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“Ladies
of the jury,
I present...
the nursing
documentation”

& gentlemen

By following this advice when you document patient care, you may sidestep a lawsuit—or be well prepared to defend yourself in court if you have to. BY SALLY AUSTIN, ADN, BGS, JD

YOU WAKE UP in a cold sweat after dreaming that you're the defendant in a medical malpractice case. The plaintiff's lawyer was about to point out the flaws and gaps in your documentation. Thankful it was only a dream, you vow to make sure your charting is up to snuff.

No matter how skilled a nurse you are, poor nursing documentation will undermine your credibility if you're ever involved in a lawsuit. Read this article for practical guidelines that will not only improve patient care, but also help shield you from legal fallout if something goes wrong despite your best efforts.

Telling the whole story

Your patient's medical record is a legal document that tells the story of his encounter with you and other professional caregivers. It should provide a complete and accurate account of his condition and the care he received. (See *Who regulates medical records?*)

Although the medical record has various functions (see *One record, many purposes*), I'll focus here on its role in lawsuits alleging professional negligence. Let's start by reviewing some basic terms and concepts. *Professional negligence* is failure to provide the prevailing standard of care to a patient, which results in injury, damage, or loss to the patient. The person filing a lawsuit is the *plaintiff*. Knowing what the plaintiff's attorney would look for in the medical record will help you make good decisions about how and what to document.

In a lawsuit alleging professional negligence, the plaintiff has the burden of proof. This means that to prevail, the plaintiff must prove all four of the following elements:

- A duty to the plaintiff existed. Duty is established when a health care professional assumes care of a patient under her scope of practice, licensure, and employment.
- The standard of care was breached. The standard of care is based on what a reasonably prudent professional with similar expertise and responsibilities would have done under similar circumstances. The standard is set by, but not limited to, the state nurse practice act, accreditation bodies, professional journals and textbooks, and facility policies and procedures.
- The patient was injured.
- The injury was caused by the breach in the standard of care.

Who regulates medical records?

Licensing statutes, accrediting organizations, state laws, federal laws, and case laws regulate the content of the medical record. In particular, the Joint Commission on Accreditation of Healthcare Organizations mandates that hospital documents be recorded accurately on a timely basis and that the medical record be readily accessible to appropriate personnel. For example, when a patient is transported to radiology for a computed tomography (CT) scan, her medical record needs to be immediately available to CT scan staff, radiologists, and other staff.

If the plaintiff prevails, he's awarded damages based on his economic losses, such as lost wages and medical expenses, and possibly noneconomic losses, such as pain and suffering. In cases of professional negligence, unlike in general negligence claims, an expert must testify about the errors of the treating health care provider. State law determines who can testify as an expert.

In most states, Good Samaritan laws shield health care professionals from liability if they volunteer to help someone in good faith in an emergency outside the scope of their employment.

Finding flaws in the record

The medical record is rich with written facts—or it should be. If it's riddled with inconsistencies, inaccuracies, or voids, the plaintiff's attorney can use it to establish and prove his case (see *Looking for red flags in the record*). These flaws are sure to catch his eye:

- pages without any patient identification, such as the patient's stamp in one of the corners
- notes written with the wrong date or with times that don't correlate with the remainder of the chart
- long narrations that don't seem to be sequential
- an entry written over a previous entry to correct or change it
- changes in slant, uniformity, or pressure of handwriting or changes in ink or pen on the same entry
- any erasure or obliterations
- itemized billings for medical expenses that are inconsistent with tests, medications, or equipment referenced in the chart, which could indicate that the patient was given the wrong medication, test, or treatment or didn't receive an item for which he was billed
- pathology report or diagnostic test findings that don't correlate with physical assessment findings or that don't show the medical necessity for a procedure.

How to avoid documentation pitfalls

Base your documentation on your objective assessment findings using your senses of sight, touch, hearing, and smell. Document at the same time as the intervention if you can, or as close to it as possible. Beware of the following shortcomings in documentation that could allow an attorney to raise questions about the quality of care you gave the plaintiff.

