Focus Charting

What is Focus Charting?
› Focus charting is a method of nursing documentation that was developed in order to help nurses condense the extensive data that is recorded on patient flow sheets in a concise statement that is called the focus note. Focus charting is referred to as such because of its “focus” on the patient
• What: Focus charting is different from the narrative nursing note, which can be lengthy, focus primarily on nursing tasks, and fail to address the patient’s concerns or the outcome of nursing interventions. Focus charting is patient-centered and emphasizes the critical thinking skills that are utilized by the nurse in making clinical decisions. In addition, focus charting is based on the nursing process framework
• How: The focus note is comprised of four distinct components, the first component being the focus (i.e., purpose or content) of the note. The three remaining sections are usually documented using the Data-Action-Response method: Data includes both objective and subjective information, Action is the nursing intervention(s) applied, and Response is the outcome or patient response to the intervention(s)
• Where: Focus charting is appropriate for use in all clinical settings
• Who: Focus charting is used not only by nurses but by other clinician specialists, including therapists, dietitians, and mental health clinicians

What Is the Desired Outcome of Focus Charting?
› Focus charting is performed with the goal of minimizing charting time while applying the nursing process framework to produce patient-centered nursing documentation

Why Is Focus Charting Important?
› Focus charting is a concise method of documentation that minimizes charting time
› Increasing emphasis is being placed on providing measurable care that is centered on the patient’s unique needs. In the focus note, nursing interventions are directly linked with a specific patient concern or problem and a detailed outcome so that each intervention is clearly defined. Focus notes thus provide legal evidence of care and serve as a good defense against legal claims
› Focus charting is cost-effective; it reduces documentation time, includes only pertinent information, and is more concise than the narrative method of charting
› Unlike narrative note taking, focus charting is appropriate for use in all clinical settings, including ambulatory and outpatient care settings
› Focus charting is outcome-driven in that it encourages nurses to write notes that describe progress toward desired patient outcomes
› Because focus notes are organized by topic, it is easy for nurses and other clinicians to search the notes and find needed information related to the patient’s nursing care

Facts and Figures
› Authors of a review of the various types of nursing documentation (including narrative charting, the VIPS model, the SOAP/SOAPIER method, clinical care pathways, and focus charting) chose to implement focus charting in their organization after completing the review. Nurses were able to utilize focus charting following staff education, and audits revealed that there was a remarkable improvement in documentation (Blair et al., 2017)
Focus charting was developed at Eitel Hospital in Minneapolis, Minnesota in 1980. The purpose of its development was to streamline nursing documentation and eliminate double charting, while ensuring that nursing documentation continued to rely on the nursing process and continued to be acceptable to regulatory organizations (Bleich et al., 1992)

What You Need to Know Before Focus Charting

Knowledge of the benefits of focus charting is important

- Focus charting improves nursing time management, reduces healthcare costs, is patient-centered, and provides legal evidence of clearly defined nursing care. For more information, see Why Is Focus Charting Important?, above

Knowledge of the components that comprise a focus note is essential

- The 4 components of a focus note include the following:
  - **Focus**, or topic of discussion which may be written as a nursing diagnosis or a patient concern (e.g., sign or symptom), problem, or behavior (e.g., “Fluid Management” or “Risk for Infection”)
  - **Data**, which includes subjective patient statements (e.g., “My leg hurts”) and/or objective findings (“BP 180/90”)
  - **Action**, which is the applied nursing intervention (e.g., “Demonstrated coughing and deep breathing techniques” or “Administered zolpidem 5 mg for insomnia”)
  - **Response**, which is the outcome to the intervention. This may be the patient’s subjective response (e.g., “Patient verbalized understanding of discharge instructions”) and/or objective assessment finding (e.g., “Patient has his eyes closed and is lying still, and breathing is 10 per minute”) related to the intervention

- Each focus entry need not include all three Data, Action, and Response statements. Data, Action, and Response statements can be entered separately and whenever needed, but each entry must be preceded by a focus

- Focus charting is typically formatted with 3 columns
  - The far-left column is for the date and time
  - The middle column is for documenting the focus
  - The far-right column is for documenting the nursing or progress note including the Data, Action, and Response notes

Knowledge of facility protocols and regulatory agency requirements for nursing documentation is essential

- Facilities vary with regard to the format that must be used to document nursing care in various clinical settings; however, nurses in all clinical settings are required to document applied interventions. In addition, The Joint Commission requires that all information entered into the medical record (The Joint Commission, 2018)
  - is dated and timed
  - is signed
  - includes observations pertinent to the patient’s treatment and care
  - includes the patient’s response to treatment and care

Preliminary steps that should be performed prior to focus charting include the following:

- Review components of the nursing process for inclusion in the focus note
- Review facility protocol for nursing documentation. Note how frequently focus notes must be charted
- Perform a patient assessment to gather information related to current concerns, appropriate interventions, and patient responses

Gather supplies, which include the following:

- Patient’s medical record (paper or electronic)
- Ink pen

How to Perform Focus Charting

Enter the current date and time in the left column or other appropriate location on the form

Document the **Focus** of the note

- This is usually documented in the middle column separate from the note itself and preceded by the current date and time in the left column. Writing the focus in a separate column aids in locating all related entries

Document Data-Action-Response in the right column

- Document data related to the patient’s concern (Data-Action-Response)
  - It is usually sufficient to precede this entry with the letter “D”
  - This information can be subjective and/or objective and might be related to the patient’s physical, psychosocial, emotional, or spiritual needs
  - The patient might have more than one concern, however, each of the patient’s concerns should be documented in a separate focus note
• Document the action applied to address the concern (Data-Action-Response)
  – It is usually sufficient to precede this entry with the letter “A”
  – Like all components of the focus note, this component should be concise but complete and adhere to facility documentation standards
    - For example, it is inadequate to write “medicated for pain.” Rather, you would write, “Administered 2 mg Dilaudid by mouth for pain”
• Document the response to the intervention (Data-Action-Response)
  – Precede this entry with the letter “R”
  – The response should be patient-centered and may be subjective or objective
    - For example for a subjective response, “Patient appears to be sleeping comfortably at this time”
› Draw a line through any blank space at the end of your entry, then sign the entry using full name (not initials) and credentials
› Create a separate focus entry for each new patient concern

Other Tests, Treatments, or Procedures That May be Necessary Before or After Focus Charting
› Write new focus notes when the patient’s condition changes, when new patient concerns arise, or when new interventions and responses have occurred

What to Expect After Focus Charting
› Nursing documentation is concise, patient-centered, outcome driven, and based on the nursing process framework

Red Flags
› Make sure that each focus note is accurately labeled with the date, time, and full signature. Never erase or scratch out entries.
   If errors are made, place a single line through the entry and initial next to the error
› It is important to complete focus notes in a timely fashion, however, do not chart interventions before performing them or responses before they occur. Do not be concerned that entries entered at a later time are invalid or will be missed. When documenting at different times and on separate pages in the medical record, the Focus will provide continuity and unify all related entries

What Do I Need to Tell the Patient/Patient’s Family?
› Encourage patients to communicate with the nurse clinician so that he/she may accurately document their concerns and apply appropriate nursing interventions to resolve issues

References