NPTE REVIEW · STUDY GUIDE

Study Guide 7

This guide goes with Practice Exam 7 and covers the last two chapters. Chapter 13 holds the rule based points that keep patients safe and keep a license intact: precautions, supervision, billing, privacy, reporting and the statistics you need to read a paper. Chapter 14 runs the lifespan from a 4 month old to an 82 year old and ends with integrated cases that train the priority order the exam rewards. Several worked cases here are pure arithmetic (units, ramp length, likelihood ratios, NNT, corrected age), so do them on paper before you look.

WHAT THIS GUIDE COVERS

- Chapter 13 · the chain of infection, standard and transmission based precautions, PPE order, body mechanics, emergencies, restraints, ethics and consent, PT, PTA, aide and student roles, documentation, Medicare rules and the 8 minute rule, practice acts and direct access, HIPAA, abuse reporting, ADA and accessibility numbers, payers, levels of evidence, validity and reliability, SEM and MDC, sensitivity, specificity, likelihood ratios, statistics tests, NNT, CPG grades, teach back, health literacy and stages of change.
- Chapter 14 · milestones and corrected age, primitive reflexes and postural reactions, CP types and GMFCS, spina bifida, Down syndrome, torticollis, DDH, IDEA Part C and Part B, Section 504, pediatric tests and equipment, normal aging, polypharmacy, delirium versus dementia versus depression, frailty and fall testing, osteoporosis and home safety, pregnancy, diastasis recti, incontinence, prostate cancer care and the integrated priority framework.

CHAPTER 13

Safety, Professional Responsibilities and Evidence

Read it in full: **Chapter 13 in the textbook**. Practice it: **Practice Exam 7** and the **flashcards**.

What to know

Standard precautions apply to everyone. Add a transmission category by organism. **Contact** (MRSA, VRE, C. difficile, scabies, draining wounds): gown and gloves, dedicated equipment. **Droplet** (influenza, pertussis, meningococcus, mumps): surgical mask. **Airborne** (TB, measles,

varicella, disseminated zoster): fit tested N95 and a negative pressure room. Alcohol rub is the default, but use **soap and water** for visible soil, C. difficile and norovirus. Don: gown, mask, eyewear, gloves. Doff: gloves, eyewear, gown, mask, then hand hygiene.

Body mechanics: wide base, load close, hinge at hips and knees, pivot with the feet, push rather than pull; a manual lift is capped near 35 pounds of patient weight. Emergencies: cardiac arrest gets CAB, 100 to 120 compressions a minute at least 2 inches deep, 30:2; seizure gets protection, no restraint, nothing in the mouth, EMS over 5 minutes; fire is RACE and PASS. A restraint is a last resort with a time limited order and monitoring. After a fall, check before moving; the incident report is not mentioned in the chart.

Ethics: autonomy, beneficence, nonmaleficence, justice, veracity, fidelity. A competent patient may refuse care: educate, respect and document. Informed consent covers the condition, intervention, benefits, material risks, alternatives (including no treatment) and the result of declining; it can be withdrawn. Never bill group time as individual care; remove an impaired colleague from care; no relationships with current patients.

Only the PT examines, evaluates, sets and changes the plan of care, reevaluates and writes the discharge summary. The **PTA** treats within the plan, collects data, progresses within plan limits and documents, and stops and calls the PT when status changes. **Aides** do nonskilled tasks under direct personal supervision. Supervision levels: general (reachable), direct (on site), direct personal (in the room). For Medicare Part B, the supervising therapist must be present and directing a student's service.

If it was not documented, it was not done. Correct paper errors with a single line, date and initials. Goals follow ABCD: audience, behavior, condition, degree. Medicare outpatient: the plan is certified (within 30 days), recertified at least every **90 days**, and a PT progress report is due at least every **10 treatment days**. The **8 minute rule**: 8 to 22 total timed minutes = 1 unit, 23 to 37 = 2, 38 to 52 = 3, 53 to 67 = 4; the leftover unit goes to the service with the most leftover minutes.

