The Focus Charting System is the accepted documentation system at Windsor Regional Hospital.

Advantages of Focus Charting

- Flexible enough to adapt to any clinical practice setting and promotes interdisciplinary documentation
- Centers on the nursing process, including assessment, planning, implementation and evaluation
- Information is easy to find because data is organized by the focus
- It promotes communication between all care team members
- Encourages regular documentation of patient responses to care
- Helps organize documentation so that it is concise and precise
- Can be easily adapted to computer based documentation systems

Focus Charting Combines:

The Focus: It describes the focus of actions

DAR format: Is the structure used to document patient assessment, care interventions or actions and patient responses to the actions or care
The Focus System Uses:

- Flow Sheets
- Focus Lists
- Progress Notes
- Care Plans

Developing the Focus

<table>
<thead>
<tr>
<th>Refers To</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>A sign or symptom</td>
<td>Hypotension, or chest pain</td>
</tr>
<tr>
<td>A patient behaviour</td>
<td>Inability to ambulate</td>
</tr>
<tr>
<td>An acute change in the patient’s condition</td>
<td>Loss of consciousness or increase in blood pressure</td>
</tr>
<tr>
<td>A significant event in the patient’s therapy</td>
<td>Surgery</td>
</tr>
<tr>
<td>A special patient need</td>
<td>Discharge planning need</td>
</tr>
</tbody>
</table>

A focus may also be written in the format of a nursing diagnosis.
The Focus List

A **FOCUS LIST** sheet is used as an index or quick reference for what you will find in the progress notes. All disciplines should record on the focus list.

<table>
<thead>
<tr>
<th>No.</th>
<th>FOCUS</th>
<th>ACTIVE</th>
<th>RESOLVED</th>
<th>RE-INSTATED</th>
<th>DISCIPLINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inability to ambulate</td>
<td>11/12/01</td>
<td>11/12/01</td>
<td></td>
<td>Nursing, PT</td>
</tr>
<tr>
<td>2</td>
<td>Chest pain</td>
<td>11/12/01</td>
<td></td>
<td></td>
<td>Nursing</td>
</tr>
</tbody>
</table>

**Enter the Focus on the Focus List:**

- The focus is numbered in order that they are listed
- Document the focus
- The date the focus is identified is indicated in the active column
- The dates are entered if the focus is resolved or reinstated
- The discipline entering the focus should identify themselves.

**Additional Information**

- Focus Lists must be regularly updated and expanded as the patient’s condition changes.
- **Note:** At discharge, focus list needs to be checked to ensure that all the foci have been addressed and / or resolved.
The Use of Care Plans

Once a focus has been identified, a plan of care needs to be documented.

- All disciplines should have a plan of care.
- "Care Plans" are included either as a standard nursing care plan or as an entry in the progress notes under the "A".
- Standardized care plans should be activated with the patient and/or significant other's input in order to make it individualized.
- Care plans should be regularly updated as required.
- A Clinical Pathway is another example of a care plan available at WRH.

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### Nursing Interventions for ACTIVITY INTOLERANCE

**Nursing Diagnosis:** Activity Intolerance

**Related to:**
- history of previous intolerance
- deconditioned status/bedrest/immobility
- presence of circulatory or respiratory problems
- inexperience with activity
- lack of motivation
- sleep disturbance

**Assessment**

**Date:**

<table>
<thead>
<tr>
<th>Evidence/Manifestation</th>
<th>Nursing Interventions</th>
<th>Expected Outcomes/Goals</th>
<th>Date Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective Verbalizes</td>
<td>Check all items that apply</td>
<td>Check all items that apply</td>
<td>Check all items that apply</td>
</tr>
<tr>
<td>fatigue</td>
<td>place in proper body alignment when on bed rest</td>
<td>maintaining active or passive ROM with the use of physical therapy</td>
<td></td>
</tr>
<tr>
<td>weakness</td>
<td>provide safety measures &gt;night-light, side-rails, call bell within reach</td>
<td>increased activity by 5 minutes per day</td>
<td></td>
</tr>
<tr>
<td>sleep loss</td>
<td>identify activity the patient enjoys; eliminate activity that aggravates symptoms</td>
<td>perform ADL as able</td>
<td></td>
</tr>
<tr>
<td>decreased energy</td>
<td>administer pain medication 1 hour before activity and evaluate effectiveness</td>
<td>participates in progressive activity program</td>
<td></td>
</tr>
</tbody>
</table>

