

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

GO REHAB ABC
A guide to clinical documentation for rehabilitation nursing

- G** **Goals**
Day of admission goals discussed and recorded / Progress in achieving goals discussed / Progress documented regularly / Care Coordinator identified and patient aware / Communication board updated
- O** **Observations & Investigations**
Vital signs / Patient Assessment – overall appearance & presentation / Changes in patient condition / Deterioration / Investigations (pathology, ECG, medical imaging) / Appointments
- R** **Risk**
Falls / Malnutrition / Pressure injury / Skin assessment / Cognitive impairment / All Risk Assessments via MRAIR – with interventions recorded and actions in place
- E** **Eating & Drinking**
Diet – modified (soft, textured, amount) / Ability to swallow – Speech Pathology referral, diet modified as appropriate / Ability to independently manage meals / Identify & record appropriate FIM score / Red Tray / Allergies documented & relevant staff informed / Enteral feeds – type and management plan
- H** **Home & Discharge Planning**
Patient aware of discharge destination and date / Family aware – discussions documented / Relevant information given to patients and families / External service referrals completed where appropriate / Aids provided by OT / PT / Medications arranged – e.g. med profile, blister packs
- A** **Ability & Assistance with ADL's**
Dressing / Toileting / Grooming / Bathing / Transfers / Locomotion – walking and stairs / Refer to FIM guides and document associated score
- B** **Bowel & Bladder**
Bowel motions documented / Level of continence – aids required / Toileting routine / Use of aperients / Fluid balance if appropriate, fluid restrictions / Use of urinal or pan
- A** **Advice & Education**
Medication education / Coaching, promoting independence or normal level of function / Preparing for discharge – Risk Prevention / Safety advice / Condition-specific information – e.g. fire precautions
- B** **Behaviours**
Mood, Appearance, Affect / Willingness to participate in therapy program / Need for Behavioural Support plan identified / commenced
- C** **Communication & Cognition**
Glasgow Coma Scale (if clinically indicated) / Comprehension / Expression / Social Interaction / Problem Solving / Memory / Cognition screen and interventions

PROBLEM SOLVING
Considerations to assist with data:
1. Includes solving problems relating to a 24-hour period.
2. Ability to make reasonable care & personal affairs.
3. Not related to performance or health to be able to identify problem.

TOILETING
Considerations to assist with data:
1. The three components of toileting:
a. path down
b. sitting up
c. washing the patient the toilet paper
2. If a patient needs to hold the valve until an assistive device for toileting.

THE FIM DECISION TREE MOTOR

FUNDAMENTALS OF FIM
Your guide to accurate FIM scoring
The Functional Independence Measure (FIM) assesses the level of independence in a person with a disability by determining the type and amount of assistance required to successfully perform basic life activities.
In this guide you will find key considerations to ensure accurate FIM scoring, as well as examples of documentation to accurately reflect scores for each of the eighteen FIM items.

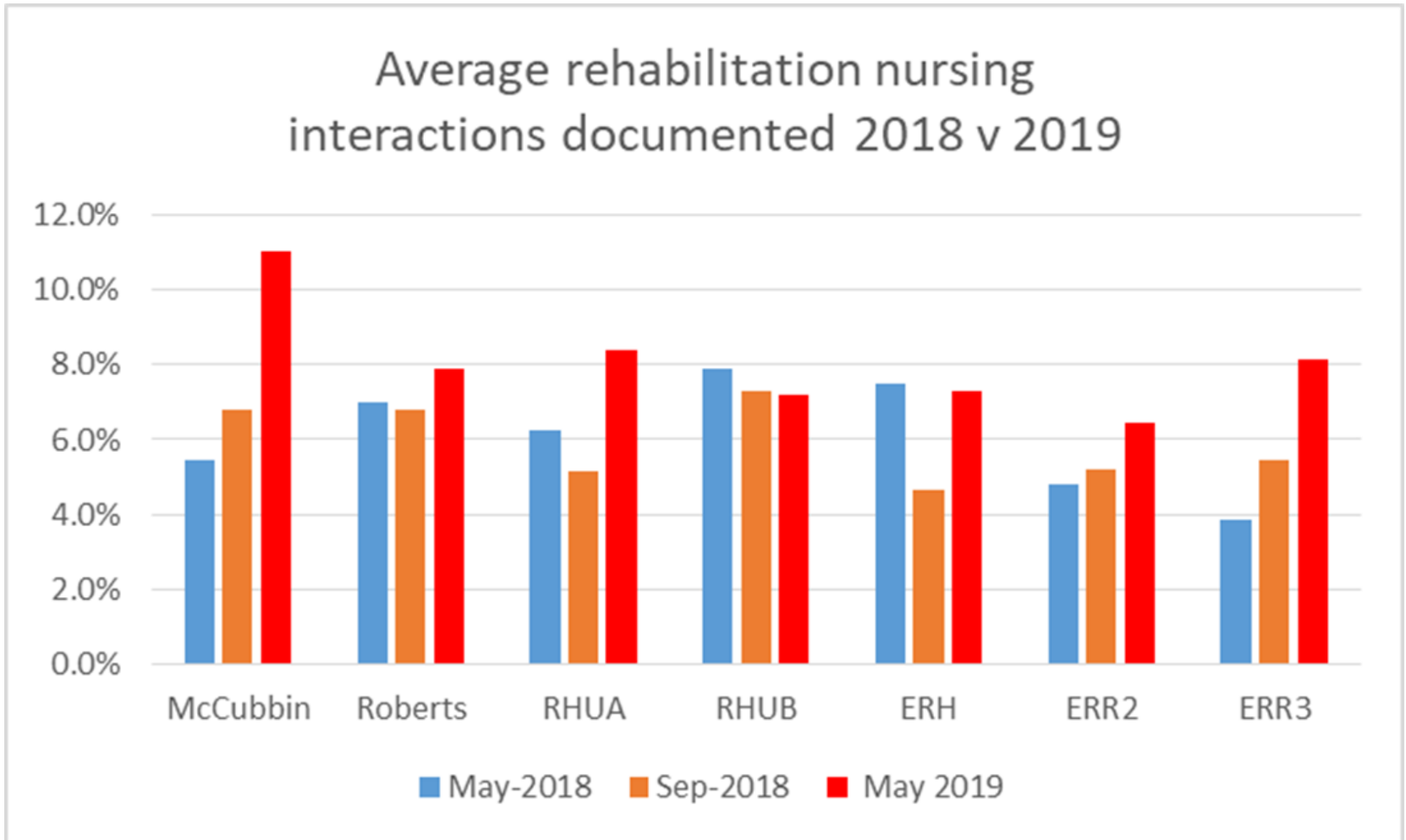
Challenges and strategies for improvement

Challenge	Strategy
Embedding use of the tool in everyday practice	GO REHAB ABC 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.