Multiple Choice: For each of the following questions, circle the letter of the answer that best answers the question.

1. A well-documented patient care record demonstrates competent practice to which of the following regulatory agencies?
   A. Medicare
   B. Third parties and other stakeholders
   C. Board of Nursing
   D. All of the Above

2. Which of the following actions is appropriate when working on a patient’s medical record?
   A. Alter a medical record
   B. Destroy a medical record
   C. Remove a medical record
   D. None of the above

3. Which of the following is an acceptable guideline to utilize when making a late addition or correction to a patient’s care record?
   A. Erase the error and rewrite the correction
   B. Use white-out to remove the error and rewrite the correction
   C. Mark with one red line through the item
   D. Use permanent marker to completely blot out the error

4. All of the following are required to ensure accurate billing EXCEPT:
   A. A description of the patient
   B. The actual provider
   C. The diagnosis
   D. The service or services provided

5. Which of the following actions do not constitute Medicare fraud and abuse?
   A. Submitting bills for services not rendered
   B. Internally auditing your facility’s documentation to ensure documentation supports the code billed
   C. Unbundle a service
   D. Upcode a service

6. Documentation of differential diagnosis in the patient care record allows the APN to:
   A. More clearly understand a patient’s condition or circumstance
   B. Upcode the service
   C. Be familiar with health plan participation contracts
   D. Alter the patient’s medical record
7. Which of the following actions place the advanced practice nurse at an increased risk for legal action?

A. Eliminating personal criticism and opinions from the medical record  
B. Leaving blank spaces so that you can come back to something later  
C. Recording all entries in ink  
D. Recording only facts, observed behavior, and health services rendered

8. The documentation technique known as SOAP stands for which of the following:

A. Strategize, Operate, Articulate, Plan of Care  
B. Simplify, Objective, Action, Post-service follow-up  
C. Subjective, Objective, Assessment, Plan of Care  
D. Subjective, Objective, Action, Post-service follow-up

9. One of the weaknesses of the SOAP documentation technique is:

A. Addresses specific problems  
B. Eliminates nonessential data  
C. Time-consuming  
D. Organized

10. Which documentation technique is a chronological account of events in a free-form, sentence-based structure:

A. SOAP  
B. Electronic documentation  
C. SOOOAAP  
D. Narrative

11. Which of the following presents a challenge to facilities using electronic medical records?

A. The documentation is often illegible  
B. It is difficult to track changes made with electronic documentation.  
C. This method requires a major psychological change for staff, who must adjust how they work and organize their time.  
D. This method does not promote documenting the nursing process.

12. What term describes a method devised to encourage a patient to review the notes made by their healthcare providers?

A. Reverse Documentation  
B. Allowable Review  
C. Nursing Process  
D. Open Charting

13. According to the HIPAA Security Rule Documentation standards, the implementation specification for “Time Limit” is:

A. Forever  
B. Two years from the date of its creation or the date when it was last in effect, whichever is later  
C. Six years from the date of its creation or the date when it was last in effect, whichever is later  
D. Ten years from the date of its creation or the date when it was last in effect, whichever is later
14. All of the following represent best practices in ensuring a facility’s HIPAA compliance EXCEPT:

A. Speaking quietly when discussing a patient’s condition with family members in a waiting room or other public area
B. Isolating or locking file cabinets or record rooms
C. Using additional security, such as passwords, on computers maintaining personal information
D. When it is necessary to leave a voicemail for a patient, stating only the patient’s name, health care provider’s name, and a brief description for the reason of the call

15. Which of the following is not a suggested technique for incident reporting?

A. Report any incident to your risk manager immediately.
B. Document only the facts.
C. Consider developing a conclusion when appropriate.
D. Do not document impressions.

