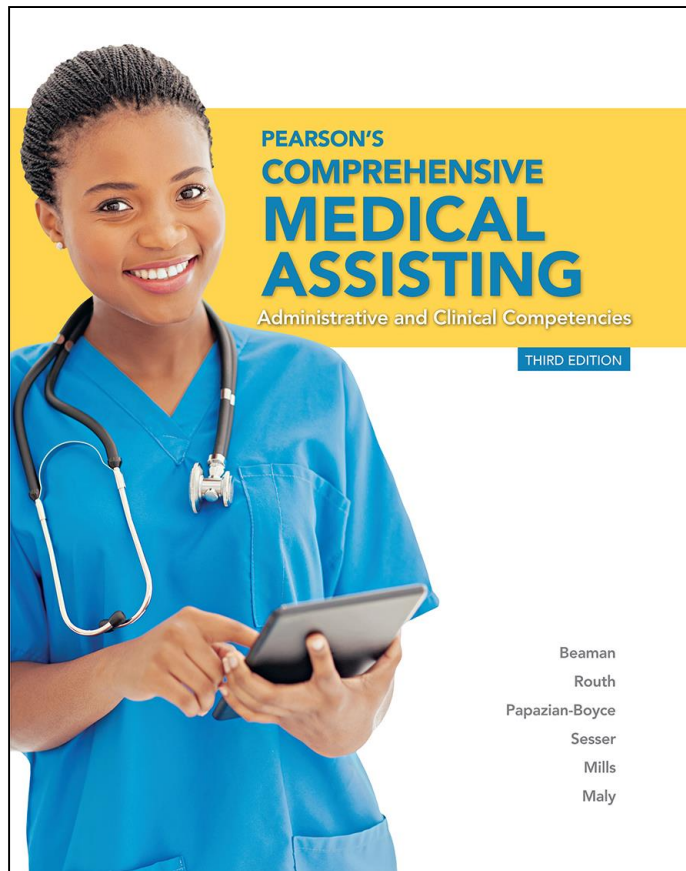


Pearson's Comprehensive Medical Assisting

Administrative and Clinical Competencies

THIRD EDITION



CHAPTER 36

Assisting with Physical Examinations

Lesson 1:

Preparing the Exam Room and Examination Methods

Lesson Objectives

Upon completion of this lesson, students should be able to:

1. Define and spell the terms to learn for this chapter.
2. Recognize six pieces of equipment commonly used during a physical examination.

Lesson Objectives

Upon completion of this lesson, students should be able to:

3. Describe the six examination methods used by physicians.
4. Discuss the steps to take in preparing a patient for a physical examination.

The Medical Assistant's Role in the Patient Physical Exam

- Preparing the exam room prior to the patient's visit
- Interviewing the patient
- Documenting information in the patient record

The Medical Assistant's Role in the Patient Physical Exam

- Positioning and draping the patient
- Assisting the physician during the exam
- Cleaning the room after the visit
- Instrument care

Cleaning the Examination Room

- Clean the examination room at the beginning of each day and between patients.
- Disinfect surfaces.
- Dispose of any trash, including gowns, in appropriate receptacle
- Allow proper amount of time between cleaning with disinfectants and bringing patients into room

Cleaning the Examination Room

- Dispose of table paper and paper drape in appropriate receptacle
- Rolling disposable items prevents microorganisms from being spread.
- Clean examination table, let it dry, and cover it with clean, new paper
- If available, remove and change pillow covers after each use.

Cleaning the Examination Room

- Disinfect all surfaces with an appropriate cleaner.
- Close the lids on all biohazard containers.

Cleaning the Examination Room

- If biohazard bag is full, seal and remove from the room to the appropriate holding area per OSHA regulations
- No evidence of any other patient should remain when a new patient is taken into examination room

Examination Room Features

- Size and layout varies based on office or facility
- Other variables include number of examination rooms and types of equipment

Examination Room Features

- Standard examination room includes:
 - Examination table (with stirrups in practice where pelvic exams are performed)
 - Pillow

Examination Room Features

- Standard examination room, continued
 - Footstool
 - Supply cupboard
 - Trash can
 - Hazardous waste and sharps containers
 - Rolling stool
 - Chair
 - Writing surface
 - Sink

Examination Room Safety

- Rooms must conform to ADA standards.
 - Width of doorways and hallways
 - Placement of door handles
 - Grab bars
 - Handrails

