Fairchild: Pierson and Fairchild's Principles & Techniques of Patient Care, 5th Edition

Chapter 01: Preparation Patient Care Activities

Test Bank

MULTIPLE CHOICE

1. Which of the following is protected information under HIPAA's Privacy Rule?
   A. Demographic data relating to the individual's past, present, or future physical or mental health condition
   B. The provision of healthcare to the individual
   C. The past, present, or future payment for the provision of healthcare to the individual
   D. All of the above

   ANS: D
   All of the above are considered examples of individually identifiable health information. HIPAA's Privacy Rule protects this information, allowing patients more access to it and more control over its use.

   PTS: 1

2. Which of the following describes standard procedures to be used for correcting a note in a handwritten medical record?
   A. Use correction fluid to completely cover the inaccurate note, and write the correction on the following line.
   B. Strike through the error with multiple lines of red ink, and provide a signature next to the correction.
   C. Draw a single line through the inaccurate information, making certain the material remains legible, and date and initial the correction.
   D. Write over the incorrect word or phrase to improve its legibility, or block out the information with a felt pen.

   ANS: C
   Careful and proper correction of an entry will help avoid accusations of tampering, changing the entry for self-serving reasons or intent, or capricious alteration of the medical record, especially if litigation is involved or being considered. When correcting a note, draw a single line through the inaccurate information, but be certain the material remains legible. Date and initial the correction, and add a note in the margin stating why the correction was necessary. Use black ink for all corrections and entries.

   PTS: 1

3. What information should be included in the setting of functional goals for a patient?
   A. All exercises expected to be used to achieve the functional outcome.
   B. The time frame, the need for assistance or equipment, the objective data to be

measured, and the desired functional outcome.
C. Only the objective data to be measured, for the sake of brevity.
D. The facility and all modalities expected to be used for treatment.

ANS: B
Goals of treatment should be established cooperatively with the patient and the caregiver. They must be stated in objective, measurable terms and should indicate who will perform the activity, by what means the goal will be accomplished, the need for equipment or assistance, the time frame in which to accomplish the goal, and the functional outcome expected.

PTS: 1

4. Which of the following statements might a therapist avoid to facilitate appropriate communication with a patient who has a visual impairment?
A. "Let's go over the plan one step at a time."
B. "Did you hear about the big fire?"
C. "I'll see you later."
D. "I want you to walk through this sequence of exercises."

ANS: C
Even the experienced caregiver may feel awkward or embarrassed when communicating with a person with a health condition, especially if an expression related to the impairment is used during the conversation. The expression about "seeing," therefore, may be best avoided. In most instances the person with impairment will recognize these statements as expressions and components of the usual communication pattern, but you may want to consider how you can limit the use of such expressions.

PTS: 1

5. Which of the following has been reported as a top reason for malpractice in the physical therapy setting?
A. Failure to monitor
B. Failure to empathize
C. Failure to schedule appropriately
D. Failure to provide pain relief

ANS: A
"Failure to monitor" (11.6 percent), "wrong procedure or treatment" (8.4 percent),"failure to supervise" (7.9 percent), and "improper management" (5 percent) were among the top reasons for malpractice reported in the physical therapy setting between 1991 and 2004.

PTS: 1

6. Which entity routinely surveys facilities and has standards that deal with organizational quality of care issues and the safety of the environment in which care is provided?
A. American Physical Therapy Association
B. Joint Commission

C. World Health Organization
D. Third-party payers

ANS: B
Joint Commission is a private, nonprofit organization whose purpose is to encourage the attainment of uniformly high standards of institutional medical care. The Joint Commission team currently surveys facilities using a "tracer methodology": a survey team enters a facility, selects a number of patients, and follows the patients' course throughout the facility.

PTS: 1

7. What categories of information constitute the documentation of a SOAP note?
A. Samples, obstacles, actions, progress
B. Subjective, objective, actions, progress
C. Samples, obstacles, assessment, plan
D. Subjective, objective, assessment, plan

ANS: D
Information about the patient and the plan of care is contained in SOAP notes, which are written in the following format: subjective, objective, assessment, and plan. The SOAP notes should contain important, relevant information about the patient; they should indicate and clearly reflect the patient's condition and subsequent changes in condition; and they should be written frequently so that information is reported promptly and regularly.

PTS: 1

8. Which is true concerning nonverbal communication?
A. It may be even more effective than verbal communication in some situations.
B. It's difficult to misinterpret.
C. It does little to enhance the patient's level of understanding.
D. It's most important when simple activities are being taught.

ANS: A
Non-verbal communication makes up the majority of human communication and may be even more effective than verbal communication; however, care must be taken to use it in an appropriate manner. For example, touch must be used in a therapeutic, caring way, and the caregiver must avoid any suggestion of sexual implications.

PTS: 1

9. Which term is used to describe a dynamic process in which the practitioner makes clinical judgments based on gathered data and identifies problems pertinent to patient management?
A. Assessment
B. Examination
C. Evaluation

D. Treatment

ANS: C
Evaluation is the dynamic process in which the practitioner makes clinical judgments based on data gathered during the assessment and examination.

