Medical Records Documentation for CNA's & HHA's

1) The first and most important rule of documentation is:
   a) Document everything you see.
   b) If it wasn’t documented, it wasn’t done.
   c) Document everything as soon as it happens.
   d) Always sign every note that you write.

2) Three reasons why everything concerning a patient’s care must be documented are:
   a) Dangerous duplication, dangerous omission, and liability.
   b) Requirements of the practice acts, liability, and providing good care.
   c) Dangerous duplication, dangerous omission, and hospital regulations.
   d) Liability, patient safety, and professional responsibility.

3) The three aspects of proper documentation are:
   a) Completeness, accuracy, and truthfulness.
   b) Accuracy, timeliness, and legibility.
   c) Timeliness, accuracy, and objectivity.
   d) Accuracy, legibility, and signing the note.

4) The four "dos" of proper documentation are:
   a) Objectivity, accuracy, completeness, and timeliness.
   b) Objectivity, truthfulness, completeness, and timeliness.
   c) Accuracy, completeness, legibility, and timeliness.
   d) Completeness, being factual, legibility, and being signed.

5) The three “don’ts of proper documentation are:
   a) Don’t be misleading, don’t be opinionated, and never document for someone else.
   b) Don’t be subjective, don’t change a written entry, and don’t document for someone else.
   c) Don’t write your opinions, don’t be subjective, and don’t document for someone else.
   d) Don’t be subjective, don’t sign someone else’s documentation, and don’t change a written entry.
6) Which of these CNA notes is an example of poor documentation:
   a) 13:30, 12/25/2009. “Assisted patient out of bed and ambulated from room to end of hall and back, total time 10 minutes. Patient, when asked, had no complaints or pain regarding the activity. Returned to bed at 13:40. Jane Doe, CNA.”
   b) 14:00, 12/25/2009. “Changed surgical dressing on right great toe. Patient, when asked, stated she had no pain during the procedure. No redness, swelling or drainage noted on or around the incision site. New dressing applied. Jane Doe, CNA.”
   c) “Helped patient with ROM exercises after checking vitals. Jane Doe, CNA.
   d) "09:00, 12/25/2009. “ Helped patient with range of motion exercises of both hips and both knees. Performed 10 flexions and extensions of each hip and each knee. Patient, when asked, stated he had no pain during the procedure. Jane Doe, CNA.

7) Which of these CNA notes is an example of good documentation:
   b) “Patient found on floor, bleeding noted, patient seemed confused.
   c) “12/25/2009. Patient’s temperature noted to be 103 degrees, and patient was noted be very diaphoretic. Jane Doe, CNA.
   d) "17:00, 12/25/2009. Bleeding noted from surgical incision site on left hip. Vital signs taken and recorded. Patient, when asked, had no complaints. John Doe, RN, notified at 17:10.  Jane Doe, CNA.

8) Which of the following three things would a CNA be responsible for documenting:
   a) Level of consciousness, fluid intake, and urine output.
   b) Patient’s ethnic origin, level of consciousness, and feelings about the doctors.
   c) Urine output, skin color, and patient’s mood.
   d) Food intake, important conversations with the nurses, and the patient’s religious beliefs.

9) The proper way to document when a note is entered late is:
   a) There is no need to do anything special as long as the note is complete and accurate.
   b) Explain why the note was entered late, then simply document what needs to be documented.
   c) “Late entry, 16:00, 12/25/2009. Checked and recorded temperature, pulse, and blood pressure at 15:00, 12/25/2009.”
   d) Late entry. Checked and recorded temperature, pulse and blood pressure at 15:00, 12/25/2009.

10) Which of the following is important to document after a therapeutic activity:
    a) How long it took to perform.
    b) The patient’s response to the activity.
    c) When you started.
    d) How difficult it was to do.