Examination Room Safety

- Rooms must conform to ADA standards.
 - Spatial accommodations for patients in wheelchairs
 - Floor surfaces
 - For more information, visit www.ada.gov

Examination Room Safety

- Unsafe situations
 - Clutter in the hallway or examination room
 - Spill on the floor
 - Improperly stored equipment
 - Unsecured electrical cords or cables

Examination Room Safety

- Check furniture routinely for proper maintenance.
 - If repairs cannot be made immediately, document in the maintenance log book

Preparing the Examination Room

- Ready instruments and equipment for the physician
- Ensure equipment is not within reach of the patient
- Position exam light to provide correct illumination for the physician

Preparing the Examination Room

- Ensure exam light is positioned so it does not tip over
- Use proper body mechanics when assisting with patient care

Patient Comfort

- Keep thermostat around 71 to 73 degrees F
- Provide blankets and sheets as needed to keep patients warm.

Patient Comfort

- Ensure examination room is well-ventilated to decrease odors
 - Properly dispose of any items causing an offensive odor.
 - Double-bag items soaked in urine, feces, blood, or infectious waste and store in dirty utility room.
 - Use room deodorizer and air freshener.

Patient Privacy

- Always knock before entering exam room
- Announce yourself, ask permission to enter, and enter when patient gives consent
- Inform patient where to store personal items
- Properly drape patients to protect their modesty and sense of well-being

Review of Patient Communication and Documentation

- Enter all communications with patient in the patient's medical record
- Complete and accurate documentation is vital to treatment and care of the patient

Review of Patient Communication and Documentation

- Patient interview takes place when patient enters exam room and MA identifies reason for office visit
- Goal is to obtain information about patient's condition and establish rapport

Review of Patient Communication and Documentation

- Effective Communication
 - Review the patient's medical record before meeting the patient; plan the interview.
 - Greet the patient using his or her last name.
 - Maintain a professional demeanor.

Review of Patient Communication and Documentation

- Effective Communication
 - Ask permission to interview the patient.
 - Make the patient feel at ease.
 - Be aware of verbal and nonverbal cues.
 - Avoid making judgmental responses.

Review of Patient Communication and Documentation

- Effective Communication, continued
 - Avoid providing medical assurances.
 - Summarize important points, giving the patient a chance to correct anything you may have misunderstood.
 - Document the interview in the patient's medical record according to facility policy.

Review of Patient Communication and Documentation

- Correct Documentation
 - Record the date and time of every entry.
 - Use accepted medical terminology and abbreviations.
 - Use correct spelling and grammar.
 - Sign every entry (digital or electronic).

Review of Patient Communication and Documentation

- Correct Documentation
 - Stick to the facts when documenting.
 - Document the proper sequence of events.
 - Document appropriate information.
 - Be concise.

BOX 36-1

The Six C's of Charting

To recall the guidelines for charting, remember the six C's:

1. *Client's* (patient's) own words must be used exactly and within quotation marks.
2. *Clarity* must be achieved when recording information, using proper spelling and medical terminology and abbreviations.
3. *Completeness* is essential for all information recorded in the medical record.
4. *Conciseness* of the entry provides a more time-saving and professional image.
5. *Chronological* order of information is imperative.
6. *Confidentiality* of patient information is mandatory in every aspect of patient care.

Review of Patient Communication and Documentation

- When documenting in paper records:
 - Write legibly.
 - Use permanent black ink.
 - Correct errors only by drawing a single line through the error and initialing it. Then record the corrected entry.

Patient Health History

- Health history form varies according to office preference and specialty
- Forms may be filled out online prior to appointment, or office can mail beforehand
- Form may also be filled out in the office

Patient Health History

- Assist frail, disabled, or illiterate patients to fill out the form.
- Depending on facility, the MA or physician may obtain patient history

Patient Health History

- History gathered during the patient's visit
 - Chief complaint
 - Present illness
 - Past medical history
 - Family medical history
 - Social history

Patient Health History

- Chief Complaint
 - Referred to as presenting problem
 - Patient's reason for making the visit
 - Usually consists of one or two signs patient is concerned about

Patient Health History

- Chief Complaint
 - Stated in patient's own words
 - Signs are objective, observable by others (e.g., weight gain, fever, or rash)
 - Symptoms are subjective, something the patient experiences (e.g., dizziness, pain, anxiety)

