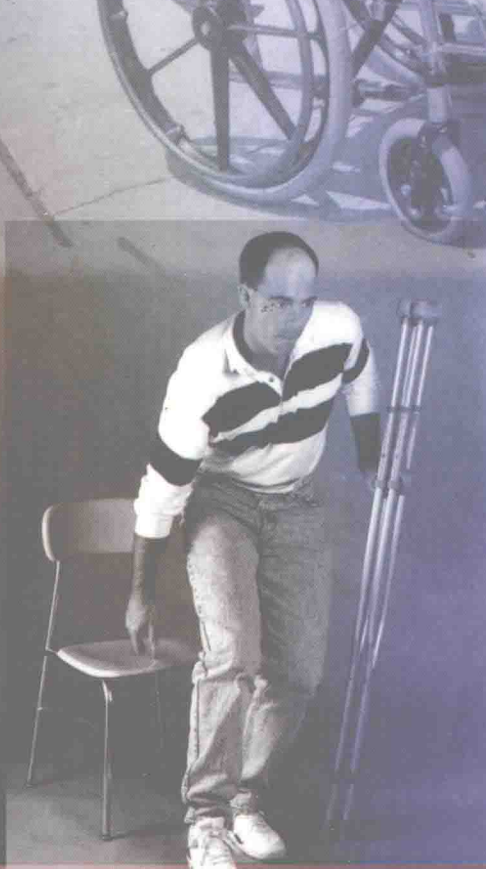
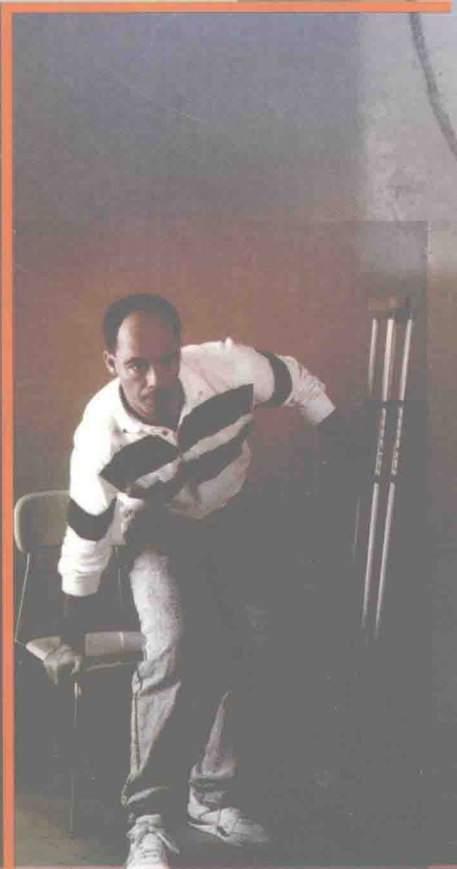
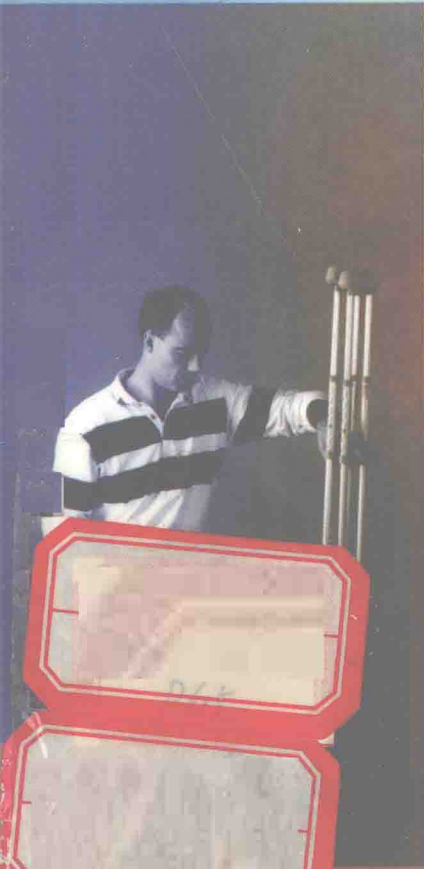


*Frank M. Pierson*

# PRINCIPLES AND TECHNIQUES OF PATIENT CARE

**Second Edition**



# Principles and Techniques of Patient Care

*Second Edition*

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## *Preface to the Second Edition*

The decision of W.B. Saunders Company to request the development of a second edition of this book and the level of acceptance of the first edition by many students, faculty, and practitioners has been very gratifying. During the past three years several suggestions and comments about ways to improve the book have been received and reviewed carefully. Although not all the recommendations were incorporated into this edition, many of them have been used to increase the amount of material in it and to make the book easier for faculty and students to use.

