Chapter 10: Documentation, Electronic Health Records, and Reporting

MULTIPLE CHOICE

1. Accurate documentation by the nurse is necessary since proper documentation:
   a. is needed for proper reimbursement.
   b. must be electronically generated.
   c. does not involve e-mails or faxes.
   d. is only legal if written by hand.

   ANS: A
   Accurate documentation is necessary for hospitals to be reimbursed according to diagnostic-related groups (DRGs). DRGs are a system used to classify hospital admissions. Health care documentation is any written or electronically generated information about a patient that describes the patient, the patient’s health, and the care and services provided, including the dates of care. These records may be paper or electronic documents, such as electronic medical records, faxes, e-mails, audiotapes, videotapes, and images.

   DIF: Remembering
   REF: p. 130
   OBJ: 10.01
   TOP: Assessment
   MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care
   NOT: Concepts: Communication

2. Which of the following is true regarding nursing documentation?
   a. Standards for documentation are established by a national commission.
   b. Medical records should be accessible to everyone.
   c. Documentation should not include the patient’s diagnosis.
   d. High-quality nursing documentation reflects the nursing process.

   ANS: D
   The ANA’s model for high-quality nursing documentation reflects the nursing process and includes accessibility, accuracy, relevance, auditability, thoughtfulness, timeliness, and retrievability. Standards for documentation are established by each health care organization’s policies and procedures. They should be in agreement with The Joint Commission’s standards and elements of performance, including having a medical record for each patient that is accessed only by authorized personnel. General principles of medical record documentation from the Centers for Medicare and Medicaid Services (2010) include the need for completeness and legibility; the reasons for each patient encounter, including assessments and diagnosis; and the plan of care, the patient’s progress, and any changes in diagnosis and treatment.

   DIF: Understanding
   REF: p. 130
   OBJ: 10.02
   TOP: Assessment
   MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care
   NOT: Concepts: Communication
3. The medical record:
   a. serves as a major communication tool but is not a legal document.
   b. cannot be used to assess quality of care issues.
   c. is not used to determine reimbursement claims.
   d. can be used as a tool for biomedical research and provide education.

ANS: D

The medical record is a clinical data archive. The medical record serves as a tool for biomedical research and provider education, collection of statistical data for government and other agencies, maintenance of compliance with external regulatory bodies, and establishment of policies and regulations for standards of care. The record serves as the major communication tool between staff members and as a single data access point for everyone involved in the patient’s care. It is a legal document that must meet guidelines for completeness, accuracy, timeliness, accessibility, and authenticity. The record can be used to assess quality-of-care measures, determine the medical necessity of health care services, support reimbursement claims, and protect health care providers, patients, and others in legal matters.

DIF: Understanding
REF: p. 130
OBJ: 10.02
TOP: Assessment
MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care
NOT: Concepts: Communication

4. Paper records are being replaced by other forms of record keeping because:
   a. paper is fragile and susceptible to damage.
   b. paper records are always available to multiple people at a time.
   c. paper records can be stored without difficulty and are easily retrievable.
   d. paper records are permanent and last indefinitely.

ANS: A

Paper records have several potential problems. Paper is fragile, susceptible to damage, and can degrade over time. It may be difficult to locate a particular chart because it is being used by someone else, it is in a different department, or it is misfiled. Storage and control of paper records can be a major problem.

DIF: Evaluating
REF: pp. 130-131
OBJ: 10.02
TOP: Assessment
MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care
NOT: Concepts: Communication

5. The nurse is charting in the paper medical record. She should:
   a. print his/her name since signatures are often not readable.
   b. not document her credentials since everyone knows that she is a nurse.
   c. skip a line, leaving a blank space, between entries so that it looks neater.
   d. use black ink unless the facility allows a different color.

