Nursing & Therapy Documentation Tips

Lisa Werner, MBA, MS, CCC-SLP

Better outcomes for everyone.
The goals of the team documentation are:

- Tell the story of the patient’s stay
- Communicate *why* you made the treatment decisions for care rendered
- Indicate *how* the patient progressed
- Present the barriers to discharge or safety concerns throughout the stay
- Let the service provider treating the patient next know what to expect
• Proving necessity of the skilled service:

- Reviewers look for evidence that the patient requires continued skilled services. This is shown through the treatment/progress notes:
  - Write progress notes that clearly explain the skilled services delivered in each treatment session.
• Team has an ongoing opportunity to document medical necessity. This is achieved by documenting:

- That services needed are of a complex nature that they require a licensed clinician

- Services are consistent with diagnosis, need, and medical condition

- Services are consistent with the treatment plan

- Services are reasonable and necessary

- Patient is making progress towards reasonable goals
Plan of Care

• Medicare wants to see the treatment plan is determined by and coordinated by the physician
  ▪ Admission Orders
    • Should indicate all therapeutic disciplines ordered – INCLUDING Rehabilitation Nursing
      ▪ If “evaluate and treat” must follow up with a clarification order
      ▪ If specific interventions are indicated the disciplines MUST have them in their plan of care

Better outcomes for everyone.
• **Nursing Admission Assessment:**
  - Consideration: IRF specific assessment vs house-wide assessment
  - What are the differences?
    - Review of current status?
    - Review of systems?
    - Problem list?
  - Where does it come together?
    - Plan of Care
  - How does it come together?
    - Use the findings in the assessment to develop goals
    - Determine what is most important to the patient
    - Use judgment to assess the factors that will most significantly impact the patient’s ability to return to independence
Plan of Care

• **How do you develop a plan of care?**
  - Physician plan drives the plan of care for clinicians
  - All clinicians document consistent findings
  - Goals are clear, measurable, functional

• **How do you document the plan of care?**
  - All clinicians document on the same form (Best Practice)
  - Everyone is aware of the team goals and supports them through treatment
• **Establishing barriers:**
  - Plan of care should answer these questions:
    - Why does the patient need a stay in inpatient rehabilitation?
    - What difference will inpatient rehabilitation make in this patient’s quality of life?
  - Problem list:
    - List the problems requiring post-acute services
    - Indicate which professionals will work on reducing the barriers
    - Set goals for how much progress will be made
    - Indicate time frame for resolving the barriers
• **Goal setting:**
  - Team goals (long-term)
    - Represent what it will take for the patient to reach their discharge goal
    - Will require care or carry-over from the team to achieve
    - Nursing goals tend to be task driven and prevention related
  
  - Discipline specific goals (short-term)
    - Should link to long-term team goals
    - Must be objective
    - Divide into processes for nursing
• **Examples of incremental short-term goals:**
  
  - **Skin integrity**
    - Create positioning schedule or plan
    - Implement schedule or plan
    - Educate patient on positioning and maintaining skin integrity
    - Monitor for breakdown and compliance
    - Outcome: Maintain skin integrity
  
  - **Medication management**
    - Establish medication schedule
    - Education patient on medications, risks and side-effects, dosage and schedule
    - Observe medication administration, identification of medications, side-effects, dosage, schedule
    - Outcome: Maintain overall health or be free of infections
Examples of incremental short-term goals:

- Bowel program:
  - Initiate bowel management program
  - Educate patient on program and schedule
  - Advance as appropriate
  - Outcome: Regular elimination

- Pain management program:
  - Determine ideal pain level
  - Establish medication schedule
  - Educate on alternative pain relief techniques
  - Educate on pain reduction strategies
  - Advance to self-management of pain control
  - Outcome: Patient will be free from pain
Plan of Care

• **Continuity**
  - Plan of care should be the guiding force for treatment decisions throughout the stay
    - Update weekly at team
    - Ensure that team is on target with established goals
    - Reorient team to long-term goals if treatment plan seems to be taking a different course
    - Adjust plan of care goals as necessary
Nursing Notes

