CRC 330- Cardiorespiratory Assessment Skills
Communication, patient chart, and history

I. Patient Communication (Egan, fig 3-9)
   A. Sender transmits the message
      1. Information or attitude communicated by the sender
      2. May be verbal or nonverbal
   B. Communication channel: method used to transmit the message
      1. Seeing, hearing, touching
   C. Receiver is the target of the communication
   D. Feedback allows the sender to measure communication success
      1. Patient adherence, return demonstration, improved health
   E. Health care communication
      1. Success as a professional depends on the therapist’s ability to communicate with patients, families, physicians, and other HCWs
      2. Important to communicate empathy (understanding, ability to put one’s self in the patient’s situation)
      3. A caring touch, eye contact, proving comfort, a gentle tone of voice
   F. Factors affecting communication (Egan, fig 3-10)
   G. Effective health care communication
      1. Key purposes are in Egan, box 3-1
      2. Roles
         a. RT is the sender or receiver of the message (as in patient teaching)
         b. Charting is often the message and channel of communication; when speaking with the patient, avoid jargon
         c. Feedback is evident in the patient’s understanding, ability to perform, adherence to the plan of care
      3. Improving communications skills
         a. Share information, rather than trying to be authoritarian
         b. Relate to people, rather than trying to be controlling
            1) Make the patient a partner in the relationship
         c. Value disagreement as much as disagreement
         d. Use effective nonverbal communications techniques
            1) Eye contact, gesturing, facial expressions, voice tone
      4. The practitioner as receiver and listener
         a. Work at listening
         b. Stop talking
         c. Resist distractions
         d. Keep an open mind, be objective
         e. Hear all the speaker has to say before evaluating
         f. Maintain composure, control emotions
      5. Provide feedback
         a. Attend: use gestures, posture, and phrases to show your attentiveness
         b. Paraphrase after the patient
         c. Request clarification
         d. Check your perception: confirm or disprove subtle components of a
communication interaction: are you unsure?
    e. reflect feelings: statements to confirm emotions

6. Minimize barriers to communication
    a. explain symbols or words that have different meanings
    b. accommodate different value systems and cultures
    c. avoid holding yourself out as being higher status
    d. avoid conflict of interest
    e. accept different points of view, feelings, values, or purposes
    f. help overcome feelings of insecurity

H. structure of the interview
    1. keep the interview focused on the patient, be interested
        a. maintain privacy
        b. be ready
        c. allow the patient to express him/herself fully
    2. be professional
        a. dress professionally
        b. smile, position for eye contact, handshake
        c. identify yourself and your purpose
        d. address the patient by Mr. or Ms.
        e. see that the patient is appropriately covered
        f. be honest, don’t try to diagnose
        g. ask if there are other needs

I. questioning the patient
    1. open ended questions give the patient an opportunity to describe their problem in more general terms
        a. ie: what brought you to the hospital? or why did you decide to seek medical help?
    2. Posed questions allow the examiner and the patient to focus on details
        a. when did you start coughing? or how much sputum do you have each day?
    3. direct and indirect questions may be mixed to gather information and aid in understanding: why?, would you say that...?, if I understand you correctly, you said that...
    4. neutral questions: What happened next?; Tell me more about...
    5. repeating what the patient said
    6. facilitating phrases: “yes”, “I see”, “umm” while maintaining eye contact
    7. communicating empathy: “this must be very hard for you”

J. alternatives
    1. patients may be too weak, unconscious, or too ill to give an interview
    2. question the family or accompanying individual
    3. some patients become so used to their symptoms that they may minimize or deny symptoms

K. Conflict and conflict resolution
    1. Most likely to occur with co-workers, not patients
    2. sources of conflict
        a. poor communication
        b. structural problems: poor management
c. poor personal behavior
d. role conflict

3. Conflict resolution
   a. compete: be assertive and uncooperative
   b. accommodate: cave-in and neglect your own needs
   c. avoid conflict: ignore it, maybe it will go away
   d. collaborate: assertive and cooperative, mutually satisfying
   e. compromising: also assertive and cooperative, not as mutually satisfying