The first chapter was revised to include more information about communicating with a person with a disability and about the process of informed consent. Greater emphasis was placed on the development of functional goals (outcomes) and the use of goal statements in the documentation of patient care. Also, the relationship of goals and functional outcomes has been tied more closely to the treatment planning process.

The chapter on "Vital Signs" was repositioned toward the beginning of the book to emphasize the importance of evaluating a patient prior to initiating treatment or physical activity. Information about and some techniques used to measure a person's body composition were added to this chapter.

Photographs of types of special equipment used for patients in an intensive care unit, including ventilation and intravenous infusion equipment and patient monitors, appear in Chapter 9. Supplemental information about selected reference laboratory values is also provided in this chapter.

More information about the management of nonsurgical wounds, particularly of pressure ulcers, including preventive measures, has been added to Chapter 10. This chapter also contains information about the use of an intermittent compression unit and the measurement and application of graduated compression garments for the upper and lower extremities. The material related to the general use of bandages, previously contained in this chapter, has been relocated to Chapter 11, which seems a more appropriate location.

A new chapter containing information about the Americans with Disabilities Act was developed to assist the reader to become aware of the more significant aspects of the act.

Overall, readers will notice a greater use of procedure outlines, boxes, and tables and the addition of directional arrows on many photographs to enhance their understanding and comprehension of many techniques or activities. Finally, new photographs appear in several chapters, and some previous photographs have been replaced to clarify or better depict specific procedures, equipment, or activities.

It is hoped that the additions and revisions presented in this edition will add to the value of the book as a teaching and learning tool for all readers.

## Acknowledgments

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## Chapter 1

# ■ Introduction to ■ Patient Care ■ Activities ■ ■ ■ ■ ■

### OBJECTIVES

After studying this chapter, the reader will be able to:

- 1 Describe a process for the general evaluation of a patient.
- 2 List the four components of a problem-oriented status note.
- 3 Identify information that would be classified as "subjective" and information that would be classified as "objective."
- 4 Describe how subjective and objective information could be obtained through an evaluation.
- 5 Identify the major components or categories of the evaluation process.
- 6 Discuss the importance of evaluating each patient before establishing a treatment program.
- 7 Describe the major components or categories of the program planning process.
- 8 List five barriers to communications and describe how you would overcome them.
- 9 Describe five guidelines to use to communicate with a person with a disability.
- 10 Describe the major components or categories of a written home program.



## ■ ■ ■ KEY TERMS

**Caregiver:** The person who is treating or working with the patient; examples are the therapist, therapist assistant, aide, or family member.

**Communication:** The exchange of information through verbal or nonverbal means.

**Documentation:** Written or printed matter conveying authoritative information, records, or evidence.

**Electrodiagnosis:** The use of an electrical current to assist with the diagnosis of a patient's condition.

**Goniometry:** The measurement of the range of motion of a joint of the body.

**Kinesthesia:** The sense by which position, weight, and movement are perceived.

**Orthosis:** An orthopedic appliance used to support, align, prevent, or correct deformities or to replace the function of parts of the body; a brace or splint is an example of an orthosis.

**Outcome measure:** A quantifiable or objective means to determine the effectiveness of treatment or performance that is usually expressed with the use of functional terms.

**Problem-oriented medical record (POMR):** A system developed to organize a medical record that uses a common list of patient problems as its base.

**Proprioception:** Perception mediated by proprioceptors or proprioceptive testing; sensation and awareness about the movements and position of body parts or the body.

**Prosthesis:** The artificial replacement of an absent body part; an artificial limb is an example of a prosthesis.

**Radiograph:** An image or a record produced on exposed or processed film through radiography.

**SOAP:** An acronym whose letters identify each section of a patient's status note: S, subjective; O, objective; A, assessment; P, plan.

