



# Documentation by the Nurse

Texas Health and Human Services  
Quality Monitoring Program



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





# Documentation Basics

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- ❖ 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





# What is documentation?

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- ❖ 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

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

- Clear
- Concise
- Correct
- Complete





# The Basics of Documentation

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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?

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- ❖ 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 reimbursement 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

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- ❖ 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







# Documentation and State Law

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## ❖ 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;





# Documentation and State Law

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## ❖ 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;





# Documentation and Federal Law

## ❖ Centers for Medicare and Medicaid State Operations Manual Appendix PP. F514, §483.70: Medical Records

### ➤ (I) *Medical records.*

- (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are—
  - (i) Complete;
  - (ii) Accurately documented;
  - (iii) Readily accessible; and
  - (iv) Systematically organized.
- (5) The medical record must contain—
  - (i) Sufficient information to identify the resident;
  - (ii) A record of the resident's assessments;
  - (iii) The comprehensive plan of care and services provided;
  - (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; and
  - (v) Physician's, nurse's, and other licensed professional's progress notes; and
  - (vi) Laboratory; radiology and other diagnostic services reports as required under §483.50





# What should be in your documentation?

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- ❖ 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

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- ❖ 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

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- ❖ 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

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- ❖ 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

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- ❖ 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

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- ❖ 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

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## 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 O<sub>2</sub> 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

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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

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## 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

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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

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## 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 acetaminophen (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

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## 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







**TEXAS**  
Health and Human  
Services

# Daily Nursing Note Flow Sheet

SIDE ONE

**DAILY SKILLED NURSE'S NOTE**

Date: \_\_\_\_\_

VITAL SIGNS			
D:	E:	N:	
Temp: _____	Temp: _____	Temp: _____	
Pulse: _____	Pulse: _____	Pulse: _____	
Resp: _____	Resp: _____	Resp: _____	
B/P: _____	B/P: _____	B/P: _____	
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 breath sounds
Comatose	<b>Skin Concerns</b>	<b>GI Concerns</b>	<b>Respiratory Concerns</b>
Memory problems	Itching	Poor Appetite	Labored breathing
Short-term (unable to recall after 5 minutes)	Rash	Poor or restricted fluid intake	Shallow breathing
Long-term	Abnormal turgor	Nausea/vomiting	Orthopnea
Memory/Recall problems	Abnormal skin color	Difficulty chewing	SOB:
Current season	Unusual temperature	Difficulty swallowing	On exertion
Location of own room	colder/warmer than adjacent skin	Abdominal distention	At rest
Staff names and faces	Desensitized to pain or pressure	<b>Bowel Sounds</b>	Present
That he/she is in nursing home	Pressure Ulcer	Active	Absent
Impaired decision making	Skin Tear/Cut	Hypoactive	Wheezing
Exhibiting signs/symptoms of delirium	Surgical Wound	Hyporeactive	Cough (if ✓, describe)
Inattention	Bruise	None	D: _____
Disorganized thinking	Venous or arterial ulcer	<b>Bowel Control</b>	E: _____
Altered level of consciousness	Other open lesion	Continent	N: _____
Psychomotor retardation	Diabetic foot ulcer	Incontinent	<b>O<sub>2</sub> needed</b>
Other Concern(s) - note on Side Two	Infection of foot	Toileting program for bowel	D: O <sub>2</sub> sats _____
<b>SENSORY/SPEECH</b>	Other open lesions on foot	Other Concern(s) - note on Side Two	E: O <sub>2</sub> sats _____
Unable to hear	Other Concern(s) - note on Side Two	Other Concern(s) - note on Side Two	N: O <sub>2</sub> sats _____
Difficulty seeing	<b>GU</b>	<b>CARDIOVASCULAR</b>	Nebulizer Treatment
Difficulty in speaking	GI WNL	Regular rhythm/WNL	Suctioning
Other Concern(s) - note on Side Two	<b>GU Concerns</b>	Radial/Apical irregular	BiPAP/CPAP
<b>MOOD PROBLEMS</b>	Bladder distention/retention	Capillary refill sluggish	Tracheotomy
Little interest/pleasure in doing things	Frequent urgency	Neck vein distention	Ventilator/respirator
Feeling down, depressed, hopeless	Burning	Chest pain	Other Concern(s) - note on Side Two
Trouble falling/staying asleep/sleeping too much	Discharge	Abnormal peripheral pulses	Paralysis weakness
Tired/has little energy	<b>Urine Color</b>	Other Concern(s) - note on Side Two	Syncope
Poor appetite or overeating	E: _____	<b>Edema (if ✓, complete below)</b>	<b>Decreased grasp</b>
Feeling bad about self	N: _____	<b>Location 1:</b>	Right _____
Trouble concentrating	<b>Urine Consistency</b>	Dependent	Left _____
Moving/speaking slowly or tidying	E: _____	Pulmonary	<b>Decreased movement</b>
Thoughts of hurting self	N: _____	Pitting: 1+ _____	RUE _____
Other Concern(s) - note on Side Two	<b>Urine Odor</b>	2+ _____	LUE _____
<b>BEHAVIOR PROBLEM</b>	E: _____	3+ _____	RLE _____
Hallucinations	N: _____	4+ _____	LLE _____
Delusions	<b>Bladder Control</b>	<b>Location 2:</b>	<b>Abnormal pupil reaction</b>
Physical behaviors (biting, hitting, etc.)	Continent	Dependent	Right _____
Verbal behaviors (screaming, cursing, etc.)	Incontinent	Pulmonary	Left _____
Other behaviors (e.g., incontinence)	Pads/Briefs used	Pitting: 1+ _____	Tremors
Physical evaluation for care	Bladder training or Toileting program	2+ _____	Vertigo
Other Concern(s) - note on Side Two	Dialysis	3+ _____	Other Concern(s) - note on Side Two
<b>PHYSICIAN FUNCTIONING</b>	Other Concern(s) - note on Side Two	4+ _____	
Code SP: Self Performance			
1 - Independent			
2 - Supervised			
3 - Extensive assistance			
4 - Total dependence			
8 - ADL Did Not Occur			
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			
8 - ADL Did Not Occur			

