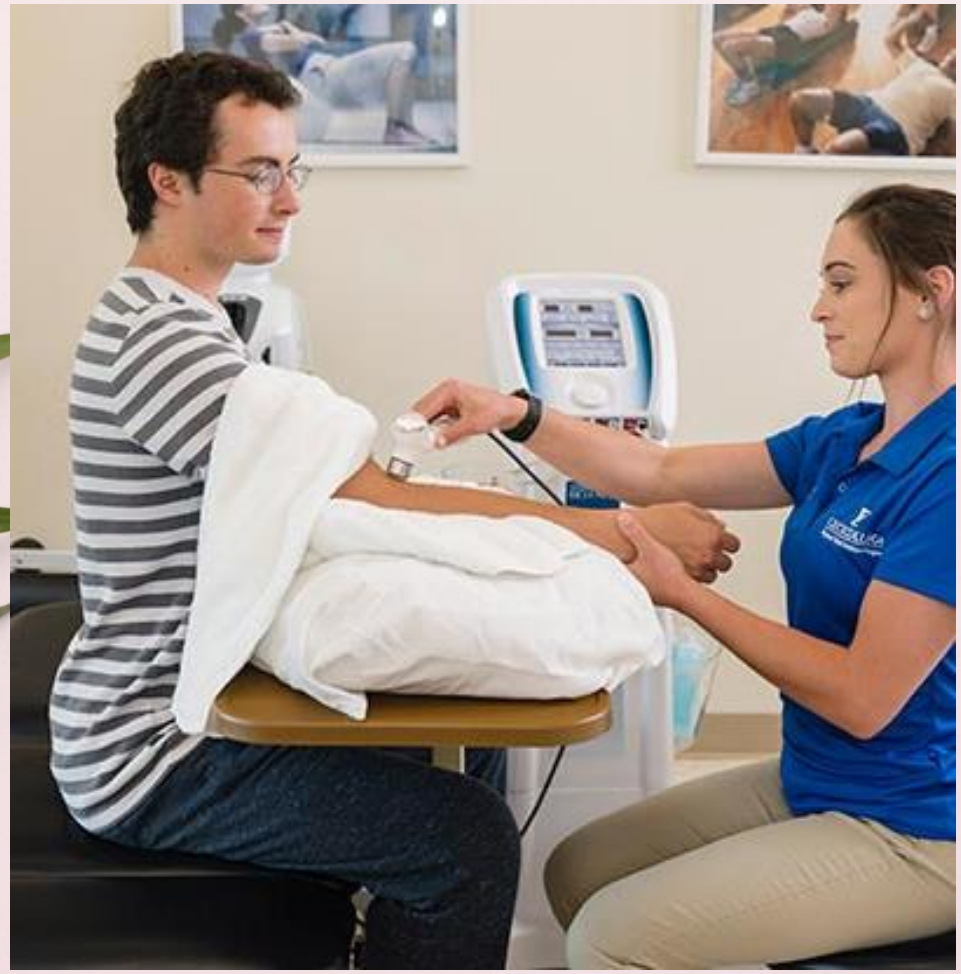
Preparation for Patient Care Activities

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

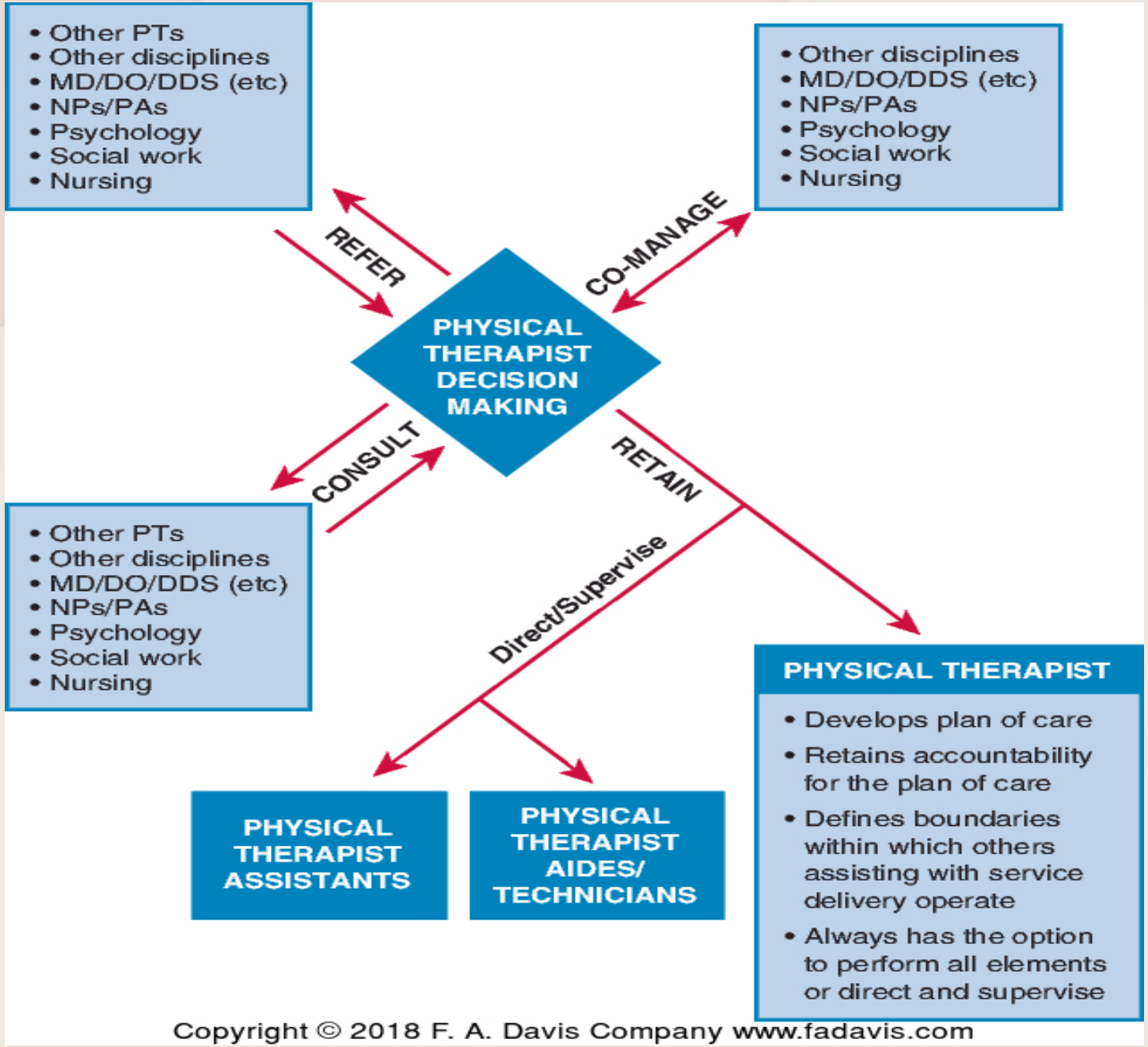


Collaboration