Gaps. Make sure you don't leave any mysterious gaps in the medical record that would permit someone to speculate about what happened. Your charting should never cover up an incident or document care that wasn't provided.

Don't leave space so you can add more documentation later. Documentation that's later squeezed into

Looking for red flags in the record

An attorney seeking to bring a professional negligence claim examines the medical record for evidence that will help him prove his case, such as:

- lack of treatment
- delayed, substandard, or inappropriate treatment
- lack of patient teaching or discharge instructions
- charting inconsistencies such as lapses in time
- references to an incident report
- patient abandonment
- battles between health care providers
- lack of informed consent
- late entries that aren't documented as such or that appear to be self-serving rather than genuine addendums
- fraudulent or improper alterations of the record
- destruction of records or missing records.

the space available could look like a cover-up or, more generally, raise questions about why documentation was done after the fact. If you need to add more information later and your facility permits entries up to a limited time, follow its policies for making an addendum. It's best to include the reason when an entry is made more than a few days later.

Failing to accurately and completely document the events of an adverse incident and subsequent treatment can result in an unsolved mystery. The plaintiff's attorney will try to solve it by creating a theory about what happened. Based on speculation, this theory may not be accurate. But without solid documentation, you'll have trouble refuting it.

What you should do is document all medically relevant facts related to an incident in the medical record, according to your facility's policies. Document the investigation of an incident in the incident report or the form your facility uses. *Don't* add to your documentation in the patient's medical record that "an incident report was filed."

Bias. Writing inappropriate comments about a patient or labeling the patient or his behavior suggests that you were biased against him. Examples of labeling include using words such as *obnoxious*, *belligerent*, *hostile*, or *rude*. These terms might suggest that you didn't provide the patient with the same level of care that you gave to other patients who were more agreeable and can lead to allegations of professional negligence or defamation.

Keep your personal opinions out of the record. However, without editorializing, you should factually and objectively document the patient's behavior (including any failure to adhere to treatment) if it's relevant to his care. This could help your lawyer demonstrate that the patient contributed to his own problems while you maintained a high standard of nursing care. For example, if you find your patient up and walking

without her antiembolism stockings on, you'd document this, what you told her, what she told you, which health care provider you notified, and how the treatment plan for the patient was modified.

Deviation from policies and procedures. When documenting, consistently follow your facility's policies and procedures. To deviate from the established norm can allow an attorney to create an unflattering scenario for the jury.

For example, if your facility uses charting by exception, you can create problems if you chart routine findings along with exceptions. For example, as you start your shift, you assess your patient's wound site and document your findings. Periodically throughout your shift, you evaluate her wound, finding no change in its status. Under charting by exception, you don't document that the wound site is unchanged.

Where nurses went wrong

Now let's consider the most common allegations brought against nurses in professional negligence cases and review guidelines that can protect you from liability in similar circumstances.*

Failure to accurately assess and monitor the patient's condition

Scenario 1. John Dooley was admitted to the hospital after sustaining serious injuries in an automobile accident. After 15 days in the trauma intensive care unit (ICU), he was transferred to a private room in the medical/surgical unit. At the time of transfer, Mr. Dooley had a tracheostomy tube because he was having difficulty breathing and was coughing up large amounts of thick yellow mucus. Because he was intubated, he couldn't speak. Mr. Dooley had a slightly elevated temperature and a blood pressure reading of 210/100. His physician ordered an arterial blood gas (ABG) test and nitroglycerin paste. His nurse called for the ABG test and applied the nitroglycerin paste, then left the patient alone. Mr. Dooley tried to summon the nurse with a call button but fell out of bed making his attempt. He was found lying on the floor and was determined to have a comminuted fracture of his hip and a head injury. He was transferred back to the trauma ICU. Suit was brought against the nurse and the hospital. The jury found for Mr. Dooley and granted him a large award.