Assessor's Signature/Title: \_\_\_\_\_

Resident's Name Last First Initial ID # Room # Attending Physician







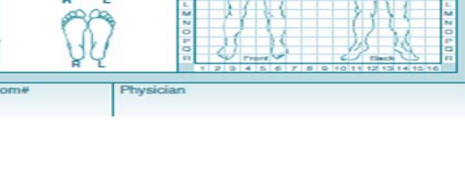


# Nursing Skin Assessment Flow Sheet

SIDE ONE

### WEEKLY SKIN INTEGRITY REVIEW

INDICATE NEW SITE(S) WITH AN "X"

<p><b>Skin Condition:</b></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> Signature/Title: _____ Date: _____	
<p><b>Skin Condition:</b></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> Signature/Title: _____ Date: _____	
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<p><b>Skin Condition:</b></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> Signature/Title: _____ Date: _____	
<p><b>Skin Condition:</b></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> Signature/Title: _____ Date: _____	
Resident Name _____ MR# _____ Room# _____ Physician _____	







**TEXAS**  
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# Wound Assessment Flow Sheet

SIDE ONE

**WOUND EVALUATION FLOW SHEET**  
 Pressure Ulcer or  Other Wound

INSTRUCTIONS: To be completed by nurse upon identification of pressure ulcer/wound and at least weekly from date of identification. For documentation guidelines reference form MP5465. Use one form for each pressure ulcer/wound. Document up to eight evaluations per form.

