# Weisman Children's Rehabilitation Hospital (WCRH)
## ADMINISTRATION MANUAL

**SUBJECT: TEAM CONFERENCES NO: AM 6.3**
**CARE PLANNING**

**EFFECTIVE DATE: 4/30/98 PAGE 1 OF 4**
**REVIEWED/REVISED DATE: 11/12/02; 04/03; 11/04; 04/05; 04/06; 02/07; 01/08; 03/09; 9/10; 9/11; 5/12; 1/13; 1/14; 1/15; 1/16; 1/17; 1/18; 1/21; 1/24**

**TJC: PC.04.01.01; PC.04.01.03; PC. 04.01.05; RI.01.02.01**

**PURPOSE:**

1. To provide organization and consistency to the rehabilitation program by means of a coordinated, collaborative interdisciplinary approach.

2. To integrate all assessment information in order to develop an interdisciplinary plan for care, treatment and services.

3. To provide an ongoing assessment of whether the care, treatment and services provided are meeting the patient's needs.

4. To facilitate a successful discharge of the patient or referral or transfer of the patient for continuing care, treatment and services.

5. To provide a forum to answer questions, conflicts or other dilemmas for WCRH, patients/family or other decisions makers about the care, treatment, services or discharge and to resolve such dilemmas.

**POLICY:**

In order to ensure that each patient receives coordinated and appropriate care, treatment and services throughout his/her stay at WCRH an interdisciplinary team of qualified professionals meets on a regular basis to assess and reassess each patient's comprehensive plan of care, rehabilitation goals and to plan a seamless transition to the next level of care, successful discharge or transfer. Care, treatment and services are provided in an interdisciplinary, collaborative manner as appropriate to the specific needs of the patient and the hospital's scope of services. This dynamic process shall consistently re-evaluate the plan for care, treatment and services to ensure that the patient's needs are met. Patients/parents/caregivers are involved in decisions about care, treatment, services and discharge.

**PROCEDURES:**

**I. TEAM CONFERENCES:**

A. Initial Interdisciplinary Team Conference:

1. An evaluation wrap-up meeting is held within 72 hours of admission to review evaluations and the team will begin to develop a plan for care, treatment and services individualized and appropriate to the patient's needs, strengths, limitations and goals. Long Term goals are established at this meeting. Estimated length of stay shall be set at this time and the interdisciplinary team shall ensure that the time frame shall meet the patient's needs.

2. The initial interdisciplinary team conference occurs within 7 days of the patient's admission to create an initial plan for care, treatment and services appropriate to the patient's specific assessed needs. The planning for care, treatment and services is individualized to meet the patient's unique needs and circumstances and includes the following:

a. Integration of assessment findings

b. Development of a plan of care that includes patient care goals that are reasonable and measurable.

c. Documentation of the plan for care, treatment and services.

d. Involvement of the patient and/or family in developing the plan of care.

e. Discharge plans are discussed, reviewed, and revised as indicated from the initial conference onward.

B. Interim Conferences:

Subsequent interim team conferences are conducted on a weekly basis, dependent upon individual patient needs, to review and revise the plan for care, treatment and services and to monitor the effectiveness of care planning and the provision of care, treatment and services. Patients and/or families continue to be involved in developing the plan of care.

C. Discharge Conference:

When indicated, discharge conferences are scheduled to optimize a safe, efficient, successful discharge process, and to ensure that teaching/training has been successfully completed. All appropriate post-discharge plan(s), referrals, activities, and services are in place prior to or by time of discharge, and that all pertinent information is communicated to the receiving
program(s) as indicated.

## II. PATIENT/FAMILY INVOLVMENT:

A. Patient/family goals and expectations are important considerations in the determination of service provision and rehabilitation program goals.

B. Patients and families are encouraged to actively participate in the rehabilitation process, including the ongoing identification of treatment goals/interventions, progress toward achievement of goals, identification and resolution of potentially interfering issues, enhancement of support systems, facilitation of necessary environmental modifications, etc.

C. Team member(s) shall communicate with the patient and/or family on an ongoing basis regarding the patient's individualized plan of care and to incorporate their input and decision making in the development/reassessment/revision of the plan for care treatment and services.

D. Patients and families are invited to attend the Team Conferences to provide formal input/decision making in the process of updating and revision of the rehabilitation treatment plan and to resolve any questions, conflicts or other dilemmas that may be presented.

## III. TEAM CONFERENCE STRUCTURE:

A. The physician or designee provides an update to the team of medical status, treatment, etc.

B. Qualified interdisciplinary team members collaboratively identify patient needs/priorities and develop a written individualized rehabilitation plan of care, based on integrated results of assessments of patient's physical, cognitive, emotional, and social status; along with the patient's/family's personal rehabilitation goals.

C. Goal Setting:

1. Rehabilitation achievable and measurable goals are identified in the team conference by incorporating:

   a. Patient/family goals/expectations.
   b. Individual team member's goals.
   c. Consideration of patient's social network/support system(s).
   d. Payor goals.

2. In order to achieve the best possible outcome for a patient, it is essential that the patient and/or family participate in the team process. The patient and/or family are assisted in understanding and establishing realistic goals within the physical, psychological,

social, recreational, economical, and vocational levels possible for that patient. Information is provided to the patient and his/her family regarding potential benefits and risks of rehabilitation services in order to assist them in making appropriate, informed decisions.

## IV. DOCUMENTATION / REHABILITATION CARE PLAN:

A. The written interdisciplinary treatment plan is based on the interdisciplinary team review and revision of the plan for care treatment and services and determining how the care, treatment and services will be provided.

B. A copy of every Team Conference Rehabilitation Care Plan shall be maintained in the patient's medical record. A copy shall be provided to the family/guardian and others as appropriate and allowed by law.

C. The attending physician will document recertification of continued need for inpatient services on every care plan.

## V. Use of External Resources:

A. When it has been determined, by the team, that external resources are needed, WCRH will participate in the coordination of care, treatment and services.

B. WCRH shall share relevant patient information, as needed, to facilitate the appropriate coordination and continuity when patients are referred to other care, treatment and service providers and ensure appropriate communication with the other providers to avoid or resolve any conflict or duplication that may occur.

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Administrator