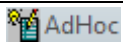







This Quick Reference Guide (QRG) reviews Inpatient Rehab Facility-Patient Assessment Instrument (IRF-PAI) PowerForms.

Common Buttons

	AdHoc icon
	Return icon
	Sign icon
	IRF-PAI icon
	Red Triangle icon
	Calendar icon
	Filter icon

Document Admission PowerForms

➤ From the Rehabilitation Summary view of the patient's chart:

STEP 1: Click AdHoc in the top toolbar.

STEP 2: Select the following check boxes:

- IRF-PAI Admission/Discharge Data
- IRF-PAI Quality Indicators Admission
- IRF-PAI Quality Indicators Cognitive Patterns

STEP 3: Click **Chart**.

IRF-PAI Admission/Discharge Form

➤ This form automatically opens when you click **Chart**.

STEP 1: Document the Primary Impairment Group Codes.

STEP 2: Click IRF-PAI **Admit** in the left-side list.

STEP 3: Document IRF-PAI **Admit** information.

NOTE: **Date of Onset of Impairment** is towards the bottom of the page. You may need to scroll down.

STEP 4: Click the **Sign** icon.

IRF-PAI Quality Indicators Admission Form

➤ Once the IRF-PAI Admission/Discharge form is signed this form will open automatically. Nursing, PT, or OT document sections B, H, J, K, and N. Therapy documents the remaining sections.

STEP 1: Document each section as appropriate.

NOTE:

- Click a grid header to document all items at once in that column.
- Click an individual cell to document just one individual item.
- Click an individual cell a second time to de-select it.
- Select appropriate check boxes.

STEP 2: Click the **Sign** icon once all sections are completed.

IRF-PAI Quality Indicators Cognitive Patterns

- Once the IRF-PAI Quality Indicators Admissions form is signed the Cognitive Patterns form will open for documentation. If a Speech Therapist is involved, they will document Section C: Cognitive Patterns. If they are not involved, Nursing or Occupational Therapy will document the needed information.

STEP 1: Document if the patient can make themselves understood.

STEP 2: Select the repeated words check boxes as appropriate.

NOTE: This section becomes active based on documentation of being understood.

STEP 3: Scroll down and continue to document.

STEP 4: Click Yes if the patient was unable to complete the BIMS.

NOTE: Document the Memory/Recall window as appropriate. Click the Return icon to return to the Cognitive Patterns form.

STEP 5: Click the **Sign** icon once the form is completed.

Document Inpatient Physical Therapy Time

- From the Ad Hoc Charting Window in a patient's chart:

STEP 1: Select the PT Inpatient Time Spent With Patient check box.

STEP 2: Click **Chart**.

STEP 3: Click the appropriate fields and enter Units and Minutes spent with the patient.

NOTE: June 2020 there will be an Additional Units field. Documentation of Units drops charges.

STEP 4: Scroll down to include all needed documentation.

STEP 5: Click the **Sign** icon.

STEP 6: Click Close to close the Ad Hoc Charting window.

Run the IRF-PAI Admission Report

➤ From the Rehabilitation Summary view in the patient's chart:

STEP 1: Click IRF-PAI Cloud in the Toolbar.

NOTE: This takes you out of the patient chart to the IRF-PAI report workflow.

STEP 2: Sign in with Cerner Millennium username and password.

STEP 3: Click IRF-PAI Export Utility.

STEP 4: Select the Facilities in which the report is being run from, and the Locations (nursing unit(s)).

NOTE: Assessment Date Range will default to the current month. Use the calendar icon to choose a different timeframe.

STEP 5: Click the Admission Report radio button.

STEP 6: Click Apply.

STEP 7: Click the Generate 4.0 Report to generate an individual report.

STEP 8: Click the tabs on the left to review and add information as appropriate to the various sections.

NOTE: Save each component or section as you review and update information.

Document the Patient Information Section

➤ From the IRF-PAI Export Utility:

STEP 1: Review the Patient Information section.

STEP 2: Scroll down to enter Etiologic Diagnoses as appropriate. Click the + sign to add an additional Etiologic Diagnosis.

NOTE: You can prioritize multiple diagnoses using the drop-down arrow and selecting the priority number needed.

STEP 3: Click Save for any diagnoses that were added.