ANS: D

Entries into paper medical records are traditionally made with black ink to enable copying or scanning, unless a facility requires or allows a different color. The date, time, and signature, with credentials of the person writing the entry, are included in the entry. No blank spaces are left between entries because they could allow someone to add a note out of sequence.
6. The nurse is admitting a patient who has had several previous admissions. In order to obtain a knowledge base about the patient’s medical history, the nurse may use the:
   a. electronic medical record (EMR).
   b. the computerized provider order entry (CPOE).
   c. electronic health record (EHR).

ANS: C

The EHR is a longitudinal record of health that includes the information from inpatient and outpatient episodes of health care from one or more care settings. The EMR is a record of one episode of care, such as an inpatient stay or an outpatient appointment. CPOE allows clinicians to enter orders in a computer that are sent directly to the appropriate department. It does not provide historical data. The American Recovery and Reinvestment Act of 2009 is the government mandate that requires the use of a certified EHR for each person in the United States by 2014.

7. The use of electronic health records:
   a. improves patient health status.
   b. requires a keyboard to enter data.
   c. has not been shown to reduce medication errors.
   d. requires increased storage space.

ANS: A

Adoption of an EHR system produces major cost savings through gains in productivity and error reduction, which ultimately improves patient health status. The most common benefits of electronic records are increased delivery of guideline-based care, better monitoring, reduced medication errors, and decreased use of care. Use of EHRs can reduce storage space, allow simultaneous access by multiple users, facilitate easy duplication for sharing or backup, and increase portability in environments using wireless systems and handheld devices. Although data are often entered by keyboard, they can also be entered by means of dictated voice recordings, light pens, or handwriting and pattern recognition systems.

8. The nurse is caring for patients on unit that uses electronic health records (EHRs). In order to protect personal health information, the nurse should:
   a. allow only nurses that she knows and trusts to use her verification code.
   b. not worry about mistakes since the information cannot be tracked.
   c. never share her password with anyone.
d. be aware that the EHR is sophisticated and immune to failure.

ANS: C
Access to an EHR is controlled through assignment of individual passwords and verification codes that identify people who have the right to enter the record. Passwords and verification codes should never be shared with anyone. Health care information systems have the ability to track who uses the system and which records are accessed. These organizational tools contribute to the protection of personal health information. Disadvantages of use of computers for documentation include computer and software failure and problems if there is a power outage.

DIF: Applying  REF: p. 132  OBJ: 10.02  TOP: Implementation
MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care
NOT: Concepts: Communication

9. Nursing documentation is an important part of effective communication among nurses and with other health care providers. As such, the nurse:
   a. documents facts.
   b. documents how he/she feels about the care being provided.
   c. documents in a “block” fashion once per shift.
   d. double documents as often as possible in order to not miss anything.

ANS: A
Nursing documentation is an important part of effective communication among nurses and with other health care providers. Documentation should be factual and nonjudgmental, with proper spelling and grammar. Events should be reported in the order they happened, and documentation should occur as soon as possible after assessment, interventions, condition changes, or evaluation. Each entry includes the date, time, and signature with credentials of the person documenting. Double documentation of data should be avoided because legal issues can arise as a result of conflicting data.

DIF: Remembering  REF: p. 132  OBJ: 10.03
TOP: Assessment
MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care
NOT: Concepts: Communication

10. Nursing documentation is guided by:
   a. the Nursing process
   b. the North American Nursing Diagnosis Association (NANDA) diagnoses.
   c. Nursing Interventions Classification.
   d. Nursing Outcomes Classification

ANS: A
Nursing documentation is guided by the five steps of the nursing process: assessment, diagnosis, planning, implementation, and evaluation. Standardized nursing terminologies such as the North American Nursing Diagnosis Association–International (NANDA-I) nursing diagnoses, Nursing Interventions Classification (NIC), and Nursing Outcomes Classification (NOC) may be used in the documentation process.

DIF: Remembering  REF: pp. 132-133  OBJ: 10.03
TOP: Assessment
MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care
11. PIE, APIE, SOAP, and SOAPIE are:
   a. chronologic.
   b. examples of problem-oriented charting.
   c. narrative charting.
   d. forms of “charting by exception.”