**Stereognosis:** The ability to recognize the form (shape) of an object by touch.

**Two-point discrimination:** The ability to recognize or differentiate two blunt points when they are simultaneously applied to the skin.

providing safe and effective care. The term *caregiver*, rather than therapist, nurse, health care practitioner, therapist assistant, technologist, technician, aide, or family member, will be used to designate the person who is treating or working with the patient or client. It is recognized the term client is sometimes more appropriate to describe a person who receives treatment. Furthermore, the term consumer may be used to describe the receiver of care. However, for consistency, the term patient is used throughout this text to describe the person who receives treatment. Similarly, the term intervention may be used rather than the term treatment, but for consistency, the term treatment is used in this text. The procedures and techniques contained in the text were selected because they can be applied or adapted for use for a variety of patients to assist them to fulfill their functional needs or goals. The knowledgeable and experienced practitioner will realize there are alternative techniques or procedures that provide safe and effective ways to perform many of the patient activities described in the text. However, it was necessary to select and describe a limited number of activities and procedures.

It is anticipated and expected that the health care practitioner or caregiver will modify or adjust any technique or procedure to benefit the patient or better suit a specific situation or environment. The safety of the patient and the persons involved with his/her care must be maintained at all times. The patient should be encouraged to perform to his/her maximal ability whenever his/her active involvement is desired.

The caregiver will need to guide, direct, and instruct each patient. For many patients a brief demonstration of an activity or the use of equipment by the caregiver or another patient will enable him/her to understand his/her role better. Verbal, nonverbal, and written communication between the caregiver and the patient and his/her family members will be necessary. The purpose of each activity, its expected outcome, and the method of performance should be explained to the patient.

No activity should be attempted unless sufficient personnel and equipment are available to accomplish the task safely. All persons who assist with the patient's care must be trained and competent; the equipment must function properly and be safe and stable; and the patient must be evaluated to determine his/her capacity to assist with or perform a particular activity.

Patient evaluation, communication between the caregiver and the patient, and patient safety are required to promote quality patient care. Lack of attention to any one of these areas will usually adversely affect the quality of care the patient receives.

## INTRODUCTION

This book has been prepared to assist persons responsible for and involved with patient care in

## INTERPROFESSIONAL COLLABORATION

A team of caregivers from different professions who review a patient's condition, determine his/her problems amenable to treatment, discuss potential treatment solutions, and make decisions to resolve his/her problems is used by many organizations. This interprofessional collaboration approach is particularly useful for the patient with complex medical, social, economic, or other problems. To be successful, interprofessional collaboration requires the team members to meet collectively and periodically to problem solve and reach decisions about management of the patient. Collaboration, coordination, and communication are the important factors used by the team to assist the patient to effectively fulfill his/her goals or needs. The interprofessional team members must be competent professionals who are willing to function interdependently to maximally benefit the patient. Team members must be prepared to recognize and accept the value of other members' professional knowledge, skills, and expertise; work through role conflicts that may develop due to overlapping roles of the members; understand the basic components of each member's profession; be able to communicate effectively with each other; and participate in leadership. The interprofessional team approach must be patient centered, rather than profession centered, so team members must be able to provide advice, counsel, and recommendations based on each member's knowledge and expertise that will lead to the best outcome for the patient. Group members need to be adept in the application of group process skills; therefore, it is recommended a portion of their formal education be devoted to an introduction to and practice of techniques, skills, and activities associated with group interaction. Furthermore, the opportunity to collaborate with students from various professional programs (i.e., medicine, social work, nursing, law, theology, allied health professions) to discuss and resolve complex case study patient scenarios would be beneficial in preparation for future interprofessional team collaboration. Table 1-1 presents rationales for the support of and opposition to the use of interprofessional collaboration from the perspective of the patient and the participating professional.

## ORIENTATION

Before providing any form of treatment, including an evaluation, the caregiver must initially orient the patient. This orientation consists of a personal in-

**Table 1-1**  
**INTERPROFESSIONAL COLLABORATION**

<b>Rationale for Client/Patient</b>	<b>Rationale Against Client/Patient</b>
<ol style="list-style-type: none"> <li>1. Comprehensive approach</li> <li>2. Reduction in duplication or fragmentation of professional services and activities</li> <li>3. Team is better able to address complex problems</li> <li>4. Team decision making is better due to input from different professionals</li> <li>5. Results in interventions for complex problems that exceed what an individual could accomplish</li> </ol>	<ol style="list-style-type: none"> <li>1. Process may overwhelm the patient</li> <li>2. May not produce better quality care</li> <li>3. May not result in best decisions due to professional role conflicts</li> <li>4. Apt to be more costly (time, money, effort)</li> <li>5. May reduce the one-on-one relationship between the patient and individual professionals</li> </ol>
<b>Rationale for Professional</b>	<b>Rationale Against Professional</b>
<ol style="list-style-type: none"> <li>1. Opportunity for members to better understand the skills, expertise, and roles of other professionals</li> <li>2. Opportunity for members to become more aware of and effective in own professional role and application of professional expertise and knowledge</li> <li>3. Enhances ability and provides opportunity to network and refer to other professionals</li> <li>4. Broadens interaction with other professionals; leads to professional development</li> </ol>	<ol style="list-style-type: none"> <li>1. May have personal and professional identity reduced; may lose professional autonomy</li> <li>2. Reduces personal decision making</li> <li>3. Takes time away from other patients; is time-consuming process</li> <li>4. Causes separation from professionals, peers, and colleagues</li> <li>5. Interprofessional collaboration may not be a value of the profession; professional becomes reluctant to participate</li> </ol>

