CESN Quality Assurance Framework for Rehabilitation Intensity

This framework is a compilation of factors identified by therapy providers at the 10 hospitals in CESN that provide inpatient rehabilitation. This framework was supplemented with information from the Toronto Stroke Networks Quality Assurance Framework for Rehabilitation Intensity Data Collection (2015).

CESN Quality Assurance Framework for Rehabilitation Intensity (RI) Data Collection		
Factors that influence the quality of the data	**How can we measure this influence?**	**How can we address this influence?**
Rehabilitation intensity (RI) data not entered: • Therapists may not remember to input RI data. • Therapists may not have the time to enter data. • Covering therapists may not know how to collect RI time and enter the data. • Therapists covering or providing therapy on weekends may not know how to capture RI. • New therapists may not be familiar with RI measurement. • Staff buy-in to RI data collection. • Therapy staff may not be aware that the patient has become rehab status (on integrated unit).	• Audit / monitor whether RI information is being entered for all stroke patients to ensure no one is missed. • Incidence of days with blank or zero RI value entries by discipline. • Number/percentage of code 99999. • Compare workload measurement vs RI by discipline. • Track documentation when there is no RI provided and identify the reasons for this.	• Therapists provide clear documentation when no RI is provided. • Include training on RI and how to enter data in staff orientation. • Ensure staff have access to RI education, pocket cards, FAQs, and other resources from Ontario Stroke Network including webinar links, etc. • Flag stroke patients in workload measurement to remind to enter RI time. • Reminder sticker on computers. • Reminders at rounds regarding rehab intensity. • Emphasize that RI data collection is required for stroke patients • Identify opportunities within workload measurement system to cue/ensure data is entered reliably (make more visible, have on same screen as workload). • Post a reminder checklist on the wall for weekend, casual, part-time and new staff.
Variability in entering RI data: • Inaccurate data entry by staff. • Delaying / lack of ability to record RI in the moment so data is absolutely accurate. Retrospective entries may not be accurate. • Understanding RI definition and what to count especially if covering or new to unit. • Inconsistency between therapists – inconsistent information received. • Recording when on a different unit. • Lose track of time or have challenges calculating time • Clock times are all different	• Review data regularly. • Track completion of therapist training for RI.	• Increase knowledge of the guidelines. Emphasize that RI data collection is only for stroke patients. • Coder monitors and speaks with therapists directly if there is an inconsistency. • Ensure managers/professional practice leaders are involved to support accountability and follow-through. • Ensure program directors aware of RI time and impact at therapist level. • Include training on RI and how to enter data in staff orientation. • Establish proficiency testing • For new staff members, implement shadowing / mentoring by current staff. • Self-learning package to promote consistency. • Communication between members involved in co-treatment about how it is being captured. • Review statistics and give each other feedback.

• Awareness of how to use the RI collection tool/spreadsheet • Inconsistency between therapists when co-treating. Therapists co-treating and forgetting to split the time. • Confusion with other data collection (e.g. CCC and RUGS). • Patients changing status from acute to rehab to CCC. • Incomplete capturing of RI. • Inaccurate data entry by staff. Charting in the wrong area.		• Provide reminders re RI frequently. Discuss at team rounds including reminders to ask the 4 guiding questions for RI. • Share within decision support to increase awareness. • Thoroughly explore program changes with respect to RI time. Increase knowledge of the guidelines. Emphasize that RI data collection is only for stroke patients. • Emphasize that therapists are accountable to ensure data is entered in a timely manner. Set expectation of timeline for RI data entry. • Accurately record start and stop times with patients. Record as you go. Enter RI throughout the day instead of waiting until end of day. Use lock-out periods as data is more accurate if collected in a timely manner. • Review during Community of Practice meetings (definition, need to document timely, etc.). • Have a quick reference available including the quick reference card but also a quick reference for how to enter, where to find it, etc.
Variation related to collection of RI data during SI days and alternate level of care (ALC).	• Incidence of RI data collected on SI transfer days. • Incidence of RI data collected on or after date ready for discharge.	• Remove Service Interruption (SI) days from reports when transferring data to the National Rehabilitation Reporting System (NRS). • Use processes to identify and communicate SIs to ensure RI data is not collected during SI days. • Enhance awareness of SI definitions and use consistently. • Regular review of reasons for SI.