ACQUIRED -  In House  Admission  Other

SITE #	LOCATION	Measurements (cm)	Exudate	Wound Bed	Periwound	DATE
Date	L ___ W ___ D ___ @ X	Color: _____ Tunneling/ Sinus Tract/ Undermining	Amount: <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Scant <input type="checkbox"/> Heavy Consistency: _____ Odor: _____	Pain: <input type="checkbox"/> No <input type="checkbox"/> Yes, intensity _____ If infection or colonization present, describe: _____ Tissue Type, Color/percent/location: _____	Wound margins _____ Surrounding tissue _____	Current Treatment: _____ Date initiated _____ Current Preventative Interventions: _____ Date initiated _____ Nutritional and/or Medical Interventions (i.e., supplements, culture): _____ Date _____ Wound Status: _____ Other: _____ Assessor's Signature _____
Week #		9 12 3 6				
Stage/Type						
Date	L ___ W ___ D ___ @ X	Color: _____ Tunneling/ Sinus Tract/ Undermining	Amount: <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Scant <input type="checkbox"/> Heavy Consistency: _____ Odor: _____	Pain: <input type="checkbox"/> No <input type="checkbox"/> Yes, intensity _____ If infection or colonization present, describe: _____ Tissue Type, Color/percent/location: _____	Wound margins _____ Surrounding tissue _____	Current Treatment: _____ Date initiated _____ Current Preventative Interventions: _____ Date initiated _____ Nutritional and/or Medical Interventions (i.e., supplements, culture): _____ Date _____ Wound Status: _____ Other: _____ Assessor's Signature _____
Week #		9 12 3 6				
Stage/Type						
Date	L ___ W ___ D ___ @ X	Color: _____ Tunneling/ Sinus Tract/ Undermining	Amount: <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Scant <input type="checkbox"/> Heavy Consistency: _____ Odor: _____	Pain: <input type="checkbox"/> No <input type="checkbox"/> Yes, intensity _____ If infection or colonization present, describe: _____ Tissue Type, Color/percent/location: _____	Wound margins _____ Surrounding tissue _____	Current Treatment: _____ Date initiated _____ Current Preventative Interventions: _____ Date initiated _____ Nutritional and/or Medical Interventions (i.e., supplements, culture): _____ Date _____ Wound Status: _____ Other: _____ Assessor's Signature _____
Week #		9 12 3 6				
Stage/Type						
Date	L ___ W ___ D ___ @ X	Color: _____ Tunneling/ Sinus Tract/ Undermining	Amount: <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Scant <input type="checkbox"/> Heavy Consistency: _____ Odor: _____	Pain: <input type="checkbox"/> No <input type="checkbox"/> Yes, intensity _____ If infection or colonization present, describe: _____ Tissue Type, Color/percent/location: _____	Wound margins _____ Surrounding tissue _____	Current Treatment: _____ Date initiated _____ Current Preventative Interventions: _____ Date initiated _____ Nutritional and/or Medical Interventions (i.e., supplements, culture): _____ Date _____ Wound Status: _____ Other: _____ Assessor's Signature _____
Week #		9 12 3 6				
Stage/Type						

Resident Name \_\_\_\_\_ ID # \_\_\_\_\_ Room # \_\_\_\_\_ Physician \_\_\_\_\_

Form # MP5465 (Rev. 09/13) © 1997-2000 MED-PASS, INC. Provider Form # MED-PASS 800-456-8884 Scale# not authored by Jill Thomas 3/16/2020





# 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 \_\_\_\_\_

<b>Best Verbal Resp.</b>	
Spontaneously	4
To Speech	3
To Pain	2
None	1
<b>Best Motor Resp.</b>	
Orients	5
Confused	4
Inappropriate Speech	3
Incomp. Sounds	2
None	1
<b>Best Motor Resp.</b>	
Obeys Commands	6
Localizes	5
Withdraws (pain)	4
Abnormal Flexion (pain)	3
Extension (pain)	2
No Movement	1

**GCS Total**

Size	Right	
Reaction	Left	
<b>Reflexes</b>		
Gag/Swallow		
Corneal		
<b>Movement</b>		
Right Arm	Stim.	Rel.
Right Leg	Stim.	Resp.
Left Arm	Stim.	Rel.
Left Leg	Stim.	Resp.
<b>Vitals</b>		
Blood Pressure		
Pulse		
Respiratory Pattern		
Temperature		

