Documentation quiz

1. A nurse teaches a client how to self-administer insulin. What information should the nurse document?
    a. The information provided to the client
    b. The client's comprehension of the information
    c. The client's ability to administer the insulin
    d. All of the above

Rationale: As per indicator 1.11 of the *Standards for Documentation*, client education must be documented and includes any informal or formal teaching.

2. A nurse has just started in a new role at a new facility. As she reviews the employer's documentation policy, she notices that it does not follow the NANB *Standards for Documentation*. The nurse should:
    a. Disregard the new employer's policy and follow the policy of her old employer
    b. Disregard the NANB *Standards for Documentation* and follow the clinical instruction provided in her nursing program
    c. Raise her concerns with her new employer and advocate for changes to the organization's policy
    d. Follow the employer's policy because it is most applicable to the practice setting

Rationale: Indicator 2.12 of the *Standards for Documentation* requires nurses to advocate for employer policies that are consistent with NANB standards.

3. Which of the following documentation practices respect the *Standards for Documentation* when correcting an error:
    a. Erase the error
    b. Put a single line through the error
    c. Use liquid paper

Rationale: Indicator 2.6 of the *Standards for Documentation* explains that when mistaken entries are corrected, the original information must remain visible. Please refer to employer policy for more specific direction on how to correct an error.

4. Client care may be at risk when documentation systems that support information sharing and decision-making within the circle of care are not in place.
    a. True
    b. False

Rationale: One of the main purposes of documentation is to support communication and decision-making within the circle of care (See pages 5-6 of the *Standards for Documentation*).

5. A nurse working in an immunization clinic is required to save client data on a portable electronic device and later take the device to her employer's office. Which of the following is *the most* important factor to safeguard the client data?
    a. Encrypt the information being stored on the device
    b. Store the device in a locked area until she is ready to take it to the office

c. Protect the info with a password

Rationale: Keeping a device in a locked area does not protect the information stored on the device; the device and its information could be lost or stolen. A password can be bypassed, allowing others to access personal health information on the device. As per the *Standards for Documentation* webinar, the information should be encrypted.

6. Under what circumstances is the nurse permitted to document for other members of the health care team?
    a. When working as a team
    b. When working with an unregulated care provider
    c. When the nurse is the designated recorder in an emergency
    d. When the coworker has forgotten an entry and is off shift

Rationale: Documentation should be completed by the individual who provided the care unless it is an emergency. It is acceptable to document for another's care provision during an emergency, when outlined in employer policy with clear direction regarding how and when to do so (e.g. during resuscitation by a code team). See "Principles of Documentation" on page 5 of the *Standards for Documentation*.

7. Appropriate documentation includes which of the following characteristics?
    a. Clear
    b. Comprehensive
    c. Sporadic
    d. Chronological

☐ a, b, c
☒ a, b, d
☐ a, c, d
☐ b, c, d

Rationale: Nurses document clear, accurate, comprehensive, legible, chronological information concerning the condition of the client, the client's needs, the nursing interventions, and the associated response. See indicators 1.1, 1.2, 2.4. of the *Standards for Documentation*.

8. A nurse is working in a long-term care facility with electronic charting and an incident reporting system. During a shift, the nurse witnesses a client fall. Where should this information be documented?
    a. Only in the client's chart
    b. Only in the incident reporting system
    c. In both the client's chart and the incident reporting system

Rationale: Documenting the fall in the client's chart is meant to ensure continuity of care. This documentation should be objective, concise, unbiased, and it should be done in a timely manner. Incident reports are used for risk management, to track trends in client care, and to justify changes to policy, procedures, and/or equipment. Employer policy should guide incident reporting; ensure you are familiar with the policies affecting your documentation practice. (See *Standards for Documentation* indicator 2.8).

The College of Nurses of Ontario granted permission to NANB to adapt questions from the Documentation section of their website.

Documentation Case study #1

Melanie is the only RN working at a 36 bed long-term-care facility. Jasmine, an LPN, asks Melanie to assess Mr. Bell. At first glance, Melanie agrees that Mr. Bell seems worse than this morning. His face is slightly diaphoretic, and he has a coarse cough. When asked how he was feeling, Mr. Bell replied, "I feel pretty tired. This coughing is wearing me out."

Melanie proceeded to assess Mr. Bell's condition: his respiratory rate was at 26/min, and coarse crackles were noted in both posterior and anterior lower lung fields. His temperature was 37.7C. Melanie informed Mr. Bell that she was going to call his family doctor to inform him of his condition.