16. An example of a reportable incident includes:

A. Being late to work
B. Complaint by a patient
C. Complaint by a supervising physician
D. All of the above

17. The Security Rule Documentation Standard of HIPAA includes implementation specifications for all of the following, EXCEPT:

A. Diagnosis
B. Time Limit
C. Availability
D. Updates

18. Which of the following are effective risk management strategies?

A. Permit visiting relatives access to the patient’s record; Practice competent nursing; Follow appropriate incident reporting
B. Comply with your facility’s policies and practices; Follow ICD-9 CMS guidelines for documentation; Do not implement password protection when using computers to document patient care
C. Follow appropriate incident reporting; Document your opinions when necessary; Comply with Nurse Practice Act
D. Comply with Nurse Practice Act; Follow appropriate billing and coding methods; seek additional educational opportunities

19. Assuring HIPAA compliance in electronic medical records is crucial because:

A. Patient information is stored and exchanged electronically through various technologies
B. Security breaches do happen
C. Unintentional distribution of e-mail addresses including sensitive patient information can happen
D. All of the above

20. An important thing to remember when following HIPAA protocol is to:

A. Avoid complacency.
B. Follow what the healthcare professional before you has done.
C. Avoid saying the last name of a patient in public areas, but first name is fine.
D. Keep a patient’s file visible at all times.
Short Answer

Name three types of documentation, give a brief description, and list at least three strengths and weaknesses for each.

1. Documentation Type:
   
   i. Strengths:
   
   ii. Weaknesses:

2. Documentation Type:
   
   i. Strengths:
   
   ii. Weaknesses:

3. Documentation Type:
   
   i. Strengths:
   
   ii. Weaknesses:
Answer Key

1. D
2. D
3. C
4. A
5. B
6. A
7. B
8. C
9. C
10. D
11. C
12. D
13. C
14. D
15. C
16. B
17. A
18. D
19. D
20. A
Name five types of documentation, give a brief description of each, and list at least three strengths and weaknesses of each type.

Documentation Type: Narrative

**Strengths**
- Is a simplified method
- Allows the author to control what is said
- Promotes chronological documentation—easy to document and track timing of events if documentation is done correctly
- Works in all clinical environments
- Is easy to teach or learn
- Requires no special form—other than blank paper

**Weaknesses**
- The author is given no guidance about what to say.
- The author must learn through experience, decide what is important to document, and develop his or her own system for organizing a note.
- This freeform can produce notes that could be any of the following: Fragmented; disjointed; non-informative, rambling; subjective; inconsistent with what is documented from one author to the next; too wordy—making it difficult to pick out patient trends and problems.

Documentation Type: SOAP (SOOOOAP)

**Strengths**
- They address specific problems.
- The structure gives guidance, so information is presented in an organized manner.
- The structure of these notes guides the nurse’s thoughts to include the patient’s thoughts or concerns as well as data the nurse has about the problem, assessment, planning of care, evaluation, and revision.
- The notes are organized the same from author to author.
- The problem list is helpful in these ways:
  - To alert all caregivers about problems being addressed
  - To ensure that all problems are addressed
  - To facilitate data retrieval about a particular problem
  - Notes show the following:
    - Continuity of care
    - Evaluation and resolution of problems
    - The format promotes documentation of the nursing process.
  - It eliminates nonessential data

**Weaknesses**
- This format is difficult to use when any of the following is true: There is a fast-paced change in the patient’s condition; the problem list is not used or kept current; all components of the note are not used.
- Routine care is difficult to document and may not be reported if flow sheets are not used.
- Frequent repetitive charting is necessary, since data may relate to more than one problem, and the
plan must be in the note and on the plan of care form.

- Many people have difficulty deciding where information needs to be placed—is it subjective or objective data? Is the data assessment or evaluation?
- This format is time-consuming to write and read due to the repetitive charting.

- SOAP notes are extremely difficult to work with for nurses who have 8 to 12 hours of constant contact with a patient. They are best used in clinical situations where nurses make summary notes for a day, week, or month at a time.
- The format isn’t suited for fast patient turnover.

**Documentation Type: Electronic**

**Strengths**

- Charting is legible.
- Several people can have access to the same record at the same time.
- Prompting is available to remind the person charting about what to chart.
- All changes to the record can be tracked.
- The system can be modified to meet facilities’ particular needs.

- Notes can be organized the same from author to author.
- You always know where the chart is.
- This method promotes documenting the nursing process.
- It decreases problems in maintaining adequate charting forms and supplies.

**Weaknesses**

- The facility must make a major cash investment for equipment, software, and training.
- Many people need to be trained to use a computer and to overcome their fear of computers.
- If the hardware or software crashes, you lose access to the chart.

**Documentation Type: Open Charting**

**Strengths**

- Encourages patients to review their own patient care record
- Promotes meticulous documentation by healthcare providers

- Fosters patient inclusion in the healthcare delivery process

**Weaknesses**

- Requires significant time
- Could raise patient queries regarding the healthcare delivery