

Digitisation of subacute rehabilitation documentation is feasible, efficient and comprehensive

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The digital transformation of treatment records from paper to electronic in a rehabilitation setting at Monash Health

BACKGROUND


Despite the introduction of electronic medical records (EMR) to the inpatient service in 2020, rehabilitation clinicians continued to use a hybrid model of paper and digital based documentation. This two-step process was inconsistent across the hospital continuum, inefficient, impacted communication and increased risk of breaching patient confidentiality.

OBJECTIVE


To evaluate if the digitisation of treatment records for physiotherapists and allied health assistants (AHAs) is feasible, comprehensive and more efficient.

METHODS

An audit tool was developed. Patient records were randomised and screened for eligibility. Data was extracted from EMR treatment records by four clinicians. Participants completed a post implementation survey evaluating their perspective on documentation efficiency.

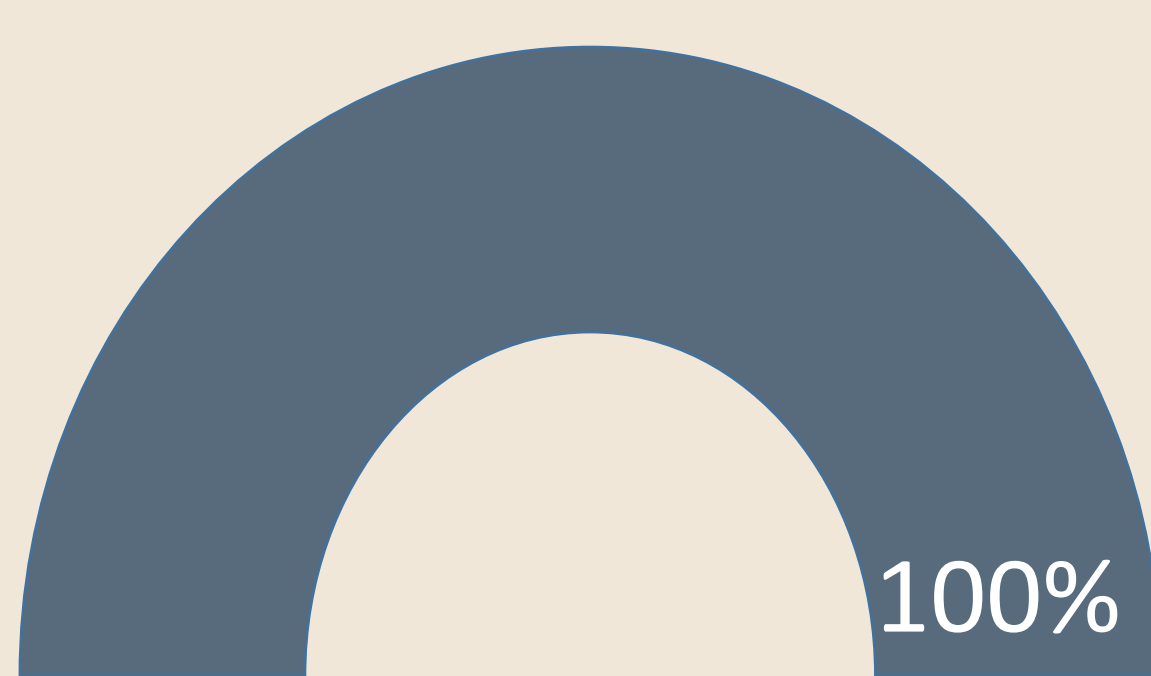
 **18 Clinicians**
14 Physiotherapists
4 AHAs

 **4 wards**
3 months

 Staff education delivered
Staff commenced documenting in digital format.

