STEERING from Med/Surg to Rehabilitation Nursing Management:

Documentation of function is not just a therapy event or responsibility when a patient is being cared for in an Inpatient Rehabilitation Facility (IRF). A patient’s path to recovery is a collaborative effort, bringing physicians, nurses, therapists and the patient’s family together to re-establish a normal, functional lifestyle for the patient. The focus is also more intense than a SNF model of care.

An article published in Nursing Times states, “The therapist roles overlap with those of the nurse and should not be viewed as separate but as complementary to each other.” Translated into practice - It is the nurse’s responsibility to aid and document patient’s function and progress, exceeding the perceived expectations of standard, medical/surgical nursing. A rehabilitation nurse goes beyond the medical/surgical model and must embrace a role that comfortably wears the hat of ‘therapist’ in the 14-16 hours these disciplines are routinely absent. That defines 24/7 Rehabilitation Nursing, as required by Federal Regulations standard of rehab care.

So, why do we care if nursing documentation doesn’t focus on functional recovery? We lose greater than two-thirds of the patient’s identifiable recovery outside the interdisciplinary record that defends medical necessity and incorporates 24/7 rehabilitation nursing as a primary requirement for an IRF level of care.

When a traditional therapy session is over, the patient continues to require assistance with movement. This further reaffirms the importance of centralized documentation for effective and efficient communication. The goal is a change in nursing culture, from a discipline-oriented to an interdisciplinary approach where every team member can contribute to the functional assessment and reinforcement of the patient’s continually enhanced plan of care leading to self sufficiency.

To define target barriers to discharge and to incorporate an interdisciplinary approach to solving those barriers is the focus of an IRF stay. Maintaining focus across disciplines from a communication standpoint is pivotal in successfully building patient skills to overcome barriers. Disparate charting or charting that does nothing to support interdisciplinary communication on function, breaks down team effectiveness. CMS expects interdisciplinary problem solving and individualized plans of care to enable the patient to return home. Accepting anything less jeopardizes the basic premise and importance of an IRF level of care over types of rehabilitation available. For units within hospitals, this premise of specialized nursing must be embraced wholeheartedly, even by coverage staff, to successfully manage this level of care. It is as important as training provided in specialty care units – it is greater than not less than what is expected in a standard acute care nursing unit.
Functional focus is achieved when a patient’s information pertaining to his or her burden of care and mobility recovery is found outside of traditional therapists notes. Charting 24-hour patient progression internal to TEAM documentation is the key to effectively portraying nursing contribution in the overall interdisciplinary plan of care.

ISSUE:

When transitioning from acute nursing to rehabilitation nursing, the ability to recognize a patient’s true 24-hour function is nowhere to be found in most rehab facilities’ documentation. CMS RAC audits have confirmed this common problem. Often, especially when a rehab unit is within an acute care hospital, nursing documentation is separate from other rehab team members. Clinical silos are created. These practices increase disconnect in the ability to communicate an interdisciplinary approach and ignore federal guidelines that outline the purpose of a brief, intense rehabilitation stay.

If nurses cannot document the change in focus to a rehabilitation level of care, the medical record does not reflect the significance of their work and value towards functional recovery.

SOLUTIONS:

1) EMPOWERING THE NURSE WITHIN THE TEAM

It is essential for rehabilitation nurses to document details on the essential steps to training functional carryover, coaching and education that make a patient more self dependent. Medical/Surgical nursing documentation does not meet that need.

2) LETTING GO OF EGOS

In a time where hospitals are budget-strapped, there is no room for ego-centric practice portioning the patient to ‘rationale’ parts or activities generally covered by a licensed practice. For example, only OT comments on ADL’s, only Speech comments on swallowing, etc. When it comes to patient mobility, the idea of “discipline-specific” roles does not meet the needs of a rehabilitation environment. The looming reality of an aging population and a dwindling Medicare trust fund is becoming apparent. This reality will completely change the way hospitals conduct business in the United States. Efficient patient management is crucial to operating hospitals in a cost-effective manner. Therefore, an interdisciplinary model of care needs to become the industry standard for rehabilitation. Nurses’ burden of care must be reflected on a 24-hour cycle enhancing a patient’s recovery process. No one profession is responsible for standard functional mobility greater than another team member. If the interdisciplinary concept of care cannot be embraced, then the argument as to whether ‘intense brief rehabilitation’ is best for the patient is a mockery in defense of medical necessity.
3) RECOGNIZING A PATIENT’S UNIQUE BARRIER TO DISCHARGE

No two patients are alike. Every patient with an illness, condition or injury is different and requires a different approach to treatment. Understanding a patient on an individual and personal level enables clinical staff to establish the **real barriers to discharge**. The specific reason an individual cannot return to the community is a reason as unique as every patient and their resources. The entire focus should represent a melding of treatment that thoroughly tackles the issues and supports solutions to overcome barriers. The focus can only be maintained through real-time communication of achievements to reinforce carryover with handoffs in care.

4) NURSES AS OBSERVERS AND FACILITATORS

A nurse’s presence is more prevalent in a patient’s daily routine than any other clinical staff members, making it possible for a nurse to observe and document a patient’s behavior, along with their physical and mental conditions throughout the day.

This ability to gather crucial information is paramount in the effort to **solve each patient’s burden of care puzzle**. But this ideal observation is shadowed because the Med/Surg Model of nursing documentation limits their scope in team contribution. According to a study conducted by K.R. Waters and L.A. Luker concerning staff perspectives on the role of the nurse in rehabilitation, it was learned that nurses perceived rehabilitation as an extended role outside of their normative routines only to be engaged in when time permitted. Further, the nurses believed they did not make a major contribution to rehabilitation and considered the work of the therapists to be more important.

This information illustrates the fact that nurses may not know what to look for in terms of rehabilitation opportunities, or they don’t know how to engage the patient in ways that continually promote what is learned in therapy sessions. Rehabilitation nursing bridges these misconceptions and every nurse practicing on a rehab unit must embrace the philosophy of rehab specialty to fill the gap not evidenced in charting. It may not yet be required to hold a CRRN to work on a rehab unit, but the philosophy of this sort of care must be practiced or it truly is not an IRF level of care. Not practicing rehabilitative nursing is problematic. It compounds missed opportunities for a patient’s progress in the other 16 hours or so of the day when other clinical/therapy staff are absent. These missed opportunities to recognize and facilitate progress as they reassess the patient’s burden of care amount to lengthier hospital stays for patients and higher costs for the hospital.
CONCLUSION:

Functional documentation for a rehabilitation admission is equal to Med/Surg documentation in an acute care facility and must be reflected in charting over an entire day. The nurse is a significant contributor to functional mobility and carryover. Equally critical is the fact that all disciplines must communicate seamlessly within the same records platform, sharing the responsibility of the entire not a partitioned patient, otherwise the value of every interaction with a patient cannot be built upon and the unique specialty we admire as rehabilitation medicine can and will be forgotten.

MEDISERVE can enable this shift in culture because solutions are built with team functionality, making it possible to incorporate a 24/7 interdisciplinary record.