

Documentation by the Nurse

Department of Aging and Disability Services
Quality Monitoring Program

November 2014



“If it wasn’t documented it wasn’t done”



What is documentation?

- ❖ Documentation is factual information about the resident
- ❖ It contains information regarding:
 - The needs and conditions of the resident
 - Care provided to the resident by the care staff
- ❖ It occurs on an on-going basis
- ❖ Firsthand record of observations made by care staff



The Basics of Documentation

- ❖ Documenting the basics includes the following:
 - Chronology: Date and Time
 - Client History
 - Interventions: Medical, Social, etc.
 - Observations: Objective and Subjective
 - Client Outcomes
 - Client and Family Response
 - Authorship: Your full Name, Credentials, and Signature



The Basics of Documentation

❖ Practicing the 4 C's when documenting will ensure that you are documenting well.

- Clear
- Concise
- Correct
- Complete



The Basics of Documentation

A good test to evaluate whether your documentation is satisfactory is to ask the following question: “If another nurse had to step in and take over care for this resident, does the chart provide sufficient information for the seamless delivery of safe, competent and ethical care?”



Why document?

-
- ❖ Documentation is done for the following reasons:
 - To ensure that services that were paid for, for that resident, are delivered
 - Provide a picture of the resident's condition
 - Detail how a resident is responding to treatment
 - Determine the amount of Medicare/Medicaid money a facility receives for the care of individual residents
 - It is a legal record of care that can be used in a court of law
 - Documentation influences the decisions subsequent caregivers will make regarding a client's condition.



Purpose of documenting

- ❖ Clear, complete, and accurate health records serve many purposes for residents, families, nurses, and other health care providers.
- ❖ The data from documentation allows for:
 - Communication and Continuity of Care
 - Coordination of Services
 - Quality Improvement/Assurance and Risk Management
 - Establishes Professional Accountability
 - Legal Reasons
 - Funding and Resource Management
 - Expanding the Science of Nursing



-
- ❖ Texas Administrative Code (TAC) Title 22, Part 11, Chapter 217, § 217.11: Standards of Nursing Practice
 - (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall:
 - (D) Accurately and completely report and document:
 - (i) the client's status including signs and symptoms;
 - (ii) nursing care rendered;
 - (iii) physician, dentist or podiatrist orders;
 - (iv) administration of medications and treatments;
 - (v) client response(s); and
 - (vi) contacts with other health care team members concerning significant events regarding client's status;



-
- ❖ TAC Title 22, Part 11, Chapter 217, §217.12: Unprofessional Conduct
 - The unprofessional conduct rules are intended to protect clients and the public from incompetent, unethical, or illegal conduct of licensees. The purpose of these rules is to identify unprofessional or dishonorable behaviors of a nurse which the board believes are likely to deceive, defraud, or injure clients or the public. Actual injury to a client need not be established. These behaviors include but are not limited to:
 - (1) Unsafe Practice--actions or conduct including, but not limited to:
 - (C) Improper management of client records;
 - (6) Misconduct--actions or conduct that include, but are not limited to:
 - (A) Falsifying reports, client documentation, agency records or other documents;



❖ Centers for Medicare and Medicaid State Operations Manual Appendix PP. F514, §483.75: Clinical Records

➤ (I) *Clinical records.*

- (1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are—
 - (i) Complete;
 - (ii) Accurately documented;
 - (iii) Readily accessible; and
 - (iv) Systematically organized.
- (5) The clinical record must contain—
 - (i) Sufficient information to identify the resident;
 - (ii) A record of the resident's assessments;
 - (iii) The plan of care and services provided;
 - (iv) The results of any preadmission screening conducted by the State; and
 - (v) Progress notes.



What should be in your documentation?

❖ Nursing documentation should contain the following:

- All aspects of the nursing process
- Plan of care
- Admission, Transfer, Transport, and Discharge Information
- Resident Education
- Medication Administration
- Collaboration with other Health Care Providers



Standards for documenting

-
- ❖ Since the care provided to the resident is viewed in the medical record by all of the care team to determine appropriate next steps of care, it is essential that the record be:
 - Clear
 - Accurate
 - Legible
 - Timely
 - Factual
 - Documented by the staff who performs the care
 - Organized



Rules for documenting

- ❖ Each facility will have their own policies and procedures (PP) centered around documentation. The below are general accepted rules for documenting:
 - Document using black or blue pen (this may also be facility driven)
 - Ensure that there are no skipped lines in between sentences, as this allows for the possibility of additions to be made to the chart at a later time
 - Document only for what you have done to care for or treat the resident. You should never document a task or treatment that you did not perform or complete
 - Do not make changes to the chart unless you are correcting your own work
 - When making corrections, be sure to line through the word with one line and initial. Do not use white out or corrective tape
 - Use only **facility approved** abbreviations and terminology
 - Line through any unused lines to decrease the chances of additional information being added at a later date or time.



