NR 509 Midterm Study Guide

General Study Tips and Recommendations

- ✓ *Topics and content on guides are intended to focus student attention when reading/studying and some topics may be repeated in multiple chapters.*
- ✓ *Multiple test items are derived from the same topic areas to encourage deeper comprehension.*
- ✓ *Students must have a broad understanding of content and not simply memorize passages in textbooks or articles.*
- ✓ *Information in **red letters** in the chapters as well as **tables** and **appendices** at the end of the chapters may include test items.*
- ✓ *Exam questions represent various levels of cognitive learning. You are expected to analyze, synthesis, and evaluate patient scenarios in order to answer the questions.*
- ✓ *Read all of the answers BEFORE reading the stem of the question. This will help you focus on the key content and not get distracted by extraneous information.*
- ✓ *Be familiar with "**Techniques of Examination**" and "**Recording Your Findings**" for all body system chapters in the textbook.*

Chapter 1 Approach to the Clinical Encounter

- **The interviewing process**
  - Generates a patient's story that is fluid and draws on various relational skills to respond effectively to patient cues, feelings, and concerns
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- **Interviewing techniques**
  - Active listening
    - Involves closely attending to what the client is communicating, connecting to the client's emotional state, and using verbal and nonverbal skills to encourage the client to expand on their feelings and concerns
  - Empathy
    - Encompasses identifying with the client and feeling their pain as one's own, then responding to them in a supportive manner
  - Guided questioning
    - Help to elicit more information, while still showing a continued interest in the client's feelings and story.
    - Some techniques of guided questioning include moving from open-ended to more focused questions; clarifying what the client means; encouraging with continuers such as "go on"; using a series of questions one at a time; and using questions that require a graded response (i.e., how many stairs can you climb before feeling short of breath?).
  - Nonverbal communication
    - Eye contact, facial expression, posture, head position, and movement such as shaking or nodding, interpersonal distance, and placement of the arms or legs (i.e., crossed, neutral, or open.)
  - Validating
    - Affirming the legitimacy of the client's emotional experience.

        - Examples include: “that must have been a difficult experience. It’s very common to feel the way you are feeling.”
    - Reassuring
        - Appropriate way to help the client feel that problems have been fully understood and are being addressed
    - Partnering
        - Expressing commitment to an ongoing relationship with the clients to build rapport
    - Summarizing
        - A summary of the client’s story during the interview helps to communicate that they have been carefully listening to
    - Transitioning
        - Used to inform the client that the direction of the interview is changing
    - Empowerment
        - Empowering clients to ask questions and express their concerns increases the chances that they will adopt your advice, make lifestyle changes, or take medications as prescribed
- **Setting the stage for the examination**
    - Make sure the patient is comfortable and the environment is conducive to the very personal information soon to be shared
    - Each interview has its own rhythm and sequence
    - Reflect on patterns of emotion and behavior
        - Pay attention to how you feel and how you behave around patients of different identities
        - The patterns you recognize may reflect biases that impact your interactions with patients as well as your clinical reasoning
        - Being aware of these biases is the first step in reducing their impact on patient care
    - Pause before starting an encounter and prepare for potential triggers of bias
    - Generate alternative hypotheses for biases anchored in behavior
        - Many biases are anchored in clinician assumptions about observed patient behavior (nonadherence, substance use, etc.)
        - Make it a habit to consider what structural forces (socioeconomic status, race/racism, homophobia, etc.) impact patient behaviors, and how they can challenge assumptions you make about patients.
    - Practice universal communication and interpersonal skills
    - Explore your patients’ identities
    - Explore your patients’ experiences of bias
- **Establishing rapport**
    - How you greet the patient and other visitors in the room, provide for the patient’s comfort, and arrange the physical setting, all shape the patient’s first impressions
    - Relating effectively with patients is among the most valued skills of clinical care
    - As you begin, welcome the patient by introducing yourself, giving your own first and last name.
        - If possible, shake hands with the patient
        - If this is the first time you are seeing the patient, explain your role, your status as a student or trainee, and how you will be involved in their care.
- **Gender pronouns**

