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| **POLICY TITLE: Interdisciplinary Patient Care Rounds/Patient Care Conferences** |
| **Department: Interdisciplinary Practices** | **Policy Number: IDP I-04-e** |
| **History of Review/Revision Dates:** 7/01, 2/04, 10/07, 8/09 | **Effective Date:** **4/29/12** |



**SCOPE:**

Nursing, Care Management Services, Physical Therapy, Occupational Therapy, Speech Therapy, Pharmacy, Dietitian, Home Care, and Spiritual Care

**PURPOSE:**

Interdisciplinary care rounds occur regularly on all units of Penrose-St. Francis Health Services to enhance the quality of patient outcomes.

**STATEMENT OF POLICY:**

Interdisciplinary care rounds/patient care conferences focus on ensuring patients meet medical necessity for admission and continued stay, the earliest possible identification of patient needs, timely discharge planning, and effective development of an appropriate discharge plan.

**PROCEDURE:**

1. During these care rounds/conferences, the Interdisciplinary team members discuss issues appropriate to each patient including but not limited to the following:
	1. Readmissions
	2. Medical issues
	3. Psychosocial issues
	4. Financial issues
	5. Spiritual issues
	6. Nutritional issues
	7. Functional/rehabilitation issues
	8. Barriers to discharge
	9. Milliman criteria for admission, continued stay
	10. Palliative care/pain service/hospice issues
2. Bedside Acute Care RNs reporting on patients are prepared with the following information:
	1. Patient diagnosis and brief medical updates
	2. Patient’s progression through continuum of care
	3. Ambulation/mobility/possible PT/OT/ST
	4. Wound care needs
	5. Pain control advancement
	6. Medication management
	7. Patient/family teaching
	8. Medical need for continued stay
3. Care Management Services case manager/social worker teams will utilize the information in the above areas to develop a safe discharge plan documenting the following:
	1. Barriers to discharge
	2. Discharge planning, specifically
	3. Target Length of Stay for each patient
	4. Review of patient plan for the day including, tests, consults pending and targeted actions related to moving patient forward through Milliman milestones
	5. Previous discharge plans that were established and why/how they will be changed if needed.
4. Role of pharmacy, therapy teams, dietitian, and spiritual care is to identify any patient needs from their perspective and address the specific plan for this stay.
5. All new admissions each day are discussed, including both inpatients and observation patients, as well as patients that will be discharged on that day. The review of each discharge plan is to identify any new barriers that may have been found since discharge plan has been established. Discharged patients’ needs before they leave the unit that day also are addressed.
6. The interdisciplinary care rounds are documented in appropriate Clinical Information System (CIS) sections by both nurse case manager/social worker teams and other team members as appropriate. Also, in each unit there is a log for manually recording names of the interdisciplinary team members attending at both Penrose Main and St. Francis Medical Center.
7. Patients and families are kept well informed of the proposed discharge plans and disposition by case management teams, nursing staff, physicians and other health professionals as appropriate.
8. Patients and families are encouraged to be involved in discharge planning and decision making regarding options for follow-up care. The patient/family provided choice for providers of services.
9. Patient/family conferences are conducted informally or formally depending on the assessed needs of the patient and request by patient/family, physicians, case managers, social workers or other members of the care teams. The conferences will be coordinated through the case manager, nursing or other care team member as appropriate, and the coordinator will record the conference outcomes, including actions to be taken. Patients/families will be educated as to medical updates, barriers to discharge, recommended solutions and priorities.

**REFERENCES AND SOURCES OF EVIDENCE:**

Powell, S. K. (2000). *Advanced Case Management Outcomes and Beyond*. Philadelphia, PA: Wolters Kluwer, Lippencott, Williams and Wilkins.

Powell, S. K., & Hussein, A. T. (2007). *Cmsa Core Curriculum for Case Management*. zPA: Lippincott Williams & Wilkins.

The Joint Commission, 2012. Hospital Accreditation Standards 2012: Standards, Elements of Performance, Scoring, and Accreditation Policies. Oakbrook Terrace, Illinois: Joint Commission Resources

**POLICY VIOLATION**

Any Centura associate who fails to abide by this policy may be subject to disciplinary action, including termination.

**Last review facilitated by Tamra Renzelman, Director of Case Management**

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| **Approval Body: Interdisciplinary Practice Committee** | **Signature/Date:****Katherine D. McCord, RN, CNO 6/16/12** |
| **Secondary Approval Body:***(If applicable)* | **Signature/Date:****Jeff Oram Smith, MD, CMO 6/16/12** |