Patient Health History

- Chief Complaint
 - Ask what-when-where questions
 - Some offices use abbreviation CC; others prefer C/O to record chief complaint
 - Do not use diagnostic terms when recording chief complaint

Patient Health History

- Chief Complaint
 - Pain is often chief complaint
 - Document using patient's own words
 - Recognize nonverbal cues (grimacing or moaning)
 - Recognize common terms used to describe pain

Patient Health History

- Common Terms to Describe Pain
 - Stabbing and sharp
 - Cutting or tearing
 - Burning, stinging
 - Dull or throbbing
 - Intermittent, continuous
 - Aching, gnawing, nagging
 - Unbearable or excruciating

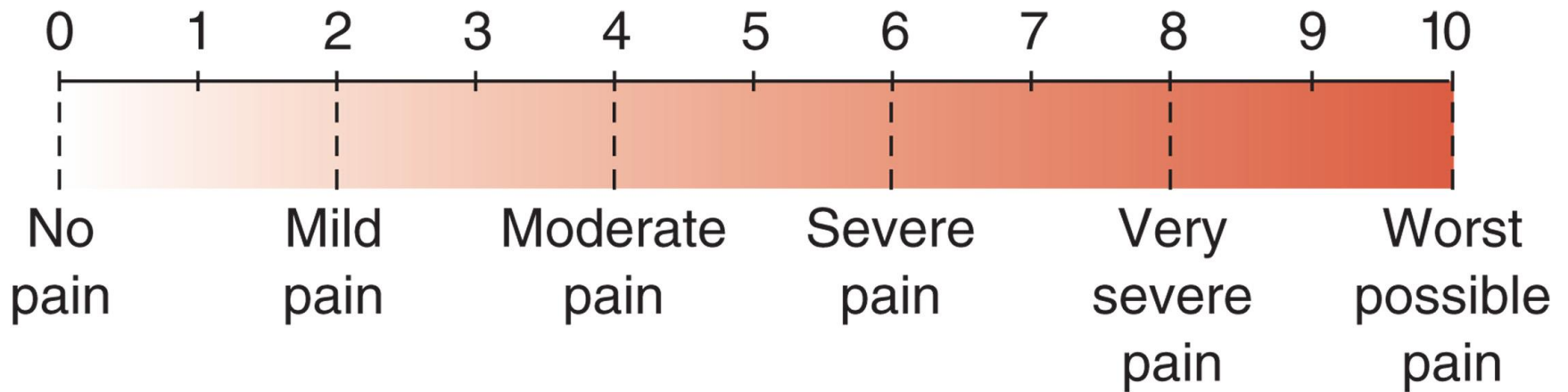
Patient Health History

- Assessment of Pain
 - Use a numerical pain measurement scale.
 - For children and non-English-speaking patients, scales with happy and sad faces are available.

Patient Health History

- Acute pain
 - Begins suddenly and may be associated with trauma or surgery
- Chronic pain
 - Long-term and interferes with function of life
- Record patient's description and length of pain

FIGURE 36-2 Numerical pain level chart with word modifiers.



Patient Health History

- Categories of Pain
 - Radiating: spreads out from a particular area
 - Referred: felt at a site away from the injured or diseased body part
 - Intractable: overwhelming, difficult to relieve, and all-consuming
 - Phantom: sensation felt in a missing body part after it has been removed

Documenting a Chief Complaint During a Patient Interview

1. Gather supplies, including the medical record with problem list or progress notes form.
2. Review briefly the patient's medical history form before greeting the patient.
3. Greet and identify the patient. Introduce yourself and escort the patient into the examination room.

Documenting a Chief Complaint During a Patient Interview

4. Ask open-ended questions (ones that can't be answered just "yes" or "no") to gather information about why the patient is being seen today. Maintain eye contact and actively listen to patient responses.

Documenting a Chief Complaint During a Patient Interview

5. Gather information about the present illness by asking questions:
 - a. What makes the problem better or worse?
 - b. When did it start?
 - c. Where does it hurt?

Documenting a Chief Complaint During a Patient Interview

6. Document the CC and PI correctly within the medical record.
 - a. Be certain to state the CC and PI in the patient's own words when necessary.

