 <p>DR. PABLO O. TORRE MEMORIAL HOSPITAL</p>	Document Code:	DPOTMH-I-P09
	Effective Date:	10-15-2022
	Document Type:	Policy
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	Department/Section:	Nursing Service Division
	Document Title:	NURSING DOCUMENTATION

PURPOSE:

To provide accurate, clear, concise, complete and timely documentation of nursing procedures and assessments paves the way to quality patient care. It serves as proof that patient care was instituted.

LEVEL:


Nursing Service Division Staff of Dr. Pablo O. Torre Memorial Hospital (DPOTMH) and Student Nurses supervised by Clinical Instructors of Riverside College, Inc. (RCI)

DEFINITION OF TERMS:


Nursing documentation- is essential for good clinical communication. Appropriate documentation provides an accurate reflection of nursing assessments, changes in clinical state, care provided, and pertinent patient information to support the multidisciplinary team to deliver great care. Documentation provides evidence of care and is an important professional and medico-legal requirement of nursing practice.

POLICY:

1. Nursing documentation is the responsibility of the registered nurses; in the case of student nurses, it shall be countersigned by a clinical instructor or staff nurse assigned.
2. All documentation shall be written legibly as it is a basis for future care and research.
3. Documentation is an integral part of the nursing care plan.

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4. Generally, documentation includes nursing interventions and client responses to care and serves as a medium of communication between members of the health team.
5. Abbreviations are strongly discouraged and only universally accepted abbreviations shall be used.
6. The documentation shall be done legibly by the Nurse-in-charge. The following shall be used in recording all notations in the Nurses' Remarks per 12 hour shift:
 - 6.1. AM shift (6 AM-6 PM) should use black ink.
 - 6.2. PM shift (6 PM-6 AM) should use red ink.
7. Charting shall include:
 - 7.1. Date and time patient was received from ER, Dr, OR, Admitting, Hemodialysis, and other nurses' stations from the previous shift
 - 7.2. Status of the client (level of consciousness)/general assessment of patients
 - 7.3. Complete IV description
 - 7.4. Procedures done during the shift
 - 7.5. Patient's complaints
 - 7.6. If medications are given, is the patient relieved?
 - 7.7. Were diagnostic test results relayed or known by the attending physician?
 - 7.8. Was the attending physician informed of his patient's condition? Visited?
 - 7.9. Complications that may arise during the shift (medication errors, etc.)
 - 7.10. Tubes/apparatus attached
 - a) ET
 - b) NGT
 - c) Tracheostomy
 - d) Airway
 - e) Gastrostomy
 - f) Nasopharyngeal tube
 - g) Tenckhoff catheter
 - h) Subclavian catheter

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- i) Foley catheter
- j) Respirator
- k) Cardiac monitor
- l) Pulse oximeter
- m) Drip meter/infusion pump
- n) Syringe pump
- o) Suction apparatus
- p) Gomco apparatus

8. Any incidents that occur during the shift shall be documented accurately.

9. All charting shall be signed legibly by the nurse on duty, and the charting of volunteer and student nurses shall be countersigned accordingly.

DOCUMENTATION:


New Policy

DISSEMINATION:

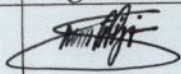
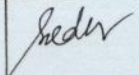


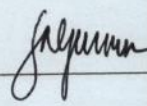
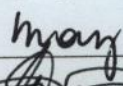
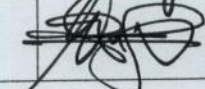
Policies and Procedures Manual
Hospital Communicator

REFERENCES:

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2. *Nursing Documentation Principles*. (n.d.). The Royal Children's Hospital Melbourne. Retrieved October 3, 2022, from https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/nursing-documentation-principles/

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