FUNDAMENTALS OF NURSING · STUDY GUIDE

Exam 3 Study Guide

This guide covers chapters 5 and 6. Chapter 5 is about the record and the lesson: how to chart so the next nurse and a court can trust it, how to protect privacy and use technology safely, and how to teach so the patient can carry on at home. Chapter 6 is about law and ethics: where nursing law comes from, what makes an act malpractice, how consent works, and how to reason through a hard ethical problem. Read the paragraphs, study the tables, then work each case with the steps covered.

WHAT THIS GUIDE COVERS

- Chapter 5 · purposes and qualities of the record, narrative, SOAP, PIE, DAR and charting by exception, late entries and corrections, objective language, the Do Not Use list, HIPAA and the minimum necessary rule, EHR risks, CPOE, decision support, BCMA, telehealth, the three learning domains, readiness, adult learning, health literacy, teach back, plain language and discharge teaching.
- Chapter 6 · constitutional, statutory, administrative and common law, the board of nursing, standard of care, the four elements of malpractice, intentional torts, incident reports, Good Samaritan laws, informed consent, capacity and surrogates, refusal, advance directives, restraint law, ethical principles and theories, moral distress, the ethics process, advocacy and mandatory reporting.

CHAPTER 5

Documentation, Informatics and Patient Teaching

Read it in full: **Chapter 5 in the textbook**. Practice it in the lab: **Chart It Right: Documentation Fix It** and **Teach-Back Coach: Patient Teaching Lab**.

What to know

The **health record** is the permanent account of care. It serves communication, legal evidence, reimbursement, quality review and accreditation, and care planning. In court the chart is often the strongest evidence of what the nurse did and when. If it was not documented, everyone will assume it was not done.

Good entries are **factual** (what you saw, heard or measured, not conclusions), **accurate** (exact amounts and units: "360 mL," not "a good amount"), **complete** (the assessment, the action and the response), **current** (as soon as possible after the event, never before it) and **organized**. Every intervention is followed by the patient's response.

Formats: **narrative** is a chronological story, good for unusual events. **SOAP** is subjective, objective, assessment, plan; SOAPIE adds intervention and evaluation, SOAPIER adds revision. A direct quote belongs in S, and A is the interpretation. **PIE** is problem, intervention, evaluation, with assessments on flowsheets. **Focus charting (DAR)** is data, action, response under a focus that can be any concern or event. **Charting by exception** records only findings that differ from written normal standards; it saves time but can be weak in court.

Rules: chart only your own care, never in advance, with the time of the event, and protect your login because it is your legal signature. A **late entry** is labeled "late entry," carries the current date and time and names when the event happened. Never squeeze it between earlier lines or backdate it. Correct errors with a single line, "mistaken entry," initials, date and time, keeping the original readable; in the EHR use the amend function, which keeps an audit trail. Never erase, white out or remove pages.

Describe behavior, not labels. "Refused 0900 metformin, stating 'It makes my stomach hurt'" is better than "noncompliant." Leave out blame, staffing complaints and any mention of an **incident report**; chart the facts of the event and file the report separately. Avoid the **Do Not Use** list: U, IU, QD and QOD, trailing zeros (5.0 mg), missing leading zeros (.5 mg), and MS or MSO4 or MgSO4. Remember "lead yes, trail no."

HIPAA protects **protected health information**: health data linked to any identifier. Sharing is allowed for treatment, payment and operations and when required by law. For other uses share only the **minimum necessary**, and only open charts of patients you care for. Confidentiality covers even the fact that someone is a patient. Never post about patients on social media, never photograph a chart, and keep identifiers off student work.

The **EHR** is built to share data across organizations through interoperability. Risks include copy forward charting, **alert fatigue**, wrong patient entries, workarounds and downtime. **CPOE**

removes handwriting errors; **clinical decision support** gives alerts, dose checks, early warning scores and order sets but supports judgment rather than replacing it.

Barcode medication administration matches patient, drug, dose and time to the order at the bedside. Scan the wristband on the patient, scan each unit dose package, and treat every alert as a hard stop. Never type in a barcode or scan a copied label. BCMA does not check whether the drug should be given now: you still take the apical pulse before digoxin, the pressure before an antihypertensive and the glucose before insulin. **Telehealth** requires confirming the patient's identity and location, consent, privacy and licensure where the patient is located.