   ANS: B
   The nurse’s notes may be in a narrative format or in a problem-oriented structure such as the PIE, APIE, SOAP, SOAPIE, SOAPIER, DAR, or CBE format. Narrative charting is chronologic, Charting by exception (CBE) is documentation that records only abnormal or significant data.

   DIF: Remembering  REF: pp. 132-134  OBJ: 10.03
   TOP: Assessment
   MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care
   NOT: Concepts: Communication

12. A type of charting that records only abnormal or significant data is:
   a. PIE.
   b. SOAP.
   c. narrative.
   d. charting by exception.

   ANS: D
   Charting by exception (CBE) is documentation that records only abnormal or significant data. A PIE note is used to document problem (P), intervention (I), and evaluation (E). A SOAP note is used to chart the subjective data (S), objective data (O), assessment (A), and plan (P). Narrative charting is chronologic, with a baseline recorded on a shift-by-shift basis. Data are recorded in the progress notes, often without an organizing framework. Narrative charting may stand alone, or it may be complemented by other tools.

   DIF: Remembering  REF: pp. 133-134  OBJ: 10.03
   TOP: Assessment
   MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care
   NOT: Concepts: Communication

13. The nurse is preparing to administer medications to the patient. Prior to doing so, she/he compares the provider orders with the:
   a. flow sheet
   b. Kardex
   c. MAR
   d. admission summary

   ANS: C
A medication administration record (MAR) is a list of ordered medications, along with dosages and times of administration, on which the nurse initials medications given or not given. A paper MAR usually includes a signature section in which the nurse is identified by linking the initials used with a full signature. The EHR includes an electronic medication administration record (eMAR). Flow sheets and checklists may be used to document routine care and observations that are recorded on a regular basis, such as vital signs, and intake and output measurements. Data collected on flow sheets may be converted to a graph, which pictorially reflects patient data. Originally, the Kardex was a non-permanent filing system for nursing records, orders, and patient information that was held centrally on the unit. Although computerization of records may mean that the Kardex system is no longer active, the term kardex continues to be used generically for certain patient information held at the nurses’ station. An admission summary includes the patient’s history.


14. The nurse is caring for a patient for the first time and needs background information such as history, medications taken at home, etc. The best central location to obtain this information is the:
   a. admission summary.
   b. discharge summary.
   c. flow sheet.
   d. Kardex.

ANS: A
An admission summary includes the patient’s history, a medication reconciliation, and an initial assessment that addresses the patient’s problems, including identification of needs pertinent to discharge planning and formulation of a plan of care based on those needs. The discharge summary addresses the patient’s hospital course and plans for follow-up, and it documents the patient’s status at discharge. It includes information on medication and treatment, discharge placement, patient education, follow-up appointments, and referrals. Flow sheets and checklists may be used to document routine care and observations that are recorded on a regular basis, such as vital signs, medications, and intake and output measurements. Although computerization of records may mean that the Kardex system is no longer active, the term kardex continues to be used generically for certain patient information held at the nurses’ station.


15. The nurse is charting using paper nursing notes. The nurse is aware that:
   a. attorneys are not allowed access to medical records during litigation.
   b. when mistakes are made in documentation, the nurse should scribble out the entry.
   c. only one nurse should document on a sheet so that it can be removed in case of error.
   d. the medical record is the most reliable source of information in any legal action.

ANS: D
The medical record is seen as the most reliable source of information in any legal action related to care. When legal counsel is sought because of a negative outcome of care, the first action taken by an attorney is to acquire a copy of the medical record. Notes should never be altered or obliterated. Documentation mistakes must be acknowledged. If an error is made in paper documentation, a line is drawn through the error and the word error is placed above or after the entry, along with the nurse’s initials and followed by the correct entry.

