 <p>B.S. Aquino Drive, Bacolod City, Negros Occidental, 6100</p> <p>DR. PABLO O. TORRE MEMORIAL HOSPITAL</p>	Document Code:	DPOTMH-I-P09-S10
	Effective Date:	06-30-2022
	Document Type:	Standard Operating Procedure
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	Department/Section:	Nursing Service Division
	Document Title:	CHARTING

PURPOSE:

1. To document pertinent aspects of nursing care given to a patient and ensure that information is current and concise.
2. To detail patient health status-management and treatment at the time of admission and discharge.

SCOPE:


Applies to all Nursing Service Division (Department/Section/Unit) Staff of Dr. Pablo O. Torre Memorial Hospital (DPOTMH)

PERSON RESPONSIBLE:

Registered Nurse

GENERAL GUIDELINES:

- 1 All charting should be signed legibly by the nurse in charge and the charting of ISTP nurses and student nurses should be duly countersigned by the Clinical Instructor and Nurse on duty.
- 2 Clearly identifying who wrote the entry assists subsequent staff in determining the significance of management plans and who to consult if there is any doubt or change in the condition of the patient.
- 3 The use of correction fluid in the medical record is prohibited.
- 4 The only people with a right to access the chart of the patient are members of the treating clinical team.
- 5 The nurses notes shall give an accurate picture of the patient's progress for the purpose of communication with other shifting staff involved in the patient's management (e.g. nursing, allied health) and also in order to be of value in the future, where they may be needed for clinical investigations, research or medico-legal purposes.
- 6 Documentation
 - 6.1 All entries must be neat and legible.
 - 6.2 Capitalize, punctuate, and spell correctly.
 - 6.3 Only standard accepted abbreviations shall be used.


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- 6.4 The person recording must write his/her full name, affix his/her signature and title. When recording during a specified time, i.e., one shift, one signature is sufficient.
- 6.5 Signature should follow last recorded sentence, should be placed next line as last entry.
- 6.6 Charting continued on a new page: Bottom of page requires signature. The next page requires same heading with date and time.
- 6.7 Use adequate space for wording: Do not leave any blank lines or columns.
- 6.8 Never erase or obliterate an error. Errors are marked by crossing through words with one horizontal line, marked error, and initialed.
- 6.9 If quoting the patient, state exact words and place in quotation marks.
- 6.10 Ditto marks are not to be used in charting.
- 6.11 Record after an intervention has taken place, not before.
- 6.12 Keep record intact. Do not remove documents from the record for charting purposes.

7 Charting Rules:


- 7.1 Date and time patient was received from the previous shift from ER, DR, OR, Admitting, Hemodialysis and other nurses' station.
- 7.2 Keep record intact. Do not remove documents from the record for charting purposes.
- 7.3 Status of the client (level of consciousness)/general assessment of patients:
 - 7.3.1 Vital signs
 - 7.3.2 Complete IV description
 - 7.3.3 Procedure done during the shift
 - 7.3.4 Patients' complaints
 - 7.3.5 If medications were given, is patient relieved?
 - 7.3.6 Were diagnostic test results relayed or known by the attending physician?
 - 7.3.7 Was the attending physician informed of his patient's condition? visited?
 - 7.3.8 Complications that may arise during the shift (medication errors, etc.)

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7.4 Tubes/apparatus attached

- 7.4.1 ET
- 7.4.2 NGT
- 7.4.3 Tracheostomy
- 7.4.4 Airway
- 7.4.5 Gastrostomy
- 7.4.6 Nasopharyngeal tube
- 7.4.7 Tenckhoff catheter
- 7.4.8 Subclavian catheter
- 7.4.9 Respirator
- 7.4.10 Cardiac monitor
- 7.4.11 Pulse oximeter
- 7.4.12 Drip meter/infusion pump
- 7.4.13 Syringe pump
- 7.4.14 Suction apparatus
- 7.4.15 Gomco apparatus
- 7.4.16 Foley catheter drainage bag


8 Incidents/ accidents that happened to the patient during the time of his/her admission shall be included in the documentation.

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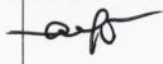

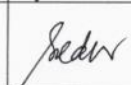


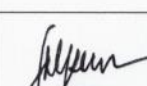
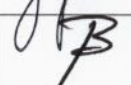
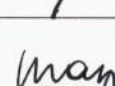
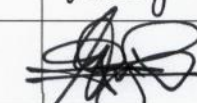
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PROCEDURES:

- 1 Nurse on duty makes an initial documentation by indicating the following:
 - 1.1 Data received during endorsement including attachments in a cephalocaudal manner
 - 1.2 Data gathered after rounds
- 2 Nurse on duty documents current status of patient, management/treatment and response base on focus charting.
 - 2.1 Focus/problem
 - 2.2 DATA (subjective or objective cues)
 - 2.3 Actions
 - 2.4 Response
- 3 Nurse on duty documents additional pertinent data not included in the FDAR under note below.
- 4 Nurse on duty ends the documentation by affixing his/her signature over printed name (Name stamp) at the end of the shift.


