

<b>UWMC Montlake</b>	
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## **8N INPATIENT REHABILITATION MEDICINE UNIT**

### **Scope of Services**

#### **PROGRAM DESCRIPTION**

8 North is a 16-bed Acute Inpatient Rehabilitation unit located at UWMC Montlake Campus at 1959 NE Pacific Street, Seattle, Washington. 8 North provides specialized medical and rehabilitation care to patients with functional disabilities resulting from acute illness or injury or progressive disease processes. It is one of two Comprehensive Integrated Inpatient Rehabilitation Programs in the UW Medicine System, accredited by the Commission of Acute Rehabilitation Facilities (CARF). Services are provided twenty-four hours a day, seven days a week.

#### **PURPOSE/GOALS**

The primary purpose of 8N is to provide a comprehensive, integrated program of medical and rehabilitation services focused on restoring or developing functional skills, minimizing activity limitations, and preventing secondary impairments. Intensive individualized treatment programs are developed with patient and family input. Goals are to assist patients to progress to the next level of care in the rehabilitation continuum, maximizing level of independence and participation in life activities. The program strives to facilitate successful return to home, community, work and school settings, although occasionally extended care living options may be needed.

Patients' strengths, abilities, needs, support systems, and preferences in each domain are assessed and considered in care planning and disposition.

#### **MISSION AND VALUES**

The 8 North interdisciplinary staff support the mission and values of the University of Washington Department of Rehabilitation Medicine, which state:

“The mission of the Department of Rehabilitation Medicine is to improve the health, function, and quality of life of those we serve. We strive to provide excellent care, enhanced by a strong commitment to teaching, community service and research. It is our belief that the highest quality rehabilitation is best achieved in partnership with the patient and their family. Our staff respects diversity and recognizes that every person deserves their own unique treatment plan.”

Our patient and family-centered care approach focuses on processes and decision making that actively engages patients, families, and staff as partners to shape the rehabilitation unit's policies, programs, facility design, and day-to-day care interactions. We have a formal Rehabilitation Advisory Council composed of patients and family members who participate in development of program and educational materials. They provide consultation to organizational design committees regarding accessibility and architectural modifications.

## PERSONS SERVED

Persons admitted to 8 North present with a variety of diagnoses that include but are not limited to: spinal cord injury or disease\*\* (including tetraplegia with mechanical ventilation), brain injury or tumor, stroke, amputation, and neuromuscular and musculoskeletal diseases. Patients with medically complex diagnoses, including those with solid organ, blood and marrow transplants, and mechanical circulatory support devices (VADs), may also be admitted. 8 North primarily serves persons of adult age, but very rarely a patient as young as 15 may be admitted. The patient population spans all socioeconomic levels, educational backgrounds and cultures. The majority of patients are admitted to the rehabilitation unit from UWMC's acute care units, but outside referrals are also accepted.

Persons served most often demonstrate limitations in mobility and activities of daily living. Some may also have difficulties with communication, cognition, swallowing, bowel and bladder management, emotional or behavioral adjustment. Other challenges may include difficulty returning to previous family, social or community roles (e.g., school, work, volunteer). While the inpatient program may begin to address some of these participation restrictions, ongoing treatment may be indicated post discharge.

\*\*Includes persons with spinal cord dysfunction due to trauma; cancer involving the spinal cord; inflammatory or degenerative diseases (e.g., multiple sclerosis); spinal infarcts; myelopathies (e.g., from stenosis); or infections (e.g., meningitis). Persons with complete and incomplete injuries at all levels are served, with comorbidities that may include but are not limited to bowel and bladder dysfunction, sexual dysfunction, autonomic dysreflexia, spasticity, pressure injuries, and behavioral health/emotional adjustment issues.

## REFERRAL INTAKE, ADMISSION AND DISCHARGE CRITERIA

Physician referrals are required for admission. For internal referrals, formal consultations are made by UWMC acute/critical care physicians to the Rehabilitation Consult team. External referrals from outside providers, hospitals, clinics, long term care hospitals or skilled nursing facilities (including UW Medicine affiliates) are made to the admission coordinator via telephone or fax. All referrals are reviewed by the Medical Director or designee to determine if patients meet admission criteria.

