Inpatient Guidelines of Care for the Physiatrist

The purpose of this document is to delineate guidelines of care for the Physiatrist for inpatient rehabilitation. This document is subject to revision from time to time as warranted by the evolution and technology of practice.

A. Pre-Admission Evaluation:

1. A pre-admission consultation should be performed whenever possible. Components of it should include determination of:
    a. medical stability
    b. complicating factors
    c. precautions
    d. bowel and bladder function
    e. skin integrity
    f. functional capacity and rehabilitation problems
    g. dispositional needs
    h. rehabilitation prognosis in relation to disposition needs

B. Admission Evaluation:

1. History & physical examination in accordance with JCAHO, Medicare, CARF and local hospital standards
2. Inclusion of premorbid functional history
3. Inclusion of range of motion, peripheral vascular findings, cranial nerve function, motor function, cerebellar function, cranial nerve function, motor function, sensory status and musculoskeletal findings on physical exam
4. Functional assessment of mobility, activity of daily living skills and communication ability
5. Psycho-social assessment
6. Diagnosis
7. Rehabilitation treatment plan including patient goals, estimated length of stay and disposition

C. Admitting Orders:

1. Medical orders in accordance with JCAHO, Medicare, CARF and local hospital standards
2. Rehabilitation orders including:
    a. diagnosis, frequency, duration, precautions and goals
    b. adaptive aids and goals for their use
    c. prosthetic and orthotic orders and goals for their use

d. identification of precautions

D. Ongoing Inpatient Care:

1. Medical diagnosis and treatment in accordance with JCAHO, Medicare, CARF and local hospital standards
2. Physician patient visits and written progress notes at least (one of which may be a team conference note)
3. Progress notes should identify medical problems, rehabilitation progress and patient care needs
4. Identification of new precautions and complications related to medical stability and rehabilitation
5. Updating functional evaluation, diagnosis and management with ongoing impairment assessment as indicated
6. Ongoing assessment of goals with setting of goals as indicated
7. Ongoing rehabilitation treatment plan formation
8. Ongoing prescription of therapeutic exercise and modalities
9. Ongoing prescription of adaptive aids, prosthetics & orthotics
10. Ongoing direction and prescription of allied health services
11. Team conference leadership
12. Monitoring need and effect of therapeutic leaves of absence
13. Monitoring need and effect of family conferences
14. Monitoring need and effect of family and patient teaching

E. Team Conferences:

1. Team conferences should be held no less than every other week.
2. The team conference note should be functionally oriented, with members of the team participating in an interdisciplinary manner.
3. The team conference note should include the following:
    a. Medical Review: this may precede the team conference note
    b. Nursing: including assessment of skin, bowel, and bladder status and safety awareness
    c. Physical Therapy; including assessment of mobility, prosthetics and orthotics, strength, endurance and balance
    d. Occupational Therapy: including assessment of activities of daily living consisting of bathing, dressing, grooming, feeding, toileting and adaptive aids
    e. Recreational Therapy (when part of the team): including assessment of auditory & visual comprehension, verbal expression and oralpharyngeal function when indicated

f. Speech/Language Pathology (when part of the team): including assessment of auditory & visual comprehension, verbal expression and oralpharyngeal function when indicated

g. Social Services: including re-entry readiness addressing dispositional status, social (family) status and equipment and architectural status

h. Psychology Services (when part of the team)

i. Dietary Services (when part of the team): nutritional status

j. Plan: establishing reasonably obtainable goals that address the rehabilitation status identified above, while determining an estimated date of discharge and associated disposition.

A. Discharge Summary:

1. In accordance with JCAHO, Medicare, CARF and local hospital standards

2. Inclusion of:

a. admitting diagnosis

b. pertinent medical history on admission

c. functional status on admission

d. admitting social history and dispositional needs

e. pertinent physical exam on admission

f. hospital course including pertinent medical and rehabilitation events

g. functional abilities on discharge

h. final diagnoses

i. medications, diet, and adaptive aids on discharge (when prescribed)

j. follow up rehabilitation therapies, social services and medical appointments after discharge (when prescribed)

k. disposition

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aaPM&R
American Academy of
Physical Medicine and Rehabilitation

Physicians Adding Quality to Life®

9700 W. Bryn Mawr Ave., Suite 200
Rosemont, Illinois 60018
phone 877/AAPMR 99
info@aapmr.org www.aapmr.org