Question: Is your inpatient department currently using real-time documentation, and if so – can you provide any helpful tips/strategies?

Each of our therapists has their own laptop and tries to document real time if they are with a patient that it is safe to do so placing a laptop on a rolling table or on the mat, ie: document the history during the initial evaluation while speaking with the parent/child, document the exercises or treadmill ambulation while the patient is performing them (usually for pre-teen/teen patients), document ROM/MMT while measuring etc. If the child is young and/or doesn't stay safely in one place this isn't possible, but we do try to do real time whenever it makes sense.

ORG A

For ORG B, the rehab staff will complete their documentation around their lunch time or at the end of the day. We have not been successful in using real time documentation. We typically complete our evaluation reports within 24-hrs and our daily notes are completed by the end of their shift or the next morning prior to 9 am.

ORG B

Probably 90% of inpt documentation is done real time. Typically the therapist talks with the RN and/or parent and documents at the end of the session. It can be difficult if we don't find a computer station near the bedside or the RN is using the computer in the room.

ORG C

We are not doing real-time documentation. We have found the thought of this to be very difficult with the hands on nature of pediatric rehab patients.

ORG D
