

Applying Documentation Principles

1. Narrative documentation of client care events will be done where in the client's record?
 - a. Physician's orders
 - b. Personal directive
 - c. Progress notes
 - d. Social worker's form

2. You should not duplicate in the progress or client notes what is already on the admission form.

True False

3. Which of the following is a primary reason why a care provider contacts the client's physician and documents this communication?
 - a. Supportive role
 - b. Social networking
 - c. Determinants of health
 - d. Change in a client's condition

4. You should include notes on the admission form about the emotional status of the client.

True False

5. When moving clients within a facility, only the receiving unit needs to document the transfer.

True False

6. Which of the following is best practice of documentation when notifying a physician or care practitioner of a change in a client's condition?
 - a. Time, method of communication, name of physician, new orders received
 - b. Date, time, name of physician, method of communication, reason for call, orders received
 - c. If the client is not sleeping and eating well
 - d. The client's mobility status and blood pressure have changed

7. If more than one care provider is involved in a client admission, only the last person taking the information has to sign the admission form.

True False

8. "Physician notified of client's deteriorating condition". This documentation statement is:

- a. Vague and ambiguous
- b. Factual and to the point
- c. Tells that the physician that the client is in really poor health and requires help immediately
- d. Supportive of the client's care

9. If a client is unable to answer your questions during admission, just record the assessment data and vital signs.

True False

10. After contact with a client's physician, why is it best practice to write in the progress notes there were "new orders received" or "no new orders"?

- a. This is a procedure and policy of employers
- b. This is an unwritten responsibility for care providers
- c. Alerts other care providers to changes in client care
- d. It makes the client or progress notes more accurate

11. A care provider should always complete vital signs when receiving a client into care.

True False

12. When documenting in a client's chart, "No response from client's physician." This statement is:

- a. Unprofessional and slanderous
- b. One way to document a lack of timely response
- c. Factual when a physician does not reply in a timely manner
- d. True and right for a client's record

13. Client consent for a treatment or procedure must always be in writing.

True False

14. Messages to report lab or test results by telephone to a physician are:
- a. Not recommended
 - b. Documented with the name and position of the care provider who received the message
 - c. Use facts only when leaving a message with someone other than the physician
 - d. A very outdated way to handle important health communications
15. The client alone can grant consent for a treatment or procedure.
- True False
16. One of the most common areas for lawsuits involves the incorrect use of medications.
- True False
17. If medication is being withheld, you need to document the reasons and who was notified.
- True False
18. After applying Health Information Act (HIA) confidentiality principles, which of the following would be documented for an incoming telephone call inquiring of a client's medical condition?
- a. Name of caller and why he is calling
 - b. Name of caller, why he is calling, what you reported to the caller
 - c. Name of caller and that you recommended the caller telephone the client's physician
 - d. Name of caller, why he is calling, what you reported, caller's response
19. Although a consent form is used for more major treatments, documentation regarding the consent discussion is highly recommended.
- True False
20. VTO means which of the following?
- a. Voluntary telephone order
 - b. Vicarious telephone order
 - c. Verified telephone order
 - d. Verbalized telephone order
21. Consent forms should use only approved abbreviations.
- True False

22. On admission, a client may be too ill to respond to your questions. Who of the following could best release client information so you could complete the admission procedure and documentation?
- a. Ambulance driver
 - b. Neighbour
 - c. Personal directive agent
 - d. Designated family
23. Witnessing the signing of the consent form is evidence that client consented to the treatment or procedure.
- True False
24. Why should assessment and vital signs be completed when you first receive a client into your care?
- a. This is part of your routine
 - b. The previous care provider may have failed to do so
 - c. So the family knows you are well qualified
 - d. So your colleagues know you are a thorough care provider
25. If a client withdraws consent, the risks must be documented in the client's health record.
- True False
26. Client assessment data that is frequently omitted but carries huge implications in the legal system is:
- a. Pain and emotional status
 - b. Pain status
 - c. Vital signs and O₂ sats
 - d. Emotional status
27. If the client withdraws consent, it is important to document the reasons for refusal.
- True False
28. When a medication error occurs, an incident report should be filed; a note mentioning the filing of the incident report should be included in the client record.
- True False