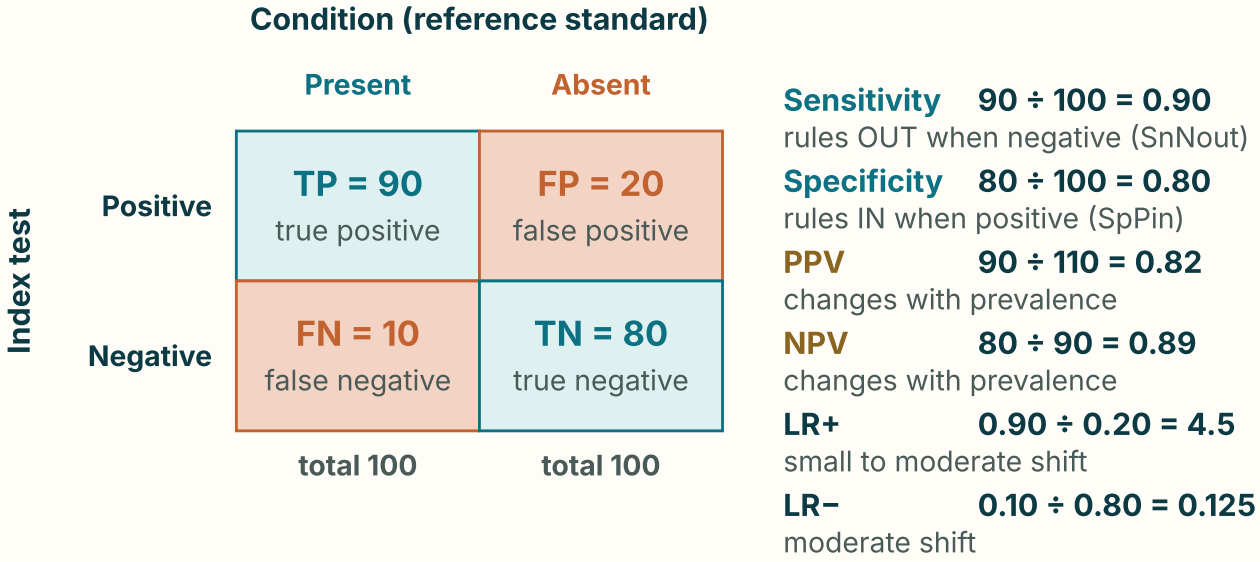
The practice act is state law; licensure protects the public. Malpractice needs duty, breach, causation and damages. Direct access raises the duty to screen. HIPAA allows disclosure for treatment, payment, operations and mandated reporting; otherwise authorization and minimum

necessary. Report suspected child or vulnerable adult abuse on **reasonable suspicion**, not proof; the duty is personal. Accessibility: ramp 1:12, 30 in rise per run, 36 in wide, 60 in landings, rails over 6 in of rise, doors 32 in clear, 60 in turning circle.

Medicare Part A covers inpatient, IRF, SNF after a 3 midnight stay (up to 100 days), home health and hospice; Part B covers outpatient. IRF patients must tolerate about 3 hours a day, 5 days a week. Home health requires homebound status. Evidence: systematic reviews and RCTs on top; randomization, blinding and intention to treat protect internal validity. ICC above 0.75 is good; kappa above 0.80 excellent. **SEM = SD × √(1 − r)**; **MDC95 = SEM × 1.96 × √2**. Change must exceed the MDC and should reach the MCID.

Sensitivity = TP ÷ all with the condition; a sensitive test rules **out** when negative (SnNout). **Specificity** = TN ÷ all without; a specific test rules **in** when positive (SpPin). Predictive values change with prevalence; sensitivity and specificity do not. **LR+** = sens ÷ (1 − spec); **LR−** = (1 − sens) ÷ spec. LR+ above 10 or LR− below 0.1 is a large shift. Type I error is a false positive (alpha 0.05); type II is a false negative; power is 1 − beta. **NNT = 1 ÷ ARR**, rounded up.

Evidence based practice blends research, expertise and patient values; frame questions with PICO. CPG grades run A (strong) to F (expert opinion). Teach to the domain (cognitive, psychomotor, affective), use **teach back**, plain language at about a sixth grade level and professional interpreters. Stages of change: precontemplation, contemplation, preparation, action, maintenance; match the strategy to the stage, and use motivational interviewing (OARS) for ambivalence. Adults need 150 to 300 minutes of moderate activity a week plus strength on 2 or more days.



Sensitivity is read down the Present column and specificity down the Absent column. Predictive values are read across the rows, which is why they move when prevalence changes.

