

_____Ability to respond to questions

COLLABORATIVE NURSING DOCUMENTATION

The following section is designed to assist the clinician in providing information to the nursing staff in effort to facilitate collaborative nursing documentation regarding a patient receiving therapy.

There are discipline specific checklists that provide corresponding suggestions for nursing documentation.

These materials are also valuable to use for an in-service to the nursing staff regarding how nursing can best describe a patient's functional status/ability.

REHAB/NURSING DOCUMENTATION OF FUNCTIONAL ABILITY

Date: _____ Resident: _____
Medical Diagnosis: _____
Therapy/Treatment Diagnosis: _____

This checklist is designed to assist the charting nurse in describing the patient's functional ability on the unit. The intent is to help facilitate nursing documentation that is functional in nature and reflects the patient's performance as it relates to their rehab program. The rehab activity or program is checked and corresponds to suggested patient activities, or functional performances which might be noted in the nursing narrative.

Occupational Therapy

Rehab Activity	Suggested Nursing Observation/Documentation
____Feeding	Describe patient's ability to feed self. This comment should include any set up needed, as well as any assistive devices the patient is using. Is there any cueing required? (example: The patient feeds self 50% of meal using a built up spoon and plate guard.)
____Grooming/Hygiene	Discuss the resident's ability to self-groom and perform routine ADL tasks. Please describe the use of any adaptive equipment or other assistance needed such as cueing or set up (example: Brushes teeth and combs hair if prompted by staff.)
____Bathing	Please note the resident's ability to bathe or participate in the bathing/showering process. This should include the ability and degree of participation exhibited by the resident as well as any assistance required. (example: Resident needs assistance with tub and shower. Is able to wash face and upper body with set up and minimal cueing.)
____Dressing	Please note the resident's ability to perform or participate in dressing. Use of adaptive devices or any required assistance should be noted. (example: Patient puts on own shirt. Requires staff assistance to dress lower body and is unable to use reacher yet.)
____Sitting Balance	Describe the resident's ability to balance unsupported. This should be functional and include the activity requiring balance. (example: Resident sits at bedside for meals, but becomes fatigued by the end of meal.)
____Transfers	Observations of the resident's ability to transfer should be noted including ability and participation, as well as any assistance needed. (example: Transfer to raised toilet seat with assist of one nurse aide.)
____W/C Mobility	This note should include a statement concerning maneuvering skill as well as endurance. (example: Resident propels self from bed to hall, endurance is poor, forgets to lock brakes.)
____Activity Tolerance	Observations related to resident's endurance for sitting and participation in an activity should be made. (example: The resident complains of fatigue after sitting 1 – 1 ½ hours in a wheel chair.)

COMMENTS: _____
_____
_____

REHAB/NURSING DOCUMENTATION OF FUNCTIONAL ABILITY

Date: _____ Resident: _____
Medical Diagnosis: _____
Therapy/Treatment Diagnosis: _____

This checklist is designed to assist the charting nurse in describing the resident's functional ability on the unit. The intent is to help provide nursing documentation that is functional in nature and reflects the resident's performance as it relates to their Rehab program. The Rehab activity or program is checked and corresponds to suggested resident activities, or functional performances which might be noted in the nursing narrative.

Speech Therapy

Rehab Activity	Suggested Nursing Observation/Documentation
____Swallowing/Chewing	Notes should include mention of the resident's ability to swallow including drooling, difficulty chewing, pocketing, coughing, choking, gagging. (example: Resident drools when give PO water. Resident coughs occasionally when given PO fluids.)
____Speech	Describe the resident's ability to be understood verbally. Include comments about intelligibility and length of sentences or word strings. (example: Speech is difficult to understand, single words are only occasionally understood.)
____Cognitive Retraining	The level of cognitive ability should be described in functional terms. Describe orientation to self-time and staff include impact of cognition or orientation to ADLs. (example: The resident is oriented to self only and is easily confused and distracted during meals.)
____Auditory Comprehension	Please note resident's ability to understand the spoken word. Does the resident respond appropriately to verbal instructions? Do comprehension problems affect ADLs? (example: Resident requires cueing and supervision for dressing and meals.)