Melanie called Dr. Simms outlining the change in Mr. Bell's condition over the previous 24 hours. In response, Dr. Simms suggested that Mr. Bell "probably has the flu that's going around" and instructed Melanie to "keep an eye on him" and to "call him back if she was concerned". Melanie returned to Mr. Bell and, as per the unit's directive, gave him some Tylenol "for comfort", made sure he was well positioned in bed and encouraged him to rest, and to notify her if his breathing got worse.

9. What should Melanie document in this situation?

    i. Client seems short of breath. Has a fever. Doctor informed.
    ii. Client's face is slightly diaphoretic. Coarse cough. Respiratory rate is 26/min. On anterior and posterior auscultation, coarse crackles in lower lung fields bilaterally are noted. Client states he 'feels pretty tired'. Dr. Simms notified of client's current condition and changes overnight. Dr. advised ongoing observation. Client repositioned and Tylenol 650mg given as per unit protocol and encouraged to rest and notify if breathing gets worse.
    iii. Client short of breath and increased respiratory rate. Lower lungs present coarse crackles. Slight fever. Client states he "feels pretty tired". Doctor notified of client's condition. Tylenol given for comfort.

    Rationale: Option B is correct. Option A is not comprehensive enough and it does not show the use of the nursing process; it omits the nurse's assessment and actions. It is unclear how severe Mr. Bell's condition is, and it does not show any evidence of intervention. Option C provides more detail; however, it is still not comprehensive enough. There is evidence of an assessment, but the information documented is incomplete and subjective. In both A & B, Melanie does not document the content of her communication with the doctor. Furthermore, the nurse's description of Mr. Bell should be factual and objective.

Over the next four hours, Melanie checked in on Mr. Bell several times: he remained tachypneic and at one point she noticed that the crackles sounded worse. Mr. Bell stated, "I feel like I can't catch my breath." His respiratory rate was now 30/minute, his chest sounds had increased, and his pulse oximeter read 92%. Melanie decided to call Dr. Simms to update him. Dr. Simms said he would be in shortly to have a look at Mr. Bell.

Melanie then realized she had several medications that she was late dispensing, so she quickly wrote the note below in Mr. Bell's chart, and then proceeded to dispense the medications.

02/06/20 – 1530 - Client's breathing looks worse. Doctor notified.----M. Clark RN

Dr. Simms arrived 10 minutes later and assessed Mr. Bell. He then ordered antibiotics and supplemental oxygen via nasal prongs at 3L/minute, and to transfer patient to emergency department if saturation below 92%.

Melanie promptly reviewed the orders, faxed the prescription to pharmacy, reassessed Mr. Bell, initiated the oxygen as prescribed (at 1600) and positioned him in a semi-fowler position. She also updated the documentation in Mr. Bell's chart as follows:

02/06/20 - 1730 - Dr in. Orders received.--- M. Clark RN

10. How could Melanie's documentation be improved to meet the *Standards for documentation*?
    a. It should include her objective assessment data for each assessment
    b. It should include more detail about her conversations with Dr. Simms
    c. It should include the client's statement about his condition
    d. It should include the medical orders
    e. It should not include her re-assessment of client's condition, because the doctor's assessment can be found in the progress notes
    f. It should include the nursing care provided
    g. It should be completed in a timely manner

- ☐ a, b, c, d, g
- ☒ a, b, c, f, g
- ☐ a, b, e, f, g
- ☐ a, b, d, f, g

Rationale: As per the following indicators of the *Standards for Documentation*, Melanie should have included her objective data and the client's statement (1.2), her communication with the doctor (1.4), including his name (2.11), documented the care (1.1) and time it was provided (2.3), all in a timely manner (2.1).

Although Melanie's documentation is concise, it does not accurately outline the situation. Documentation is meant to serve as a communication tool for the care team. However, Melanie does not provide sufficient information for the care team to fully understand Mr. Bell's condition or the plan of care. As mentioned in the *Standards for Documentation* indicator 2.2, nurses must document more frequently when a client is at risk of harm, is unstable, or there is a higher degree of complexity involved in the nursing care. Melanie's shift has been very busy, but it is still important for nurses to plan their care to have time to document. Her documentation is missing information and fails to meet the NANB standards.

The British Columbia College of Nursing Professionals granted permission to NANB to adapt their case study.

