Patient Interview
Documentation of Assessment

R. Hernandez

RPTH 410

Patient Interview

- Gathers complete and accurate data about the patient's impressions about his or her health including a description and chronology of any symptoms
- Establishes rapport and trust so the patient feels accepted and comfortable in sharing all relevant information
- Develops and shows an understanding about the patient's health state which in turn enhances the patient's participation in identifying problems
- Builds rapport to secure a continuing working relationship

The Interview Setting

- Internal Factors
  - Encompass what the practitioner brings to the interview.
    - Genuine concern for others
    - Empathy
    - Ability to listen
- External Factors
  - Ensure privacy
  - Prevent interruptions
  - Secure comfortable physical environment

SENSORY/EMOTIONAL FACTORS

INTERNAL FACTORS

Previous experiences

Attitudes, values

Cultural heritage

Religious beliefs

Self-concept

Listening habits

Preoccupations, feelings

Fear

Stress, anxiety

Pain

Mental acuity, brain damage, hypoxia

Sight, hearing, speech impairment

INTERNAL FACTORS

Previous experiences

Attitudes, values

Cultural heritage

Religious beliefs

Self-concept

Listening habits

Preoccupations, feelings

Illness

ENVIRONMENTAL FACTORS

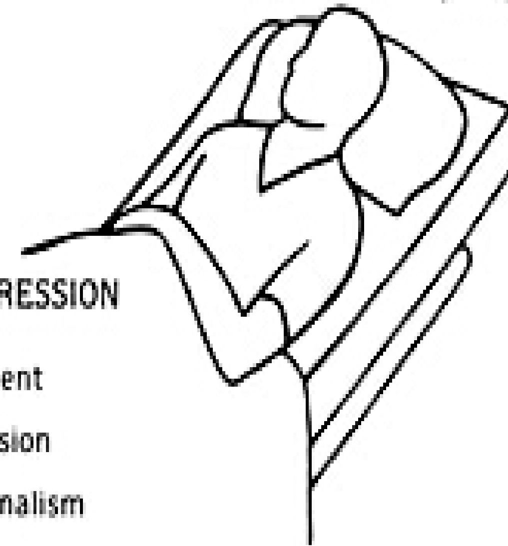
Lighting

Noise

Privacy

Distance

Temperature



VERBAL EXPRESSION

Language barrier

Jargon

Choice of words/questions

Feedback, voice tone

NONVERBAL EXPRESSION

Body movement

Facial expression

Dress, professionalism

Warmth, interest

Copyright © 2003, Elsevier Inc. All Rights Reserved.

Techniques of Communication

- Open-Ended questions
  - To begin the interview
  - To introduce a new section of questions
  - To gather further information whenever the patient introduces a new topic

“What brings you to the hospital?”

Tell me why you have come to the hospital today.”

Techniques of Communication

- Closed or Direct questions
  - Used to elicit a short one or two word answer
  - Yes or nor
  - Forced choice

“Have you ever had this chest pain before?”

How many times in the last year have you had an asthma attack?”

“On a scale of 1 to 5, how bad do you

Assisting the Narrative

- Facilitation
  - Encourage the patient to say more.
    - “Tell me more about how you felt”
    - “Go on”
    - “Continue”
  - Non verbal cues
    - Maintaining eye contact
    - Shifting forward

Assisting the Narrative

<u>Reflection</u>

Patient: "I'm here because of my breathing. It's blocked."

Examiner: "It's blocked?"

Patient: "Yes, every time I try to exhale, something blocks my breath and prevents me from getting all my air out."

Assisting the Narrative

<u>Empathy</u>

Patient: “This is just a great! I used to work out every day, and now I don’t have enough breath to walk up the stairs.!”

Examiner: “It must be hard-you used to exercise every day, and now you can’t do a fraction of what you used to.”

Assisting the Narrative

<u>Clarification</u>

Patient: "I always have a hard time breathing when I breathe in bad air."

Examiner: "Tell me what you mean by bad air?"

