Department of Developmental Services
NURSING GUIDELINES

96.3 NURSING DOCUMENTATION GUIDELINES

Title: Guidelines for the Use of the Focus Charting

Outcome:

The nurse shall complete documentation of the individual's progress toward and achievement of outcomes utilizing focus charting. The attached form may be used or facilities may use existing forms as long as the focus method of documentation is used. (See Attachment A)

Nature:

1. The focus charting form is part of the permanent medical record.
2. Client, name, DDS number in left upper corner.
3. The form will be completed in blue or black ink.
4. Correct a mistaken entry by placing a single line through the entry and write "omit" above it and initial.

Definitions:

Focus Charting - is a method for organizing health information in the individual's record. It is a systematic approach to documentation, using nursing terminology to describe individual's health status and nursing action.

Focus

- a key word or diagnostic category from a nursing diagnosis or collaborative problem on the plan of care (action plan),
  i.e. skin integrity, coping, activity tolerance, self care deficit
- a current individual concern or behavior,
  i.e. nausea, chest pain, pre-op teaching, hospital admission
- a sign or symptom of (possible) importance to the nursing and/or medical diagnosis or treatment plan,
  i.e. fever, constipation, hypertension, incontinence, lethargy
- an acute change in an individual's condition,
  i.e. respiratory distress, seizure, fever, discomfort
- a significant event in an individual's care,
  i.e. begin treatment regimen (oxygen), change in diet, catheterization
- a key word or phrase indicating compliance with a standard of care or agency policy,
  i.e. self medication teaching plan, transition

Components of a Focus Note

Data: Subjective and/or objective information supporting the stated focus or describing observations at the time of significant

events.

Action: Nursing interventions performed, planned to be performed, and/or protocols and procedures initiated.

Response: Description of individual's response to medical and/or nursing care. Statement that the Action Plan of Care outcomes have been attained or are progressing toward attainment.

Applicable Population:

Is used for all individuals in all DDS operated programs.

Responsible Person:

Focus notes are written by RNs and LPNs.

Placement:

Nursing focus notes will be kept in the individual's medical/health or master file.

Detailed Instructions:

1. Date each sheet. Time every entry in corresponding column.
2. Write in the Focus column the individual's care focus as defined above.
3. Document the entry related to the focus in the **DAR** (data, action, response) section of the form. An entry may be one or any combination of Data, Action, and Response.
    a. **Data**: Document individual data obtained related to focus, identified by charting "D:", and then relevant data. When there is not any new data, the "D:" is omitted.
    b. **Action**: Document interventions performed related to focus identified by charting "A:", and then relevant information. When there are no interventions that have been performed, or are planned, omit "A:"
    c. **Response**: Document individual's response related to the action taken for the focus identified by charting "R:" and the relevant description of the objective and subjective patient response. When there are no new responses, the "R:" is omitted.

Formulated: October 1, 1996

Approved:

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