troductory; informing the patient of the treatment goals, expected outcome, and potential risks; interviewing the patient (as part of the evaluation) to obtain information; instructing the patient regarding his/her participation; and initiation of the treatment or evaluation.

In a treatment setting, the caregiver should greet and identify the patient, state his/her own name clearly, and indicate his/her professional or technical status. The patient should be informed why he/she has been referred to the service unit, the type of treatment he/she will receive, and any potentially serious risks or adverse effects associated with the proposed treatment. At this time the patient should have the opportunity to ask questions, obtain additional information, and agree to or decline treatment. During the interview the caregiver should confirm the patient's name and diagnosis and then progress to the remainder of the evaluation. After the patient interview and evalua-

## PROCEDURE 1 – 1

### Orientation of the Patient

1. Introduce yourself by name and title or professional designation.
2. Verify or confirm patient information you have received such as his/her name, diagnosis, purpose of treatment, and referral source.
3. Interview the patient to obtain relevant information about him/her as part of the evaluation process.
4. Perform additional evaluation activities to establish the patient's capabilities, condition, problems, needs, and goals.
5. Inform the patient of the treatment plan and techniques selected to fulfill outcome goals; include information about potential risks or adverse effects associated with the treatment.
6. Encourage the patient to ask questions to obtain information to enable him/her to consent to or decline treatment.
7. Request that the patient sign an informed consent document or record his/her verbal consent in the medical record.

tion, the caregiver should instruct the patient more specifically about the treatment and the patient's role or expected level of performance. The last step in the process is the initiation of the treatment session. During subsequent treatment sessions, several of the steps can be eliminated or modified as the patient becomes more familiar with the treatment process. However, the caregiver should always discuss each treatment activity with the patient and instruct or guide his/her performance (Procedure 1–1).

### INFORMED CONSENT

Before the initial treatment of a patient, the caregiver has the responsibility to inform the person about the proposed treatment, some of the alternative treatments available, and associated primary, known risks. The patient then has the right to consent to or reject the proposed treatment. This is the process of informed consent.

To ensure the patient is properly informed, the caregiver must provide sufficient information about the proposed treatment and alternative treatment, appropriate for the person's condition, to permit him/her to arrive at an intelligent and knowledgeable decision. The patient must be able to understand the information, so it must be presented with the use of terms and in a language he/she can comprehend. A translator or an interpreter may be required for persons who do not speak or comprehend English.

Known or potential primary risks associated with the treatment should be explained, and he/she should have an opportunity to ask questions, and receive responses to them, about any aspect of the proposed treatment. The caregiver should provide responses that are within his/her level of knowledge, training, and competence and based on expected or anticipated results or outcomes. The caregiver should not state or imply that certain results or outcomes will occur, and he/she should not offer any indication to guarantee that specific results or outcomes will be attained.

If the patient has not reached the legal age of consent or has been judged to be mentally confused or incompetent to participate in the informed consent decision-making process, it probably will be necessary to obtain consent from a legally qualified surrogate, such as a parent, guardian, family member, or court-appointed advocate.

The caregiver should document that he/she applied the process of informed consent in accordance with pre-established, written policies and procedures of the service unit or agency with which the caregiver is associated (i.e., hospital department, school system, home health agency, outpatient facility, skilled nursing facility, or subacute care facility). In some situations, it may be prudent to have the patient, or his/her surrogate, sign a document to indicate he/she has been informed of the proposed treatment and consent to the treatment is authorized. The caregiver will need to use his/her judgment and follow the recommendations of the facility or agency, risk manager, or legal counsel to