Documenting a Chief Complaint During a Patient Interview

7. Before leaving the room, make sure the patient is comfortable and ask if he or she has any questions.
8. Thank the patient and explain that the physician will come in shortly to perform the examination.

Patient Health History

- Present Illness
 - Provides a more complete, expansive description of patient's chief complaint
 - Must include onset, duration, and intensity of each symptom
 - Document each symptom as to its relationship to chief complaint

Patient Health History

- Past Medical History
 - Includes all diseases and medical problems the patient has experienced in the past

Patient Health History

- Complete past medical history includes:
 - Childhood diseases
 - Major illnesses
 - Injuries
 - Hospitalization
 - Surgeries
 - Allergies

Patient Health History

- Complete past medical history includes:
 - Immunizations
 - Current and past medications (prescription and OTC)
 - Last examination
 - Herbal supplements

Patient Health History

- Family Medical History
 - Health problems of the patient's blood relatives
 - May sometimes be limited to immediate family members only
 - Information obtained details current health status, major health problems, cause of death, and age at death
 - Focus on diseases that may be inherited

Patient's Health History

- Social History
 - Lifestyle patterns that could affect health status of the patient (smoking, drinking, use of recreational drugs)
 - Patient's occupation, marital status, and sexual preferences are also noted

Patient's Health History

- Social History
 - Dietary choices, frequency of exercise, sleep habits, and other health habits also included
 - See Box 36-2 for Social History Questions.

Interviewing a Patient to Obtain Medical History Information and Preparing for a Physical Examination

1. Identify the patient, greet the patient warmly, and identify yourself.
2. Escort the patient to a private examination room and explain that you will be preparing the patient to be seen by the physician.

Interviewing a Patient to Obtain Medical History Information and Preparing for a Physical Examination

3. Review the medical history form with the patient. Be sure that all the sections have been appropriately filled out.
 - a. Ask for additional information to complete any blank lines of information.

Interviewing a Patient to Obtain Medical History Information and Preparing for a Physical Examination

4. Speak in a clear voice and avoid using medical terminology when communicating with the patient.
5. Ask the patient why he or she is visiting the medical office today and record the chief complaint in the patient's own words, as appropriate.

Interviewing a Patient to Obtain Medical History Information and Preparing for a Physical Examination

6. Gather additional information about the present illness (PI) to provide more information about the patient's chief complaint (CC).
 - a. Ask the patient open-ended questions to gather more information.
 - b. Use observation skills during the interview.

Interviewing a Patient to Obtain Medical History Information and Preparing for a Physical Examination

7. According to physician preference or office policy, gather additional information regarding the patient's social and family histories. Document this information appropriately and as stated by the patient within the patient's medical record.

Interviewing a Patient to Obtain Medical History Information and Preparing for a Physical Examination

8. Inquire about the patient's allergies. Record allergy information as appropriate within the electronic health record or using red ink in the paper record.
 - a. If the patient states he or she does not have any allergies, record NKA (no known allergies) according to the office policy and as appropriate for the method of charting.

Interviewing a Patient to Obtain Medical History Information and Preparing for a Physical Examination

9. Note any other information or observations you feel are relevant to the patient's chief complaint or present illness.
 - a. This may include illness of other family members at home – the recent loss of a loved one, for example.

Interviewing a Patient to Obtain Medical History Information and Preparing for a Physical Examination

10. Record all information using correct charting guidelines according to the method of charting used in the medical office.
 - a. Correct any errors as necessary. If using a paper medical record, draw one line through the error, and date and initial each error. Record the correct information.

Interviewing a Patient to Obtain Medical History Information and Preparing for a Physical Examination

11. Inform the patient if a gown must be worn and which items of clothing will need to be removed. Provide the patient with a gown and drape the patient for modesty.

Interviewing a Patient to Obtain Medical History Information and Preparing for a Physical Examination

12. Ask the patient if he or she has any questions before leaving the examination room and inform the patient that the physician will be in shortly to perform the examination.

Interviewing a Patient to Obtain Medical History Information and Preparing for a Physical Examination

13. Thank the patient and leave the examination room, closing the door behind you to ensure privacy.
14. Place the medical record with completed health history form in the designated location for the physician's review and inform the physician that the patient is ready to be examined.