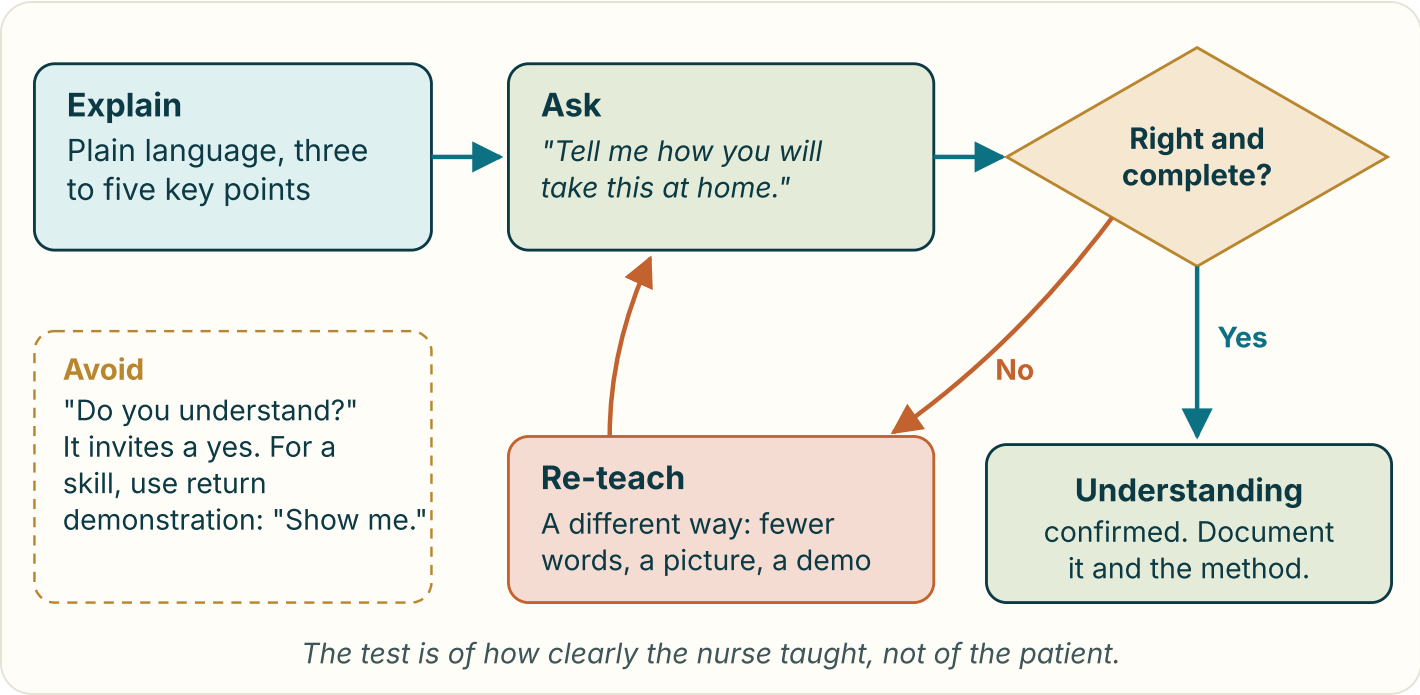
Teaching is an independent nursing duty. The three **learning domains** need different methods: **cognitive** (knowledge; discussion, reading; evaluate with teach back), **psychomotor** (skills; demonstration and practice; evaluate with return demonstration) and **affective** (attitudes and values; discussion, role play, support groups; evaluate by statements and choices). Objectives use measurable verbs.

Assess **readiness to learn** first: physical (pain, fatigue, nausea, hypoxia, sensory aids), emotional (anxiety, denial, grief), experiential (prior knowledge, culture) and motivation. Treat pain first and come back after bad news. Adults learn best when teaching is self directed, uses their experience, solves a real problem now and explains why. Keep sessions short, start with what matters most to the patient and go simple to complex.

Health literacy cannot be seen. Red flags: incomplete forms, "I forgot my glasses," naming pills by color, missed appointments. Use **universal precautions**: plain language, three to five key points, pictures, and confirm with **teach back** ("I want to make sure I explained this clearly. Tell me how you will take this at home."). Avoid "Do you understand?" **Return demonstration** (show me) confirms skills, and chunk and check tests understanding after each small piece. Written materials aim for about a 6th to 8th grade reading level or lower.

Discharge planning starts on admission. Teach medications (including changes from reconciliation), warning signs, self care skills with return demonstration, activity and diet, follow up and home safety. Include caregivers with the patient's permission, teach early, and document who was taught, the method, the response and the evaluation. Adapt teaching to age: parents and

play for small children, privacy for adolescents, and for older adults less glare, lower pitch, large print and more repetition.



Teach back is a loop, not a quiz. Ask the patient to say it in their own words, re-teach any gap a different way, and ask again until it is right.