From a 2 by 2 table to every accuracy number. Sensitivity and specificity belong to the test; predictive values belong to the test in a particular population.

LOCK THESE IN

- Contact: gown and gloves. Droplet: mask. Airborne: N95 and negative pressure.
- Soap and water for C. difficile, norovirus and visible soil.
- Don gown, mask, eyewear, gloves; doff gloves first.
- PTA never evaluates, changes the plan or discharges.
- Medicare: recert every 90 days; progress report every 10 visits.
- 8 minute rule: 8 to 22 = 1, 23 to 37 = 2, 38 to 52 = 3, 53 to 67 = 4.
- Report abuse on reasonable suspicion; ramp 1:12; door 32 in.
- SnNout, SpPin; LR+ > 10 or LR− < 0.1 is large; NNT = 1/ARR.

Formulas for the evidence items

Measure	Formula or rule
Sensitivity	TP ÷ (TP + FN)
Specificity	TN ÷ (TN + FP)
PPV; NPV	TP ÷ (TP + FP); TN ÷ (TN + FN)
LR+; LR−	sens ÷ (1 − spec); (1 − sens) ÷ spec
Odds and probability	odds = p ÷ (1 − p); p = odds ÷ (1 + odds)
SEM; MDC95	SD × √(1 − r); SEM × 1.96 × √2
ARR; NNT	CER − EER; 1 ÷ ARR, round up
Ramp length	Rise (in) × 12 = minimum run (in)

Choosing a statistical test

Question	Parametric; nonparametric
Two independent groups	Independent t test; Mann-Whitney U
Pre and post, same people	Paired t test; Wilcoxon signed rank
Three or more groups	One way ANOVA; Kruskal-Wallis
Repeated measures, 3 or more	Repeated measures ANOVA; Friedman
Association	Pearson r; Spearman rho
Nominal frequencies	Chi square
Ordinal examples	MMT grades, Berg items, ASIA scale
Ratio examples	Force, distance, time, degrees

Worked cases

WORKED CASE 1 · THE 8 MINUTE RULE

A Medicare patient receives 28 minutes of therapeutic exercise, 12 minutes of manual therapy and 6 minutes of gait training. How many units, and which?

STEP 1 · TOTAL

28 + 12 + 6 = 46 timed minutes: in the 38 to 52 band, so **3 units**.

STEP 2 · FULL UNITS FIRST

Therapeutic exercise has one full 15 minute unit (15), leaving 13 minutes.

STEP 3 · LEFTOVERS

Leftover: exercise 13, manual 12, gait 6.

STEP 4 · ASSIGN

Two more units go to the largest leftovers: exercise and manual. **Exercise 2, manual 1, gait 0.**

WORKED CASE 2 · RAMP LENGTH

A home has four steps of 6.5 inches each. How long must a code compliant ramp be?

STEP 1 · RISE

4 × 6.5 = 26 inches.

STEP 2 · RUN

26 × 12 = 312 inches = **26 feet** of ramp at 1:12.

STEP 3 · CHECK LIMITS

26 inches is under the 30 inch maximum rise per run, so one run works, with 60 inch level landings at top and bottom and rails on both sides (rise over 6 inches).

WORKED CASE 3 · FROM A 2 BY 2 TABLE TO A POST-TEST PROBABILITY

A test is studied in 200 people: 100 have the condition (90 test positive) and 100 do not (80 test negative). Your patient has a 30 percent pretest probability and tests positive.

STEP 1 · SENSITIVITY

90 ÷ 100 = 0.90.

STEP 2 · SPECIFICITY

80 ÷ 100 = 0.80.

STEP 3 · LR+

0.90 ÷ (1 − 0.80) = **4.5**, a small to moderate shift.

STEP 4 · PRETEST ODDS

0.30 ÷ 0.70 = 0.43.

STEP 5 · POST-TEST ODDS

0.43 × 4.5 = 1.93.

STEP 6 · BACK TO PROBABILITY

1.93 ÷ 2.93 = about **66 percent**.

WORKED CASE 4 · MDC AND NNT

A balance test has SD 4 points and test retest ICC 0.91. In a trial, 40 percent of controls and 25 percent of the exercise group fall.

STEP 1 · SEM

4 × √(1 − 0.91) = 4 × 0.3 = 1.2 points.

