

PROCEDURE FOR: Documentation: Charting by Exception-Assessment Parameters

- POLICY:**
1. A progress note will be written whenever a variance from unit-specific assessment parameters (Appendix A) is identified.
 2. More than one related variance may be consolidated into a single progress note.

EQUIPMENT: Progress notes
Flow sheet

PROCEDURE:

<u>ACTION</u>	<u>POINTS OF EMPHASIS</u>
1. Place (*) on the patient's flow sheet when a variance is identified.	See Appendix A.
2. Write a corresponding progress note.	

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 12/97

REVISION DATES: 3/02

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APPENDIX A

NOTE: These parameters are listed on page four of the Oncology 6 Nursing Flowsheet.

CHARTING BY EXCEPTION (CBE) GUIDELINES:

Listed below are considered NON-VARIANCES.

Each piece of data entered must be evaluated.

- If within limits place ✓ in variance column
- If a new variance place * in variance column
- Ongoing variance place → in variance column
- NEW VARIANCE REQUIRES A DAR NOTE.

NOTES NEEDED FOR:

- Admission, discharge or transfer
- Every shift while receiving chemo
- Post-op a note needed q shift x 24 hours
- Family meeting or significant event
- Code blue or death

PARAMETERS: MD orders will supersede this list:

- Cardiovascular: HR reg, skin-pink, warm, edema: 0 - 1
- Central lines: site benign
- Chemotherapy: Must chart q shift chemotherapy received
- Edema: 0 - 1; any pitting is considered > 1
- Emesis: not occurring
- GI: soft, non-distended, + bowel sounds + quadrants
- GU: clear, yellow
- Lab results: per MD order or if result/clinical sx causes concern
- Mentation: AAO X 3
- Neuro: No changes in LCO
- Pain Scale: Rating < 5
- Pulse Oximetry > 90% Resp: clear, equal bilaterally
- Sedation Scale Rating ≤ 1
- Skin: Intact
- Sputum Color/Amt: clear/white, small amt
- Stool: no diarrhea or constipation
- Transfusions RBC/PLT: no reactions
- Urine Output: per MD order or > 30 ml/hr, clear, no dysuria
- Vital Signs (T, HR, B/P, RR) per MD order parameters