- 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

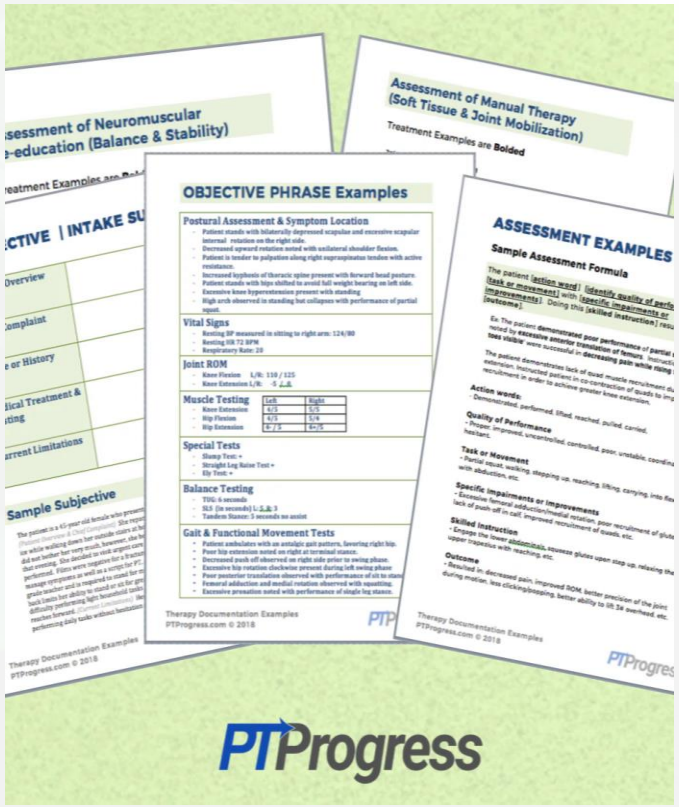
●Expected prognosis and outcomes

●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

