MEDITECH Content Updates – 2019.3

HCA Inpatient Rehab Facility

Overview

This document is a high-level overview for end user education purposes about significant changes within the Inpatient Rehab routines. These changes are intended to meet regulatory requirements, improve screen flow, eliminate errors, and/or provide additional clinical content. We solicited feedback from the Rehab Physician Advisory Group, Rehab End User Advisory Group, and numerous change requests submitted through the SGO Change Governance process. CMS changes must be in place prior to October 1, 2019 to meet regulatory measures for all patients discharged on or after October 1, 2019.

How to use this guide

Be aware the enhancements may not be in your test environment when this document is published. Your Facility and/or Division IT support team will notify you when the updates will be available in your software.

Please follow the selected prompts and/or read the MEDITECH yellow information boxes put in place to assist you in adapting to the changes to the Inpatient Rehab Standardized Documentation.

Contact for Questions

After go-live, should you have technical questions or time sensitive questions regarding these updates contact your local Customer Support Help Desk.

For clinical support, please email [CORP.RehabDocSystem@HCAHealthcare.com](file:///C:/Users/wpn3728/AppData/Local/Microsoft/Windows/Temporary%20Internet%20Files/Content.Outlook/Y7POYX2D/CORP.RehabDocSystem@HCAHealthcare.com)

# Appendix Summary of Revisions

| **Date** | **Revision** |
| --- | --- |
| 8/20/19 | IRF Preadmission Screen updated for Room Number and Prior device use.  PT Assessment updated for Prior device use.  Team Conference Change Scoring typo corrected |
| 8/15/19 | Published to Enterprise |

*Click the topic name to be taken to the specific documentation within this update:*

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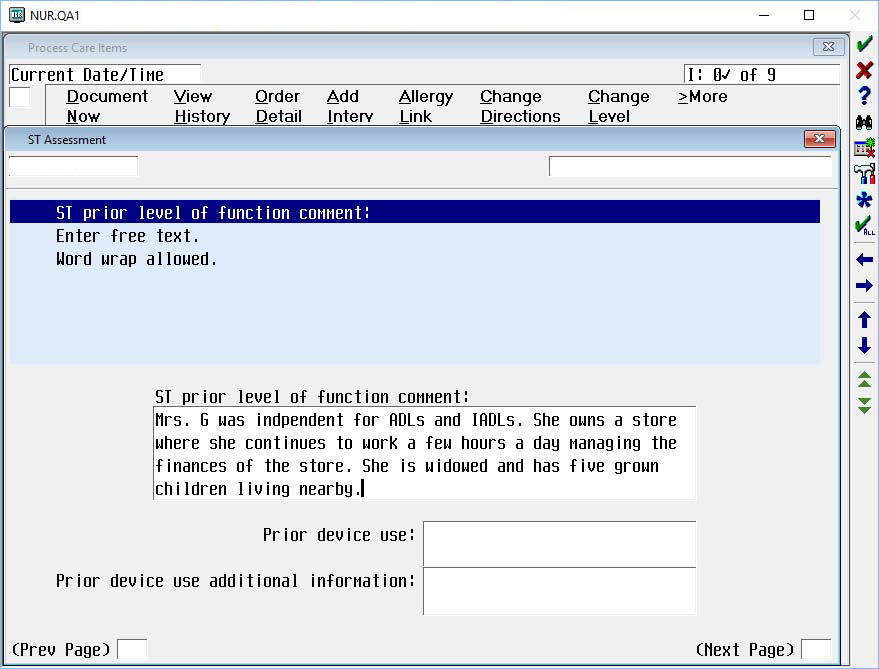
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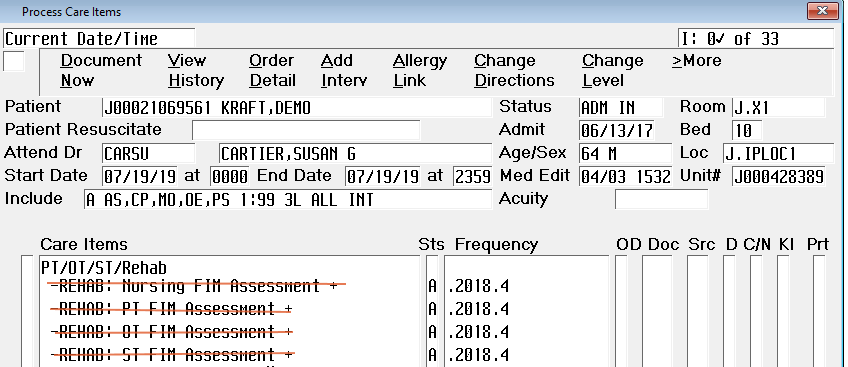
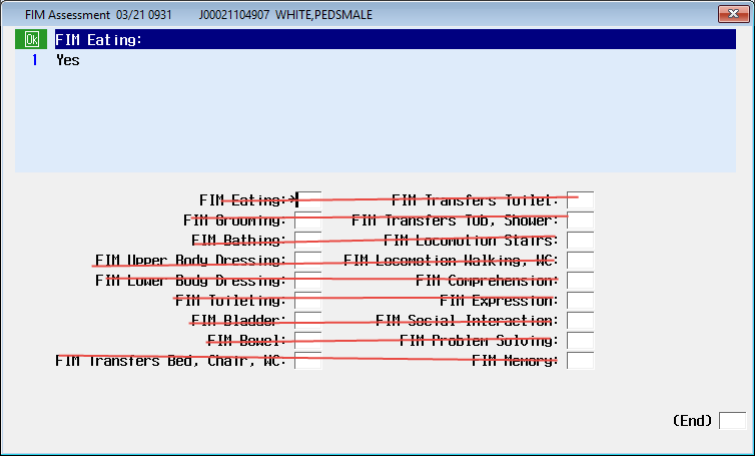
[ST Goals 97](#_Toc17205488)

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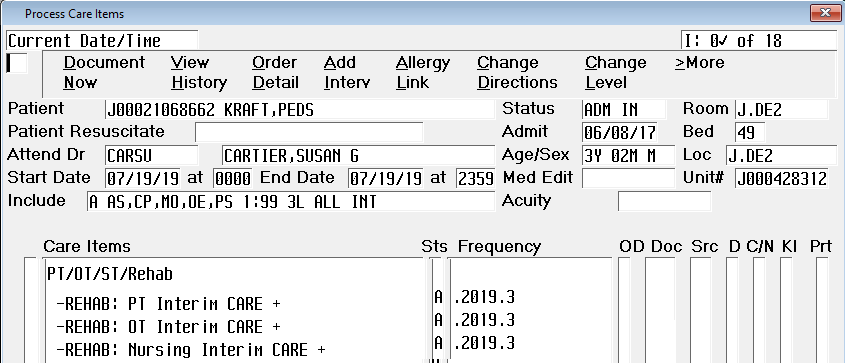
# Overall Screen Enhancements

Narrative comment boxes now allow wrap text. This means you no longer have to stop at the end of a line and press the **ENTER** key to start on the next line. Now, *simply continue typing* until all of your documentation is entered. When finished, press the **Escape** key or click in the next field to continue moving through the screen.