To avoid allegations of failure to monitor and assess, you should obtain a nursing history and perform a complete initial nursing assessment for each of your assigned patients. Follow a systematic process for assessing your patients so that you don't overlook important data. Use sound judgment in developing

the care plan based on the patient's signs, symptoms, and immediate needs and a determination of how stable he is. Document all findings and interventions consistently with your facility's policies and procedures. Write the complete date, including the year, and the complete time, including a.m. and p.m. or following a 24-hour time, following your facility's preference consistently. Authenticate all documentation entries by signing your name and credentials.

Continually reassess your patient's condition and revise the nursing care plan when his condition changes—and document all reassessment findings and interventions according to the same standards.

Failure to monitor the patient's condition can be alleged as any of the following circumstances:

- failure to properly monitor the patient's care, treatment, and condition
- failure to monitor in a timely fashion
- failure to use the proper equipment to monitor the patient
- failure to document the monitoring.

As a nurse, you're responsible for monitoring your patient's condition to ensure that he receives proper care and treatment. Patients and their health care providers rely on you for this. Failure to monitor is a breach of the standard of nursing care that exposes you to liability.

Failure to notify the health care provider of problems

Scenario 2. In this case, patient Matilda Bennett's condition was worsening. Her nurse called the attending physician several times to report the deterioration but failed to document her initial unsuccessful attempts to reach the physician. In a deposition, the nurse testified that she'd called the physician as soon as she noted a change in Ms. Bennett's condition. Her nursing documentation indicated that the patient's condition changed for the worse at 2:40 p.m., but an attempt to contact the patient's physician wasn't documented until 3:45 p.m. The attending physician corroborated the nurse's testimony, saying that he'd received a call from her at 3 p.m., but the jury refused to overlook the lack of documentation.

Your duty to monitor the patient's condition and your duty to notify the patient's health care provider of pertinent information go hand in hand. You're expected to use your judgment to determine when to notify the health care provider and what to communicate. If you fail to communicate and that results in harm to the patient, you can be held liable.

Depending on the situation, communication with the health care provider can be in person, by telephone, or through your documentation. When the information being communicated is routine, commu-

* Scenarios presented here are based on real cases. Names of individuals have been changed to protect their privacy.

nicating through the written record is appropriate. But urgent situations require notification in person or by telephone. Notification is more than merely making a call; it's also clearly communicating the pertinent information.

When you make calls to relay urgent information, make sure that you relay all important information and that you document the date and time of each attempt you make to reach the provider (whether or not you reach her), the time you reach and speak to her, the information you communicate to her, and her response to the information you provide. Be sure to include the provider's name in your documentation; don't refer to her as simply "the MD."

Failure to follow orders

Scenario 3. Lily Huang was admitted to the hospital with the diagnosis of sinusitis and an upper respiratory tract infection. Her physician ordered a computed tomography scan and an opioid analgesic to alleviate her pain. According to the written order, Ms. Huang was supposed to receive opioid analgesic every 4 hours, p.r.n. Ms. Huang's physician had also ordered that her vital signs be checked every 4 hours. At midnight, her nurse noted that Ms. Huang's blood pressure reading was 90/60, down from an 8 p.m. reading of 160/80. Because Ms. Huang was still complaining of pain, her nurse administered another dose of meperidine only 2 hours and 25 minutes after her last dose, without consulting with the patient's physician. When the nurse checked Ms. Huang at 4 a.m., she found her in cardiac arrest. Ms. Huang was resuscitated but suffered severe hypoxic brain injury. The hospital and nurse were sued.

Failure to give nursing care as ordered can be a deviation in the standard of care unless you have legitimate concerns about the appropriateness of the order based on your nursing assessment. A plaintiff's attorney will look at the health care provider's orders to determine what time orders were written and at the nurse's documentation to determine when they were

One record, many purposes

Your patient's medical record serves several purposes.