• **Nursing progress summaries:**
  - Prior to team conference summarize this week’s progress
  - Include reasons for progress or lack thereof
  - State focus for the next week
  - Ensure that these summaries and focus goals coincide with the plan of care
• **Ongoing documentation of skilled services:**
  - Use skilled terminology and objective measurements in documentation to show functional progress and improved safety as a result of the delivery of skilled intervention.
    - Examples include:
      - Assessment of performance
      - Adaptation of the task or environment
      - Training in the use of adaptive equipment
      - Use of specialized treatment techniques
      - Adjusting the treatment program as the patient's condition changes
      - Providing analysis of performance and skilled feedback on performance
• **Ongoing documentation of skilled services:**
  - Document that the patient is able to follow directions, retains the skills learned, and shows carryover of the learned skills into other functional areas.
  - Justify the need to continue treatment based on progress, treatment goals, and functional level needed at discharge.
  - Explain any setback or lack of progress while supporting that the patient retains good potential to achieve the set goals.
Rehabilitation nursing services are necessary 24/7

- Nursing plan addresses rehabilitation needs of the patient
- Supports medical management as laid out by physician
- Addresses education needs of the patient
- Establishes continuity of care among the team
• **Daily Documentation:**
  - Daily system assessment
  - Notes that state
    - Care rendered
    - Patient’s response to care
    - Patient’s performs in areas where functional deficits exist
      - Transfers
      - Self care
      - Communication/cognition
    - Education provided
    - Patient/family’s response to education
• Care rendered and patient’s response of care:
  ▪ How do we talk about nutrition?
    • Patient ate 50% of lunch. Supplement was offered, which the patient completely consumed.
    • Patient is on fluid restrictions, which was communicated to therapy.
    • Poor intake resulted in dietary consult, which has been ordered.
    • Patient asked for grapefruit for breakfast, which is contraindicated with Xanax. I explained this to the patient and she ordered cereal and banana instead.
    • Appetite stimulant was ordered and today the patient was able to eat all of his lunch.
  ▪ Others?
• Care rendered and patient’s response of care:
  - How do we talk about sleep disturbance?
    • Patient is on an altered sleep schedule, which is interfering with morning ADLs. Discussed this with the patient who requested something to help him sleep.
    • Patient is reporting restless sleep, so a sleep log was initiated to track times slept.
    • Patient is having difficulty sleep. Today she was fatigued and refusing therapy. Alerted doctor of missed therapy.
    • Ambien was effective in helping patient maintain a normal sleep cycle. Results recorded and reported to the rehab physician.
    • Other?
• Care rendered and patient’s response to care:
  ▪ How do we talk about skin integrity?
    • Checked patient q2 hours for position of hemiparetic arm. Repositioned arm each time because patient is neglecting left arm.
    • Reviewed pressure relief techniques with patient and caregiver this evening. Patient continues to forget to self-initiate repositioning when in his wheelchair.
    • Healing noted by reduction of sacral wound size to xx cm. Patient observed using pressure relief techniques while in wheelchair today.
  ▪ Other examples?
• Care rendered and patient’s response to care:
  - How do we talk about pain?
    - Patient is maintaining a pain level of 3 by initiating the request for medication prior to therapy without reminders.
    - Patient was supervision with transfers this shift, which he reports is related to pain reduction.
    - Patient was unable to participate in therapy sessions this morning due to extreme pain. Continuing to monitor pain levels to achieve control that will allow participation in this afternoon’s program.
  - Other examples?
• **Care rendered and patient’s response to care:**
  - How do you talk about bladder and bowel elimination?
  - Change of dosage of Detrol resulted in reduced bladder leakage. Patient did not have any accidents this shift, which is significantly improved from 2/21 when the patient experienced 3 bladder accidents in one shift.
  - Patient had hard stool today. Will encourage increased fluid intake to 200 cc/hr and notify team to assist with fluid reminders.
  - Due to frequent accidents, a q2 hour bladder program has been initiated.
  - Patient alerts nurses for toileting at the top of the even hours in keeping with his bladder protocol.
  - Other examples?
• **Care rendered and patient’s response to care:**
  - How do we talk about safety?
    - Patient attempted to get up to go to the bathroom without calling for help. Patient was reminded of limitations due to his recent surgery requiring him to be supervised with transfers and mobility. Patient indicated understanding of how to call for assistance.
    - Due to increased confusion tonight, patient required frequent observation from nursing. He required checking every 30 minutes for safety. Patient required redirection about half of the time.
    - Patient and family educated on the importance of close monitoring for basic needs to decrease the risk of the falls as patient tried to complete task unsupervised.
    - Other examples?
• **Functional Performance Examples:**
  - Patient showed no signs and symptoms of aspiration while taking noon meds with nectar thick liquids.
  - Patient required moderate assistance while transferring to the toilet due to loss of balance.
  - Patient was reminded to keep his feet on the floor while transferring with sliding board as instructed by PT.
  - Patient experienced a bladder accident due to a urinal spill. Caregiver was needed to change the patient’s bed linens.
  - Patient required moderate assistance while bathing this morning due to increased pain. He was unable to wash lower extremities, buttocks, and perineal area.
  - Others?
• Family/patient education examples:
  ▪ Patient has not exhibited improved performance with external cath placement. Family is discouraged, but willing to continue education in order to assist the patient at home.
  ▪ Patient demonstrating signs of difficulty adjusting to disability. Nurse provided support group information to patient and wife.
  ▪ Patient and family educated on blood sugar testing and monitoring. Family performed task with nurse supervising. More instruction with finger sticks is required.
  ▪ Patient/family continues to require education regarding medication administration and signs/symptoms of disease exacerbation.
• **Showing progress:**
  - At least weekly, return to the established team goals.
  - Think of where progress has been made by stating current status compared to prior status.
  - Review previous narrative notes to determine what burden of care was present earlier that is now resolved.
  - Consider how nursing interventions resulted in a positive outcome.
Nursing Notes