ST Assessment example of wrap text

CMS is retiring the FIM assessment on the IRF PAI. As a result, the FIM interventions will be removed on the day of Go Live.

Due to the CMS change to utilize CARE as the new metric for IRFs, the discipline specific CARE Tools have been revised. New Interim CARE interventions have been created for Nursing, OT, and PT.



# Preadmission

## IRF Preadmission Screen

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|  | *Do you have an advance directive* has been changed to *Patient has advance directive*.  *Content of advance directive/living will/plan of care* now allows free text. |
|  | *Consulting physician* has been changed to *Consulting physicians* to allow for documenting multiple Physicians and their specialty.  State specialty of each consulting physician listed. |
|  | The *room number* is now a free text field. |
| C:\Users\moc8618\Documents\_Projects\_EHR\IRF\2019.3\PAS\Art&Audio\Art\Background15.bmp | NEW yellow information box added for the *Date of onset* field.  Refer to the IRF PAI training manual for detailed instructions for assignment of Date of Onset. |
|  | *Date of current surgery* has been changed to *Current surgery date and type*, and a new yellow information box has been added.  Document all surgery dates and types relevant to this admission.  *Current comorbid conditions* has been changed to *Active comorbid conditions.* |

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| C:\Users\wpn3728\Downloads\77c19586-b03c-4070-992c-99ffe99d9eb5(1).png | Response options for *Risk for medical/clinical complications* have changed as follows:   * Removed **transfusion, telemetry** and **dysphagia** * Changed **Blood pressure fluctuate** to **BP fluctuation** * Added **Blood sugar fluctuation** * Separated **hypoxia** and **respiratory insufficiency** * Added Incisional dehiscence * Added new **Injury+** for the following options:   + **Injury d/t behavioral changes**   + **Injury d/t falls**   + **Injury d/t impulsivity**   + **Injury d/t ROM limitations**   + **Injury d/t WB precautions**   + **Injury d/t visual neglect** |
| C:\Users\moc8618\Documents\_Projects\_EHR\IRF\2019.3\PAS\Art&Audio\Art\Background72.bmp | NEW yellow information box for *Acute hospital stay summary.*  Document the patient’s story including the medical course and how it impacts function. This is critical for determining if rehab admission criteria is met. Include information not captured in the previous queries. Include an overall description of patient’s PLOF at home and within community. |
| C:\Users\moc8618\AppData\Local\Microsoft\Windows\INetCache\Content.Word\39.png  2019-08-05_14-25-51 | The *Vital signs* **Yes/No** query has been removed. Now, after completing the *Acute hospital stay summary*, you are taken directly to *vital signs fields* for documentation.  A new information box has been added to the vital signs *Date* field.  Document at least one complete set of vital signs. Capture abnormal vitals to identify trends pertinent to inpatient rehab stay. Values should be updated within 48 hours of admission.  A new *Temperature C* query has been added.  The order of the *vital signs* fields has been rearranged to reflect the order of *vital signs* in EBCD. |

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| 36 | The *Supporting diagnostics/labs/radiology/cardiology* **Yes/No** query has been removed. |
|  | Now, the *lab fields* are available on the screen once the date is entered. Up to three dates of information can be entered here.  The *Additional labs* field is a new field.  Document all relevant labs not captured above. Capture abnormal results to identify trends pertinent to inpatient to inpatient rehab stay. Values should be updated within 48 hours of admission. |
| C:\Users\moc8618\Documents\_Projects\_EHR\IRF\2019.3\PAS\Art&Audio\Art\Background101.bmp | *Cultures* and *Imaging* are NEW fields that allow free-text entry of pertinent results for the patient. There are examples included in the yellow information box for each query. |
|  | The query *Other supporting lab/diagnostics* has been changed to *Other supporting diagnostics.*  Document date and outcomes for any other supporting diagnostics that support the IRF admission.  The query *Neurological status* has been changed to *Neurologic status* and now allows free text, in addition to the group response options. |
| Background141 | The field *Number of bladder accidents in last 4 days prior to IRF admission* field has been changed to *Number of bladder accidents in last 48 hours.* |
| C:\Users\moc8618\Documents\_Projects\_EHR\IRF\2019.3\PAS\Art&Audio\Art\Background149.bmp    C:\Users\moc8618\Documents\_Projects\_EHR\IRF\2019.3\PAS\Art&Audio\Art\Background158.bmp | A new information box has been added to *Insertion date.*  When documenting a straight catheterization, the insertion date refers to the last in and out cath.  The NEW *Bladder comment* field is free-text.  Document pertinent catheter care, i.e. flushing, discontinue order, specimen collection, etc.  The field *Number of bowel accidents in last 4 days prior to IRF admission* field has been changed to *Number of bowel accidents in last 48 hours.*    The NEW *Bowel comment* field is free-text.  Document pertinent colostomy/ileostomy care, irrigation, collection, or other. |
|  | Additional response options for *Eating compensatory strategies* have been added:   * **Alternate solids/liquids** * **Double swallow** * **Hard swallow** * **No straw** * **Small bites/sips** |
| Background201  Additional options for Isolation+ Additional options for Weight bearing+ | Additional response options have been added for *Special rehabilitation precautions:*   * **Isolation+** * **Weight bearing+** |
| C:\Users\moc8618\AppData\Local\Temp\SNAGHTML46a2e4.PNG | The *CARE prior level of function* queries have been removed from the Preadmission Screening and added to the discipline specific documentation.  *CARE Self care prior level of function* and *CARE Functional cognition prior level of function* have been assigned to the OT Eval Assessment; *CARE Indoor mobility prior level of function* and *CARE Stairs prior level of function* have been assigned to the **PT Eval Assessment**. |
| C:\Users\moc8618\Documents\_Projects\_EHR\IRF\2019.3\PAS\Art&Audio\Art\Background251.bmp | To align with the CARE 6 point rating scale, response options for the prior level of function queries have been changed. The prior level of function groupings are   * *Bathing* * *Upper body dressing* * *Lower body dressing* * *Bed/chair* * *Toilet transfer* * *Locomotion* * *Stairs\**   ~~\*~~ The *Stairs level of function* queries are new. |
| C:\Users\moc8618\Documents\_Projects\_EHR\IRF\2019.3\PAS\Art&Audio\Art\Background252.bmp  C:\Users\moc8618\Documents\_Projects\_EHR\IRF\2019.3\PAS\Art&Audio\Art\Background255.bmp | The three *Speech/Language* level of function queries and the three *Cognition* level of function queries have been condensed into one NEW *Language and cognition* free text field.  Provide brief summary of patient’s ability to express needs, understand directions and cognition to include memory and problem solving.  The *Functional assessment comment:* query has been changed to *Overall functional comment*. There is also a NEW yellow information box.  This is not intended to repeat what was previously documented. Provide additional clinical details about functional deficits, i.e. balance, safety, etc. |
| The *Prior device use* field’s**Walker** response options now include **RW/FWW** and free text capabilities.  C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML1eccf570.PNG | |
| C:\Users\moc8618\Documents\_Projects\_EHR\IRF\2019.3\PAS\Art&Audio\Art\Background280.bmp | *Home type* has been changed to *Expected discharge physical layout*. This field now has response options and allows free text.    When *external stairs*, *internal stairs* or *grab bars* are selected for *Expected discharge physical layout*, your cursor will visit the corresponding field for adding specific details. |
|  | A new information box has been added for *anticipated services upon discharge*.  Select either outpatient or home health, and then select appropriate disciplines. |
| C:\Users\moc8618\Documents\_Projects\_EHR\IRF\2019.3\PAS\Art&Audio\Art\Background309.bmp | *Barriers to discharge* now allows free text, in addition to the following updates to the response options:   * Changed:   + ***Poor motivation* to *Requires encouragement***   + ***Poor medical prognosis* to *Medically complex***   + ***Lack of caregiver support* to *Caregiver support***   + ***Unsafe home setup* to *Home physical layout*** * Added:   + ***Endurance***   + ***Cognition*** |
|  | The response options for *Caregiver can provide* have been updated with the following:   * Added **Supervision only** * Removed: * **Constant supervision** * **Intermittent supervision** |
| C:\Users\moc8618\AppData\Local\Microsoft\Windows\INetCache\Content.Word\Background328.bmp | The response options for *Current treatment interventions* has been updated to include a new option of **Respiratory Therapy***.* |
|  | The query *Patient able to tolerate 15 hrs of therapy a week* now only has a **Yes** option. The programming has been updated so that this query is only visited when *Patient able to tolerate 3 hrs of therapy a day* is answered **NO** – it will also become required.  For the query *Altered therapy schedule comment*, the programming has been updated so that it is only visited when *Patient able to tolerate 3 hrs of therapy a day* is answered **NO** – it will also become required. |
|  | A new yellow information box has been added foreach of the *OT, PT* and *ST intensity (minutes per day)* queries.  Intensity: minutes per day. Total number of therapy minutes per day must equal 180 minutes, unless altered therapy schedule is required.  A new yellow information box has been added for each of the *OT, PT* and *ST duration (number of days)* queries.  Duration is the total number of days the patient will receive therapy during the Inpatient Rehab stay. Example: ELOS is 21 days, Frequency is 6 days per week, Duration would be 18. |
|  | The *CRS credentials* queries have a new yellow information box  CRS credentials query response requires licensure and not job title, do not enter CRS. |

