

تقييم
كلية تقني
٦٢

Chapter 1

Preparing for Patient Encounter

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المعالج لتقييم له دور
في تقييم المريض عند طرحه
① المساعدة في عملية التقييم والجمع

تظهر لنا في
إيجاد الحلول
استداع وتقييم خطة العلاج

١. مرضى الـ ICU يحتاجون مساعدة في حفظ السجلات
٢. مرضى الأقسام يحتاجون تقييم في الأوردة والأجهزة والأدوية

Role of RT in Patient Assessment

✓ Help physician in process of diagnosis & management

This HOW? BY

1. Cognitive skills in communicating
2. Selecting appropriate assessment tests
3. Interpreting results
4. Formulation solutions
5. Suggest & evaluating treatment plans

مهارات التواصل في
التواصل
التقييم المنهجية

RT helps with selection of tests and interpretation of these tests to help determine problem & to take an action

1. In ICU bedside determination of help to solve problem immediately
2. On general floors patient requiring changes in medications, procedures, oxygen devices, etc

Stages of Patient-Therapist Interaction

المرحلة التي ما قبل التوافق

❖ Pre-interaction stage:

- Review of patient chart → مراجعة ملف المريض
- Make initial assessment of pt → تقييم اركي للمريض
- Clarifies your role in patient care

❖ Introductory stage:

- Introduce yourself and where from → قدم نفسك
- Your purpose → قول غرضك
- Check armband with permission → شكرك ايد المريض
- Establish positive rapport → توافق
- Look for resistance behavior and act appropriately →

المرحلة المتقدمة
خاصة العلاقة ايجابية
للمريض راضية
قدرت في التعامل

Stages of Patient-Therapist Interaction

مرحلة التقييم الاركي

❖ Initial assessment stage:

- Brief assessment determining patient's illness → تقييم سريع
- Brief physical assessment → لتحدد من المريض
- Pulse, respirations, breath sounds, SpO2
- Compare these findings to RT notes or nurses notes

❖ Treatment and monitoring stage:

- Begin tx after assessment → مرحلة العلاج
- After a few minutes reassess vital signs, BS
- Record positive and negative effects of tx etc..
- Any adverse effects, stop tx, monitor, document and inform appropriate health care team.

Stages of Patient-Therapist Interaction

5 Follow-up stage:

– After tx has ended

بعد نهاية العلاج

- Reassess vital signs
- Clean equipment, replace equipment as needed
- Return pt to pre-tx position if needed
- Let pt to know when you will return
- Thank patient

جمع الأدوات
بعد تنظيفها

قول للمريض متى ارجع

مع المريض
لوضوحته بالأدوية

Communicating the Assessment Findings

Example

ليس للخطأ

– 13/01/2019 09:00 am.

Patient received med nebulizer tx with dose 1.25 mg.

Pre tx:

- Pulse 86/min SpO2 98%/ RR 18/min, Bp 110/70 Temp is 36.5
- breath sounds included expiratory bilateral wheezing throughout all lung fields.

Post tx:

- Pulse = 120/min SpO2 = 98% RR = 16/min, Bp = 100/50
- Decrease in expiratory wheeze in bases, unchanged in other areas of the lung

❖ Patient tolerated tx well, wearing nasal canulae at 2L/min.

Communicating the Assessment Findings

Document the tx include the following

- ✓ Date and time
- ✓ Type of treatment/procedure (ABG's)
- ✓ Drugs and dosages
- ✓ Result of response to tx including adverse effects
- ✓ Goals, objectives or end-point criteria for tx
- ✓ Sign name/credentials (SRT)
- ✓ Double check is very important step in documentation

Use of Space

Social space:

المسافة الاجتماعية

– 4-12 feet from patient (edge of bed)

وقت التحدث

– Use this to begin your introduction

– This will give you the overall picture of the patient

- Breathing, position in bed, family members, table and chairs, patient tray if you need to move these

Personal space:

المسافة الشخصية

– 18" to 4 feet (beside bed)

– Used with interview/asking general questions

– Develop rapport with patient-Best

اصنع علاقة جيدة

Use of Space

Intimate space:

- Up to 18" **inch**
- Move slowly into this area
- Do assessment/give treatment
- Always ask permission before doing these

دائماً استأذن قبل ما تقرب
هذه المسافة

المعلومات - لازم تكون سرية .