STEP 4: Review the Date of Onset of Impairment for accuracy.

STEP 5: Scroll down to review and/or enter Comorbid Conditions.

NOTE: You can prioritize multiple Comorbid Conditions using the drop-down arrow and selecting the priority number needed.

STEP 6: Click the next tab to continue to review/document.

Review the Therapy Information section

➤ From the IRF-PAI Export Utility:

STEP 1: Review for accuracy.

Document Sections A, B, C, D, GG, H, I, J,

From the IRFPAI Export Utility:

STEP 1: Click section A and review the documented information.

NOTE: Two values indicate the item was documented multiple times.

STEP 2: Click the highlighted value to view the details.

STEP 3: Click the **More Info** hyperlink (blue circle with white i) for a tooltip explaining what each value indicates.

STEP 4: Enter values for the Admission Report where you see the Red Triangles icon.

NOTE: The Red Triangle icon indicates no charted scores were input to flow over to the Admission Report.

STEP 5: Scroll down to review the entire section, document as appropriate.

STEP 6: Click **Save** for each section before moving to another one.

Document Section K, M, N, O

➤ From the IRFPAI Export Utility:

STEP 1: Click the section K tab.

STEP 2: Review and document as appropriate.

NOTE: If the patient has a special menu order it will auto-populate.

STEP 3: Click **Save** at the bottom of the section.

Document Section M

➤ From the IRFPAI Export Utility:

STEP 1: Click the M section tab.

NOTE: This information comes from the Incision Wound Skin Dynamic Group that Nursing documents on.

STEP 2: Click **Save**.

Document Section N

➤ From the IRFPAI Export Utility:

STEP 1: Click the N section tab.

NOTE: This section opens defaulted to No issues found, which can change throughout a patient's stay.

STEP 2: The pharmacist will do a **Drug Regimen Review** and will document if the patient is taking medications in any of the listed high risk medication categories and if an indication was documented by the provider. Information from the Drug Regimen Review form can be copied into this section.

STEP 3: Review and document if medication issues were found during the Drug Regimen Review.

NOTE: Depending on documentation, the secondary question may activate.

STEP 3: Click Save.

Document Section O

➤ From the IRFPAI Export Utility:

STEP 1: Click the O section tab.

STEP 2: Review and document as appropriate.

Review the Incomplete Items Section

➤ From the IRFPAI Export Utility:

STEP 1: Click the **Incomplete Items** button.

NOTE: This is a great way to see what is missing from the report before signing and submitting it.

STEP 2: Review what is incomplete.

STEP 3: Click the appropriate tab to complete the missing information, as needed or request the therapist or nurse to complete the documentation.

STEP 4: Click **Sign**.

STEP 5: Review the **Missing/Invalid Fields Exist** window if it opens.

- Click **Incomplete Items** to go back to the report and continue documentation.
- Click **Override** to sign the form without updating the missing or incomplete data.

Export Admission Report

➤ From the IRF-PAI Patient List:

STEP 1: Once the report has been signed, the Status will update to Signed.

STEP 2: Highlight the patient row for the report you want to export.

STEP 3: Click **Export**.

STEP 4: Leave the **Export Transaction Type Code** set to **Add new record**. If needed, the exported record can be modified or inactivated.

Prepare Discharge PowerForms

➤ From the Rehabilitation Summary page in a patient chart:

STEP 1: Click IRF-PAI in the top menu.

STEP 2: Select the following forms:

- IRF-PAI Admission/Discharge Data
- IRF-PAI Quality Indicators Cognitive Patterns
- IRF-PAI Quality Indicators Discharge
- IRF-PAI Quality Indicators Ongoing Discharge

STEP 3: Click **Chart**.

Document IRF-PAI Quality Indicators Admission/Discharge Data

STEP 1: Click **Discharge IRF-PAI**.

NOTE: The Discharge section is the only section needed for documentation at this time.

STEP 2: Document the **Discharge IRF-PAI** information by clicking the appropriate information to select it.

NOTE: Don't forget to scroll down and note any interruption information, as appropriate.

STEP 3: Click the **Sign** icon.

Document IRF-PAI Quality Indicators Cognitive Patterns

Upon signing IRF-PAI Quality Indicators Admission/Discharge Data, Section C: BIMS window opens:

STEP 1: Document if the patient can make themselves understood.

