

The image features a decorative background with a large, dark green monstera leaf on the right side. A large, white rectangular overlay covers the center of the image, providing a space for the text. The background also includes soft, light green and pinkish-purple geometric shapes.

Preparation for Patient Care Activities

Objectives

- Describe a process for the examination and evaluation of a patient.
- Describe a health care team and the health care directives including informed consent and HIPPA.
- Identify information that would be classified as “subjective” or “objective.”
- Describe how subjective and objective information could be obtained through an evaluation.
- Discuss the importance of examining and evaluating each patient before establishing a plan of care.
- Describe the major components or categories of the patient management process.
- List barriers to communication, and describe how they can be overcome.
- Describe guidelines to use when communicating with a person who has an impairment.
- Describe the major components of a written home program.

● KEY TERMS:

Assessment

Caregiver

Communication

Documentation

Electrodiagnostic tests

Evaluation

Examination

Goniometry

Health Insurance Portability and Accountability (HIPAA)

Kinesthesia

Orthosis

Outcome measure

Proprioception

Prosthesis

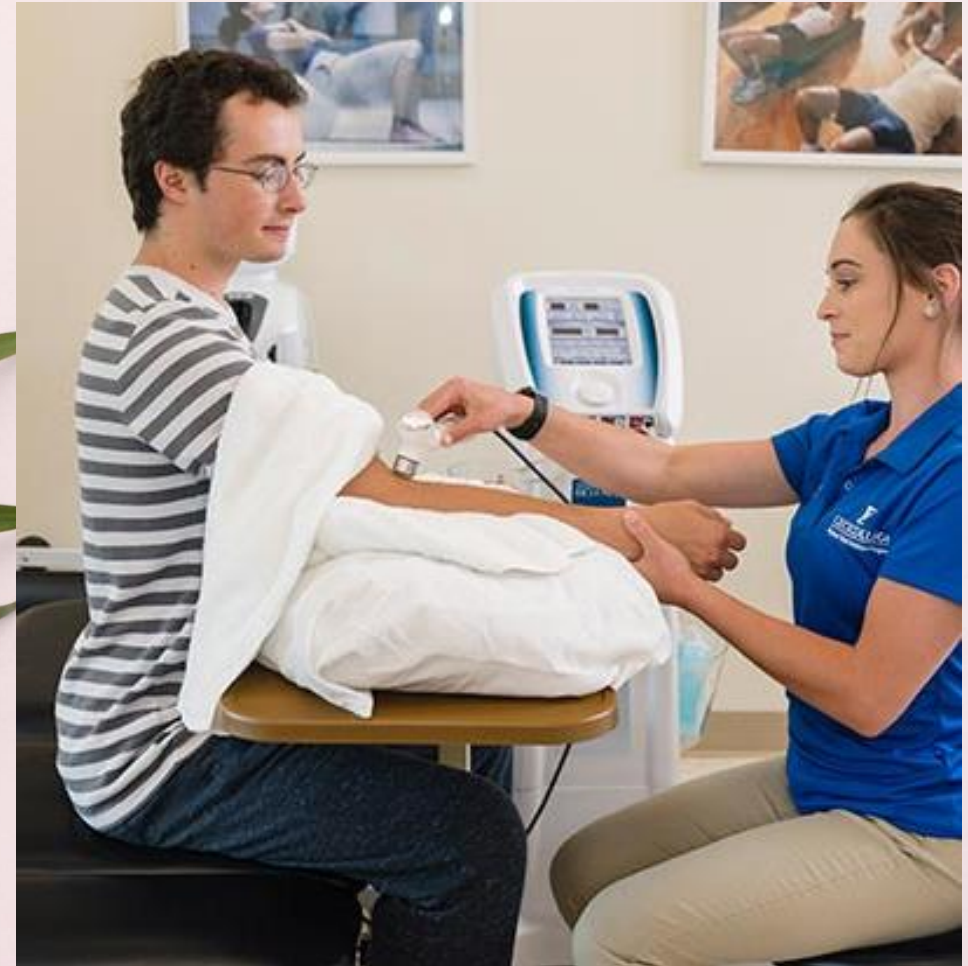
Radiograph

SOAP

Stereognosis

The Joint Commission

Two-point discrimination

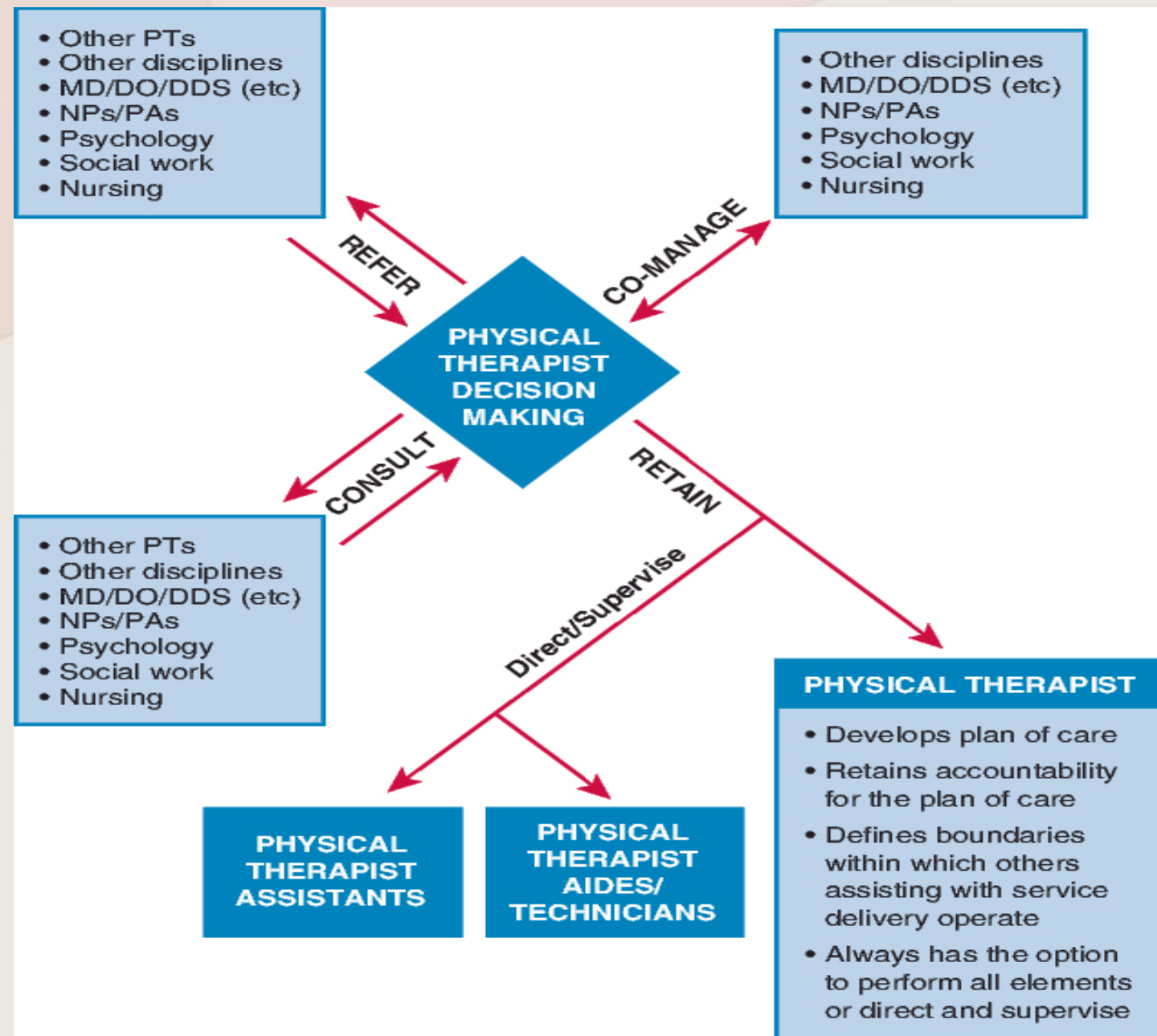


Collaboration

- Interprofessional
- Professional: PT/PTA
Supervision Requirements



Collaboration



Collaboration

INTERPROFESSIONAL

- Patient centered
- A team of caregivers from different professions review a patient's condition
- Coordination and communication among professionals **functioning interdependently** to benefit the patient
