DOCUMENTATION AND LEGAL ASPECTS 2HR

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Question 1

Some of the purposes for documentation includes:
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- Answer A. Compliance with standard of practice
- Answer B. Communication among the health care team and providing education to staff
- Answer C. To provide continuity of care
- Answer D. All of the above

Question 2

It is legal to document ones personal feelings in the patient's medical record so that the patients will be better treated for their medical condition.

- True
- False

Question 3

HIPAA stands for:

- Answer A. Health Information Portability and Accountability Act
- Answer B. Health Institution Privacy and Accountability Act (HIPAA)
- Answer C. Health Insurance Portability and Accountability Act (HIPAA)
- Answer D. Health Insurance Privacy and Accountability Act (HIPAA)

Question 4

HIPAA violations involve both civil and criminal penalties which include fines and imprisonment.

- True
- False

Question 5

Certified nursing assistants as well as everyone who works with the patient has to maintain confidentiality of patient information.

- True
- False

Question 6

Health Insurance Portability and Accountability Act (HIPAA) gives the health care worker the ability to share the patient's information with everyone.

- True
- False

Question 7

When you are documenting, which of the statement is not accurate?

- Answer A. Always write clearly (legibly)
- Answer B. Avoid charting in advance, this too is illegal and can lead to devastating errors.
- Answer C. Do not document any complaints of the patient and/ or family
- Answer D. When standard time is used, always include AM or PM with notations

Question 8

Which statement regarding empty spaces in the documentation is not accurate?

- Answer A. Empty spaces will allow you to return later and document what you had forgotten earlier.
- Answer B. Avoid leaving spaces in charting.
- Answer C. If blank spaces are left, this will allow others to make additions to the patient's medical record, to your notation.
- Answer D. Make a straight line through any empty space.

Question 9

Computerized documentation systems have many advantages including:

- Answer A. Records are legible; no need to worry about unclear handwriting,
- Answer B. Security of patient information; need password to log in to access patient information,
- Answer C. Reduction in errors
- Answer D. All of the above

Question 10

When documenting the Certified Nursing Assistant (CNA):

- Answer A. Does not have to document the care completed with the resident because the nurse will document that.
- Answer B. Should update the nurse with all abnormalities noted with the resident
- Answer C. Does not have to tell the nurse of all abnormalities noted with the resident
- Answer D. Will not face fines or imprisonment if the patient's information is shared with unauthorized persons; only the nurses and physicians will face fines or imprisonment.

Question 11

When making corrections in the medical record, the error:

- Answer A. Cannot be white-out,
- Answer B. Cannot be erased,
- Answer C. Cannot be scratched out to make illegible.
- Answer D. All of the above

Question 12

It is appropriate to correct an error by drawing a line through the text and writing the word error, sign your name and date the cross off.

- True
- False

Question 13

While providing care the Certified Nursing Assistant (CNA) noticed that the resident has a small new open wound on the skin, the CNA should:

- Answer A. Place a Band-Aid on it because it is a small area should heal on its own
- Answer B. Promptly notify the Nurse

- Answer C. Do not interrupt the nurse because she is having a busy day
- Answer D. Tell the resident to start turning and positioning.

Question 14

If catheter is present, documentation should include:

- Answer A. Medical justification for the catheter,
- Answer B. Type and size of catheter,
- Answer C. Color of the urine,
- Answer D. All of the above

Question 15

Some information such as allergies/ sensitivities, Patient's identification; name and other identifying information should be on every page of every document in the patient's medical record.

- True
- False

Question 16

The certified nursing assistant is not required to perform accurate and complete documentation.

- True
- False

Question 17

Fall Assessment risks that should be included in the documentation include:

- Answer A. Medications that the resident is taking that has side effects such as dizziness
- Answer B. hypotension
- Answer C. Patient has a history of falls,
- Answer D. All of the above

Question 18

Electronic medical record is the computerized patient medical record. With the use of the computerized documentation system, computer terminals may be located in the patient's room, therefore:

- Answer A. The computer should be logged off
- Answer B. There is no reason for the computer to be logged off
- Answer C. The computer should be left on for others to use
- Answer D. All of the above.

Question 19

There is only one format for documentation.

- True
- False

Question 20

Do not use abbreviations unless they are approved, acceptable and included in your facility's policy and procedure.

- True
- False