Essential Elements of Documentation

1. What is one of the most common complaints about written documentation?

   a. Illegible or messy handwriting
   b. Recording on incorrect record
   c. No signature
   d. Failing to record nursing actions

2. When your client notes are completed, you should print your signature.

   True False

3. Which of the following would the legal system view as care "not done"?

   a. Failing to record pertinent health or medication information
   b. Failing to record nursing actions
   c. Failing to record medications given
   d. Failing to document discontinued medication or treatment

4. A chart or client record that has documentation of another client's care raises suspicion in the legal system.

   True False

5. Which of the following happens frequently and may not be discovered until the next shift?

   a. Failing to record nursing actions
   b. Failing to record mediation given
   c. Failing to document discontinued medication or treatment
   d. Recording on the incorrect health record

6. Only significant or major reactions to medications should be recorded.

   True False

7. You should only record the significant details of changes in a client's condition and avoid excessive wordiness.

   True False

8. Which of the following is most likely to require special precautions and extra attention to detail?

   a. Telephone orders
   b. Medication reactions
   c. Discontinued medication or treatment
   d. Medication administration

9. If pages or specific forms of a client record are missing, this raises suspicion in the legal system and may be evidence of poor care.

   True False

10. Which of the following is most likely to create an undesirable impression of the person doing the client documentation?

    a. Messy handwriting
    b. Inappropriate abbreviations
    c. Misspelled words and poor grammar
    d. Fancy signatures

11. Which of the following strategies are helpful in improving your spelling and grammar?

    a. Medical dictionary at the charting desk
    b. Posted list of commonly misspelled words
    c. Checking context when using spell check

12. What is the best approach to use when you are unsure of the correct abbreviation?

    a. Spell out the word
    b. Check with a colleague
    c. Check your facility policies
    d. Google it

13. Which of the following abbreviations may contribute to unsafe client outcomes?

    a. FOF
    b. FOB
    c. D/C
    d. LOC

14. Nearly all documentation systems use the nursing process as a guide for recording client details.

    True False

15. In which step of the nursing process would you NOT normally chart or document?

    a. Assessment
    b. Nursing diagnosis
    c. Planning
    d. Implementation
    e. Evaluation / outcomes

16. During which step of the nursing process would you record direct quotes from the client and/or his family?

    a. Assessment
    b. Nursing diagnosis
    c. Planning
    d. Implementation

17. When doing a client assessment, it is prudent to document your professional opinions as this will assist other healthcare team members provide better care.

    True False

18. One area that is often excluded from assessment details is that of not recording:

    a. Current medications
    b. Vital signs
    c. Health history
    d. Emotional status

19. At what step of the nursing process does the care provider document the client's health problems?

    a. Assessment
    b. Nursing diagnosis
    c. Planning
    d. Implementation
    e. Evaluation / outcomes

20. Nursing diagnosis is very similar to medical diagnosis.

    True False

21. Nursing diagnosis is always easy to document.

    True False

22. In which step of the nursing process do you document all that you did for the client?

    a. Assessment
    b. Nursing diagnosis
    c. Planning
    d. Implementation
    e. Evaluation / outcomes

23. In the evaluation / outcomes step of the nursing process you document the client's response to your interventions including any unexpected responses.

    True False

24. You should use the term "writer" while documenting or charting in progress notes.

    True False

25. If you are unable to chart immediately, what is the best thing to do?

    a. Ask a colleague to chart for you
    b. Try and remember the important details
    c. Keep pocket notes
    d. Don't worry if you forget some minor details

26. If you make a mistake in the progress notes, use whiteout or erase the error, and make the appropriate changes.

    True False

27. You should do your documentation in pencil since it is easier to correct any errors.

    True False

28. You should NEVER document in slang.

    True False

29. Statements such as "he's not all there" or "she's not sure what is going on" are appropriate ways to document the client's cognitive status.

    True False

30. Why should you NOT leave blank spaces in your notes or entries?

    a. It makes notes look neater
    b. It saves paper
    c. It makes information more organized
    d. Prevents additional information being added

31. You should document in chronological order promptly.

    True False

32. When documenting a late entry, you must give the reason why it is a late entry.

    True False

33. You should leave a blank space before and after your name and designation so it is easier to see who did the documenting.

