Chapter 3

Managing Client Care: Documentation and Delegation

Test Item File

1. Client care plans are used in client care for which of the following reasons? Choose one answer.

a. To describe specific medication orders that are to be followed.

b. To determine client status.

c. To document laboratory values and specific diagnostic tests.

d. To provide a source of communication between nurses on various shifts.

Clinical Situation: You have just completed an admission assessment on the following client, and based on the collected data, you begin the client care plan.

The client is a 39-year-old single male admitted for upper right-quadrant pain following a week-long episode of flu-like symptoms. He has not eaten for 7 days and presents with signs and symptoms of dehydration and malnutrition. He has not been out of bed during the week. He lives alone and states he either buys frozen foods or eats in fast-food restaurants.

Questions 2 through 6 refer to the client care plan. (When filling in the content in the care plan, remember that the material is not necessarily related. This exercise is designed to determine your care plan knowledge base, not your medical knowledge. Use the care plan found later in the text for documenting data.)

2. Which one of the following client problems is related to the client's condition? Circle the correct letter, and write the selected problem in the appropriate section of the care plan.

a. Fluid volume excess.

b. Fear.

c. Sensory perceptual alterations (kinesthetic).

d. Impaired skin integrity.

3. Based on the collected data, circle the letter of the short-

term goal that is the most appropriate. Write the selected short-term goal in the appropriate section of the care plan.

a. Improved skin turgor within 24 hours.

b. Respiration unlabored and 20/minute.

c. Able to ambulate without assistance.

d. Noncompliance related to poor dietary habits.

4. From the statements below, select the most appropriate long-term goal, and write it in the care plan in the designated section.

a. Able to demonstrate ability to care for self.

b. Positioned off coccyx to prevent skin breakdown.

c. Check skin condition every shift.

d. Stable vital signs.

5. The fact that the client lives alone should be documented in which section of the care plan?

_____

6. Briefly explain the intent of the checkpoint and deadline section of the care plan.

_____

_____

7. Nursing care plans should be updated at least

a. Prior to discharge.

b. When a new nurse is assigned to the client.

c. Every 24 to 48 hours.

d. Each time a new problem arises.

8. When activating a care plan, the most appropriate method is to

a. Place a care plan in the chart.

b. Draw a line through the interventions that are not relevant.

c. Sign the care plan in the appropriate section.

d. Circle and date the relevant problems and nursing interventions.

9. Briefly state the three primary methods by which communication takes place in a nursing unit.

a. _____

b. _____

c. _____

10. Critical or clinical paths are used primarily in the following health care setting

a. Short-term admission facilities.

b. Out-patient facilities.

c. Recovery or post anesthesia rooms.

d. Managed care delivery settings.

11. When a client does not achieve the expected outcomes listed on the clinical path, in a specific time frame, what consequences occur?

a. Hospitals must obtain permission to continue to treat the client.

b. An individualized care plan is initialed for the "variance."

c. All documentation must now be completed on the individualized care plan.

d. Documentation continues on the individualized care plan until the client is discharged.

12. Which one of the following statements regarding clinical paths is correct?

a. This is a format for documenting nursing tasks and eliminates the need for other flow sheets, graphic forms, etc.

b. Discharge planning is initiated after the first "variance" occurs.

c. Use of critical paths reduce client complication rates and hospital costs.

d. All clients should be placed on a clinical path at the time of admission.

13. Charting is one of the nurse's most important functions. Which of the following is the most important purpose of charting?

a. To communicate to other members of the client's health care team.

b. To evaluate the staff's performance.

c. To provide information for a nursing audit.

d. To enable physicians to monitor nursing care.

14. Circle T if the statement is true or F if the statement is false.

T F a. Nurses' notes for all shifts should contain a completed assessment.

T F b. The quality of nursing care is frequently evaluated from the quality of the charted notes.

T F c. Clinical observations should be documented at the time they occur.

T F d. Alterations from normal findings are charted, but normal findings do not need to be charted.

T F e. Usual activities of daily living, such as bed baths and oral care, are charted only when abnormalities exist.

T F f. The client's plan of care needs to reflect current standards of nursing practice in the community.

T F g. Each entry in the nurses' notes must be signed by the nurse providing the care.

T F h. Errors in charting should be obliterated with a black pen so they are not legible.

T F i. Each new idea begins on a separate line in the nurses' notes.

T F j. Charting is completed using complete sentences.

T F k. After charting client observations, your interpretation of the findings should be summarized in the chart.

T F l. Clients' statements regarding their symptoms and feelings should be included in the charting.