RESULTS

Survey (n=10)



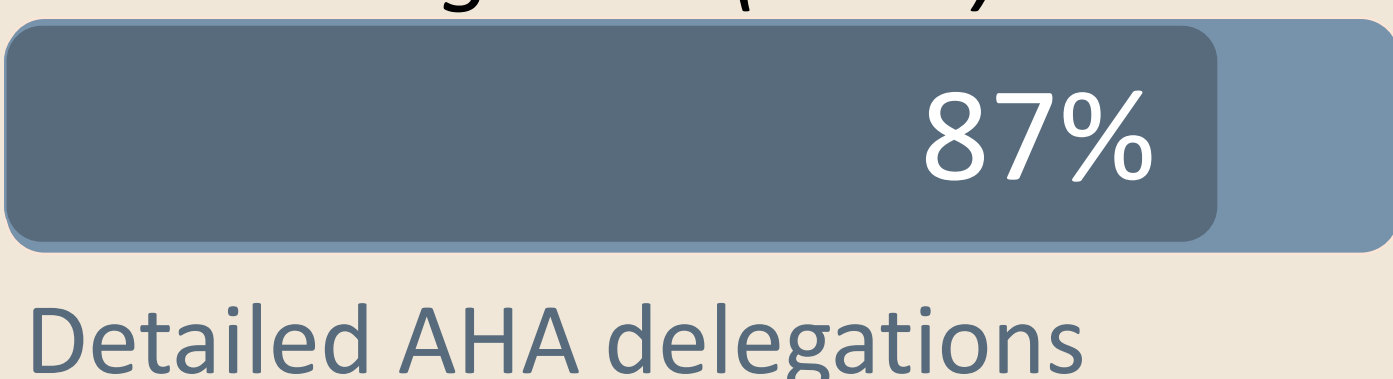
All clinicians (n=10) reported documentation on EMR is more efficient

Audit (n=133)

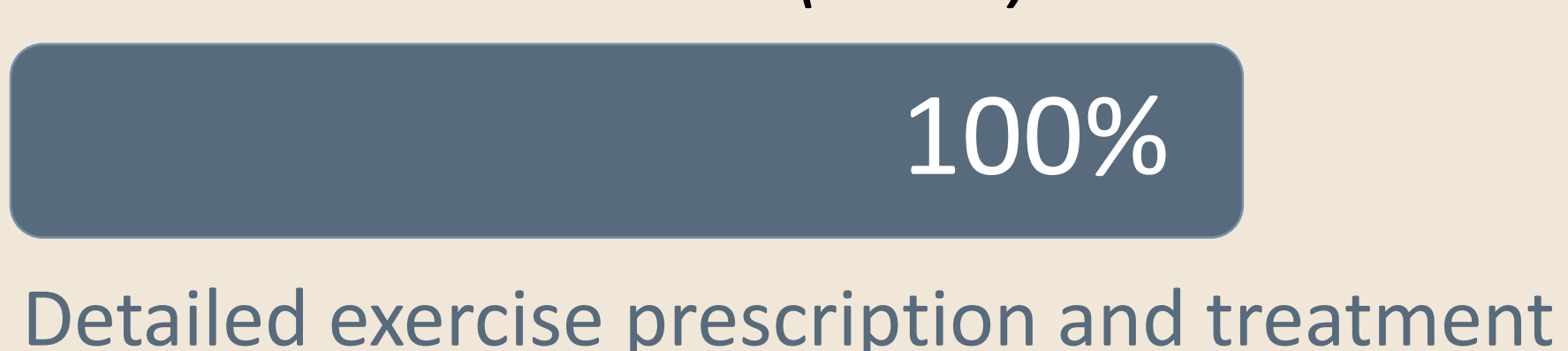
Physiotherapist documentation (n=80)



AHA delegation (n=16)



AHA documentation (n=37)



PDSA CYCLE ONE

4 Feedback/ Review

April 2024:
Feedback to key stakeholders.
Education adjusted.

1 Focus Group

Nov 2023:
Key stakeholders engaged.
Expectations established.



3 Survey/ Audit

February 2024:
Staff survey
File audit

2 Trial

Dec 2023:
3 wards, 12 weeks.
Education delivered.
Trial transition of documentation to digital format



PDSA CYCLE TWO

4 Process Refined

June 2024
Any refinements made. Project closed.

1 Establish plan

April 2024:
Engagement with all subacute service



3 Open feedback

May 2024
Staff encouraged to provide feedback

2 Change

April 2024
9 wards, ongoing.
Education delivered.
Permanent transition to digital format

CONCLUSION

Physiotherapist and AHA treatment record documentation on EMR is feasible, comprehensive, efficient, and streamlines documentation standards across the continuum. EMR documentation replaced existing paper based documentation for all physiotherapy and AHA treatment sessions across all rehabilitation wards. Future work requires exploration of documentation for Exercise Physiology, Aquatic Physiotherapy and groups.