LOCK THESE IN

- Factual, accurate, complete, current, organized; always chart the response.
- SOAP: quote in S, interpretation in A. PIE: problem, intervention, evaluation. DAR: data, action, response.
- Late entry: labeled, current date and time, names the event time.
- Correct with a single line so the original stays readable; never erase or white out.
- Lead yes, trail no: 0.5 mg, 5 mg. Write out "unit" and "daily."
- Never mention the incident report in the chart.
- A BCMA alert is a hard stop, and the pre drug assessment is still yours.
- Cognitive: teach back. Psychomotor: return demonstration. Affective: statements and choices.

Key terms and comparisons: charting formats

Format	Parts	Strength and weakness
Narrative	Chronological story	Flexible for unusual events; long, trends hard to find
SOAP, SOAPIE, SOAPIER	Subjective, objective, assessment, plan (+ intervention, evaluation, revision)	Problem focused and shared across disciplines; can be repetitive
PIE	Problem, intervention, evaluation	Built in evaluation; needs separate assessment flowsheets
Focus (DAR)	Data, action, response	Focus can be any concern or event; choosing the focus takes skill
Charting by exception	Only deviations from written normal standards	Fast; legally weak if standards are unclear
Flowsheets	Structured fields	Trends easy to see; context and patient voice can be lost

Priority rules: abbreviations and teaching

Item	Do not write	Write instead
Unit	U, u	"unit"
International unit	IU	"international unit"
Daily, every other day	QD, QOD	"daily," "every other day"
Trailing zero	5.0 mg	5 mg
Leading zero	.5 mg	0.5 mg
Morphine or magnesium	MS, MSO4, MgSO4	The full drug name
Checking learning	"Do you understand?"	"Tell me in your own words how you will..."
Written material	Dense, technical text	About 6th to 8th grade or lower, 12 point font or larger, action first

Worked cases

WORKED CASE 1 · CHARTING BY EXCEPTION AND A CHANGE

Mr. Albrecht, 61, is two days after a knee replacement on a unit that uses charting by exception. At 0900 his neurovascular check was normal. At 1300 his right foot is cool, capillary refill is 4 seconds and he reports numb toes.

STEP 1 · RECOGNIZE THE CHANGE

Coolness, slow capillary refill and numbness in the operative leg suggest compromised circulation or nerve compression.

STEP 2 · ACT

Compare with the other foot, check the dressing and devices for tightness, keep alignment and notify the surgeon promptly.

STEP 3 · DOCUMENT FULLY

Describe each abnormal finding, the actions, the time of notification, what was reported and the response.

RULE

Checking "within defined limits" because the morning check was normal would be false documentation.

WORKED CASE 2 · A LATE ENTRY AND A CORRECTION

At 1430 a student helped Ms. Varga walk 30 m with a walker but was pulled away before charting. At 1620 she also notices she charted a dressing change on the left leg when it was the right.

STEP 1 · WRITE THE LATE ENTRY

"11/9 1620 LATE ENTRY for 1430: Patient ambulated 30 m in hall with walker and standby assist, no dizziness." Then sign it.

STEP 2 · CORRECT THE ERROR ON PAPER

Draw one line through "left," write "mistaken entry," add initials, date and time, then write "right." The word "left" stays readable.

STEP 3 · IN THE EHR

Use the amend or correct function, which keeps the original and an audit trail.

RULE

Do not squeeze the note between earlier lines, backdate it or erase anything.

WORKED CASE 3 · A BCMA ALERT ON A BETA BLOCKER

A nurse scans Mrs. Ruiz, 74, and a tablet of metoprolol. The scanner says "Dose given 2 hours ago." The record shows a dose charted at 0800. Her apical pulse is 54 and her pressure is 96/60.

STEP 1 · TREAT THE ALERT AS A STOP

Do not override it because the scheduled time is now.

STEP 2 · ADD THE ASSESSMENT

A pulse of 54 and a low normal pressure are beta blocker effects.

STEP 3 · ACT

Hold the dose, verify with the night nurse and the record whether it was given, and notify the provider of the heart rate and pressure.

RULE

Technology plus assessment. The right answer never trusts or bypasses the machine alone.

WORKED CASE 4 · TEACHING A HIGH ALERT SKILL

Mrs. Odum, 80, with mild hearing loss, is going home on enoxaparin injections after hip surgery. Her husband, 83, will help. She watched one demonstration and says, "I've got it."

STEP 1 · NAME THE DOMAIN

Giving an injection is psychomotor. Watching does not prove learning.

STEP 2 · SET UP THE SESSION

A quiet, well lit room, the actual prefilled syringe, face her and use a lower pitch.

STEP 3 · CONFIRM

Return demonstration by whoever will inject at home, ideally both, then teach back on bleeding signs to report.