T F m. If medications are refused by the client, the policy is that the medication is not charted in the medication record.

T F n. Client behaviors are charted, not your feelings about the client.

T F o. Abbreviations are not acceptable in a chart due to legal ramifications.

15. Which of the following items would you always include in a client's chart? List all that apply.

1. Initial assessment at beginning of shift.
2. Abnormalities noted during assessment.
3. Changes in client's condition.
4. General verbatim comments.
5. Client's response to teaching.

16. It is important to record any unscheduled or prn medication. The following is an accurate representation of this type of charting.

"8 P.M. c/o abdominal incisional pain after ambulation. Depo Dur 10 mg IM for pain."

a. True

b. False

17. List three disadvantages of problem-oriented charting.

a. _____

b. _____

c. _____

18. The following statements relate to minimizing the legal risks of computer charting. Circle T if the statement is true or F if the statement is false.

T F a. The password you use to enter the computer cannot be given to a physician to assist him or her with data entry.

T F b. Computer entries are not deleted even when they are no longer relevant to client care.

T F c. The nurse must be extremely careful when entering data into the computer, as it is very easy to delete information.

T F d. It is important that records have backup files as a safety factor.

19. A major advantage of a computer-based documentation system is

a. All health care staff can chart in the nursing notes.

b. The system provides reference material for common nursing problems.

c. Nurses do not need to check the physician's orders as they are transferred to the appropriate department for implementation.

d. Information is readily available with minimal delays.

20. Charting by exception (CBE) is best described as a system of charting that

a. Does not encompass the use nursing diagnosis.

b. Necessitates a complete nursing assessment at the beginning and end of each shift.

c. Requires a data entry every 2 hours in the nursing notes.

d. Only addresses client changes when the predetermined norm is not met.

21. Which one of the following statements is true regarding CNAs abd UAPs charting.

a. They can not chart except on a vital signs clipboard at the nurses' station.

b. They can chart hygienic care when flow sheet charting is used.

c. They can document hygienic care on nurses' notes when narrative charting is used.

d. They cannot chart any information on any charting system.

22. Unusual occurrences serve the purpose of documenting quality of care, identifying areas where in-service education is needed, and recording the details of the incident for legal documentation.

a. True

b. False

23. The consent form can be signed by which one of the following? Circle the correct number.

1. The person himself or herself.
2. A spouse.
3. A guardian of a 22-year-old.
4. A mother of a 16-year-old.

a. 1, 2, 3

b. 1, 3, 4

c. 1, 2, 4

d. All of the above

24. State three examples of "Rights of Delegation" state boards of nursing have identified.

a. _____

b. _____

c. _____

25. The team leader RN can delegate all of the following client activities to other health care workers *except*

a. Admission vital signs.

b. Wound dressing change.

c. Reviewing a teaching activity with the client.

d. Establishing long-term client goals.

ANSWERS

Content Examination

1. d

2. d. Impaired skin integrity.

3. a. Improved skin turgor.

4. a. Able to demonstrate ability to care for self.

5. Relevant information.

6. Checkpoint indicates how often the intervention should be checked, observed, completed, and charted. The deadline column indicates the time when the goal should be met or the intervention is no longer necessary.

7. c. Every 24 to 48 hours.

8. d. Circle and date the relevant problems.

9. a. Nurses' notes.

b. Shift-to-shift report.

c. Client care conferences.

10. d

11. b

12. c

13. a

14.

a. T	f. T	k. F
b. T	g. T	l. T
c. T	h. F—errors should be legible. Draw a single line through the error, date it, write "mistaken entity" and intial the entry.	m. F—include an explanation as to why the medication was not taken. Refusal of the medication or treatment must be documented.
d. F—all answers must be charted.	i. F—nurse's notes may be continuous unless a time change occurs. You may need a new line for a new idea, depending on agency protocol.	n. T
e. F—the usual activities must be charted for. If not, anyone reading the chart will assume they were not done.	j. F--complete sentences do not have to be used.	o. F—chart only those abbreviations and symbols approved by the facility or Joint Commission.

15. 1, 2, 3, 5

16. a

17. a. Time-consuming.

b. Can lack information on client care outcomes.

c. Difficult to monitor data for quality assurance.

d. Relevant information found in many parts of chart.

18. a. T

b. T

c. F—Once information has been stored, it's difficult to delete.

d. T

19. b

20. d

21. b

22. a. T

23. b

24. Examples of "Rights of Delegation" include: right task, right circumstance, right person, right communication, and right supervisor.

25. Establishing long-term client goals is designated as RN responsibility.