LEGACY HEALTH

PATIENT CARE
Standard of Care: 907.1400
Origination Date: JUN 1997
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SECTION: STANDARD OF CARE
SUBJECT: REHABILITATION INSTITUTE OF OREGON PATIENTS*

** Adult (≥ 18 years)*

PATIENT EXPECTATIONS: *Care and treatment provided will assist the patient in meeting the following expectations:*

A. Optimal physiologic function.
B. Improved knowledge and functional application of compensatory techniques for mobility, personal care, communication, and/or cognition.
C. Maintenance of physical safety, which preserves dignity, privacy, and provides emotional support.
A. Early identification of complications and intervention to reduce effect(s).
B. Improved or maintained psychosocial adaptation to disability.
C. Active participation in the discharge planning process.

INTERVENTIONS: The RN applies the nursing process in support of the interdisciplinary plan of care.

1. Consider application of rehabilitation nursing unit standards for management of neurogenic bladder, neurogenic bowel, aspiration precautions, cognitively impaired adults who are at risk of elopement and cervical traction with halo braces etc. Implement selected interventions based on patient condition and/or physician orders.

2. Assess pain and relevant major body systems with a maximum duration of approximately 12 hours between observations as warranted by the patient's condition and nursing judgment, current or potential problems and **document findings**.

3. Assess skin integrity at least morning and night. Collaborate with the team to prevent pressure ulcers by teaching the patient to do pressure relief, especially when sitting.

KEY POINT: Monitor high risk areas for signs of skin breakdown due to friction or pressure with each turn and immediately after moving from wheelchair to bed. Check for pressure spots approximately every hour under new or newly adjusted splints or braces, etc.

4. Assess vital signs twice daily unless ordered otherwise. Notify physician if:
   a. Oral temperature > 38 C (101^0F)
   b. Pulse >150 or <50mmHg
   c. Systolic Blood Pressure <90 mmHg or >150 mmHg, or for person with spinal cord injury: < 85 mmHg.
   d. Diastolic Blood Pressure >110 mmHg.

5. Complete **and document** functional assessments (i.e. FIMs™) approximately every 12 hours for Toileting, Toilet Transfers, Bed/Chair Transfers, Bowel Function, Bladder Function, Problem Solving, Social Cognition and Memory.

KEY POINT: Admission FIM™ scores are recorded on the Admission FIM™ flow sheet by the end of the 3rd patient day. The lowest score from the 3 day period is recorded on the RIO ADMISSION FIM™ FLOWSHEET. Discharge FIM™ scores are recorded on the Discharge FIM™ flow sheet by the end of the day before discharge.

6. For chronic pain, evaluate effectiveness of pain management program approximately every 12 hours. Revise the pain management program in collaboration with the team for patients whose pain is interfering with their functional activities and/or therapy. Document impact of pain medications or modalities on the patient's functional abilities.

7. Turning and repositioning are essential aspects of care for patients who are insensate and immobile. Take care to accommodate the patient's convenience, comfort and sleep when assuring that all aspects of skin care are complete, for prevention of skin breakdown or to promote healing of existing open areas.

KEY POINT: Preventative care may be skipped only with a physician's order. Skin checks and pressure relief is mandatory for participation in the program in the same way attending therapy is required.

8. If ordered, apply anti-embolic stockings and/or wraps to lower extremities before the patient's legs are in a dependent position. Remove anti-embolic stockings and/or wraps at HS. Try to elevate the patient's legs at times during the day. It is especially important to reduce the pooling of fluids in the legs during the day for spinal cord injured patients.

KEY POINT: **Check devices throughout the day and reposition as needed to prevent circulatory compromise in the legs.**

9. Collaborate with therapist treatment plans including application and removal of splints, pressure garments, and other devices as directed.

10. Record fluid intake and output on all patients until adequate hydration and urinary output are stable. Individuals with dysphagia, neurogenic bladder dysfunction or neurogenic bowel dysfunction may need fluid balance monitoring until discharge.

11. Provide or assist with a complete shower every other day and additional personal hygiene as needed.

12. Reinforce therapeutic functional techniques as recommended by the team for activities of daily living, behavior management, cognitive retraining, eating, mobility, safety, etc. Monitor the patient's carry over on the nursing unit, of therapeutic functional techniques for mobility, safety, night time toileting, increasing independence with bathing, dysphagia management, etc. over the 24 hour day.

KEY POINT: Document actual night time care needs such as toileting and level of assistance for transfers.

13. Have the patient &/or family view the RIO Orientation DVD on the day of admission.

INTERDISCIPLINARY PLAN OF CARE: *Within each discipline's scope of practice, members of the interdisciplinary rehabilitation treatment team collaborate to provide the following treatment and care as warranted by the patient condition and professional judgment:*

1. Begin the initial therapy interdisciplinary evaluation within approximately 24 hours of admission.

2. Document the admission evaluation and treatment plan based on individual functional needs within approximately 3 days of admission.

3. Identify specific functional goals/expected outcomes for the individual to achieve by the time of discharge.

4. Record admission and predicted goal functional assessment scores (i.e. FIM™ scores) as on the admission FIM flow sheet assigned by discipline by 4pm of the third day of the stay.

5. Record discharge functional assessment scores (i.e. FIM™ scores) on the discharge FIM™ flow sheet by 4pm the day before a planned discharge. Dayshift nursing records the nursing scores.

6. Collaborate among rehabilitation nurses and therapists to provide 24-hour care/treatment based on individual patient needs.

7. Promote fall prevention through implementation of the RIO admission fall prevention guidelines.
   a. Emphasize to patients and families that we take safety very seriously and are committed to their safety while they become adjusted to their new abilities. Assure that your behavior doesn't indicate diminished or a lack of respect for the person while using seatbelts, wheelchair or bed alarms.

   b. Initiate seatbelts with alarms for all patients at the time of admission. Use chair alarms until the patient consistently demonstrates the ability to safely move about (see documentation for this on the neuro section of the nurse shift assessment). Rehabilitation nursing is responsible to determine when the alarm may be applied or discontinued.

   c. Post signs at head of bed and in the bathroom with transfer status.

   d. Do not leave any patient alone in the bathroom only when you are certain they will remember to call for help appropriately.

   e. Use bed alarms and iBed awareness devices for all patients unless instructed otherwise by the patient's nurse.

8. All patients must wear a seatbelt with or without an alarm at all times when in a wheeled chair. Patients with limited trunk control may require a chest belt to maintain upright position in the chair.
9. .

KEY POINT: A patient may sit on the edge of the bed ONLY with close supervision. A chair with wheel brakes locked or a regular chair is provided as a substitute if a patient wants to sit a (on) the side of the bed.

10. Record and update instructions for interdisciplinary interventions on the plan of care and designated signage in the patient room.

11. Provide discipline specific treatments and education to meet individual patient, family and/or caregiver needs.

12. Each discipline writes a brief summary of progress related to goals each week for the patient discharge planning conference. The CRC collates the notes in Epic with their summary of the conference discussion each week.

13. Participate in the patient's weekly discharge planning conference to discuss discharge plan. Include the patient, family, and external case manager as appropriate in these weekly interdisciplinary discharge planning meetings.

14. Include the patient and family in community outings as appropriate.

Key Words: STANDARDS, REHABILITATION

References: Center for Medicare & Medicaid Services, 2010. Inpatient Rehabilitation Facility Patient Assessment Instrument Manual.
2011. The specialty practice of rehabilitation nursing, a core curriculum (6th ed., pp. 2-16). Skokie, IL: Rehabilitation Nursing Foundation.

Replaces:

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Approval: RIO Leadership
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