29. Discharge from care services begins when which of the following occurs?
- Client believes he is no longer being helped
 - Care provider states there is no benefit to the client
 - Physician issues an order for discharge
 - The client expires
30. When notifying a physician of a change in client's condition, it is not necessary to document if no new orders were provided.
- True False
31. Besides the date and time, client notes on discharge should include which of the following?
- Appointments, teaching, location to, mode, who accompanies, final assessment
 - Location to, mode, who accompanies
 - Appointments and teaching, location to, mode, who accompanies
 - If the client really agrees with the discharge order and wants to stay longer
32. If you have reason to believe the physician is not responding appropriately to your concern, then it may be necessary to activate chain of command and complete an incident report or a professional responsibility form.
- True False
33. What should a care provider document when a client is discharging himself from care?
- That the client is making a huge mistake
 - Discussion of discharge instructions and teaching
 - That the client is entering a self-neglect status
 - That the care provider made several attempts to dissuade the client from leaving
34. When reporting significant client details to a supervisor or nurse in charge, you should document "supervisor aware of client's deteriorating condition".
- True False
35. Documentation of conversations with the client's family should be done:
- As quickly as possible
 - In a paraphrasing format
 - Using full first and last names
 - Using names and direct quotes

36. Telephone orders must be given directly to you, and not through a third party.
- True False
37. When administering PRN pain medications, why should a care provider document in the progress notes?
- a. Gives evidence of a pain assessment, interventions, and outcomes
 - b. It is a College standard and employer policy to document in the progress notes
 - c. It is a medication competency for care providers
 - d. Explains details that lawyers may be looking for
38. You should write down telephone orders as soon as possible after you have finished your conversation with the physician.
- True False
39. Assessment is not required prior to the administration of PRN medications.
- True False
40. When a care provider administers an incorrect medication, why are the words, "error" or "mistake" not written in the client's progress notes or incident reports? They are words that:
- a. Lawyers are checking for
 - b. Mean admission of guilt or wrong doing
 - c. Are not professional
 - d. Are vague and meaningless
41. It is important that the physician sign his telephone orders within the policy time limit.
- True False
42. A key point in documentation of a client or family care meeting is:
- a. Document the details of the meeting in the progress notes
 - b. Handwrite all your documentation notes first in draft
 - c. Document all the care needs that were discussed.
 - d. Do not repeat the meeting minutes in the progress notes
43. When a client is discharged, it is important to document date, location to, time and mode of discharge in the progress notes.
- True False

44. What must be documented after you have completed a teaching session with a client?
- a. How you evaluated the client's learning
 - b. If the client was a quick learner
 - c. If the client was ready to learn
 - d. How many times you repeated the demonstration
45. Clients have a right to be discharged from care services even if doing so may result in complications or death.
- True False
46. Which of the following may be documented as a potential learning barrier for a client?
- a. Poor mobility
 - b. Positive attitude
 - c. Obesity
 - d. English as a second language
47. When a client discharges himself AMA (against medical advice), it is not necessary to do a final vital signs check.
- True False
48. When documenting a client's pain, which of the following is included?
- a. Intensity on a pain scale and the medication outcomes
 - b. Intensity, type and medication outcomes
 - c. Type, location, medication outcomes
 - d. Intensity, type, location, pain strategies and medication outcomes
49. In an emergency such as a cardiac arrest, it is usually permissible to assign a recorder to track the time, assessments, interventions and responses of the client.
- True False
50. Which of the following would describe a partial assessment of pain that a client is experiencing?
- a. Throbbing
 - b. Mild
 - c. Moderate
 - d. Severe