- Reduces duplication or fragmentation of services; treatments for complex problems
- Opportunity for understanding skills, expertise, and roles of other team members; increases communication and coordination among team members

PROFESSIONAL

- Professional teamwork or cotreatment
- May include different levels or types of caregivers, for example, PT/PTA;OT/COTA

Primary caregiver is responsible for: evaluation/examination

- developing plan of care
- interventions
- evaluation of patient's response to treatment
- discharge of the patient from services.

Orientation

- Review of the patient's medical record.
- Introduce yourself.
- Verify the patient being treated.
- Interview the patient.
- Perform assessments, examinations, and evaluations.
- Establish **treatment goals** and **functional outcomes**
- Inform patient of treatment plan and techniques.
- Encourage patient to ask questions.
- Obtain **informed consent**, written or orally, and document.



Cultural Diversity

- Culture
- Cultural competence
- Cultural diversity
- Cultural sensitivity
- Culturally appropriate
- Ethnicity
- Race



HIPPA and Informed Consent

HIPPA (Health Insurance Portability and Accountability Act)

●Protection of individual's health care information (**PHI**)

●**PHI**: identifiable personal information, for example, demographic information, services provided, payment information.

●Violations:

- sharing information with anyone who is **not involved in the patient's care**
- looking up information in the medical record when **not** involved in the patient's care

INFORMED CONSENT

- Description of patient's status
- Description of recommended treatment plan
- Risks, complications, and precautions
- Expected prognosis and outcomes
- Alternative forms of treatment
- Explanation of possible **consequences of no treatment**
