Review for Patient Care Skills – Test I

* “Take home message” = 5 Cardinal Rules - Keep the load close, Create an appropriate base of support, Use isometric contractions of trunk, Lift with the Legs, Do Not Twist.
* Most common contracture is ankle plantar flexion – use night splints
* Venus pulling
* Bony end-field - elbow extension
* Soft end-field – elbow flexion
* Adhesive capsulitis – frozen shoulder
* The axis is perpendicular to the plane
* Sagittal plane motion occurs around a coronal (frontal) axis (elbow flexion, hip flexion)
* Coronal plane motion occurs around a sagittal axis (abduction of shoulder ) adduction
* Transverse plane motion occurs around a longitudinal axis (int. and ext rotation or trunk or head) True rotation only occurs and neck and trunk.
* Pressure relieving (fluid beds and kinetic beds, expansive stuff) and pressure reducing (egg crates, gel overlase, air bubbles)
* Hi!!!!
* Static supports surface - pt’s with some movement
* Dynamic support surface - for pt’s with no movement
* 3 risks of pressure ulcers – poor nutritional status, de-sensation of area, and no movement
* Anterior tilt -increased lordosis
* Posterior tilt flattens lower spine
* Lateral tilt – hip hike – the hooker….
* Decubitus stages –
  + 1 – redness
  + 2- partial thickness – blister
  + 3 – full thickness – subcutaneous= necrosis
  + 4 – full thickness – to the bone

1 and 2 are reversible, 3 & 4 nopeee.

* Supine pressure points – sacrum, calcaneous, and scapula
* Side lying pressure points – great trochanter and medial and lateral maleollus
* Sitting pressure points – coccyx, scapula, and ischial tubes
* Input – lines (antibiotics, oxygen)
* Output – tubes (draines) (monitoring devices)
* Folding chairs – pros (transportation, storage), cons ( more parts- more likely break, higher weight)
* Fixed frame WC – pros(lighter weight, less maintenance, stable sitting) cons (difficult transport, $$$)
* Trapeze – triangular structure on top, used for moving, NOT for transferring.
* Verbal and non-verbal communication. (what you say---body movement or facial expressions)
* If pt is on a wheel chair, try not to talk over him- sit down in front of him. (Same level)
* Paraverbal communication – How you say what you say (tone, volume, cadence)
* A common barrier of effective communication is lack of empathy by PT. also (visual, auditory, language, vocabulary, etc.)
* Empathic (Active) listening is a powerful tool to develop good relationships.
* If pt has anxiety – be empathetic
* If pt is defensive – take control by setting limits
* Avoid individual intervention if pt is trying to intimidate you.
* Cushions are good because they provide comfort, skin protecting, and positioning, but may need maintence and cushion cover washing.
* Independent WC propulsion is important and a treatment itself.
* An individualized wheelchair assessment and proper seating can prevent nursing home residents from sliding out of their chairs, increase their comfort level and eliminate restraint use.
* 11 point checklist
* Light weight WC (allow pt to propel faster) are as good as heavy weight WC.
* Rigid (easier to propel) v. folding (easier to transport,
* The CSHCN measurement is a great tool for evaluation for WC.
* Hybrid Cushions The hybrid cushion typically has a dense foam base to stabilize and support the pelvis, and additional layers of either a gel, a silicone-like fluid or air closest to the user’s body to conform to his or her natural shape.
* Flotation Cushions - Air cushions can be customized by adding or removing air.

- Gel cushions are easier to clean, but more expensive than foam cushions.

-Foam Cushions - Made of latex or polyurethane and covered with fabric or vinyl, foam cushions - are either high-density or low-density (how closely the foam cells are spaced), and closed cell or open cell.

