Frank M. Pierson

# Principles and Techniques of Patient Care

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# Preface

This text was developed and prepared to assist students and health care workers to gain or to improve their knowledge and skills to benefit both the caregiver and the patient during patient care activities. Students enrolled in educational programs related to physical therapy, occupational therapy, and nursing should benefit the most from the use of the text. Health care workers involved in those three and other professions may desire to use this text as a reference. In addition, family members and friends of patients can utilize this book as a guide to manage or to care for patients.

The word caregiver was selected as a generic term that could be applicable to a health professional, such as a physical therapist, occupational therapist, or nurse. It is believed the term can designate equally well a family member, an assistant, an aide, a technician, or other supportive persons.

The concepts, principles, and application techniques presented here were selected because of their broad use or general acceptance by practitioners and by many authors. There are adaptations, modifications, and alternative ways to perform the procedures or activities discussed in the text. The skilled, creative, or innovative practitioner will be able to modify the techniques or use alternative techniques to provide the safest and most efficient care.

Prior to the application of any of the procedures or techniques presented in the text with a patient, it is recommended that the activity be practiced with an able-bodied person. In some instances, several practice sessions may be necessary before you will be able to perform the activity safely and efficiently.

The topics selected for this text represent aspects of patient care or management that require basic knowledge and skill by a caregiver employed in a health care setting. The initial chapters provide principles related to documentation, general safety, patient evaluation, body mechanics, and patient positioning and draping. This preliminary information is necessary to promote safe, efficient, comprehensive, and quality patient care by the caregiver.

The next several chapters explain and illustrate exercise methods, transfer procedures, and mobility activities. The concepts and principles presented are designed to assist the reader to better understand when or why to select a particular transfer or mobility activity for a given patient. Examples of equipment that is most frequently employed for these activities is described, including the rationale for the selection of a particular item or technique.

It is important to be able to determine a patient's physiologic response to and recovery from physical activity. Therefore, methods to measure the patient's vital signs, particularly blood pressure, heart rate, and respiration rate, are explained and demonstrated. Possible abnormal results or changes in the vital signs are outlined. The rationale for careful monitoring of a patient's vital signs is also provided.

Medical technology has made it possible to prolong the life of many seriously ill or traumatized individuals. In addition, cost containment measures have required that the seriously ill be treated sooner and for shorter periods of time. Thus, a chapter related to treating the patient who requires special equipment or who receives care in a special environment is included to acquaint the entry-level caregiver with these aspects of health care.

The threat of the spread of disease exists, and all health care providers must be able to protect

themselves and their patients from contamination and infection. The value and techniques of frequent handwashing and the proper use of protective clothing or garments are presented as primary methods to reduce contamination. Information related to Universal Precautions and ways to prevent the transmission of pathogens contained in or associated with body fluids, especially blood, are provided. Basic principles and techniques related to wound care—the application and removal of dressings and the application of basic bandages—are also presented.

The final chapter contains information about possible injury-causing incidents that might occur in a treatment setting. Basic emergency care actions or interventions are described so that the caregiver can act appropriately prior to the arrival of trained, qualified medical personnel.

Many of the terms in each chapter are defined to assist the reader to gain knowledge and to comprehend the text material better. A periodic review of the terms and use of a dictionary to learn the definitions of other unfamiliar terms will further increase knowledge and comprehension.

Throughout the text, there are opportunities for the reader to problem solve or to use judgment based on the concepts, principles, and rationales provided to determine an appropriate approach to patient care. The figures and supportive descriptive information are designed to assist the reader to develop skills to enable him/her to perform many patient care activities safely and efficiently.

You are encouraged to review the chapter objectives before you read the text and to refer to them frequently to assure yourself that you are gaining maximal benefit from the material. Furthermore, conscientious review of and response to the self-study and discussion items at the conclusion of each chapter should assist you in enhancing your problem-solving or decision-making skills. Comparing your responses to the items with the responses of classmates, clinicians, or instructors will assist you in determining how complete and accurate were your responses.

The bibliography contains additional references about the various topics presented in the text. The list is not exhaustive, but it presents some excellent resources for further study.

You are encouraged to use proper body mechanics as you work with each patient. Application of the basic techniques of body mechanics will enable you to protect yourself and the patient from undue stress or strain and to reduce the possibility of injury.

# Acknowledgments

This text would not have been completed without the suggestions, critical reviews, and support that was provided by many individuals, and I am sincerely grateful for their assistance. Everyone who participated in the development, preparation, and completion of this book was, in one way or another, a valuable contributor.

Margaret Biblis, Senior Acquisitions Editor, Health-Related Professions, W.B. Saunders Company, encouraged me to transform a collection of class notes into a manuscript, and I thank her for that initial encouragement.