# Nursing

## Nursing CARE Assessment

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|  | *Nursing CARE Tool* has been renamed to *Nursing Care Assessment*. |
|  | All **Admission** **CARE assessments** include the query: *Based on clinical judgement, pt unsafe to complete w/o tx intervention*.  The corresponding yellow information box has been updated and includes examples of therapeutic interventions related to each task.  The programming for the query is as follows:  **Yes** = score Not attempted (88)  **No** = Continues to next query |
|  | Note: For some CARE items, the “*based on clinical judgement*…” query replaces the “*complex instructions*…” query. The query verbiage has been updated secondary to clarification provided by CMS on the utilization of “Not attempted (88)”. The Nursing CARE item impacted by this change are:   * *Toileting hygiene* * *Toileting Transfer* |

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|  | The online display for the “…not completed for the following reason” query has been updated to remove “Environmental limitations: lack of equipment or weather constraints.” verbiage in the following queries:   * *Toileting hygiene not completed for the following reason:* * *Toilet transfer not completed due to following reason:* |
|  | The Discharge CARE score query text has been updated to remove *Interim* because **Nursing Interim CARE** documentation is completed in the new standalone intervention. In other words, only admission and discharge CARE are documented in the **Nursing Eval/Daily Note** bundles. |

## Nursing Interim CARE

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| C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML1a7da774.PNG | A new standalone intervention **REHAB: NUR Interim CARE** has been created for Interim CARE documentation. |
|  | Once in the intervention, you’ll see the main selection page has two options to select from for Interim CARE documentation:   * *Toileting hygiene* * *Toilet transfer*   Document CARE scores for all activities attempted each shift. All clinically-appropriate CARE items should be completed prior to next scheduled team conference. |
|  | The Interim care queries use the same *CARE assessment verbiage and score* programming as the Admission and Discharge CARE assessments.  Reminder: You can find helpful hints in the yellow information box for each question. |

## Nursing Daily Note

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|  | Due to CMS change to utilize CARE as the new metric for IRFs, FIM queries have been replaced with CARE discharge goals and bowel/bladder function goals. |
|  | *Nursing daily note* free text box has been removed. |
|  | The Nursing Daily Note has added seven new fields.  *Nutrition*/*hydration* is a new field.  Document patient’s level of participation with nutrition/hydration. Include how nutrition/hydration impacts the patient’s overall rehab plan of care. |
|  | *Bowel continence*is a new required field documented every shift.  When rating bowel continence do not consider level of assistance for clean-up and use of diaper. |
|  | *Bowel function* is a new field.  Document level of assistance and patient's progression towards established bowel management goals. Collaborate with MD where barriers to meeting goals are identified, i.e. constipation, incontinence, diarrhea, infection. |
|  | *Bladder continence* is *a new* required field documented every shift.  When rating bladder continence do not consider level of assistance for clean-up and use of peri-pad or diaper. Stress incontinence: associated with physical movement, or activity such as coughing, sneezing, laughing, or exercise.  No urine output: dialysis and patient does not void. |
|  | *Bladder function* is a new field.  Document level of assistance and patient's progression towards established bladder goals. Collaborate with MD where barriers to meeting goals are identified, i.e. retention, incontinence, infection. |
|  | *Language* and cognition is a new field.  Document how patient's language and/or cognitive deficits impact the overall rehab plan of care. |
|  | *Nurse/therapy carryover* is a new field.  Document patient's functional status observed during nursing activities, i.e. reverse ADL's in the pm, self-care activities, ambulation within room, and transfers. |