STEP 4 · DOCUMENT

Who was taught, the method, the return demonstration and the result.

RULE

A pamphlet for the husband to read later leaves an unsafe gap.

TRAPS PEOPLE FALL INTO

- **Charting a dose before giving it.** Pre charting is falsification and invites missed or double doses.
- **Putting the patient's quote in A.** Quotes go in S. A is the interpretation.
- **Writing "incident report filed" in the chart.** Chart the facts only. Naming the report can make it discoverable.
- **Using a trailing zero.** 5.0 mg can be read as 50 mg. Lead yes, trail no.
- **Opening a chart "just to check."** Access without a care need is a HIPAA violation even if nothing is shared.
- **Typing a barcode for an unreadable band.** Replace the wristband. Workarounds defeat the safety check.
- **Asking "Do you understand?"** Most people say yes. Use teach back.
- **Teaching right after bad news or with severe pain.** Readiness comes first. Treat pain and return later.
- **Using return demonstration for a cognitive goal.** Match the evaluation to the domain: teach back for knowledge, return demonstration for skills.

Chapter 5 self-test · ten items

1. Which entry is the most complete documentation of a pain intervention?

A. Patient seems comfortable after receiving the pain medicine
B. Oxycodone 5 mg PO given at 1015 per the provider's order
C. Pain 7/10, oxycodone 5 mg given at 1015; at 1115 pain 3/10
D. Pain medication given for incision pain as ordered at 1015

C. Pain 7/10, oxycodone 5 mg given at 1015; at 1115 pain 3/10 A complete entry has the assessment, the action and the response.

2. In a SOAP note, where does the statement "I feel short of breath" belong?

A. O
B. A
C. P
D. S

D. S Direct quotes are subjective data. A holds the interpretation.

3. A nurse remembers an observation two hours after it happened. How should it be charted?

A. Labeled late entry, timed now, naming the event time
B. Left out, since it was not charted when it occurred
C. Inserted on the line where it would have been
D. Timed at the moment the event actually happened

A. Labeled late entry, timed now, naming the event time A late entry is honest when labeled, with the current time and a reference to the event time.

4. Which way of writing a dose follows safe abbreviation rules?

A. 0.250 mg
B. 0.25 mg
C. .25 mg
D. .250 mg

B. 0.25 mg Always a leading zero, never a trailing zero.

5. A coworker asks a nurse to look up a neighbor's lab results. What should the nurse do?

A. Look them up if the neighbor gave permission earlier
B. Ask the charge nurse to look them up for the coworker
C. Look them up but share only the normal values
D. Decline, because the nurse is not caring for that patient

D. Decline, because the nurse is not caring for that patient Access is limited to records needed for care. Curiosity or a favor is not a care need.

6. The scanner gives an alert when a nurse scans a medication. What should the nurse do?

A. Stop and investigate before giving the drug
B. Give the drug and then report the alert afterward
C. Override it if the dose is due within the hour
D. Type in the barcode number again by hand

A. Stop and investigate before giving the drug A BCMA alert is a hard stop until the discrepancy is explained.

7. Which objective belongs to the psychomotor domain?

A. Expresses willingness to check glucose daily
B. Explains why insulin is needed with meals
C. Demonstrates drawing up insulin without cues
D. States three signs of low blood glucose

C. Demonstrates drawing up insulin without cues A physical skill is psychomotor. Stating and explaining are cognitive; willingness is affective.

8. Which question best confirms understanding of new discharge medicines?

A. "Do you understand how to take these at home?"
B. "Tell me how you will take these at home."
C. "Do you have any questions about these at all?"
D. "You know to take them with meals, don't you?"

B. "Tell me how you will take these at home." Teach back asks the patient to explain in their own words and puts the burden on the nurse's clarity.

9. A patient two hours after surgery rates pain 8/10. The nurse planned discharge teaching. What comes first?

A. Give the written sheet, teach tomorrow
B. Shorten the teaching to five minutes
C. Treat the pain first, then teach later on
D. Teach now while the family is present

C. Treat the pain first, then teach later on Physical readiness comes first. Pain blocks learning.

10. What reading level is commonly recommended for written patient materials?

A. About 6th to 8th grade or lower
B. About 10th to 12th grade
C. The level of a college textbook
D. Whatever the patient last finished

A. About 6th to 8th grade or lower Experts commonly recommend 6th to 8th grade or lower, and many aim for 5th to 6th.

CHAPTER 6

Legal and Ethical Practice

Read it in full: **Chapter 6 in the textbook**. Practice it in the lab: **Consent Checkpoint: Witness, Hold or Surrogate** and **Ethics Compass: Principles, Dilemmas and Duties**.