Objective

| decreased mobility     |
| diminished reflexes    |
| inability to perform ADL's |

| plan rest and activity periods | | | |
Flow Sheets

- There are numerous pre-printed flow sheets available at WRH.
- These are helpful in accurately and concisely documenting routine and frequently collected data.
- Use flow sheets whenever it is logical and helpful to do so. For example: Any documentation which is required on a regular basis by hospital policy or standard.
- Any nursing care activity which is provided on a regular basis (i.e. activities of daily living).

WINDSOR REGIONAL HOSPITAL

PEDIATRIC FLOW CHART

Respiratory Core Assessment
- Findings: Normal, labored, moans, use of accessory muscles, retractions
- Alarms: Sputum, cyanosis, change in condition

Nasal Airway: Clear or Nasal
Buzy: Spontaneous or Nasal
Breath Sound: Clear or Nasal
Sputum: Quantity, character, color, smell

Vascular Assessment
- Findings: T or P, BP, skin turgor, capillar refill
- Alarms: Change in condition, color, temperature

Pulse: Regular, normal
Blood Pressure: Normal
Skin: Moist, warm, turgor

Cardiovascular Core Assessment
- Findings: Heart rate, rhythm, conduction, murmurs, gallops
- Alarms: Change in condition, heart rate, rhythm

Pulse: Regular, normal
Blood Pressure: Normal
Heart Rate: 60-100
Rhythm: Regular
Conduction: Normal
Murmurs: None
Gallops: None

Gastrointestinal Core Assessment
- Findings: Bowel sounds, vomit, stool, feeding
- Alarms: Change in condition, feeding, bowel sounds

Bowel Sounds: Present or Absent
Vomiting: None or Intermittent
Stool: Normal or Constipated
Feeding: Normal or Naso-gastric

Renal Core Assessment
- Findings: Urine output, specific gravity, color, odor
- Alarms: Change in condition, urine output, specific gravity

Urine Output: Normal or Decreased
Specific Gravity: Normal or Increased
Color: Clear or Cloudy
Odor: Normal or Ammonia

Nervous System Core Assessment
- Findings: Level, orientation, speech, gait, motor function
- Alarms: Change in condition, level, orientation

Level: Alert, Oriented, Cooperative
Speech: Normal or Slurred
Gait: Normal or Ataxic
Motor Function: Normal or Weak

Hemodynamic Core Assessment
- Findings: Blood pressure, pulse, skin turgor, capillar refill
- Alarms: Change in condition, blood pressure, pulse

Blood Pressure: Normal
Pulse: Regular, normal
Skin: Moist, warm, turgor

Hematologic Core Assessment
- Findings: Blood count, hemoglobin, hematocrit, INR
- Alarms: Change in condition, blood count, hemoglobin

Blood Count: Normal or Decreased
Hemoglobin: Normal or Decreased
Hematocrit: Normal or Decreased
INR: Normal or Increased

Pharmacology Core Assessment
- Findings: Medications, allergies, side effects, compliance
- Alarms: Change in condition, medications, allergies

Medications: List or None
Allergies: List or None
Side Effects: None or Intermittent
Compliance: Isolated or Continuous

Plan: Corrective or Preventive
Implementation: Immediate or Delayed
Follow-Up: As Needed or Daily
Examples of Flow Sheets

- vital signs record
- medication record
- intake and output
- post op flow sheet
- wound assessment record

Things to Remember

- All flow sheets must be correctly dated and must contain the patient’s name on both sides.
- All entries on the flow sheets must be initialed (no use of check marks) by the person who assesses or provides the care and must have initials with full signature on a master copy.
- Any variances from normal should be recorded in DAR format.
Progress Notes

Are Used to:

- Provide detail to data in a flow sheet
- Document patient response to care
- Record an unusual or unexpected event
- Record changes in patient condition and notification to the MD
- Describe the status of the patient at the time of admission, transfer from one nursing unit to another, or at the time of discharge

When writing progress notes you should include information about:

- The details about the patient’s condition (assessment data)
- The interventions or nursing actions implemented and their effectiveness
- The patient’s response to care

How to Complete a Progress Note

When starting a note the focus is documented first.

