COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Evaluation, Treatment, and Discharge General Procedures for OT		**504**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: Occupational Therapists and Occupational Therapy Assistants (under the supervision of a licensed OT) practicing occupational therapy at Mangum Regional Medical Center.

PURPOSE: To outline and maintain the Rehabilitation Services' policy and procedure as it relates to treatment, and discharge of patients by Occupational Therapy.

POLICY: Assessments are performed within Occupational Therapy's scope of practice, state licensure laws, applicable regulations, or certifications.
The scope and intensity of the assessment are based on the patient's diagnosis, the care setting, and patient's desire for care, and the patient's response to previous care.
Assessments are individualized to meet the special needs of the patient. The following are assessed and documented as appropriate to the patient's age and needs for an infant, child, or adolescent:

1. Emotional, cognitive, communication, education, social, and daily activity needs:
2. Developmental age, length, head circumference, and weight:
3. Effect of the family or guardian on the patient's condition and the effect of the patient's condition on the family:
4. Immunization status:
5. Family's/guardians expectations for and involvement in the patient's assessment, initial treatment, and continuing care.

PROCEDURE: Established procedures as outlined will be followed.

1. Identify the relevant medical diagnoses for the patient being treated. These include, but are not limited to:
   a. CVA or other neurological condition
   b. Traumatic Brain Injury (TBI)
   c. Orthopedic conditions (fractures, joint replacements, etc.)
   d. Spinal Cord Injury
   e. Oncology Diagnosis
   f. Renal Diagnosis

g. General Medical Diagnosis
h. Cardiac Diagnosis
i. Pulmonary Diagnosis
j. Arthritis
k. Debilitation Illness
l. Amputation
m. Burns
n. Hand Trauma
o. Mental Illness
p. Developmental Illness

2. Evaluation: General
   a. Chart review inclusive of pertinent previous medical history, present medical status, psychosocial information, and possible barriers.
   b. Patient/family interview inclusive or previous level of functioning, patient/family goals, reason for referral, discharge plans, and other pertinent information.
   c. Written evaluation may be adapted per needs of patient.
      1. Evaluation my include, but is not limited to:
         2.c.1.1 Range of motion
         2.c.1.2 Muscle strength, tone
         2.c.1.3 Balance and posture
         2.c.1.4 Sensation, kinesthesia, and proprioception
         2.c.1.5 Activity tolerance/endurance
         2.c.1.6 Dexterity/coordination
         2.c.1.7 Bed mobility/transfers
         2.c.1.8 WC management and mobility
         2.c.1.9 Gait (including stairs, curbs, uneven surfaces)
         2.c.1.10 WC seating/positioning
         2.c.1.11 Prosthesis/orthosis evaluation
         2.c.1.12 Evaluation of Cognition: the ability to learn and retain learning
         2.c.1.13 Evaluation of Cognition: functional reasoning/problem solving
         2.c.1.14 Patient's level of reflex integration
         2.c.1.15 Sensory Integration
         2.c.1.16 Reciprocal Motion
         2.c.1.17 ADL management
         2.c.1.18 IADL management
         2.c.1.19 School function
   d. Developmental and Perceptual Evaluation may include, but is not limited to:
      1. Denver Developmental Screening Inventory
      2. Gessell Development Appraisal
      3. Developmental Test of Visual Perception (DTVP-2)
      4. Test of Visual-Perceptional Skills-Non motor (Gardner)

5. Battelle Developmental Inventory (BDI)
6. Bayley Scales of Infant Development II (IDA)
7. Vineland Social Maturity Scale
8. Catell Infant Intelligence Test
9. Bruininks-Oseretsky Test of Motor Proficiency (I and II)
10. Alberta Infant Motor Scale (AIMS)
11. Lincoln Osertslay Development Scale
12. Handwriting Without Tears
13. Evaluation Tool of Children's Handwriting
14. Toddler and Infant Motor Evaluation (TIME)
15. Gross Motor Function Measure (GMFM)
16. Infant Motor Screen (IMS)
17. Movement Assessment Battery for Children (Movement ABC)
18. Peabody Developmental motor Scares (PDMS) (PDMS II)
19. Test of Gross Motor Development (TGMD)
20. HELP Stands
21. Infant-Toddler Developmental Assessment (IDA)
22. Pediatric Evaluation of Disability Inventory (PEDI)
23. School Function Measure
24. Wee Functional Independence Measure (WeeFIM)
25. Motor Free Visual Perceptual Test
26. Test of Visual Perceptual Skills
27. Barthel Index (Original and Modified)
28. Southern California Sensory Integration Test
29. Frostig Developmental Test of Visual Perception
30. Purdue Perceptual Motor Survey
31. Berry Buktenica Developmental Form Sequence
32. Visual Motor Integration Evaluation (VMI)
33. Functional Self Care Adaptive skill level
34. Prosthesis and Orthosis Evaluation
35. Pre-Vocational Evaluation
36. Homemaking Evaluation
37. Psychosocial/Leisure Evaluation
38. Low Vision Screening

e. Impressions, problems, and assessments
1. Contraindications/barriers
2. Severity level
3. Prognostic Indicators
4. Recommendations/referrals

f. Plan of Care/treatment
1. Establish both long-term and short-term goals
2. Establish objectives
3. Estimate length of stay

4. Referrals as indicated
5. Reason for skilled intervention

g. Treatment
   1. Rehabilitation procedures are designed to maximize functional mobility and independence with ADL and IADL skills at home, work, or in the classroom setting.
   2. They may include, but are not limited to:
      - 2.g.2.1 Follow-up on recommendations from the evaluation
      - 2.g.2.2 Coordination, communication, and documentation
      - 2.g.2.3 Caregiver/patient/family training
      - 2.g.2.4 Therapeutic exercise
      - 2.g.2.5 Functional training in self-care and home management
      - 2.g.2.6 Functional training in community integration/reintegration
      - 2.g.2.7 Modification of the environment
      - 2.g.2.8 ADL/IADL management
      - 2.g.2.9 Electrotherapeutic modalities
      - 2.g.2.10 Physical agents and mechanical modalities
      - 2.g.2.11 Adaptations to treatment to meet patient needs
      - 2.g.2.12 Development and facilitation of compensatory strategies
      - 2.g.2.13 Consultation with other allied health professionals
      - 2.g.2.14 Planning for discharge setting and modifications

h. Ongoing Assessment
   1. Daily documentation
   2. Every 10th visit day and monthly progress notes/recertifications
   3. Update, review goals/care plan as necessary.

i. Engaging in consultation and education as appropriate.

3. Discharge
   a. Planning for discharge begins with the initial plan of care.
   b. Ongoing adaptation and modification of discharge goals as indicated as the patient progresses through plan of care.
   c. Family/caregiver conference as needed for discharge environment and provision of ongoing care needs
   d. Multi-disciplinary approach
   e. Referral for post discharge care and resources as appropriate/necessary

REVISIONS/UPDATES

Date	Brief Description of Revision/Change