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| **Isolation** and **weight bearing** are now multi-select options when documenting *Special rehab precautions*:  C:\Users\wpn3728\AppData\Local\Temp\SNAGHTMLe8bbe03.PNG | |
|  | The yellow information box was updated for the definition of a fall, to include additional clarification that anticipated losses of balance that occur during supervised therapeutic intervention is NOT an intercepted fall.  A fall is the unintentional change in position coming to rest on the ground or next lower surface. Intercepted fall is when the patient would have fallen if they hadn't caught themselves or been intercepted by another person. Anticipated losses of balance that occur during supervised therapeutic intervention is NOT an intercepted fall. |
|  | *Physician/physician designee contacted by the facility for med issues* and *Medication issue comments* have updated yellow information boxes.  Make every effort to communicate with physician during your shift to resolve all med issues. If multiple med issues are pending resolution, document **Pending response** until ALL are complete. |
|  | Selecting the click box (A) displays a new window where the four most recent med issue comments may be viewed (B).  After reviewing the issue comments press **Return**, **Escape**, or **Exit** to close this window. |
| C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML22804586.PNG  *Equipment recommended* has been changed to *Anticipated discharge equipment.* **Walker** response options now include **RW/FWW** and free text capabilities. | |

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|  | Prior to documenting *Nursing team conference update* field, a new click box has been added to assist in reviewing previous daily notes in **Clinical review**.  The yellow information box guides you through the steps.  First, click into the box (A), then press the F3 function key on your computer keyboard. |
|  | **Clinical Review** displays all daily note documentation. You can open a dailynote by selecting the grey **Date/Time** field next to the assessment. |
|  | The daily note’s documentation displays. Once you’ve reviewed the information, you can click the **Back** button to return to the **Clinical Review** list, or click the **red X** on the toolbar to return to your **Daily Note**. |
|  | *Nursing team conference update* has an updated yellow information box.  Summarize the patient's functional progress since last team conference.  This must be completed within 24 hours PRIOR to next scheduled team conference. |
|  | *Bowel and bladder continence team* conference update is a new field. A new click box was created to display the seven most recent entries.  Summarize bowel and bladder status. Must be completed within 24 hours PRIOR to the next scheduled team conference.  After reading the comments in the display window, Press **Return**, **Escape**, or **Exit** to close the popup window. |

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|  | **Team communication** and **collaboration** are often cited as missing elements by external auditors. The following **Collaboration** screens are redesigned to capture team coordination among disciplines. A new reference page was added prior to new collaboration fields. |
|  | *Interdisciplinary team collaboration this shift* replaces multiple individual yes/no collaboration queries. Document the various disciplines you collaborated, consulted, communicated with during your shift. This is a required field. |
|  | *Focus area of collaboration this shift* replaced multiple individual**Yes/No** queries. This is a required field. |
|  | *Results and continued need for team collaboration* replaced multiple yes/no and comment queries. Document in this free text field the outcome of the interdisciplinary collaboration. This is a required field*.* |

## Nursing Goals

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|  | *CARE Toilet Transfer discharge goal* has been moved to **Nursing Goals**, from **OT Goals**. |
| 100 | The Nursing goals have been reduced from 7 narrative goals to 5 narrative goals. All 5 narrative goals default the most recent saved documentation. Most recently documented goals will flow into team conference. |

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| Slide7_a_new | The first two goals have been renamed to be specific to bowel and bladder function.  Nursing goals 3 through 5 are available for any additional clinical goals pertinent to the patient’s current rehab stay. |
| C:\Users\moc8618\AppData\Local\Microsoft\Windows\INetCache\Content.Word\101.jpeg | The FIM Discharge Goals have been removed. |
|  | A new query, *Patients identified discharge goal,* has been added. The information documented in the query is shared between all disciplines (Nursing, OT, PT, and ST) and will default information entered by other clinicians. The information is editable and will default forward into Team Conference. When documenting the patient’s goal for your discipline, enter your discipline before the Goal, like the example in the screenshot.  NOTE: Do not remove documentation in your goals. Removal of existing documentation should only be completed during Team Conference. |

# Therapy Intensity of Services & Therapy Time Provided

## Intensity of Services

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|  | The yellow information box for *duration* of therapy has been updated to include the *Prescreen ELOS* in days and an example of how to calculate duration is provided.  Enter total number of days patient will receive therapy in acute rehab.  Prescreen ELOS xx days  Example: Patient with a 14 day LOS and frequency of therapy is 6 days per week, duration would be 12 days. |
|  | The yellow information box for *Mode of therapy* has been updated to guide you through selecting the modes of therapythat are clinically appropriate for the patient. If any mode other than individual is selected, the *comment* field will become required.  If you choose any mode other than individual, you will be required to provide clinical rationale for use of other modes of therapy. Any mode other than individual should be provided on a limited, patient appropriate basis. |

## Therapy Time Provided

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|  | *Concurrent treatment* has an enhanced yellow information box to further explain options other than individual treatment.  Provision of therapy services by one licensed or certified therapist, or assistant, treating two patients at the same time who are performing different activities. Any mode other than individual should be provided on a LIMITED, patient appropriate basis. |
|  | *Co-treatment* has an updated yellow information box.  Therapy services provided by 2 therapists/assistants, from different therapy disciplines working w/ 1 patient simultaneously. Each discipline must document full treatment time, only 50% of therapy time will count towards intensity of services provided. Any mode other than individual should be provided on a LIMITED, patient appropriate basis. |
|  | *Group treatment* has an enhanced yellow information box to further explain options other than individual treatment.  Provision of therapy services by one licensed or certified therapist, or assistant, treating two to six patients at the same time who are performing the same or similar activities. Any mode other than individual should be provided on a LIMITED, patient appropriate basis. |

# Occupational Therapy

## OT CARE ADL and Eating and Oral Hygiene

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| Example of OT CARE ADLs    Example of OT CARE Eating/Oral Hygiene | All **Admission** assessments include the query *Based on clinical judgement, pt unsafe to complete w/o tx intervention*.  The corresponding yellow information box has been updated and includes examples of therapeutic interventions related to each task.  The programming for the query is as follows:  **Yes** *= score Not attempted (88)*  **No** *= Continues to next query*  Note: For some CARE items, the “*based on clinical judgement*…” query replaces the “*complex instructions*…” query. The query verbiage has been updated secondary to clarification provided by CMS on the utilization of “Not attempted (88)”. The OT CARE items impacted by this change are:   * *Patient eats by mouth* * *Patient bathed or showered* * *Patient dressed/undressed upper body* * *Patient dressed/undressed lower body* * *Patient put on/removed footwear* |
|  | The online display for the “…not completed for the following reason” query has been updated to remove “Environmental limitations: lack of equipment or weather constraints.” verbiage in the following queries:   * *Not eating by mouth for the following reason:* * *Oral hygiene not completed due to the following reason:* * *Reason unable to bathe or shower self* * *Reason unable to dress/undress upper body* * *Reason unable to dress/undress lower body* * *Reason unable to put on/remove footwear* |
|  | The **Discharge CARE assessments** have *Interim* removed from the score query text, because there are separate interventions to document Interim CARE. Only admission and discharge CARE are documented in the discipline-specific **Eval/Daily Note** bundles. |