STEP 2: Select the repeated words check boxes as appropriate.

NOTE: This section becomes active based on documentation of being understood.

STEP 3: Scroll down and continue to document.

STEP 4: Click **Yes** if the patient was unable to complete the BIMS.

NOTE: Document the Memory/Recall window as appropriate. Click the Return icon to return to the Cognitive Patterns form.

STEP 5: Click the Sign icon once the form is completed.

Document IRF-PAI Quality Indicators Discharge

➤ Upon signing IRF-PAI Quality Indicators Cognitive Patterns form, Section A: Administrative Information opens.

STEP 1: Document Section A.

NOTE: Sections B, D, J, and O are completed by Nursing.

STEP 2: Click Section N: Discharge Medications in the left-side list.

STEP 3: Document Discharge Medications information as appropriate.

NOTE: If the provider is notified of anything during the patient's stay by inpatient rehab the information should be populated in the Provider Notification pane.

STEP 4: Click Discharge Information in the left-side list.

STEP 5: Document the Swallowing Status, Influenza Vaccine and Tub or Shower Transfer as appropriate.

STEP 6: Click the Sign icon.

Document IRF-PAI Quality Indicators Ongoing Discharge

➤ Upon signing IRF-PAI Quality Indicators Cognitive Patterns, Section GG: Self-Care Performance opens.

STEP 1: Click the header for the column you want to document to select all items at the same time.

STEP 2: Click the individual cell to document the appropriate self-care items one at a time.

STEP 3: Click Section GG: Mobility Functional Abilities in the left-side list.

STEP 4: Click the appropriate header to document all items at once, as before.

STEP 5: Click the individual cell to document each cell individually, as before.

STEP 6: Click Section GG: Mobility Continued.

STEP 7: Document the patient's mobility performance.

STEP 8: Click the Sign icon.

Run the Discharge IRF-PAI Report

➤ From the Rehabilitation Summary page of the patient's chart:

STEP 1: Click IRF-PAI Cloud in the Toolbar.

NOTE: This takes you out of the patient chart to the IRF-PAI report workflow.

STEP 2: Sign in with Cerner Millennium username and password.

STEP 3: Click IRF-PAI Export Utility.

STEP 4: Select the **Facilities** in which the report is being run from, and the **Locations** (nursing unit(s)).

NOTE: **Assessment Date Range** will default to the current month. Use the calendar icon to choose a different timeframe.

STEP 5: Click the **Discharge Report** radio button.

STEP 6: Click **Apply**.

STEP 7: Click the **Generate 4.0 Report** to generate an individual report.

STEP 8: Click the tabs on the left to review and add information as appropriate to the various sections.

NOTE: **Save each component or section as you review and update information.**

STEP 9: Click the **Incomplete Items** button.

STEP 10: Review and decide what needs additional documentation.

STEP 11: Click the appropriate section as needed to update. Click **Save** for any section you reviewed and/or modified.

NOTE: **Remember, if there is a Red Triangle icon, you will need to decide which value you want to flow to the Discharge Report.**

STEP 12: Click the **Incomplete Items** tab.

STEP 13: Review again, as needed.

STEP 14: Click **Sign**.

STEP 15: Review the Missing/Invalid Fields Exist window if it opens.

- Click **Cancel** to go back to the report and continue documentation.
- Click **Override** to sign the form without updating the missing or incomplete data.

Export Discharge Report

➤ From the IRF-PAI Patient List:

STEP 1: Once the report has been signed, the Status will update to Signed.

STEP 2: Highlight the patient row for the report you want to export.

STEP 3: Click **Export**.

STEP 4: Leave the Transaction Type Code set to Add new record.

Filter Patient List

➤ From the patient list results:

STEP 1: Click the **header** of the column to be filtered.

- The **Patient Name** column will switch from alphabetical to reverse alphabetical when filtered.
- The **Admission Date** and **Discharge Date** columns will switch from chronological order to reverse chronological order when filtered.
- The **Status** column when filtered will bring the rows with a status of Signed or Exported to the top or the bottom of the list.

NOTE: **Patient Name, Admission Date, Discharge Date, and Status are the columns that can be filtered.**