Test Yourself

Evaluate your knowledge of the College's *Documentation* practice document with the following test questions.

Participation in this quiz is self-directed and anonymous.

The College does not collect individual quiz scores or answers.

You can perform this test at any point in this learning module, and as many times as you want.
1. A nurse teaches a client how to self-administer insulin. What should the nurse document in the client’s health record?

  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

Correct - Click anywhere to continue
Incorrect - Click anywhere to continue
You must answer the question before continuing
Question 1 response

Options A, B and C are all correct; therefore, the right answer is D, all of the above.
2. A client tells a nurse “I’ve never had surgery before and I’m sort of nervous about it.” The nurse documents the client’s statement in his chart. The client’s statement is an example of:

○ a) Objective data

• b) Subjective data

○ c) Third-party reporting
Question 2 response

Option B is correct.

Option A is incorrect. Objective data includes data that can be observed and measured, such as blood pressure.

Option C is incorrect. Third-party information comes from a person other than the client or member of the circle of care.
3. A nurse has just started in a new role at a new facility. As she reviews the agency’s documentation policy, she notices that it does not follow the College’s *Documentation, Revised 2008* practice document. The nurse should:

- [ ] a) Disregard the new employer’s policy and follow the policy of her old employer
- [ ] b) Disregard the agency’s policy and follow the clinical instruction provided in her nursing program
- [x] c) Raise her concerns with her new employer and advocate for changes to the organization’s policy
- [ ] d) Follow the agency’s policy because it is the most applicable to that practice setting
Question 3 response

**Option C** is correct.

**Option A** is incorrect. The policy of her former employer won’t be applicable to her new practice setting. The nurse needs to advocate for her new employer to modify the policy to follow the *Documentation* practice document.

**Option B** is incorrect. The instruction from her nursing program won’t be applicable to her new practice setting. The nurse needs to advocate for her new employer to modify the policy to follow the *Documentation* practice document.

**Option D** is incorrect. Though the policy is the most applicable to the practice setting, the nurse needs to advocate for her new employer to modify the policy to follow the *Documentation* practice document.
4. It is solely the employer’s responsibility to identify systems problems that may have an impact on a quality practice setting.

○ a) True
○ b) False
Question 4 response

Option B is correct.

Option A is incorrect. It is the responsibility of the employer and members of the health care team to identify systems problems.
5. When correcting an error in documentation a nurse should:

- a) Also correct any errors made by other nurses
- b) Correct the error, leaving the original entry visible, and sign the entry
- c) Permanently erase the error
Question 5 response

Option B is correct.

Option A is incorrect. A nurse should never alter another nurse’s documentation.

Option C is incorrect. All documentation, even errors, must remain visible or retrievable.
6. A nurse practising in the community takes temporary notes on relevant client information. When he returns to the office, he enters the information into the client’s permanent health record. What should he do with the temporary documentation?

- a) He should not use temporary documentation
- b) He should ensure the temporary documentation is destroyed in a secure way, such as shredding
- c) He should file the temporary documentation for later retrieval

Submit  Clear

Correct - Click anywhere to continue
Incorrect - Click anywhere to continue
You must answer the question before continuing
Question 6 response

Option B is correct.

Option A is incorrect. Temporary documentation is permissible, as long as the information is transferred to the client’s permanent health care record and the temporary documents are destroyed securely.

Option C is incorrect. Once the information has been entered into the client’s permanent health record, the temporary documentation should be securely destroyed.
7. 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
Question 7 response

Option A is correct.

Option B is incorrect. One of the main purposes of documentation is to support communication and decision-making within the circle of care.
8. 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 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) Keep the information password-protected

Correct - Click anywhere to continue
Incorrect - Click anywhere to continue
You must answer the question before continuing.
Question 8 response

Option A is correct.

Option B is incorrect. Keeping a device in a locked area doesn't protect the personal health information stored on the device if it is stolen or lost.

Option C is incorrect. A password can be bypassed, allowing others to access the personal health information stored on the device.
9. Under what circumstances is a 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 has been designated the recorder
- d) When a coworker has forgotten an entry and is off shift
Question 9 response

Option C is correct.

Option A is incorrect. The only time a nurse should document for another member of the health care team is when that nurse has been designated the recorder, such as in an emergency situation.

Option B is incorrect. Unregulated care providers should document the care they provide.

Option D is incorrect. Documentation should be completed by the individual who provided the care, unless it is an emergency situation.
10. A Registered Practical Nurse (RPN), has recently obtained a baccalaureate degree in business administration (BBA). When signing documentation, what should her signature include to meet College requirements?

- a) RPN, BBA
- b) BBA, RPN
- c) RPN

Correct - Click anywhere to continue
Incorrect - Click anywhere to continue
You must answer the question before continuing
Question 10 response

Option C is correct.

Option A is incorrect. The College requires only the nurse’s designation to be included with the signature.

Option B is incorrect. The College requires only the nurse's designation to be included with the signature.
## Documentation

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