COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Evaluation, Treatment, and Discharge General Procedures for ST		**505**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Rehabilitation		
DEPARTMENT	REFERENCE	
Rehabilitation Services		

SCOPE: Speech Therapist practicing speech 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 Speech and Language Therapy.

POLICY: Assessments are performed within Speech and Language 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. Communication Disorder
   a. Though other communication disorders may be present and identified in the evaluation report, it is the major communication disorder that is to be used for diagnostic purposes, outcome studies, and justification for third party payor services.
   b. Diagnostic Evaluation includes, but is not limited to:
      1.b.1 Identifying information
      1.b.2 Case history

1.b.3 Reason for referral
1.b.4 Background information
1.b.5 Previous status
1.b.6 Interview(s)
1.b.7 Chart review
1.b.8 Written evaluation: May be adapted per needs of patient
1.b.9 Behavioral observations
1.b.10 Sensory deficits (e.g. vision, hearing, etc.)
1.b.11 Oral motor/peripheral examination
1.b.12 Motor speech examination
1.b.13 Swallow screening
1.b.14 Voice and fluency screening
1.b.15 Language assessment
    1.b.15.1 Expressive skills: Verbal, gestural, written
    1.b.15.2 Receptive skills: Auditory, reading, gestural
    1.b.15.3 Cognitive status: Memory, orientation
    1.b.15.4 Attention, problem solving/judgment
    1.b.15.5 Pragmatic skills: Eye contact, turn taking
    1.b.15.6 Topic maintenance, referencing, topic initiation
    1.b.15.7 Where appropriate, impressions of psychological state
    1.b.15.8 Other applicable information/assessments

c. Impressions, problems, conclusions, assessments
1.c.1 etiological factors
1.c.2 severity levels
1.c.3 contraindications/barriers
1.c.4 prognostic factors/indicators
1.c.5 recommendations (including frequency, duration, type of treatment and/or modalities:
1.c.6 referrals

d. Plan of treatment/care
1.d.1 Establish long-term and short-term goals
1.d.2 Establish objectives
1.d.3 Develop estimated length of stay or treatment duration
1.d.4 Set-up referrals

e. Rehabilitation procedures are designed to maximize functional communication skills and to facilitate achievement of the long-term goals. They may include, but are not limited to:
1.e.1 Follow-up on recommendations from the evaluation
1.e.2 Projection of rehabilitation potential
1.e.3 Adaptation to needs of the patient/resident
1.e.4 Facilitate rehabilitation goals
1.e.5 Modify environment
1.e.6 Develop and facilitate compensatory strategies

1.e.7 Ongoing assessment of changes and other possible problem areas
1.e.8 Caregiver/family/resident/patient education and training
1.e.9 Planning for discharge
1.e.10 Other consultation in conjunction with treatment

f. Ongoing assessment
1.f.1 provision of treatment with modification to plan of care as needed
1.f.2 Every 10th visit day and monthly progress summaries
1.f.3 Trial treatment utilizing facilitative and compensatory techniques
1.f.4 Update and review of goals/care plan, as necessary

g. Discharge
1.g.1 Planning for discharge begins at the initial plan of care
1.g.2 Ongoing adaptation and modification of discharge goals as indicated
1.g.3 Attainment of goals
1.g.4 Failure to progress over a maximum of a 2-week period
1.g.5 Development of other problems contraindicating further treatment
1.g.6 Goals modified to reflect the patient's needs and/or status
1.g.7 Referral to other disciplines in healthcare as appropriate
1.g.8 Indication of refusal to participate.

2. Swallowing disorder
a. The diagnosis of dysphagia is to be used
b. The medical diagnosis can be dysphagia or other diagnosis (e.g. vocal cord paralysis)
c. Diagnostic evaluation
2.c.1 Identifying information
2.c.2 Case history
2.c.2.1 Reason for referral
2.c.2.2 Background information
2.c.2.3 Previous status
2.c.2.4 Interview(s)
2.c.2.5 Chart review
2.c.3 Written evaluation: May be adapted per need of the patient
2.c.3.1 Behavioral observation
2.c.3.2 Any sensory deficits (e.g. vision, hearing, etc.)
2.c.3.3 Current P.O. intake (if any)
2.c.3.4 Respiratory status
2.c.3.5 Communication screening
2.c.3.6 Cognitive screening
2.c.3.7 Oral motor/oral peripheral examination
2.c.3.8 Condition of dentition
2.c.3.9 Sitting posture, head control
2.c.3.10 Strength, coordination, ROM, and mobility of oral structure
2.c.3.11 Presence/absence of asymmetries
2.c.3.12 Presence or absence of laryngeal evaluation during swallow

2.c.3.13 Cough reflex
2.c.3.14 Cough to command
2.c.3.15 Presence or absence of wet vocal quality

d. Deglutition Assessment
- 2.d.1 Consistencies of solids and liquids tried, method of presentation and amount of presented material.
- 2.d.2 Adequacy of mastication
- 2.d.3 Timeliness of preparation to swallow, oral preparatory phase
- 2.d.4 Adequacy of bolus control and formation
- 2.d.5 Presence or absence of stasis and place of stasis
- 2.d.6 Adequate labial seal results of trial positioning techniques.
- 2.d.7 Oral transit time, timeliness, efficiency, swallow initiation, laryngeal elevation
- 2.d.8 Other

e. Impressions, problems, conclusions, assessments.
- 2.e.1 Etiological factors
- 2.e.2 Severity levels
- 2.e.3 Contraindications/barriers
- 2.e.4 Strengths/weaknesses
- 2.e.5 Prognostic factors/indicators
- 2.e.6 Recommendations (including frequency, duration, type of treatment and/or modalities needed
- 2.e.7 Referrals

f. Plan of treatment/care
- 2.f.1 Establish long-term and short-term goals.
- 2.f.2 Establish objectives
- 2.f.3 Develop estimated length of stay or treatment duration
- 2.f.4 Set-up referrals
- 2.f.5 Rehabilitation procedures are designed to maximize functional swallow skills and to facilitate achievement of all long-term goals. They ay include, but are not limited to:
  - 2.f.5.1 Follow-up on recommendations from the evaluation
  - 2.f.5.2 Projection of rehabilitation potential
  - 2.f.5.3 Adaptation to needs of the patient
  - 2.f.5.4 Facilitate rehabilitation goals.
  - 2.f.5.5 Modify environment
  - 2.f.5.6 Develop and facilitate compensatory strategies
  - 2.f.5.7 Ongoing assessment of changes and other possible problems
  - 2.f.5.8 Caregiver/family training
  - 2.f.5.9 Development of restorative programs
  - 2.f.5.10 Planning for discharge
  - 2.f.5.11 Other consultation in conjunction with treatment

g. Ongoing assessment
   - 2.g.1 Provision of treatment with modifications to plan of care as needed
   - 2.g.2 Every 5th visit and monthly progress notes
   - 2.g.3 Trial treatment utilizing facilitative and compensatory techniques
   - 2.g.4 Update and review of goals/care plan as necessary

h. Discharge
   - 2.h.1 Planning for discharge begins at the initial plan of care
   - 2.h.2 Ongoing adaptation and modification of discharge goals as indicated
   - 2.h.3 Attainment of goals
   - 2.h.4 Failure to progress over a maximum of a 2-week period
   - 2.h.5 Development of other problems contraindicating further treatment
   - 2.h.6 Goals modified to better reflect the patient's needs and/or status referral to restorative type nursing care
   - 2.h.7 Indication of refusal to participate

REVISIONS/UPDATES

Date	**Brief Description of Revision/Change**