• At least weekly, a summary of the patient’s progress should be documented.
  - Document progress toward goals
  - Detail barriers to achievement of goals
  - Describe changes to the plan of care as appropriate
  - Describe patient’s response to treatment
  - State the justification for continued stay on the rehab unit
The patient’s condition must be sufficiently stable to allow the patient to actively participate in an intensive rehabilitation program and willing to participate in the program.

- This does not mean the patient’s medical conditions will be fully resolved. Rather, the requirement is that a patient’s medical condition be such that it can be successfully managed in the IRF setting while the patient is participating in the intensive rehab therapy program.
• **Requirement for Evaluating the Appropriateness of an IRF Admission / Inpatient Rehabilitation Facility Medical Necessity Criteria**
  - Must demonstrate that the following criteria were met at the time of admission to the IRF:
    - The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines, one of which must be PT or OT.
• **Requirement for Evaluating the Appropriateness of an IRF Admission / Inpatient Rehabilitation Facility Medical Necessity Criteria**
  
  The patient must generally require an intensive rehabilitation program: current industry standards are 3 hours of therapy per day at least 5 days per week.
  
  ▶ CMS does not intend for this measure to be used as a “rule of thumb” for determining whether a particular IRF claim is reasonable and necessary.
  
  ▶ In certain well documented cases, this intensive program might instead consist of at least 15 hours of intensive rehab therapy within a 7 day consecutive period, beginning with the date of admission to the IRF.
  
  ▶ CMS will provide guidance in manuals on additional instances in which they might find that the patient is receiving intensive rehab therapy services despite not receiving the generally expected intensity of therapy services for a brief period of time.
The Rule

• Requirement for Evaluating the Appropriateness of an IRF Admission / Inpatient Rehabilitation Facility Medical Necessity Criteria

• The patient must generally require an intensive rehabilitation program: current industry standards are 3 hours of therapy per day at least 5 days per week.
  ‣ The intensity of therapy provided must never exceed the patient’s level of tolerance or compromise the patient’s safety.
  ‣ One on one (individualized) therapy is the standard of care for IRF patients. Group therapies are an adjunct. In instances in which group better meets the patient’s needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient’s medical record.
The Rule