What to know

Law is a set of rules enforced by government. Ethics asks what is right. Nurses are bound by four sources of law. **Constitutional** law is at the top. **Statutory** law comes from legislatures (HIPAA, the Patient Self-Determination Act, the ADA, EMTALA, and at the state level the **nurse practice act**). **Administrative** law is rules written by agencies, such as the board of nursing. **Common** law comes from court decisions that become precedent. **Criminal** law covers offenses against society; **civil** law covers disputes between parties, such as malpractice. One act can lead to criminal, civil and licensure actions.

The **board of nursing** exists to protect the public. It approves programs, licenses, investigates and disciplines, from reprimand to revocation. A license is a privilege. **Scope of practice** is set by the practice act; facility policy can narrow it but never widen it. Following an order outside your scope does not protect you.

The **standard of care** is what a reasonably prudent nurse with similar preparation would do in similar circumstances. Courts find it in the practice act, regulations, facility policy, professional

standards, accreditation standards, evidence and textbooks, expert witnesses and manufacturer instructions. Students are held to the standard of a licensed nurse for any task they perform.

Negligence is failure to use reasonable care, by act or omission. **Malpractice** is professional negligence. It needs all four elements: **duty**, **breach**, **causation** and **damages**. An error with no harm is not malpractice, though it must still be reported. Common claims: failure to assess and monitor, to communicate or notify, medication errors, failure to ensure safety, to follow policy, and to document. The chain of command is both a safety tool and a legal protection. Under **respondeat superior** the employer is liable too, but the nurse remains personally liable.

Intentional torts: **assault** is a threat that causes fear of contact, with no touch needed. **Battery** is touching without consent. **False imprisonment** is unjustified confinement, such as a restraint without an order or holding a capable adult who wants to leave. **Invasion of privacy** includes photos without consent. **Defamation** is a false statement that harms reputation: **slander** if spoken, **libel** if written.

An **incident report** records any event outside routine care, including near misses, for quality improvement and risk management, not punishment. Write facts only, promptly, and keep it out of the chart. **Good Samaritan** laws protect good faith emergency help given outside work without pay against ordinary negligence, not gross negligence. Stay within your training and do not leave until someone equally or more qualified takes over.

Consent can be **implied** (holding out an arm; a true emergency), **express**, or **informed**. Valid informed consent needs **capacity**, **voluntariness** and **information** (diagnosis, nature and purpose, risks, benefits, alternatives including none, who will do it), in language the patient understands. The provider who will do the procedure informs and obtains consent. The nurse confirms understanding and witnesses the signature. If the patient voices doubt, has new questions or has been sedated, stop and notify the provider. Consent can be withdrawn at any time.

Capacity is a clinical, decision specific judgment: can the person understand, appreciate, reason and communicate a choice? It can fluctuate. **Competence** is a legal ruling. A diagnosis, older age or disagreeing with the team does not remove capacity. Surrogates decide when capacity is absent (guardian or health care agent first, then relatives in the order set by state law), using substituted

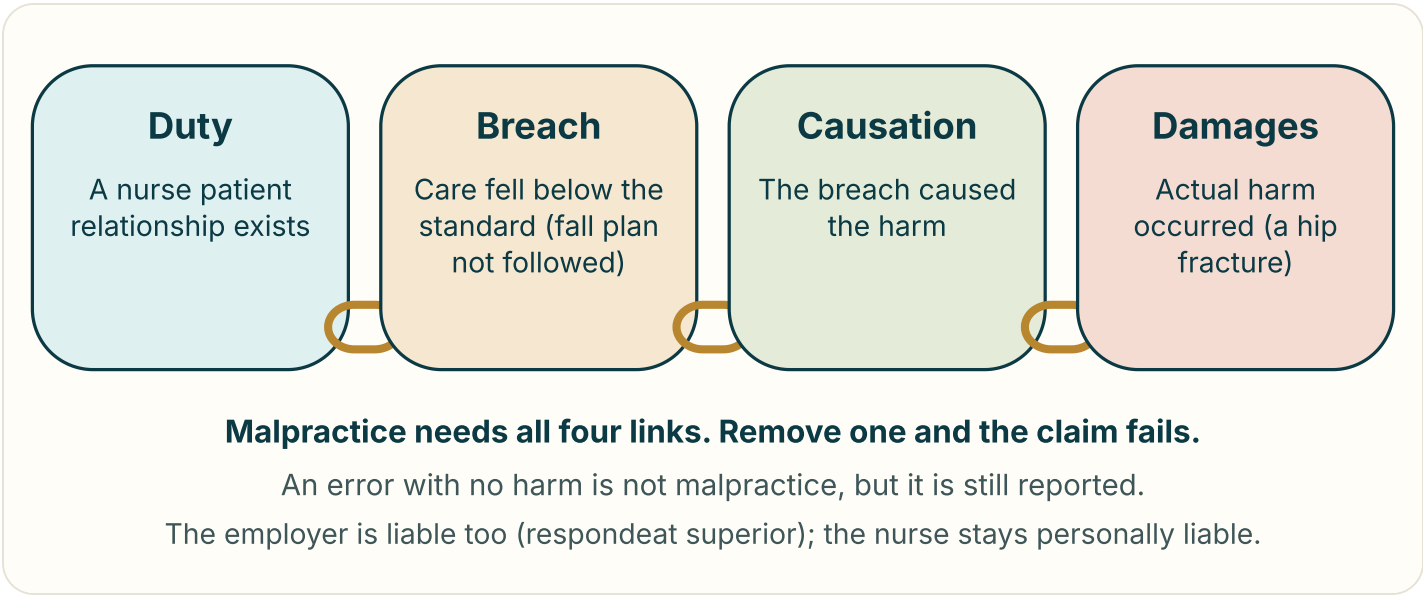
judgment when wishes are known. Minors need a parent or guardian, with exceptions such as emancipated minors and certain services; older children give assent.

