Chapter 7
Principles of Effective Documentation

1. What space on the patient care report should your objective "story" about the incident be documented?
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*A.) Narrative
B.) Explanation
C.) Theory
D.) Synopsis

2. Which of the following is NOT correct about the information in the narrative?
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*A.) It should be subjective
B.) It should document the patient's history
C.) It should provide explanation
D.) It should provide care information

3. Which documentation method uses a fill-in-the-bubble format?
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A.) Handheld computer
B.) Paper form
C.) Laptop computer
*D.) Computer-scan form

4. Which statement about correcting an error on a patient care report is correct?
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A.) Use a new form
*B.) Initial the change
C.) Use white out
D.) Blackout the wrong information

5. What is in most cases the only means by which your medical director can determine the appropriateness of your care?
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A.) Patient care results
B.) Emergency department evaluation
C.) Dispatch notes
*D.) Patient care report

6. Which section of the patient care report includes the date and time of the incident?
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*A.) Run data
B.) Narrative
C.) Patient data
D.) Fill-in section

7. Which of the following is NOT part of the minimum data set?
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A.) Time of dispatch
B.) Patient's demographics
*C.) Level of first responder
D.) Patient's chief complaint

8. For which reason should your reports be accurate so they can be used to improve the overall quality of the EMS system?
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A.) Continuity of care
B.) Administration
C.) Education
*D.) Quality assurance