Legal Issues in Documentation

1. From a legal standpoint, failure to document client care means which of the following?

   a. The care provider made errors
   b. Care provider forgot to document
   c. Care was completed according to plan
   d. Care was not completed according to plan

2. The facility or agency owns the client's health record; however the client owns the information in it.

   True False

3. Why is it important to know and follow employer documentation policies and procedures?

   a. To protect you in case of a lawsuit
   b. You have been trained to do this
   c. This is an expectation of the client
   d. This is an expectation of colleagues

4. Lawyers may NOT request records of a care provider's work history and education credentials.

   True False

5. Which of the following describes a breach in a standard of care?

   a. A care standard was met
   b. A care standard was not met
   c. A care standard was changed
   d. A care standard is for protection of the client

6. A care provider's continuing education activities may be examined to see if he or she has kept current as per employing agency or facility policies and procedures.

   True False

7. Late entries of documentation done after the death or serious injury of a client are often viewed as which of the following?

   a. Guilt
   b. Suspicion
   c. Factual
   d. Pride

8. A plaintiff is the individual who is being accused of wrong doing or incompetent care.

   True False

9. Defendants are generally described as:

   a. Care providers, physician, and/or facility
   b. Care providers and facility
   c. Physician and facility
   d. Care providers and physician

10. Lawyers for the plaintiff are attempting to prove that the standard of care was breached and that these breaches caused the injuries or death.

    True False

11. Which of the following is examined to reconstruct client events by the legal team?

    a. Lab reports
    b. Physician orders
    c. Progress notes
    d. Personal directive

12. Defendants in a lawsuit are typically the main care provider involved.

    True False

13. A plaintiff's action is described as which of the following?

    a. Disputes a lawsuit
    b. Initiates a lawsuit
    c. Defends a lawsuit
    d. Records the lawsuit

14. From a legal standing, the client's record becomes the evidence if a lawsuit is initiated.

    True False

15. Which of the following is true regarding a client's health record?

    a. It must be hand written and signed off
    b. It contains care provider interventions
    c. It is a medical and legal document
    d. It always follows the nursing process

16. Personal notes, sticky notes or a journal of a serious client issue that have been kept privately by care providers may NOT be demanded by the legal system.

    True False

17. In Canada, lawsuits are generally initiated within _____ of an adverse event, except in the case of a child or minor.

    a. One year
    b. Two years
    c. Three years
    d. Four years
    e. Five years

18. The defendant's lawyer tries to prove that the actions of the care provider are prudent, reasonable and that there is no causal link between the actions of the care provider and the client's injury or death.

    True False

19. It is generally NOT in your best interests to keep which of the following as they may be demanded in a lawsuit.

    a. Personal practice statements
    b. Private notes on client care
    c. Incident reports
    d. Inadequate progress reports

20. Judges and juries are qualified to determine if the standard of care was met or not.

    True False

21. During oral discovery, which party may bring in unbiased care experts to scrutinize the documentation?

    a. Lawyers for plaintiff
    b. Lawyers for defendants
    c. Both plaintiff and defendant lawyers
    d. The judge and jury

22. In the Oral Discovery phase, lawyers will examine all relevant documents and will decide which ones are significant to use in the case.

    True False

23. Which of the following is a major documentation problem area according to lawyers?

    a. Recording only your own actions
    b. Recording long after the event
    c. Recording in chronological order
    d. Recording concisely, factually and clearly

24. Very few lawsuits go to trial.

    True False

25. Which of the following is a major documentation problem area according to lawyers?

    a. Following realistic agency policies
    b. Recording correctly and clearly
    c. Recording accurately and completely
    d. Recording infrequently

26. In a legal sense, electronic client documents that require review have advantages over paper systems.

    True False

27. Which of the following should NOT be included in the client record?

    a. What happened
    b. To whom it happened
    c. When it happened
    d. Result of what happened
    e. Who was at fault

28. Staff who have inadequate keyboarding skills may do less electronic documentation.

    True False

29. Which of the following documents may be requested in lawsuit?

    a. Medication records
    b. Work schedules
    c. Shift trades
    d. Care provider credentials

30. When correcting errors on a chart or incident report, clearly indicate that the change made was due to an "error" or "mistake".

    True False

Answer Key to Module 4 Quiz

Q01	d	Care that has not been documented means that the care did not occur according to the legal system.
Q02	True	
Q03	a	Policies and procedures protect the employer, the client and the care provider.
Q04	False	They have the authority to request ALL related records.
Q05	b	A breach means that the standard was missed or the care provider did not meet the expectations of the standard. A breach in the standard of care may result in harm or injury to a client.
Q06	True	
Q07	b	Late entries after a serious injury or death are often viewed suspicious, as they may be an attempt to cover up wrong doing.
Q08	False	The plaintiff is the person claiming injuries or damages; the defendant is accused of wrong doing.
Q09	a	Defendants are anyone or an agency or facility that is being sued and have been connected to the client's care that resulted in potential or actual injury to the client.
Q10	True	
Q11	c	Although all parts of a client's chart are studied, the documentation found in the progress notes is the main source of information to reconstruct client events.
Q12	False	Defendants could be a physician, facility or agency and the person or persons accused of wrongdoing.
Q13	b	A plaintiff may be an individual or a family who initiates a lawsuit and claims injury or damages caused by improper and unsafe client care.
Q14	True	Many other documents may be requested and reviewed.
Q15	c	A client's health record whether paper based or electronic is both a legal and medical document.
Q16	False	That is why it is a good idea either not to keep these, or destroy them daily.
Q17	b	
Q18	True	
Q19	b	If you keep personal notes that are laden with opinions and accusations, be prepared to share these with both legal teams. It should be you usual practice to shred draft client notes each day.
Q20	False	This is why unbiased care experts are often called in to scrutinize the documentation and offer their opinions.
Q21	c	
Q22	False	This is done during the Disclosure phase, not oral discovery where defendants are examined or questions by the plaintiff's lawyer.
Q23	b	Long delays in documentation create negative impressions of the care provider.

Q24	True	Most are resolved via a pre-court settlement.
Q25	d	Frequent documentation prevents charges that nothing was done or inadequate care was provided.
Q26	False	Electronic records have more challenges as chronologies are more difficult to construct and may have, numerous blank areas and limited narrative notes.
Q27	e	
Q28	True	Legally, this may give the impression that the client was not monitored routinely.
Q29	a,b,c,d	All of these may be requested by lawyers.
Q30	False	Never use the terms “mistake” or “error” as these words can be used to determine that something you did or did not do was your fault. Write about facts only, be objective and do not write accusations or blame.