## OT Interim CARE

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|  | A new standalone intervention **REHAB: OT Interim CARE Assess** has been created for Interim CARE documentation. |
|  | Once in the intervention, you’ll see the main selection page has six options to select from for Interim CARE documentation:   * *Eating* * *Oral hygiene* * *Shower/bathing* * *Dressing upper body* * *Dressing lower body* * *Footwear* |
|  | The new **Interim CARE** queries use the same **CARE assessment** verbiage and score programming as seen on the Admission and Discharge CARE assessments.  Document CARE scores for all activities attempted each shift. All clinically-appropriate CARE items should be completed prior to next scheduled team conference.  Reminder: You can find helpful hints in the yellow information box for each question. |

## OT Assessment

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|  | *CARE Self care prior level of function* has been added to the **OT Assessment** and is required on admission by CMS.  Self Care includes bathing, dressing, using the toilet, or eating. DEPENDENT: Helper completed activities for patient. NEEDED SOME HELP:  Pt needed partial ass't w/ activities. INDEPENDENT: Pt completed activities with NO assistance from helper (w/wo assistive device). |
|  | *CARE Functional cognition prior level of function* have been added to the **OT Assessment** and required on admission by CMS. |
|  | *OT prior level of function comment* field has been increased along with adding wrap text functionality. |
|  | *Home type* has been changed to *Expected discharge physical layout.* |
|  | *Neglect/visual function comment* has been changed to *Visual perception/cognition comment.* The comment field has been increased along with adding wrap text functionality. |
|  | *Upper extremity function comment* has been changed to *Upper extremity/endurance comment.* The comment field has been increased along with adding wrap text functionality. |
|  | *Neuro function comment* now has a larger comment field along with wrap text functionality. |
|  | *Balance function comment* field has been increased along with adding wrap text functionality. |
|  | A new yellow information box has been added to *OT special tests* examples. |
|  | *Barriers to discharge* now includes free text capability. |
|  | *Anticipated assistance required for transfer to community* now includes free text capability. |
|  | *Anticipated services upon discharge* now includes free text capability. |
|  | *Caregiver availability* now includes free text capability. |
|  | *Caregiver can provide* now includes free text capability. |

## OT Eval/Daily Note

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|  | Due to CMS change to utilize CARE as the new metric for IRFs, *FIM queries* have been replaced with *CARE discharge goals*. |
|  | *OT daily note* free text box was removed. |
|  | The Daily Note now has six new fields.  *Range of motion and strength* is a new field. |
|  | *Transfers* is a new field.  Document patient's overall performance with toilet, tub/shower, bed, chair, or wheelchair transfers. Include compensatory strategies and equipment introduced during this therapy session. |
|  | *Activities of daily living* is a new field.  Document patient's overall performance with basic and instrumental ADLs. Include compensatory strategies and equipment introduced during this therapy session. |
|  | *Cognition* is a new field.  Document patient's overall performance with cognition, problem solving, and memory. Include how patient's language and/or cognitive deficits impact the overall rehab plan of care and therapeutic interventions. |

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|  | *Upper extremity* is a new field. |
|  | *OT daily note comment* is a new field intended for additional comments not captured in previous documentation or to complete a SOAP note.  This section can be used for any additional comments not captured previously or to complete a narrative note. |
| C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML1015b675.PNG | **Isolation** and **weight bearing** are now multi-select options when documenting *Special rehab precautions*: |
|  | The yellow information box was updated for the definition of a fall, to include additional clarification that anticipated losses of balance that occur during supervised therapeutic intervention is NOT an intercepted fall.  A fall is the unintentional change in position coming to rest on the ground or next lower surface. Intercepted fall is when the patient would have fallen if they hadn't caught themselves or been intercepted by another person. Anticipated losses of balance that occur during supervised therapeutic intervention is NOT an intercepted fall. |
| C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML2358574e.PNG  *Equipment recommended* has been changed to *Anticipated discharge equipment.* **Walker** response options now include **RW/FWW** and free text capabilities. | |
|  | *Barriers and strategies* comment field has been increased along with adding wrap text functionality. |

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| C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML6798ef.PNG | | Prior to documenting *OT team conference update* field, a new click box has been added to assist in reviewing previous daily notes in **Clinical review**.  The yellow information box guides you through the steps.  First, click into the box (A), then press the F3 function key on your computer keyboard. |
|  | | **Clinical Review** displays all daily note documentation. You can open a daily note by selecting the grey **Date/Time** field next to the assessment. |
|  | The daily note displays. Once you’ve reviewed the information, you can click the **Back** button to return to the **Clinical Review** list, or click the **red X** on the toolbar to return to your Daily Note. | |
|  | An updated yellow information box has been added to *OT team conference update*.  Utilize OT team conference update to summarize the patient's functional progress since last team conference.  This must be completed within 24 hours PRIOR to next scheduled team conference. | |
|  | **Team communication** and **collaboration** are often cited as missing elements by external auditors. The following **Collaboration** screens are redesigned to capture team coordination among disciplines. A new reference page was added prior to new collaboration fields. | |
|  | *Interdisciplinary team collaboration this shift* replaces multiple individual yes/no collaboration queries. Document the various disciplines you collaborated, consulted, communicated with during your shift.  This is a required field. | |
|  | *Focus area of collaboration this shift* replaced multiple individual**Yes/No** queries. This is a required field. | |
|  | *Results and continued need for team collaboration* replaced multiple yes/no and comment queries. Document in this free text field the outcome of the interdisciplinary collaboration. This is a required field*.* | |

## OT Goals

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|  | The OT goals have been reduced from 7 narrative goals to 5 narrative goals. All 5 narrative goals default the most recent saved documentation. |
|  | *CARE toileting hygiene* and *toilet transfer* have been moved to **Rehab Nursing** and removed from **OT CARE Discharge Goals.** |
|  | The FIM Discharge Goals have been removed. |
|  | A new query *Patients identified discharge goal* has been added. The information documented in the query is shared between all disciplines (Nursing, OT, PT, and ST) and will default information entered by other clinicians. The information is editable and will default forward into **Team Conference**. When documenting the patient’s goal for your discipline, enter your discipline before the goal, like the example in the screenshot.  NOTE: Do not remove documentation in your goals. Removal of existing documentation should only be completed during **Team Conference.** |

