UDS-PRO Doc™ System Clinical Documents

UDS-PRO® System

12/9/2016

The UDS-PRO Doc™ System includes a comprehensive set of documents that allows authors to develop their own templates for capturing the individualized evaluations, treatments, and care they provide to the patient, as well as the patient's progress. Comprehensive documentation by the entire rehabilitation team represents the interdisciplinary planning and care provided during the preadmission evaluation and throughout the patient's rehabilitation stay.

Preadmission Assessment	Description
Preadmission assessment	When completed thoroughly, the information in this assessment will serve as the primary documentation of the patient's status prior to admission and the specific reasons that led the physician to conclude that the patient's admission to the IRF was reasonable and necessary.
Physician Documents	**Description**
• Postadmission physician evaluation (PAPE) • Progress notes • Discharge summary	These physician documents help provide evidence of the physician's involvement in the patient's medical and functional care, progress, goal setting, and goal attainment. They also demonstrate the physician's involvement in decisions made throughout the patient's rehabilitation stay that maximize the benefits of the rehabilitation process. (The PAPE includes H&P information needed to capture the patient's medical status as well as rehabilitation-specific information.)
Overall plan of care	The UDS-PRO Doc™ System makes creating the physician's overall plan of care easy. The physician can easily "synthesize" the team goals by using the copy forward feature, which allows each discipline's overall goals from the admission assessment to be duplicated into this document. The physician is then responsible for completing the physician-specific areas, including anticipated interventions, required therapies, and the patient's anticipated discharge destination.
Admission Evaluations	**Description**
• Nursing • Physical therapy • Occupational therapy • Speech language pathology • Dietary/nutrition • Case management • Social work • Recreational therapy	Documenting a comprehensive, individualized admission evaluation is straightforward when you can choose information from the multiple sections available in each document. Although the software offers choices common to all admission evaluations, each discipline's evaluation focuses on the specialties of their practice with detailed information. An array of drop-down choices allows you to detail the patient's condition and function. The FIM® instrument is embedded into each document to capture the burden of care, and the software suggests a FIM® rating that matches the choices you make. The FY 2016 quality indicator information is also embedded within each discipline's evaluation. This feature eliminates the need to document the same interaction in multiple areas or on multiple systems and reduces errors. The software includes multiple standardized assessments, but customization is an option if you find something is missing.
Progress Notes	**Description**
Nursing shift assessment	The FIM® items are incorporated into the daily shift assessment. This assessment allows a nurse to document throughout the day in specific sections. Free-text boxes allow the nurse to create notes periodically throughout the day.
• Physical therapy • Occupational therapy • Speech language pathology • Dietary/nutrition • Case management • Social work • Recreational therapy	Demonstrating an intense level of rehabilitation by an interdisciplinary team is easy when your team members complete their individualized progress notes. The available sections of each note allow the author to document the patient's progress through therapeutic interventions, exercise, training, and reeducation. The documents were created to help demonstrate both the expertise each discipline provides to a patient during the rehabilitation course and the progress the patient made. FIM® items are also embedded within each discipline's to allow ease of use for daily documentation.

Uniform Data System
for Medical Rehabilitation

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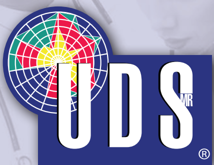
Weekly Summaries	Description
• Nursing • Physical therapy • Occupational therapy • Speech language pathology • Dietary/nutrition • Case management • Social work • Recreational therapy	Weekly summaries provide each discipline the opportunity to review and update the patient's current status and progress made during the week. They allow team members to document the patient's progress toward goals, any problems that are impeding the patient's progress, and the team's recommendations. A weekly impression and plan will help all team members prioritize their efforts for the next week.
Standalone Assessments	**Description**
Balance assessments: • Tinetti assessment • Berg Balance (long form) • Berg Balance (short form)	Standardized balance assessments are incorporated into the appropriate admission evaluations and progress notes. They are also provided as standalone assessments. Upon completion of a standardized assessment, the software calibrates the results and risk for falls and displays this information automatically.
• Interdisciplinary FIM® assessment • Quality indicators assessment • FIM® and quality indicators assessment	A facility can use these freestanding FIM® and quality indicator documents as an alternative to the areas provided in the discipline-specific assessments and daily notes.
Vitals assessment	Documenting vitals is easy: complete the standalone vitals assessment, or complete the vitals section as part of another assessment. You can record blood pressure, pulse, respirations, oxygen saturation levels (and source), and BMI. (The software includes a BMI calculator.)
Pain assessment	Use this assessment to identify the patient's pain level; the location, type, and duration of pain; interventions; and the patient's response to interventions.
Encounter	Use this tool to communicate to your team that something has occurred that requires their attention prior to working with a patient. Many encounter types are available for selection, including falls, changes in medical status, and a change in weight-bearing precautions that allows the patient to particupate in therapy to a greater extent. The software provides additional fields that allow you to document details normatively.
Hendrich II fall risk assessment	This standardized assessment can be administered quickly to determine the patient's risk for falling based on specific factors. After you complete the assessment, the software automatically calculates and displays the results.
Morse fall assessment	This assessment uses six variables to provide a fast, easy method of assessing a patient's likelihood of falling. The software uses the scores of each variable to calculate the risk level, which is displayed on-screen.
Skin assessments: • Norton scale • Braden scale	These two standardized assessments help identify patients who are at risk, the factors placing them at risk, and which patients may require prevention.
Team Conferences	**Description**
Weekly team conference	The team conference is designed to foster team communication and decision making between all team members and the physician. The copy forward feature allows the overall goals from each discipline to be included on the form for discussion by the team. A weekly impression and plan will focus the team on the plan for the next week and any modifications that may need to be made regarding goals, interventions, and discharge planning.



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Discharge Summaries	Description
• Nursing • Physical therapy • Occupational therapy • Speech language pathology • Dietary/nutrition • Case management • Social work • Recreation therapy	Discharge summaries allow the author to indicate the patient's progress throughout the rehabilitation course, the education provided to the patient, the response of the patient or the patient's caregiver to the education, the final discharge destination, the suport available to the patient at the discharge destination, and all recommendations made by the author's discipline. This information helps paint a complete picture of the patient's rehabilitation stay.

Additional Notes:

- Documents may be customized to meet facility-specific needs. Additional standardized assessments may be added as a customization.
- As a time-saving feature, the software provides copy forward capabilities in instances when the patient's medical or functional status remains unchanged from one document to the next.
- Free-text fields are included in most areas of the system. These fields allow users to record notes of more than ten thousand characters.

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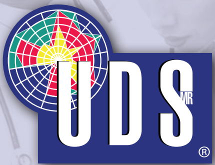

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