SUBJECT: DOCUMENTATION REQUIREMENTS	REFERENCE #9001
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DEPARTMENT: REHABILITATION SERVICES	
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- Each Rehabilitation Services inpatient and outpatient has a medical record of care and treatment which includes subsequent referrals, copies of progress notes and treatment plans.

- Rehabilitation Services documents the overall course of patient treatment within its scope of practice.

- Documentation must support medical necessity of Rehabilitation Services.

- All entries in the medical record are dated, timed and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided. Additionally, the time and date of each entry (orders, reports, notes, etc.) must be accurately documented.

- Clinical observations are made in the Rehab progress notes by Rehabilitation Services staff. These progress notes give a pertinent chronological report of the patient's response to care, treatment and services provided in the hospital and reflect any change in condition, the results of treatment and plan of care revisions when indicated.

- Consultation reports contain a written or dictated opinion by the consultant that reflect an actual examination of the patient, when applicable, and the patient's medical record.

- Opinions requiring medical judgment are written and authenticated only by the medical staff members in the progress notes or on consultation reports.

- All medications ordered are documented in the medical record.

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- Medication administration is documented in the patient's medication record to include:
  - Strength
  - Dose, rate of administration
  - Route
  - Administration devices used
  - Any adverse drug reaction
- Complications, including healthcare associated infections (HAIs), shall be documented.
- Patient and family education is documented by all disciplines, as applicable, in the patient's medical record.
- Communication with the patient, verbally or via e-mail or telephone, is documented in the patient's medical record.
- All patient-generated information is documented (i.e., information entered into the record over the Internet or various forms of electronic media from laboratory or other diagnostic avenues, pre-visit clinical data or other types of information).
- Discharge planning is documented in the patient's medical record.
- A copy of the discharge instructions given to the patient is filed in the medical record.
- The medical record shall contain the following Rehabilitation Services information:
  - Appropriate referrals and/or prescription
  - Signed registration
  - Attendance sheet

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- Daily/weekly progress notes:
  - Document objective, measurable improvements in the patient's functional status
- Initial evaluation and re-evaluations:
  - Clarify the date when therapy intervention started and current frequency of treatments
  - Identify actual problems that require the skills of a qualified Rehabilitation Therapist
  - Indicate the patient's restorative potential, in specific measurable terms
  - Document objective, measurable improvements in the patient's functional status
  - Assess the patient's current status and compare this with the status at the time treatment was initiated
  - Specifically address decreased functional ability
  - Address other complicating problems that impede the patient's functional progression
- Signed monthly progress notes
- Discharge summary:
  - The discharge summary will "briefly summarize the significant findings and events of the patient's hospitalization, condition at time of discharge and the recommendations and provisions for future care".

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- For those patients who are receiving continuing outpatient (ambulatory) services, a list of the following will be made upon initial presentation, if possible; however, no later than the third visit (when more complete information can be listed due to continuing care):
    - Known diagnoses (significant and secondary)
    - Known or observed conditions
    - Prior operative and invasive procedures
    - Drug allergies
    - Known adverse drug reactions
    - Medication:
        - Current prescriptions
        - Over-the-counter medications
        - Herbal supplements
- Any cancellations or missed appointments will be documented and will include the reason for the missed treatment, if provided.

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