# Physical Therapy

## PT CARE Transfers and Mobility

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| Example of PT CARE Transfers  Example of PT CARE Mobility | All **Admission** **CARE assessments** include the query *Based on clinical judgement, pt unsafe to complete w/o tx intervention.*  The corresponding yellow information box has been updated and includes examples of therapeutic interventions related to each task.  The programming for the query is as follows:   * **Yes** = score Not attempted (88) * **No** = Continues to next query   The PT CARE items impacted by this change are:   * *Patient rolled left and right:* * *Patient performed sitting to lying:* * *Patient performed lying to sitting on side of bed:* * *Patient performed sit to stand:* * *Patient transferred to/from bed to chair:* * *Patient transferred in and out of car:* * *Patient walked minimum of 10 feet:* * *Patient stepped over a curb or up and down one step:* * *Patient picked up small object from floor from standing position:* * *Patient attempted WC 50 feet AND made two turns:* * *Patient attempted WC 150 feet:* |

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|  | Note: For some CARE items, the “*based on clinical judgement*…” query replaces the “*complex instructions*…” query. The query verbiage has been updated secondary to clarification provided by CMS on the utilization of “Not attempted (88)”.  The PT CARE items impacted by this change are:   * *Unable to roll left and right due to the following reason:* * *Sitting to lying not completed for* the *following reason:* * *Lying to sitting not completed for the following reason:* * *Sitting to standing not completed for the following reason:* * *No bed to chair transfer due to the following reason:* * *Not walking 10 feet for the following reason:* * *Reason unable to step over curb or one step:* * *Reason unable to pick up small object from standing:* * *Reason unable to wheel 50 feet AND make two turns:* * *Reason unable to wheel 150 feet:* |
|  | The online display for the “…not completed for the following reason query” has been updated to remove “Environmental limitations: … weather constraints.” Verbiage for the following queries (Note: it remains in the Car transfer section):   * *Unable to roll left and right due to the following reason:* * *Sitting to lying not completed for the following reason:* * *Lying to sitting not completed for the following reason:* * *Sitting to standing not completed for the following reason:* * *No bed to chair transfer due to the following reason:* * *Not walking 10 feet for the following reason:* * *Reason unable to step over curb or one step:* * *Reason unable to pick up small object from standing:* * *Reason unable to wheel 50 feet AND make two turns:* * *Reason unable to wheel 150 feet:* |
|  | The **Discharge CARE assessments** have *Interim* removed from the score query text, because there are separate interventions to document Interim CARE. Only admission and discharge CARE are documented in the discipline-specific Eval/Daily Note bundles. |

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|  | A NEW yellow information box has been added for the *Patient uses wheelchair or scooter* field.  Use clinical judgement to determine if WC is used for self-mobilization or used ONLY for transport. Do NOT assess WC mobility if WC is for transport only. Select NO if WC is used for transport only. Select YES if WC assessment is based on patient's ability to mobilize in WC. | |
| Patient attempted WC 50 feet AND made two turns | The following screens have a new question and no change to the scoring logic.  The yellow information boxes were streamlined, removing directions for when to answer NO.  The verbiage changed from *Patient wheeled minimum* of 150 feet to *Patient attempted wheelchair 150 ft.*   * Patient attempted WC *50 feet AND made two turns* * *150 feet* * *Bed to chair transfer* * *Car transfer* | |
| Patient attempted WC 150 feet AND made two turns |  | |
|  | | The corresponding yellow information box has been updated:  Once standing, assess patient's usual performance with walking at least 10 feet in a room, corridor or similar space.  If patient travels LESS than 10 feet, answer NO. Patient may take a brief standing pause during ambulation task. |

## PT Interim CARE

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|  | A new standalone intervention **REHAB: PT Interim CARE Assess** has been created for Interim CARE documentation. |
|  | Once in the intervention, you’ll see the main selection page has sixteen options to select from for **Interim CARE** documentation:   * *Roll left to right* * *Sit to lying* * *Lying to side of bed* * *Sit to stand* * *Bed/chair transfer* * *Car transfer* * *WC 50 feet w/ 2 turns\** * *WC 150 feet\** * *Walk 10 feet* * *Walk 50 feet w/ 2 turns* * *Walk 150 feet* * *Walk 10 feet on uneven surface* * *1 step (curb)* * *4 steps* * *12 steps* * *Picking up object*   Document CARE scores for all activities attempted each shift. All clinically-appropriate CARE items should be completed prior to next scheduled team conference. |
|  | Information boxes have been added to **WC 50 feet w/ 2 turns** and **WC 150 feet**.  Use clinical judgement to determine if WC is used for self-mobilization or used ONLY for transport. Do NOT assess WC mobility if WC is for transport only.  Select YES if WC assessment is based on patient's ability to mobilize in WC. |
|  | The new Interim CARE queries use the same CARE assessment verbiage and score programming as seen on the Admission and Discharge CARE assessments.  Reminder: You can find helpful hints in the yellow information box for each question. |

## PT Assessment

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|  | *CARE Indoor mobility level of function* has been added to the **PT Assessment** and is required required on admission by CMS. |
|  | *CARE Stairs prior level of function* has been added to the **PT Assessment** and is required on admission by CMS. |
|  | *PT prior level of function comment* field has been increased along with adding wrap text functionality. |
| C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML1ed3259b.PNG  The *Prior device use* field’s**Walker** response options now include **RW/FWW** and free text capabilities. | |
|  | *Prior device use additional information* field has added wrap text functionality*.* |
|  | *Hobbies/leisure activities* comment field has been increased along with adding wrap text functionality. |
|  | *Neurological Status* field has been changed to *Neurologic Status*. The comment field has been increased along with adding wrap text functionality. |
|  | *Neurological comment* now has a larger comment field along with wrap text functionality. |
|  | *Sensation comment* now has a larger comment field along with wrap text functionality. |
|  | *Musculoskeletal comment* field has been changed to *Musculoskeletal/endurance comment.* |
|  | *Balance function comment* now has a larger comment field along with wrap text functionality. |
|  | *Home type* has been changed to *Expected discharge physical layout*. |
|  | A new yellow informationbox has been added to *PT special tests.*  Capture additional tests not captured elsewhere. |
| 2019-08-08_12-00-59 | *Gait/wheelchair performance* field has been changed to *Mobility performance.* |
| 2019-08-08_12-01-09 | *Evaluation results field* has been changed to *PT evaluation results.*  Provide brief summary of clinical evaluation. |