- It's a vehicle for communication among health care providers about the patient's care and response to treatment.
- It's used for reimbursement purposes.
- It may provide data for research studies.
- It may be the basis for planning and implementing quality improvement measures.
- It's the most credible evidence in various legal proceedings, including professional negligence and malpractice lawsuits, disability determinations, workers' compensation actions, domestic abuse cases, and competency determinations.

transcribed and carried out.

You're responsible for more than simply carrying out orders in a timely way; you're also expected to identify inconsistent or inappropriate orders that could endanger the patient—and to intervene appropriately. Make sure you clarify any confusing or conflicting orders, then document that the orders have been reviewed by a senior physician or other appropriate health care provider before you carry them out.

Contributing to medication errors

Scenario 4. A physician ordered doxycycline hyclate (Vibramycin), intramuscularly (I.M.), even though intravenous (I.V.) administration is the only parenteral route approved for doxycycline hyclate. Based on the order, the patient received doxycycline I.M. rather than I.V. In a lawsuit, the patient alleged that she suffered a mass at the injection site, resulting in pain, swelling, and disability. The nurse who gave the injection was named in the lawsuit.

Lawsuits arising from medication administration errors are common. Typically, allegations involve a nurse's failure to appropriately follow a physician's order or to carry out the order. But as in the case of Scenario 4, you can also be cited for following an inappropriate or erroneous order; the prescriber's mistake doesn't let you off the hook.

Always follow the "five rights" of medication administration: right drug, right patient, right time, right dose, right route. If you give a drug parenterally, document the specific site. Besides ensuring injection site rotation, this information can be used to correlate the sites used with any subsequent claims of injection injuries.

For all medications you give to patients, you must know indications, contraindications, dosage parameters, and adverse reactions. Make sure that the ordered medication is appropriate for the patient. Question any unclear or seemingly inappropriate order. Many errors stem from the prescriber's sloppy handwriting. If you can't read an order, don't guess; clarify it with the prescriber. When you question an unclear or potentially inappropriate order, document the inquiry. Include the date and time, the prescriber's name, and the prescriber's response.

Once you've given a medication, monitor the patient for signs and symptoms of drug toxicity or other adverse reactions, and document his response. If he has an adverse reaction, document whom you notified and what actions were taken (including any new orders and your nursing interventions) and the patient's response to your nursing interventions. This creates a record establishing that you met the standard of patient care when administering medication.

Failure to convey discharge instructions

Scenario 5. Stephanie Henning was admitted as an outpatient to have drainage tubes placed in her rectal area to treat a fistula. Following the procedure, she was discharged. It isn't clear whether she received discharge instructions to follow up with her physician. Approximately 5 years after the procedure, Ms. Henning developed abdominal pain. She was evaluated by a physician and determined to have an abscess, which was reportedly related to the drainage tube. Her abscess was drained, but no tube was found during this procedure. Ms. Henning denied having been told that she was to follow up with her attending physician after the tube was placed. She sued the facility and the nurse responsible for discharge instructions.

If you were a defendant in such a malpractice action, the plaintiff would have to prove that you had a duty to advise her about follow-up on discharge and that you failed to do so. She'd also have to prove that this failure resulted in an injury. Lack of documentation about discharge instructions leaves questions for a jury to decide.

The Joint Commission on Accreditation of Healthcare Organizations has established a standard of care requiring that patients receive discharge instructions when they're released from the hospital. These instructions should include an assessment of the patient's continuing health care needs and a plan of care to meet these needs that the patient can realistically carry out. The instructions should spell out the patient's responsibilities for her ongoing health care and include any teaching you provided to the patient or her family to help them meet their responsibilities.

You should always provide written instructions to prevent confusion about what the patient was told. When documenting your teaching and discharge instructions, include the instructions you give the patient about activity restrictions, ongoing treatments, medications, diet, and potential complications. Also document any teaching about equipment or procedures and note whether follow-up is needed. Because so much legal emphasis has been placed on the discharge instructions when evaluating the potential for a malpractice action, you'd be wise to have the patient sign a copy of the discharge instructions and make this part of the medical record.