Persons served must be medically stable at admission and of a medical acuity that allows them to participate in a minimum of three hours of therapy 5-6 days per week. They may not have medical or psychiatric conditions that impede them from participating and benefiting from an intensive rehabilitation program. Specific admission criteria further define which persons served will be accepted into the rehabilitation program based on their medical stability and acuity. In accordance with the Center for Medicare and Medicaid Services (CMS), 60% of patients admitted to Inpatient Rehabilitation must meet specific diagnostic criteria placing them in the following impairment groups: Stroke, Brain Injury, Spinal Cord, Neuro, Ortho, Amputee, Arthritis, Cardiac, Pulmonary, Pain, and Multiple Trauma. Patients with other diagnoses or impairments are still considered for admission if they meet all other eligibility criteria. Refer to [Admission Criteria \(Joint UWMC/HMC Policy\)](#).

For patients who will be admitted, the admissions coordinator verifies funding sources with the Financial Access and Counseling Team. UWMC/8N accepts various funding sources, including but not limited to commercial insurance, worker's compensation, self-pay, HMO/PPO, Medicare, Medicaid, and TriCare. If no funding is available, patients are evaluated for financial assistance and assisted to make application for uncompensated care. The admissions coordinator and the unit charge nurse discuss bed availability, patient placement and projected admission date. All patients are formally admitted to the Acute Rehabilitation Service and a separate hospital record is maintained. Upon admission, the person served will be given a disclosure statement providing information about benefits, co-pays, and out-of-pocket fees.

Discharge planning begins on admission. Plans for disposition and expected discharge date are based on the person's rehabilitation diagnosis, other medical problems, discharge goals, and resources available. An initial discharge date is estimated within 48 hours of admission and communicated to the patient and family; this date may be changed for a variety of circumstances during the inpatient rehabilitation stay. The patient is discharged when:

1. The patient's discharge goals have been met or approximated to such a degree as deemed reasonable or realistic.
2. There is appropriate placement or disposition.
3. The patient, family, and caregivers have been instructed in how to provide necessary self-care or care to the patient.
4. Medical status change necessitates readmission to an acute/critical care unit.
5. The patient withdraws from treatment. In cases where the physician considers the person's discharge unsafe, attempts will be made to establish an acceptable alternative disposition that would be considered a safe discharge option.

Upon discharge, a discharge summary is sent to the patient's primary care provider. Refer to [Discharge Process \(Joint UWMC/HMC Policy\)](#).

## **INTERDISCIPLINARY TEAM PROCESS**

Patients are assigned to an interdisciplinary team of health care professionals which include: physiatrists (attending and resident physicians), rehabilitation nurses, occupational therapists, physical therapists, speech language pathologists, recreational therapists, dieticians, social workers, vocational counselors, clinical pharmacists, rehabilitation psychologists, patient care technicians and a rehabilitation case manager. Refer to *Appendix A, [Rehabilitation Team](#)*.

The team meets three days a week for coordination of care, review of discharge goals, and to review the day's care plan. Additionally, there are weekly team conferences, in which the patient/family attends as key members in the care partnership. The focus of these meetings is to update the patient and family on overall progress, answer questions and determine what is needed before discharge (e.g., caregiver training, equipment, architectural modifications at home). More in depth patient conferences may occur when the patient care needs are complex.

Patient/family education is an ongoing process throughout the length of stay. Various tools are utilized to facilitate patient and family education including written materials, 1:1 observation and training, peer counseling and videos. Families and caregivers are encouraged to participate in daily cares, therapies and therapeutic community outings. Feedback from patient/family surveys and rounding are addressed and incorporated in care. Other support available to families/caregivers include supportive counseling (with Rehab Psychology or outside referral), overnight stays, referral for local lodging and transportation options, and information about advocacy organizations (e.g., Brain Injury Alliance of Washington, Northwest Regional Spinal Cord Injury System).

Rehabilitation care is planned throughout the continuum. Transition points are considered opportunities to ensure information is communicated about the patient to caregivers at the next level of care to ensure progression of the plan. The social worker, case manager, and therapists coordinate with outpatient clinics, home health, and other agencies or facilities to ensure follow up care is in place at discharge.