Late entries in documentation

- ❖ The definition of a late entry should be determined by facility policy. Documentation should occur as soon as possible after the event occurred.
- ❖ Late entries or corrections incorporating omitted information in a health record should be made, on a voluntary basis, only when a nurse can accurately recall the event or care provided
- ❖ Late entries must be clearly identified and should be individually dated. They should reference the actual time recorded as well as the time when the care/event occurred and must be signed by the nurse involved
- ❖ Late entries must be entered on a chart on the same shift that the care was provided and/or the event occurred, even if the information isn't in chronological order



Good documentation vs. Poor documentation

- ❖ Good documentation is a clear, concise, and accurate description of the care that you have given.
- ❖ Poor documentation leaves the record open to questions, with no clear direction to follow.



Common mistakes to avoid

- ❖ Failing to record resident health or drug information
- ❖ Failing to records nursing actions
- ❖ Failing to record medications have been given
- ❖ Recording on the wrong chart
- ❖ Failing to document a discontinued medication
- ❖ Failing to record drug reactions or changes in the resident's condition
- ❖ Transcribing orders improperly or transcribing improper orders
- ❖ Writing illegible or incomplete records



Ways to improve documentation

- ❖ Whether you are a seasoned nurse or a new grad, documenting can be an issue for anyone. Here are some tips that will assist with improving the documentation:
 - Be extra careful when you think you are “too busy”
 - Critical values should be reported to the MD within 30 minutes of verification
 - If you chart by exception, know what the defined limits are, as charting in this instance is reporting “abnormal” findings.
 - Allergies should be highlighted
 - Charting patterns including flow sheets will be reviewed.
 - Consult the policy and procedure for accepted abbreviations
 - Evaluate any new onset of pain



Sample Nurses Notes

These samples are only examples and are used for educational purposes. These samples are not to be used in actual resident charting



Proper Documentation

Example #1: 03/21/14 0800

Mrs. GH alert, awake, and oriented to person and situation but is confused as to time and place. She is able to state her name and that she is in the nursing home but states that it is afternoon and that it is 1990. She asks you if her son got to school on time because he usually misses the bus in the morning. Was reoriented to time and place. Skin warm, dry, pale but without pallor or cyanosis. Bilateral arms have purpura but skin remains intact and without skin tears. No noted decubitus ulcers on coccyx, hips, or heels. Respirations regular and non-labored. Lung sounds clear except for crackles noted in left lower lobe but improved when compared to earlier assessment done 03/20/2014. Encouraged to cough and deep breathe (CDB); crackles lessened after CDB exercise. Pulse ox on right index finger showing saturation of 96% on 2 liters O₂ by nasal cannula. Ears and nares checked and are clear of irritation. Peripheral pulses are +2 at radius and +1 at dorsalis pedis pulses. Equal hand grips; left pedal push is weaker but unchanged since admission. Per flow sheet, voided clear amber urine at 0715. C/O abdominal pain of 7 on 0-10 pain scale. Abdomen firm, distended, and tender to slight touch. Bowel sounds hyperactive in RUQ and absent in remaining quadrants. States she does not know when she last had a bowel movement. No indication of BM on flow sheet since admission. Refuses breakfast stating she is nauseous. VS 148/92, 100.6 F (oral), 114, 24. -----E. Doe, LVN



Proper Documentation

Example #1: 03/21/14 0815

Dr. J Smith notified of change of status r/t abdominal pain, absent bowel sounds. STAT Abdomen series x-rays ordered and resident placed NPO,. -----E. Doe LVN

Example #1: 03/21/14 0900

Portable x-ray arrived at facility to perform STAT abdominal series -----E. Doe LVN

Example #1: 03/21/14 1000

X-ray results called to Dr. Smith. MD orders for resident to be transferred to hospital. ----E. Doe LVN

Example #1: 03/21/14 1010

Call placed to Metro Ambulance to transport resident to North Hills Hospital ASAP. -----E. Doe LVN