PTS: 1

10. What is stereognosis?
A. The ability to recognize the form (shape) of an object by touch
B. The ability to differentiate two blunt points when they are simultaneously applied to the skin
C. The sense by which position, weight, and movement are perceived
D. Sensation and awareness about the movements and position of body parts

ANS: A
Stereognosis refers to the ability to distinguish the form of an object by touch. For example, stereognosis allows a patient who is grasping a key with the eyes closed to distinguish the object as a key rather than a marble, pencil, or spoon.

PTS: 1

11. What is the term used for a type of medical event during which no harm occurs either due to intervention by an individual or due to chance?
A. Sentinel event
B. Potential adverse event
C. Active event
D. Latent event

ANS: B
A potential adverse event, often referred to as a "close call" or a "near miss," is one during which no harm occurs either due to intervention by an individual or due to chance. A sentinel event, on the other hand, is one during which an injury is caused due to the medical management process.

PTS: 1

12. Which group of physiologic changes is commonly associated with aging?
A. Altered visual acuity, loss of bone density, decreased balance
B. Advanced wound healing, increased strength, increased tactile sense
C. Altered mental capacity, increased proprioception, increased muscle elasticity
D. Increased connective tissue elasticity, altered hearing acuity, improved physical condition

ANS: A
Physiologic changes associated with aging commonly include decreased skin integrity, loss of bone density, decreased strength, worsened physical condition, decreased tissue elasticity, decreased balance, and altered acuity of senses.

PTS: 1

13. What hospital emergency code represents infant and child abduction?
    A. Code blue
    B. Code orange
    C. Code gray
    D. Amber alert

    ANS: D
    An amber alert represents infant and child abduction. Code blue represents heart or respiratory stoppage. Code orange represents hazardous material spill or release. Code gray alerts staff to a combative person.

    PTS: 1

14. What is the single most important recommendation to prevent the spread of infection in a health care setting?
    A. Do not leave patients unattended.
    B. Routinely evaluate equipment.
    C. Perform hand hygiene before and after patient treatment.
    D. Avoid storing potentially hazardous equipment or materials in a location where there is a risk of a patient accessing them.

    ANS: C
    Performing hand hygiene before and after treating each patient to reduce cross-contamination and transmission of disease is the single most important activity for preventing the spread of infection.

    PTS: 1

15. According to the APTA guidelines, for which elements should documentation be performed?
    A. Initial evaluation and reexamination only
    B. Initial evaluation and discharge summary only
    C. Initial evaluation, reexamination, and discharge summary only
    D. All patient visits (including initial evaluation and reexamination) and discharge summary

    ANS: D
    The documentation of patient care is an important component of the written record maintained for each patient. All patient visits should be documented, and a discharge or discontinuation summary should be written following the end of a patient's total care.

    PTS: 1

16. Which four-phased system of medical record keeping uses a common list of patient problems as its base in addition to a series of progress notes to assess the effectiveness of treatment plans?
    A. POMR
    B. SOAP
    C. HIPAA
    D. NVC

    ANS: A
    The problem-oriented medical record (POMR) uses the following four phases to enhance quality of care:
    - Formation of a database (current and past information about the patient)
    - Development of a specific, current problem list (problems to be treated by various practitioners)
    - Identification of a specific treatment plan (developed by each caregiver)
    - Assessment of the effectiveness of the treatment plans

    PTS: 1

17. Which of the following defines cultural diversity?
    A. Differences in race, ethnicity, language, nationality, or religion among various groups within a community, organization, or nation
    B. An awareness of the nuances of one's own and other cultures
    C. A set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups
    D. The shared values, norms, traditions, customs, art, history, folklore, and institutions of a group of people

    ANS: A
    Cultural diversity describes the differences in race, ethnicity, language, nationality, or religion among various groups within a community, organization, or nation. A city is said to be culturally diverse if its residents include members of different groups.

    PTS: 1

18. What is needed before a caregiver is able to educate an adult patient's family about the treatment program and activities?
    A. Physician permission
    B. Patient permission
    C. Supervisor permission
    D. Family member permission

    ANS: B
    The caregiver has the responsibility to educate the patient and family about the treatment program and activities, but patient confidentiality must be respected and the patient's permission must be obtained before the sharing of information with the family.

PTS: 1

19. What knowledge of the patient should a therapist have before the patient visit begins?
    A. Physician request for treatment
    B. Medications prescribed
    C. Past medical history
    D. All of the above

    ANS: D
    Before seeing a patient, the therapist should do a comprehensive review of the patient's medical record, including the physician's notes on the past medical history, current history, physical findings, and diagnosis; test results; physician request for treatment; nursing notes; medications prescribed; and any consultations to other medical/surgical specialties.

    PTS: 1

20. Which are examples of individually identifiable health information?
    A. Hair style and eye color
    B. Hand preference and leg dominance
    C. Address and date of birth
    D. All of the above

    ANS: C
    Individually identifiable health information includes many common identifiers, such as name, address, date of birth, and Social Security number. Care must be taken to avoid leaving paperwork that includes patient identifiers in a public area and to avoid open discussion of patients in a public area. Information such as eye color or hand preference is not specific enough to identify an individual.

    PTS: 1