A competent adult may refuse any treatment, even life saving. Make the refusal informed: explore the reason, correct misunderstandings, explain consequences, notify the provider, document the patient's words, and keep giving all other care. The **Patient Self-Determination Act** requires facilities to inform adults of their right to advance directives and to ask. A **living will** states treatment wishes; a **durable power of attorney for health care** names an agent; a **DNR** order covers CPR only, not other care; portable medical orders travel across settings. Current wishes of a patient with capacity override an older document.

A **restraint** is any device, manual method or drug that limits movement and that the patient cannot easily remove; a drug used to control behavior that is not standard treatment is a **chemical restraint**. Restraints need an order (never PRN), are for immediate safety after less restrictive measures fail, and stop as soon as possible. For violent or self destructive behavior, orders last up to 4 hours for adults, 2 hours for ages 9 to 17 and 1 hour under 9, up to 24 hours before a new evaluation, with a face to face evaluation within 1 hour.

Ethical principles: **autonomy** (choice), **beneficence** (doing good), **nonmaleficence** (avoiding harm), **justice** (fairness), **fidelity** (keeping promises) and **veracity** (truth), plus accountability and confidentiality. **Paternalism** puts beneficence over a competent adult's autonomy. Theories include deontology (duty), utilitarianism (greatest good, as in triage), virtue ethics, ethics of care and principlism. A **dilemma** is a conflict between acceptable choices. **Moral distress** is knowing the right action but being blocked from it.

Work through ethical problems in steps: gather facts, name the conflict, identify stakeholders and who decides, list options, choose with the patient or surrogate, act and document, evaluate. Anyone, including a nurse, patient or family, can request an **ethics consultation**; it is advisory. **Advocacy** protects the patient's own values. Nurses are **mandated reporters** of suspected child abuse, abuse of vulnerable adults and other listed events, on **reasonable suspicion**, not proof; they do not investigate or confront.



Malpractice needs all four links. Duty, breach, causation and damages. A near miss breaks the chain at damages, but it still gets reported.

LOCK THESE IN

- Statute (practice act) from the legislature; rules from the board; precedent from courts.
- Facility policy can narrow scope, never widen it.
- Malpractice needs duty, breach, causation and damages; no harm, no malpractice.
- Assault is a threat; battery is touch without consent; false imprisonment is confinement; slander spoken, libel written.
- Consent = capacity + voluntary + informed. The provider informs; the nurse witnesses.
- Capacity is clinical and decision specific; competence is a court ruling.
- DNR means no CPR, not "do not treat." No PRN restraint orders.
- Report suspected abuse on reasonable suspicion; do not investigate or confront.

Key terms and comparisons: legal wrongs and directives

Term	What it is	Example
Assault	A threat causing fear of contact; no touch	"Take this or I'll give you a shot."
Battery	Touching without consent	Injecting a drug the patient refused
False imprisonment	Unjustified confinement	Restraint without an order; blocking a capable adult from leaving
Slander and libel	False spoken or written statement harming reputation	Charting that a patient is "a known drug seeker"
Living will	Written treatment wishes for terminal illness or permanent unconsciousness	Declines a ventilator in those conditions
Health care proxy	Named agent who decides when the patient cannot	A daughter named in a durable power of attorney for health care
DNR order	Provider order not to perform CPR	All other treatment continues
Restraint order limits (violent behavior)	Up to 4 h adults, 2 h ages 9 to 17, 1 h under 9; face to face within 1 h	Renew up to 24 h, then a new evaluation