51. A client's learning can be cognitive, which involves feelings and attitudes.
True False
52. Health Literacy means which of the following?
a. A client knows how to phone a physician
b. A client reads and understands the English language
c. A client knows his main health problem, understands what to do, why it's important
d. A client is taking English language courses so he can better understand his health problem
53. Cognitive learning involves the learning of a skill.
True False
54. How could the vague statement "appears to sleep well" be documented accurately?
a. "eyes closed on night rounds"
b. "sleeping soundly with eyes closed"
c. "snoring and sleeping deeply when checked on night rounds"
d. "eyes closed with regular snoring breaths when checked on night rounds"
55. The minutes of a client and family meeting should be included in the progress notes.
True False
56. "Tolerated procedure well" is a meaningless statement because it:
a. Describes that a client has no complications
b. Gives no evidence of assessment data
c. Describes that a client is doing well
d. Describes a client's present condition
57. It is good practice to listen attentively and take family issues or complaints seriously.
True False
58. The statement "arouses easily" is inaccurate to describe a client who has just returned from surgery. Which of the following is the best way to describe this client's situation?
a. "Alert and opens eyes when called"
b. "Alert when called"
c. "Awakens when name called and aware of surroundings"
d. "Wakes up easily when called"

59. Most falls in facilities are reported to occur at the bedside when the client is getting out of bed.

True False

60. The word "error" or "mistake" should not appear in your documentation.

True False

Answer Key to Module 5 Quiz

- Q01 c Care providers document client data based on the nursing process in the progress notes. Progress notes are sometimes called client or patient notes, team notes, nurses' notes or interdisciplinary notes.
- Q02 True Increases risk of mistakes and errors and it is not an efficient use of your time.
- Q03 d Reporting a change in a client's condition is a very common and valid reason to contact the client's physician and must be done so accurately.
- Q04 True The client may have very real fears of being in care.
- Q05 False BOTH the transferring care provider and the receiving care provider must complete documentation.
- Q06 b Selection "b" has all the necessary details a care provider would need to document in the progress notes when notifying a physician or care practitioner of a significant change in a client's condition.
- Q07 False Depending on your facility's policies and procedures, all care providers may have to sign or initial parts of the admission form.
- Q08 a This example of documentation does not include the name of the physician, the method of contact, date and time, the reason for contact and if there were new orders or no new orders. It lacks the exact words what the physician recommended or stated.
- Q09 False Ask the family or significant other for information. Be sure to document who provided the information, and what was their relationship to the client.
- Q10 c Stating in a client's notes if there were new orders or instructions provides another care provider who reads the notes with a reminder that care has perhaps changed. The second care provider should go back and review what the physician ordered.
- Q11 True As the previous care provider may have not done so on discharge from his or her care unit.
- Q12 a When documenting lack of responses from a physician or practitioner, document the actual times of the contacts. It is unprofessional to document that the physician did not reply to your requests or calls. You may need to refer this lack of responses to a supervisor and activate the chain of command and complete an incident report.
- Q13 False It may be expressed verbally, or implied with such actions as a nod or permitting the care provider to continue on with the treatment or procedure.
- Q14 b When reporting lab or other test results not directly to the physician or practitioner, you must document the name and position of the person you reported the results to.
- Q15 False Consent can also be given by the client's legal decision maker.
- Q16 True All medication errors require documentation as a care provider does not know ahead of time which medications may cause serious injury or death.
- Q17 True
- Q18 d You would first apply principles of the HIA that includes "who needs to know and why" before you document an inquiry. You may not be permitted to release client information to anyone who calls to inquire of a client's condition. Legally, you first

need to apply HIA principle of “who needs to know and why” before you would document the name of the caller, why he was inquiring, what you reported and the caller’s response.