Example #1: 03/21/14 1020

Ambulance arrives to transport resident to hospital. Copies of all records provided to transport team. VS taken prior to release from facility: 144/94, 124, 24, 101.4F -----E. Doe, LVN



Proper Documentation

Example #2 04/18/2014

0645: Received report from the night nurse and assumed care. Assessment completed. VSS. Resident awake, alert and oriented. Complains of pain as an 8 on a scale of 0-10 in fractured right hip. Medicated with two Vicodin per MD orders. Will continue to monitor. Discussed plan of care with resident. Goals are to have pain level at or below 5 for the duration of the day and for resident to walk around nurse's station at least once by the end of the shift. Resident verbalized understanding. Call light within reach. -----A. Dunn, LVN



Proper Documentation

Example #3: 11/15/13 0815

Assessment performed, resident with C/O SOB, states “ I just can’t seem to catch my breath and I am coughing up green phlegm”. On auscultation, breath sounds decreased in bases bilaterally, coarse rhonchi bilaterally in upper lobes, accessory muscle use noted bilaterally, breathing is shallow and lips are cyanotic. Vital signs assessed; temp: 100.5, BP: 110/76, HR: 108, RR: 32, SpO2: 95% on room air. -----J.Smith, RN

Example #3: 0820

Assessment findings reported to Dr. Halifax----J. Smith, RN

Example #3: 0825

Resident assessed by Dr. Halifax -----J. Smith, RN



Poor Documentation

Example #1

6th Oct 09: Dave appears upset this morning and was reluctant to have his dressing changed. Dave complaining of a temperature and advised to take 2 paracetamol (500mgs) every 4 hours. Wound swab taken. Next visit for 7th October 2009 at 10.00

Example #2

“unresponsive and in no distress”

Example #3

“The need to maintain dialogue with the family regarding the appropriateness of limiting futile care to the resident is noted”



Poor Documentation

Example #4

“She diuresed pretty well. I gave her 40 of Lasix and she put out 2000 liters

Example #5

“Pleasant man lying comfortably in bed. Appears to be somewhat uncomfortable”

Example #6

“The resident is difficult historian. The question is as to what is going on with the patient”



Samples of Nursing flow sheets

The flow sheets shown below are just examples of some of the different types of flow sheets on the market. These examples should not be used for the purposes of charting on your residents. These are only examples



Nursing Assessment Flow Sheet

ADMISSION EVALUATION AND INTERIM CARE PLAN					
Resident Name: Last	First	MI	ID #	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Admitting Diagnosis:			Resident has Living Will: <input type="checkbox"/> Yes <input type="checkbox"/> No Copy placed on chart: <input type="checkbox"/> Yes <input type="checkbox"/> No		
History received by: <input type="checkbox"/> Resident and/or <input type="checkbox"/> Other (name/relationship)			Organ Donor: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Contact Person:			Relationship:		
Admitting Physician:			Primary Physician:		
Phone:			Phone:		
SECTION A MEDICAL HISTORY					
Arrival Time: <input type="checkbox"/> AM <input type="checkbox"/> PM		Room #:		Admission Date: / /	
<input type="checkbox"/> No major problems Endocrine/Metabolic <input type="checkbox"/> Diabetes <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism Heart/Circulation <input type="checkbox"/> Cardiovascular disease, describe: <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypotension <input type="checkbox"/> Peripheral vascular disease Musculoskeletal <input type="checkbox"/> Arthritis <input type="checkbox"/> Hip fracture <input type="checkbox"/> Missing limb <input type="checkbox"/> Osteoporosis Neurological <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Stroke <input type="checkbox"/> Hemiplegia <input type="checkbox"/> Aphasia <input type="checkbox"/> Dementia/DMS <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Seizure <input type="checkbox"/> Quadriplegia		Psychiatric/Mood <input type="checkbox"/> Depression Pulmonary <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema/COPD Sensory <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma Other <input type="checkbox"/> Cancer, etc. <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Kidney/bladder Other, describe: _____ Surgery, date: _____			
NURSING ADMISSION HISTORY/EVALUATION/CARE PLAN (must be completed by RN or LPN)					
Arrived via: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Stretcher		Orientation: <input type="checkbox"/> Oriented <input type="checkbox"/> Disoriented			
From: <input type="checkbox"/> Hospital <input type="checkbox"/> E.D.		<input type="checkbox"/> Activities <input type="checkbox"/> Fire policy <input type="checkbox"/> Roommate <input type="checkbox"/> Business Office <input type="checkbox"/> Mealtimes <input type="checkbox"/> Lighting <input type="checkbox"/> Staff <input type="checkbox"/> Telephone		<input type="checkbox"/> Smoking policy <input type="checkbox"/> Facility/floor plan <input type="checkbox"/> Bathroom <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Home: <input type="checkbox"/> Alone <input type="checkbox"/> With: _____ <input type="checkbox"/> Nursing Home: _____ <input type="checkbox"/> Other: _____		<input type="checkbox"/> Unable to orient, reason: _____			
Language(s) understood: <input type="checkbox"/> Eng. <input type="checkbox"/> Other: _____		ALLERGIES			
Language(s) spoken: <input type="checkbox"/> English <input type="checkbox"/> Other: _____		<input type="checkbox"/> None known Medication			
Prefers to be: _____		Reaction			
Religious/cultural practices: _____		Food			
Resident state of mind on admission: _____		Reaction			
Vitals Temperature: _____ <input type="checkbox"/> Oral <input type="checkbox"/> Axillary <input type="checkbox"/> Rectal <input type="checkbox"/> Tympanic Blood Pressure: Lying _____ Sitting _____ Standing _____ Pulse: _____ <input type="checkbox"/> Radial <input type="checkbox"/> Apical Respirations: _____ Weight: _____ Scale used: <input type="checkbox"/> Standing <input type="checkbox"/> Bed <input type="checkbox"/> Chair Height: _____		Other Reaction			