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

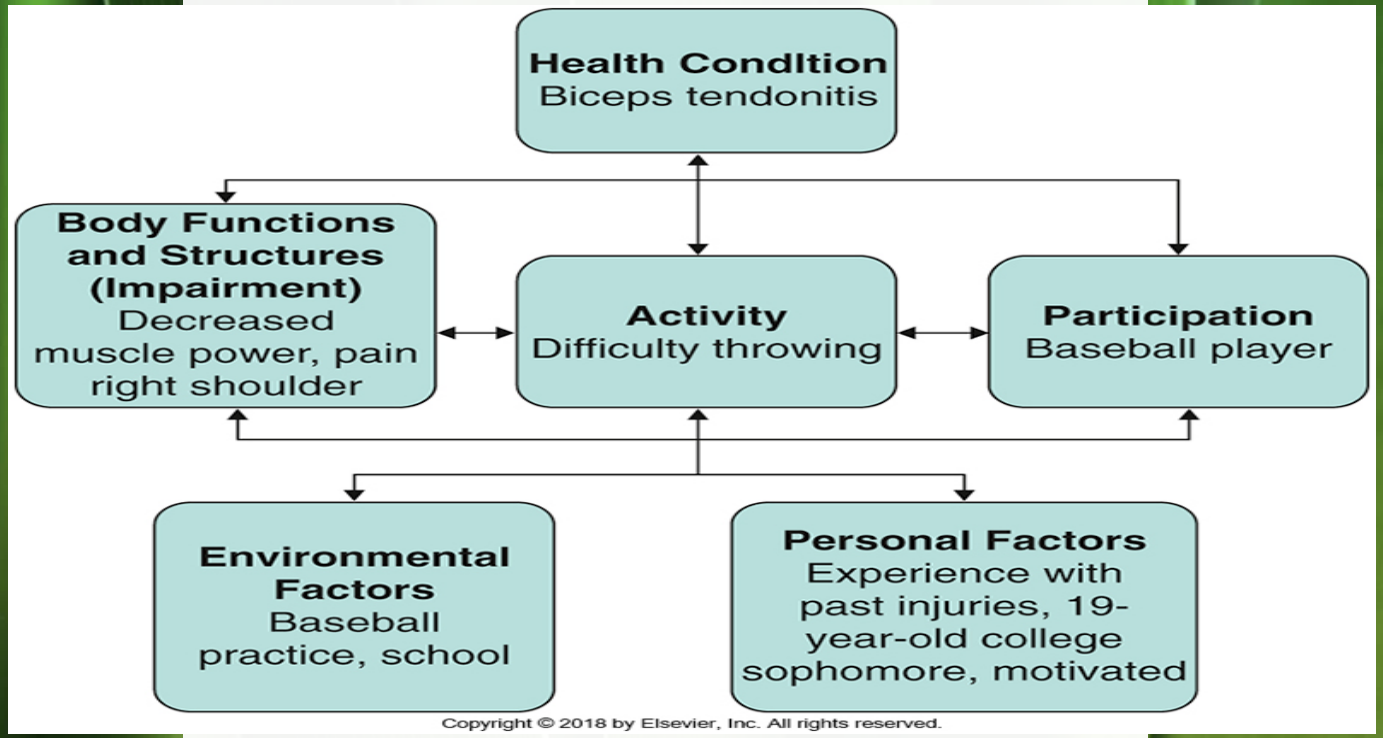
Accurate, timely documentation is crucial for patient care

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