Equipment Used for Physical Examinations

- Flashlight or penlight
- Laryngeal or dental mirror
- Nasal speculum
- Ophthalmoscope
- Otoscope

Equipment Used for Physical Examinations

- Reflex hammer and pinwheel
- Tuning fork
- Vaginal speculum Stethoscope
- Sphygmomanometer
- Tape measure

Supplies Used for Physical Examinations

- Examination table paper
- Paper drapes and gowns
- Various dressings and bandages
- Tongue depressors
- Disposable gloves (sterile and nonsterile)

Supplies Used for Physical Examinations

- Alcohol pads
- Cotton applicators
- Disposable sponges
- See Table 36-1 for additional supplies and equipment.

Supply Inventory

- A supply inventory system should contain:
 - List of supplies used in your facility
 - Item numbers for each supply item
 - Each supplier's name, address, telephone number, and contact person
 - Amount of each supply used monthly
 - Reordering frequency

Inspection Method of Physical Examination

- Visual examination of exterior surface of the body
- General state of health, demeanor, grooming, and social interactions observed
- Some interior portions of the body, including the throat, eyes, ears, vaginal wall, cervix, and rectum may be inspected using special instruments.

Inspection Method of Examination

- Notes are made of any unusual color, size, shape, position, or symmetry of the areas being inspected.

Palpation Method of Physical Examination

- Performed by using the hands to feel the skin and accessible underlying organs
- Other areas examined by palpation include the axilla (armpits), neck, and chest

Palpation Method of Physical Examination

- Used to determine any unusual tenderness, size, shape, and texture
- Oftentimes, abnormalities and masses in the abdomen can be discovered through palpation.

FIGURE 36-6A An example of light palpation of the abdomen. (B) the physician uses two hands for deep bimanual palpation.