- Document an opportunity for informed consent and the patient's consent or refusal has been provided.

Documentation

- Initial examination/evaluation
- Visit/encounter
- Reexamination and/or reevaluation
- Primary diagnosis and treatment
- Physician's order
- Possible barriers to treatment and potential solutions
- Patient's consent to treatment
- Plan of Care including long- and short-term goals, treatments, frequency, duration of services, discharge/discontinuation plans
- Risks/benefits of treatment

The image displays several overlapping PTProgress documentation forms. The primary form in the foreground is titled 'OBJECTIVE PHRASE Examples' and contains sections for 'Postural Assessment & Symptom Location', 'Vital Signs', 'Joint ROM', 'Muscle Testing', 'Special Tests', 'Balance Testing', and 'Gait & Functional Movement Tests'. Each section provides specific examples of objective phrasing for clinical documentation. To the right, another form titled 'ASSESSMENT EXAMPLES' shows 'Sample Assessment Formula' and 'Action words'. A third form in the background is titled 'Assessment of Manual Therapy (Soft Tissue & Joint Mobilization)'. The PTProgress logo is visible at the bottom of the forms.

OBJECTIVE PHRASE Examples

Postural Assessment & Symptom Location

- Patient stands with bilaterally depressed scapulae and excessive scapular internal rotation on the right side.
- Decreased upward rotation noted with unilateral shoulder flexion.
- Patient is tender to palpation along right supraspinatus tendon with active resistance.
- Increased kyphosis of thoracic spine present with forward head posture.
- Patient stands with hips shifted to avoid full weight bearing on left side.
- Excessive knee hyperextension present with standing.
- High arch observed in standing but collapses with performance of partial squat.

