Documentation for Advanced Practice 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 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

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. _____ 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 rendered

4. _____ 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

5. _____ 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

6. _____ 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

7. _____ One of the weaknesses of the SOAP documentation technique is:
   a. Addresses specific problems
   b. Eliminates nonessential date
   c. Time-consuming
   d. Organized

8. _____ 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

9. _____ 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

10. _____ 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

Read each question carefully regarding proper documentation techniques, and then write "T" (true) or "F" (false) on the line next to the question.

11. _____ Keep charting limited to the patient himself/herself, even if a family member or interpreter is included in the conversation.

12. _____ There is no need to chart routine activities once a pattern has been established.

13. _____ 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.

14. _____ When charting a symptom, also chart your intervention and the patient's response.

15. _____ 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.

16. _____ Do not document test results without also including a description of subsequent actions taken.

17. _____ Reauthorization of a prescription does not need to be documented as long as the original prescription was included in the healthcare information record.

18. _____ Seeking additional educational opportunities is a good risk management strategy.

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

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

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

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

22. _____ 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.

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

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

25. _____ 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.

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

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

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

29. _____ Write anything you want in emails, text messages, or any other electronic communication – they are your private messages.

30. _____ Rely on automatic and pre-filled entries to document in electronic healthcare information records.

Answer Key

Multiple Choice

1. C
2. F
3. A
4. B
5. D
6. C
7. C
8. D
9. C
10. A

True/False

11. False. In addition to charting the teaching and response of a patient, you should also document if a family member was involved.
12. False. All activities, even routine actions, should be documented.
13. True
14. True
15. False. Electronic healthcare information records automatically date and time each entry and identify electronic deletions, so any attempt to alter the record is apparent and can be discoverable.
16. True
17. False. Prescription refill authorizations need to be documented, including the method of authorization, the name of the pharmacy and pharmacist, and a verification that the prescription was read-back correctly.
18. True

Do's/Don'ts

19. Don't write imprecise descriptions. Be specific.
20. Do
21. 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.
22. Do
23. Do
24. Don't give excuses.
25. Do
26. Don't alter a patient's record – this is a criminal offense.
27. Do
28. Do
29. Don't write anything in an email, text message, or other electronic message that you would not be comfortable including in the patient's healthcare information record.
30. Don't overuse automatic or pre-filled entries.