**BOX 1-1****Elements of the Informed Consent Process**

- Description of the patient's condition, diagnosis, or evaluative data and information
- Description or outline of the proposed, recommended treatment plan, techniques, or procedures
- Primary, known, anticipated, or potential risks; complications; and precautions associated with the proposed treatment
- Expected prognosis or outcome of the proposed treatment without a stated or implied guarantee of results (i.e., decrease or absence of pain, specific functional improvement, specific flexibility or strength gain)
- Alternative forms of treatment appropriate for the person's condition with potential risks, complications, and precautions and the expected prognosis of the alternative treatment
- Questions from the patient and responses from the caregiver that are thorough and honest; if you are unsure of or do not know the response to a question, indicate that to the patient but attempt to locate the information or refer the patient to a qualified resource (i.e., nurse, physician, social worker, pharmacist)
- Explain the potential or possible consequence of no treatment if the patient refuses or rejects treatment
- Document you provided the patient with the opportunity for informed consent before initiation of treatment and his/her decision to consent to or refuse treatment

determine whether each patient should be required to sign an informed consent authorization for treatment. If signed documents are not used, policies and procedures of the facility or agency must be specific and clearly indicate the process each caregiver is to use when discussing informed consent decisions with the patient. Failure by the caregiver to fully inform a patient about the proposed treatment before the initiation of treatment and obtain his/her consent to receive treatment can, in some situations, constitute professional negligence. Informed consent is a right to which each patient is entitled; therefore, the caregiver has the obligation to inform the patient of the proposed treatment, its alternatives, and its foreseeable risks before initiation of treatment (Box 1-1).

**PRINCIPLES OF DOCUMENTATION**

The *documentation* of patient care is an important component of the written record maintained for each patient. Documentation is performed by physicians, nurses, therapists, social workers, and many other persons involved with providing patient care. Lawrence Weed developed the concept of the *problem-oriented medical record (POMR)* in the 1960s. This system has been accepted for use by many health care facilities throughout the United States, some of which have developed their own variations. This system is based on a list of patient problems, a database, and a series of status (progress) notes designated as the "initial," "interim," and "discharge" notes. When all departments or service units of a given facility use the POMR approach to record keeping, a higher quality of patient care may be anticipated, better communication between and among the caregivers is more likely to occur, and better decisions about the patient's treatment can be made. Information about the patient and his/her plan of care is contained in the status notes, which are written in the following format: subjective, objective, assessment, and plan information, or *SOAP*.

**POMR DESCRIPTION**

The POMR has four phases: formation of a database (current and past information about the patient); development of a specific, current problem list (problems to be treated by various practitioners); identification of a specific treatment plan (developed by each caregiver); and assessment of the effectiveness of the treatment plans. When the POMR system is used, each practitioner relates his/her evaluation, treatment planning, and treatment decision making to the patient's database and problem list.

The SOAP notes should contain important, relevant information about the patient; they should indicate and clearly reflect the patient's condition and subsequent changes in his/her condition; and they should be written periodically and frequently so information is reported promptly and regularly. The method used to gather the information and the development of the assessment and planning phases are described in the section related to the evaluation process. The relationship of the SOAP notes to the decision-making process and the purposes of documentations are described in several articles and textbooks. Excellent resources for information about the POMR and SOAP notes are listed in the Bibliography.

Some suggestions of ways to improve the quality and meaningfulness of documentation are listed in Box 1-2.