If the patient doesn't speak and understand English well, provide written discharge instructions in his primary language. Use an interpreter to verify that the patient understands the written and verbal instructions, then have the patient sign the discharge instructions to indicate he understands them. Document the methods you use to address any language barriers.

Failure to ensure patient safety

Scenario 6. David Evans, 74, underwent surgery for an abdominal aneurysm. Several days after surgery, while he was a patient in the surgical ICU, he fell from his bed and hit his head on the floor. He died as a result of the head injury from the fall. The hospital was sued for failing to ensure patient safety.

Patient falls lead to many lawsuits against health care providers. You should know which patients are at particular risk for falling and you must know your facility's policies and procedures for addressing fall risks and other patient-safety issues. Some patients who are more prone to falling include those with a history of falling, heavily sedated patients, patients with equilibrium problems, frail patients, mentally impaired patients, patients who get up in the night, and uncooperative patients. An attorney investigating a fall case will want to know if:

- an order for a bed alarm was written and if it was carried out (as documented in the medical record)
 - the nurses followed established policies and procedures related to patient safety
 - the patient was injured from the fall
 - the patient was properly evaluated and treated after a fall
 - the attending health care provider and family were notified of the fall
 - conditions in the surrounding area were hazardous at the time of the fall (for example, the floor was wet)
 - the patient was restrained at the time of the fall.
- Because restraints can increase the risk of falls and injury, use them only as permitted by your facility's policies and procedures on restraint use.

Document all fall precautions you took as well as instructions you gave to the patient; for example, instructing him to call for assistance before trying to get out of bed. Complete an incident report but don't note in the medical record that an incident was filed.

If he falls, you should document the incident appropriately, including your observations but not your assumptions or speculations. Include the following:

- the patient's condition when you found him; for example, if you found him lying on the floor you'd note that, but you wouldn't assume he'd fallen
- any direct quotes from the patient, including complaints or denials of pain
- your physical assessment findings
- safety initiatives taken to prevent harm or further harm to the patient
- efforts taken to contact the physician to evaluate the patient
- the time the physician arrived
- any diagnostic studies performed as a result of the fall and the results of the studies

- any contact made with the patient's family and what was said to them
- anything else required by the facility's policies and procedures.

Failure to follow policies and procedures

Scenario 7. Sheila Bell, a patient in the ICU, went into cardiac arrest during the early morning hours. During a successful resuscitation effort, she was intubated.

Later in the day, after she'd been weaned and extubated, she suffered another cardiac arrest. The crash cart that had been used for the earlier code was just outside her room, but it hadn't been checked and restocked. Because the appropriate-sized laryngoscope blade wasn't on the cart, the physician couldn't intubate her. After he'd made several unsuccessful attempts, a nurse left to get the correct size blade. The physician then intubated the patient, but the delay caused severe brain damage. Ms. Bell died without regaining consciousness.

Facility policies and procedures establish a standard of care. Any deviation from standards can result in liability exposure. As this case demonstrates, a patient was injured because the staff failed to follow established protocol for checking and restocking the crash cart.

In such a case, the plaintiff's attorney would request copies of the facility's policies and procedures to determine whether pertinent policies were followed. For example, he'd want to see a copy of the code cart checklist and a list of staff assignments at the time of the event. Documenting nursing actions taken shows that you followed the proper protocols and did what a reasonably prudent nurse would do.

Remember the "five rights" of delegation

Before you delegate a task to someone else for a particular patient, consider these five rights:

- *right task* for a specific patient. For instance, it should be a task that recurs frequently in the day-to-day care of a patient, it doesn't require nursing assessment or judgment, it doesn't require complex or multidimensional application of the nursing process, the results are predictable, the potential risk is minimal, and a standard, unchanging procedure is used.
- *right circumstances*, considering factors such as appropriateness of patient setting and available resources.
- *right person* is delegated for the task; that is, one who has the appropriate skill set
- *right communication*, which includes a clear, concise description of the task, including objective limits and expectations
- *right supervision*, with appropriate monitoring, evaluating, and intervening, as needed.