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# Contents

# 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 of each patient prior to establishing a treatment 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 by 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.

**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 record produced on exposed or processed film by 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 applied to the skin simultaneously.

This book has been prepared to assist persons responsible for and involved with patient care in providing safe and effective care. The term *caregiver* will be used to designate the person who is treating or working with the patient, such as a therapist, therapist assistant, aide, or family member. 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 knowledgable and experienced practitioner will realize that 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 to 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 and comprehend 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 all 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.

## Orientation

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

## 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.*

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 an 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 that 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 *Writing S.O.A.P. Notes* by Kettenbach. This book uses a workbook approach to instruct the reader on how to develop SOAP notes. It is an excellent resource for the person who is unfamiliar with the POMR and SOAP notes format.

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

**BOX 1–1**

**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."
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 Medical Records 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 prior to 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.

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 about the patient's care arise, the medical record is the primary source of information about the care a patient received and his/her response to treatment. Therefore, accurate and timely 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 that if all the persons who were originally treating a patient were to disappear suddenly, the next group of practitioners could continue to provide the best quality treatment immediately, 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 practitioner or facility will be more likely to receive payment from a third-party payer (e.g., Medicare or an insurance company). In addition, well-organized, accurate, relevant, and prompt documentation improves communication among the persons providing care.

## Principles of Patient Evaluation

Patient evaluation guidelines are given in Box 1–2. In addition to these, the evaluation should consider the patient's emotional response to his/her condition, the family unit interactions and the support system available to the patient, the potential for improvement or regression of the patient's condition, and the goals or expectations the patient has for the treatment program. The patient should be informed

BOX 1–2

### 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. The patient's concept of his/her primary complaint or problem.
2. The patient's description of the progression or regression of his/her condition (e.g., better, worse, or unchanged) over a period of time.
3. The general health of the patient.
4. Any previous history of any similar condition, complaint, or problem.
5. The patient's description of the primary cause of his/her condition, complaint, or problem.

*Continued on following page*

BOX 1–2

## GUIDELINES FOR PATIENT EVALUATION *Continued*

### Subjective Information *Continued*

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 by 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, and composition.
   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.
   C. Sensory mechanisms, including
      1. Protective reactions to pain, temperature, touch.
      2. Discriminative reactions to pressure, *kinesthesia, proprioception,* response to textures, *stereognosis* and *two-point discrimination.*
      3. Reflexes, including those related to stretch, posture, and "righting," or equilibrium.
      4. Automatic reactions, such as synergies or other movement patterns.

IV. Assess functional activities and abilities, including
   A. Ambulation, by observing the patient's gait pattern and any gait deviations.
   B. The patient's ability to transfer and to change position.
   C. The patient's ability to perform personal care and hygiene.
   D. The patient's mental status and cognitive abilities.
   E. The patient's ability to apply, remove, and use assistive devices.
   F. The patient's communication abilities.
   G. The patient's mobility, other than ambulation.

V. Evaluate cardiopulmonary function by
   A. Measuring the patient's vital signs, including the heart rate, respiration rate, blood pressure at rest and during and following activity.
   B. Reviewing the results of exertion tests.

VI. Consider special tests, such as
   A. *Radiography.*
   B. Laboratory tests.
   C. *Electrodiagnosis.*
   D. Biopsy.
   E. Tests performed by other practitioners, such as speech, hearing, sensory integration, and psychological tests.

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 1–2 is intended as a guide to the general areas that should be considered for an evaluation prior to initiating treatment. Not all of the activities will be necessary or appropriate for every patient, 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 treatment 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, the abilities of the patient, and the patient's needs and goals. The development of a treatment program should include establishing objective and measurable goals, which are usually related to functional tasks or abilities. Implementation of the treatment program requires the application of specific techniques, procedures, or activities that have been selected to accomplish the pre-established objectives and goals. Finally, re-evaluation of the patient is necessary to determine his/her response to treatment; to identify the need to modify, alter, or revise the treatment program; and to measure the extent to which treatment objectives and goals have been accomplished.

The caregiver must be vigilant and must consciously re-evaluate the patient frequently to provide quality care. Failure to adjust or revise the treatment program, based on the patient's response to the current program, will delay the patient's recovery of or limit the extent of his/her recovery of functional independence.

To summarize the evaluation process, remember that it is necessary to include evaluation as a primary component of the treatment planning and implementation process, to provide a solid base for all patient care.

## Patient/Family Education

Currently the public is exhibiting a greater interest in and desire to become better informed about medical/health care in general and also about the specific medical/health care that individuals receive. Patients and family members expect to be consulted and informed about the care they receive. Questions related to the need for, the efficacy of, and the expected results or outcome of treatment are routinely asked by patients and family members. The practitioner must be prepared to provide appropriate and accurate responses without expressing or implying a guarantee or promise that a specific outcome or result will be achieved. The patient must be informed about the treatment he/she is to receive so he/she can make an informed decision about its value and safety.