STEP 2 · MDC95

1.2 × 1.96 × 1.414 = about **3.3 points**; smaller changes may be error.

STEP 3 · ARR

0.40 − 0.25 = 0.15.

STEP 4 · NNT

1 ÷ 0.15 = 6.7, rounded up to **7**.

WORKED CASE 5 · A PTA MEETS A RED FLAG

A PTA treating a patient 3 weeks after TKA finds new calf swelling, warmth and tenderness. The patient says, "Just do the exercises and see."

STEP 1 · NAME THE CHANGE

Possible DVT: a change in medical status.

STEP 2 · ACT WITHIN SCOPE

Hold exercise, notify the supervising PT and the provider per policy, and document.

WHY NOT THE OTHERS

Continuing violates nonmaleficence; changing the plan exceeds the PTA role; calf massage could dislodge a clot.

TRAPS PEOPLE FALL INTO

- **Alcohol rub after C. difficile.** It does not kill spores; wash with soap and water.
- **A mask for C. difficile.** It is contact, not droplet or airborne.
- **A PTA "reevaluating and updating goals."** Always wrong.
- **Waiting for proof before reporting abuse.** Reasonable suspicion is the standard.
- **Saying prevalence changes sensitivity.** Only PPV and NPV change with prevalence.
- **"Do you understand?"** Use teach back and return demonstration.

Chapter 13 self-test · ten items

1. A patient is admitted with suspected pulmonary tuberculosis. Which precaution does the PT need?

A. Standard precautions with eye protection
B. Gown and gloves with shared equipment
C. A surgical mask within 3 feet of the patient
D. A fit tested N95 in a negative pressure room

D. A fit tested N95 in a negative pressure room TB is airborne: N95 respirator and an airborne infection isolation room.

2. What is the correct order for removing PPE?

A. Gown, gloves, mask, eyewear, then wash
B. Mask, gown, eyewear, gloves, then wash
C. Gloves, eyewear, gown, mask, then wash
D. Eyewear, mask, gloves, gown, then wash

C. Gloves, eyewear, gown, mask, then wash Remove the most contaminated item first: gloves, then eyewear, gown and mask, then hand hygiene.

3. A competent patient declines gait training after a clear explanation of the risks. What should the PT do?

A. Insist, citing the physician's order
B. Respect the refusal and document it
C. Discharge the patient from all care
D. Ask the family to persuade the patient

B. Respect the refusal and document it Autonomy: a competent adult may refuse. Educate, document the refusal and inform the team.

4. Which task may a PTA perform?

A. Progress exercise within the plan
B. Perform the 30 day reevaluation
C. Change the long term goals alone
D. Write the final discharge summary

A. Progress exercise within the plan The PTA delivers and progresses interventions within the plan; evaluation, reevaluation, plan changes and discharge belong to the PT.

5. A Medicare patient receives 33 minutes of exercise and 7 minutes of manual therapy. How are the units billed?

A. 3 units: all therapeutic exercise
B. 2 units: 1 exercise, 1 manual
C. 3 units: 2 exercise, 1 manual
D. 2 units: both therapeutic exercise

C. 3 units: 2 exercise, 1 manual 40 minutes is 3 units. Exercise fills 2 full units with 3 minutes left; manual has 7 left, more than 3, so the third unit is manual.

6. A PT suspects elder abuse but has no proof. What is required?

A. Report to adult protective services now
B. Confront the caregiver at the next visit
C. Gather more evidence before reporting
D. Tell the supervisor, who decides

A. Report to adult protective services now Mandated reporters report on reasonable suspicion; the duty is personal.

7. A test has sensitivity 0.95 and specificity 0.60. What does a negative result do?

A. Helps rule the condition in
B. Helps rule the condition out
C. Confirms the diagnosis
D. Changes nothing at all

B. Helps rule the condition out SnNout: LR− = 0.05 ÷ 0.60 ≈ 0.08, a large downward shift.

8. The same test is used in a clinic where the condition is much rarer. What changes?

A. The sensitivity of the test falls
B. The specificity of the test rises
C. The LR+ of the test rises sharply
D. The positive predictive value falls

D. The positive predictive value falls Sensitivity, specificity and likelihood ratios belong to the test; PPV and NPV change with prevalence.