DIF: Applying	REF: p. 135	OBJ: 10.03	TOP: Implementation
MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care
NOT: Concepts: Communication

16. The nurse is charting using electronic documentation. With electronic documentation:
   a. errors can be corrected and totally removed from the record in the screen view.
   b. log-on access to the electronic record identifies the person charting.
   c. each entry requires the nurse to sign her/his name and credentials.
   d. documenting significant changes in the electronic record ends the nurse’s responsibility.

ANS: B
Log-on access to the electronic record identifies the person charting or making a change. If an error is made in electronic documentation, it can be corrected on the screen view but the error and correction process remains in the permanent electronic record. Any correction in documentation that indicates a significant change in patient status should include notification of the primary care provider.

DIF: Understanding	REF: p. 135	OBJ: 10.03
TOP: Assessment
MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care
NOT: Concepts: Communication

17. How should the nurse correct an error in charting?
   a. remove the sheet with the error and replace it with a new sheet with the correct entry.
   b. scribble out the error and rewrite the entry correctly.
   c. draw a single line through the error, and then write “error” above or after the entry
   d. leave the entry as is and tell the charge nurse.

ANS: C
Documentation mistakes must be acknowledged. If an error is made in paper documentation, a line is drawn through the error and the word error is placed above or after the entry, along with the nurse’s initials and followed by the correct entry. Notes should never be altered or obliterated. Documentation mistakes must be acknowledged.

DIF: Applying	REF: p. 135	OBJ: 10.03	TOP: Implementation
MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care
NOT: Concepts: Communication

18. If a verbal or phone order is necessary in an emergency, the order:
   a. must be taken by an RN or LPN.
   b. must be repeated verbatim to confirm accuracy.
   c. documented as a written order.
d. does not need further verification by the provider.

ANS: B

If a verbal or phone order is necessary in an emergency, the order must be taken by a registered nurse (RN) who repeats the order verbatim to confirm accuracy and then enters the order into the paper or electronic system, documenting it as a verbal or phone order and including the date, time, physician’s name, and RN’s signature. Most facility policies require the physician to co-sign a verbal or telephone order within a defined time period.

DIF: Understanding

TOP: Assessment

MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care

NOT: Concepts: Communication

19. The process of making a change-of-shift report (handoff):
   a. is an uncommon occurrence of little importance.
   b. occurs only at change of shift and only to oncoming nurses.
   c. can lead to patient death if done incorrectly.
   d. does not allow for collaboration or problem solving.

ANS: C

An ineffective handoff may lead to wrong treatments, wrong medications, or other life-threatening events, increasing the length of stay and causing patient injury or death. The handoff process can be an opportunity for collaborative problem solving. Improvement in the handoff process can increase patient safety and promote positive patient outcomes. During an average hospital stay of approximately 4 days, as many as 24 handoffs can occur for just one patient because shifts change every 8 to 12 hours and many individuals are responsible for care.

DIF: Understanding

TOP: Assessment

MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care

NOT: Concepts: Communication

20. The patient has fallen when trying to climb out of bed. The nurse:
   a. needs to complete an incident report as a risk management document.
   b. completes an incident report since it is a permanent part of the medical record.
   c. must document that an incident report was completed in the medical record.
   d. should say nothing about the incident in the medical record.

ANS: A

Incident reports are objective, nonjudgmental, factual reports of the occurrence and its consequences. The incident report is not part of a medical record but is considered a risk management or quality-improvement document. The fact that an incident report was completed is not recorded in the patient’s medical record; however, the details of a patient incident are documented.

DIF: Applying

TOP: Implementation

MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care

NOT: Concepts: Communication
1. Expected nursing documentation includes: (Select all that apply.)
   a. nursing assessment.
   b. the care plan.
   c. critique of the physician’s care.
   d. interventions.
   e. patient responses to care.

