

7 Documentation of Nursing Care

CHAPTER PRETEST

Have the students answer these questions prior to covering this chapter to understand where they stand in relation to the content.

- 1) The written document that contains the patient's information is known as the: **ANSWER**
a) consent.
b) medical record.
c) protocol.
d) report sheet.
- 2)
3) Organizations outside of the health facility that are usually allowed access to patient information include:
a) nonprofit organizations.
b) credit bureaus.
c) **insurance companies.**
d) retail pharmacies.
- 4)
5) The results of the patient's skull x-ray findings may be found with which forms?
a) Laboratory results
b) Face sheet
c) Risk assessment
d) Radiology report.
- 6)
7) Which of the following individuals does *not* have the privilege to access the patient's information?
a) Nurse
b) Visitor
c) Phlebotomist
d) Respiratory therapist
- 8)
9) Focus charting utilizes which of the following?
a) SOAP notes: subjective, objective, assessment, planning
b) Standards of care
c) DAR: data, action, response
d) Clinical pathway
- 10)
11) Written documentation is also known as:
a) making rounds.
b) charting.
c) case management.
d) evidence.
- 12)
13) The form used to obtain authorization for a surgical procedure is known as a(n):
a) consent.
b) evaluation form.
c) surgical procedure form.
d) treatment sheet.
- 14)
15) The military, or 24-hour time, for 3:00 PM is:
a) 0300.
b) 1500.
c) 1800.
d) 2400.
- 16)
17) Which of the following is a disadvantage of focus charting?
a) If the database is not complete, patient problems may be missed.
b) It requires development of detailed protocols and standards.
c) It requires retraining staff to use unfamiliar methods of record keeping and documenting.
d) Nurses become so used to not charting that important data are sometimes omitted.

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