Documentation Case study #2

Rick Ross, Emergency Department (ED) RN is waiting for the paramedics to bring in Mr. Hugo Stivic, a 58-year-old man experiencing chest pain. The paramedics report shortness of breath with oxygen, and administration of aspirin and three sprays of nitroglycerin with minimal relief of chest pain. Rick notified the physician on call who requested to institute the hospital's chest pain protocol upon patient's arrival in ER.

As per the chest pain protocol, Rick asked Janet, RN, if she would draw up some morphine and prepare a nitroglycerin infusion while he assessed Mr. Stivic. Rick took Mr. Stivic's vital signs, noting them on his temporary worksheet, and asked him about his pain:

- 'what would he rate his pain on a scale of 1-10 with 10 being the worst pain he had ever experienced?'… a 7 out of ten
- 'had his pain decreased with the nitroglycerin?'…it had gone from 10 to 7
- 'could he describe his pain?'…it was a crushing pain in the middle of his chest that was making it difficult to breathe
- 'did his pain radiate anywhere?'…down his left arm and up into his jaw
- 'were there other symptoms?' …yes, he was short of breath, diaphoretic and could not breathe
- 'when did it start?' just after dinner time a little over an hour ago.

Rick fumbled through the pile of papers that would become Mr. Stivic's chart. Finding the ED admission record, Rick documented his pain assessment as follows:

02/06/20 - 1920 - Patient arrived in ED experiencing severe chest pain.--- R. Ross RN

11. What should Rick have included in his documentation?
    i. His complete pain assessment
    ii. That the doctor had been called
    iii. That the chest pain protocol had been implemented
    iv. The vitals recorded on his worksheet
    v. All of the above

    Rationale: In this situation, Rick's documentation should have been more thorough. Since Rick conducted a complete pain assessment, that information should have been charted. Indicator 1.4 of the *Standards for Documentation* explains that communication with other healthcare providers that may impact the client's plan of care should be documented. Furthermore, Rick should have included that the chest pain protocol was implemented as it is part of the nursing care he provided. The vital signs should be noted in the chart because Rick's worksheet is only temporary documentation (indicator 1.6).

As Rick was obtaining blood samples from Mr. Stivic, Janet administered 2 milligrams of morphine IV and she handed the bag of nitroglycerin to Rick, who proceeded with the infusion at 20 mcg/min. Janet ran a 12 lead ECG on Mr. Stivic, while Rick reassessed his chest pain: he reported that it was now 5/10.

Dr. Sinclair then arrived at the bedside, looked at the ECG, assessed Mr. Stivic's chest pain, and indicated to increase the nitroglycerin infusion to 30 mcg/min (which Rick did). She then proceeded to arrange transfer by air ambulance for a Percutaneous Transluminal Coronary Angioplasty at another hospital.

At 1940, Rick assessed Mr. Stivic's chest pain again, then Janet prepared him for transfer. Rick returned to the ED record to document the care provided. Here is a copy of Rick's documentation:

DATE & TIME	NURSES' NOTES	SIGNATURE
1920	Patient arrived in ED experiencing severe chest pain	*R. R*
1924	Bloodwork drawn	*R. R*
1925	Morphine 2 mg IV given for chest pain	*R. R*
1926	Nitroglycerin infusion commenced at 20mcg/min	*R. R*
1930	12 lead ECG obtained. Dr. Sinclair arrived.	*R. R*
1935	Nitroglycerin infusion increased	*R. R*
1940	Patient prepared for transfer to tertiary facility	*R. R*

Signature	Initials
Rick. Ross. RN	*R. R*
Ann. Smith, LPN	*A. S*

12. In the table above, what errors has Rick made with his documentation?
    a. His signature is incomplete
    b. He did not provide enough detail
    c. He is missing the date of his charting
    d. He charted interventions made by another nurse

- ☐ a, b, c
- ☐ a, b, d
- ☐ a, c, d
- ☒ b, c, d

Rationale: As per Indicator 1.7 of the *Standards for Documentation,* a signature including a professional designation must be included with all documentation; however, the use of initials is acceptable when a master list of signatures/initials is incorporated into the documentation tool or health record.

Standard 1 requires documentation to be comprehensive, Rick is missing important pieces of information such as, his pain assessments, the increased nitroglycerin rate, evaluation of his interventions, and the location where the patient was being transferred.

Indicator 2.3 states, "document the date and time that the care was provided." In this situation, Rick has provided the time, but there is no date on his charting.

Finally, Rick should not have charted the interventions made by the other nurse, or he should have identified in his charting that these interventions were completed by Janet Martin RN. His

charting provides the assumption that he cared for this patient by himself, without assistance from another nurse.

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