COMMENTS: _____
_____
_____
_____

REHAB/NURSING DOCUMENTATION OF FUNCTIONAL ABILITY

Date: _____ Resident: _____
Medical Diagnosis: _____
Therapy/Treatment Diagnosis: _____

This checklist is designed to assist the charting nurse in describing the resident's functional ability on the unit. The intent is to help provide nursing documentation that is functional in nature and reflects the resident's performance as it relates to their Rehab program. The Rehab activity or program is checked and corresponds to suggested resident activities, or functional performances which might be noted in the nursing narrative.

Physical Therapy

Rehab Activity	Suggested Nursing Observation/Documentation
____Ambulation	Address the resident's ability to ambulate on the unit. Include distance and any assistance required. This could include staff or a device such as a walker. (example: Ambulates in hall with the assistance of a CNA. Resident ambulates 25 feet to and from the bathroom with a walker and contact guard of one.)
____Transfers	Discuss the resident's ability to transfer and how much assistance if any is required. (example: Resident transfers from bed to chair with the assistance of one CNA. Resident requires cueing not to bear weight on left leg.)
____Bed Mobility	Describe the resident's ability to move about the bed including positioning devices used and assistance provided. (example: Resident rolls side to side with use of the side rails with minimal cueing. A pillow is placed between knees.)
____Supine to Sit	Describe resident's ability to sit up from a recumbent position. Include any assistive devices such as half rails or staff assistance.
____Sit to Stand	Describe the resident's ability to rise from a sitting position. Include any assistance required as well as an understanding of any compensatory techniques. (example: Resident needs assist of 2 to stand. Unable to bear weight on legs. Needs support at knees to keep from buckling.)
____Balance	Discuss the resident's ability to sit or stand without loss of balance. This should include any compensatory devices or assistance required.

COMMENTS: _____
_____
_____
_____

SUPPORTIVE NURSING DOCUMENTATION

Occupational Therapy

The following table provides examples of how nursing can document resident status related to *occupational therapy.*

MDS Section to Review	MDS Title/Functional Skill	Nursing Documentation Example
G1b(A.B.)	Transfers	Transfers to raised toilet seat with assist of one nurse aide.
G1e	Locomotion on unit/wheelchair skills	Wheelchair endurance poor; forgets to lock brakes. Resident complains of fatigue after sitting 1 – 1 ½ hours in wheelchair.
G1f	Locomotion off unit (outside room)	Resident propels self from bed to hall. Requires frequent rests.
G1g(A.B.)	Dressing	Resident puts on own shirt. For lower body dressing, he needs nursing staff assist as he is not yet able to use reacher.
G1h(A,B)	Eating	Feeds self 50% of meal with built-up spoon; some pocketing of food in right cheek.
G1j(A,B)	Personal hygiene	Brushes teeth and combs hair if prompted by nursing staff.
G2(A,B)	Bathing	Needs nursing staff assist with tub and shower. Attempts to wash face and upper body.
G3b	Sitting balance	Sits at bedside to eat meals, but becomes fatigued by end of meal.

SUPPORTIVE NURSING DOCUMENTATION

Speech Therapy

The following table provides examples of how nursing can document resident status related to *speech-language pathology*.

MDS Section to Review	MDS Title/Functional Skill	Nursing Documentation Example
B3	Orientation	Resident is oriented to place and person, but not time. **NOTE:** If the resident is not oriented, nursing should report how the disorientation is interfering with ADLs.
C3	Modes of expression	Resident is using a communication board to request items. When communication board is offered, resident uses it to request items for ADLs. Nursing staff uses board to get the resident to express needs. Does not consistently follow instructions.
C4	Making self understood	Listening to resident is confusing. Resident is unable to make himself understood with any degree of consistency. Speech is difficult to understand; occasional single words understood. Resident is unable to explain what he wants. Attempts to point but is unsuccessful.
C6	Ability to understand others	Smiles and turns head when greeted. Resident follows simple commands but cannot express needs. Nods yes/no, but not always correctly.
K1b	Swallowing problem	Resident has difficulty swallowing liquids. Resident coughs frequently when eating. Resident pockets food.

