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POD2PAS Podiatric Assessment

Lecture one.

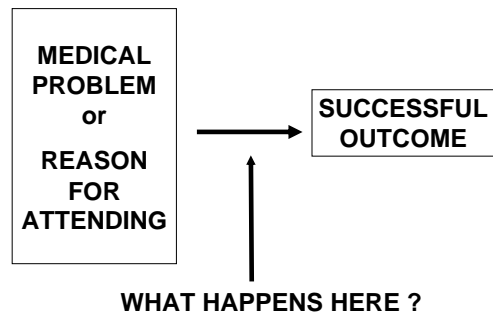
Lecture one - overview

- Introduction to unit
- Assessment protocol
- Use of the – PQRST mnemonic
- Review of:
 - Communication issues
 - Documentation of medical records
 - SOAPE format for progress notes

Aims

- At the end of this lecture you should:
 - Be able to identify the main aims of this unit
 - Be familiar with the PQRST mnemonic as an aid to exploring the primary complaint in pt. assessment
 - Be able to identify good and bad communication strategies
 - Be able to accurately document patient notes using SOAPE format
 - Be able to give examples of leading/closed/open/direct questions

Key concepts.....



What is a successful outcome?

- May not always be 'cure' as such
- Medical model often based on 'disease and cure'
- Allied health may be more focused on 'care' but may also include 'cure' when possible and necessary
- Challenge is to clearly identify problems and determine what is the 'podiatric diagnosis'

Concept of podiatric diagnosis

- Term 'diagnosis' generally used in medical context
- Identification of particular disease, illness condition or syndrome
- This does not always reflect the specific nature of the podiatric approach
- The podiatric diagnosis **the identification of problems which are of significance in the overall health of the patient and their feet**

Examples:

- Elderly patient with multiple medical problems
 - Osteoarthritis, heart disease, hypercholesteroleamia, obesity
 - Whilst it is necessary to identify and document these medical conditions, what is the podiatric diagnosis?
 - Further questioning and patient examination reveals the following:

Example:

- Patient complains of pain due to involuted nails and her inability to cut them due to OA
- Vascular assessment reveals poor blood flow to both lower limbs and feet

Example:

- So.....the podiatric diagnosis in this case could be:
 - Pt unable to self care due to OA
 - Pt at risk of tissue loss (ulceration) due to poor blood flow
- These two identified problems are the podiatric problems that we need to be addressing
- We cannot 'fix' the OA or poor blood supply, but we can address the outcomes of these pathologies

Examples:

- Teenager with acute onychocryptosis,
 - Pain, purulent exudate, minimal swelling
- Attends for assessment, diagnosis and management of this specific problem
- What are you providing as a podiatrist?
- What is the podiatric diagnosis?
- What is the 'successful outcome'?

Example:

- The podiatric diagnosis in this case is far more clear:
 - Patient suffering with onychocryptosis
- Treatment will be tailored specifically to:
- Accurate assessment, provision of local anesthesia and removal of cryptosis
- In this instance it can be considered more of a 'cure' for this problem whilst you are also providing medical care

Scenario 1:

- Pt X:
 - 54 yo female
 - Med Hx hypertension, sciatica,
 - Pt c/o discolouration of hallux nail, breaking away and difficulty walking due to pain in left leg
- WHAT ARE THE PODIATRIC PROBLEMS?
- WHAT COULD BE THE POTENTIAL PLANS?

Scenario 2:

- Pt Z:
 - 23 yo male
 - Med Hx: diabetes melitis
 - Meds: insulin twice daily
 - Pt c/o pain in lateral ankle following 'turning in on my ankle playing sport'
- WHAT IS THE PODIATRIC DIAGNOSIS?
- WHAT COULD BE THE POTENTIAL PLAN?

So keep in mind:

- Pts may attend for multitude of reasons
- Objective is to provide 'successful outcome'
- This may vary depending on specific case
- Consider what is the 'podiatric diagnosis'
- Consider what you are providing in terms of care
 - Palliative, curative, correctional etc....
- Every consultation requires assessment of some sort to determine history, diagnosis and treatment
- This subject will deal with general and specific assessment strategies

Assessment protocol

- Basic Preparation
 - Clinical area
 - Relevant documentation/forms
 - Referrals
 - Previous patient history if available
 - Instrumentation
 - Choice of space/physical environment

Assessment starts with history:

- Thorough assessment of a patient starts with good history taking:
 - Demographic information
 - Past and current medical/surgical problems and medications
 - Details of the presenting problem
 - Any previous treatment, diagnoses, tests, other health care providers involved etc
 - Also important to understand your patients expectations – what do they want you to do or what do they think you can do.....