## UNIT MANAGEMENT

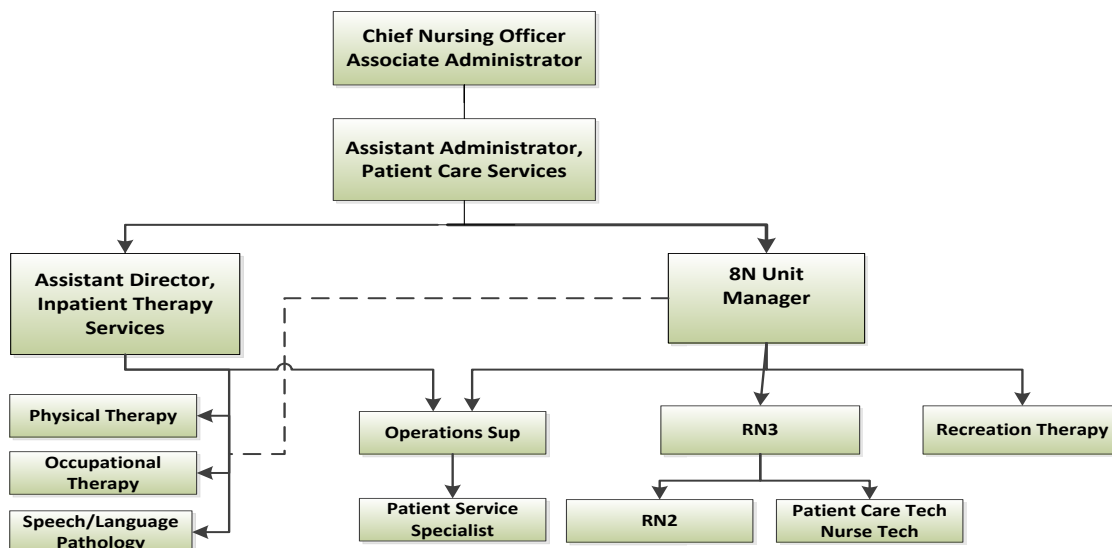
The Medical Director of 8 North Inpatient Rehabilitation unit, with delegated authority by the Medical Director of the University of Washington Medical Center, provides physician oversight of the unit and of the medical staff. Refer to [Medical Director Position Description \(Joint UWMC/HMC Policy\)](#).

Nursing direction is provided through the Division of Patient Care Services. The accountability and responsibility for nursing practice is delegated to the Unit Manager through the Chief Nursing Officer and the Assistant Administrator of Patient Care Services. The unit is staffed at all times by Registered Nurses who are responsible to the Unit Manager, and who facilitate the medical aspects of care and direct the nursing management of patient care.

The Unit Manager is responsible for all operational aspects of the unit, reports to the Assistant Administrator of Patient Care Services, and performs the functions and responsibilities outlined in the Nurse Manager job description. The Unit Manager also has accountability for coordination of patient services among nursing and therapy disciplines on 8N. The Unit Manager works collaboratively with the Medical Director and the Director of Inpatient Therapy Services to integrate all staff into one interdisciplinary team.

There are three RN3s on 8N with specialized roles: Admission Coordinator, Case Manager, and Clinical Oversight. RN3s assume administrative responsibility for the unit when the Unit Manager is unavailable. A charge nurse is designated for each shift and assumes responsibilities as outlined in the document "Charge Nurse Orientation", located on the 8N intranet home page. An Operation Supervisor is responsible for supervisory and administrative non-clinical department functions, including supervision of unit Patient Services Specialists.

## ORGANIZATIONAL CHART



## **NURSING CARE**

8N aligns with the philosophy of nursing care for UWMC Nursing Services, which is based upon the Relationship Based Care Model and implemented through Patient and Family Centered Care. Of primary importance are the beliefs that patients and their families have the right to participate in and direct their own health care decisions, and that their relationship with their health care team is essential to achieving optimal health care outcomes. Care is individualized for each patient and is delivered in accordance with the standards of practice and professional performance guidelines of the American Nurses Association (ANA) as well as the Association of Rehabilitation Nurses (ARN). Refer to [\*Inpatient Rehabilitation Nursing Services \(Joint UWMC/HMC Policy\)\*](#) and [\*APOP: UWMC Plan for Nursing Care\*](#).