SUPPORTIVE NURSING DOCUMENTATION

Physical Therapy

The following table provides examples of how nursing can document resident status related to *physical therapy*.

MDS Section to Review	MDS Title/Functional Skill	Nursing Documentation Example
G1a(A,B)	Bed mobility	Resident holds onto bed rail to pull self onto right or left side. Pillow is placed between knees.
G1b(A,B)	Transfers	Resident sits with assist, but cannot stand up without assistance of two nursing staff.
		Resident needs assist of two nursing staff to stand. Unable to bear weight on legs. Needs support at knees to keep from buckling.
G1c(A,B)	Walks in room	Working with therapist on ambulation training. Unsafe with nursing staff
G1d(A.B.)	Walks in corridor	
G1e(A.B.)	Locomotion on unit	Attempts to take several steps when transferring from bed to chair. Unsafe with nursing staff.
GF(A.B.)	Locomotion off unit	Resident is receiving training in stair climbing with physical therapists to prepare for D/C home.

PT Nursing Documentation Examples

Bed mobility	Resident holds onto bed rail to pull self onto R or L side. Pillow is placed between knees.
Transfers	Resident sits with assistance but cannot stand up without assistance of 2 nursing staff, OR Resident needs assistance of 2 nursing staff to stand. Unable to bear weight on legs. Needs support at knees to keep from buckling.
Walk in room Walk in corridor	Working with therapist on ambulation training. Unsafe with nursing staff
Locomotion on unit	Attempts to take several steps when transferring from bed to chair. Unsafe with nursing staff.
Locomotion off unit	Resident is receiving training in stair climbing with physical therapists to prepare of D/C home.

ST Nursing Documentation Examples

Orientation	Resident is oriented to place & person, but not time. NOTE: If resident is not oriented, nursing should report how the disorientation is interfering with ADL's.
Modes of Expression	Resident is using a communication board to request items. When communication board is offered, resident uses it to request items for ADL's. Nursing staff uses board to get the resident to express needs. Does not consistently follow instructions.
Making Self Understood	Listening to resident is confusing. Resident is unable to make himself understood with any degree of consistency. Speech is difficult to understand; occasional single words understood. Resident is unable to explain what he wants. Attempts to point but is unsuccessful.
Ability to Understand	Smiles & turns head when greeted. Resident follow simple commands, but cannot express needs. Nods yes/no, but not always correctly.
Swallowing problem	Resident has difficulty swallowing liquids. Resident coughs frequently when eating. Resident pockets food.

OT Nursing Documentation Examples

Transfers	Transfers to raised toilet seat with assistance of one nurse aide.
Locomotion on unit/Wheelchair skills	Wheelchair endurance poor; forgets to lock brakes. Resident fatigue after sitting 1 – 1 ½ hours in wheelchair.
Locomotion off unit/outside room	Resident propels self from bed to hall. Requires frequent rests.
Dressing	Resident puts on own shirt. For lower body dressing, he needs nursing staff assistance as he is not yet able to use reacher.
Eating	Feeds self 50% of meal with built up spoon; some pocketing of food in right cheek.
Personal Hygiene	Brushes teeth and combs hair if prompted by nursing staff.
Bathing	Needs nursing staff to assist with shower.
Sitting balance	Sits at bedside to eat meals but becomes fatigued by end of meal.

Other documentation hints:

Psych. Medications: target behavior, interventions prior to use, non-med interventions.
Tube Feeding: bowel sounds, lung sounds due to potential for aspiration, tolerance-diarrhea/vomiting.
Hydration Status: skin turgor, oral mucous, taking fluids, fluid restrictions.
HTN: facial flushing, headache, dizzy, tinnitus, epistoxis.
Wounds: response to TX, s/s infections, pain.
DM: s/s hypo/hyperglycemia, if IDDM-why unable to inject.
Wt: up or down.
Respiratory-based DX: lung sounds, sob, response to o2-inhalers-TX.
Labs: abnormal values.

