Import Settings:

Base Settings: Brownstone Default

Information Field: Complexity

Information Field: Ahead

Information Field: Subject

Information Field: Feedback

Information Field: Taxonomy

Information Field: Objective

Highest Answer Letter: D

Multiple Keywords in Same Paragraph: No

**Chapter: Documentation - Documentation - TBNK**

**Multiple Choice**

1. Which of the following is a subjective finding?

A) Pale, cool, clammy skin

B) Obvious respiratory distress

C) A complaint of chest pressure

D) Blood pressure of 110/60 mm Hg

Ans: C

Complexity: Moderate

Ahead: Introduction

Subject: Documentation

Page: 170

Feedback: Introduction, page 170

2. All of the following are subjective findings, EXCEPT:

A) visible blood in the ear canal.

B) a feeling of impending doom.

C) a persistent dull headache.

D) acute and severe nausea.

Ans: A

Complexity: Moderate

Ahead: Introduction

Subject: Documentation

Page: 170

Feedback: Introduction, page 170

3. In order to ensure that all recorded times associated with an incident are accurate, the paramedic should:

A) frequently glance at his or her watch.

B) radio the dispatcher after an event occurs.

C) document the time that each event occurs.

D) get a copy of the dispatch log after the call.

Ans: B

Complexity: Moderate

Ahead: Documenting Incident Times

Subject: Documentation

Pages: 185–186

Feedback: Documenting Incident Times, pages 185–186

4. The patient care report:

A) provides for a continuum of patient care upon arrival at the hospital.

B) is a legal document and should provide a brief description of the patient.

C) should include the paramedic's subjective findings or personal thoughts.

D) is only held for a period of 24 months, after which it legally can be destroyed.

Ans: A

Complexity: Moderate

Ahead: Introduction

Subject: Documentation

Page: 170

Feedback: Introduction, page 170

5. The MOST significant problem associated with making up your own medical abbreviations and documenting them on the patient care report is:

A) insurance denial.

B) a potential lawsuit.

C) an error in patient care.

D) confusion at the hospital.

Ans: C

Complexity: Easy

Ahead: Legal Implications of a PCR

Subject: Documentation

Pages: 170–171

Feedback: Legal Implications of a PCR, pages 170–171

6. Data collected from the state EMS office for the purpose of research would likely NOT include:

A) patient outcomes.

B) the nature of all calls.

C) average cost per call.

D) call volume per month.

Ans: C

Complexity: Easy

Ahead: Purposes of Documentation

Subject: Documentation

Pages: 171–172

Feedback: Purposes of Documentation, pages 171–172

7. The National Emergency Medical Services Information System (NEMSIS):

A) defines the scope of practice for all levels of EMS provider.

B) collects relevant data from each state and uses it for research.

C) is a nationwide billing system that any EMS provider can use.

D) defines the minimum data that must be collected on each call.

Ans: B

Complexity: Moderate

Ahead: Purposes of Documentation

Subject: Documentation

Page: 172

Feedback: Purposes of Documentation, page 172

8. Which of the following incident times is NOT commonly documented on the patient care report?

A) Time of primary assessment

B) Time of departure from the scene

C) Time of arrival at the hospital

D) Time of medication administration

Ans: A

Complexity: Easy

Ahead: Documenting Incident Times

Subject: Documentation

Pages: 185–186

Feedback: Documenting Incident Times, pages 185–186

9. Which of the following statements is LEAST descriptive when documenting the events of a cardiac arrest call on your patient care report?

A) “Followed ACLS protocols.”

B) “Intubated with a 7.5-mm ET tube.”

C) “Gave 1 mg of epinephrine at 1002.”

D) “Inserted 18-gauge IV in right forearm.”