Rehabilitation nurses provide nursing assessment of the persons served upon admission and throughout the rehabilitation stay. They are responsible for implementing physician orders, precautions, and the individualized plan of care, planning for discharge and setting appropriate recommendations to facilitate health promotion and safety in the discharge environment, in collaboration with the rest of the team.

Registered nurses supervise all direct nursing care given on 8N, including delegation of activities to assistive personnel. The role of assistive personnel (patient care technicians, nurse technicians) is described in job descriptions and competencies as specified by the organization.

Patient assignments are made by the charge nurse. Continuity of care is prioritized across assignments and shifts.

8N follows all documentation policies and procedures as outlined by the organization. Patients, family members and significant others are informed about and included in patient care as reflected in the initial nursing assessment and subsequent notes. Patient cultural preferences and learning needs, as well as those pertinent to families and caregivers, are identified and documented in the electronic medical record. When online systems fail, all documentation is done on paper.

## **SCHEDULING AND STAFFING**

### **Nursing**

Staffing parameters for nursing personnel are based on budgeted hours of care for average daily census, which are informed by historical data and reviewed at least annually. Daily staffing decisions are guided by the 8N work load trigger tool, which accounts for dynamic changes in census, patient acuity, and required skill mix. Staffing needs are assessed by the charge nurse every 4 hours and reported to the central staffing office.

8N follows all scheduling policies and procedures as outlined by the organization, and as specified by Kronos, the UWMC scheduling and timekeeping system. Staff are currently scheduled for both 8- and 12-hour shifts.

### **Ancillary and Therapy Services**

Staffing for Occupational, Physical and Speech Language Therapies is based on daily census. The therapist to patient ratio for OT and PT is typically 1:4. With Speech Language Pathology, the therapist to patient ratio is 1:5. Recreation Therapy services are provided by 2 part-time therapists (.5 FTE each), who share a caseload over 6 days per week. Up to four staff from Rehabilitation Psychology (faculty and fellows/residents in training) serve 8N and are available on weekdays. One full-time Social Worker and 2 part-time Clinical Pharmacists are present on the unit 5 days per week.

Additional hospital services available by consultation include: Respiratory Care Services (24 hours per day, 7 days per week), Prosthetics and Orthotics, Neuropsychology, Spiritual Care, Clinical Nurse Specialists (ostomy and wound care, pain, diabetes, behavioral health), and Peer Mentors. For persons who require special equipment or assistive devices not available on site (e.g., power wheelchairs, communication devices), arrangements are made with local vendors to provide.

Patients on Inpatient Rehabilitation have access to a full scope of medical specialty, diagnostic, laboratory and pharmacy services on site, via order or consultation request. All departments have demonstrated the capacity to provide necessary services to 8N, with the expectation of a 24-hour turn-around in reporting results (unless otherwise indicated/ordered by the physician). Results of critical or urgent diagnostic tests, imaging and/or lab results are typically available to view via the EHR within 1-2 hours of order. Emergency medical services are available immediately via rapid response/code teams, 24 hours a day.

## **METHODS TO ASSURE COMPETENCY**

Orientation for new staff combines centralized and unit-based orientation activities. An orientation plan is developed based on 8 North specific competencies and the learning needs that are identified by Professional Nursing Development during central orientation. New staff are assigned a preceptor for the orientation period, which may last 2-6 weeks, based on individual nurse experience and learning needs. Assessments of rehabilitation nursing competencies are performed at the beginning and at the end of orientation. Completed competencies are kept in personnel files on 8N. Nurses are oriented to the Preceptor and Charge roles via organizational workshops and mentoring by the RN3. Preceptor guidelines and Charge competency checklists are available on the Professional Nursing Development and the 8 North intranet sites.

## **SPECIAL COMPETENCIES**

Unit orientation is competency based; individuals complete the following competencies, which are kept in their personnel file on the unit:

1. Nursing Care of the Ventilator Dependent Patient
2. Management of Mechanical Circulatory Support Devices

Hospital-mandated annual competencies for all staff may include but are not limited to: Workplace Safety, Corporate Compliance/HIPAA, Cultural Awareness, Infection Prevention, and Organizational Topics. This requirement is met by reading modules and completing a quiz through the online Learning Management System. Some modules may also require skill demonstration.