9. Which test compares pre and post scores on an ordinal scale in one group?

A. Chi square goodness of fit
B. Wilcoxon signed rank test
C. Independent Mann-Whitney U
D. Paired samples t test

B. Wilcoxon signed rank test Related measures with ordinal data call for the Wilcoxon signed rank test.

10. A patient says he knows he should exercise but is not sure it is worth it and has not decided. Which stage is he in?

A. Contemplation
B. Action
C. Precontemplation
D. Preparation

A. Contemplation Aware and ambivalent, not yet planning: contemplation. Use motivational interviewing.

CHAPTER 14

Lifespan, Special Populations and Integrated Cases

Read it in full: **Chapter 14 in the textbook**. Practice it: **Practice Exam 7** and the **flashcards**.

What to know

Development runs cephalocaudal, proximal to distal, gross to fine. Milestones: head steady and prone on forearms by about 4 months; rolls supine to prone and sits with arm support by 6; sits alone by 8; creeps, pulls to stand and cruises at 9 to 10; walks about 12 months (range 9 to 15; **evaluate if not walking by 18**). Use **corrected age** (chronological age minus weeks of prematurity) for babies born before 37 weeks until about 24 months.

Most primitive reflexes integrate by about 4 to 6 months: rooting, palmar grasp, Moro, ATNR, TLR. The plantar grasp lasts to about 9 to 12 months; STNR appears about 6 to 8 months and integrates by 10 to 12. Persistence, asymmetry or an obligatory response suggests CNS dysfunction; a one sided absent Moro suggests a brachial plexus injury. Protective reactions: forward about 6 to 7 months, sideways 7 to 8, backward 9 to 10.

Cerebral palsy is a nonprogressive brain lesion with changing musculoskeletal effects. Spastic is most common; spastic diplegia follows periventricular leukomalacia in preterm infants. **GMFCS** I walks without limits; II walks with limits; III uses a hand held device; IV needs assistance or powered mobility; V is transported. Hip displacement risk rises with level. Strengthening does not increase spasticity. A posterior walker suits spastic diplegia.

Myelomeningocele: Chiari II and a VP shunt are common. Shunt malfunction (headache, vomiting, lethargy, irritability; in infants a bulging fontanelle and sunsetting eyes) is an emergency. Tethered cord brings progressive scoliosis, new weakness and bladder change. Use latex free equipment. **Down syndrome**: hypotonia, laxity, walking near 2 years, heart disease in about half, and **atlantoaxial instability**. **Torticollis**: head tilts toward and rotates away from the tight SCM; stretch the other way. **DDH**: Ortolani reduces, Barlow dislocates; Pavlik harness in flexion and abduction.

Part C: birth to 3, family centered IFSP in natural environments, reviewed every 6 months. **Part B**: 3 to 21, IEP, PT is a related service with educationally relevant goals in the least restrictive environment; reevaluate every 3 years; transition plan by 16. **Section 504**: accommodations without special education. Tests: AIMS (birth to walking), Peabody (to about 5), BOT (4 to 21), GMFM (change in CP), School Function Assessment (IEP goals).

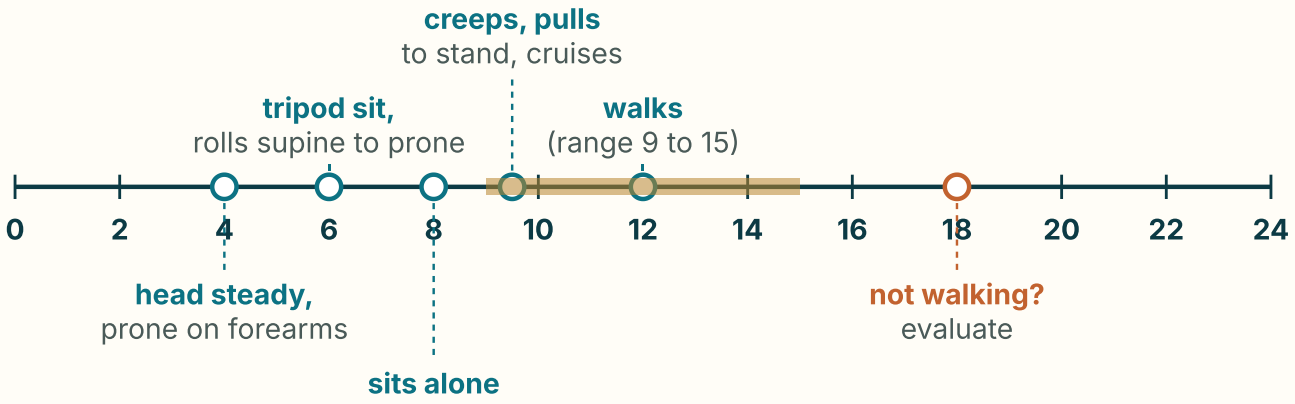
Aging lowers reserve but never causes sudden decline. Sarcopenia hits type II fibers and power; train at moderate to high intensity. **Polypharmacy** (five or more drugs) raises fall and delirium risk. **Delirium** is acute, fluctuating and inattentive, usually from infection, drugs or dehydration: a medical emergency. Dementia is insidious; depression gives "I don't know" answers. MoCA below 26 suggests impairment. Frailty is 3 or more of weight loss, exhaustion, weak grip, slow gait and low activity.