Daily Nursing Note Flow Sheet

SIDE ONE

DAILY SKILLED NURSE'S NOTE

Date: _____

VITAL SIGNS			
D:	E:	N:	
Temp: _____ Pulse: _____ <input type="checkbox"/> Unstable	Temp: _____ Pulse: _____ <input type="checkbox"/> Unstable	Temp: _____ Pulse: _____ <input type="checkbox"/> Unstable	
Resp: _____ <input type="checkbox"/> Unstable	Resp: _____ <input type="checkbox"/> Unstable	Resp: _____ <input type="checkbox"/> Unstable	
Pain: <input type="checkbox"/> No <input type="checkbox"/> Yes Describe on Side Two	Pain: <input type="checkbox"/> No <input type="checkbox"/> Yes Describe on Side Two	Pain: <input type="checkbox"/> No <input type="checkbox"/> Yes Describe on Side Two	

DIRECTIONS: For each shift, check (✓) all applicable boxes. Document specifics regarding Other Concerns and changes in condition on Side Two or per facility policy. After completion, sign under appropriate shift. Identify Services Provided on Side Two.

COGNITIVE	SKIN	GI	RESPIRATORY
Alert	Skin WNL	GI WNL	Normal breathing
Comatose	Skin Concerns	GI Concerns	Respiratory Concerns
Memory problems	Itching	Poor Appetite	Labored breathing
Short-term (unable to recall after 5 minutes)	Flash	Poor or restricted fluid intake	Shallow breathing
Memory/Recall problems	Abnormal turgor	Nausea/vomiting	Orthopnea
Current season	Abnormal skin color	Difficulty chewing	SOB:
Location of own room	Unusual temperature	Difficulty swallowing	On exertion
Staff names and faces	colder/warmer than adjacent skin	Abdominal distention	Chest
That he/she is in nursing home	Desensitized to pain or pressure	Bowel Sounds	Lung Sounds
Impaired decision making	Pressure Ulcer	Active	Crackles/rhonchi
Exhibiting signs/symptoms of delirium	Skin Tear/Cut	Hypoactive	Wheezing
Inattention	Surgical Wound	Hyperactive	Cough (if ✓, describe)
Disorganized thinking	Bruise	Normal	D: _____
Altered level of consciousness	Venous or arterial ulcer	Distended	E: _____
Psychomotor retardation	Other open lesion	Distended	N: _____
Other Concern(s) - note on Side Two	Diabetic foot ulcer	Bowel Control	O₂ needed
SENSORY/SPEECH	Infection of foot	Continence	D: O ₂ sats _____
Unable to hear	Other open lesions on foot	Incontinent	E: O ₂ sats _____
Difficulty seeing	Other Concern(s) - note on Side Two	Toileting program for bowel	N: O ₂ sats _____
Difficulty in speaking		Continence device	Nebulizer Treatment