- **Requirement for Evaluating the Appropriateness of an IRF Admission / Inpatient Rehabilitation Facility Medical Necessity Criteria**
  - The patient must generally require an intensive rehabilitation program: current industry standards are 3 hours of therapy per day at least 5 days per week.
    - Treatments must begin within 36 hours from midnight of the day of admission to the IRF.
  - Therapy evaluations constitute the beginning of the required therapy services and are included in the total/daily/weekly provision of therapies used to determine the intensity of therapy services.
• Exceptions Policy: if an unexpected clinical event occurs during the course of a patient’s IRF stay that limits the patient’s ability to participate in therapy for a period not to exceed 3 consecutive days (e.g. extensive diagnostic tests off premises, prolonged IV infusion of chemotherapy or blood products, bed rest due to signs of deep vein thrombosis, exhaustion due to recent ambulance transportation, surgical procedure, etc.), the specific reasons for the break in the provision of therapy services must be documented in the patient’s IRF medical record.
  ▶ If appropriately documented in the patient’s IRF medical record, such a break in service will not affect the determination of the medical necessity of the IRF admission.
  ▶ Medicare contractors may approve brief exceptions to the intensity requirement in these particular cases if they determine that the initial expectation of the patient’s active participation in intensive therapy during the IRF stay was based on a diligent pre-admission screening, post-admission physician evaluation, and overall plan of care that were based on reasonable conclusions.
CMS Q&As:

- “Therapy time” is time spent directly with the patient.
- Breaks in therapy for up to 3 days should be explained in the record.
- “Missed” time can be made up on another day.

For example, if a patient receives his or her intensive rehabilitation therapy program Monday through Thursday, but then refuses to participate in the last 30 minutes on Friday, then the additional 30 minutes of “missed” therapy time can be made up on either Saturday or Sunday. In no case can the “missed” therapy time be made up in a different week; it must be made up within the same week (7 consecutive day period starting with the day of admission) that the “missed” time occurred. The reasons for the “missed” therapy time on Friday must be well documented in the patient’s medical record at the IRF, and repeated refusals by the patient to participate in the intensive rehabilitation therapy program should prompt the interdisciplinary team to investigate further and consider discharging the patient to a more appropriate setting.
**CMS Q&As:**

- Not providing weekend therapy jeopardizes your ability to provide intensive therapy services and puts you at risk for denial of the claim.
- The same rules apply for therapist illness and inclement weather.
- Time spent in family conferences cannot be counted toward the 3-hour rule.
- It is not acceptable to round the number of therapy minutes.
- Day of admission is DAY 1.
- There is no such thing as Medicare holiday.
<table>
<thead>
<tr>
<th>Physical Therapy</th>
<th>3/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Exercise Program Review/Warm Up</td>
<td>Supervision with verbal cues</td>
</tr>
<tr>
<td>Gait Training</td>
<td>Amb 150ft with RW – min assist</td>
</tr>
<tr>
<td>Supine to Stand Transfers</td>
<td>Mod assist</td>
</tr>
<tr>
<td>Stairs/Curbs</td>
<td>2 inch curb – min assist with RW</td>
</tr>
<tr>
<td></td>
<td>Stairs – max assist with bilateral hand rails</td>
</tr>
</tbody>
</table>
PT Narrative Note

- Initiated treatment with standing Home Exercise Program as warm up. Pt completed 15 reps of marching, hip adduction/abduction, hip extension, knee flexion and heel raises with verbal cues to remain upright and move through the entire range of motion. Blood pressure prior to exercise 125/80, immediately post ther ex 130/85. Patient stated, “those exercises are getting easier.”

- Gait training with rolling walker on even surfaces required minimal assistance to ambulate 150 feet. Completed activity 4 times during session. Minimal assist required to initiate hip elevation in swing phase to allow left foot to advance. Patient wearing AFO due to foot drop. Skin under AFO viewed before and after gait training, no redness or skin breakdown noted. BP after gait training 132/86. HR 88. Patient is somewhat impulsive, moving to stand for gait training when therapist was 5 feet away. Reinforced safety awareness and patient was able to restate why assistance was required. Impulsive behavior was not repeated during treatment session.
• **PT Narrative Note Continued:**

  - Focused on supine to stand transfers as patient reports having a near fall when performing this transfer with his wife yesterday. Practiced log roll, supine to sit and sit to stand. All components required moderate assistance with verbal cues for sequencing. The patient’s wife was present and she was educated to correct positioning to assist without injuring herself. The patient requires verbal cues to scoot his left hip forward prior to standing. If he does not do this and attempts to stand he leans towards the left and is at risk for falling. The patient and wife were both able to verbalize the safety concerns and perform the transfer safely at the end of the treatment session. The patient’s nurse, Sandy, was educated to this specific requirement for transfer and will continue to reinforce this technique and safety awareness outside of therapy.