STEADI asks about falls, unsteadiness and worry. Cutoffs: **TUG 12 s or more** (13.5 in an older study), Berg 45 or below, gait speed below 1.0 m/s, unable to hold tandem stance 10 s. Balance plus strength exercise at least 3 hours a week (tai chi, Otago) prevents falls; add home modification and medication review. Osteoporosis: load bone, avoid loaded flexion and twisting.

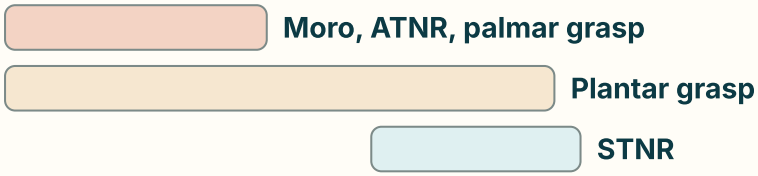
Pregnancy: 150 minutes a week of moderate exercise, talk test, no prolonged supine after about 20 weeks, stop for bleeding, fluid leakage, contractions, chest pain or calf swelling. **Diastasis recti** is tested with a head lift; more than about 2 finger widths is significant; teach transversus activation, splinting and log rolling. Stress incontinence gets pelvic floor training and the knack; urge gets bladder training; overflow gets referral. After prostatectomy, pelvic floor training speeds continence; during ADT, combined resistance and aerobic exercise counters bone and muscle loss; watch for bone metastases.

Integrated cases follow a fixed order: **life threats**, then **red flags and referral**, then **session safety and precautions**, then **functional goals**, then **impairments**. Match who you call to the setting: nurse and provider in the hospital, EMS in an outpatient clinic, the school nurse and parents in school. "Continue and monitor" is rarely right when a red flag is present.

Gross motor milestones, months of corrected age (drawn to scale)



Primitive reflexes usually integrated



Usual windows: Moro, ATNR and palmar grasp gone by about 4 to 6 months, plantar grasp by 9 to 12, STNR from 6 to 8 until 10 to 12. Persistence or asymmetry suggests CNS dysfunction.

Milestones and reflex windows on one timeline. Judge a preterm infant by corrected age. A milestone that is late, lost or one sided matters more than any single date.

LOCK THESE IN

- Sit about 6 to 8 months; walk about 12; evaluate if not walking by 18.
- Corrected age = chronological age minus weeks premature, until about 2 years.
- Most primitive reflexes gone by 4 to 6 months; plantar grasp lasts to 9 to 12.
- GMFCS I to V; spastic diplegia follows PVL.
- Shunt malfunction = emergency; Down syndrome = check C1 to C2.
- Torticollis: tilt toward, rotate away from the tight SCM.
- Part C: IFSP, natural environment. Part B: IEP, educationally relevant.
- Sudden confusion in an older adult = delirium until proven otherwise.

