

ASSESSMENT OF 30 MCQs

FPSC No : 61
MCQs ON TRANSITIONAL CARE FOR FAMILY PHYSICIANS
Submission DEADLINE: 23 JUNE 2015, 12 NOON

INSTRUCTIONS

- To submit answers to the following multiple choice questions, you are required to log on to the College Online Portal (www.cfps2online.org)
- Attempt ALL the following multiple choice questions.
- There is only ONE correct answer for each question.
- The answers should be submitted to the College of Family Physicians Singapore via the College Online Portal before the submission deadline stated above.
- There will be NO further extension of the submission deadline.

1. **Based on what is known about transitional care, which of the following elements is most likely to contribute to its success?**
 - A. Programmes that are specific and targeted at one aspect of patient care.
 - B. Programmes with competing stakeholders that drive competition.
 - C. Programmes that have a high level of intensity of care.
 - D. Programmes that only use nursing interventions.
 - E. Fee for service programmes.
2. **During communication of the care plans in transitional care which of the following is an important feature that will improve the chances of success?**
 - A. Maintain confidentiality as the risk of lapses in confidentiality is exceptionally high in transitional care.
 - B. Good medical record-keeping to ensure that the roles and responsibilities are clearly delineated between the various care providers.
 - C. Practice open disclosure to ensure that liability is minimised when care goes wrong.
 - D. Ensure that information is kept within individual disciplines that are contributing to the care of the patient.
 - E. Ensure the plan is shared and clearly understood by all parties involved in the care of the patients.
3. **Which of the following specific skills is most important for doctors who are involved in providing transitional care?**
 - A. Effectiveness in communication and working within a multidisciplinary environment.
 - B. Ability to think and act independently without the need to constantly request support of other team members.
 - C. Aptitude in learning medical procedures that are required in home care services.
 - D. Familiarity with medico-legal issues that may affect the doctor-patient relationship.
 - E. Knowledgeable in the health care financing system so that cost to the patient is kept to the minimum.
4. **Which of the following is the main imperative that drives the development of transitional care?**
 - A. Evidence-based medicine.
 - B. Ageing population.
 - C. Quality improvement.
 - D. Health promotion.
 - E. Universal access to care.
5. **What is the main objective in care planning in transitional care?**
 - A. Ensure safe and timely transfer of patients to the next setting of care.
 - B. Maximise cost savings to the entire health care system.
 - C. Reduce hospital acquired infection rate.
 - D. Ensure patients have the shortest possible length of stay in the hospital.
 - E. Minimise waiting time between care settings.
6. **Which of the following factors is associated with a high risk of 30-day hospital re-admission?**
 1. Polypharmacy
 2. Multiple co-morbidities
 3. Admitting discipline
 4. Poor functional status
 - A. 1, 2 and 3
 - B. 2, 3 and 4
 - C. 1, 2 and 4
 - D. None of the above
 - E. All of the above

- 7. Which of the following are not components of effective discharge planning?**
1. Early discharge
 2. Multidisciplinary team input
 3. Communication to next care provider
 4. Medicine reconciliation
 5. Discharge when all investigation results available

- A. 1, 2
B. 2, 3
C. 3, 4
D. 1, 5
E. 3, 5

- 8. Effective strategies used for patient/ caregiver education include:**
1. Teach back
 2. Written material
 3. Technical jargon
 4. Follow-up home visit within 72 hours
 5. Simplified communication

- A. 1, 2, 3
B. 2, 3, 4
C. 1, 3, 5
D. 2, 4, 5
E. 1, 2, 5

- 9. Low health literacy is associated with:**

- A. Correct drug use
B. Low emergency care attendance
C. Low use of preventative medicine
D. Overall good health
E. Low mortality

- 10. Discharge Summaries should always contain:**

1. Diagnoses
2. Pending investigations
3. Specialist follow-up appointments
4. Follow-up tasks
5. Results of all blood investigations

- A. 1, 2, 3
B. 2, 3, 4
C. 2, 3, 5
D. 1, 2, 3, 4
E. All of the above

- 11. Care fragmentation and duplication arises from the following except:**

- A. Lack of communication amongst colleagues.
B. Giving excessive information to colleagues.
C. Giving inappropriate information to colleagues.
D. Failure to involve patient and family in the management plan.