**BOX 1-2****Ways to Improve Documentation**

1. Avoid general statements and provide specific, clarifying information. Instead of stating “The patient is uncooperative,” state in what manner he/she is uncooperative: “Patient refused to perform active assistive exercise.”
2. Use objective statements. Instead of stating “Patient ambulates,” state “Patient ambulates 25 feet in 1 minute using bilateral axillary crutches on a level surface, with assistance, using a three-point pattern for three repetitions, with a 5-minute rest period between ambulations.” Functional *outcome* measure statements will more accurately describe the patient’s condition and assist with obtaining reimbursement for the services provided.
3. Be complete with your statements; record the significant or important information about the patient’s condition, progress, or response to treatment. Remember: If an activity is not documented, it may be considered as not having occurred. If an unusual activity or procedure is used, document why it was selected and used. Unusual incidents and the action taken after the incident should be recorded. An objective description of the patient’s condition or reaction after the incident should be recorded. An incident report should be filed with the risk manager or similar individual, but there is no need to document that it was prepared and filed.
4. Provide continuity with your status (i.e., progress) notes; be certain to indicate why or how you reached a particular decision about the care or treatment you provided, particularly if it deviated from the usual, acceptable care or treatment. Programs or treatment plans designed for the patient to follow at home should be well documented and should include precautions. Your documentation should indicate how you determined (or the steps taken to ensure) that the patient or family member understood and could comply with the instructions.
5. Identify that you informed the patient of the treatment he/she was to receive and its potential risks or hazards; that this information was understood by the patient; and that he/she consented to the treatment. If a consent form was used by the service unit, a copy signed by the patient should be in the medical record.
6. Be prompt and timely with your entries and be certain your writing is legible, including your signature and professional or staff designation; be certain the information is accurate and there is consistency between entries; investigate and clarify contradictory information. For example, is it the right hip or the left hip that requires treatment?
7. Use abbreviations that have been standardized or accepted and approved by the facility or the profession.
8. Be certain there are no empty or open lines between entries and that there are no open spaces within the notes; use the format approved by the human information systems department or used by the facility or profession.
9. Outline the major elements of the notes in your mind or on paper before you enter it in the record to avoid having to make a correction or a change in the notes. Avoid omissions, such as the date of initial or subsequent treatments, a change in treatment, or a discharge summary.
10. Properly countersign the entries of other persons according to state statutes and facility requirements; read the entry before countersigning it. In many cases it will be prudent to review the proposed entry before it is placed in the record to be certain it is accurate and complete.



## ENTRY CORRECTIONS

Occasionally it may be necessary to correct an entry. Careful and proper correction of an entry will help to avoid accusations of tampering, changing the entry for self-serving reasons or intent, or capricious alteration of the medical record, especially if litigation is involved or being considered. Standard procedures should be followed when correcting a note:

1. Draw a single line through the inaccurate information, but be certain the material remains legible.
2. Date and initial the correction, and add a note in the margin stating why the correction was necessary.
3. Enter the corrected statement in the chronologic sequence of the record, and be certain it is clear which entry the correction replaces.

In some situations it may be beneficial to have the corrected statement witnessed by a colleague. Avoid alterations that create the appearance of tampering (e.g., erasing or writing over a word or phrase to improve legibility). Never attempt to obliterate material in the record by using a felt marker, correction fluid, a typewriter overstrike, or an eraser. Improper alteration of an entry can create many problems for the practitioner if the entry is questioned or used as evidence during litigation. The practitioner's credibility, honesty, and intent will be challenged, which may lead to charges of incompetence, negligent behavior, or poor judgment. Many errors of judgment are not negligent acts, but any attempt to hide them can create serious problems for the practitioner. Never enter a note or sign an entry for someone else, and do not ask someone else to perform such acts for you. During litigation or when questions arise about the patient's care, the medical record is the primary source of information about the care a patient received and his/her response to treatment; therefore, accurate, timely, and proper documentation is important. Failure to maintain proper documentation and records can delay or cause denial of reimbursement, lead to dismissal or disciplinary action against the practitioner, affect the accreditation status of the facility, weaken the defense of the defendant during litigation, or cause improper or poor quality treatment to be delivered. A basic principle to follow is this: maintain the record so if all the persons who were originally treating a patient were to disappear suddenly, the next group of practitioners could immediately continue to provide the best quality treatment by using only the information from the record.

Documentation is becoming more and more important as a means to assess or measure the quality of care received by the patient so the caregiver or facility will be more likely to receive payment from a third-party payer (e.g., Medicare or an insurance company).

When a caregiver documents the treatment he/she has provided or supervised, it is necessary to indicate the functional outcome or outcomes attained by the patient. Through the use of objective and measurable terms, language, or data, the documentation must report the extent of change in the patient's condition that resulted from the treatment. The results of initial and repeated muscle strength tests, *goniometric* measurements, and vital signs data are examples of objective, measurable information. However, it is also necessary to provide objective information that indicates the patient's ability or capacity to perform functional activities that are related to his/her activities in the home, workplace, and community and during recreation. Strength and range-of-motion data could be linked to the person's functional ability to perform dressing, feeding, and personal hygiene tasks at home; reaching, lifting, and carrying objects or use of office equipment at work; transfer and mobility activities in the community; and various sport or recreational activities. The reader is encouraged to propose other examples that would associate treatment techniques with functional outcomes. The caregiver should be certain the functional outcomes relate directly to the pre-established treatment goals or outcome measures stated in the treatment plan.