II. The patient*s chart and record keeping
   A. purpose and function
      1. located at the nurse*s station, by room number
      2. precise written document which chronicles the patient*s stay
         a. kept indefinitely by the medical records dept
         b. always accessible in the event the patient is readmitted
      3. each procedure is recorded by a health care worker
      4. each time a procedure is performed, or data reported, it is placed in the chart
      5. provides the legal record, should care be questioned
      6. if it wasn*t written, it wasn*t done

   B. confidentiality (HIPPA)
      1. confidential document
      2. not to be discussed in the presence of unknown persons
      3. not to be photocopied
      4. violation leads to litigation
      5. information may be shared in case study presentations, but identifiers must be removed

   C. subdivisions of the chart (Egan, box 3-2, p. 48)
      1. prefatory material
         a. admission form
         b. consents
         c. consultation forms
      2. physician*s orders
         a. no procedure can be done without a physician order, unless it is by a hospital policy, such as a standing order or protocol
         b. date, time, substance, signature
         c. policy varies as to verbal orders, must be cosigned
      3. graphic chart
         a. graphs of vital signs: T, P, R, BP
         4. medications or MAR (medication administration record)
         5. nurses notes
         6. laboratory reports
         a. all clinical labs (ABGs, CRC, chemistry, microbiology, etc.)
      7. radiographs
         a. reports of all radiography - plain films, CT, MRJ, tomograms
      8. history and physical
a. complete health history of the patient and family if applicable
b. review of systems
c. list of problems
d. plan of care
e. diagnosis (upon which the DRG is based)

9. progress notes
   a. physician*s and sometimes other*s daily notes
   b. subjective, objective, assessment, plan
   c. excellent source of info. for case studies

10. report of operation
    a. typed report of surgical procedures
    b. anesthesiology reports
    c. interesting, informative and detailed

11. others
    a. respiratory therapy notes
    b. other allied health notes
    c. other labs* reports
    d. ECG

D. General rules of charting (Egan, box 3-3, p. 50)
   1. Write your material legibly!
   2. Sign your first initial and last name, f/b SRT
   3. No dittos or erasing
   4. See others on slide and in box

E. SOAP charting (Egan, box 3-4, p. 50; fig 3-12 p. 51, table 3-2 p. 51)

III. Pulmonary history
   A. comprehensive health history
      1. depends on the patient*s condition, age, emergent nature of the problem
      2. history is obtained (Wilkins, box 2-1 p 13)
      3. physical exam: objective data
      4. review of systems: symptoms the patient has subjectively noticed, by body part or system (Wilkins, p. 14)

   B. chief complaint
      1. this is what brought the patient to seek medical attention
      2. symptoms are written in patient*s words
      3. get the patient to clearly describe symptoms
      4. get the patient to sequence the symptoms

   C. history of present illness
      1. describes chronologically and in detail each symptom in the chief complaint
      2. CODIERS mnemonic
         a. Chronology: The sequence of events leading up to the present problem
         b. Onset: When the problem began
         c. Description/duration: What it*s like, How long it lasts, If it*s constant, or comes and goes
         d. Intensity: How severe it is, Whether it*s getting better or worse
         e. Exacerbation: Things that make it worse or bring it on
         f. Remission: Things that make it better or make it go away
g. Social/psychological: How it has affected work, family, activity, or self image

D. past medical history
   1. The mnemonic for this is MMASH which represents a series of inquiries designed to provide you with more knowledge about the other aspects of the patient’s current health and problems of the past. The letters stand for:
      a. Medical Illness: Other noteworthy illnesses including injuries in the patient’s past
      b. Medications: Prescriptions and over the counter drugs currently being taken
      c. Allergies: Including hay fever, insect bites, drug sensitivities, food allergies (particularly helpful when dealing with asthmatics)
      d. Surgeries: Routine and otherwise which the patient has had, including transfusions.
      e. Hospitalizations: Any other hospitalizations without surgeries, for any reason

E. family history
   1. Learn about the health status of immediate family
   2. Form such as Wilkins, fig 2-5, p. 19
   3. Determine presence of hereditary respiratory disease (alpha-1 antitrypsin deficiency, emphysema, cystic fibrosis)
   4. Determine genetic tendencies to cardiovascular disease, cancer
   5. Determine present/past familial respiratory disease, contacts with diseased family members
   6. Determine family stability and stressors in the home