* Proper sitting can prevent pressure ulcers. Ischemia due to pressure - ~35 mm Hg for arterial flow, and ~12 mm Hg for venous flow. Pressure ulcer severity, depends on amount and direction of force, and amount of time.
* Protect bony areas and joint. (e.g. heel protector)
* Align joints and extremities – splints
* Egg crate, static air, and gel overlay cushion are static mattresses.
* Alternating air is an example of a dynamic mattress.
* Splints, wedges (abduction wedge, side positing), and pillows are all examples of positioning aids.
* If pt can’t avoid existing ulcer then a dynamic bed would be beter.
* Increased tone and shortened position is a contracture.
* Compressive force is pressure, shearing force is friction.
* Decubitus stages-
  + Redness
  + Partial thickness
  + Full-thickness/subcutaneous = necrosis
  + Full-thickness/fascia bond = undermining
* Pressure ulcers have the highest incidence at nursing homes (1 in 4), then home (1 in 8), then hospitals (1 in 10).
* Complications associated with pressure ulcers are pain, disfigurement, and infection.
* 100,000 cost for pressure ulcer, 3 billion/yr.
* Lateral and medial malleolus and great trochanter for side lying.
* Sitting pressure points – ischial tuberosity, coccyx, and scapula
* Even with a 3 inch foam cushion, high pressure at coccyx
* The guide describes PT practice, who they are, test and measures and our preferred practice patterns.
* Writing in medical records is pt focused not PT. Use Ink.
* Examination (hs, systems review, test and measures), Evaluation (assessment, analysis), Diagnosis (PT dx, classification of problems), prognosis (expected level of outcome, timeframe, POC), Intervention (what you do, treatment.
* SOAP Notes – Subjective (relevant pt history, what pt tells you), Objective (Observation, tests and measures, tx, pt response the treatment) , Assessment ( what you think, progression or regression) , and Plan (Freq. and duration, POC, referrals)
* Look at Sample Subject Notes.
* Traditional definitions of culuture, there are non-physical traits and social traits.
* Primary characteristics - Nationality, Race, Color, gender, age, religious beliefs
* Secondary characteristics - Educational status, socioeconomic status, military beliefs, political beliefs, urban v. rural, marital status, parental status, physical characteristics, sexual orientation, occuptation.
* Healthcare subculture – student v. clinician
* Document, jargon, and patient management --- PT culture: habits
* Listen and elicit with patient. Recommend and negotiate
* Leave your stereotypes at home!
* ROM – normal extent of movement at a joint
* Mm ROM
* AROM – Active Range of Motion (Independent)
* AAROM – Active Assisted ROM – assisted motion w/ mm. contraction
* PROM – (passive ROM) - no active mm. contraction by the pt.
* End feel – resistance of the tissue at the end of the range.
  + Bony (hard) end feel – limited by bone on bone
  + Tissue end feel – soft tissue end feel
  + Firm (capsular) – taut capsule or ligament – (varius strain of the knee)
  + Empty – limited by pain, unable to determine an anatomical barrier for movement.
* Abnormal end feel – spasm, spasticity, fear of pain, pain
* Stretching can be either active or passive, push beyond available ROM, designed to increase ROM.
* PROM is performed slowly and carefully (assessing and feeling)
* Purpose for PROM – maintain ROM, some sensory stimulation, maintain circulation (minimal), maintain mm. elasiticty, prevent shortening, jt capsul, ligaments, or tendon adhesions. Enhance cartilage nutrients and synovial fluid mvmt. Within jt.
* PROM can NOT – reduce adipose(fat) tissue, increase strength or mm. endurance or increase ROM.
* Promote awareness of jt. Motion
  + Kinesthesia – (awareness of mvmt.), proprioception ( position in space, position sense), mental imaging
* Myalgia –mm. pain with mm. contraction
* arthralgia - jt. Pain with jt. Compression
* PROM – make sure you are engaged and can see pt’s face, establish a sequence so you won’t do double the work, can do multiple movement at once.
* PT body mechanics – level of bed, weight shifting, same side of side you are working on, you larger mm. group, aware of surroundings
* Be careful over bony prominences, drap, and stabilize to get desired movement.
* Brown shoe – old military
* “duck and cover” drills
* Traditionalist – stay in line/ adhere to rules. 10% divorce rate. Respect authority. Sacrifice.
* Boomers –(1946-64) – Me generation – Wanted to be “different”, Protestors. Wanted to have it all. Females in grad school. Promised the “American Dream”
* Generation X (1965-81) – “whatever”, Busters HS graduation rat >80%. Started to see internal enemies (guns, drugs, ). Get real – be individual. 33% affected by divorce. Latch key kids.
* Millenials (1983 – xx) – Generation Y – connected. Boomer are learning our ways. Lives were schedules. Be smart – you are special. Connected 24/7. Serve your community. 9-11 terrorist attacks.
* Workplace
  + Boomer – expect to lead. Chain of Command. “NFL”
  + Gen X – No need to lead. Individual 1st. “NBA”
  + Millenials – wants mentor, family time.
* Lifestyle
  + Boomer – “live to work”
  + Gen X –“work to live”
  + Millenials – “ work to live”, choose lifestyle
* Social Values
  + Boomer – Prestige 1st, equal rights, luxury traveler
  + Gen X – cheap in price, diversity, time is most important..(When employing a Gen X – offer time off)
  + Millenials – extreme fun, avoid consumer, global diversity
* Motivation
  + Boomer - $$$, public recognition (make a big deal about completion of program)
  + Gen X – Time off, be flexible with Gen X group,
  + Millenials – Time off, pay important and recognition. Want to do meaningful work.
* If a patient