After the history....physical examination

- Physical examination should only proceed after the history has been taken
- This will provide info to determine necessary assessments and investigations for diagnosis or treatment planning
- Things to consider:
 - Position and exposure of the patient
 - Expose lower limb from knee down if possible
 - Do not hyperextend leg at the knee whilst patient in the chair

Types of assessment

- Local or specific
 - May be related to specific problem eg sprained ankle
 - Pain, swelling, deformity,
 - Assessment is focused on the specific tissues or structures that are presenting with the complaint or are thought to be related to the symptoms
- General or systems
 - More related to assessment of general structures or processes
 - Dermatological
 - Neurological
 - Vascular
 - Biomechanical
- Will give you an overall perspective of that system

When to use them?

- Listen to your patient
- Take a good thorough history
- Consider what information you need to gather
- This will determine what assessments you use
- Eg – pt c/o pain in calf muscle when walking
 - Is it a muscle problem?
 - Thorough history should reveal enough info to suggest 'intermittent claudication'
 - Assessment necessary - vascular

Need more information?

- Information gathered from history
- Information gathered from physical assessment
- Can also use various tests to isolate more specific information
 - X-rays
 - Bone scans
 - MRI's
 - Laboratory tests etc

How to question your patient

- Use a variety of open and closed ended questions
- Take control of the consultation to guide the amount of information your patient gives
- Jot down notes to jog your memory
- Keep in mind good communication skills and body language
- Listen well to your patient – give them your focused concentration

Communication

- Supports pt. autonomy
 - Enhances understanding
 - Essential for good practice
- Forms basis of history taking, obtaining consent, diagnosis and treatment explanations
- Helps establish trust, rapport and confidence in the care giver
- Most complaints relate to communication breakdown

Barriers to communication:

- Sender does not convey clearly
 - may be competing or conflicting messages
- Unintended messages
 - e.g. nonverbal body language
- Distortion through chain
 - compare "take only if necessary" to "take it whenever you need it"
- Receivers behaviour -
 - Pre-judgemental, not interested, thinking of response rather than listening

Patient – Care giver

- Establish a rapport with patient
 - project warmth, empathy, avoid patronising behaviour, avoid making judgements
- Avoid using technical terminology
- Watch patient body language and your own
- Give the patient time and keep good eye contact

Patient - care giver cont...

- Use variety of questions:
 - Direct questions
 - 'do you experience pain at night'
 - Indirect questions
 - 'I imagine the pain makes walking difficult'
 - Open ended questions
 - 'what can I do for you'
 - Closed ended questions
 - 'what type of pain is it'
 - Leading questions - may be biased - should be avoided

Cont....

- Examples of leading questions:
 - Would you say your foot hurts more in the morning and eases as you walk more
- Loaded questions - 'do you really want to make this wound worse' - can be very confrontational

Research results

- Stewart et al (1979)
 - 299 patients and 5 doctors.....questionnaire data revealed doctors failed to elicit 54% of patients reasons for consultation
- Starfield et al (1981)
 - Interviewed 135 patients and their care-givers - disagreed on reason for consultation 50% of the time

Research results:

- Beckman & Frankel (1984)
 - Studied opening segments of consultations - patients allowed to speak for avg. 18 secs before being interrupted
- Consistent findings suggest that certain ways of communicating with patients will improve health care and satisfaction

Categorise these questions:

- Where is the pain?
- Do you experience difficulty managing your foot care due to having OA?
- Tell me why you are here today?
- Do you think your nail has only been painful since you bought new shoes?
- Do you really want to live with this pain?
- Are you in pain now?

In summary:

- Good communication is essential for quality care
- Be aware of how you communicate with your patients and how they communicate with you:
 - Eye contact, body language, types of questions you use, types of answers you get etc
- Practice, practice, practice, - no one expects you to be an expert but we do expect you will try and improve your communication skills...

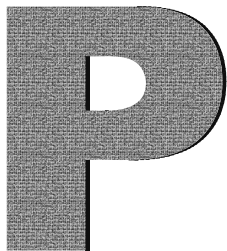
How much is enough?

- The foundation of quality assessment and diagnosis is HISTORY
- You must be prepared to gather information
- If your patient presents with a specific symptoms you can use the following guide for questioning
- Remember this is a memory trigger only

PQRST as a guide

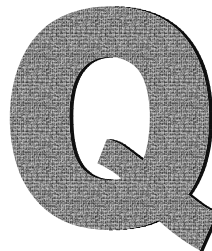
- This is a simple method to trigger your memory of what to ask to gather detailed information...