F. Occupational history (Wilkins table 2-1, pages 20-21)

G. Social history
   1. Information regarding support (physical and emotional) available to the patient
   2. The patient’s life style, including the assessment of risk factors possibly related to the patient’s symptoms, and ability to comprehend the instructions you might give. These would include questions regarding:
      a. Smoking: pack years = #PPD X #years
      b. Home conditions; including marital/family status, diet, pets, hobbies and exercise.
      c. Stress level; including recent life events, present occupation and financial status.
      d. Life history information; including past occupations, military service and travels.
      e. Habits; including use of tobacco, alcohol, caffeine and drugs.
      f. Education.
      g. Sexual history (if pertinent).

IV. Common symptoms of pulmonary disorders (Wilkins, ch 3)

A. coughing
   1. Most common, arises from receptors in the pharynx, larynx, trachea, large bronchi, lung, visceral pleura
   2. Four-part mechanism
   3. May be characterized as acute, chronic, paroxysmal, productive, strong, weak, barking, brassy, hoarse, wheezy..., each of which suggests a different diagnosis, Wilkins, table 3-
4. Questions to ask about cough Wilkins p.28

B. shortness of breath (dyspnea)
   1. common to pulmonary and cardiac disease
   2. mechanisms unclear - altered length-tension relationships
   3. record duration, progression, severity, relationship to other symptoms
   4. PND, orthopnea
   5. what effect does dyspnea have on the activities of daily living
   6. review Wilkins table 3-7, p. 33 for diseases and symptoms assoc. with dyspnea
   7. May be quantified using Borg scale (Wilkins table 3-5, p. 31, or 3-6, p. 32)
   8. Review box 3-2, table 3-9, 3-10

C. sputum production
   1. all respiratory system secretions that are expectorated
   2. phlegm is sputum from the lungs and TBT
   3. the normal 100 cc/day is swallowed
   4. describe color, consistency, quantity, time of day, odor, and presence of blood or other foreign substances
      a. color may denote a specific pathogen
      b. consistency: thin, thick, viscous, tenacious, frothy
      c. quantity: scant, small, moderate, large, measured amount
      d. odor: foul-smelling sputum indicates anaerobic process
   5. review Wilkins table 3-3, p. 28

D. hemoptysis
   1. coughing up blood (causes, Wilkins box 3-1, p. 29)
   2. slight bronchial bleeding, associated with pneumonia (dark in color)
   3. massive bright red arterial bleeding: bronchial erosion
   4. up to 75% mortality if massive
   5. frothy, blood tinged or pink sputum is associated with pulmonary edema
   6. must be differentiated from hematemesis (Wilkins table 3-4, p. 30)

E. chest pain
   1. denotes the involvement of the chest wall or parietal pleura
   2. pleuritic pain: inspiratory pain due to pleurisy
   3. also a cardinal symptom of cardiac disease, must be differentiated (Wilkins table 3-11, p. 37-8)
   4. pain is subjective
   5. describe: onset, location, frequency, radiation, duration, severity, precipitating and relieving factors

F. noisy breathing
   1. wheezing and stridor, discussed later

G. hoarseness or voice change
   1. irritation of the upper airway; infection, tumor, nerve damage

H. dizziness and fainting (syncope)
   1. temporary loss of consciousness due to vascular disease, loss of peripheral venous tone, paroxysmal coughing

I. swelling of the ankles (dependent edema)
   1. caused by pulmonary hypertension, cor pulmonale
2. edema ascends as disease process progresses, eventually the liver swells (hepatomegaly)
3. pressing into the edema, such that a depression is formed is called pitting edema

J. fever, chills, night sweats
   1. fever will be covered later
   2. chills occur due to peripheral vasoconstriction
   3. night sweats occur when BT falls abruptly, as in intermittent fever: lung abscess, TB, pneumonia, empyema

K. headache, altered mental status, personality changes
   1. hypoxemia, hypercapnia
   2. sleep apnea, CO₂ retention in chronic bronchitis
   3. hypersomnolence, decreased functional ability