Nursing Documentation <u>suggestions</u> to support…..PT…..OT…..ST

PT	Nursing Documentation Examples
Bed mobility	**Resident holds onto bed rail to pull self onto R or L side. Pillow is placed between knees.**
Transfers	**Resident sits with assistance but cannot stand up without assistance of 2 nursing staff, OR Resident needs assistance of 2 nursing staff to stand. Unable to bear weight on legs. Needs support at knees to keep from buckling.**
Walk in room Walk in corridor	**Working with therapist on ambulation training. Unsafe with nursing staff.**
Locomotion on unit	**Attempts to take several steps when transferring from bed to chair. Unsafe with nursing staff.**
Locomotion off unit	**Resident is receiving training in stair climbing with physical therapists to prepare of D/C home.**

ST	Nursing Documentation Examples
Orientation	**Resident is oriented to place & person, but not time. NOTE: If resident is not oriented, nursing should report how the disorientation is interfering with ADL's.**
Modes of Expression	**Resident is using a communication board to request items. When communication board is offered, resident uses it to request items for ADL's. Nursing staff uses board to get the resident to express needs. Does not consistently follow instructions.**
Making Self Understood	**Listening to resident is confusing. Resident is unable to make himself understood with any degree of consistency. Speech is difficult to understand; occasional single words understood. Resident is unable to explain what he wants. Attempts to point but is unsuccessful.**
Ability to Understand	**Smiles & turns head when greeted. Resident follow simple commands but cannot express needs. Nods yes/no, but not always correctly.**
Swallowing problem	**Resident has difficulty swallowing liquids. Resident coughs frequently when eating. Resident pockets food.**

OT	Nursing Documentation Examples
Transfers	**Transfers to raised toilet seat with assistance of one nurse aid.**
Locomotion on unit/Wheelchair skills	**Wheelchair endurance poor; forgets to lock brakes. Resident fatigue after sitting 1to 1 ½ hours in wheelchair.**
Locomotion off unit/outside room	**Resident propels self from bed to hall. Requires frequent rests.**
Dressing	**Resident puts on own shirt. For lower body dressing he needs nursing staff assistance as he is not yet able to use reacher.**
Eating	**Feeds self 50% of meal with built up spoon; some pocketing of food in right cheek.**
Personal Hygiene	**Brushes teeth and combs hair if prompted by nursing staff.**
Bathing	**Needs nursing staff to assist with shower. Attempts to wash face and upper body.**
Sitting balance	**Sits at bedside to eat meals but becomes fatigued by end of meal.**

Nursing Supportive Documentation Tool

Problem	What to document
Slides out of chair (sacral sitting)	Res. sliding out of chair, high fall risk, unable to maintain safe position for function.
Falls out of chair (poor position in space.	Res. Unable to reposition self in w/c, has had a fall from the w/c.
Sitting tolerance	Res. Unable to remain up in w/c (or geri- Chair) due to pain, weakness or deformity longer than ___; unable to participate in facility activities.
Pressure areas	Res has a stage ___ on ___ (site) and unable to remain up in w/c without risk of further breakdown in current out of bed positioning.
Poor head position	Res. Exhibits poor head control, limits interaction with staff and co-residents, environment, participation in activities, etc. (list out what other areas may be affected).
Poor neck position	Poor head/neck control results in difficulty swallowing, high risk for unsafe swallow.

Lateral Lean	Res. Leaning to ___ (direction), unable to maintain posture in w/c without assistance
Self propel	Decreased w/c mobility. UE/LE weakness or reach needed to propel w/c.
Transfers	Unable to transfer self safely. Staff experiencing increased difficulty transferring resident.
Functional Reach	Res. Experiencing difficulty reaching areas necessary for personal needs as a result of poor posture.
Tone	High tone resulting in extension or flexion in w/c, or low tone resulting in inability to maintain an upright posture
Contractures	UE/LE contractures impairs safe sitting position at risk for further contracture or fall from chair
Pain/Edema	Pain or edema as a result of poor posture

