

Flex Therapist CEUs

Medical Errors Prevention: Patient Safety in Physical Therapy

1. A patient with osteoporosis nearly falls during transfer training, but the physical therapist catches her and no injury occurs. A subsequent review finds that fall-risk precautions were not followed. According to the course definitions, how should this event be classified?

- A. A near miss, because a failure in care could have caused harm but was corrected before injury occurred
 - B. A medical error that must be classified as a sentinel event because the patient was at high risk
 - C. A non-preventable adverse event, because no actual injury occurred
 - D. A minor incident that does not meet criteria for medical error because the patient remained safe
-

2. During a therapy session, a patient with heart failure has an inappropriate exercise progression that results in syncope and an emergency transfer to the hospital. The episode is traced to failure to review new medication orders. Which term best describes this outcome?

- A. A near miss, because the therapist eventually recognized the problem and stopped treatment
 - B. A non-preventable adverse event because the patient's heart failure made the response unpredictable
 - C. A sentinel event by definition, because all cardiovascular events during therapy are sentinel events
 - D. A preventable adverse event resulting from healthcare management rather than the underlying condition
-

3. In a hospital-based outpatient clinic, internal incident reports show multiple events in which incorrect precautions were almost followed but stopped just in time. No patients were injured. Why are these events particularly valuable for improving safety in this setting?

- A. They are primarily useful for determining which individual clinicians should receive disciplinary action
 - B. They are considered low priority because no adverse events or malpractice claims resulted
 - C. They are near misses that reveal system vulnerabilities and allow proactive changes before serious harm occurs
 - D. They must be documented only when they meet the threshold for sentinel events requiring root cause analysis
-

4. Malpractice data show that physical therapists account for a small proportion of total claims and that formal malpractice events are estimated at about 2.5 per 10,000 practicing therapists per year. How should PTs and PTAs interpret this statistic in relation to their daily safety practices?

- A. They should focus primarily on documenting defensive justifications rather than improving clinical systems, given the low incidence
 - B. They can reasonably reduce the intensity of screening and monitoring because the specialty has relatively low liability risk
 - C. They should recognize that, despite low formal claim rates, underreported near misses and minor events still require consistent safety behaviors
 - D. They can assume that malpractice databases capture nearly all relevant patient safety events in physical therapy practice
-

5. A clinic director wants to reduce communication-related errors between PTs and PTAs. Which change best aligns with trends that have already improved safety in rehabilitation settings?

- A. Reducing the amount of information exchanged to shorten handoff time and increase clinic productivity
 - B. Eliminating written handoffs to encourage PTs and PTAs to develop independent clinical impressions
 - C. Implementing standardized communication tools such as SBAR and consistent documentation templates for treatment handoffs
 - D. Relying solely on informal hallway conversations instead of structured communication frameworks
-

6. An 82-year-old patient with diabetes, hypertension, and a recent fall is transitioning from acute care to a skilled nursing facility. Based on the course content, what combination of factors most increases this patient's vulnerability to medical errors during rehabilitation?

- A. Advanced age, multiple comorbidities, and care transitions that heighten the risk of fragmented communication and missed precautions
 - B. Advanced age alone, because comorbidities do not significantly change the risk profile during rehabilitation
 - C. Residence in a facility rather than home, since facility-based care eliminates most transition-related safety issues
 - D. The presence of chronic disease without age-related changes, because older adults without comorbidities are at low risk
-

7. A patient with moderate dementia repeatedly forgets hip precautions and performs unsafe movements during transfers. Which safety strategy is most consistent with the course's recommendations for patients with cognitive impairments?

- A. Increase exercise intensity to improve cognition, assuming that functional gains will resolve safety concerns

- B. Provide a single verbal explanation at the evaluation and then allow the patient to self-monitor for learning
 - C. Rely more on observation, caregiver input, and structured safety strategies rather than expecting the patient to independently maintain precautions
 - D. Rely primarily on written handouts, expecting that the patient will use them to compensate for memory deficits
-

8. A middle-aged patient who speaks limited English inconsistently follows a home exercise program and later returns with a preventable overuse injury. Which underlying mechanism best explains how communication barriers contributed to this medical error?

- A. Interpreter use would have been inappropriate because communication barriers do not affect rehabilitation outcomes
 - B. The patient's age alone placed them at inherently high risk for injury regardless of instruction quality
 - C. Overuse injuries are unrelated to communication quality and are expected in most strengthening programs
 - D. Misunderstanding of instructions and precautions due to language and health literacy barriers led to incorrect performance of exercises
-

9. After a serious treatment-related fall, a rehabilitation department conducts a Root Cause Analysis (RCA). Which statement best reflects the primary purpose of RCA as described in the course?

- A. To systematically identify underlying process and system factors contributing to the event so that recurrence can be prevented
 - B. To determine which individual clinician is at fault so that appropriate punishment can be assigned
 - C. To document that an event occurred without examining the sequence of contributing conditions
 - D. To confirm that existing policies are adequate and that the event was purely due to patient noncompliance
-

10. In reviewing Case Study 2 (post-stroke patient using a cane instead of a recommended walker), which system-level corrective action most directly addresses the identified contributing factors?

- A. Relying on informal verbal reports from family members instead of reviewing discharge summaries or orders
 - B. Reducing the thoroughness of initial evaluations to decrease visit length and improve patient satisfaction
 - C. Allowing patients to select any mobility device they prefer as long as they can ambulate short distances
 - D. Implementing a mandatory assistive device reconciliation process at intake to verify discharge recommendations and equipment use
-

11. According to the course, what is the primary safety-related responsibility of the physical therapist in the PT–PTA team?