## PT Eval/Daily Note

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|  | | Due to CMS change to utilize CARE as the new metric for IRFs, *FIM queries* have been replaced with *CARE discharge goals*. |
|  | | The Daily Note has added eleven new fields.  *PT daily note* free text box was removed. |
|  | | *Range of motion and strength* is a new field. |
|  | | *Transfers* is a new field. |
| 2019-08-08_12-33-10 | | *Mobility* is a new field. |
| 2019-08-08_12-34-18 | | *Gait distance* is a new field.  Farthest distance without a rest break. |
| 2019-08-08_12-34-22 | | *Gait device* is a new field. |
| 2019-08-08_12-34-46 | | *Wheelchair distance* is a new field.  Farthest distance without a rest break. |
| 2019-08-08_12-34-51 | | *Wheelchair device* is a new field. |
| 2019-08-08_12-34-56  C:\Users\moc8618\AppData\Local\Microsoft\Windows\INetCache\Content.Word\2019-08-08_12-35-00.jpg | | *Mobility description* is a new field.  Include detailed description of patient’s mobility during therapeutic activities.  Examples: description of gait, wheelchair management (including ramps), assistance required for stairs (include number of steps).  *Oxygen saturation with activity* is a new field. |
| 2019-08-08_12-35-03 | | *Fall recovery* is a new field.  As clinically appropriate, recommend assessing fall recovery for patients prior to discharge to home. |
|  | | The *PT daily note comment* is a new field intended for additional comments not captured in previous documentation or to complete a SOAP note.  This section is intended for additional comments not captured in previous documentation or to complete a narrative note. |
| C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML1073a1bc.PNG | | **Isolation** and **weight bearing** are now multi-select options when documenting *Special rehab precautions*. |
|  | The yellow information box was updated for the definition of a fall, to include additional clarification that anticipated losses of balance that occur during supervised therapeutic intervention is NOT an intercepted fall.  A fall is the unintentional change in position coming to rest on the ground or next lower surface. Intercepted fall is when the patient would have fallen if they hadn’t caught themselves or been intercepted by another person. Anticipated losses of balance that occur during supervised therapeutic intervention is NOT an intercepted fall. | |
|  | *Equipment recommended* has been changed to *Anticipated discharge equipment.* | |
| Additional options can be seen  under *F9 For More Options.*  C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML42427519.PNG | | |

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| 2019-08-08_13-08-54 | **Walker** response options now include **RW/FWW** and free text capabilities. |
| 2019-08-08_13-10-59 | *Barriers and strategies* commentfield has been increased along with adding wrap text functionality. |

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| --- | --- | --- |
| C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML1082c112.PNG | Prior todocumenting *PT team conference update* field, a new click box has been added to assist in reviewing previous daily notes in**Clinical review**.  First, click into the box (A), then press the **F3** function key on your computer keyboard. | |
|  | **Clinical Review** displays all daily note documentation.You can open a dailynote by selecting the grey **Date/Time** field next to the assessment. | |
|  | | Once you’ve reviewed the daily note, you can click the **Back** button to return to the **Clinical Review** list, or click the **red X** on the toolbar to return to your Daily Note. |

|  |  |
| --- | --- |
|  | An updated yellow information box has been added to *PT team conference update*.  Summarize the patient's functional progress since last team conference.  Must be completed within 24 hours PRIOR to next scheduled team conference. |
|  | **Team communication** and **collaboration** are often cited as missing elements by external auditors. The following **Collaboration** screens are redesigned to capture team coordination among disciplines. A new reference page was added prior to new collaboration fields. |
|  | *Interdisciplinary team collaboration this shift* replaces multiple individual **Yes/No** collaboration queries. Document the various disciplines you collaborated, consulted, communicated with during your shift. This is a required field. |
| *Focus area of collaboration this shift* replaced multiple individual**Yes/No** queries. This is a required field*.*  Additional options are seen under **F9 For More Options**.  C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML4295f67a.PNG | |
| 2019-08-08_13-16-55 | *Results and continued need for team collaboration* replaced multiple yes/no and comment queries. Document in this free text field the outcome of the interdisciplinary collaboration. This is a required field*.* |

## PT Goals

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| --- | --- |
|  | The *PT goals* have been reduced from 7 narrative goals to 5 narrative goals. All 5 narrative goals default the most recent saved documentation. |
|  | The *FIM Discharge Goals* have been removed. |
|  | A new query *Patients identified discharge goal* has been added. The information documented in the query is shared between all disciplines (Nursing, OT, PT, and ST) and will default information entered by other clinicians. The information is editable and will default forward into **Team Conference**. When documenting the patient’s goal for your discipline, enter your discipline before the goal, like the example in the screenshot.  NOTE: Do not remove documentation in your goals. Removal of existing documentation should only be completed during Team Conference. |

# Speech Therapy

## ST Assessment

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| --- | --- | --- |
|  | | *ST prior level of function comment* field has been increased along with adding wrap text functionality. |
|  | | *Home type* has been changed to *Expected discharge physical layout*. |
|  | | *Neurological status* has been changed to *Neurologic status.* |
|  | *Cognition comment* field has been increased along with adding wrap text functionality. | |
|  | *Neglect/visual comment* field has been increased along with adding wrap text functionality.  *Receptive language complex sequential directions* field has been removed from the Expressive language function section.  *Receptive language comment field has been increased along with adding wrap text functionality.* | |
|  | *Expressive language verbal description* fieldhas been removed from the *Expressive language function* section.  *Expressive language comment* field has been increased along with adding wrap text functionality. | |
| 2019-08-08_13-51-05 | *Bedside swallow assessment* field has been increased along with adding wrap text functionality. | |
|  | A new yellow information box has been added to *ST special tests*  Examples: MMMSE, SLUNS, MOCA, Beside WAB  *Evaluation results* has been changed to *ST evaluation results The* comment field has been increased along with adding wrap text functionality.  Provide brief summary of clinical evaluation. | |
|  | *Barriers to discharge* now includes free text capability. | |
| 2019-08-08_13-55-09 | *Return to work/school plan* field has been increased along with adding wrap text functionality. | |

