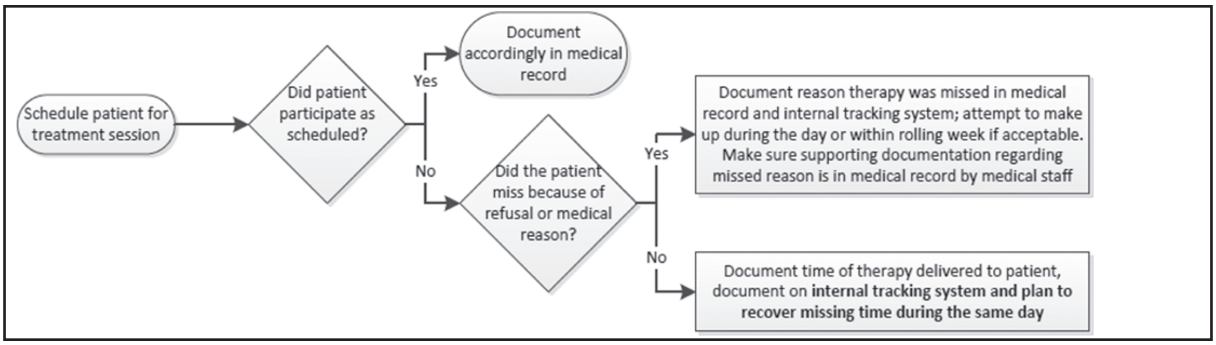

Figure 11-3. Decision-making process for documentation of patient participation with therapy.

TABLE 11-7

DISCHARGE

1. Re-evaluation results of standardized and informal measures
2. Discharge FIM, FCM, and IMPACT scoring
3. Summary and analysis of patient progress and change during the stay, including comprehensive description of objective performance in education and functional goal areas
4. Discharge diagnosis
5. Recommendations/plan of care, including:
   a. Need for further skilled therapy
   b. Frequency and duration of intervention
   c. Long-term goals
   d. Your contact information for patient and clinician follow-up
   e. Warm handoff to next care provider recommended

when. The use of a workflow checklist can be a valuable aid in consistent documentation of accurate documentation completion.

Templated Documents

Long before the advent of the EHR, clinicians developed templates for their documentation. Templates help capture the essential diagnostic information and streamline the documentation process. The formatted note can also help the reader know where to find the specific information he or she is looking for. The challenge with a template note is that it may lend itself to generalized description. To guard against this, the clinician should provide a descriptive analysis of the data and an individualized patient care plan.

Point-of-Care Documentation

There has been an emphasis on increasing point-of-care documentation since the advent of the EMR and use of portable documentation devices. Clinicians struggle with documenting in the presence of a patient and are concerned about the impact on face-to-face communication and rapport. Speech-language pathologists are accustomed to scoring tests and noting behavioral observations during assessments and treatment sessions, and use of the EMR for this purpose feels less connected than writing on a piece of paper. When a speech-language pathologist has access to a documentation device (portable or stationary) and/or is able to interact with a patient in a configuration that does not require his or her back to be turned to a patient for any notable period of time, he or she may be able to incorporate documentation observations and brief remarks of analysis while providing assessment or treatment. The speech-language pathologist can engage with a patient throughout the session and, in the context of education, summary, and support, describe to the patient his or her performance while making note of it directly into the record. Talking with your patient about why you are documenting your interaction and the importance of recording daily changes can eliminate awkwardness in the interaction or can reveal individual patient discomfort with the arrangement. Clinicians should always be mindful of a patient's individual needs and interact accordingly. Capturing real-time information in the medical record decreases the risk that observations are recorded inaccurately. It also allows other care providers to act on the information in a timely manner.