Priority rules: principles and who to call

Principle or duty	What it protects	Cue in a question
Autonomy	The patient's choice	A competent adult declines treatment
Beneficence	The patient's good	Advocating for pain control
Nonmaleficence	Avoiding harm	Refusing to give an unsafe dose
Justice	Fairness	Same care regardless of insurance
Fidelity	Promises	Returning at the promised time
Veracity	Truth	Answering honestly about discomfort
Suspected child abuse	The child	Report to child protective services per state law
Impaired colleague	Patients	Chain of command and the board of nursing

Worked cases

WORKED CASE 1 · TESTING THE FOUR ELEMENTS

A nurse gives a patient another patient's antihypertensive. The patient's pressure is unchanged and there is no harm. A family member says they will sue for malpractice.

STEP 1 · DUTY

The nurse was caring for the patient, so a duty existed.

STEP 2 · BREACH

Giving the wrong drug falls below the standard of care.

STEP 3 · CAUSATION AND DAMAGES

No injury occurred, so there is nothing the breach caused.

STEP 4 · CONCLUDE

Malpractice fails because damages are missing. The error is still reported through an incident report and disclosed per policy.

RULE

All four links must be present for malpractice.

WORKED CASE 2 · AN INFORMED REFUSAL, NOT A THREAT

Mrs. Kowal, 82, alert and oriented, refuses her evening heparin: "My stomach is covered in bruises." A nurse replies, "Then I'll have the aide hold your arms and give it anyway."

STEP 1 · NAME THE WRONGS

The statement is assault. Doing it would be battery and could be false imprisonment.

STEP 2 · MAKE THE REFUSAL INFORMED

Ask about the reason, explain that heparin prevents clots and what refusing risks, and ask whether another site or option is possible.

STEP 3 · RESPECT AND REPORT

Respect the refusal, notify the provider, and document her words, the teaching and the notification.

RULE

An order permits treatment, but only consent makes it lawful.

WORKED CASE 3 · DOUBT AFTER SIGNING

Mr. Tanaka, 47, signed consent for a cardiac catheterization an hour ago. He got a sedative 20 minutes ago. Now he says, "I don't remember hearing about a stroke risk. Maybe I shouldn't."

STEP 1 · SPOT THE CUES

New doubt about a material risk, and a recent sedative.

STEP 2 · STOP

Pause the preparation.

STEP 3 · NOTIFY THE PROVIDER

The cardiologist must explain the risks again and reconfirm the choice when he can understand.

RULE

The nurse does not explain the risks in the provider's place and does not say "everyone signs it." Consent is a process and can be withdrawn.

WORKED CASE 4 · SUSPECTED CHILD ABUSE

A 3 year old is brought in 8 hours after a reported fall from a couch. There is a spiral fracture of the arm and bruises of different ages on the back and buttocks.

STEP 1 · RECOGNIZE THE CUES

The story does not fit the injury, there are bruises of several ages on protected areas, and care was delayed.

STEP 2 · STABILIZE AND PROTECT

Treat the injury and keep the child safe in the department.

STEP 3 · REPORT

Report the suspicion to child protective services per state law and facility policy.

STEP 4 · DOCUMENT

Record sizes, colors and locations of injuries and exact quotes.

RULE

Do not confront the adult, wait for confirmation or ask the child leading questions.

TRAPS PEOPLE FALL INTO

- **Thinking professional groups license nurses.** Associations set voluntary standards. The board of nursing licenses and disciplines.
- **Calling any error malpractice.** No harm means no damages. Report the error anyway.
- **Mixing up assault and battery.** Assault is the threat. Battery is the touch.
- **Holding a capable adult who wants to leave.** That is false imprisonment. Explain risks, notify, offer the AMA form and document.
- **Having the nurse explain the procedure for consent.** The provider informs. The nurse verifies understanding and witnesses.
- **Treating a dementia diagnosis as no capacity.** Capacity is judged for each decision and can be present.
- **Reading DNR as "do not treat."** DNR covers CPR only. Every other treatment continues.
- **Waiting for proof of abuse.** Reasonable suspicion is enough to report.
- **Assuming an ethics consult is binding.** Consultations are advisory and anyone can request one.

Chapter 6 self-test · ten items

1. Which body issues nursing licenses and disciplines nurses in a state?

A. The state board of nursing
B. The hospital's nursing department
C. The national student association
D. The national nursing association

A. The state board of nursing The board, created by the nurse practice act, licenses and disciplines to protect the public.

2. A hospital policy says only certified RNs may insert a certain catheter, though the practice act allows any RN. Which statement is correct?