Failure to properly delegate and supervise

Scenario 8. A charge nurse asked a patient-care technician (PCT) to perform a finger-stick blood glucose test for a patient with diabetes. The PCT performed the test and documented the reading on the chart. At the end of the shift, she asked the PCT what the reading was. He said it was HHHHH. Alarmed, the charge nurse repeated the test and got a reading above 800 mg/dl. The patient was transferred to the ICU.

Staff members who supervise others—including licensed nurses who supervise other nurses or unlicensed assistive personnel—are expected to know the skills, experience, and expertise of staff when making assignments. Supervisory staff members are also expected to ensure that members of the staff have received proper orientation to the unit and appropriate policies and protocols and proper training on the equipment and supplies being used for patient care. Supervisory staff delegating tasks should tell the person which circumstances need to be reported immediately. According to facility policy, managers should provide documentation that demonstrates that appropriate assignments have been made. (See *Remember the "five rights" of delegation.*) To avoid allegations related to improper delegation, you must know which patient-care needs can be met by a PCT and which require a professional nurse. Know and follow your state's nurse practice act about delegation and the skill set of the person who will be performing the task.

What would a jury think of you?

Because legal actions may be initiated years after care was provided, you may not remember the incident in question—until you review your careful documentation. Not only will it bolster your credibility in the jury's eyes, but it can also establish that the nursing care you gave met the standard of care. ◀▶

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Sally Austin is associate general counsel for Children's Healthcare of Atlanta in Georgia. The author has disclosed that she has no significant relationship with or financial interest in any commercial companies that pertain to this educational activity.

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GENERAL PURPOSE To provide nurses with an overview of the legal implications of nursing documentation and practice.

LEARNING OBJECTIVES After reading the preceding article and taking this test, you should be able to: **1.** Identify liability issues in nursing practice and documentation. **2.** Identify documentation and practice pitfalls you should avoid. **3.** List the four elements necessary for professional negligence.

1. Which statement is correct about professional negligence lawsuits?

- The person filing the lawsuit is the defendant.
- The defendant has the burden of proof.
- The plaintiff needn't prove injury, damage, or loss.
- The plaintiff must prove that a breach in the prevailing standard of care caused an injury.

2. The burden of proof in a lawsuit alleging professional negligence requires that

- a duty to the patient existed.
- care was given only by registered professional nurses.
- the injuries were caused by the patient's failure to follow procedures.
- the patient's injuries occurred only after his discharge.

3. The prevailing standard of care is based on

- the skills of the nurse delivering the care.
- the patient's perception of the care he received.
- what a reasonably prudent professional with similar expertise would have

- done under similar circumstances.
- the requirements of care as proposed by the legal community.

4. In cases of professional negligence

- the plaintiff's lawyer determines who can testify as an expert witness.
- expert witnesses aren't required to testify.
- an expert must testify about the errors of the treating health care provider.
- federal law determines who can testify as an expert witness.

5. Leaving space in the medical record so you can add documentation later

- is an approved way to evaluate the effect of care before documenting it.
- prevents speculation about what actually happened.
- prevents the appearance of a cover-up.
- raises questions about why the documentation was done after the fact.

6. Which statement is best to document a patient's behavior in an unbiased way?

- "The patient's hostility created difficul-

ties for the nursing staff."

- "The patient threw the water pitcher across the room during shift change."
- "The patient's rudeness prevented administration of his medications."
- "The patient's dressing change was interrupted by his belligerent behavior."

7. When the patient's condition suddenly changes for the worse, you're required to notify the health care provider

- by marking the documentation in the chart as urgent.
- in person or by telephone.
- no later than the end of your shift.
- when the health care provider appears in the unit for scheduled rounds.