Vital Signs

- Resting BP measured in sitting in right arm: 124/80
- Resting HR 72 BPM
- Resting SpO2 98%

Joint ROM

- Knee Flexion: L/R: 130 / 125
- Knee Extension: L/R: 0 / 0

Muscle Testing

	Left	Right
Knee Extension	4/5	5/5
Knee Flexion	5/5	5/5
Hip Extension	2/5	4/5

Special Tests

- Slump Test: +
- Straight Leg Raise Test: +
- Hip Test: +

Balance Testing

- TUG: 4 seconds
- SLS (30 seconds) L: 5.5, R: 3
- Tandem Stance: 3 seconds no assist

Gait & Functional Movement Tests

- Patient ambulates with an antalgic gait pattern, favoring right leg.
- Poor hip extension noted on right at terminal stance.
- Decreased push off observed on right side prior to swing phase.
- Excessive hip relative flexion observed during mid swing phase.
- Poor posterior translation observed with performance of sit to stand.
- Increased adduction and medial rotation observed with squating.
- Excessive pronation noted with performance of single leg stance.

ASSESSMENT EXAMPLES

Sample Assessment Formula

The patient [action word] [identify quality of each impairment] with [specific impairment(s)] [outcome].

Ex: The patient demonstrated poor performance of partial squat limited by excessive anterior translation of femurs, insufficient knee flexion, and poor recruitment of gluteal muscles resulting in decreased push off during stance.

The patient demonstrates lack of quad muscle recruitment during extension. Instructed patient to co-contraction of hamstrings to help recruit quad in order to achieve greater knee extension.

Action words

- Demonstrated, performed, lifted, reached, pulled, carried, resisted.

Quality of Performance

- Poor, improved, uncontrolled, controlled, poor, unstable, confident, hesitant.

Task or Movement

- Partial squat, walking, stepping up, reaching, lifting, carrying, into flex with abduction, etc.

Specific impairments or improvements

- Excessive lateral subtalar motion, excessive poor recruitment of gluteal muscles, lack of push off in call, improved recruitment of quads, etc.

Skilled Instruction

- Engage the lower abdominal muscles when you step up, relaxing the upper trapezius with reaching, etc.

Outcome

- Reduced low back pain, improved ROM, better precision of the joint during motion, less clinking/clipping, better ability to sit 30 overhead, etc.

Principles of Documentation

- Document every visit.
- Comply with regulatory requirements.
- Include patient and caregiver identification information.
- Indicate referral source.
- Sign and date with your name and title.
- Use specific, concise, and clarifying statements.
- Use **functional objective outcome** information
- Use only approved abbreviations.

SOAP Note Format:

- **S (subjective)**: what the patient states relevant to treatment.
- **O (objective)**: what is observed or measured.
- **A (assessment)**: interpretation of subjective and objective information.
- **P (plan)**: treatment to be provided, frequency, and duration.



Entry Corrections

- Draw a single line through the inaccurate information.
- Date and initial the correction.
- Enter the corrected statement in the proper chronologic sequence.
- Use black or blue ink.
- Electronic late or corrected entries will have specific programs for making corrections

Accurate, timely documentation is crucial for patient care



Differential Diagnosis: what is it???

