UDS-PRO® System

4/11/2018

UDS-PRO Doc™ System Clinical Documents

The UDS-PRO Doc™ System includes a comprehensive set of templates that allow clinicians to develop their own documents for capturing the individualized evaluations, treatments, and care they provide to their patients, as well as their patients' progress. Comprehensive documentation by the entire rehabilitation team illustrates 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 serves 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 demonstrate the physician's involvement in the patient's medical and functional care, progress, goal setting, and goal attainment. They also illustrate 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 to copy the overall goals in each discipline's admission assessment into this document. The physician is then responsible for completing the physician-specific areas, including the anticipated interventions, required therapies, and 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 in each document. Although the UDS-PRO Doc™ System offers choices common to all admission evaluations, each discipline's evaluation focuses on detailed information that illustrates the specialized care the discipline provides. An array of drop-down choices allows users to detail the patient's condition and function. The embedding of the FIM® instrument and quality indicator information into each document allows clinicians to capture their burden of care, and the software suggests a FIM® rating that matches the choices your staff members make. This feature reduces errors and eliminates the need to document the same interaction in multiple areas. The software includes multiple standardized assessments, but customization is an option if your facility has a specific need not addressed by the system.
Progress Notes	**Description**
Nursing shift assessment	The FIM® items are incorporated into the daily shift assessment, which allows your nurses to document information throughout the day in specific sections. Free-text boxes allow nurses to create notes periodically throughout the day.
• Physical therapy • Occupational therapy • Speech-language pathology • Dietary/nutrition • Case management • Social work • Recreational therapy	Demonstrating the intense level of rehabilitation your interdisciplinary team provides is easy when your team members complete their individualized progress notes. Each note's sections allow the clinician to document the patient's progress through therapeutic interventions, exercise, training, and reeducation. The documents help demonstrate the expertise each discipline provides to the patient during the course of the patient's rehabilitation, as well as the patient's progress. The FIM® items embedded in each discipline's notes make it easy for staff members to provide documentation on a daily basis.

Uniform Data System
for Medical Rehabilitation

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Team Conferences	Description
Weekly team conference	The team conference document fosters communication and decision making between all team members and the physician. The document's copy-forward feature allows team members to incorporate their overall goals into the form for discussion by the entire team. A weekly impression and plan helps the team focus on the plan for the next week and any necessary modifications to the patient's goals, interventions, and discharge planning.
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 UDS-PRO Doc™ System calibrates the results and risk for falls and displays this information automatically.
• Interdisciplinary FIM® assessment • Quality indicators assessment	A facility can use these freestanding FIM® and quality indicator documents as alternatives 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.
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.
Fall assessments: • Hendrich II fall risk assessment • Morse fall assessment	The standardized Hendrich II fall risk assessment can be administered quickly to determine the patient's risk for falling based on specific factors. After you complete the assessment, the system automatically calculates and displays the results. The Morse fall assessment uses six variables to provide a fast, easy method of assessing a patient's likelihood of falling. The system uses the scores of each variable to calculate the patient's risk level, which is displayed on-screen.
Skin assessments: • Norton scale • Braden scale	These standardized assessments help identify patients who are at risk, factors placing them at risk, and patients who may require prevention.
Weekly Summaries	**Description**
• Nursing • Physical therapy • Occupational therapy • Speech-language pathology • Dietary/nutrition • Case management • Social work • Recreational therapy	These weekly summaries allow each discipline to review and update the patient's current status and the progress the patient made during the week. They also 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 helps all team members prioritize their efforts for the next week.
Discharge Summaries	**Description**
• Nursing • Physical therapy • Occupational therapy • Speech-language pathology • Dietary/nutrition • Case management • Social work • Recreation therapy	These documents allow clinicians to document 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 support available to the patient at the discharge destination, and the clinician's discipline-specific recommendations. This information helps paint a complete picture of the patient's rehabilitation stay.

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Additional Notes:

- Documents can be customized to meet your facility's needs. Additional standardized assessments may be added as a customization.
- As a time-saving feature, the software provides copy-forward capabilities that can be used when the patient's medical or functional status remains unchanged from one document to the next.
- Most areas of the system include free-text fields. These fields allow users to record notes of more than ten thousand characters.
- Software administrators can define facility-specific required fields for any clinical document template.

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