Evidencing specialist rehabilitation nursing through documentation

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Introduction

All nurses, regardless of specialty, are required to maintain accurate, comprehensive and timely documentation of assessments, planning, decision-making, actions and evaluations. As specialist rehabilitation nurses, the ability to accurately articulate the contribution of nursing care to the rehabilitative process is vital in order to validate the provision of rehabilitation nursing care and their contribution to the interdisciplinary team.

Following an audit of nursing documentation, it was evident that despite a number of interventions to educate our nurses on documentation, there was a deficit in the ability of our nurses to articulate the need for and provision of skilled rehabilitation nursing.

Purpose / Objectives / Methods

Develop a consistent approach to the documentation of specialist rehabilitation nursing care through the provision of rehabilitation nursing education combined with resources providing standardised guidelines for documentation for all nurses working a specialist rehabilitation unit.

This project involved the development of:

1. Rehabilitation Nursing Documentation Guide poster to be located in the rehabilitation wards and in the front of every patient's medical record file as a reference document
2. Fundamentals of FIM guide located in the wards
3. Whole of division introductory education program post development of resources
4. Survey nurses post education to determine the value of the learning in relation to their documentation practices
5. Audit of the progress notes in seven rehabilitation wards at Epworth HealthCare over three audit periods during 2018 and 2019.

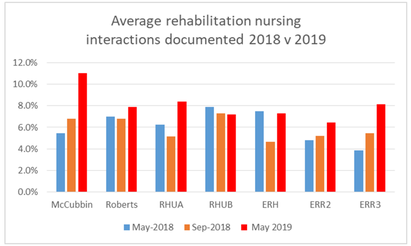
GO REHAB ABC

Challenges and strategies for improvement

Challenge	Strategy
Embedding use of the tool in everyday practice	GOREHABABC poster in each patient medical file as a reference tool Displayed in department areas Personal reference card for staff
New staff knowledge	Included in new starter orientation, Transition to Specialty practice program and throughout the RN and EN graduate programs
Nurse Unit Manager engagement	DCS driving the project and Included in NUM meetings
Consistency across all shifts	Discussion at ward huddles and meetings

Outcomes

- Development of the GO REHAB ABC algorithm as a guide to rehabilitation nursing documentation
- Development of the Rehabilitation Nursing Documentation Framework
- Development of the Epworth Fundamentals of FIM Guide
- Survey demonstrated that nurses understood it is their role to provide nursing care to patients, act as an educator, assist the patient to reach their goals to return to independence/pre morbid functional status, and to counsel patients.
- Improvement in documentation of specialist rehabilitation nursing interventions was identified in all but one of the seven rehabilitation units over three audit periods.
- integration of the new resources into all rehabilitation nursing education programs.



There was a variation in the percentage of the documentation of the potential nursing interventions recorded across all rehabilitation sites. Five units improved over time following the training, however this was not always sustained consistently. Further education sessions increased use of the resources.

Conclusion

The documented nursing interactions during the project period did improve slightly over time. The development of the resource did have an effect in increasing documentation in some units. Ongoing improvement has relied on NUM and educator commitment to embed the use of the resources consistently.