## **CONTINUING EDUCATION**

Responsibility for professional development is shared between the individual professional staff member and the organization. The unit-based continuing education program includes regularly scheduled in-services, based on identified topics of staff interest and learning needs related to: 1) high risk or new patient populations or procedures, 2) rehabilitation-specific competencies, or 3) accreditation or regulatory requirements (e.g., emergency evacuation, IRFPAI Quality Indicators certification).

Consistent with the WSNA contractual agreement, every effort is made to support staff with the desired \$250 tuition allowance per full time FTE (pro-rated for part-time employees) and 24-40 hours of educational leave days per year (pro-rated per FTE percentage). The ability to grant professional education leave is based on staffing and budgetary considerations.

All nurses are encouraged and provided financial support for specialty certification in Rehabilitation or Medical-Surgical nursing. Study modules are purchased through the Association of Rehabilitation Nursing and nurses are reimbursed for exam costs once certified.

## **PERFORMANCE APPRAISAL**

Performance appraisals are completed to assure competence, to promote professional growth and development and to recognize staff for their accomplishments. The Unit Manager and RN3s share responsibilities for conducting performance evaluations on nursing staff, as do the Unit Manager and the Operations Supervisor for Patient Services Specialists. Recreation Therapy staff are evaluated by the Unit Manager; OT, PT and SLP staff, by the Associate Director of Inpatient Therapy Services. Counseling may be conducted by the Unit Manager and/or RN3. Progressive corrective action is the responsibility of the Unit Manager.

**UNIT COMMUNICATION**

Staff meetings are held on 8N twice a year, in conjunction with educational in-services. Meetings and educational offerings are mandatory, and staff are scheduled to attend. Minutes or presentations are posted and communicated by e-mail.

Clinical coordination meetings with the interdisciplinary staff are scheduled quarterly, and typically focus on unit-wide initiatives, continuous quality improvement and team communication. Work groups are initiated for process changes and may also include representatives from the Rehabilitation Patient and Family Advisory Council, other Rehab service areas (Outpatient/Acute Care), or other UWMC departments (e.g., Nutritional Services, Materials Management, Respiratory Care Services). Involvement in coordination and work group meetings is voluntary, but strongly encouraged. Support for interdisciplinary staff participation is typically provided by management.

Unit updates related to "need to know" information and unit activities are sent out to staff via email, posted on the communication clipboard ("brain board") at the front desk, and posted in the report room. All staff and physicians carry pagers, Spectra-link telephones, or cell phones for immediate access and text messaging. E-mail is also used for routine communications, project management, and distribution of educational updates.

Unit goals, objectives and action plans are developed in conjunction with the 8N Unit Practice Council. The Council typically meets every other month for 2 hours, except during the summer months. Meeting minutes are posted and disseminated via email. Staff are encouraged to participate in unit and hospital wide committees, such as the Local Practice Council, Staffing committee, Nursing Education committee and others. Involvement is on a voluntary basis, but paid time is offered.

For escalation of issues, staff are familiar with the chain of command, including how to access information and authority via the nursing structure and the medical structure. In addition, Charge nurses are familiar with the process for obtaining consultation on ethical issues and risk management. At any time, a staff member may call a team huddle to address urgent safety concerns (e.g., post fall huddle, code gray debrief).

**APPENDIX:**

Rehabilitation Team

**REVIEW/REVISION DATES:**

06/1991, 02/2002, 06/2002, 07/2005, 07/2008, 08/2010, 08/2011, 09/2014, 01/2015, 01/2016, 09/2017, 10/2018, 09/2019, 07/2020

**APPROVED BY:**

Lynn Farrier Date 8/28/2020

Lynn Farrier, MCSD, SLP, Manager, Inpatient Rehabilitation

Sherri Del Bene Date 8/28/2020

Sherri Del Bene, MN, RN, Assistant Administrator, Patient Care Services

Cindy Sayre PhD, RN Date: 8/28/20

Cindy Sayre, PhD, RN, Chief Nursing Officer, Patient Care Services

Denise Li Lue Date: 8/28/2020

Denise Li Lue, MD, Medical Director, Inpatient Rehabilitation



## Appendix A:

### Rehabilitation Team

The rehabilitation team consists of the following:

- **Persons Served**—The persons served, the patient and their support system, are the most important members of the treatment team. Throughout the transitions of care, from preadmission to discharge, the individual preferences and goals of the persons served are considered. They participate in weekly team conferences, either in person or via teleconference, and in patient and caregiver training throughout the rehab stay.
- The **Physiatrist** is a medical doctor (MD) who specializes in rehabilitation medicine. The Physiatrist evaluates and addresses medical and rehabilitation needs, to support the patient to reach their highest level of functional independence and recovery. This individual provides or arranges for and coordinates the medical care of each person served and directs the rehabilitation team. A physiatrist is available 24 hours per day, 7 days per week.
- **Rehabilitation Psychologists and Neuropsychologists** evaluate and address cognitive, psychological, emotional, and behavioral functioning. Psychologists address questions and concerns related to emotional adjustment to illness or injury, including those of families/caregivers, deferring physical concerns to the physiatrist or other specialist as appropriate. Additionally, the psychologist works closely with the treatment team to assist with recommendations related to behavioral management (including behavioral plans and environmental management systems), sexuality, independence, and return to work or school. Neuropsychologists, who have specialized training in the interrelationships between the brain and behavior, may perform a variety of tests to determine level of cognitive, communicative, and behavioral function.
- **Rehabilitation Nursing** is provided on a 24/7 basis. The rehabilitation nurse provides medical assessment throughout the stay, including implementation of physician orders, safety precautions, and the individualized plan of care. In the care plan, they lead the team in assisting the persons served to manage medications, pain, bowel and bladder, and skin integrity. Nurses work collaboratively with the patient, family, and team to integrate therapeutic goals into the care process and to reinforce learning from other disciplines during daily activities.
- The **Rehabilitation Nurse Case Manager** is the liaison for the patient, family, treatment team, outside consultants, and payer. The Case Manager is available to meet with families and provides tours or information about the program. They oversee the plan of care, including goal setting and documentation of progress toward discharge. The Case Manager is responsible for coordinating flow of information between the team and insurance representatives to maximize coverage for the hospital stay, equipment and post-discharge services.
- **Social Workers** provide support to persons served and their families relative to coping with new challenges and planning for discharge. They assess and provide recommendations for addressing psychosocial needs (e.g., counseling for chemical dependency, family/support system, crisis management), and resources for community services (e.g., meal delivery, transportation to appointments, housing, hiring personal care assistants). They assist with identification of alternate placement options if a patient cannot return to home, and coordinate discharge transition and follow up.
- **Physical Therapists** evaluate and address physical impairments and activity limitations due to mobility. Physical therapists work on improving strength, balance, endurance, coordination and flexibility. Physical Therapists also make recommendations for appropriate durable medical equipment, environmental modifications, seating systems, and orthotics/prosthetics, to facilitate improved independence with mobility.



- **Occupational Therapists** evaluate and address impairments of upper extremity or fine motor performance and any self-care or activity limitations caused by these impairments. Occupational therapists assess each patient's ability to live independently (e.g., eating, bathing, dressing, budgeting, meal preparation) as well as visual-motor and cognitive functioning. They may also provide training with assistive technology for access to environmental controls or computers or make recommendations for environmental modifications or equipment following discharge.
- **Speech/Language Pathologists** evaluate and treat impairments/ disorders of swallow function, motor speech ability, communication (reading, writing, comprehension, and expression), and cognition (orientation, attention, memory, problem-solving, judgment, reasoning, etc.).
- A **Certified Recreational Therapist** works to restore the ability to participate in prior recreational and leisure pursuits and/or introduces new activities and adaptive devices. They conduct community integration activities to practice skills learned in therapies and provide resources for community transportation and recreational opportunities.
- **Rehabilitation Counselors** assess issues related to returning to independent living, work, or school. They make recommendations about vocational reentry and accommodations (including assistive technology) to ensure success. They act as a liaison with schools or employers prior to discharge and make recommendation for vocational rehabilitation services once patients have returned to the community.