- **Direct Access:**

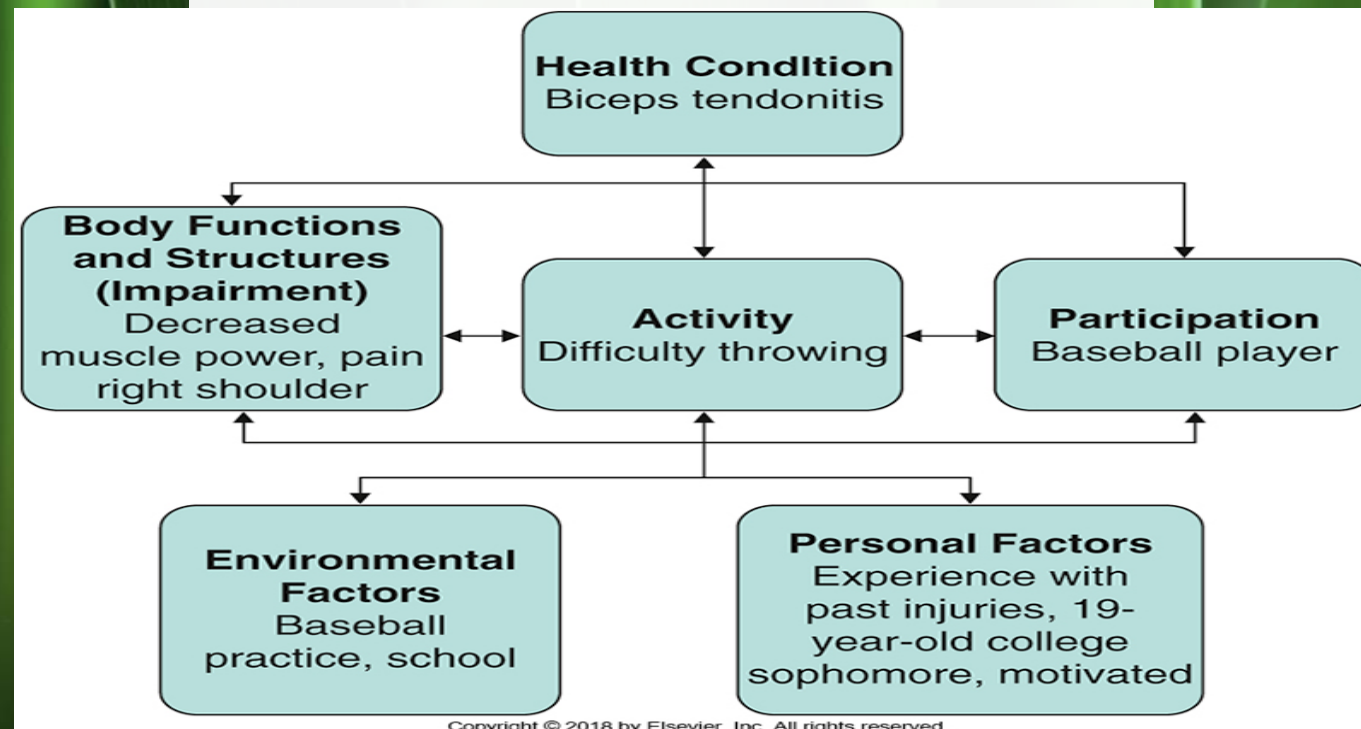
- *the removal of the physician referral mandated by state law to access physical therapist services for evaluation and treatment. if patients have an issue that may benefit from physical therapy, they can make an appointment without a referral.*

- **Diagnosis:**

PT diagnosis vs. Medical diagnosis



International Classification of Function



Evaluation and Examination

- **Observation:** Posture, movement,
- **Interview:** History: present illness, previous medical hx
- Medications
- **Review of Body Systems:** Vital signs, ROM, MMT, palpation, tests and measures
- **Current Functional Level:** mobility, levels of assistance, transfers, assistive devices
- **Prognosis:** expected outcome
- **Plan of Care:** treatment interventions, frequency, duration

Plan of Care: established by the PT

- Interventions
- Short Term Goals
- Long term Goals
- Home Exercise Program

Communication

- Verbal
- Nonverbal
- Audiovisual
- Written/electronic
- Barriers





Patient and Family Communication: Home Programs

- Written, oral, digital
- Include value to treatment
- Environment and assistance required
- Goals and expected outcomes
- Specific directions- reps, positions, safety
- Precautions and contraindications
- When to terminate
- Document HEP and instructional session

Hospital and Clinic Safety

Medical Errors: Right patient? Right treatment?
(Verify)

Prevention:

- hand hygiene

- clear space of obstacles

- evaluate and position equipment

- patient safety: position, gait belt, body mechanics

- prepare/plan treatment in advance