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APPROVAL:

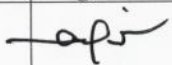




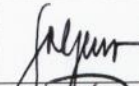

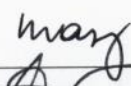
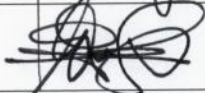
	Name/Title	Signature	Date
Prepared by:	ANTONIO O. LINACERO, RN Head Nurse		6/13/22
Verified:	RICHARD S. MONTILJAO, RN OIC Policy Development Officer		6/15/22
	SHALAINE SOCORO L. DURAN, RN Nurse Manager for Operations		6/15/22
	HANNAH KHAY S. TREYES, RN, MN Chief Nurse		6/15/2022
Reviewed:	DENNIS C. ESCALONA, MN, FPCHA, FPSQua Quality Assurance Supervisor		6/14/2022
Recommending Approval:	MARIA LIZA C. PERAREN, RN, MAN Nursing Director		6/15/2022
	FREDERIC IVAN L. TING, MD OIC- Total Quality Division		7/27/22
	MA. ANTONIA S. GENSOLI, MD, FPPS, FPCHA Vice President- Chief Medical Officer		7.29.22
Approved:	GENESIS GOLDI D. GOLINGAN President and CEO		11/11/22

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KEY TASKS	PERSON RESPONSIBLE
1. Makes an initial documentation on data received during endorsement including attachments in a cephalocaudal manner and data gathered after rounds.	Nurse-on-duty
2. Documents current status of patient, management/treatment and response base on focus charting.	
3. Documents additional pertinent data not included in the FDAR under note below.	
4. Ends the documentation by affixing his/her signature over printed name (Name stamp) at the end of the shift.	

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APPROVAL:

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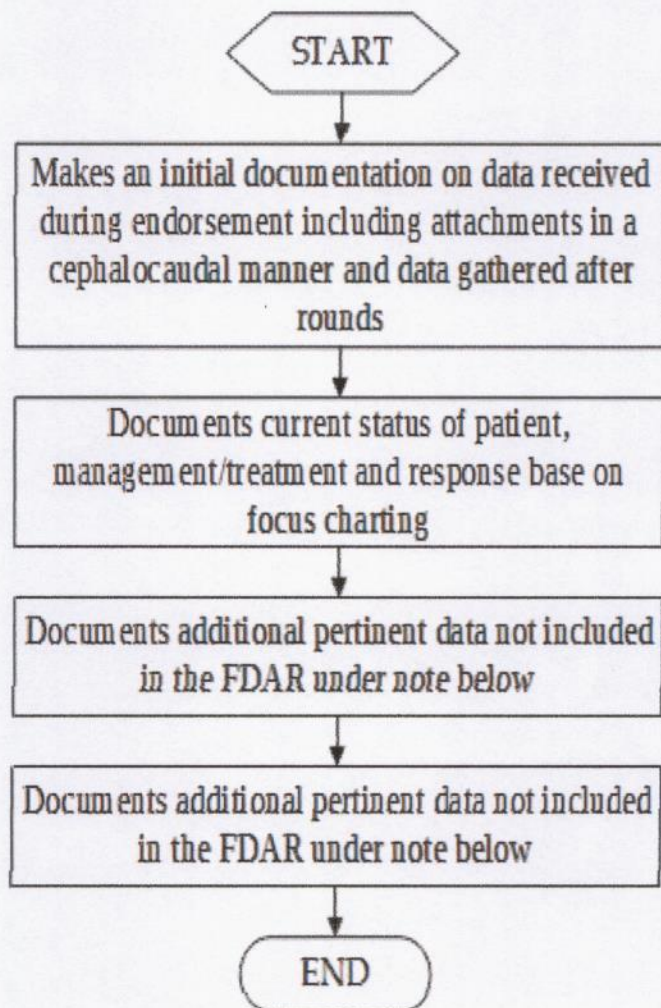



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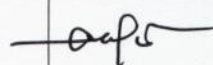




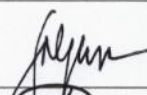

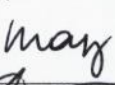
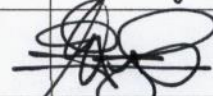
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