A. Any RN may still insert it in an emergency
B. The facility may narrow scope this way
C. The practice act overrides the facility rule
D. The policy is invalid unless the board agrees

B. The facility may narrow scope this way Facility policy can restrict what the practice act allows but can never expand it.

3. Which situation contains all four elements of malpractice?

A. A fall occurs even though every precaution was in place
B. A wrong dose is given but the patient has no effects
C. A missed reassessment leads to an unnoticed bleed and shock
D. A nurse charts late but the patient recovers as expected

C. A missed reassessment leads to an unnoticed bleed and shock Duty, breach, causation and damages are all present only in the missed reassessment case.

4. A nurse tells a patient, "If you don't hold still, I will strap you down." Which tort is this?

A. Slander
B. Libel
C. Battery
D. Assault

D. Assault A threat that causes fear of contact is assault, even without touch.

5. A patient who is alert and oriented insists on leaving against advice. What should the nurse do?

A. Apply soft wrist restraints until the provider comes
B. Ask security to keep the patient on the unit
C. Explain the risks, notify the provider and document
D. Tell the patient that leaving is against the law

C. Explain the risks, notify the provider and document Holding a capable adult would be false imprisonment. Make the decision informed and document.

6. Who is responsible for explaining the risks of a surgical procedure?

A. A family member chosen by the patient
B. The provider who will perform it
C. The charge nurse on the unit
D. The nurse who witnesses the form

B. The provider who will perform it The provider informs and obtains consent. The nurse confirms understanding and witnesses.

7. A patient has a DNR order and develops a fever with low blood pressure. What should the nurse do?

A. Treat the fever and pressure as ordered
B. Provide comfort only, since DNR is in place
C. Withhold antibiotics until the provider visits
D. Ask the family whether treatment is wanted

A. Treat the fever and pressure as ordered DNR covers CPR only. All other appropriate treatment continues.

8. A patient was told the nurse would be back at 1400 to help with a walk, and the nurse arrives at 1400. Which principle does this show?

A. Justice
B. Autonomy
C. Veracity
D. Fidelity

D. Fidelity Keeping promises is fidelity. Veracity is truthfulness.

9. A nurse suspects an older resident is being financially exploited by a relative. What is the nurse's duty?

A. Report the suspicion per state law
B. Gather proof before reporting it
C. Confront the relative at the next visit
D. Wait until the resident asks for help

A. Report the suspicion per state law Mandated reporting rests on reasonable suspicion. The nurse does not investigate or confront.

10. For an adult with violent behavior, what is the longest a restraint order may last before renewal?

A. 2 hours
B. 8 hours
C. 4 hours
D. 24 hours

C. 4 hours Adults up to 4 hours, ages 9 to 17 up to 2 hours, under 9 up to 1 hour, with renewals up to 24 hours before a new evaluation.

Cram sheet

Chapters 5 and 6 on one page. These are rule chapters, so say each rule and the reason behind it.

Documentation, privacy, technology and teaching

Item	Rule
Good entry	Factual, accurate, complete, current, organized; include the response
SOAP	S quote, O measured, A interpretation, P plan; IE and R extend it
PIE and DAR	Problem, intervention, evaluation; data, action, response
Never	Chart in advance, chart for others, share a login
Late entry	Labeled, timed now, names event time
Correction	Single line, readable, initialed and timed; EHR amend
Do Not Use	U, IU, QD, QOD, trailing zero, missing leading zero, MS
Incident report	Facts only, separate, never mentioned in the chart
HIPAA	Treatment, payment, operations; minimum necessary; only your patients
BCMA	Scan band on patient and each package; alert is a hard stop; still assess
Domains	Cognitive teach back; psychomotor return demonstration; affective statements
Readiness	Pain, anxiety, motivation first; plain language; 6th to 8th grade or lower

Law, consent and ethics

Item	Rule
Sources of law	Constitution, statute, administrative rule, common law
Board of nursing	Protects the public; licenses and disciplines
Standard of care	Reasonably prudent nurse in similar circumstances
Malpractice	Duty, breach, causation, damages
Torts	Assault threat; battery touch; false imprisonment confinement; slander and libel
Good Samaritan	Good faith, outside work, no pay; not gross negligence
Consent	Capacity, voluntary, informed; provider informs, nurse witnesses
Capacity versus competence	Clinical and decision specific versus legal ruling
Directives	Living will; health care proxy; DNR is CPR only; ask on admission
Restraints	Order, never PRN; 4, 2 and 1 hour limits; face to face within 1 hour
Principles	Autonomy, beneficence, nonmaleficence, justice, fidelity, veracity
Reporting	Reasonable suspicion; report, do not investigate or confront

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