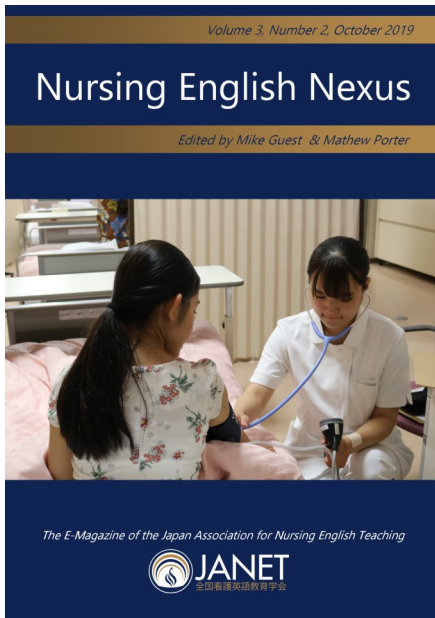


# Getting Patient Information: A Worksheet for Teaching Patient Interviewing and Data Reporting

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## Article citation

Guest, M. (2019). Getting Patient Information: A Worksheet for Teaching Patient Interviewing and Data Reporting. *Nursing English Nexus*, 3(2), 25-27.

## Nursing English Nexus

<http://www.janetorg.com/nexus>

ISSN 2433-2305

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## Getting Patient Information: A Worksheet for Teaching Patient Interviewing and Data Reporting

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In this short paper, I will describe a single teaching item that constitutes the core of my Nursing Communicative English 1 course at the University of Miyazaki. This item (see Appendix A) involves not a single lesson but can occupy up to 5 or 6 lessons, depending upon the speed at which students appear to be mastering the target skills and internalizing the contents.

The purpose of this item (entitled 'Getting Patient Information') is to familiarize Japanese nursing students not only with appropriate methods of asking and reporting patient data, but also to help them become sensitized to the categories of inquiry such that there may be a positive cognitive washback effect on the students' holistic professional training.

As the reader can see, the worksheet is divided into four sections: Basic Patient Data, Medical and Social History Information, History of Present Illness (HPI), and O/E (On Examination). The specific items included in each section have been chosen based upon the author's previous inquiry and research into spoken nursing English, nursing admission documents, and clinical case presentations and have thus been identified as the most significant categories for nurses when collecting or reporting patient data.

In carrying out the task of mastering this material, students need to concern themselves with not only the language forms needed to conduct nurse-patient interviews but also used in data reporting between nurses and health professionals and in clinical case presentations.

I recommend that each section be covered in a single class and be reviewed consistently and cumulatively until the entire set of items has been mastered. This involves regular role-playing among students using the worksheet as an information gap activity for both vertical (nurse-patient) and

horizontal (nurse-health professional) spoken discourse. To do so, students are required to create their original patient data which is then conveyed to partners during role-play, completed by the listener on the form, and is then further conveyed to a new partner as nurse-nurse reporting. Confirming the accuracy of the data at each stage is another essential feature of this pair-work activity.

Considerations for managing each section:

### 1. General Patient Data

Students will make profiles of a non-Japanese patient. This requires not only some imagination but also care in terms of the names' written/spoken order and the form in which the birthdate is presented.

### 2. Medical and Social History

The students will likely require a list of suitable items in order to complete the items allergies, underlying conditions, current medications, and reasons for hospitalization which the teacher should compile and familiarize students with in advance. It is also noteworthy that the lifestyle items such as work, sleep, or drinking habits tend to have fluctuating and inexact values in real life and therefore that a certain degree of vagueness or approximation is not only acceptable, but normal.

### 3. History of Present Illness (HPI)

When introducing this section, teachers should offer the students a list of suitable location terms (upper middle, lower right etc.). Abbreviations used in describing duration (hrs, wks, mths, yrs) should also be introduced here. Frequency and duration will also tend to bring up crucial distinctions between chronic, intermittent, and acute conditions

#### 4. On Examination (O/E)

This section will focus upon the reporting of basic vital sign and systems review data between nurses and other health care professionals. Instructions regarding the application of these tests in nurse-patient discourse can (and should) be dealt with separately.

Considerations for effective class management and student performance:

- Having the instructor merely 'tell' the students the 'correct' question form for each item is demotivating, as it requires a highly teacher-centered, discrete information-based classroom approach. To avoid this, in each section I have students work in groups to guess/predict what the most suitable question form would be before eliciting the 'best' responses from them. Instructors should keep in mind that there are invariably valid alternative question forms for most data items.
- The entire 'Getting Patient Information' activity can, and should, be prefaced with an introduction performed by the student (for nurse-patient interviews) and followed by explanations of each subsequent section as well as a suitable closing. Students are also required to maintain a pleasant demeanour and good posture while performing the activity.
- While the nurse-patient interview requires the utilization of social competencies (see above) the nurse-nurse reporting element focuses upon speed and accuracy. Truncated grammatical forms are encouraged, such that each item of data does not always require that a new, full sentence be formed (e.g., 'The patient is a John Smith, male, aged 55...')
- Numerous extemporaneous activities, such as item flash cards, in which one student

shows a flash card to a team and then gives it to the first student who gives an adequate matching question, can be added in order to more deeply internalize the language forms.

- Treated as a whole, this item can easily translate into a role-play test (spread over two classes in order to include all 30 students). I act as the patient while nursing students enter two-by-two and elicit responses from me while completing the form, before reporting the data (nurse-nurse) to each other. The completed patient information forms are then handed in in order to ensure data accuracy.

This activity not only helps to develop practical nursing English skills, with the professional relevance serving as a primary motivational factor, but also to reinforce awareness of the clinical categories, lines of inquiry, and organization of data that are most important to practicing nurses in any language.

## Appendix A

# Getting Patient Information 1

## Personal Information:

- Name \_\_\_\_\_
- Sex/Gender \_\_\_\_\_
- DOB \_\_\_/\_\_\_/\_\_\_
- Marital Status \_\_\_\_\_
- Nationality \_\_\_\_\_
- Occupation \_\_\_\_\_

## Medical and Social History Information:

- Blood Type \_\_\_\_\_
- Allergies \_\_\_\_\_
- Current Medications \_\_\_\_\_
- Underlying Conditions/Ongoing treatments \_\_\_\_\_
- Hospitalizations (why) \_\_\_\_\_ (when) \_\_\_\_\_
- Ht \_\_\_\_\_
- Wt \_\_\_\_\_
- Working habits – hrs per day/days per week \_\_\_\_\_ level of stress \_\_\_\_\_
- Sleeping habits – hrs. \_\_\_\_\_ quality \_\_\_\_\_
- Eating habits - meal frequency \_\_\_\_\_ balance \_\_\_\_\_
- Exercise (frequency) \_\_\_\_\_ (type/length) \_\_\_\_\_
- Smoking \_\_\_\_ yes \_\_\_\_ no (if yes, amount per day: \_\_\_\_\_)
- Alcohol (frequency) \_\_\_\_\_ (type/amount) \_\_\_\_\_

## HPI:

- Present Complaint \_\_\_\_\_
- Duration \_\_\_\_\_
- Location \_\_\_\_\_
- Frequency \_\_\_\_\_

## O/E:

- P \_\_\_\_\_
- BP \_\_\_\_\_
- TEMP. \_\_\_\_\_
- HS \_\_\_\_\_
- RS \_\_\_\_\_

\*Notes on worksheet abbreviations:

DOB- Date of Birth (or Birthdate), HT- Height, WT- Weight, P- Pulse, BP- Blood Pressure, HS- Heart Sounds, RS- Respiratory System