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HEALTH RECORDS AND INFORMATION TECHNOLOGY LEVEL 5
HE/OS/HR/CR/08/5/A
Manage Health Records
July/Aug 2023

TVET CURRICULUM DEVELOPMENT, ASSESSMENT AND CERTIFICATION COUNCIL (TVET CDACC)

WRITTEN ASSESSMENT

Time: 3 hours

INSTRUCTIONS TO CANDIDATES

1. This paper has three sections **A**, **B** and **C.**
2. You are provided with a separate answer booklet.
3. Marks for each question are as indicated.
4. Do not write on the question paper.

This paper consists of 8 printed pages
Candidates should check the question paper to ascertain that all pages are printed as indicated and that no questions are missing

SECTION A: (20 Marks)

*Answer **all** questions in this section.*

Each question carries one Mark.

1. Which is the correct Hippocratic oath statement pledged by health records technicians;

   A. Whatsoever in my practice or not in my practice, I shall see or hear amid the lives of men which ought not to be noised abroad as to this I shall speak it out to others, not holding such things unfitted to be spoken.
   B. Whatsoever in my practice or not in my practice, I shall see or hear amid the lives of men which ought not to be noised abroad as to this I shall keep silence, holding such things unfitted to be spoken.
   C. Whatsoever in my practice or not in my practice, I shall see or hear amid the lives of men which ought to be noised abroad as to this I shall speak, not holding such things unfitted to be spoken.
   D. Whatsoever in my practice or not in my practice, I shall see or hear amid the lives of men which ought to be noised abroad as to this I shall only speak it to the patient family members, not holding such things important information without informing them.
2. Which of the following is an example of a primary purpose of the medical record?
   A. Education
   B. Policy making
   C. Research
   D. Patient care management
3. During the communication in the hospital concerning medical records, it is important to maintain one of the following.
   A. Integrity
   B. Anger
   C. Rudeness
   D. Happy

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4. In which year was the department of health records started in Kenyatta National Hospital in Nairobi;
   A. In 1967
   B. In 1948
   C. In 1990
   D. In 1995
5. The act of ensuring that medical records are maintained in order in the patient file is known as?
   A. Editing
   B. Auditing
   C. Coding
   D. Scheduling
6. The system of medical records management where the patient is only allowed one registration number is the called.
   A. Serial system
   B. Terminal digit
   C. Unit record system
   D. Serial unit system
7. Which one of the following is not a way of conveying information to the waiting list?
   A. Card created for every patient.
   B. Appointment system
   C. Nurse or doctor sending list of patients
   D. Letter from a consultant.
8. When is the appropriate time to develop a file if the patient is required to be admitted?
   A. During discharge
   B. Any time it is required
   C. When patient has been admitted
   D. During admission

9. Which of the following pairs consist of the two main types of medical record files classification?
   A. Individual and community
   B. Active and inactive
   C. Government and private
   D. Acute and chronic
10. What is Registration?
    A. Registration is the documentation of bio data of individual patients/client needed for his/her attendance in the hospital.
    B. Registration is the process of taking a patient to the ward for in-patient care and management
    C. Registration is the procedure given to the patient indicating the venue, date and time of clinic.
    D. Registration is the procedure which either manual or electronic used to arrange the documents in a prescribed order or in systematic manner.
11. Which one of the following is least considered during the storage of medical records?
    A. Accessibility
    B. Timeliness
    C. Security
    D. Aesthetic value
12. When records are disclosed to another medical agency for purpose of continued treatment is. classified as
    A. Expressed consent
    B. Implied Consent
    C. Advance Directive
    D. Acknowledgement
13. A standard time frame for disposing an Outpatient medical record is?
    A. 5 years
    B. 7 years
    C. 10 years
    D. 30 years

14. The first and essential criteria to be considered when using a Master Index will be?
    A. The money available
    B. Fast access and clarity of facts
    C. Frequency of access to the index
    D. Quantity of records involved
15. Which one of the following is one of the duty and responsibility of health records and information technician?
    A. Provide first aid services to a patient
    B. Provide injection to a patient
    C. Provide drug prescription to a patient
    D. Provide surgical services to a patient
16. The movement of a medical patient file is monitored by which of the following?
    A. Tracer card
    B. Master index
    C. Computers
    D. Storage
17. The medical records filing area must remain with the following conditions. (1mark)
    A. Enough light and ventilation
    B. Full computers
    C. Inappropriate humidity
    D. Dust –free and wet
18. One of the ways in which patients' documents are protected is by not disclosing their information to anybody unless you are granted permission by.
    A. The owner
    B. Next of kin
    C. Guardian
    D. Doctor

19. Which of the following best describes how to store a file in medical health records?
    A. As per person
    B. According to the standard procedures
    C. As per instructions of the government
    D. As per hospital requirements
20. One limitation of centralized waiting list is that;
    A. It does not give a fair presentation of all demands being made on the inpatient facilities
    B. All enquires are referred into one place
    C. Staff dealing with the waiting list develops skills in dealing with the enquiries, and in the maintenance of the waiting list.
    D. List becomes so big that some patients may be left out of the waiting list.

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SECTION B: (40 MARKS)

*Answer **all** questions in this section.*

21. Identify THREE equipment used to store health records (3 Marks)

22. State FOUR factors to consider when selecting the health case folder (4 Marks)

23. Outline FOUR basic principles of medical form design that a health record technician should have in mind before designing a form (4 Marks)

24. Give FOUR health records indices used and maintained in a health records department (4 Marks)

25. State FOUR details that must appear on patient master index card (4 Marks)

26. Outline the FOUR main stages of medical records? (4 Marks)

27. State THREE legal aspects in maintaining Medical Health Records (3 Marks)

28. State THREE filing techniques used in filing master index cards (3 Marks)

29. State THREE equipment used to maintain the diagnostic index (3 Marks)

30. Give FOUR information that should be in included in the accident and emergency register (4 Marks)

31. State any FOUR functions of health records (4 Marks)

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SECTION C: (40 Marks)

*Answer any **two** questions in this section*

32. The health records Department is mandated to manage certain special Health Records,

    a) Briefly explain SEVEN of these special Records. (14 Marks)

    b) Explain THREE ways of ensuring security of these special health records. (6 Marks)

33. A health record is a confidential compilation of pertinent facts of an individual's health history, including all past and present medical conditions

    a) Explain THREE types of health records (6 Marks)

    b) Discuss SEVEN purposes of health records in the health sector (14 Marks)

34. Records management department falls under the directorate of health administration. Discuss TEN functions of health records department (20 Marks)

THE END