- Q19 True
- Q20 c Although telephone orders are not ideal, a care provider would sign his or her name and designation after the issuing physician when receiving telephone orders.
- Q21 False There should be NO abbreviations on the consent form as the client may not understand them and thus be uncertain as what he or she is consenting to.
- Q22 d If available, family would know the client best and could assist a care provider with admission data. An ambulance driver may be a driver who does not have medical training.
- Q23 False Witnessing a consent form only gives evidence of the form being signed, and is not evidence of the consent process. If a client expresses doubt about the consent, the witness should not sign but refer the client to the physician for further explanation.
- Q24 b Because health care services are extremely busy environments, it is a possibility that a previous care provider unintentionally failed to do an assessment or vital signs when the client was removed or discharged from a previous department or area (e.g. ER, Recovery)
- Q25 True
- Q26 a When lawyers review client records, they are also checking to see if care providers provided emotional support and pain control for a client.
- Q27 True Note reasons if known and also outcomes of client not receiving care or treatments.
- Q28 False No mention of the incident report should be made in the documentation.
- Q29 c The client’s physician issues a written order when a client is discharged from care services. A client may be discharged when he recovers or when health care services are no longer beneficial. Complete documentation in the progress notes will follow by the care provider.
- Q30 False It is important to document any new orders OR if no new orders were given.
- Q31 a It is extremely important to do a final assessment with vital signs on a client who is leaving your care and facility. This is done in case there is new, significant data that would nix or nullify the discharge. It may also prevent a client from returning back into care after a short discharge.
- Q32 True You would document the times of the physician contacts, but you would NOT document that the physician ignored your requests or that you filled out an incident report.
- Q33 b Although a client may be discharging himself against medical advice, it remains the care provider’s responsibility to provide the necessary teaching materials and instructions for follow-up care.
- Q34 False State name of supervisor, exactly what was reported and supervisor’s response and instructions received.
- Q35 d When documenting conversations, names of family members other than stating son or daughter is best. There could be several sons and daughters. Use direct quotes, including slang words.

- Q36 True
- Q37 a PRN medications should give evidence that a pain assessment was done, if the analgesic was given was effective, if other pain interventions were used and client responses.
- Q38 False You should write down the orders while on the phone with the physician. Repeat back the order to the physician to make sure you got it correct!
- Q39 False Your documentation must show evidence that an assessment was done prior to the administration of PRN medications.
- Q40 b If words like "error" and "mistake" are written in the client's progress notes, lawyers may take these to mean admission of guilt or wrongdoing.
- Q41 True Otherwise you could be held liable for practicing medicine without the authority to do so.
- Q42 d The more times the same client information is repeated and documented, the more chances for error and incorrect information being copied.
- Q43 True Also it should be noted if the client was accompanied by another person.
- Q44 a Teaching sessions are evaluated after they are completed. Sometimes it could be done by a return demonstration or verbally by the client.
- Q45 True That is why it is important to document who was notified, date and time, discharge teaching and materials, and how and when the client left the premises.
- Q46 d Clients who do not speak and understand the English language well may require extra time and several methods for teaching sessions. There are approximately 250,000 new Canadians annually who may access health services.
- Q47 False Although not mandatory, doing a final vital signs check is best practice.
- Q48 d Management of pain is a critical area of clients who are in care. Selection "d" discusses what documentation of pain entails.
- Q49 True Check your facility's policies and procedures for emergency-related documentation.
- Q50 a Pain assessment is done according to a pain scale or method that your employer has. "Throbbing" would be a descriptive word to describe the type of pain a client is experiencing.
- Q51 False Cognitive learning involves retention of knowledge; affective learning involves feelings and attitudes.
- Q52 c Health literacy means having skills to access health services and an understanding of personal health: his main health problem, what he needs to do and why his actions are important.
- Q53 False Psychomotor learning involves the learning of a skill; cognitive learning involves the retention of knowledge.
- Q54 d Although documentation is not "black and white" for every situation, this option gives indication to the reader that the client was sleeping when checked during night rounds.
- Q55 False You should not duplicate the meeting minutes in the progress notes, but state a few general discussion points and the client's response. Meeting minutes are usually kept in the appendix.

- Q56 b Statements that describe a client's condition must be backed up by assessment data in your documentation.
- Q57 True Do not argue with family members or defend your actions. Apologies can prevent lawsuits.
- Q58 c "Alert" and "easily" are vague words. How does the care provider know that the client is alert? "Arouses easily" could be taken as sexual arousal which is not the case here.
- Q59 True Full details of the fall and steps taken to prevent further falls need to be recorded.
- Q60 True This implies fault or responsibility of the care provider.