لو افزاد بعناتك
أولك مدهم
عاه الدكتور
إع إذا لازم السواك
خاص بار RT
مثل

Confidentiality

- Information gained from patient is private (medical records and interview)
- Many patient issues are sensitive
- Discuss with health care team only
- Family members may ask questions-refer them to the physician unless specific for RT
 - Medications, tx's, oxygen, SpO2, vitals etc, why these are being done

Expressing Concern

- ✓ Face the patient and make appropriate eye contact
- ✓ Maintain a relaxed, open stance

خالي في تواصل في العيون

الدكتور عن اطلع

اللمس
تطير لعلامة
اليد على الكتف / الذراع
اليد

Expressing Concern

Appropriate use of touch:

- Use only after developing rapport
- Hand on shoulder, arm, wrist, hand
- Keep in mind gender, age, cultural difference

Be an active listener:

- Again make eye contact
- Respond appropriately with head gesture, verbal response.
I see....
- Ask for clarification as needed
- Take notes (Do you mind if I take some notes?)

حط في تبايك
الجنس والعمر واضلالت
الثقافات

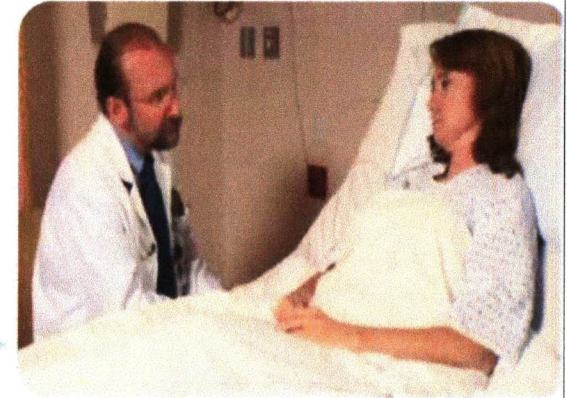
سيف توضحه ؟!
اوان يعرف

Ten Rules for Clinical Etiquette

في طبي وظهرك اجتراني

1. Maintain a professional appearance
2. Identify yourself-name and role → معرفتك عم نفعك
3. Call patient by Mrs, Mr, Miss, Ms → اجتراني المريض
4. Respect and preserve patient's modesty → لا تخط وجهك على سرير
5. Do not rest foot on bed, or sit on bed
6. Keep pt's info confidential → حافظ على السرية
7. Do not discuss pts prognosis with others or in front of patient → لا تناقش على قدر المريض على السرية
8. Do not argue in front of patient → لا تجادل أمام المريض
9. Do not criticize the actions of others on health care team in front of or near patient → لا تنقد الأخرين من الزملاء أمام المريض
10. Keep disagreements and criticisms out of patient's chart → لا تضع الرغوض والانتقادات في حطب المريض

Interview and Respiratory History (History taking)



Overview

طريقة شاملة

- The history is the comprehensive way of assessment.
- It is a written picture of patient's past and present health status.
- It provides a chronological description of development of symptoms.
- It guides the rest of the assessment process.
- In 75% of the cases it will lead to diagnosis even before physical exam takes place.
- All clinicians should be able to locate and interpret information on the medical record.
- Subjective data:
- Those which the patient reports, feels, or experiences that cannot be perceived by the therapist. it helps to determine therapeutic intervention

تقدر
بأقوى عميد
الطبي

data < subj. → symptoms (مستور) / obj. → signs (physical. exam.)

صباريا التواصل

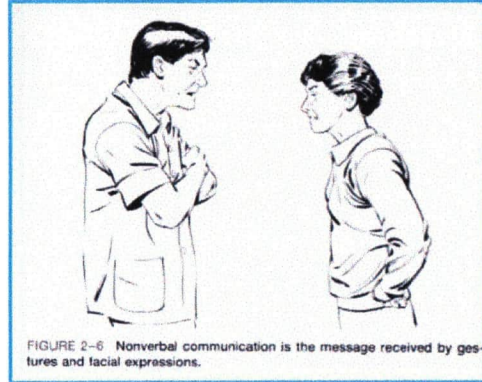
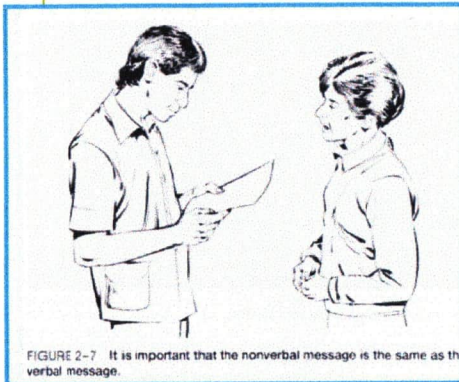
Interviewing the Patient