    True False

34. When reporting a change in a client's condition in the progress notes to a supervisor or physician, which of the following is inappropriate?

    a. Identify the individual by name and designation
    b. Describe negative actions of the person you reported to
    c. State what follow up was expected
    d. Identify any new orders or no orders

35. You can release client information to the family or legal guardian anytime.

    True False

36. Clients who are competent have the right to change their agent identified on the personal directives at any time.

    True False

37. If you are using pre-printed client or hospital forms, what should you do with blank areas that do not apply to your client?

    a. Write "not applicable" or "N/A"
    b. Leave them blank
    c. Draw a big X through the area
    d. Make up some credible information

    True False

38. If a client consistently refuses a medication, it is sufficient to record this in the progress notes.

    True False

39. Which of the following senses are you least likely to use when gathering objective assessment data?

    a. Sight
    b. Hearing
    c. Smell
    d. Touch
    e. Taste

40. Subjective data is the information obtained from "what the client said" and/or "what others said about the client".

    True False

41. In the case of an adverse event, it is important that you document what you think happened.

    True False

42. When documenting the orientation status of a client, which of the following is inappropriate?

    a. Awake and aware of surroundings
    b. Oriented to time, person and place
    c. "I'm Joe Smith and in the hospital"
    d. Alert

43. When describing pain, which of the following types of terms should you use?

    a. Mild
    b. Moderate
    c. Intense
    d. 5 out of 10 on the pain scale

44. When documenting food intake at meal time, use the standard terms of "fair, good or poor."

    True False

45. When describing wounds or lacerations, and if you don't have a ruler, use your thumb nail width as the unit of measurement.

    True False

46. Which of the following is the descriptive phrase is inaccurate?

    a. Awake and resting in bed
    b. No complaints of pain
    c. Tolerated procedure well
    d. Awake, resting with no complaints of pain

47. "Client condition satisfactory" should NOT be used as there is no indication that an assessment was done.

    True False

48. If you are busy caring for clients and are having difficulty finding time to document, you should get a friend to chart your care, or you can record ahead of time.

    True False

49. If you find that the above or preceding entry in the progress notes was not signed, what should you do?

a. Locate the provider to get their signature
b. Leave it as it will get picked up next shift
c. Report it to your supervisor
d. Fill out an incident report

50. It is important that you document relevant complaints from staff, poor care and accusations in the client's record.

True False

51. Which type of signature means that you witnessed or participated in the care or event and are legally responsible for the entries or documentation?

a. Co-signing
b. Countersigning
c. Cursive signing
d. Endorsement signing

52. Which type of signature means that you reviewed the entry and approved the care or orders given?

a. Co-signing
b. Countersigning
c. Cursive signing
d. Endorsement signing

53. In your client documentation, you generally do not use names of roommates or visitors, as this is a breach of their confidentiality.

True False

54. Most documentation systems share the nursing process as a framework.

True False

55. The majority of documentation frameworks are those of:

a. Charting by exception (CBE)
b. Inclusion
c. Exclusion
d. Narrative

56. Which type of documentation system records only unusual findings or exceptions to normal findings?

    a. Charting by exception (CBE)
    b. Inclusion
    c. Block charting
    d. Narrative

57. Which of the following documentation methods opens up legal issues?

    a. Problem-Oriented Medical Record
    b. Focus Charting
    c. Block Charting
    d. Problem/Intervention/Evaluation

58. What are the major disadvantages of the narrative documentation?

    a. Wordiness
    b. Time consuming
    c. Inflexible to client situations
    d. Difficult to record in chronological order

59. Adverse events are unexpected events that have increased potential or risk to cause client harm or injury.

    True False

60. A minor client or visitor fall does not have to be documented.

    True False

61. Equipment failures should not be documented on a client's record.

    True False

62. Only medication errors that require intervention must be reported.

    True False

63. If you suspect that a client's injuries are from criminal activity or abuse, you must document very carefully.

    True False

Answer Key to Module 3 Quiz

Q01	a	It is preferable to print your client notes if you have poor handwriting. Ask your colleagues if they can read your writing.
Q02	False	Signature should be in a written format and not printed. A cursive signature is more difficult to reproduce or falsify than a printed signature.
Q03	b	The legal system views undocumented care as "not done".
Q04	True	The competency of the caregiver who has documented on the incorrect client record is then in question.
Q05	d	In the meantime, a client could receive incorrect or no care.
Q06	False	All reactions, no matter how minor, should be documented. If a client has a serious allergic reaction to a medication, and it is given again, this could cause serious injury or even death.
Q07	False	You must provide all the necessary information. Missing details have often been cited in lawsuits and this may reflect on inadequate or incorrect care.
Q08	a	Transcribing orders incorrectly or transcribing inaccurate orders are problematic. Numbers and dosages must be repeated back to the health professional issuing client orders. This repetition may need to be done more than once in the interests of client safety.
Q09	True	Removing pages from a client's record is an illegal activity.
Q10	c	Others who read documentation with misspelled words and poor grammar may think or believe that the care provider who wrote the notes was uneducated or careless.
Q11	a,b,c	All of these are good suggestions. You should strive for consistent and appropriate writing tense and express facts in an unbiased manner.
Q12	a	It is best practice to spell out the word when you are in doubt! This is especially essential if you receive physician orders over the telephone.
Q13	a,b,c,d	None of these should be used: FOF (found on floor); FOB (fell out of bed); D/C (discharged or discontinued); and LOC (loss of consciousness or level of consciousness)
Q14	True	If you are working in a setting where there is no formal system of documentation, you can always depend on the nursing process as a way to guide your thinking to complete the client documentation.
Q15	c	You normally would not chart or document during the planning step, but you could make brief paper notes.
Q16	a	When doing assessment, it is useful to use direct quotes as this minimizes your opinions of the client.
Q17	False	You should omit opinions, even if you are correct in your assumptions.
Q18	d	Caregivers typically do not include an adequate assessment of emotional status of clients and thus care providers do not document the emotional support they provided.