Initials \_\_\_\_\_ Signature \_\_\_\_\_

Initials \_\_\_\_\_ Signature \_\_\_\_\_

Resident Name \_\_\_\_\_ ID # \_\_\_\_\_ Room # \_\_\_\_\_ Physician \_\_\_\_\_

SIDE ONE

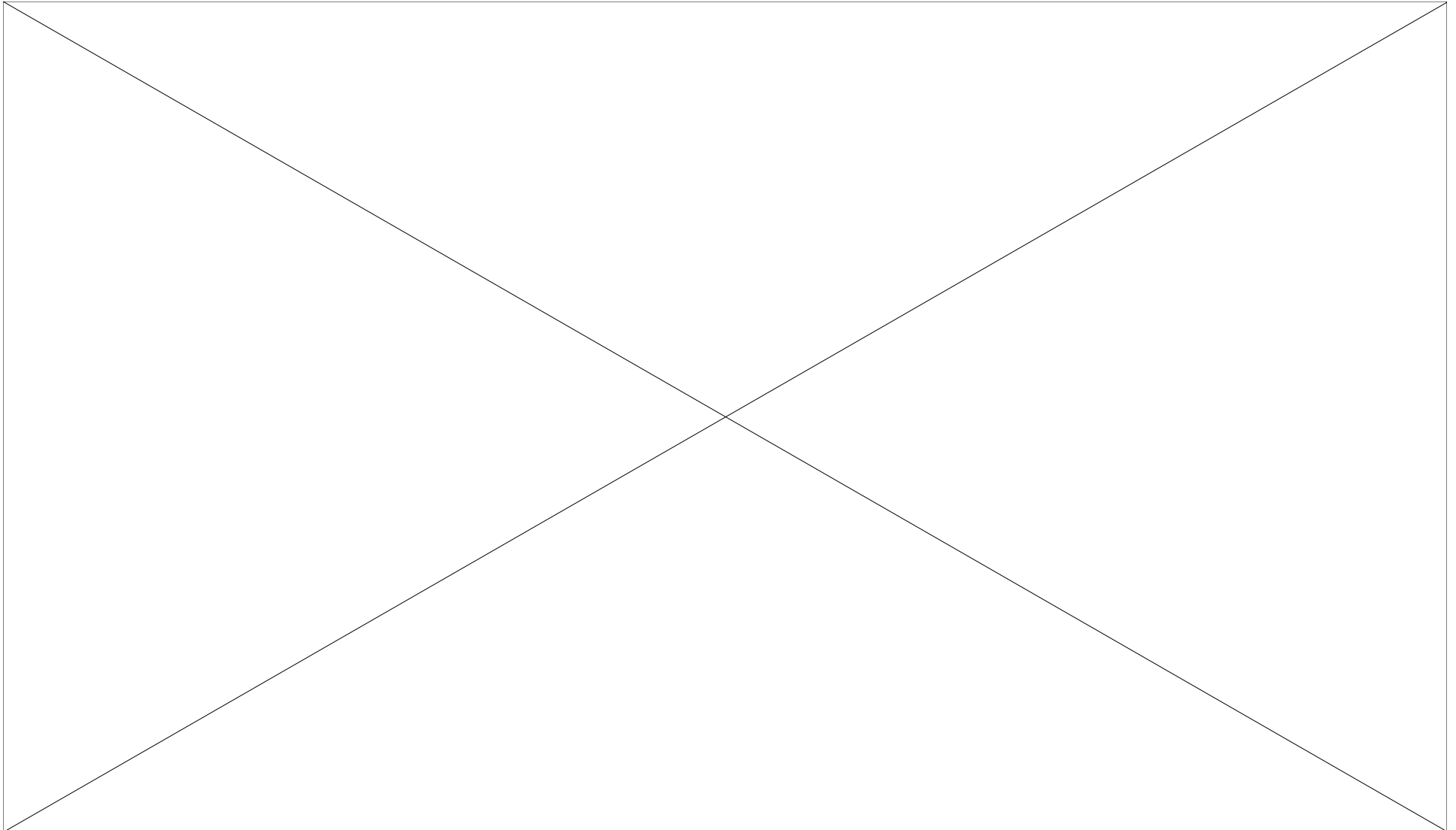






**TEXAS**  
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# Medical Record Review



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  - ❖ Med-pass documentation forms. <http://www.med-pass.com/>



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- ❖ 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>