8. All of the following are errors in medication administration that you can be liable for except

- failing to carry out a proper order.
- following an inappropriate order.
- questioning a medication order that seems inappropriate.
- failing to document follow-up action for an adverse reaction.

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9. If you aren't sure about a medication order, you should

- a. administer the medication if you trust the prescriber.
- b. administer the medication as ordered, then contact the prescriber.
- c. confer with another nurse before administering the medication.
- d. clarify the order with the prescriber.

10. If a patient being discharged doesn't speak and understand English well, you should

- a. advise her to find an interpreter at home to explain the discharge instructions.
- b. try to clarify the discharge instructions nonverbally.
- c. provide discharge instructions in her primary language.
- d. omit the discharge instructions.

11. Which statement about patient falls is true?

- a. Patient falls lead to many lawsuits against health care professionals.
- b. Most patient falls are unavoidable.
- c. Heavily sedated patients are no more likely to fall than other patients.
- d. Frail patients rarely fall because they're too weak to get out of bed.

12. If a patient falls, your documentation should include

- a. your assumptions about why the patient fell.
- b. direct quotes from the patient about his complaints or denial of pain.
- c. speculations about events leading up to the fall.
- d. accusations of blame.

13. Documentation in the medical record should always include

- a. references to any incident reports you completed.
- b. a detailed explanation of your disagreement with the health care provider's order.
- c. late entries that you squeeze into the appropriate section.
- d. the name of the health care provider with whom you discussed a patient's condition and the time of the discussion.

14. When you supervise unlicensed assistive personnel (UAPs), you

- a. can assume that they've been oriented to the unit.
- b. know that they'll use only the equipment and supplies they're trained to use.
- c. should know their skills and expertise.

d. can expect that they'll know which circumstances need to be reported immediately.

15. Which task isn't appropriate to delegate to UAPs?

- a. emptying and measuring a urinary collection bag
- b. determining whether a pressure ulcer is infected
- c. reporting a nearly empty I.V. bag
- d. assisting an ambulatory patient out of bed

16. The medical record

- a. is the most credible evidence in various legal proceedings.
- b. can't be relied on for reimbursement purposes.
- c. may never be used to provide data for research studies.
- d. may not be introduced as evidence in domestic abuse cases.

17. When you delegate a task, good communication includes all of the following except

- a. a clear description of the task.
- b. any limits for performing the task.
- c. permission to delegate the task to another person, if desired.
- d. what the person needs to report to you.

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From time to time, we make our mailing list available to outside organizations to announce special offers. Please check here if you do not wish us to release your name and address.

B. Test Answers: Darken one circle for your answer to each question.

- | a | b | c | d | a | b | c | d | a | b | c | d | a | b | c | d | | | | |
|--------------------------|-----------------------|-----------------------|-----------------------|--------------------------|-----------------------|-----------------------|-----------------------|---------------------------|-----------------------|-----------------------|-----------------------|---------------------------|-----------------------|-----------------------|-----------------------|---------------------------|-----------------------|-----------------------|-----------------------|
| 1. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | 5. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | 9. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | 13. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | 17. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | 6. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | 10. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | 14. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | | | | |
| 3. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | 7. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | 11. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | 15. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | | | | |
| 4. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | 8. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | 12. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | 16. <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | | | | |

C. Course Evaluation*

- 1. Did this CE activity's learning objectives relate to its general purpose? Yes No
- 2. Was the journal home study format an effective way to present the material? Yes No
- 3. Was the content relevant to your nursing practice? Yes No
- 4. How long did it take you to complete this CE activity? ___ hours ___ minutes
- 5. Suggestion for future topics _____

D. Two Easy Ways to Pay:

- Check or money order enclosed (Payable to Lippincott Williams & Wilkins)
- Charge my Mastercard Visa American Express
- Card # _____ Exp. date _____
- Signature _____

*In accordance with the Iowa Board of Nursing administrative rules governing grievances, a copy of your evaluation of the CE offering may be submitted directly to the Iowa Board of Nursing.