POLICY:

Greenville Hospital System Nurses will use Focus Charting® as the methodology of organizing the narrative documentation.

Registered Nurses will document assessments, actions and responses using the focus charting methodology. The Registered Nurse will also document a FOCUS summary note on patients assigned to the Licensed Practical Nurse.

The Licensed Practical Nurse can document observations and actions taken and the patient’s subjective response as well as observed data resulting from the action taken.

The unlicensed assistive personnel staff may document procedures/events as a statement in a FOCUS Note.

A Focus Note will address specific activities and interventions on a shift. A FOCUS summary note which is to be documented prior to the completion of each shift includes the registered nurse’s evaluation of the patient’s progress toward outcomes/discharge.

The focus is identified on the Interdisciplinary Plan of Care or clinical pathway as the patient concern or behavior. The documentation will be integrated with the Interdisciplinary Plan of Care and the clinical pathway. The data for the focus format is based on the Outcome Status evaluation included in the Interdisciplinary Plan of Care.

A focus is NOT a medical diagnosis. A focus is a statement of what is happening to the patient which, at times, is a result of the medical diagnosis. (i.e., diabetes is a medical diagnosis).

Focus Note:

Focus Charting® will use the format of focus or topic notes organized to include:

1. **Data**: Subjective, assessment, objective, and observation data that supports the focus.

2. **Action**: Describes nursing interventions or actions such as medication, treatment, calls to the physician, and patient teaching.

3. **Response**: Record patient’s response or evaluation to nursing interventions or actions. This entry may be added at a later time if necessary.
Examples of when Focus Charting® notes must be completed:

1. at the time of admission;
2. with change in condition or any untoward event potentially impacting the patient’s plan of care;
3. with a variance from the expected outcome(s) on Interdisciplinary Plan of Care or Clinical Pathway;
4. at the time of intra-unit or intra-hospital transfer;
5. with progress toward goal of expected outcome(s) on Interdisciplinary Plan of Care or Clinical Pathway;
6. with symptoms requiring an intervention or action;
7. with patient’s response to newly initiated interventions;
8. at the time of discharge, including the actual time the patient left the nursing unit.

Summary Note:

This note includes a summary of the patient’s events and care during a period of care. Content of the summary note includes but not limited to the following:

- Progress toward outcomes/discharge
- Events during the shift which may include activity, nutrition, vital signs, intake and output (including bowel movement), procedures, mental status, family support
- A lack of improvement in the patient’s condition

PERSONNEL:

Registered Nurses, Licensed Practical Nurses and unlicensed assistive personnel will document using the FOCUS note format.

DESIRED OUTCOME:

Standardized methodology for documenting the implementation and evaluation of the patient’s plan of care.

SUPPORTIVE DATA:

GHS Nursing Staff Policies & Procedures:  Document 11 – Interdisciplinary Plan of Care
Document 16 – 24-Hour Flow Sheet
NursCare 3: Patient Assessment

GHS Nursing Staff Policy NS-1-9: Supervision of Student Nurses

NOTE: For routine documentation, the Focus Charting® methodology and FOCUS Summary Note will not be used in the Emergency Department, Perioperative Areas, Labor and Delivery, or Neonatal Intensive Care Units.
REFERENCES:


AUTHORS:

Documentation PI Team Subcommittee

REVIEWED BY:

Nursing Clinical Practice Council

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APPROVAL SIGNATURE APPEARS ON THE ORIGINAL DOCUMENT ON FILE IN THE OFFICE OF THE CHIEF NURSING OFFICER FOR:

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