Other Concern(s) - note on Side Two	GU	Other Concern(s) - note on Side Two	Suctioning
MOOD PROBLEMS	GI WNL		BIPAP/CPAP
Little interest/pressure in doing things	U Concerns	CARDIOVASCULAR	Tracheotomy
Feeling down, depressed, hopeless	Bladder distention/retention	Regular rhythm/WNL	Ventilator/respirator
Trouble falling/staying asleep/sleeping too much	Frequent urgency	Radial/Apical irregular	Other Concern(s) - note on Side Two
Tired/has little energy	Burning	Capillary refill sluggish	NEURO/MUSCULAR
Poor appetite or overeating	Urine Color	Neck vein distention	Gait steady
Feeling bad about self	E: _____	Chest pain	Gait unsteady
Trouble concentrating	N: _____	Abnormal peripheral pulses	Balance problem
Moving/speaking slowly or tired	Urine Consistency	Other Concern(s) - note on Side Two	Paralysis weakness
Thoughts of hurting self	E: _____	Edema (if ✓, complete below)	Syncope
Other Concern(s) - note on Side Two	N: _____	Location 1:	Decreased grasp
BEHAVIOR PROBLEM	Urine Odor	Dependent	Right
Hallucinations	E: _____	Pulmonary	Left
Delusions	N: _____	Pitting: 1+	RUE
Physical behaviors (bitting, banging, etc.)	Bladder Control	2+	LUE
Verbal behaviors (screaming, cursing, etc.)	Continent	3+	RLE
Other behaviors (e.g., incontinent)	Incontinent	4+	LLE
Physical evaluations (e.g., vital signs)	Pads/Briefs used	Location 2:	Abnormal pupil reaction
Physicals evaluate (e.g., care)	Bladder training or Toileting program	Dependent	Right
Physicals evaluate (e.g., care)	Incontinent	Pulmonary	Left
Other Concern(s) - note on Side Two	Dialysis	Pitting: 1+	Tremors
PHYSICIAN/JUNCTIONAL	Other Concern(s) - note on Side Two	2+	Vertigo
Code SP: Self Performance		3+	Other Concern(s) - note on Side Two
1 - Independent		4+	
2 - Supervised			
3 - Extensive assistance			
4 - Total dependence			
5 - ADL not performed			
Code SU: Support Provided			
0 - No set-up or physical help			
1 - Set-up help only			
2 - One person physical assist			
3 - Two person physical assist			
4 - ADL Did Not Occur			

Assessor's Signature/Title: _____

Resident's Name: _____ First _____ Initial _____ ID # _____ Room # _____

Assessor's Signature/Title: _____

Attending Physician: _____

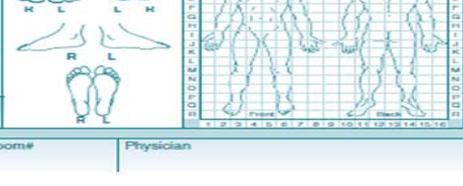


Nursing Skin Assessment Flow Sheet

SIDE ONE

WEEKLY SKIN INTEGRITY REVIEW

INDICATE NEW SITE(S) WITH AN "X"