Therapy Related Charting Phrases for Nursing Documentation

Physical Therapy

Documentation to support the need for PT

- Resident requiring additional assistance to walk due to _____ (loss of balance, falls, unsteadiness, weakness in legs, etc.)
- Resident has had episode(s) of near falls
- Resident demonstrates decreased walking distance with unsteady gait. (i.e. was walking to the dining room but now only walking in room)
- Resident appears fatigued or SOB with ambulation
- Resident requiring increased assistance to transfer
- Resident requires increased assistance to move self or reposition in bed
- Resident has become increasingly unsafe while walking or transferring
- Resident complaining of pain
- Resident has decreased use of wheelchair to get around in facility
- Resident exhibits decreased range of motion
- Patient able to ambulate however displays shuffling gait. PT recommended for falls prevention program.
- Established Functional maintenance program no longer appropriate due to_____

Documentation to support progress made with PT

- Resident walking has improved due to participation in PT. Resident now able to walk with assistance to the bathroom. Gait still unsteady therefore continued therapy needed
- PT provided training on modified transfer technique to increase safety with transfers.
- PT provided training on optimal bed positioning techniques due to left side weakness.
- Patient now requires less assistance with bed mobility tasks
- Restorative nursing currently following walk to dine program established by PT

Occupational Therapy

Documentation to support the need for OT

- Resident now requiring more assistance with self care (dressing, bathing, toileting, grooming/hygiene, self feeding)
- Resident displays difficulty manipulating objects such as buttons, containers, utensils, writing objects, etc)
- Resident is unable to sit upright in wheelchair and is therefore required more assistance with self-feeding.
- Resident exhibits decreased range of motion in R hand.

- Resident is unable to maintain position in bed, (slides, stays on one side, appears to have contractures
- Residents splint no longer fits appropriately
- Resident exhibits increased confusion interfering with care, resulting in decreased participation in self care, decreased participation in activities, social isolation, abusive or combative behavior, impulsive behaviors placing patient at risk for falls
- Resident is unsafe with ADL tasks
- Resident is having increased episodes of incontinence
- Impaired vision inhibiting participation in self-care, activities, placing patient at risk for falls
- Patient currently a passive participate in activities program because of cognitive impairment. OT indicated to provide training on specific ADL and activity strategies based on her cognitive level.
- Resident at risk for decline in ADL and motor skills because of Dementia. OT indicated to develop functional maintenance program based on cognitive level.
- Patient at risk for additional decline in ROM because of sever tone therefore OT indicated to develop a contracture management program.
- Patient has visual problems. Room modifications implemented as recommended by OT increase independence.

Documentation to support progress made with PT

- Self-feeding skills have improved due to progress with OT treatment. Continued OT indicated to improve self-dressing skills.
- ADL skills have improved and patient now able to dress upper body after-set as per instructions by OT. Continued OT needed due to address safely issues with lower body dressing.
- OT provided instructors on room modifications to reduce falls
- OT provided training on compensatory strategies to help reduces left side neglect.
- OT provided training on contracture management program for L hand.
- OT provided training on ADL routine and activity programming based on the patient's cognitive level of function.

Speech Therapy

Documentation to support the need for SLP

- Resident unable to express wants/needs
- Caregivers unable to understand resident's attempts to express wants/needs
- Resident exhibiting negative behavior due to inability to communicate
- Resident unable to swallow meds
- Resident complaining of feeling of food/meds sticking in throat

- Resident with episodes of coughing/choking, gagging during meals
- Resident exhibits clear runny nose during and/or after meals
- Resident exhibiting increased confusion, unable to find way around facility
- Resident exhibits decreased interaction with staff/co-residents, decreased participation in activities
- Resident on restricted diet (textures- puree, mechanical soft, honey thickened liquids, NPO, etc) but patient observed eating food/drinking liquids not allowed with no apparent signs of aspiration, family brings patient hamburgers weekly which patient eats without apparent difficulty.
- Patient at increased risk for falls due to inability to communicate. SLP need to develop compensatory communication strategies.
- Previous FMP longer appropriate due to _____
- Patient at risk for further decline with cognitive/ communication skills due to medical history of _____

Documentation to support progress made with SLP

- SLP provide training on use of external memory aid. Patient able to use to remember ….
- SLP provide training to on appropriate positioning to reduce patient specific swallowing issues. Less coughing noted during meals.
- SLP provided training on how to elicit yes/no responses from patient. Patient now able to select clothing for the day.
- SLP provided training on how to use communication board. Patient able to us communication board to express basic wants and needs.
- Family currently following commutation program developed by SLP.