   ANS: A, B, D, E

   Expected nursing documentation includes a nursing assessment, the care plan, interventions, the patient’s outcomes or response to care, and assessment of the patient’s ability to manage after discharge. Documentation should be factual and nonjudgmental.

   DIF: Remembering
   REF: pp. 132-133
   OBJ: 10.03
   TOP: Assessment
   MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care
   NOT: Concepts: Communication

2. Nurses must be aware of the danger of using abbreviations that may be misunderstood and compromise patient safety. The Joint Commission has compiled a list of do-not-use abbreviations, acronyms, and symbols to avoid the possibility of errors that may be life threatening. Of the following, which are acceptable? (Select all that apply.)
   a. Daily
   b. QD
   c. qod
   d. 0.X mg
   e. X mg

   ANS: A, D, E

   Nurses must be aware of the danger of using abbreviations that may be misunderstood and compromise patient safety. The Joint Commission (2013) has compiled a list of do-not-use abbreviations, acronyms, and symbols to avoid the possibility of errors that may be life threatening. QD, Q.D., qd, q.d. (daily), QOD, Q.O.D., qod, and q.o.d. (every other day) can be mistaken for each other. Periods after Q can be mistaken for I, and the O mistaken for I. Write daily or every other day. Trailing zero (X.0 mg) or a lack of leading zero (.X mg) can be confusing. Write as X mg or 0.X mg.

   DIF: Applying
   REF: p. 133
   OBJ: 10.03
   TOP: Implementation
   MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care
   NOT: Concepts: Communication

3. Standardized nursing terminologies such as the North American Nursing Diagnosis Association–International (NANDA-I) nursing diagnoses, Nursing Interventions Classification (NIC), and Nursing Outcomes Classification (NOC) may be used in the documentation process. Use of standardized language: (Select all that apply.)
   a. provides consistency.
   b. improves communication among nurses while excluding non-nurses.
   c. increases the visibility of nursing interventions.
   d. enhances data collection.
   e. supports adherence to care standards.
ANS: A, C, D, E

Standardized nursing terminologies such as the North American Nursing Diagnosis Association–International (NANDA-I) nursing diagnoses, Nursing Interventions Classification (NIC), and Nursing Outcomes Classification (NOC) may be used in the documentation process. Use of standardized language provides consistency, improves communication among nurses and with other health care providers, increases the visibility of nursing interventions, improves patient care, enhances data collection to evaluate nursing care outcomes, and supports adherence to care standards.

DIF: Remembering  
TOP: Assessment  
MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care  
NOT: Concepts: Communication

4. The nurse is charting using the DAR charting system. This form of charting requires documentation about: (Select all that apply.)
   a. the patient problems.
   b. subjective data.
   c. any actions initiated.
   d. objective data.
   e. the patient’s response to interventions.

ANS: A, C, E

A DAR note is used to chart the data (D) collected about the patient problems, the action (A) initiated, and the patient’s response (R) to the actions. A SOAP note is used to chart the subjective data (S), objective data (O), assessment (A), and plan (P).

DIF: Remembering  
TOP: Assessment  
MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care  
NOT: Concepts: Communication

5. The Health Insurance Portability and Accountability Act (HIPAA) mandates that health information can be shared: (Select all that apply.)
   a. In order to provide treatment for the patient.
   b. To determine billing and payment issues.
   c. To enhance health care operations related to the patient.
   d. In public areas such as the cafeteria or elevator.
   e. Over the telephone with any family member.

ANS: A, B, C

The Health Insurance Portability and Accountability Act (HIPAA), originally passed in 1996, created standards for the protection of personal health information, whether conveyed orally or recorded in any form or medium. The act clearly mandates that protected health information may be used only for treatment, payment, or health care operations. HIPAA privacy standards should be applied during phone, fax, e-mail, or Internet transmission of protected patient information.

DIF: Understanding  
TOP: Assessment  
MSC: NCLEX Client Needs Category: Safe and Effective Care Environment: Management of Care  
NOT: Concepts: Communication