Ans: A

Complexity: Moderate

Ahead: Completing a PCR

Subject: Documentation

Page: 179

Feedback: Completing a PCR, page 179

10. Which of the following documentation styles would likely be MOST difficult and time consuming to apply in EMS?

A) SOAP method

B) CHARTE method

C) Body systems approach

D) Chronological approach

Ans: C

Complexity: Easy

Ahead: Completing a PCR

Subject: Documentation

Page: 179

Feedback: Completing a PCR, page 179

11. Which of the following statements includes a pertinent negative?

A) “The patient complains of nausea but denies vomiting.”

B) “The patient rates his pain as an 8 on a scale of 0 to 10.”

C) “The possible smell of ETOH was noted on the patient.”

D) “The rapid head-to-toe exam revealed abrasions to the chest.”

Ans: A

Complexity: Moderate

Ahead: Completing a PCR

Subject: Documentation

Page: 181

Feedback: Completing a PCR, page 181

12. When documenting a statement made by the patient or others at the scene, you should:

A) document the exact time that the statement was made.

B) include the statement in an addendum to your run report.

C) translate the statement into appropriate medical terminology.

D) place the exact statement in quotation marks in the narrative.

Ans: D

Complexity: Moderate

Ahead: Completing a PCR

Subject: Documentation

Page: 182

Feedback: Completing a PCR, page 182

13. The accuracy of your patient care report depends on all of the following factors, EXCEPT:

A) including all pertinent event times.

B) the severity of the patient's condition.

C) the thoroughness of the narrative section.

D) documenting any extenuating circumstances.

Ans: B

Complexity: Moderate

Ahead: Completing a PCR

Subject: Documentation

Pages: 181–182

Feedback: Completing a PCR, pages 181–182

14. If you receive another call before completing the patient care report accurately for the previous call:

A) you should submit what you have completed to the receiving facility.

B) pertinent details about the previous call may be omitted inadvertently.

C) your patient care report must be completed within 36 hours after the call.

D) you should ask the dispatcher to send another paramedic crew to the call.

Ans: B

Complexity: Moderate

Ahead: Completing a PCR

Subject: Documentation

Page: 182

Feedback: Completing a PCR, page 182

15. Prior to submitting a patient care report to the receiving hospital, it is MOST important for:

A) your partner to review the report to ensure accuracy.

B) the EMS medical director to review the report briefly.

C) the paramedic who authored the report to review it carefully.

D) the quality assurance team to review the report for accuracy.

Ans: C

Complexity: Moderate

Ahead: Completing a PCR

Subject: Documentation

Page: 182

Feedback: Completing a PCR, page 182

16. When a competent adult patient refuses medical care, it is MOST important for the paramedic to:

A) ensure that the patient is well informed about the situation at hand.

B) contact medical control and request permission to obtain the refusal.

C) perform a detailed physical exam before allowing the patient to refuse.

D) obtain a signed refusal from the patient as well as a witness signature.

Ans: A

Complexity: Moderate

Ahead: Situations Requiring Additional Documentation

Subject: Documentation

Pages: 174–175

Feedback: Situations Requiring Additional Documentation, pages 174–175

17. For purposes of refusing medical care, a patient's mental status may be considered impaired if he or she:

A) is notably frightened.

B) makes a derogatory comment.

C) is not sure of the exact time.

D) makes nonsensical statements.

Ans: D

Complexity: Moderate

Ahead: Situations Requiring Additional Documentation

Subject: Documentation

Page: 175

Feedback: Situations Requiring Additional Documentation, page 175

18. Which of the following statements regarding revisions or corrections to a patient care report is correct?

A) The original patient care report should be destroyed if a revision is necessary.

B) Only the person who wrote the original report can revise or correct it.

C) A patient care report cannot be revised or corrected after submission.

D) If a report needs revision, the revision must be made within 12 hours.

Ans: B

Complexity: Moderate

Ahead: Errors and Falsification

Subject: Documentation

Page: 184

Feedback: Errors and Falsification, page 184

19. A poorly written patient care report:

A) often indicates that the paramedic was too busy providing patient care.