Q19	b	The client's health problems relate to the standard of care required for each problem and is documented in the nursing care plan.
Q20	False	Nursing diagnosis is about client's health problems that are documented in the care plan. Medical diagnosis is done by the physician and states what the medical problems are.
Q21	False	It may get burdensome if a client has numerous health issues and several corresponding interventions for each health problem on the care plan.
Q22	d	It is important to document ALL the details of care because in the legal system, undocumented care means that it was not done!
Q23	True	When documenting outcomes, this proves that you followed up a concern and demonstrates how the client responded to your intervention.
Q24	False	It is NOT appropriate to use "writer". This is because the care provider signs the notes and is obviously the writer. In the legal process, lawyers may question who this "mystery writer" is.
Q25	c	Keeping notes is the best approach. HOWEVER, these notes must be destroyed at the end of every shift so there is no breach of client confidentiality. Also if notes are saved, they could be demanded in court.
Q26	False	You should NEVER do this! Check your facility's policies regarding the right way to correct entries.
Q27	False	Write neatly, legibly and in ink. Some employers prefer a dark blue pen as it is easier to differentiate the original record from a photocopy.
Q28	False	You may document in slang when it is a direct quote by a client. Remember to place quotation marks around direct quotes.
Q29	False	These are not acceptable as they are slang and unkind expressions, although you may be correct that the client has memory issues.
Q30	d	Blank spaces may be used to alter or add in data at a much later date. This will be viewed with suspicion by the legal system.
Q31	True	This makes it easier for another care provider to know what events happened in order of occurrence.
Q32	True	
Q33	False	Never leave blank spaces as it allows for the alteration or addition of data after the actual recording.
Q34	b	Document only the facts. If you are not getting an appropriate response, activate the chain of command or fill out a professional responsibility form.
Q35	False	You must take care that you have the client's permission to release information and any other details such as the name of the individual regarding the release of his information.
Q36	True	
Q37	a	Do not leave these areas blank, as this may be concluded that you have not read through the form entirely or forgot to cover this section of the form.
Q38	False	You should also record the reason why (if known) and what you did about the situation.

Q39	e	
Q40	True	To make subjective data more accurate, use direct quotes of clients and their families.
Q41	False	You only document the objective data and the specific facts surrounding the event, and not what you think happened.
Q42	d	"Alert" is an opinion that does not accurately tell the reader how you know the client is alert.
Q43	d	Use your facility's pain scale or a scale of one to ten, with one being very mild and ten being very severe pain. Document that you asked the client about his pain level and record his response.
Q44	False	It is best to use percentages that describe the amount of food consumed.
Q45	False	You should use actual metric measurements, and correct medical terminology to describe any drainage from the wound.
Q46	c	"Tolerated procedure well" is a meaningless statement as it does not give any indication that a client assessment was done.
Q47	True	This is one of those meaningless statements.
Q48	False	Document ONLY the care you provide and NEVER ahead of time.
Q49	a	If you can't find the care provider, there should be a clear difference in handwriting and the pen used when you begin your charting.
Q50	False	Keep your documentation strictly client focused.
Q51	a	Co-signing makes you legally responsible for entries or documentation you co-sign.
Q52	b	An example of countersigning would be signing your name and designation after reviewing and checking a physician's medical orders. Countersigning means you are signing for authentication.
Q53	True	
Q54	True	
Q55	b	Most documentation systems are inclusive, i.e., data is recorded that describes both expected and unexpected outcomes.
Q56	a	Since the CBE system has much subjectivity, there must be clear guidelines for what the "norm" or "normal" are. Abnormal findings must be explained in further detail in the client notes.
Q57	c	Block Charting is a documentation method that is done within a given time frame or shift. It is not recommended as it opens up legal issues, mainly because important assessment data is not captured at regular intervals. This makes it unclear if the client was monitored and when the client's condition changed.
Q58	a,b	The major disadvantages of narrative documentation are wordiness and it is time consuming.
Q59	True	That is why documenting adverse events requires dutiful care and attention.

Q60 False Injuries from falls may not be evident for several hours or days. Falls are a common source of lawsuits.

Q61 True Equipment failures should be documented on a special form or incident report.

Q62 False ALL medication errors must be reported; those that require intervention must be documented precisely.

Q63 True ALL medication errors must be reported; those that require intervention must be documented precisely.