The caregiver has the responsibility to educate the patient and family about the treatment program and activities, but he/she must respect patient confidentiality and have the patient's permission before sharing information with the family. Goals of treatment should be established cooperatively by the patient and caregiver once the patient has been informed of the various possibilities for his/her care. These goals should be stated in objective, measurable terms, which should include a time frame, how or by what means the goals will be accomplished, the need for equipment or assistive aids, and an indication of the expected functional outcome.

Interim, or short-term, goals and terminal, or long-term, goals must be developed and agreed on. Short-term goals are usually a specific component or lead-in activity for a long-term goal. For example, a short-term (3-week) goal may be to have the patient able to use his/her upper extremities to perform a sitting push-up in a wheelchair 10 times in 1 minute. This goal would become a lead-in for the long-term (6-week) goal of having the patient able to perform an independent sitting transfer from his/her bed to a wheelchair in 2 minutes and then return to the bed. After the goals have been established, the therapist can provide an overview or explanation of the types of techniques or procedures that will be used to accomplish the goals. The effectiveness of the treatment program is measured by the accomplishment of the goals by the patient. Goals can be revised when it is apparent the goal was an under- or overestimate of the patient's ability or progress.

Another component of patient and family education is instruction for a home program. Many patients will require assistance from others to perform exercises and other activities in the environment of a home, health club, school, or other nonmedical facility. The home program should be performed by the patient prior to the termination of his/her treatment, with a family member present and under the direction of the caregiver. The family member must be instructed about his/her responsibilities and level

of assistance he/she is required to provide. The patient and family member should practice the specific activities included in the home program while the caregiver observes and corrects improper performance. The home program should be printed or written and given to the patient for future reference. A copy is maintained with the patient's medical record or documentation materials at the treatment facility.

Instructions should include an outline of the exercises or activities to be performed, the frequency of performance of the program, the number of repetitions for each exercise, precautions or contraindications for each exercise, the required equipment or supplies, specific instructions and diagrams to guide and direct the patient, the therapist's name and telephone number so he/she can be contacted, and information regarding any scheduled re-evaluation or reappointment sessions.

Frequently, the caregiver is the primary liaison between the patient and his/her family and other practitioners. Therefore, the caregiver has the responsibility to educate all persons involved about the treatment program and its anticipated or projected outcomes. Information about the health care delivery system may need to be provided to assist the patient or family member to contact a particular agency or to obtain available benefits.

Education can be performed through direct contact between the patient and family members and the caregiver, through printed materials, through slides or videotapes, and through demonstrations by other patients. The specific instructional methods selected should coincide with the social, economic, mental, and physical factors manifested or available to the patient and his/her family members.

## Communication

*Communication* between and among persons is a primary function of life. For a therapist or other caregiver, communication with patients, family members, other practitioners, and coworkers is a necessity. The caregiver should recognize that different forms of communication, such as verbal, nonverbal, and listening, may be required depending on the purpose or situation related to the communication. Various barriers to communication should be recognized and avoided whenever possible. Patient–caregiver rapport can be established quickly through the use of effective communication or delayed by the lack of it. The information presented in this chapter is designed to provide guidelines or reminders for the caregiver and should not be considered all-encompassing or complete.

Instructions and information can be presented to the patient verbally, nonverbally and with various audiovisual methods. Verbal communication (VC) is the most prevalent style used. When you communicate verbally, terms and concepts should be presented in language the listener understands. Lay language is the most satisfactory for most patients and family members. For example, use "bend" rather than "flex"; "turn" or "twist" rather than "rotate"; and "straighten" rather than "extend" when instructing the patient or family. Directions should guide the patient to perform or act and should be brief and concise. Functional terms or phrases such as "push," "stand," "sit," "turn toward me," and "reach to the left" are more effective than nonfunctional terms such as "Now, the first thing I want you to do is . . ." or "The next thing I want you to do is. . . ." However, it is necessary to provide some transitional terms and phrases such as, "Push with your hands on the armrests," "Straighten your hips and knees," or "Move your right crutch and left leg forward." The patient should be given time to process the message he/she receives, and this time will vary from person to person.

The tone, volume, and inflection of your voice can detract from or add to your message. You can either stimulate or calm a patient merely with your voice and behavior. For example, consider the mixed message you may give to a patient if you scowl or grimace while telling the patient that he/she performed well. When you desire to encourage or stimulate a patient to act quickly, use a louder than normal volume and a sharper tone to your voice as you say, "Stand up, now!" and simultaneously clap your hands. For the nervous or apprehensive patient you can use a lower than normal volume and a softer tone as you talk with him/her. It may also help assure the patient if you sit next to him/her or rest a hand on his/her shoulder while you talk with him/her. Think of other examples of how the volume, tone, and inflection of your voice, along with your nonverbal cues, can add to or detract from your message.