<p>Skin Condition:</p> <input type="checkbox"/> Skin Intact <input type="checkbox"/> Dry <input type="checkbox"/> Bruises <input type="checkbox"/> Rash <input type="checkbox"/> Redness <input type="checkbox"/> Skin Tears <input type="checkbox"/> Blisters <input type="checkbox"/> Other _____ <input type="checkbox"/> Open Area: <input type="checkbox"/> New <input type="checkbox"/> Old <i>If Open Area, proceed to appropriate skin condition record.</i> <p>Signature/Title: _____ Date: _____</p>	
<p>Skin Condition:</p> <input type="checkbox"/> Skin Intact <input type="checkbox"/> Dry <input type="checkbox"/> Bruises <input type="checkbox"/> Rash <input type="checkbox"/> Redness <input type="checkbox"/> Skin Tears <input type="checkbox"/> Blisters <input type="checkbox"/> Other _____ <input type="checkbox"/> Open Area: <input type="checkbox"/> New <input type="checkbox"/> Old <i>If Open Area, proceed to appropriate skin condition record.</i> <p>Signature/Title: _____ Date: _____</p>	
<p>Skin Condition:</p> <input type="checkbox"/> Skin Intact <input type="checkbox"/> Dry <input type="checkbox"/> Bruises <input type="checkbox"/> Rash <input type="checkbox"/> Redness <input type="checkbox"/> Skin Tears <input type="checkbox"/> Blisters <input type="checkbox"/> Other _____ <input type="checkbox"/> Open Area: <input type="checkbox"/> New <input type="checkbox"/> Old <i>If Open Area, proceed to appropriate skin condition record.</i> <p>Signature/Title: _____ Date: _____</p>	
<p>Skin Condition:</p> <input type="checkbox"/> Skin Intact <input type="checkbox"/> Dry <input type="checkbox"/> Bruises <input type="checkbox"/> Rash <input type="checkbox"/> Redness <input type="checkbox"/> Skin Tears <input type="checkbox"/> Blisters <input type="checkbox"/> Other _____ <input type="checkbox"/> Open Area: <input type="checkbox"/> New <input type="checkbox"/> Old <i>If Open Area, proceed to appropriate skin condition record.</i> <p>Signature/Title: _____ Date: _____</p>	
<p>Skin Condition:</p> <input type="checkbox"/> Skin Intact <input type="checkbox"/> Dry <input type="checkbox"/> Bruises <input type="checkbox"/> Rash <input type="checkbox"/> Redness <input type="checkbox"/> Skin Tears <input type="checkbox"/> Blisters <input type="checkbox"/> Other _____ <input type="checkbox"/> Open Area: <input type="checkbox"/> New <input type="checkbox"/> Old <i>If Open Area, proceed to appropriate skin condition record.</i> <p>Signature/Title: _____ Date: _____</p>	
<p>Resident Name _____ MR# _____ Room# _____ Physician _____</p>	



Neurological Assessment Flow Sheet

NEUROLOGICAL EVALUATION FLOW SHEET

Suggested Frequency
Complete checks:
• every 15 minutes x 1 hour
• every 30 minutes x 2 hours
• every 1 hour x 2 hours
• every shift x 72 hours

Physician's orders for alternate neurological check frequency schedule:
• state frequency: _____

GLASGOW COMA SCALE: See reverse side for directions.

DATE	TIME	INITIALS	Eyes Open		Best Verbal Resp.		Best Motor Resp.		GCS Total		Pupils		Reflexes		Movement		Vitals	
			Spontaneously	4							Size	Right						
			To Speech	3							Reaction	Left						
			To Pain	2							Gag/Swallow							
			None	1							Corneal							
			Oriented	5														
			Confused	4														
			Inappropriate Speech	3														
			Incomp. Sounds	2														
			None	1														
			Obeys Commands	6														
			Localizes	5														
			Withdraws (pain)	4														
			Abnormal Flexion (pain)	3														
			Extension (pain)	2														
			No Movement	1														

© JAO MED. PASS, INC. Hospital Form MED-PASS 800-433-8884

Form 10/2015 (Rev. 1/11)

Initials Signature Initials Signature

Resident Name ID # Room # Physician

SIDE ONE



<https://www.youtube.com/watch?v=FZdkOwUC9LU>



References

- ❖ Advantage Consultants, Inc. Documentation Mini-Tool kit: Those Essential Basics.
<http://www.glatfelterhealthcarepractice.com/documents/HCCISToolkit.pdf>.
- ❖ College of Nurses of Nova Scotia. Documentation Guidelines for Registered Nurses.
<http://www.crnns.ca/documents/DocumentationGuidelines.pdf>.
- ❖ Keenan GM, Yakel E, Tschannen D, et al. Documentation and the Nurse Care Planning Process. Chapter 49: Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Agency for Healthcare Research and Quality <http://www.ncbi.nlm.nih.gov/books/NBK2674/>
- ❖ Med-pass documentation forms. <http://www.med-pass.com/>



References

- ❖ Texas Administrative Code (TAC): Title 22, Part 11, Chapter 217, §217.12 Unprofessional Conduct.
[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=11&ch=217&rl=12](http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=11&ch=217&rl=12)
- ❖ Texas Administrative Code (TAC): Title 22, Part 11, Chapter 217, §217.11 Standards of Nursing Practice.
[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=11&ch=217&rl=11](http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=11&ch=217&rl=11)
- ❖ Centers for Medicare and Medicaid(CMS) State Operations Manual (SOM). F514 §483.75 (I) Clinical Records.
<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-37.pdf>