- E. Being genuinely interested in the frail elderly.

- 12. To ensure “team climate”, the following factors are important:**

- A. Having shared vision and goals.
B. Being well trained in problem solving techniques.
C. Gathering team members with the same training and from the similar backgrounds.
D. Having regular and allocated time for gatherings and meeting.
E. Having proper channels for communication among team members.

- 13. The role of the pharmacist in multidisciplinary teams include all of the following except:**

- A. Home medication review.
B. Advance care planning.
C. Medication reconciliation to reduce polypharmacy.
D. Assessment of risks vs benefits of complex medication regimens.
E. Patient education in medication compliance and adherence.

- 14. The components of an effective team include:**

- A. Not utilising standard practice guidelines and protocols as part of the decision-making process.
B. Good team leadership and proper organisation of team.
C. Having a good “team climate”.
D. Adequate training with continuing medical education for team members.
E. Proper channels to mitigate disagreements amongst team members.

- 15. The benefits of multidisciplinary teamwork include the following except:**

- A. Increased the length of stay in acute hospitals.
B. Improved discharge planning.
C. Increased cost effectiveness in health care.
D. Less duplication of services.
E. Overall improved patient satisfaction.

- 16. With regards to prognostication in advance care planning, which of the following is CORRECT:**

- A. It is not possible for any discussion on advance care plans if a precise prognosis is not available to frame the context for detailed advance care planning.
B. Advance care planning can be carried out when the likelihood of dying is considered.
C. It is useful to provide a more conservative estimate of the prognosis so that patients will feel relieved if they get to cross it.
D. It is useful to provide a better estimate of the prognosis in order not to take away the hopes of the patient.

- E. Prognostication should be avoided during ACP whenever possible as research has demonstrated its inexactness and the use of hypothetical examples are sufficient to elicit patient preferences.
- 17. A doctor guides his 60-year-old patient with advanced breast cancer through a discussion on end-of-life issues. Which of the following most accurately describes his role in this discussion?**
- He needs to inform the patient and her family about what is important for her wellbeing.
 - His patient's choices are paramount and should not be challenged.
 - He needs to allow his patient to work through her own internal conflicts and dilemmas by herself.
 - He advocates for timely planning but gives his patient time to come to her decisions.
 - He protects his patient from unhealthy conflict with her family.
- 18. A 45-year-old male has well-controlled hypertension. Which of the following statements regarding an advance care planning discussion with this patient is CORRECT?**
- Trying to imagine the situation where one becomes very ill can be very abstract to some patients and it may not be possible for them to decide accordingly.
 - Starting the first conversation about dying and death with someone who has a chronic illness is invariably difficult and should not be attempted by the GP as it is very likely to generate resistance and despair.
 - It is imperative to stop a session when the patient or a participant becomes emotional because persisting will traumatise them unnecessarily.
 - If a patient decides to change his plans after talking with his family, it is our duty to encourage him to stand firm with his earlier decisions.
 - Establishing that the patient without known kin has cognitive impairment, the ACP process is necessarily precluded such that the doctor may use his sole discretion to plan in the patient's best interest
- 19. An 80-year-old male with advanced dementia has previously always expressed his wish for no invasive measures to be taken if he becomes incapacitated. Specifically, he does not wish to be "hooked up to a machine". He had made an advanced medical directive in his 60s, before the onset of dementia. He also has a lasting power of attorney for personal welfare, vesting his son as his donee. He has now been admitted with an extensive stroke, and the question is raised to his family members regarding their wishes for antibiotic treatment. As his long-time family physician, what do you tell his family to consider, primarily, in coming to a decision?**
- The instruction in his advanced medical directive.
 - The opinion of his son as the personal welfare donee.
 - The opinion of 2 independent consultants.
 - The opinion of the hospital ethics board.
 - His previously expressed wishes.
- 20. A 70-year-old female has diabetes with target organ failure. Her doctor initiates a discussion on end-of-life care. Which of the following is necessary in this discussion?**
- Knowledge of patient's religious values.
 - A record of previously executed legal documents, e.g. AMD, a will, etc.
 - The presence of at least one family member.
 - Knowledge of trajectory of her illness.
 - Accreditation of doctor by MOH to conduct advance care planning.
- 21. Family engagement is part of holistic management of patients and studies have shown several benefits. These include:**
- Increased length of stay
 - Increased satisfaction
 - Improved discharge planning
 - Improved clinical decision-making
 - Improved psychological wellbeing
- 22. In conducting a family conference, preparatory steps are important. Some of which are listed below:**
- 1. Health care team to meet and update one another on the latest situation.**
 - 2. Coordinator to arrange for a date, time and venue.**
 - 3. Clarifying the reasons for requesting for a family conference.**
 - 4. Family member initiates a request for a family conference.**
 - 5. Bring up the request for a family conference at a team meeting.**
- Which of the following is the correct sequence in which the above should be carried out?**
- 4, 5, 1, 3, 2
 - 4, 2, 5, 1, 2
 - 4, 3, 5, 2, 1
 - 5, 4, 1, 3, 2
 - 5, 3, 4, 2, 1
- 23. The recommended duration of a family conference is about _____?**
- 30 minutes
 - 60 minutes
 - 90 minutes
 - 120 minutes
 - 150 minutes