    - Let the patient dictate how they would like to be addressed
    - Clinicians should ask all patients their preferred name and gender pronouns, ideally at the beginning of the visit and/or on an intake questionnaire.
        - This includes formal titles such as Mr., Mrs., Ms., or honorifics such as Professor or Dr.
        - This promotes a welcoming environment, especially those individuals whose preferred titles or names do not conform to societal norms.
    - Example:
        - Student: “Good morning. I am Jane Doe, a third-year clinical student. I am part of the clinical team taking care of you. I am here to assist them figure out how we can best help you. Are you Joe Walsh?”
        - Patient: “Yes.”
        - Student. “How would you like me to address you?”
        - Patient. “You can call me Mr. Walsh.” Or, “Joe is fine.”
        - Student: “It is a pleasure to meet you, Mr. Walsh. Please call me Jane. May I ask you a few more background questions before we start?”
        - Patient: “Sure”
        - Student: “In our effort to promote an inclusive and respectful environment, we use pronouns that are right for us. The pronouns I prefer when other talk about me are ‘she’ and ‘her’. How about you? What pronouns do you prefer?”
        - Patient: “I use ‘he’ and ‘him’, I guess.”
- **Patient-centered medical care**
    - This approach recognizes the importance of patients’ expressions of personal concerns, feelings, and emotions” and evokes “the personal context of the patient’s symptoms and disease.
    - Following the patient’s lead to understand their thoughts, ideas, concerns, and requests, without adding additional information from the clinician’s perspective.
- **The FIFE model**
    - Feelings: including fears or concerns, about the problem
    - Ideas: about the nature and the cause of the problem
    - Function: the effect of the problem on the patient’s life
    - Expectations: of the disease, of the clinician, or of health care, often based on prior personal or family experiences

Chapter 2 Interviewing, Communication, and Interpersonal Skills

- **Fundamentals of skilled interviewing**
    - Active or attentive listening
    - Guided questioning
    - Empathetic responses
    - Summarization
    - Transitions
    - Partnering
    - Validation
    - Empowering the patient
    - Reassurance
    - Appropriate verbal communication
    - Appropriate nonverbal communication

- **Verbal and nonverbal communication**
    - Use simple, recognizable and clear words
    - Use short sentences and words and only communicate essential information
    - Avoid saying, “Does the pain radiate?” instead- “does the pain move anywhere?”
    - What is my main problem?
    - What do I need to do?
    - Why is it important for me to do this?
    - Posture, gestures, eye contact, and tone of voice all convey the extent of your interest, attention, acceptance, and understanding
    - Body orientation toward and physical proximity to patient
    - Gaze orientation (eye contact) toward patients
    - Head nodding with facial animation
    - Head nodding with gesture
    - Posture
    - Tone and use of voice
    - Use of silence
    - Use of touch
- **Challenging patient situations and behaviors**
    - Silent
    - Talkative
    - With confusing narrative
    - With altered state or cognition
    - With emotional lability
    - Angry or aggressive
    - Flirtatious
    - Discriminatory
    - With hearing loss
    - With low or impaired vision
    - With limited intelligence
    - Burdened by personal problems
    - Nonadherent
    - With low literacy
    - With low health literacy
    - With limited language proficiency
    - With terminal illness or dying

Chapter 3 Health History

- **Focused and comprehensive health histories**
    - Comprehensive:
        - Is appropriate for new patients in the office or hospital
        - Provides fundamental and personalized knowledge about the patient
        - Strengthens the clinician-patient relationship
        - Helps identify or rule out physical causes related to patient concerns
        - Provides a baseline for future assessments
        - Creates a platform for health promotion through education and counseling
        - Develops proficiency in the essential skills of physical examination
    - Focused:

        - Is appropriate for established patients, especially during routine or urgent care visits
        - Addresses focused concerns or symptoms
        - Assesses symptoms restricted to a specific body system
        - Applies examination methods relevant to assessing the concern or problem as thoroughly and carefully as possible
- **Determining the scope of the patient assessment**
    - The scope and detail of the history depends on the patient's needs and concerns, your goals for the encounter, and the clinical setting (inpatient or outpatient, the amount of time available, primary care or subspecialty)
        - For new patients, in most settings, you will do a comprehensive health history
        - For patients seeking care for specific concerns, for example, cough or painful urination, a more limited interview tailored to that specific problem may be indicated; this is sometimes known as a focused or problem-oriented history
        - For patients seeking care for ongoing or chronic problems, focusing on the patient's self-management response to treatment, functional capacity, and quality of life is most appropriate
        - Patients frequently schedule health maintenance visits with the more focused goals of keeping up screening examinations or discussing concerns about smoking, weight loss, or sexual behavior.
        - A specialist may need a more comprehensive history to evaluate a problem with numerous possible causes
- **The seven attributes of a patient's principal symptoms**
    - **Location**
        - Where in/on the body the problem, symptom, or pain occur or move to other areas
    - **Quality**
        - An adjective describing the type of problem, symptom, or pain
    - **Quantity or severity**
        - Patient's nonverbal actions or verbal description as to the degree or extent of the problem, symptom, or pain: pain scale 0-10, comparison of the current problem, symptom, or pain to previous experiences
    - **Timing including:**
        - Describes when the symptom or pain started
        - **Onset**
            - Setting in which it occurs, what actions or circumstances cause the problem, symptom, or pain to occur, worsen, or improve
        - **Duration**
            - How long the problem, symptom, or pain have been present or how long the problem, symptom, or pain last
        - **Frequency**
            - How often the problem, symptom, or pain occur
    - **Modifying factors**
        - Actions or activities taken to improve the problem, symptom, or pain and their outcome
    - **Associated manifestations**
        - Other signs or symptoms that occur when the problem, symptom, or pain occur

- **Subjective versus objective data**
    - Subjective information: includes symptoms which are health concerns that the patient tells you
        - Examples include complaints of a sore throat, headache, or pain
        - It also includes feelings, perceptions, and concerns obtained from the clinical interview
    - Objective information: physical examination findings or signs you detect during the examination
        - All laboratory and diagnostic testing results are also considered objective information
        - For example: "chest pain" is subjective information while "tenderness on palpation of anterior chest" is objective
- **Modifying of the clinical interview for various clinical settings**
    - Ambulatory care: focus information gathering not only on the chief complaints but also chronic health issues and any changes to them since their last visit.
        - You should ask about routine health care maintenance, especially in an ambulatory setting with a primary care focus
    - Emergency care: ensure that your patient is clinically stable before initiating a detailed focused interview
        - Ask about symptoms related to possible causes of the patient's problem to quickly rule out life-threatening illnesses
        - Information gathering may be intermittently interrupted
        - Patients may be incapable of providing information due to confusion or change in mental status.
        - Obtain a health history from family members, caregivers, other clinicians
    - ICU**:** clinical information will need to be gathered from family members, other clinicians, or prior documentations in the electronic health record
        - Ask a series of questions regarding preferences about treatment as well as resuscitation and use of life-sustaining interventions if required
    - Nursing home: patients are called residents. Always attempt to obtain history from the resident first.
        - Always include information as to how well they can care for themselves (ADLs)
        - Getting a detailed history that covers not only medical but functional and social can be taxing on these frail residents. Do not feel pressured to get every part of the history on a single occasion.

Chapter 4 Physical Examination

- **Determining the scope of the physical examination**
    - Reflect on your approach to the patient
    - Adjust the lighting and the environment
    - Check your equipment
    - Make the patient comfortable
    - Observe standard and universal precautions
    - Choose the sequence, scope, and positioning of examination
- **Techniques of examination (Note: Be familiar with specific techniques in body system chapters)**
    - Inspection**:** visual examination