- Notes are chronologically entered. The date and time is documented in the columns provided. The time and date you are actually writing the note is used.
- The service or discipline writing the note is recorded
- In focus charting the structure of the progress note that follows the focus uses a DAR outline: Data, Action Response

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>D - Assessment done as per referral-------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Left hand swollen. Digits in extension.---</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Painful to passive ranging.-------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A - Discussed splint use and benefits with Pt.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Splint molded. On-off schedule developed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R - Pt. concerned splint will be painful</td>
</tr>
<tr>
<td></td>
<td></td>
<td>----K Smith OT</td>
</tr>
</tbody>
</table>
D.A.R. is an acronym

**Data** - subjective & objective patient assessment data that supports the Focus Statement or describes observations of a significant event

**Action** - immediate or future actions or plans of action or care based on the evaluation of assessment data

**Response** - the patient response to the action taken.

**Things to Remember About Progress Notes**

The Response may not need to be immediately charted. There may not be an immediate response, therefore, only Data and Action may be charted. Eventually, there should be a Response entered to that action taken.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Nrsg. Wound Dressing</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 June 98</td>
<td>1000</td>
<td>D - Moderate amount of purulent, foul smelling drainage from abdominal incision noted. Suture line red and swollen and warm to touch. T 39.5°C complaining of pain at the site.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A - Dr. B. Jones notified and informed of patient's incisional status, orders received. Analgesic and antipyretic given as ordered, C&amp;S of wound taken and sent to Lab. Wound cleansed with antibacterial solution and dry drsg. Applied.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R - T38. Patient states incisional pain improving. Dressing remains dry and intact, no discharge noted. Antibiotic initiated as ordered.</td>
</tr>
</tbody>
</table>

- There may be more than one focus that requires charting at one time
- Progress notes must have a signature after each entry
Write patient progress notes only when necessary. The goal is to minimize duplication of information and to save time.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 June 98</td>
<td>1700</td>
<td><strong>Nrsgr.</strong> #1 pneumonia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D - pt. c/o of chest pain on inspiration, fatigue.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>T-39.5 at 1515, wheezy breath sounds, productive cough for purulent tenacious sputum. IV infusing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A - 02 at 3 litres, chest x-ray this am, sputum for C&amp;S referral for chest physio. Tylenol ii for elevated temp at 1520. Fluids encouraged.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R-T @1620 - 38---------------------Amy Nurse, RPN</td>
</tr>
</tbody>
</table>

**Focus Charting Do’s and Don’ts**

Progress notes can be improved by choosing language which is:

- Objective
- Precise
- Specific
- Thorough

Inconsistencies in documentation can leave you and the health care facility open to accusations of incompetence.

A medical record containing inconsistencies can be difficult to defend in court. **DO NOT** use words like confused, uncooperative and depressed. These words may be interpreted in different ways and are not specific in accurately describing the patient.

<table>
<thead>
<tr>
<th>Poor Wording</th>
<th>Good Wording</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eats poorly</td>
<td>Ate ½ the meal and drank 80 ml fluid</td>
</tr>
<tr>
<td>Patient confused</td>
<td>Patient unable to recognize family</td>
</tr>
<tr>
<td>Uncooperative</td>
<td>Refuses to assist with am care</td>
</tr>
<tr>
<td>Patient complaining of pain</td>
<td>Complaining of constant, sharp RUQ abd. Pain</td>
</tr>
<tr>
<td>Good day</td>
<td>Patient states has been pain free without medication and still able to complete activities of daily living</td>
</tr>
<tr>
<td>Diuresing well</td>
<td>Lasix 10 mg IV at 1430 resulted in 1000 ml of clear, yellow urine</td>
</tr>
<tr>
<td>Walking ad lib</td>
<td>Walks around the unit, up to the elevator and back to room without any discomfort</td>
</tr>
</tbody>
</table>

Remember to be factual, specific, precise, and thorough. Avoid summarizing or using value judgments.