Milestones and reflexes

Item	Typical age
Head steady, prone on forearms	About 4 months
Rolls supine to prone, tripod sit	About 6 months
Sits independently	About 8 months
Creeps, pulls to stand, cruises	9 to 10 months
Walks independently	About 12 months (9 to 15)
Stairs reciprocal up; hops	3 years; 4 years
ATNR, Moro, palmar grasp	Integrate by about 4 to 6 months
Plantar grasp	Integrates by about 9 to 12 months

Aging and falls

Item	Rule
Polypharmacy	Five or more medications
Delirium	Acute, fluctuating, inattentive; treat the cause
MoCA; MMSE	< 26 of 30; < about 24 of 30
Frailty	3 or more of 5 Fried criteria
TUG	12 s or more (STEADI)
Berg	45 or below
Gait speed	< 1.0 m/s risk; about 1.2 m/s to cross a street
Exercise dose	Challenging balance plus strength, 3 or more hours a week

Worked cases

WORKED CASE 1 · CORRECTED AGE

A baby born at 28 weeks is 10 months old chronologically. She sits alone but does not pull to stand. Is she delayed?

STEP 1 · WEEKS EARLY

40 − 28 = 12 weeks, about 3 months.

STEP 2 · CORRECT

10 − 3 = **7 months corrected**.

STEP 3 · COMPARE

Sitting alone is expected by about 8 months; pulling to stand by 9 to 10. She is **on track for her corrected age**.

WORKED CASE 2 · WHICH WAY TO STRETCH?

A 6 week old holds his head tilted to the left and rotated to the right, with a firm mass in the left SCM.

STEP 1 · NAME THE TIGHT MUSCLE

Head tilts toward and rotates away from the tight SCM: **left** torticollis.

STEP 2 · REVERSE IT

Stretch into **right lateral flexion and left rotation**.

STEP 3 · ADD THE REST

Strengthen the right neck muscles, position to encourage turning left, supervised tummy time, parent education, and screen the hips.

WORKED CASE 3 · SHUNT MALFUNCTION AT SCHOOL

A 7 year old with lumbar myelomeningocele and a VP shunt has been sleepy, vomited twice this week, has headaches and is irritable today.

STEP 1 · READ THE PATTERN

Headache, vomiting, lethargy and behavior change in a child with a shunt.

STEP 2 · NAME IT

Possible shunt malfunction, which can cause rapid deterioration.

STEP 3 · ACT

No therapy today; notify the school nurse and parents for emergency evaluation.

NOT TETHERED CORD

Tethered cord usually brings progressive scoliosis, weakness and bladder change, not acute vomiting and lethargy.

WORKED CASE 4 · DELIRIUM ON TOP OF DEMENTIA

An 82 year old in a SNF with mild Alzheimer disease walked 150 feet yesterday. Today she is drowsy, inattentive and pulling at her clothes, and her urine is cloudy.

STEP 1 · TIMING

Overnight change: dementia does not worsen this fast.

STEP 2 · FEATURES

Fluctuating attention and altered alertness: delirium, likely from a UTI.

STEP 3 · ACT

Notify the nurse and provider, hold challenging gait training, keep her safe (supervised mobility, low bed, glasses and hearing aids, reorientation).

WORKED CASE 5 · THREE PROBLEMS, ONE FIRST

Two days after posterior THA, a 68 year old with diabetes, heart failure and mild dementia has HR 112, SpO_2 89% (baseline 95%) and new pleuritic chest pain before gait training.

STEP 1 · RANK

Life threat first: tachycardia, new hypoxemia and pleuritic pain after hip surgery suggest PE.

STEP 2 · ACT

Do not mobilize; keep him at rest, notify the nurse and provider at once, call the rapid response team if he worsens.

LATER

Hip precautions and glucose checks matter, but they come after the threat to life.

TRAPS PEOPLE FALL INTO

- **Using chronological age for a preterm infant.** Correct for prematurity until about 2 years.
- **Stretching a torticollis toward the tilt.** Tilt away and rotate toward the tight side.
- **Calling a sick child with a shunt "viral."** Headache, vomiting and lethargy mean possible shunt failure.
- **Moving early intervention to the clinic.** Part C services belong in natural environments.
- **Calling overnight confusion dementia progression.** It is delirium until proven otherwise.

- **Pelvic floor exercises for leaking fluid in pregnancy.** Amniotic fluid leakage means stop and call the obstetric provider.

Chapter 14 self-test · ten items

1. A 15 month old born at term is not yet walking but pulls to stand and cruises. What is the best interpretation?

A. A sign of cerebral palsy in most cases
B. Typical only for a premature infant
C. Within the normal range; recheck later
D. Clearly delayed; refer for evaluation now

C. Within the normal range; recheck later Independent walking ranges from about 9 to 15 months; evaluate if not walking by 18 months.

