COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Evaluation, Treatment, and Discharge General Procedures for PT		**503**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: Physical Therapists and Physical Therapist Assistance (under the supervision of a licensed PT) practicing physical 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 Physical Therapy.

POLICY: Assessments are performed within Physical 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
   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

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 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
   d. Developmental Evaluation may include, but is not limited to:
      1. Denver Developmental Screening Inventory
      2. Gessell Development Appraisal
      3. Battelle Developmental Inventory (BDI)
      4. Bayley Scales of Infant Development II (IDA)
      5. Vineland Social Maturity Scale
      6. Catell Infant Intelligence Test
      7. Bruininks-Oseretsky Test of Motor Proficiency
      8. Alberta Infant Motor Scare (AIMS)
      9. Toddler and Infant Motor Evaluation (TIME)
      10. Gross Motor Function Measure (GMFM)
      11. Infant Motor Screen (IMS)
      12. Movement Assessment Battery for Children (Movement ABC)
      13. Peabody Developmental motor Scares (PDMS) (PDMS II)
      14. Test of Gross Motor Development (TGMD)

15. HELP Stands
16. Infant-Toddler Developmental Assessment (IDA)
17. Pediatric Evaluation of Disability Inventory (PEDI)
18. School Function Measure
19. Wee Functional Independence Measure (WeeFIM)

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

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.
   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 Manual therapy techniques
      - 2.g.2.8 Wound management
      - 2.g.2.9 Electrotherapeutic modalities
      - 2.g.2.10 Physical agents and mechanical modalities

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. Multi-disciplinary approach

REVISIONS/UPDATES

Date	Brief Description of Revision/Change
