Documentation for Nurses

Name: _____ Period: _____

Class _____ Date: _____

For each of the following questions, read each question carefully and then write your answer on the line next to the question.

1. _____ Which of the following are the four elements that must exist for an incident to be considered medical malpractice?
   a. duty of care, breach of duty, physical injury, causation
   b. standard of care, duty of care, breach of duty, harm
   c. duty of care, breach of duty, harm, causation
   d. license, breach of license, harm, monetary losses

2. _____ Which of the following is NOT a reportable incident?
   a. Missed or incorrect diagnosis
   b. Visitor complaint
   c. Patient fall
   d. Medication error
   e. All of the above
   f. None of the above

3. _____ Under which of the following circumstances is it acceptable to "copy and paste" in electronic healthcare information records?
   a. When documenting high-risk items
   b. When documenting electronic correspondence
   c. When documenting standard entries
   d. When restating something another clinician has already written
   e. All of the above
   f. None of the above

4. _____ Who may access the patient's healthcare information record without the patient's consent?
   a. An adult patient's roommate
   b. A pediatric patient's adult sibling
   c. An adult patient's spouse
   d. A pediatric patient's parent/legal guardian

5. _____ When administering medications, which of the following must be documented?
   a. Time given
   b. Route
   c. Dose
   d. Response
   e. All of the above

6. _____ Keep charting limited to the patient himself/herself, even if a family member or interpreter is included in the conversation. (True/False)

7. _____ There is no need to chart routine activities once a pattern has been established. (True/False)

8. _____ It is important that you chart when the event occurs instead of waiting until the end of the shift, when you must rely on memory and may run out of time. (True/False)

9. _____ When charting a symptom, also chart your intervention and the patient's response. (True/False)

10. _____ One of the benefits of electronic health records is that when you need to make a correction, you can simply delete the entry and correct it. (True/False)

After reading each documentation practice, write whether it is a "do" or "don't".

11. _____ In order to provide the whole picture, write descriptions such as "bed soaked" or "a large amount".

12. _____ Chart the time you gave a medication, the administration route, and the patient's response.

13. _____ In order to save time, it is ok to chart care ahead of time.

14. _____ Chart a patient's refusal to allow a treatment or take a medication. Be sure to report this to your manager and the patient's physician.

15. _____ Record each phone call to a physician, including the exact time, message, and response.

16. _____ If necessary, give explanations such as "medication not given because not available".

17. _____ If you remember an important point after you've completed your documentation, chart the information with a notation that it's a "late entry". Include the date and time of the late entry.

18. _____ Sometimes it's ok to alter a patient's record.

19. _____ Check that you have the correct chart because you begin recording.

20. _____ Chart patient care at the time you provide it.

Answer Key

Multiple Choice

1. C
2. E
3. B
4. D
5. E

True/False

6. False. In addition to charting the teaching and response of a patient, you should also document if a family member was involved.
7. False. All activities, even routine actions, should be documented.
8. True
9. True
10. False. Electronic healthcare information records automatically date and time each entry nd identify electronic deletions, so any attempt to alter the record is apparent and can be discoverable.

Do's/Don'ts

11. Don't write imprecise descriptions. Be specific.
12. Do
13. Don't chart care ahead of time – something may happen and you may be unable to actually give the care you've charted. Charting care that you haven't done is considered fraud.
14. Do
15. Do
16. Don't give excuses.
17. Do
18. Don't alter a patient's record – this is a criminal offense.
19. Do
20. Do