PRINCIPLES OF COMMUNICATION

- ❖ Process of imparting a meaningful message.
- ❖ Multiple factors can influence communication, these factors could change the interpretation of message to and from the patient.
- 1- Patient's level of comfort plays a very important role in the interview process.
- 2- Clinician should learn to recognize non-verbal signs of patient discomfort.
- ❖ Most common mistake → not listening to answers and questions
- ❖ Actively listen to patient by responding with a yes or no or shaking head yes or no.

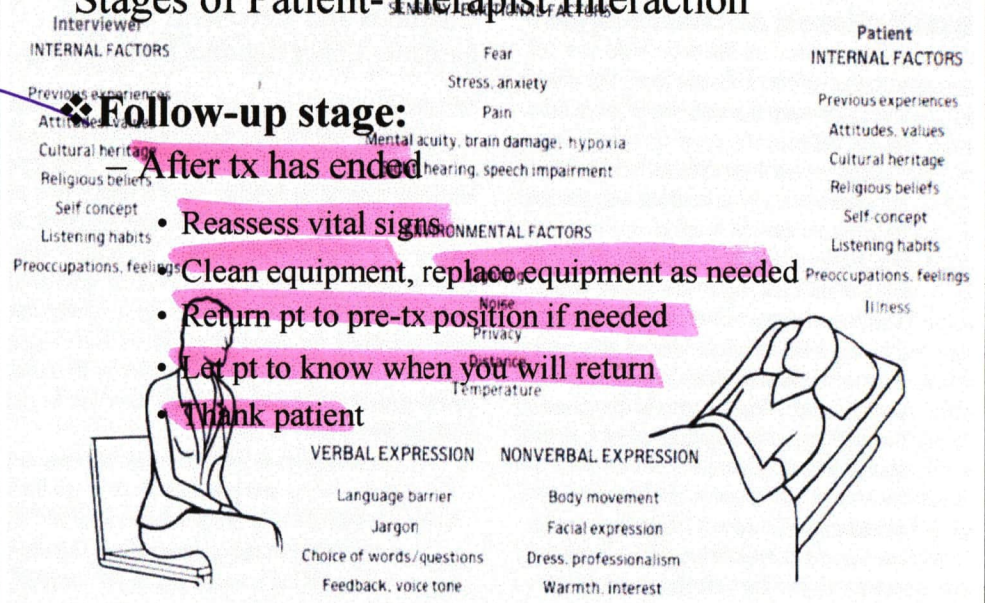
أسهل خطيا / على الأسماع

مكررة ليس؟! ←



Factors influence communication : → لا بد
في الصغى التاليه

Stages of Patient-Therapist Interaction



- Follow-up stage: After tx has ended
- Reassess vital signs
- Clean equipment, replace equipment as needed
- Return pt to pre-tx position if needed
- Let pt to know when you will return
- Thank patient

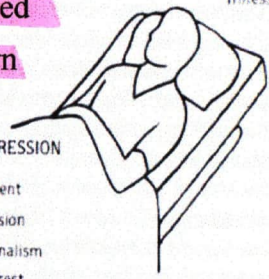
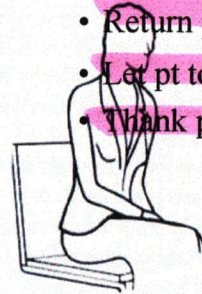


Fig. 2-1 Factors that influence communication.