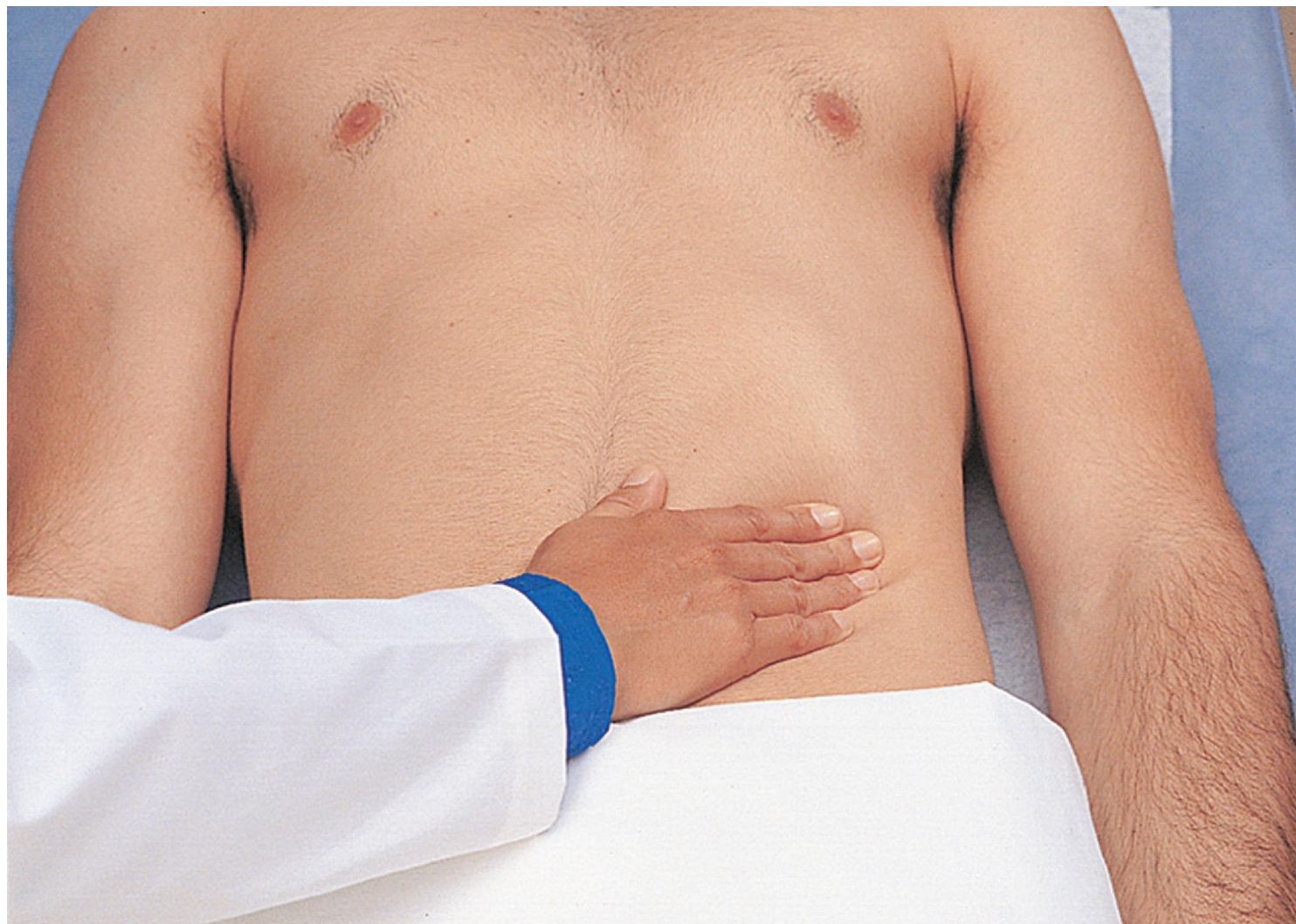


FIGURE 36-6B The physician uses two hands for deep bimanual palpation.



Percussion Method of Physical Examination

- Refers to use of the fingertips to tap the body lightly but sharply to gain information about the position and size of the underlying body parts
- To do this, two fingers of one hand are placed on the patient's skin and then struck with the index and middle finger of the other hand.

Percussion Method of Physical Examination

- The physician uses his or her fingers to percuss the chest wall and abdomen by gentle thumping or tapping, which produces a standard sound or vibrations.
- An alteration of this sound or vibration aids in determining the presence of fluid or pus in a cavity.

FIGURE 36-7 The physician uses percussion—tapping—to detect sound or vibration.



Auscultation Method of Physical Examination

- Listening to sounds that are found within the body
- Sounds made by the heart, lungs, stomach, and bowel are assessed for strength, presence or absence, and rhythm.
- The physician will differentiate normal body sounds from abnormal ones.

Auscultation Method of Physical Examination

- A stethoscope is usually used to amplify body sounds; however, auscultation can also be performed by placing the ear directly over the body surface.

FIGURE 36-9 The physician uses auscultation to listen to a patient's heart.
Monkey Business Images/Shutterstock



Mensuration Method of Physical Examination

- Use of special tools to measure the body or specific parts, such as scale, tape measure, and calipers
- Scales used to measure adult and pediatric weight

Mensuration Method of Physical Examination

- Tape measure used to determine an infant's head and chest circumference and the abdomen, the diameter of a limb, the length of a limb, or the length and width of a wound

Mensuration Method of Physical Examination

- Calipers are used to determine the amount of body fat.
- A goniometer is used to measure range of motion of a joint.

FIGURE 36-10 Calipers are used to measure the body fat on the triceps of a patient.
3360 Group Inc/Getty Images



Manipulation Method of Physical Examination

- Passively assessing the range of motion of a joint
- When a physician is performing this examination method, he or she may palpate the joint for abnormalities and warmth.

Adult Examination

- Performed by the physician at each visit, regardless of type of appointment
- Purpose is to assess the body, determine diagnosis, and measure effectiveness of current plan of care of previously diagnosed issues

Adult Examination

- May also include laboratory and diagnostic tests
- Patients will often have a routine yearly wellness visit.
 - The physician must have up-to-date medical records to compare current physical exam to previous exams.

Adult Examination

- Physician will look for weight changes, blood pressure variances, or other conditions requiring more frequent evaluations by the healthcare provider
- Physician will analyze information gained from physical exam and combine it with past medical history, laboratory findings, and other medical information to determine diagnosis

Adult Examination

- Only the physician may diagnose a condition.
- The MAs role is to assist the physician in obtaining correct, current data.
- Clinical (working) diagnosis – preliminary, presumptive diagnosis

Adult Examination

- Differential diagnosis
 - Process of determining which, of multiple possibilities, is the cause of the problem

Adult Examination

- Physician will rule out (R/O) diagnoses in an attempt to determine the most correct one
- Prognosis is made after diagnosis; consists of predicting the course of the condition and determining recovery rate

Adult Examination

- Physician will monitor patient's progress and adjust treatment as needed

Questions?