- A. Relying on nursing and medical staff to identify all patient risk factors before therapy begins
 - B. Implementing all daily treatments while the PTA focuses on documentation and administrative tasks
 - C. Conducting the initial examination and evaluation, establishing the plan of care, and anticipating risk factors that influence supervision and progression
 - D. Delegating initial evaluation and plan-of-care decisions to the PTA in order to increase department efficiency
-

12. During gait training with a high-risk cardiac patient, a PTA notes new dizziness and significant shortness of breath. According to the described PTA role in error prevention, what is the most appropriate action?

- A. Encourage the patient to work through symptoms and document them at the end of the day if they persist
 - B. Stop or modify treatment and promptly notify the supervising PT, following clinic emergency or escalation protocols as indicated
 - C. Independently change the overall plan of care and continue treatment at a lower intensity without contacting the PT
 - D. Ignore symptoms if vital signs were normal at the beginning of the session, because they are likely due to deconditioning
-

13. In Case Study 3 (post–total hip arthroplasty patient with intermittent unsteadiness), what was the key documentation failure that increased the risk of a near fall?

- A. The PTA documented symptoms but omitted billing codes, which directly caused the physical instability
 - B. The PT documented too many details about previous sessions, overwhelming the PTA with information
 - C. The PTA did not document observed unsteadiness and reduced tolerance, preventing the PT from recognizing functional decline
 - D. The PT documented pain scores but not vital signs, which is unrelated to PT–PTA communication
-

14. A PT in acute care needs to communicate urgent safety concerns about a patient's new onset of confusion and balance loss to the hospitalist. Based on the course, which strategy best supports clear, safe communication in this situation?

- A. Using SBAR (Situation, Background, Assessment, Recommendation) to structure the message and highlight specific safety concerns
- B. Leaving a brief voicemail that the patient is "not doing well" without further detail to avoid taking too much time
- C. Waiting until interdisciplinary rounds later in the week to discuss the concerns informally

D. Relying solely on chart notes, assuming that the physician will independently review and interpret them

15. A home health PT wants to systematically reduce fall-related adverse events. Which approach most closely matches the proactive strategies recommended in the course?

- A. Using standardized fall-risk screening tools, safety checklists, and ongoing risk reassessment throughout the episode of care
 - B. Relying on clinical intuition during each visit without formal screening instruments or checklists
 - C. Focusing fall prevention efforts only at the initial evaluation, assuming risk remains stable over time
 - D. Educating patients about fall risk but avoiding formal documentation to keep notes concise
-

16. Florida Statute 486.109 requires PTs and PTAs to complete continuing education, including content on medical error prevention, as a condition of license renewal. From a safety perspective, what is the most important implication of this requirement?

- A. It replaces the need for organizational quality improvement activities because individual knowledge is sufficient
 - B. It primarily functions as a punitive measure for clinicians who previously caused adverse events
 - C. It promotes ongoing competence so clinicians remain current with emerging safety risks, evidence-based practices, and error-prevention strategies
 - D. It allows clinicians to maintain licensure without needing to integrate new knowledge into clinical practice
-

17. A rehabilitation aide without a PT or PTA license begins independently progressing patients' exercises in a Florida outpatient clinic. Which statutory principle is most clearly violated according to the course?

- A. The legislative intent 486.015, which states that unlicensed personnel may practice as long as a PT is in the building
 - B. The continuing education requirement under 486.109, because aides are required to attend the same courses as PTs
 - C. The disciplinary actions statute 486.125, which prohibits all delegation of any task to support personnel
 - D. The requirement under 486.028 and 486.151 that only appropriately licensed individuals may practice physical therapy and represent themselves as such
-

18. A PTA in Florida repeatedly ignores post-surgical precautions and fails to report adverse symptoms, leading to patient harm. Which regulatory mechanism described in the course is most directly designed to protect the public in this situation?

- A. The continuing education requirement under 486.109, which automatically restores safe practice regardless of behavior
 - B. Disciplinary actions under 486.125 that allow the Board to impose penalties for unsafe or negligent practice
 - C. The legislative intent under 486.015, which prevents the Board from acting unless criminal charges are filed
 - D. The license requirement under 486.028, which applies only to PTs and not to PTAs
-

19. A PT is pressured to continue high-intensity therapy with a medically complex patient despite new signs of instability, in order to meet productivity targets. According to the course's description of ethical responsibility, what action best aligns with the PT's professional obligations?

- A. Prioritize patient safety by modifying or pausing treatment, communicating concerns, and advocating for appropriate medical evaluation
 - B. Maintain the current intensity to meet productivity expectations, because administrative targets outweigh safety concerns
 - C. Document that the patient tolerated treatment well to avoid conflict with supervisors, regardless of observed instability
 - D. Discharge the patient solely to eliminate the safety risk, without discussing concerns or arranging appropriate follow-up
-

20. A clinic experiences several events in which potential falls were narrowly avoided during therapy but not reported because no one was injured. Based on the course's discussion of reporting, what is the strongest argument for documenting these near misses?

- A. They are irrelevant to safety improvement because reporting should focus exclusively on events that cause documented injury
 - B. They provide critical information about workflow and communication gaps, allowing system changes before a serious adverse event occurs
 - C. They mainly serve as a way to identify individual clinicians for punitive action rather than improve systems
 - D. They are useful only when associated with malpractice claims, not with internal quality improvement efforts
-