Interviewing the Patient

STRUCTURING THE INTERVIEW

- history taking is an art that takes time and experience to develop
- **Points to keep in mind:**
- Project a sense of undivided interest in the patient. حصة برصق ابنه معاه
- Privacy, no interruptions, listen carefully. خصوصية / مفين مقابله
- Proper introduction. مقدمه صديه
- Dress appropriately, eye contact, state your role and purpose of the visit, call the patient by name, check the patient's armband. وكر
- Professional conduct. Patient properly covered, never guess at information you don't know, be honest, no moral judgments, clarify vs. argue. لا تخن المعلومات التي لا تعرفها
- Use of relaxed, conversational style.
- Accept silence periods, close by asking if there is anything else the patient needs.

↓
ابتد فدا = اهدت
اعلم المريض
ب / هل تحتاج أي شيء إلهاني؟

Interviewing the Patient

تاركه بالخدمات فقط مع الامراض المزمنة (مثل في الاطباء)

- Patient's comments are confidential. Share these comments with other health professionals only. Not on the elevator
- If using this patient for a case study the name of the patient is protected.
- Alternate methods of obtaining history may be from family, friends, doctors if the health of the patient prevents extensive questioning.

طوبى لايه لاخذ

المستورب لو برصق

حالتها ما بتسبح بالاعراض الكيرة

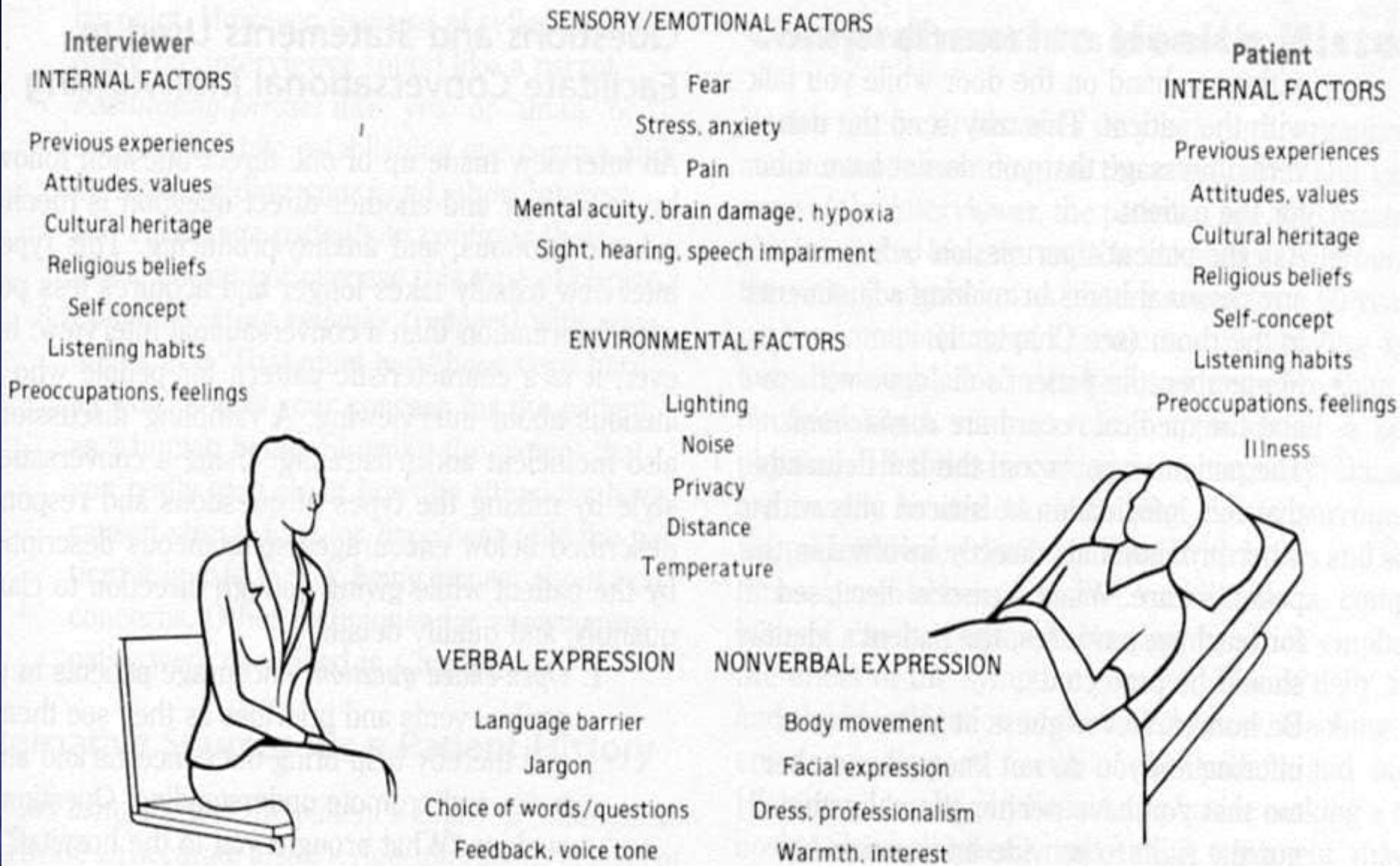


Fig. 2-1 *Factors that influence communication.*

Interviewing the Patient

QUESTIONS AND STATEMENTS

- Open-ended Questions vs. Closed Questions (yes or no)
- What brought you to the hospital?, What happened next?
- When did your cough start?, How long did the pain last?

* Direct Questions (intimidating). → الأرشيت مباشرة

* Why? - avoid series of direct questions. يمكنكم كيف بالمرتب

* Indirect Questions (sound like statements). → الأرشيت الغير مباشرة

* If I understood correctly ..., I gather ...

* Neutral Questions and Statements.

* Tell me more about ..., Would you say ...

* Facilitating Phrases and Communicating Empathy.

Cardiopulmonary History

الأعراض النظامية لها أهداف تفصيلية

- Systemic disease frequently have respiratory symptoms.
- Respiratory problems may affect all body systems. المتأكل للتفصيلية
- Assessment should not be limited to the chest. يمكنكم تأثر على كل
- Comprehensive evaluation of the patient is essential. أوجهة الجسم
- Variations in health hx- 60 year old, vs ER pt, vs young patient
- Diagnosis and Tx is then based on history as well as other tests performed such as lab, x-ray, blood gases etc.

الاختلاف
على حسب العمر

التشخيص والعلاج
يعتمدان على مستوى