  - The patient is progressing well towards his short term goals of minimal assistance for all mobility. He needs to be at supervision assistance or better to return home with his wife and sister who will share his care giving 50/50. His sister cannot provide any physical assistance due to back problems.

  - The patient is progressing well towards his short term goals of minimal assistance for all mobility, but must achieve supervision level by discharge.
PT Narrative Note RESTATED:

- Pt completed 15 reps of home exercise program. Patient needed verbal cues to remain upright and move through the entire range of motion.
- Gait training with rolling walker and wearing AFO on even surfaces required minimal assistance to ambulate 150 feet x 4. Minimal assist required to initiate hip elevation in swing phase to allow left foot to advance. Patient is somewhat impulsive, moving to stand for gait training when therapist was 5 feet away. Reinforced safety awareness. Impulsive behavior was not repeated during treatment session.
- Focused on supine to stand transfers as patient reports having a near fall when performing this transfer with his wife yesterday. Transfers were moderate assistance with verbal cues for sequencing and scooting left hip forward. The patient’s wife was present and was able to perform the transfer safely at the end of the treatment session. The patient’s nurse, Sandy, was educated for carryover purposes.
<table>
<thead>
<tr>
<th>Occupational Therapy</th>
<th>3/17</th>
</tr>
</thead>
</table>
| **Dressing**         | Lower body – max assist  
|                      | Upper body – mod assist  |
| **Toilet transfers** | Mod assist            |
| **Toileting**        | Max assist             |
| **Coordination**     | Fair -                |
• OT Narrative Note

- Treatment began at 9 am in the patient’s room. Nursing took blood pressure just prior to treatment 128/90. HR 82.
- Dressing – Therapist got clothing out of the closet for patient. Supine to sit transfer required moderate assist. Sitting on edge of bed, patient required minimal assist to maintain upright position and max verbal/tactile cues to engage truncal muscles. Patient returned to supine with moderate assist. Patient was able to bridge and pull pants up on the left and right using the right arm. Transferred patient to the wheelchair with minimal assistance. Patient began pushing to the left so the therapist had him put both hands on his knees to stand/pivot to the wheelchair. Once in the chair the patient required help to thread the left arm through the t-shirt sleeve, then he was able to the shirt over and down with minimal assistance. Patient was short of breath after dressing. RR 22. Nursing notified. Oxygen saturation recorded at 88% on room air. Nursing applied PRN oxygen – saturation improved to 96%.
Patient reported he felt like he needed to go to the bathroom. The patient was able to navigate his wheelchair into the bathroom independently, but required verbal cuing to lock both sides of the wheelchair prior to transfer. Moving from the wheelchair to toilet required moderate assistance with therapists right knee blocking the patients left knee to prevent buckling during the stand pivot transfer to the patient’s right. Additional assistance was required to get the patient to bend his right arm to sit properly on the toilet seat as the patient is exhibiting “pusher” syndrome. The patient used a forward grab bar to lift to standing with his right arm with minimal assistance. He required maximal assistance to lift and lower pants and perform hygiene tasks. The transfer back to the wheelchair required minimal assistance with tactile cues to guide right hand to the wheelchair armrest and blocking of the patient’s left knee to prevent buckling. The patient’s nurse was informed of the continent incident, technique to prevent knee buckling, and that the patient requires less assistance with transfers to his left.
OT Narrative Note RESTATED:

- **Dressing** – Sitting on edge of bed, patient required minimal assist to maintain upright position and max verbal/tactile cues to engage truncal muscles. Patient was able to bridge and pull pants up on the left and right using the right arm. Patient began pushing to the left so the therapist had him put both hands on his knees to stand/pivot to the wheelchair. Once in the chair the patient required help to thread the left arm, then he was able to pull the shirt over and down with minimal assistance. Patient was short of breath after dressing. Nursing intervened.