Persons who review claims and make reimbursement- and treatment-related decisions have focused on indicators of functional outcomes of treatment contained in the caregiver's documentation. This process can be expected to continue; therefore, the caregiver must be aware of the need to provide accurate, current function-oriented documentation. In addition, the use of function-oriented, objective, and measurable data in the documentation process will result in the greatest likelihood of obtaining a favorable reimbursement response to submitted claims and gaining approval to continue treatment from the third party payer. Furthermore, it seems reasonable to anticipate that a patient will have more motivation to accomplish a functional goal or task that is meaningful to him/her than to strive to attain a given strength or range-of-motion value. In addition, well-organized, accurate, relevant, and prompt documentation improves communication among the persons providing care.

## PRINCIPLES OF TREATMENT PLANNING

Before the initial treatment of a patient, the caregiver must establish an organized, preplanned treatment approach and process. A four-step process can be used: (1) evaluate the patient, (2) develop a treatment program, (3) implement the program and

re-evaluate the program frequently, and (4) terminate the program.

Information about the evaluation phase is presented in the next section of this chapter; however, it is important to understand the evaluation establishes a baseline of data and information to measure the patient's progress and response to treatment. The evaluation assists in establishing a functional diagnosis for the patient, setting outcome goals, and developing the treatment plan and program. Goals of treatment should be established cooperatively by the patient and caregiver once the patient has been informed of the various approaches available or possible for his/her care. These goals are usually designated as interim, or short-term, and terminal, or long-term, goals. Short-term goals are usually a specific component or lead-in activity for a long-term goal. An example of a short-term goal is the patient will be able to perform a sitting push-up in a wheelchair 10 times in 1 minute within 2 weeks. This would be a lead-in goal for the long-term goal of the patient being able to perform an independent sitting transfer from his/her bed to a wheelchair within 2 minutes and then return to the bed in 2 minutes within 4 weeks. These goals must be stated in objective, measurable terms and should indicate who will perform the activity, by what means the goal will be accomplished, the need for equipment or assistance, the time frame in which to accomplish the goal, and the functional outcome expected. Goals can and should be revised or modified depending on the patient's performance and progress. Finally, goals should be realistic and attainable for each patient.

The treatment plan and program developed by the caregiver should contain treatment procedures, techniques, and activities that will have the greatest effectiveness to fulfill the previously established goals and outcome measures. The sequence and frequency of the program must be determined, as well as the need for equipment and level of assistance required by the patient. Consideration should be given at this time to planning for the termination of treatment. Due to the cost-containment requirements of most third party payers, many patients will receive only a few treatment sessions from a qualified caregiver; therefore, the caregiver must begin planning a program for extended treatment activities after the patient's formal treatment program is terminated. Equipment needs, financial assistance, family education and training, referral procedures, and follow-up or extended care may need to be considered as alternate treatment plans are developed.

Implementation of the procedures, techniques, and activities selected by the caregiver should be performed using the sequence and frequency determined previously. The caregiver must frequently and consistently re-evaluate and measure the patient's progress and response to treatment. The extent to

which the patient fulfills the short- and long-term goals and accomplishes the functional outcomes must be measured and documented. It is not sufficient, for example, to document a patient's active range of motion of shoulder flexion has increased from 90 to 120 degrees. Reporting a functional outcome, such as the independent application and removal of clothing over the head, should be a component of the documentation. The caregiver must be prepared to continue, revise, or modify the treatment plan or the individual components of the treatment program based on the patient's progress and response to the treatment. During this phase, greater attention will need to be given to the plan and program for extended treatment if it is determined extended treatment will be necessary. Education and training of the patient and a family member should be provided, as well as the opportunity to practice activities to be performed at home.

When the treatment program is to be terminated, the caregiver should evaluate and measure the patient's functional outcomes and compare them with the expected outcomes, and the extended treatment program should be reviewed and finalized. The written or printed program should be given to the patient or family member, and a copy should be placed in the medical record or maintained in a separate file.

A summary of the patient's condition and the functional outcomes and goals he/she has accomplished, future treatment plans, and any re-evaluation or follow-up care appointments should be documented in the medical record.

Additional information about the treatment planning process (Procedure 1-2) can be found in several of the resources listed in the Bibliography.

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## PRINCIPLES OF PATIENT EVALUATION

Patient evaluation guidelines are given in Box 1-3. In addition to these, the evaluation should consider the patient's emotional response to his/her condition, family unit interactions and the support system available to the patient, potential for improvement or regression of the patient's condition, and goals or expectations the patient has for the treatment program. The patient should be informed of the findings or results of the evaluation, and he/she should be consulted about and assist with the development of the goals for treatment.