2. A 9 month old still shows an obligatory ATNR. What does this suggest?

A. Normal development at this age
B. A peripheral nerve injury
C. Typical hypotonia of Down syndrome
D. Possible CNS dysfunction

D. Possible CNS dysfunction ATNR usually integrates by about 4 to 6 months; an obligatory, persistent response suggests CNS dysfunction.

3. A 9 year old with CP walks with a hand held device indoors and uses a wheelchair for longer distances. What is the GMFCS level?

A. Level I
B. Level III
C. Level IV
D. Level II

B. Level III Level III walks with a hand held mobility device indoors and uses wheeled mobility for longer distances.

4. A teen with Down syndrome reports new neck pain, clumsiness and brisk reflexes. What is the action?

A. Immediate medical referral
B. Wait two weeks and reassess
C. Cervical stretching to ease the pain
D. Strengthening of the neck flexors

A. Immediate medical referral These suggest atlantoaxial instability with cord compression.

5. A student with juvenile arthritis does well academically but needs an elevator pass and extra time between classes. Which plan fits?

A. No plan; it is not required
B. An IFSP under Part C
C. An IEP under Part B
D. A Section 504 plan

D. A Section 504 plan Section 504 gives accommodations to students who do not need special education.

6. Which test best measures change in gross motor function in a child with CP?

A. Apgar
B. GMFM
C. TIMP
D. AIMS

B. GMFM The GMFM is a criterion referenced, evaluative test designed for children with CP.

7. An 80 year old becomes acutely confused overnight with fluctuating attention. What is most likely?

A. Normal aging
B. Depression
C. Delirium
D. Dementia

C. Delirium Acute onset, fluctuation and inattention define delirium, a medical emergency.

8. Which result most suggests fall risk under STEADI?

A. TUG of 14 seconds
B. Holds tandem stance 15 s
C. Berg score of 52
D. Gait speed 1.3 m/s

A. TUG of 14 seconds A TUG of 12 seconds or more signals risk. The other results are reassuring.

9. During a head lift a postpartum woman has a 3 finger width gap at the umbilicus. What is first line?

A. No abdominal exercise for 6 months
B. Heavy lifting to load the core
C. Full sit ups to close the gap fast
D. Transversus activation and splinting

D. Transversus activation and splinting A gap over about 2 finger widths is significant; teach transversus activation with exhalation, splinting and log rolling.

10. Six weeks after radical prostatectomy, a man leaks with coughing. What is first line care?

A. Pelvic floor muscle training
B. Avoiding all resistance exercise
C. Referral for catheterization
D. Bladder training with urge suppression

A. Pelvic floor muscle training Post prostatectomy leakage is stress incontinence; pelvic floor training speeds return of continence.

ONE PAGE

Cram sheet

One page for Study Guide 7. Cover the right column and say the answer before you look.

Safety, law and evidence

Topic	Rule
Precautions	Contact gown and gloves; droplet mask; airborne N95
PPE	On: gown, mask, eyewear, gloves. Off: gloves first
CPR	100 to 120/min, at least 2 in, 30:2
Roles	PT evaluates and discharges; PTA treats within plan
Medicare	Recert 90 days; progress report 10 visits
8 minute rule	8 to 22 = 1; 23 to 37 = 2; 38 to 52 = 3
Abuse	Reasonable suspicion; personal duty
Access	Ramp 1:12; door 32 in; turn 60 in
Diagnosis	SnNout; SpPin; LR+ > 10 or LR− < 0.1 strong
Change	Exceed MDC; reach MCID; NNT = 1/ARR

Lifespan

Topic	Rule
Milestones	Head 4 mo; sit 6 to 8; creep 9 to 10; walk 12; refer by 18
Reflexes	Most integrate 4 to 6 mo; plantar grasp 9 to 12
CP	GMFCS I to V; diplegia from PVL
Spina bifida	Shunt failure emergency; tethered cord; latex
Torticollis	Tilt toward, rotate away; stretch opposite
IDEA	Part C IFSP birth to 3; Part B IEP 3 to 21
Cognition	Delirium acute; dementia insidious
Falls	TUG ≥ 12 s; Berg ≤ 45; speed < 1.0 m/s
Pregnancy	150 min/week; no prolonged supine; stop signs
Priority	Life threat, red flag, safety, function, impairment

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