## ST Eval/Daily Note

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|  | | Due to CMS change to utilize CARE as the new metric for IRFs, *FIM queries* have been removed from this page. |
|  | | The **Daily Note** now has four new fields.  *ST daily note* free text box was removed. |
|  | | *Dysphagia* is a new field. |
|  | | *Expression/comprehension* is a new field. |
|  | | *Cognition* is a new field.  Comments should include memory, problem solving, attention, and social interaction details as appropriate. |
|  | | The *ST daily note comment* is a new field intended for additional comments not captured in previous documentation or to complete a SOAP note.  This section can be used for any additional comments not captured previously or to complete a narrative note. |
| **C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML107f7a34.PNGIsolation** and **weight bearing**  are now multi-select options  when documenting *Special rehab precautions*: | | |
|  | | The yellow information box was updated for the definition of a fall, to include additional clarification that anticipated losses of balance that occur during supervised therapeutic intervention is NOT an intercepted fall.  A fall is the unintentional change in position coming to rest on the ground or next lower surface. Intercepted fall is when the patient would have fallen if they hadn’t caught themselves or been intercepted by another person. Anticipated losses of balance that occur during supervised therapeutic intervention is NOT an intercepted fall. |
| C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML42ccf95d.PNG | | *Equipment recommended* has been changed to *Anticipated discharge equipment*. **Walker** response options now include **RW/FWW** and free text capabilities. |
|  | | *Barriers and strategies* comment field has been increased along with adding wrap text functionality |
| C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML108125e0.PNG | | Prior to documenting *ST team conference update* field, a new click box has been added to assist in reviewing previous daily notes in **Clinical Review**.  The yellow information box guides you through the steps.  First, click into the box (A), then press the **F3** function key on your computer keyboard. |
|  | | **Clinical Review**displays all daily note documentation. You can open a daily note by selecting the grey **Date/Time** field next to the assessment. |
|  | The daily note displays. Once you’ve reviewed the information, you can click the **Back** button to return to the **Clinical Review** list, or click the **red X** on the toolbar to return to your Daily Note. | |
|  | An updated yellow information box has been added to *ST team conference update.*  Utilize *ST team conference update* to summarize the patient's functional progress since the last team conference.  This must be completed within 24 hours PRIOR to next scheduled team conference.  **Note**: When Speech Therapy is involved, speech therapy must document at least 1 to 2 goals - and goal progression - in the weekly *ST Team conference update*. | |
|  | **Team communication** and **collaboration** are often cited as missing elements by external auditors. The following **Collaboration** screens are redesigned to capture team coordination among disciplines. A new reference page was added prior to new collaboration fields. | |
|  | *Interdisciplinary team collaboration this shift* replaces multiple individual yes/no collaboration queries. Document the various disciplines you collaborated, consulted, communicated with during your shift.This is a required field. | |
| *Focus area of collaboration this shift* replaced multiple individual**Yes/No** queries. This is a required field.  *Focus area of collaboration this shift* replaced multiple individual**Yes/No** queries. This is a required field.  C:\Users\wpn3728\AppData\Local\Temp\SNAGHTML42d539ca.PNG | | |
|  | *Results and continued need for team collaboration* replaced multiple yes/no and comment queries. Document in this free text field the outcome of the interdisciplinary collaboration. This is a required field. | |

## ST Goals

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| C:\Users\moc8618\AppData\Local\Microsoft\Windows\INetCache\Content.Word\STGOALALL.jpeg | The *ST goals* have been reduced from 7 narrative goals to 5 narrative goals. All 5 narrative goals default the most recent saved documentation. |
| C:\Users\moc8618\AppData\Local\Microsoft\Windows\INetCache\Content.Word\STFIM.jpeg | The *FIM Discharge Goals* have been removed. |
|  | A new query *Patients identified discharge goal* has been added. The information documented in the query is shared between all disciplines (Nursing, OT, PT, and ST) and will default information entered by other clinicians. The information is editable and will default forward into **Team Conference**. When documenting the patient’s goal for your discipline, enter your discipline before the goal, like the example in the screenshot.  NOTE: Do not remove documentation in your goals. Removal of existing documentation should only be completed during Team Conference. |

# Team Conference

|  |  |
| --- | --- |
|  | The programming for the yellow information box for *Etiologic diagnosis* and Current/active comorbid conditions has been updated to display the last filed answer from **Preadmission screening (PAS)** or from **provider (PDoc) documentation.** |
|  | CMS is retiring the **FIM assessment** on the **IRF PAI**. As a result, all the *FIM queries* have been removed. |
|  | In response to CARE being the only functional assessment metric as of 10/1/19, new CARE fields for *Admission total*, *Interim total* and *total score change* have been added to **Team Conference**.  The programming will default in the answer for each field and is not editable. The calculation for each field is as follows:   * *Admission total* the sum of the first documented entries. Not attempted responses are calculated as a 1. * *Interim total* is the sum of the most recent documented interim or admission CARE scores. * *Change* is the difference in admission and interim scores - admission total is subtracted from the interim total. |
|  | * + *A negative change* indicates a decline in the patient’s overall status since admission. |
|  | * + *“0” in “…change”* occurs when there is no progress between admission and interim scores. |
|  | The categories and CARE items for each total and change groupings are:   * *Self care (OT CARE)*   + *Patient eats by mouth*   + *Patient bathed or showered*   + *Patient dressed/ undressed upper body*   + *Patient dressed/undressed lower body*   + *Reason unable to put on/remove footwear*   + *Patient put on/removed footwear* * *Transfer (PT CARE Transfers)*   + *Patient rolled left and right*   + *Patient performed sitting to lying*   + *Patient performed lying to sitting on side of bed*   + *Patient performed sit to stand*   + *Patient transferred to/from bed to chair*   + *Patient transferred in and out of car* |
|  | * *Mobility (PT CARE Mobility)*   + *Patient walked minimum of 10 feet*   + *Patient stepped over a curb or up and down one step*   + *Patient picked up small object from floor from standing position*   + *Patient attempted WC 50 feet AND made two turns*   + *Patient attempted WC 150 feet*   Notice the yellow information box displays scoring ranges as well as possible change scores and best practice information. |
|  | Two new fields *Wheelchair distance* and *Mobility description* have been added to capture the Wheelchair dependent patient’s status. The most recent answer from the **PT Daily Note** will default in and can be edited, as needed. |
|  | Two new queries *Bowel continence admission rating* and *Bladder continence admission rating* have been added to allowing review of the patient’s Admission CARE ratings based on documentation from the Nursing Daily Note during the 3 day Admission assessment period. This rating is not editable.  The yellow information box includes the possible ratings and important distinctions.  NOTE: This field will be blank if team conference is held prior to day 4 of the patient’s stay. |
|  | *Bowel and bladder continence team conference update* defaults the most recent documentation from the **Nursing Daily note***.* This field can be edited in Team conference.  Note: Edits in **Team Conference** do not flow into the **Nursing Daily Note**. |
|  | *Weekly team goal* has been removed. |
|  | *Barriers and strategies* field has increased in display size to allow for enhanced text review and documentation. |
|  | *Equipment recommended* has been changed to *Anticipated discharge equipment.* |
|  | *Patients identified discharge goal* is a new query that is shared amongst all disciplines and flows in the **Team Conference**. |
|  | In response to FIM being retired, the *FIM discharge goals* in **Team Conference** have been replaced with *CARE discharge goals*. Documentation pulls in from discipline-specific CARE discharge goal documentation (noted in the yellow information box of each query). The documentation that flows into **Team Conference** here can be edited, but it does NOT flow back to the discipline specific CARE discharge goals. |
|  | The *Nursing goals* have been reduced from 7 narrative goals to 5 narrative goals. All 5 narrative goals default the most recent documentation from the *Nursing Goals*.  The first two goals have been specified for bowels and bladder function. Nursing goals 3 through 5 are available for any additional clinical goals pertinent to the patient’s current rehab stay. |

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