The material in Box 1-3 is intended as a guide to the general areas that should be considered for an evaluation before initiation of treatment. Not all of the activities will be necessary or appropriate for every pa-



## **PROCEDURE 1 – 2**

### **Treatment Planning Process**

1. Patient evaluation
  - a. Determine his/her present condition, including functional abilities and limitations
  - b. Establish a functional diagnosis and outcome goals
  - c. Gather data and information to use to develop a treatment plan and program
  - d. Gather data and information for documentation
2. Develop treatment program
  - a. Based on outcome goals related to function
  - b. Determine and select appropriate treatment activities, techniques, procedures, and equipment
  - c. Determine the sequence and frequency of the treatment methods
  - d. Initiate planning for extended treatment, after formal treatment is terminated, as necessary
  - e. Prepare and document the treatment plan and program
3. Implement treatment program
  - a. Techniques, activities, and procedures performed or applied according to the predetermined sequence and frequency and the equipment used
  - b. Patient's response to treatment is evaluated frequently and consistently; progress toward accomplishment of functional outcomes is determined
  - c. The program is revised or modified depending on patient progress or response to treatment
  - d. Planning for termination of treatment is intensified; patient/family member receives instruction, if necessary, for extended treatment program
  - e. Patient's progress or performance is documented and linked to functional outcomes
4. Termination of treatment
  - a. Patient's condition and functional abilities are assessed; the need for extended treatment is determined
  - b. Patient/family member practices activities for additional treatment program as necessary
  - c. Written extended treatment program (home program) is prepared and given to patient/family member
  - d. Patient's condition and functional outcome abilities are documented; the date for re-evaluation or follow-up care is established and documented

tient, and selection of the most appropriate tests or procedures is the responsibility of the practitioner. In many instances a specific evaluation will be required to obtain the information or data necessary to develop the best treatment program for the patient. Remember that frequent re-evaluation of the patient is an important part of the evaluation and treatment process; without re-evaluation, the patient's response to treat-

ment or his/her change in function or achievement of the treatment goals or objectives cannot be identified. This information is necessary to maintain the most beneficial treatment plan and to enhance quality care.

The patient assessment or evaluation is used to identify the problems to be overcome, abilities of the patient, and patient's needs and goals. The development of a treatment program should include estab-

**BOX 1-3****Guidelines for Patient Evaluation****Subjective Information**

Subjective information can be obtained through interviews with the patient, family members, friends, or other practitioners and by reading the medical record. Effective listening skills and interview techniques by the evaluator are necessary to obtain the most beneficial information. The following information should be elicited:

1. Patient's concept of his/her primary complaint or problem.
2. Patient's description of the progression or regression of his/her condition (e.g., better, worse, or unchanged) over a period of time.
3. General health of the patient.
4. Any previous history of any similar condition, complaint, or problem.
5. Patient's description of the primary cause of his/her condition, complaint, or problem.
6. The patient's description of the results of any previous treatment for a similar condition, complaint, or problem.
7. The patient's occupation, lifestyle, recreational activities, social interactions, goals, needs, and values.

**Objective Information**

Objective information can be obtained with observation, palpation, and specific tests.

- I. Observe the patient's
  - A. General appearance, body build, or configuration and any deformities or absence of any body part.
  - B. Posture as he/she stands, sits, and walks.
  - C. Skin condition and its appearance (i.e., color, lesions, or scars).
  - D. Locomotion or mobility activities: these could include ambulation; use of a wheelchair; functional abilities, such as reaching, bending, or a change in position; and his/her level of performance (i.e., dependent, semidependent, or independent).
  - E. Use of assistive devices, ambulation aids, *orthoses*, *prostheses*, bandages, slings, or casts.
  - F. Balance and stability while he/she sits, stands, and ambulates.
  - G. Coordination and motor control in his/her extremities and total body.
- II. Palpate the patient's
  - A. Skin and subcutaneous tissue to determine its texture, temperature, flexibility, and pain response.
  - B. Muscles, tendons, and ligaments for their tone, pain response, bulk, composition, strength, and stability/laxity.
  - C. Joints to determine any swelling, change in shape, tenderness, amount of joint space, and pain response.
  - D. Skeletal components, such as bone surfaces, bone ends, and specific landmarks.
  - E. Arterial pulses to establish their rate, force, presence/absence, and rhythm.
- III. Assess the patient's
  - A. Muscle strength by performing a muscle test either manually or mechanically.
  - B. Joint motion, both active and passive, by performing goniometric measurements.