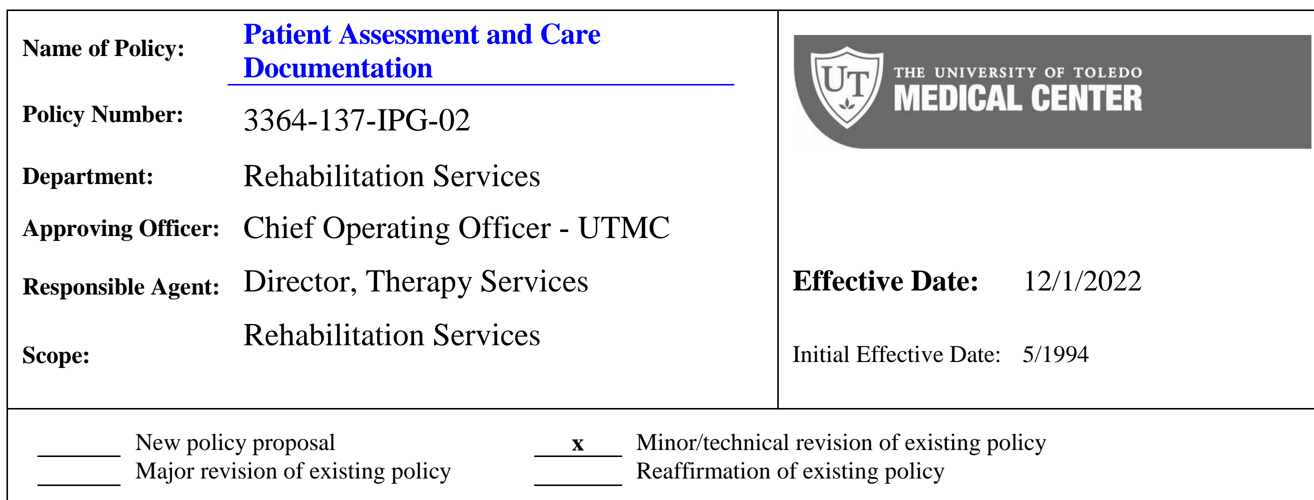

Name of Policy:	**Patient Assessment and Care Documentation**		
Policy Number:	3364-137-IPG-02		
Department:	Rehabilitation Services		
Approving Officer:	Chief Operating Officer - UTMC		
Responsible Agent:	Director, Therapy Services	**Effective Date:**	12/1/2022
Scope:	Rehabilitation Services	Initial Effective Date:	5/1994

_______	New policy proposal	**x**	Minor/technical revision of existing policy
_______	Major revision of existing policy	_______	Reaffirmation of existing policy

(A) Policy Statement

All patients will receive a thorough assessment prior to initiation of services. Services provided will be based on the assessment, collaborated with the patient, and coordinated with team members. All patient documentation will be thorough, complete, and timely for optimal patient care.

(B) Purpose of Policy

To ensure quality patient care provided in a coordinated interdisciplinary framework.

To establish guidelines and time frames for completion of required documentation for all patients served by Rehabilitation Services.

(C) Procedure

1. EVALUATIONS

   a. Acute Care

   Evaluations will be initiated within 48 hours of receipt of orders. Notations will be made in the electronic medical record if therapist are unable to see due to restrictions and/or unavailability.

   b. Outpatient Services

   All acute and OP rehab initial evaluations and documentation will be completed via the electronic medical record system within 48 hours of completion with the following exceptions: 1) swallow evaluations will be entered on the same day as the evaluation is rendered, 2) speech-language evaluations will be entered in the chart within 5 working days of completion, and 3) neuropsychological test results, 2 weeks after completion.

2. PLANS OF CARE

   Each person served will have an individualized plan of care. The plan will be developed based on the individual's preferences, health risk factors, strengths, abilities, and needs as identified in the assessment. Each treatment plan will include goals, therapeutic interventions utilized to achieve each goal (specification) and time frames to achieve stated goals. The plan will be assessed and modified as indicated. Revisions in the plan will be made following input from the person served and/or the family. The care coordination staff assigned to the person served will assume responsibility for coordination of services.

3. TREATMENT NOTES

   A note describing progress towards goals will be completed following each treatment session.

4. TEAM CONFERENCE REPORTS

Information will be provided for each team conference by all services involved. Description of progress and current level of function will be provided either as a specific team conference report or in reference to weekly treatment notes. Interdisciplinary team communication maintained through Microsoft Teams.

5. DISCHARGE SUMMARY

A summary of patients' status at discharge compared to status upon initiation of treatment will be completed on all outpatients. Discharge summaries for all outpatients, will be completed in a timely manner with notification to referring physician, however, no later than 30 days from the last appointment.

Approved by:		**Review/Revision Date:**	
/s/	12/01/2022	7/97	8/2006
Alison Matson PT, DPT, NCS Director of Therapy Services	Date	9/97	1/2008
/s/	12/01/2022	10/97	9/2009
Christine Stesney-Ridenour, COO	Date	3/98	7/2012
		9/98	12/2012
		9/99	7/2013
		9/2000	11/1/2016
		2/2001	11/2019
		5/2002	12/2022
		9/2003	
		11/2004	
		9/2005	
		Next Review Date: 12/1/2025	
Policies Superseded by This Policy: 23-IPG-02			

It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.