B) generally results in a lawsuit, even if the patient outcome was favorable.

C) may raise questions by others as to the paramedic's quality of patient care.

D) is unavoidable during a mass-casualty incident and is generally acceptable.

Ans: C

Complexity: Moderate

Ahead: Completing a PCR

Subject: Documentation

Pages: 183–184

Feedback: Completing a PCR, pages 183–184

20. Which of the following is a significant benefit of electronic documentation?

A) The ability of the data to be shared between health care facilities

B) The elimination of the need to complete a narrative section

C) The use of drop-down boxes, which minimizes the possibility for errors

D) The ease with which it can be applied during mass-casualty incidents

Ans: A

Complexity: Easy

Ahead: Types of PCRs

Subject: Documentation

Pages: 172–173

Feedback: Types of PCRs, pages 172–173

21. An accurate and legible patient care report:

A) should be complete to the point where anyone who reads it understands exactly what transpired on the call.

B) is not possible on every call, especially if there is more than one patient or the patient is critically ill or injured.

C) is a relatively reliable predictor of the quality of care that the paramedic provided to the patient during the call.

D) provides immunity to the paramedic if the patient decides to pursue legal action against the paramedic.

Ans: A

Complexity: Moderate

Ahead: Errors and Falsification

Subject: Documentation

Page: 185

Feedback: Errors and Falsification, page 185

22. Which of the following statements contains objective and subjective information?

A) “The patient's behavior was consistent with alcohol intoxication.”

B) “The patient's pulse was rapid and weak and he was diaphoretic.”

C) “The patient's wife stated that he began feeling ill a few hours ago.”

D) “The patient appeared confused and stated that he had a headache.”

Ans: D

Complexity: Moderate

Ahead: Introduction

Subject: Documentation

Page: 170

Feedback: Introduction, page 170

23. HIPAA requires that:

A) a patient's personal information must be shared with the patient's immediate family members.

B) patient information shall not be shared with entities or persons not involved in the care of the patient.

C) a penalty will be imposed for any release of any portion of a patient's personal information to any entity.

D) patient information can only be shared with the receiving physician in the emergency department.

Ans: B

Complexity: Moderate

Ahead: Legal Implications of a PCR

Subject: Documentation

Page: 171

Feedback: Legal Implications of a PCR, page 171

24. Which of the following laws or entities requires that a statement of medical necessity be clearly documented on a patient care report?

A) HIPAA

B) Medicare

C) Medicaid

D) State law

Ans: B

Complexity: Easy

Ahead: Purposes of Documentation

Subject: Documentation

Page: 171

Feedback: Purposes of Documentation, page 171

25. Which of the following data would a state EMS office be the LEAST likely to require an EMS agency to report?

A) Call volume

B) Types of calls

C) Patient gender

D) Patient outcome

Ans: C

Complexity: Easy

Ahead: Purposes of Documentation

Subject: Documentation

Pages: 171–172

Feedback: Purposes of Documentation, pages 171–172

26. Which of the following constitutes minimum data that must be included on every patient care report?

A) Chief complaint, level of consciousness, vital signs, assessment, and patient's age and gender

B) Level of consciousness, field impression, vital signs, assessment, and patient's name and address

C) Scene size-up, detailed assessment, blood glucose reading, vital signs, and patient's age

D) Chief complaint, vital signs, assessment, tentative field diagnosis, and patient's ethnic background

Ans: A

Complexity: Easy

Ahead: Documentation for Every EMS Call

Subject: Documentation

Page: 173

Feedback: Documentation for Every EMS Call, page 173

27. If a patient with decision-making capacity adamantly refuses treatment for an injury or condition that clearly requires immediate medical attention, the paramedic should:

A) request law enforcement assistance at once.

B) contact online medical control for guidance.

C) make other arrangements for patient transport.

D) ask the patient to sign a refusal of treatment form.