Assessment protocol



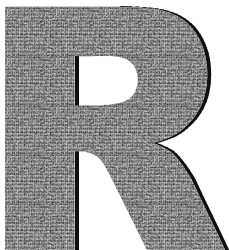
- Provocative or palliative
 - What provokes/relieves the symptoms
 - What triggers the symptoms
 - What makes the symptoms worsen or subside

Assessment protocol



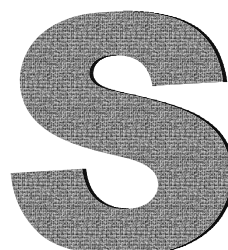
- Quality or quantity
 - What does the symptom feel like
 - Are you having the symptom right now?
 - To what degree does the symptom affect your normal activities

Assessment protocol



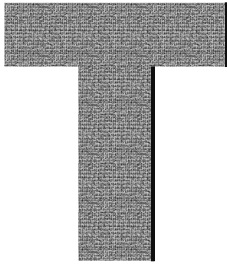
- Region or radiation
 - Where in the body does the symptom occur?
 - Does the symptom appear in other regions if so where?

Assessment protocol



- Severity
 - How severe is the symptom? How would you rate it from 1 - 10?
 - Does it get worse, better or stay the same?

Assessment protocol



- Timing
 - When did the symptoms begin?
 - Was the onset sudden or gradual?
 - How often does it occur?
 - How long does it last?

Video

Class exercise

- Work with a partner
- One be podiatrist one be patient
- Patient to 'make up' some complaint
- Practice interviewing each other without PQRST
- Then practice same interview with PQRST

PROBLEM ORIENTATED MEDICAL RECORDS

- This is a method of data gathering and documentation
- POMR developed in late 1960's
- Attempt to improve quality of medical records
- POMR in four main parts
 - 1. The problem list
 - 2. A defined data base
 - 3. Initial plans
 - 4. Progress notes

S.O.A.P.E.

- Form of documenting **patient progress notes**
- These serve to:
 - Document and evaluate condition
 - Form basis for planning of care
 - Provide means of communication
 - Provide basis for review of Quality Assurance
 - Meet legal requirements
 - Provide data base for research and education

S.O.A.P.E. Cont...

- Is way of formatting the progress notes
- Stands for:
 - Subjective data
 - Objective data
 - Assessment
 - Plan
 - Evaluation
- Is good systematic way of documentation

Examples

- Subjective:
 - What the patient tells you - can be paraphrased or quoted directly
 - Eg Patient complains of right heel pain during wt. Bearing or
 - "my heel hurts when I'm standing on it".
 - This section of notes may record responses to PQRST style of questioning

Examples

- Objective:
 - This is your measurable observation - relates to what is seen or observed through examination
 - Eg: pain elicited on palpation of the medial calcaneal tubercle right foot
 - Heel spur evident on X-ray
 - Lesion measures 0.4 cms in diameter
 - Nail appears dry, friable, with yellow streaks of discolouration

Examples

- Assessment
 - Opinions of the problems cause or status
 - Essentially the 'podiatric diagnosis'
 - Eg: provisional diagnosis (P/dx) - enthesopathy of the right foot due to heel spur syndrome
 - Suspected onychomycosis
 - Suspect pain due to involution of medial and lateral nail sulci - right hallux.

Examples

- Plan
 - Stated series of action based on information
 - Otherwise referred to as the 'care plan' 'treatment plan'
 - This should clearly note the relationship between the problems and the interventions
 - Education you provide to the patient can also be considered an intervention
 - Eg: Ultrasound 5mins 1Wcm² pulsed given to right plantar heel area. Low dye strapping applied. For biomechanical assessment on next visit.

Examples

- Evaluation:
 - A list of those outcomes or goals identified by the patient and the podiatrist to be worked towards
 - E.g. – Identified goals for next 6 treatments are to
 - Reduce pain in ankle
 - Improve range of motion and flexibility
 - Then re-evaluate state of ankle mobility

Categorise these.....

- Patient sent for x-ray of left foot
- Green pus was noted to be oozing from under the nail
- "I think I've got tinea"
- Crumbling, thickening and discolouration of left nail due to onychomycosis
- X-ray results reveal fracture of right 5th metatarsal

Don't forget

- Document everything you do and don't do....
 - Eg patient may refuse treatment - must be stated
 - Lesions must be measured so that size can be evaluated on return - ? Bigger ? Smaller etc.
 - Lesions should be described as best you can:

Continued

- Erythematous, irregular border, pinpoint haemorrhaging, scaly, smooth, etc
- Document expectations for next visit, e.g. pain levels to be reported, any improvement/deterioration in condition etc. - is what you are doing working?????

End of lecture

- Review the aims of this lecture
- Can you meet them?
- Think about the forms of examination for this subject
- How might you change your approach to study to ensure deeper learning?

THANK YOU