والعوامل

التفصيل
الشمولية لهم

Skeleton of the history

Summary of History

- Introduction
- Name, age, occupation background or personal data
- Presenting complaint or chief complain
- History of presenting complaint(HPC)
- Systemic enquiry
- Past medical history (PMH)
- Family history (FH)
- Social history (SH)
- Drug history & drug allergies
- Review
- Summary

General Content of Health Histories

معلومات
عامة

Background Information.

Who the patient is: education, culture, health, attitudes and finances on health.

Description of the Patient's Current Illness:

- Chief complaint (CC)
- History of Present Illness (HPI), screening Information:
- Uncover problem areas patient forgot or omitted.
- Review of all body systems (ROS). Both negative and positive responses.

General Content of Health Histories

Review of Systems

- Looks at past and present illness that will help determine current problem
- Records both positive and negative responses and leaves no doubt as to what questions were asked.
- Physical exam provides objective data that is determined by the examiner (seen, felt, heard etc) and are called signs.
- Subjective manifestations are called symptoms and are expressed by the patient.

نفس اسيد
كل عرض يكتب لوحده
تكتب تكلمت بالمرئيه

Chief Complaint

- What brought you to the hospital?
- What has the problem been?
- What made you go to the doctor



- Each symptom recorded separately.
- Written in patient's own words.
- Should express patient's, not examiner's, priorities.

كل حسب اولويه للمريض
رئيسي اولويه الاضاهف

Common Respiratory Symptoms

- Cough with or without expectoration.
- Breathlessness (dyspnea).
- Chest pain.
- Wheezing.
- Other: hemoptysis, hoarseness, headache, syncope, ankle swelling, altered mental status, cyanosis.
- Closing with "Is there anything else bothering you at this time?"

History of Present Illness (HPI)

Describes chronologically and in detail the CC.

It describes effects on patient's life.

Usually the most difficult part of history to obtain.

Patient should be able to express freely.

Avoid yes or no questions.

History of Present Illness (HPI)

Asking about symptoms can follow a similar line of questioning:

- When did the problem start?
- Is it a new or old problem?
- What did it feel like?
- How often does it occur?
- What starts it off?
- How long does it last?
- What makes it worse?
- What makes it better?
- Does anything else happen to you at the same time, before or after?
- What medicines have you tried? (prescribed or over the counter)
- What effect have they had?