- 24. When deciding the attendees of a family conference, the following statements are true except:**
- A competent patient should be in attendance as far as possible.
 - The donee of a patient's lasting power of attorney should be present.
 - Families should be discouraged from bringing young children to the family conference.
 - If a language interpreter is needed, it should be a family member.
 - A scribe should be present to document the family conference.
- 25. When non-consensus occurs and emotions flare up during a family conference, the following are steps to regain control of the situation. Which of the following is false?**
- Restate the goals of the family conference and reinforce the context of the discussion.
 - Allow family members with differing views to ventilate their emotions and arguments at one another.
 - Get the family members to present their views and arguments through the facilitator.
 - Explore family members' ideas, concerns and expectations which could have resulted in their decision.
 - Acknowledge emotions and allow adequate time for reflection and consideration.
- 26. A 78-year-old Chinese retiree was admitted to the hospital for a right MCA infarct. He was subsequently referred to the community hospital for rehabilitation. After a month's stay the physical therapist noted that he was not making any progress and likely would need a carer post-discharge from the community hospital. Patient is single and lives in a one-room rental flat in the Chinatown area. Given patient's current condition and therapist recommendation, the team decided to refer him for placement in a Voluntary Nursing Home and he is agreeable. How would you as his doctor assess his functional status?**
- Use the Resident Assessment Form (RAF).
 - Refer him to the Social Worker.
 - Refer him to the Occupational Therapist
 - Arrange for a community assessment.
 - Administer the Abbreviated Mental Test.
- 27. A 50-year-old with a blue CHAS card walks into the clinic for consultation of his xerotic eczema. He has no other chronic medical problems. He was prescribed some emollients and bethametasone cream. As part of the CHAS benefit, how much can you claim for the consultation?**
- \$80
 - \$18.50
 - \$28.50
 - \$135
 - \$50
- 28. Mr Chan, a 65-year-old retiree lives with his wife and son in a three-room flat. His son works as a mechanic with a gross monthly income of \$1500. Recently, Mr Chan was admitted to the hospital for a stroke. The neurologist recommends that he be admitted to the community hospital for further rehabilitation. What would be his per capita household income?**
- \$700
 - \$1500
 - \$100
 - \$500
 - \$1000
- 29. A 46-year-old divorcee was involved in a road traffic accident. He sustained multiple traumatic injuries which required prolonged hospitalisation and multiple operations. He was subsequently stepped down to the community hospital for rehabilitation. After two months, he is now able to walk with a walking stick and able to perform all his ADLs independently. However, he is currently unemployed and has no home to return to. Which community resources can you refer him to?**
- Voluntary Nursing Home
 - Sheltered Home
 - Destitute Home
 - Senior Group Homes
 - Transitional Convalescent Facilities
- 30. A 45-year-old odd jobber is the sole bread winner of a family of six. He lost his job recently due to a minor motorcycle accident. They live in a two-room rented HDB flat. He has no savings and the family depended on his salary for their daily necessities. He has approached his church for help but they are only able to provide him with some food provisions. He has approached you for help. Which community resources can you refer him to?**
- Town council
 - Family Service centers
 - Community Resource Engagement and Support Team (CREST)
 - Social Service Office
 - NTUC