- **Toileting and toilet transfer**– The patient wheeled into the bathroom independently, but required verbal cuing to lock brakes. Toilet transfer was moderate assistance with therapists right knee blocking the patients left knee to prevent buckling during the stand pivot transfer to the patient’s right. Facilitated elbow bend of the right arm as the patient is exhibiting “pusher” syndrome. The patient was minimal assistance to stand with grab bar. He required maximal assistance to lift and lower pants and perform hygiene tasks. The patient’s nurse was educated on using knees to block for a safe transfer.
• **Common Treatment Areas:**
  - **Self-Care Dependence** –
    - Will be noted in such areas as eating, bathing, dressing, maintaining hygiene
    - May be due to:
      - Decreased strength
      - Marked muscle spasticity
      - Moderate to severe pain
      - Contractures
      - Incoordination
      - Perceptual motor loss
• **Common Treatment Areas:**
  - **Mobility Dependence** –
    - Will be noted in such areas as transfer, gait deviation, stair climbing, and wheelchair maneuvering
    - May be due to:
      - Decreased strength
      - Marked muscle spasticity
      - Moderate to severe pain
      - Contractures
      - Incoordination
      - Perceptual motor loss
      - Orthotic need
      - Need for ambulatory or mobility device
• **Common Treatment Areas:**
  
  - **Safety Dependence/Secondary Complications** –
    - May manifest in the performance of activities of daily living or to acquired secondary complications that could intensify medical sequelae such as fracture nonunion, or decubiti.
    - Some examples of safety dependence are high probability of
      - Falling
      - Swallowing difficulties
      - Severe loss of pain or skin sensation
      - Progressive joint contracture
      - Infection requiring skilled PT intervention to protect the patient from further complication
• **Care rendered and patient’s response to care:**

  - How do we talk about pain?
    - Describe the presence or absence of pain and its effect on the patient's functional abilities
    - Indicate the intensity, type, changing pattern, and location at specific joint positions
    - Describe the limitations placed on the patient's self care, mobility, or safety as well as subjective progress made in reducing pain through treatment
• **Care rendered and patient’s response to care:**
  - How do we talk about exercise?
    - Indicate the type of exercise, number of repetitions, and resistance used
    - Document the impact that the exercise has on functional performance
    - Note changes in the patient’s performance as a result of the exercises
    - Identify changes in the patient’s vital signs as a result of exercise (respirations, heart rate, blood pressure, oxygen saturation)
    - Document the patient’s level of assistance to properly complete the exercise program
• Care rendered and patient’s response to care:
  ▪ How do we talk about mobility and transfers?
    • Clarify the patient's gait deviation, amount of assistance required and distance walked
    • Identify the gait problem being treated (e.g., to correct a balance/incoordination and safety problem or a specific gait deviation, such as a Trendelenberg gait)
    • Identify the functional limitations in mobility or safety during ambulation
    • Note the amount of assistance and devices required to transfer safely
    • Indicate compensatory strategies taught for safe transfers
    • Indicate caregiver instruction completed to ensure carry-over
Care rendered and patient’s response to care:

- How do we talk about medical issues?
  - Therapists should be aware of active medical conditions for their patients and share this information in handoffs to other providers
  - Document the impact medical conditions have on the patient’s:
    - Ability to participate
    - Willingness to participate
    - Performance of functional tasks
    - Endurance and strength
    - Safety
    - Comfort/pain level
    - Balance/coordination
    - Cognition
• **Subjective-Statement provided by the patient about:**
  - Rating of pain
  - Patient’s goal
  - Complaints or comments about tolerance of prior session
  - Missed time and reason for variance
  - Attempts to meet missed minutes
Therapy Documentation

- **Objective-Actual treatment performed:**
  - Exercises
  - Activities
  - Modalities
  - Measurements
  - Standardized test results
  - Balance assessments
  - Communication with other team members
Therapy Documentation

- **Assessment-Skilled summary of the session:**
  - Clinical diagnoses
  - Review of the patient’s performance
  - Progress with interventions
  - Barriers to progress
  - Therapist’s conclusion of the patient’s performance
  - Appropriateness for continued care
Plan-Recommendations for following sessions:

- Hand-off communication of treatment strategies to next therapist
- Changes in established treatment plan and goals
- Changes in repetitions, weight, exercises
- Alterations to frequency, duration
- Addition of modalities
- Educational needs and plans
- Plan for making up missed minutes
Questions?

Lisa Werner
lwerner@erehabdata.com
(202) 588-1788

Better outcomes for everyone.