Care CEUs

Health Care Documentation: A Means to Safe and Effective Patient Care

1. Health care documentation can be a method to prevent health care information from being lost and a means to ensure relevant patient information reaches the necessary individuals who have the ability to directly impact and improve a patient's care, treatment and health care outcomes.

A. True
B. False

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2. Which of the following statements is most accurate?

A. Health care documentation, such as a patient's medical record, is not considered a legal document.
B. Health care documentation may come into question in the case of litigation or legal actions against or pertaining to a health care professional.
C. Health care documentation is never used in litigation or legal actions against or pertaining to a health care professional.
D. Health care documentation has no legal implications.

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3. Standards of practice can refer to the authoritative statements of duties that all health care professionals, regardless of role, population or specialty are expected to perform competently.

A. TRUE
B. FALSE

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4. The sole function of health care documentation is communication.

A. TRUE
B. FALSE

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5. Which of the following statements is most accurate?

A. Objectivity can refer to the process of obtaining meaning or information that is true outside of an individual's judgment, bias and/or opinion.
B. Subjectivity can refer to the process of obtaining meaning or information that is true outside of an individual's judgment, bias and/or opinion.
C. Objectivity can refer to the process of forming an opinion and/or judgment based on one's own point of view or perspective.
D. Subjectivity can refer to the process of determining fact and/or reproducible data.

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6. A nurse is observing a 29-year-old male patient. The patient has a rash on his left arm and the patient's blood pressure is 140/40 mmHg. The nurse believes the patient's elevated blood pressure is a result of agitation from a recent family visit, although the nurse cannot confirm the reason for the patient's elevated blood pressure. According to the See Rule, what information should the nurse document to ensure accurate, reproducible/measurable data is recorded?

A. The patient has a rash on his left arm.
B. The patient's blood pressure is 140/40 mmHg.
C. The patient's elevated blood pressure is due to a recent family visit.
D. Both A and B

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7. To ensure accuracy, health care documentation should include information which can be measured or verified by another individual.

A. TRUE
B. FALSE

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8. Labels such as 'difficult,' 'needy' or 'unpleasant' should be avoided when completing health care documentation because they may represent subjective information based on judgment, bias and/or opinion and thus may prove to be inaccurate.

A. True
B. False

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9. Which of the following statements is most accurate?

A. Health care documentation should be completed at the end of a shift.
B. Health care documentation should be completed before the health care is administered to a patient at all times.
C. Health care professionals should complete health care documentation as close to the administration of health care as possible to foster accurate up-to-date information.
D. Health care documentation is not essential to accurate, up-to-date patient information.

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10. A nurse administers a medication to a patient. The patient has a slight reaction to the medication. How can the nurse ensure the health care documentation regarding the medication administration is effective?

A. The nurse should be as concise as possible, only stating relevant information.
B. The nurse should complete all the necessary components of the health care documentation.
C. The nurse should include the time and date of the medication administration.
D. All of the above

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