Assisting the Narrative

Interpretation

Links events and data, makes associations, and implies causes. Provides the basis for inference or conclusion:

"It seems that every time you have a serious asthma attack, you have had some kind of stress in your life."

Assisting the Narrative

Explanation

Provides the patient with factual and objective information.

“It is very common for your heart to increase a bit after a breathing treatment.”

Nonproductive Verbal Messages

- Providing Assurance or Reassurance
  - “Everything will be fine”
- Giving Advice
  - Answer based on knowledge and experience
- Using Authority
  - “Now, we know what’s best for you.”
- Professional Jargon
  - “Bronchodilator” treatment

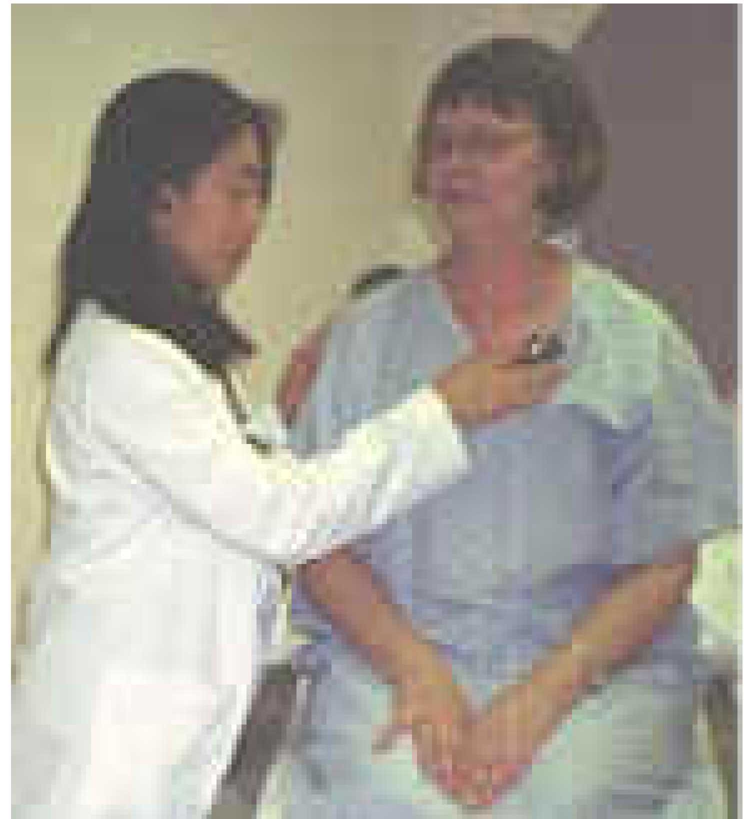
Nonproductive Verbal Messages

- Asking Leading or Biased questions
  - "You don't smoke anymore, do you?"
- Talking Too Much
- Interrupting or Anticipating
- Using "Why" Questions
  - "Why did you wait so long before calling your doctor?"
  - "Why didn't you take your asthma medication with you?"

Nonverbal Skills

- Physical Appearance
- Posture
- Gestures
- Facial Expression
- Eye Contact
- Voice
- Touch

Patient Interview



General Purposes of Documentation

- Serve as a legal record
- Collect evidence in support of patient's complaints
- Provide communication between members of the health care team
- Support appropriate reimbursement
- Provide documentation of compliance with standards of care
- Serve as an educational tool

JCAHO 1999 manual regarding required medical record elements.

IM.7.2 The medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers. (To include the following:)

- Reasons for treatment
- Goals of treatment and the treatment plan
- Progress notes made by the medical staff and other authorized individuals
- All reassessments and any revisions of the

JCAHO 1999 manual regarding required medical record elements.

- “Respiratory care services are provided to patients consistent with a written prescription y the patient’s medical record” (p. IM-21)
- “When specific care goals are developed as part of the initial assessment process, progress or lack of progress toward goals is documented in the patient’s medical record” (p. IM-22)

JCAHO 1999 manual regarding required medical record elements.