Ans: B

Complexity: Moderate

Ahead: Situations Requiring Additional Documentation

Subject: Documentation

Pages: 174–175

Feedback: Situations Requiring Additional Documentation, pages 174–175

28. Components of a thorough patient refusal document include:

A) assurance by the paramedic that the patient's ability to pay is of no concern.

B) notification of the patient's physician to apprise him or her of the situation.

C) documentation of a complete assessment, even if the patient refused assessment.

D) willingness of EMS to return to the scene if the patient changes his or her mind.

Ans: D

Complexity: Moderate

Ahead: Situations Requiring Additional Documentation

Subject: Documentation

Pages: 174–175

Feedback: Situations Requiring Additional Documentation, pages 174–175

29. Most EMS agencies require a double signature system any time a:

A) medication that alters a patient's physiology is given.

B) patient's condition warrants diversion to a closer hospital.

C) patient is given more than one dose of any medication.

D) controlled substance is checked, used, discarded, or replaced.

Ans: D

Complexity: Easy

Ahead: Situations Requiring Additional Documentation

Subject: Documentation

Page: 179

Feedback: Situations Requiring Additional Documentation, page 179

30. If the paramedic is unable to complete his or her patient care report before departing the emergency department, he or she should:

A) leave, at a minimum, the patient's name and age, but recognize that the physician will perform his or her own exam.

B) leave an abbreviated form with pertinent data with the receiving provider and complete the patient care report as soon as possible.

C) obtain the emergency department fax number and transmit the completed patient care report within 12 hours after delivering the patient.

D) advise the receiving provider that he or she will return to the emergency department with the completed patient care report within 24 hours.

Ans: B

Complexity: Moderate

Ahead: Completing a PCR

Subject: Documentation

Page: 182

Feedback: Completing a PCR, page 182

31. Additions or notations added to a completed patient care report by someone other than the original author:

A) may raise questions about the confidentiality practices of the EMS agency.

B) are generally acceptable, provided the additions are made by a paramedic.

C) are not legal and may result in criminal action against the original author.

D) must be initialed by the original author or the patient care report will be deemed null and void.

Ans: A

Complexity: Moderate

Ahead: Errors and Falsification

Subject: Documentation

Page: 184

Feedback: Errors and Falsification, page 184

32. If you make an error when completing a written patient care report, you should:

A) circle the error, initial it, and write the correct information next to it.

B) not alter the original patient care report and write the correct information on an addendum.

C) use different colored ink when drawing a single line through the error.

D) leave the error, but write the correct information in parentheses next to it.

Ans: C

Complexity: Moderate

Ahead: Errors and Falsification

Subject: Documentation

Page: 184

Feedback: Errors and Falsification, page 184

33. What should occur if a physician on scene performs an intervention that is outside of the paramedic’s scope of practice?

A) The paramedic is required to disallow the physician to perform the intervention.

B) The physician is required to accompany the patient in the back of the ambulance.

C) The medical director must authorize the physician to perform the intervention.

D) The paramedic must allow the intervention and then transport the patient.

Ans: B

Complexity: Moderate

Ahead: Situations Requiring Additional Documentation

Subject: Documentation

Page: 179

Feedback: Situations Requiring Additional Documentation, page 179

34. In which of the following situations would the documentation on a patient care report MOST likely be limited?

A) Cardiac arrest

B) Physical abuse

C) Mass-casualty incident

D) Injury to a paramedic

Ans: C

Complexity: Easy

Ahead: Situations Requiring Additional Documentation

Subject: Documentation

Page: 175

Feedback: Situations Requiring Additional Documentation, page 175

35. In which of the following situations would a medical necessity for ambulance transport MOST likely be required?

A) The patient was able to walk to the ambulance.

B) The patient required a splint prior to moving.

C) The patient does not require emergent transport.

D) The patient has minor bleeding that is controlled.

Ans: B

Complexity: Moderate

Ahead: Purposes of Documentation

Subject: Documentation

Page: 171

Feedback: Purposes of Documentation, page 171