Observation of the patient's reaction to the message will help you to determine whether he/she understands it, has questions, or is puzzled by it. Maintaining eye contact between yourself and the patient allows both persons to relate to nonverbal cues and maintain better interaction. For example, when you are working with a patient's foot and ankle and he/she is supine or sitting, be certain to look at the patient's face, rather than at the patient's foot, as you give your instructions.

It will be helpful to provide an overview or a

description of the total activity and its components prior to giving specific instructions or directions. The specific responsibilities or activities expected of the patient can be presented and emphasized later. Many caregivers find it helpful to have the patient repeat the instructions to determine his/her ability to comprehend and retain the information and to estimate his/her preparedness to perform. It is not sufficient to ask, "Do you understand what you are to do?" or "Do you understand the instructions?" because most patients will respond affirmatively even when they do not understand. Listen for the appropriate sequence and completeness of the repeated instructions. You may request the patient to demonstrate certain activities, such as pre-positioning an extremity or his/her body or performing wheelchair tasks such as locking or unlocking the wheels, swinging away the front rigging, or positioning other equipment. These activities, when performed properly, will assist the caregiver to assess the patient's level of comprehension and readiness to function.

Nonverbal communication (NVC) makes up the majority of human communication and may be even more effective than verbal communication. Nonverbal communication is done through facial expressions, posture, gestures, body movements, or changes in body responses. Some forms of NVC are planned, whereas other forms are spontaneous, uncontrollable, or involuntary (Table 1–1). Most of us have been in embarrassing or stressful situations and have sensed a change in the color of our skin or noticed an increase in perspiration. These are examples of spontaneous, uncontrolled, or involuntary NVC. Facial expressions tend to be spontaneous, but at times they are planned for a specific effect. A frown or smile will indicate a negative or positive response to a patient's performance. When we use specific hand gestures or pantomime or demonstrate activities, we are using planned NVC. The skilled caregiver will know when and how to best use these various forms of NVC.

TABLE 1–1
**Forms of Nonverbal Communication**

| Form | Examples |
|---|---|
| Appearance | Dress, grooming, cleanliness |
| Body movements | Abrupt, slow, threatening, caring |
| Body positions | Sitting, standing, walking |
| Facial expressions | Smiling, frowning, grimacing |
| Gestures | Using hands and arms to guide or direct |
| Pantomime | Demonstrating the activity |
| Posture | Erect, slouched |
| Touch | Therapeutic, caring, directive, guiding |
| Spontaneous response to stress | Blushing, perspiring, trembling |

The caregiver should also observe the patient to identify his/her NVC. Often, more information and a more accurate estimation of the patient's response or reaction to instructions can be obtained through his/her NVC.

The use of touch by the therapist is another form of NVC that can add to the communication process. A brief hug, a hand squeeze, or a pat on the back can convey a message to a patient, and to other persons as well, that cannot be sent as effectively verbally. However, touch must be used in a therapeutic, caring way, and the therapist must avoid any suggestion of sexual implications. Examples of improper and unacceptable forms of touch include patting, slapping, or stroking a patient's buttocks; squeezing the thigh; or stroking various body parts, except during a therapeutic massage or exercise activity. You must demonstrate care when you grasp, handle, or touch the patient, especially during massage and exercise when sensitive body areas are touched. The perineum and buttocks of all patients and the breasts of women and sometimes men should be draped as described in Chapter 3. When it is therapeutically necessary to massage, grasp, hold, or touch a potentially sensitive area, it may be prudent to state the reason the area is being touched or handled. In some situations, it may be wise to have another person observe or assist as you perform a particular treatment to protect yourself and to demonstrate your concern for the patient. Because touch may be construed to have a sexual implication by any patient, regardless of how careful the therapist has been, any indication of impropriety must be avoided.

Written communication should follow guidelines similar to those listed for verbal communication. It should be brief, concise, and specific and should use language the reader will be most likely to understand. The guidelines previously given for the development of home programs are applicable here. Typed or printed instructions are more easily read than handwritten ones. Diagrams, drawings, or photographs are extremely useful to show specific positions or the sequence of movements. Films, videotapes, and slides are other forms of communication that can be useful to educate or instruct a patient or his/her family.

The use of consistent language and the manner in which verbal or written instructions or directions are given to a patient by the various persons involved with the patient's care should enhance the patient's level of understanding and capacity to learn. This concept is particularly important when complex activities are being taught and when a patient's mental capacities have been altered. Repetition and practice of activities that require motor con-