- TX.1.3 Patient’s progress is periodically evaluated against care goals and the plan of care when indicated, the plan or goals are revised.
  - The frequency of evaluation is appropriate to the services provided and patient’s needs.
- TX1.1 When care is not planned to meet all identified needs, this is documented in the medical record.
- PE.1.1 The scope and intensity of any…assessment (are) based on the patient’s diagnosis, the care setting, the patient’s desire for care, and the patient’s response to any previous care.
- PE.1.4.1 When a test report requires clinical interpretation, any relevant clinical information is provided with the request.

JCAHO 1999 manual regarding required medical record elements.

- The absence of information or the lack of documented recognition of specific problems could constitute malpractice.

Types of medical records for RCP's Documentation

- Flow Charts
- Parameter sheets
- Test results
- Treatment records
  - Date and time of test or treatment
  - Type of test or treatment
  - Drugs and their dosages, if used
  - Result, or response to treatment, including adverse reactions
  - Monitoring of patient
    - Baseline

Charting Methods

- Assessment, Plan, Implementation and Evaluation (APIE)
- Problem, Intervention, and Plan (PIP)
- Subjective, Objective, Assessment, and Plan (SOAP)

SOAP Charting

- Subjective:
  - What is the patient’s chief complaint?
  - How does the patient feel at the time of the assessment?
  - Can the patient contribute any information that affects his/her diagnosis or treatment plan?
  - What is the patient’s level of

SOAP Charting

- Objective – everything we see, hear, feel, smell, and learn from tests and procedures.
  - Vital signs
  - Physical examination – inspection, palpation, percussion, and auscultation.
  - Clinical laboratory studies
  - ABG's
  - Pulmonary function tests
  - X-rays, Imaging
  - ECG's

SOAP Charting

- Assessment – reviewing data and assessing the patients issues
  - Are the data normal or abnormal
    - Mild, moderate, or severe
  - Is this an acute or chronic problem?
  - Are any of these signs and symptoms related to each other?
  - Do the data indicate that there is something you can do about the patient's

SOAP Charting

- Plan – what are you going to do?
- Continue with current plan
- Modify plan?
  - Patient not responding adequately
    - Change frequency
    - Change treatment
    - Consult with physician

Patient Scenario

- Lauire Cable, a 26 year old female. Admitted to the emergency room with acute onset of shortness of breath. Patient is alert and somewhat anxious; she is seen in the emergency room.
- Pulse 136, regular, BP 146/88, temperature 39°C, respirations 26, shallow and labored. Breath sounds decreased throughout with wheezing superimposed over a prolonged expiratory phase. Patient has a dry nonproductive cough and nasal congestion.

Patient Scenario

- Pulse oximetry reveals 89% on room air
- Recommendation is to delivery oxygen therapy via a nasal cannula delivering six liters per minute at 100% Fi02.

Patient Scenario

- Using the SOAP charting method document this information.

Respiratory Assessment Flow Chart

Subjective →	Objective →	Assessment →	Plan →

Objective

Vital signs: RR ___ HR ___ BP ___

Temp. ___ On antipyretic agent? ☐ Yes ☐ No

Chest assessment:

Insp. ___

Palp. ___

Perc. ___

Ausc. ___

Radiography ___

Bedside spir.: PEFR $\bar{a}$ ___ $\bar{p}$ ___ Tx

SVC ___ FVC ___ NIF ___

Cough: ☐ Strong ☐ Weak

Sputum production: ☐ Yes ☐ No

Sputum char. ___

ABG: pH ___ Pa_{CO_2} ___ HCO_3^- ___

PaO_2 ___ Sa_{O_2} ___ SpO_2 ___

Neg. O_2 transport factors ___

Other: ___

Plan

PRESENT PLAN

PLAN MODIFICATIONS

Subjective

Anterior

R L

Posterior

L R

Pt. name		
Age	Male	Female
Date	Time	
Admitting diagnosis		
Therapist		
Hospital		

Copyright © 2003. Elsevier Inc. All Rights Reserved.