  + Boomer – involve in POC, educate, they will question your youth( you will have to prove that you are qualified). Promised care (some angry because of broken promises).
  + Gen X – Fun, informal, independent, test authority
  + Millenials – extreme fun, competitive, prevention, seek guidance
* Prepare for a transfer – medical record, evaluate and examination, equipement, get help, use gait belt, explain procedure to patient, prepare area.
* Level of transfers
  + Independent – does not assist (either physically or verbally) in transfer.
  + Modified Independent - same as independent but requires assistive device.
  + Stand by Assist or Supervision – pt. requires verbal cueing for safety. PT does not physically touch the pt.
    - SBA – arm’s length
    - Supervision – across the room
  + Contact Guard Assist – PT has hand on pt, usually through a gait belt, but does NOT physically assist the pt in getting up or maintaining balance.
  + Min assist – pt perform 75% of physical activity
  + Mod assist – pt perform 50 -75%
  + Max assist – pt performs 25 – 50%
  + Dependent or total assist – pt performs less than 25% of physical activity.
  + DO NOT DO THIS!!! (Patient required max assist x 2 to complete transfer bed to WC) – instead clarify by stating that pt requires 2 pt conducting max assist each.
  + Segmental: turning – knee on bed and leg supported
  + 2 person lifts – Lift & carry,, Elevate surface, support under knees
    - Stronger therapist/person should be behind if lifting from the floor.
  + Mechanical lift – “Hoyer”
  + Quad lift – when pt need trunk support.
  + Trapeze – primary use is for pt comfort, NOT USED for transfers
  + Dependent sliding board
  + During pivot transferring – make sure you block knees (is only way to have lower body control over the transfer)
  + Assisted transfers can use cane, pivot, or sliding board.
  + Sliding board – block knees
  + Consider safety - Establish control of patient, Plan ahead, Make sure surfaces are even (if possible) and stable, Clear pathways, Communicate with patient, Use good patient positioning, Use momentum
  + Nearly all finding in a Eval can effect the pt ability to transfer.
  + FWB, WBAT (weight bearing as tolerated), PWB, TTWB (balance only, no weight bearing trough LE), NWB (may not touch the ground or bear any weight whatsoever.
  + Partial UE propulsion may need special push rims.
  + Hemi propulsion –
  + In a WC assessment find patients physical and functional needs for the WC, evaluate future needs.
  + Factors that can affect WC fit – Motor function, neurological, postoral control, and cardio-respiratory status, perception/cognition, skin, deformities, and others.
  + Look at patients ability to transfer, living conditions, goals the pt has - prognosis. How will the chair be transported? Who will be paying for it?
  + In justification (documentation) explain why pt needs the WC – OVERLOAD them with info…
  + Eleven point checklist when writing (LMN)
    - Make sure insurance cover equipment
    - Understand insurer’s definition of medical neccisity
    - Gear letter toward audience – sound professional and autorative, don’t use acronyms, EXPLAIN..
    - State who you are –expertise, experience, education
    - Explain pt condition
    - Detailed and specific descriptions of equipment
    - Explain cost-effectiveness – ex. 10,000 compared to a pressure ulcer which could cost 100,000
    - Describe medical necessity of each part
    - Make the situation real – explain how pt life will be improved….add guilt
    - Enclose prescription
    - Including pictures of equipment helps
    - Don’t go over a page..
  + Manual Wheelchairs – Folding v. Fixed
    - Folding – easier to transport, easier to store, increased weight,
    - Fixed – decreased weight, less moving parts, more stable sitting, may be hard to transfer or store.
  + Companion (travel chair) – made to push by caregiver, small back wheels, convenience and economy.
  + Standard weight – institutional, fixed armrest and footrests, heavy (35-50 lbs.),
  + Light weight – under 35 lbs, can be manuvured by either caregiver or patient. Adujustable arm rest and leg rest.
  + Ultra light weight – for ultra performance.
  + Hemi height – adjustable axial height
  + Amputee – axle adjusts back to balance body weight over frame, often has anti-tippers
  + Reclining – Full back reclines, for pt’s to weak to tolerate standard back height
  + Tilt –in – space – seat and back tilt together, great for pressure relief
  + Wheel chair breaks/locks
    - Anterior locking, posterior locking, Scissor mount (push underneath chair for transfer protection), Brake extensions (opposite hand and increases leverage)
  + Pelvic positioned (seat belts)
  + Front casters
    - Solid casters – no maintenance, firmer ride, Pneumatic casters – smoother ride, but increased maintenance
  + Mag Wheels – rear drive wheels
  + Push rims – coating to help with grip
  + Armrests – attached, removable, height adjustable
    - Removable or swing-way will be better for transfers
  + Foot rest and Leg Rest
  + Lateral supports
* Front wheel chair
* Mid wheel chair
* Rear wheel chair
* Controls – joystick, foot control, chin control, sip and puff, head array
* Scotter – BAD, BAD, BAD,,,company must die – “ I kill u”
* All-terain, standing WC, iBOT, power assist
* Cushions – decrase pressure, increase sitting time, increase height, maintain posture
  + Foam – different layers of thickness, usually less expensive
  + Gel – heavier than foam, can move with pt when transferring
  + Air – good at relieving pressure, but high maintenance, difficult w/ sliding transfers
  + Honeycomb – breathable, washable, comfortable but not as good for pressure relief.